Council for International Organizations of Medical Sciences

9th meeting of the CIOMS Working Group on Patient Involvement

5 July 2021, virtual meeting

Minutes

Participants
Leanne Angst-Wu (Roche), Alex Asiimwe (Bayer)*, Nathalie Bere (EMA), Stella Blackburn (IQVIA), Stephen Heaton (Bayer), Sanna Hill (CIOMS), Shinji Hirasawa (PMDA), François Houÿez (EURORDIS), Stefan Kaehler (Celgene), Regina Kamoga (CHAIN), Talia Lacroix (Health Canada), Ana Macarenco (Pfizer)*, Dinesh Mehta (EMA), Sten Olsson (ISOP), Lembit Rägo (CIOMS), Theo Raynor (formerly Leeds University), Ken Sakushima (PMDA), Corinna Schaefer (WMA), Kawaldip Sehmi (IAPO), Sabine Straus (MEB), Christine Stürchler (Novartis), Jun Urushidani (PMDA), Annemiek van Rensen (MEB), and Jamie Wilkins (Pfizer).

Absent members (including Alternates)
Alison Bateman-House (Grossman School of Medicine, NYU Langone Health), Patrick Beeler (Swissmedic), Matthias Boedding (Merck), Wang Dan (CFDA), Ton de Boer (MEB), Nikos Dedes (EATG), Ratna Devi (IAPG/IAPO), Mick Foy (MHRA), Yan Gao (NMPA), Juan Garcia (EMA), Charles Garrigan (Janssen), Linda Härmark (Lareb), Javier Hourcade Bellocq (Civil Society Sustainability Network/International Civil Society Support/Independent Consultant, Argentina), Kaisa Immonen (EPF), Kerry Leeson-Beevers (Alström Syndrome), Marie Lindquist (UMC), Christine MacCracken (Janssen)*, Marilyn Metcalf (GSK), Theresa Mullin (US FDA), Rebecca Noel (Eli Lilly), Elisabeth Oehrlein (US NHC), Shanthi Pal (WHO), Ravi Patel (United Therapeutics Industry), Peter Pitts (CMPI), Indra Purevjal (Takeda)*, Cheryl Renz (AbbVie), Leo Russo (Pfizer), Daisaku Sato (PMDA), Meredith Smith (Alexion), Panos Tsintis (CIOMS), Oi Tsunehiro (MHLW), Pujita Vaidya (Amgen), Manal Younus (ISOP), and Judy Zander (US FDA).

* New member since the 8th meeting

Welcome and opening remarks

- Lembit welcomed everyone and thanked them for their time.
- Version 1.1 of the CIOMS Cumulative Pharmacovigilance Glossary was published on 10 June 2021 and is available on the CIOMS website. This version includes some newly added terms and definitions, including for vaccines too.
- The CIOMS WG on Clinical Research in Resource-Limited Settings has published its consensus report;
- The CIOMS WG on Recommended Standards for Education and Training for Health Professionals Participating in Medicines Development has been launched;
- New CIOMS WG on Principles of Good Governance for Research Institutions will be launched in July;
- Indra Purevjal, Takeda, has joined the WG XI, taking over from Veronique Kugener.
- Ana Macarenco, a fellow working with Jamie, joined the meeting as a silent observer.

Chapters overview

As many of the report chapters are now mature, the meeting agenda included only the later-maturing chapters, but the minutes covers all comments made.

Foreword

Regina proposed to remove the word "subject" in the third sentence and replace it with "participant" in recognition of an effort to change research-related terminology.

Chapter 1: Introduction

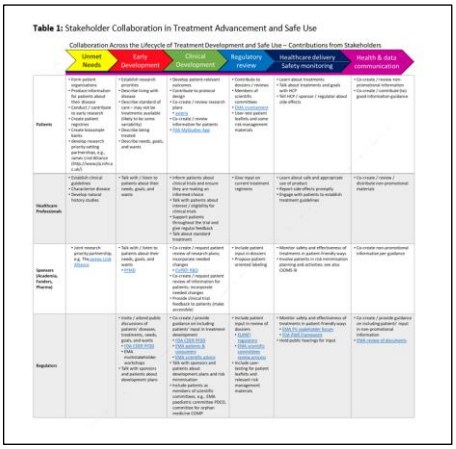
The chapter has been updated and feedback is welcome.

