

# CLINICAL TRIALS DIRECTIVE

— *it is nothing more than good practice*

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**T**he Clinical Trials Directive 2001/20/EC was brought into UK law through the statutory instrument SI 2004/1031 on 1 May 2004. This brings into force the controls on the preparation and testing of clinical trial materials, now known as Investigational Medicinal Products (IMP).

It may surprise many that this is the first time that any legal controls are imposed on the preparation of trial materials, which are used to judge whether or not a licence is granted for the marketing of medicinal products. Such controls are to be welcomed — it is 35 years since controls were placed on the manufacture of medicines. It is only now that the fundamentals behind the marketing of licensed medicines are to be controlled.

All clinical trials products will now have to be made under a Clinical Trials Authorisation (CTA) in a licensed site, with a manufacturer's authorisation for investigational medicinal products (IMP[MA]), issued by the Medicines and Healthcare products Regulatory Agency (MHRA) and released by a Qualified Person (QP). The trials will have to be under the control of a named sponsor whose responsibility it will be to ensure that all the regulations are complied with. The gains that will be accrued should easily outweigh the hassle of the inevitable bureaucracy, which is designed to ensure the quality of IMPs and the protection of patients on the trial and future users of medicines.

The increasing sophistication of modern medicines requires an approach to validation of trial

data and materials which is suited to the 21st century rather than the 19th century. It is this data, based on the trial products, which goes to justify the marketing and use of the medicine. We are all aware of what happens when the foundations of any structure are faulty.

Initial concerns regarding the future viability of non-commercial trials, due to the difficulty surrounding the definition of a potential sponsor particularly for multi-centre trials, has been overcome by a healthy dose of good British compromise. Where responsibility can be apportioned between involved bodies then multiple sponsors can be named. The continuance of these multi-centre, non-commercial trials is essential to the future health of the public. It was only through public funding that the health gains of aspirin in heart disease prevention, magnesium sulphate in pre-eclampsia, the complex multi-product regimens from different companies used to treat cancer and HIV, and many other non-profitable, or non-company specific, medicines are known.

On the introduction of the statutory instrument there is an allowance for the creation of QPs in the hospital pharmacy via the "Grandparent Clause", however, future QPs will be required to qualify via the permanent provisions. Unless those provisions are changed to allow experience in the preparation of IMPs to be recognised as a basis for QP qualification, then the NHS will be unable to release IMPs in the future. This issue will need to be addressed as a matter of urgency if we are serious about the continuance of non-commercial trials in the NHS.

As an interim it is incumbent on all who comply with the "Grandparent Clause" to register

as a transitional QP under the existing statutory instrument. It must be noted that these rights will expire in two years. Registration now will safeguard the near future and give breathing space for the arguments to develop on the evolution of future QPs in the health service. This is a problem unique to the UK. Our European colleagues are automatically eligible, as pharmacists, to become QPs.

## TAKE THE LEAD

All these trials are concerned with the use of medicines, and pharmacy must take a lead role in advising on the implementation of the law. There are strategic alliances to be formed with the research and development leads and the ethics committees, both of which are given strength in the new law. But hospital pharmacists, who are charged with the keeping of all investigational medicinal products in hospitals, and have the experience of the regulatory authorities through their licences with "specials", are in a commanding position to take a lead on advising on the supply and handling of the trial materials. Guidance on the interpretation of the statutory instrument and the basis of a good practice guide is available on the Department of Health sponsored website, [www.ncchta.org](http://www.ncchta.org)

There is a degree of foreboding within the multi-professional groups looking after clinical trials due to the added bureaucracy that is now being introduced. Many fear that it is the death knell of the local entrepreneurial researcher and that all but the largest commercial clinical trials will now cease. This is not the aim of the directive, nor the subsequent

statutory instrument, and it is the responsibility of hospital pharmacists who have experience in the preparation and handling of "specials", and the incumbent bureaucracy, to assure other health care colleagues that this statutory instrument is to be welcomed and not regretted.

It is to be hoped that the regulations are seen as nothing more than good practice which is currently being implemented by the majority of sites, but will now have to be monitored and validated. The good clinical practice inspections, against the International Conference on Harmonisation Good Clinical Practice (ICH GCP) guidelines, are new but we are privileged to be served by a practical, supportive regulatory authority and compliance will not be an issue to the majority.

In summary we are now entering a new phase in the assurance of the quality of medicines. The quality of the test substance is to be controlled, the circumstances in which it is used will be controlled and each trial will be registered (*Pharmaceutical Journal* 2003;271:618–22), and an outcome noted, whether it be good, bad or indifferent. This is not before time, bearing in mind the current complaints in the press regarding the lack of reporting of clinical trials information. As quoted in the *BMJ*, "there have been some one million clinical trials since 1948 but the results of only half have ever been published". Even though the European database is currently only available to regulatory authorities it will be an improvement on the current situation. We can now be assured that the information will be made available to those making decisions on awarding licences for the marketing of medicinal products.

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