Chapter 2: The landscape of patient engagement in the development and safe use of medicines

The chapter is still work in progress.

Chapter 4. Patient involvement in advancing treatments for their disease

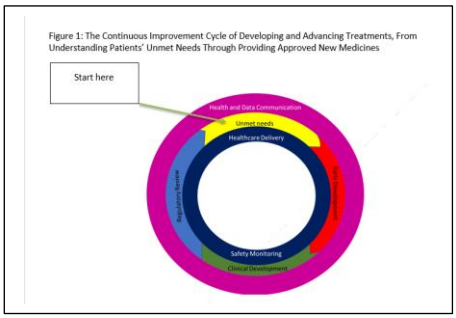
- François commented on Table 1:
    - The table describes well the flow of interactions (unmet needs, development, evaluation, authorization) and the different interventions and role descriptions (patients, healthcare professionals, sponsors, regulators).
    - However, it seems rather theoretical, or depicting what we would like to see happening, whereas in practice, patient involvement discussions rarely start with discussing unmet needs.
    - In reality, patient organisations will more frequently enter into conversation with developers for the following types of reasons:
        - Developers contact patient organisations to recruit for clinical trials;
        - Patient groups contact developers about promising products for compassionate use;
        - Sometimes first conversations take place following a safety signal once the product is already on the market.
    - Are these other entry modes reflected in chapter 4? Would it be helpful to add them to Table 1 so that we avoid giving the wrong impression? Christine offered to help with this task.



- As Table 1 is already fairly busy, perhaps these entry points can be related in the chapter body copy? François offered to provide some text.
- Panos agreed that Table 1 seems rather static, like we have to enter at one end and come out of the other, whereas we would like to show that we can enter at any point. Perhaps we need to clarify the most common points?
- As a member of the chapter 4 team, Christine explained that the aim was to show that patient engagement should really start as early as possible. This is not yet done in a systematic way across the pharmaceutical companies and academia although there exist pockets of excellence. The intention was to show a balance between the vision and reality, and how patient engagement can enrich the drug development lifecycle.
- At the editorial team discussions, it was agreed that we would make the last dark pink arrow entitled "Health & data communication" and the penultimate dark blue arrow entitled "Healthcare delivery safety monitoring" clearly run the full length of the table, i.e. making the dark pink and dark blue show more above and below the other arrows.
- Steven suggested that we reflect how the rather rigid, regulatory benefit-risk lifecycle contrasts with the more fluid, dynamic patient voice. Patients can be involved very early on, go the full

circle with product development, and then come back, e.g. patients can be consulted regarding risk minimization during clinical development, and then when after the drug has gone to market, patients can revisit regarding a new indication, and so forth.

- The editorial team discussed removing the chapter 4 circular diagram on the grounds that Table 1 describes the same subject in a self-explanatory, intuitive way that everyone understands. The circular diagram does not communicate as well, it would need adjusting to reflect our messaging, and seems to need lengthy explanations. There was general agreement on this.
- Talia requested that we keep the lifecycle diagram with the different stages in chapter 2 or 3 in order to show the lifecycle as a cycle.



Chapter 7. Guiding principles for patient engagement in the development and use of safety and effectiveness data

- The new chapter lead, Alex Asiimwe, Bayer, introduced himself. Alex has been working at Bayer in Berlin for over six years, and is now heading the public-private partnerships area, rendering epidemiology more useful to patients' lives. He has been working as the Head of Epidemiology for some time, with over 15 years of experience in pharmaceutical companies from Bayer, to AstraZeneca and Eli Lilly; and previously at the Uppsala Monitoring Centre; as well as a Professor in clinical epidemiology at Cambridge.
- Much work has been done already on chapter 7, and the chapter team is currently working to put patients at the centre of the chapter – to design studies with patients.
- The chapter 7 team has been working to streamline the content and add sections on:
    - Adverse event management of spontaneous reports;
    - Insights about data ownership and patient data safety;
    - How data should interact between the patient and different stakeholders in the healthcare delivery system;
    - Challenges and future directions.
- The chapter is quite lengthy.
- There is an effort underway to remove duplication between chapters 6 and 7, but chapter 7 will need to refer to patient-level data and additional risk minimisation efforts a little also.
- The WG looks forward to seeing a more mature version of the chapter.

Chapter 9. Challenges and opportunities for patient involvement in resource-limited settings

- Dinesh is in the process of consolidating all the relevant points from the various chapter drafts, the Uganda workshop report, and the teleconference held between the representatives from different resource-limited settings (RLS). He is also restructuring the content and removing all content outside the remit of patient involvement in the development and safe use of medicines.
- The new chapter structure has four parts:
    1. Description of the barriers to patient involvement in health policies, health research and regulation;
    2. Recommendations for improving patient participation;
    3. Implications from implementing changes to improve patient participation;
    4. What has been achieved and what remains to be done.
- There will be one case study on the treatment action campaign in South Africa on HIV. It deals with the denialism that patients originally faced in South Africa and their involvement in treatment policies. This will be elaborated on when we come to the case studies.
- Lembit added that this chapter is challenging because RLS differ amongst themselves in terms of the problems they face.

- If we compare the number of clinical trials taking place in some RLSs and those going on in Western Europe and the US, the numbers are very low, although they have been increasing during the recent years.
- Christine pointed out that sometimes the terms “low- and middle-income countries” and “RLS” are used interchangeably, and the chosen one probably needs to be defined in the chapter and/or in the glossary.
- We can refer to the CIOMS WG report on Clinical Research in Resource-Limited Settings and discuss if the definition there is helpful or whether we need something different.
- Christine and Talia have added comments to the chapter 9 draft. [Post-meeting note: Christine added comments to all chapters.]

Chapter 11 Pandemic effects: lessons learned

- Stephen thanked everyone for their input.
- Some of François’ comments warrant further discussion from the wider WG.
- The HIV pandemic has been mentioned as an example of the importance of the patient voice in product development and the regulatory settings, and other chapters may need to refer to it.
- There was a discussion on the definition of the term “Pandemic”:
    - The WHO refers to the HIV situation as a global epidemic, not as a pandemic.
    - There is an international distinction between the definitions.
    - We have members from WHO in the WG and CIOMS is in official relation with the WHO.
    - Stephen felt HIV is a pandemic because it is in every country in the world; this is an epidemiological term.
    - This is a very sensitive, political topic.
    - We could qualify the term or avoid using the word “pandemic”.
    - Nikos acknowledged that the WHO describes HIV as a global epidemic, and this is after working for 20 years on the subject and after 26 years since his diagnosis. As CIOMS is under WHO, we cannot subversively introduce a new term. Having said that, he struggles to understand the difference between a global epidemic and a pandemic.
    - Stephen clarified that discussing the HIV pandemic was in contrast to the SARS-CoV-2 pandemic.
    - Dinesh pointed out the changing terminology in an article published on Transformation of HIV from pandemic to low-endemic levels: a public health approach to combination prevention.
- Both viruses are here to stay and have affected everything in society. This is one of the points in the chapter. Maybe we can re-phrase but still bring out the comparison?

Future directions

Meredith and Stephen drafted a piece to address the gaps identified in the report. The idea is so the reader can understand what needs to still get done and that the book will hopefully lead to the fulfilment of the patient voice down the road.

- It was originally intended to be placed at the end of the book, as a coda, but there has also been a suggestion to place it at the front of the report, perhaps as a preface, in order to contextualise the whole report, given that much of the ideals discussed have not yet been implemented.
- The patient members are invited to provide any missing ideas to the text.
- Corinna thought it was a well drafted piece, and she provided some comments already, but in response to the discussion at the meeting, she made an alternative suggestion regarding the “unanswered questions” concept. In a scientific context (scientific investigation through trials), we could say that there is hardly no evidence to suggest that patient involvement changes anything. We would need an evaluation of the processes and obtain more qualitative insights into what works and whether we meet the goals that we have set for ourselves. She suggested

being clearer about what these open questions are about, saying they are not questions but processes that have been implemented and others that have not yet been implemented, or ideas that could improve the process of patient and public involvement. The driver for involving patients and members of the public is more of an ethical issue, more about legitimacy, or democratic processes, than about evidence.
- Stephen invited Corinna to add some text, although his understanding from when Meredith started drafting this piece was that there are questions / gaps in the book that we should highlight and address in this section. This was the original concept.

Case studies

- We will need to indicate which chapters will cross-reference with which case studies.
- The case studies will help to drive home all the points made throughout the entire report and are valuable in showing that patient involvement actually does happen in real life.
- All of the case studies are at different stages of completion. The AdrenalNET, EMA, and Lareb case studies are very advanced; and Roche, Takeda, and Meredith's case study on additional risk minimization measures (aRMM) are at earlier stages of completion.
- The Takeda case study and Meredith's case study on aRMM were not presented at the meeting.
- We might be able to add one or two further case studies fairly quickly if needed / offered.
- Below are the case studies to date:

A regulatory agency involving patients; public hearing on valproate (EMA)

- This is a post-authorization phase example involving PRAC (Pharmacovigilance Risk Assessment Committee), showing engagement with patients and other stakeholders, using a range of engagement methodologies.
- It focuses on valproate, which has been used for many years for the treatment of epilepsy, bipolar disorder, and preventing severe migraine in some European member states.
- There was an association with women taking valproate and a risk of birth defects for the unborn baby.
- Risk minimization measures were in place, but the agency was requested to review these because there was reason to believe that the measures were not optimal and a lot of patients were unaware of the risks. This procedure was started in 2017.
- The PRAC felt the need to hear from all the stakeholders and specifically from patients taking valproate, but also from the prescribers, healthcare professionals, and risk minimization specialists.
- At the beginning, PRAC carried out a written consultation to understand the prescribing and use across Europe and this was followed with a public hearing.
- The public hearing allowed members of the public to join the PRAC's meeting and was broadcast live. People joined as participants, observers, and speakers from each of the stakeholder groups and were able to give their perspectives to the committee.
- We defined a list of questions to scope the information shared about experiences and suggestions for ways forward to tangibly improve the risk minimization measures. We wanted to know what was not working and how to improve. We received important information during the public hearing from the patients, those who had been affected by valproate, from some of the children, health care professionals, pharmacists, everyone involved, and also from the pharmaceutical company.
- The feedback received during the public hearing fed into a dedicated stakeholder meeting, where PRAC could take the information and start putting together proposed improvements. They had a dedicated stakeholder meeting and discussed in depth different adjustments.
- Patients and healthcare professionals came up with tangible proposals e.g. an acknowledgement form to be signed, seeing patients more often, signs on the package, leaflet, etc., and the information gathered shaped the resulting recommendations.

- There was a final consultation where the proposed recommendations were shared in writing with all the stakeholders, and disseminated within their various communities, to ensure everyone had an opportunity to contribute.
- The outcomes were tangibly impacted and developed with the different stakeholders, agreed by the PRAC, and implemented at a national level.

Medication formulation created to meet patients' and doctors' needs (AdrenalNET)

- This example shows a patient organisation taking initiative following problems with the taste of their hydrocortisone tablets, the size of the tablets, and an unstable medication supply.
- The patient organisation identified a new pharmaceutical company to help with a new formulation and a stable supply.
- The positive result is five or six different dosages in increasing strengths with self-explanatory differences in colour going from light yellow to dark red in increasing dosages, which is convenient for the patients to use. Three or four of the strengths have been registered in the Netherlands and the final ones are in progress.
- For the patients, it eases their daily medication use and reduces their concerns.

Pilot collaboration between the Netherlands Pharmacovigilance Centre and a patient organisation in communicating a signal (Lareb)

- Lareb wanted to disseminate a signal that had been found in collaboration with a patient organisation in order to target patients who were using the drug, Levothyroxine.
- Lareb worked closely with the patient organisation to adapt the signal to have a clear message for the patients and shared that with the organisation's members.
- The patients had a lot of interest in safety issues, and according to the patient organisation, this message had one of the highest viewing rates among their messages.
- Thanks to social media, Lareb created a feedback mechanism to get more input from the patients, which strengthened the signal further, thereby effectively creating a communication tool.
- The case study has been published.

Creating partnerships between industry and patient groups for therapy development (Roche)

- This is a case study involving a spinal muscular atrophy therapy.
- Roche engaged patient groups early on from clinical development through to the approval process and product access. The development programme was co-created together with a patient group.
- The patient voice shaped a lot of the decision making within the clinical programme as well as with the operational activities throughout the lifecycle of the product.
- Leanne received some comments from the editorial team, and is addressing them, but would prefer to have a consolidated set of comments.
- Roche will need to conform to its internal compliance review process.

AIDS patients' Treatment Action Group

- Dinesh proposed a case study in conjunction with chapter 9, as mentioned previously.
- This case study would be on the early South African state's response to AIDS, which was dominated by denialism and the fact that effective treatments were unaffordable and inaccessible to the majority of the population.
- A Treatment Action Group educated patients on the HIV science, discredited the AIDS denialism, and eventually got public pressure to force a change in the state stance.
- In a lot of the other case studies, patients were invited to take part in activities, whereas with this one, the action was initiated by the patients, and for this reason, it might be interesting (the AdrenalNET case study has some similarities).

- This case study has certain other dimensions too and is good for a more global perspective.

European Association of Neurology

- Alex proposed a case study on prostate cancer patients participating in study teams, alongside scientists and clinicians, to shape research questions and outcomes.
- This involves the European Association of Neurology guideline office and study funds.
- The differentiator in this instance is that patients are sitting at the table for the first time in designing the research question up to the publication point. It is unique for prostate cancer patients to address the treatment guideline change.
- Lembit requested that Alex share a short text summary for the WG members to review.
- Annemiek questioned whether this case study could fit with chapter 10 on patient involvement in clinical practice guideline development, although this chapter is a little apart from the main focus of the report and there exists a lot of examples of patients participating in guideline development.
- Corinna was not sure whether chapter 10 needs a case example. As there are many such examples, the question would be which one to choose. The involvement of patients depends on the resources of the developing organisations, e.g. NICE in the UK has a large team to support and train patient representatives, and other single-specialty societies do not have the same means. If we have a case example, perhaps it should be of a smaller institution. The chapter 10 mentions some research and best practices, and if the editorial team feels it would be helpful, Corinna is also willing to illustrate this.

Glossary

- The chapter leads have been filling in the Excel spreadsheet on the main terms in their chapters, indicating references where possible, and explaining how all the different terms are used in their chapters, to help ensure consistency throughout the report.
- The chapter teams of the later-maturing chapters will be requested to do the same in time.
- We have just over 50 different terms in the report glossary.

Terms explicitly used in the report and terms relevant to the report

- The CIOMS Cumulative Pharmacovigilance Glossary has a handful of terms with outdated definitions, and where they are relevant to the CIOMS WG XI report subject area, they could be included in the CIOMS WG XI glossary with improved definitions. Stella has been working on these rare exceptions and the proposed definitions will be presented to the WG members in email format.
- Talia suggested including the term “Patient-Focused Drug Development (PFDD)” in the WG XI glossary, finding this term can create confusion depending on the reader. She would be in favour of including a term like this in the report glossary even if it is not in the report itself, but overall, she supports only defining terms used in the report. Both the ICH Reflection Paper on PFDD and some of the main FDA guidances might have definitions for PFDD as they are driving the term.
- Stephen added that Juan proposed referencing the EMA’s Medical Terms Simplifier – a compilation of all the medical terms the EMA uses in lay language – and we should check if PFDD is also defined there.
- We would have to make it clear if the glossary is overextended and not just limited to the report.
- Talia suggested adding an opening paragraph to say that the glossary includes the terms used within the guidance, however, we encourage you looking at these other resources as the field and its terms and references are evolving.
- Stephen agreed about a qualifying statement and proposed something like “we have included terms that we felt were relevant to this book although they may not have explicitly been used within the text”.

Comments on the glossary terms and definitions

- Corinna questioned the definition for “Patient organisation” and its origin given that the wording uses war metaphors (“combating a condition or disease”), which she sees as problematic, because the work of the organisations is more about helping people live with a disease. If you use such war metaphors, then everyone who has the condition can be seen as a loser.
- François felt the current definition is acceptable because when you combat a disease, you can win some battles and lose others; the importance is to persevere. No one should be seen as a loser when the fight continues. People who join a patient organisation have very much in their genes to act against their disease and they often refer to their fight for life, even when they know they can or will die. No one dying from a disease is seen as a loser.
- The working group can create its own definition. We are not obliged to reference other sources. Some of the references may not be fit our purpose and the WG can come up with something more suitable if preferred.
- Corinna proposed an alternative definition from the German patient umbrella organization (translation done quickly through Google): "Patient Organizations are voluntary associations of patients and / or their relatives that do not seek economic profit, whose activities focus on coping with illnesses, providing information about illnesses and their therapeutic options, representing interests in health and social policy area, the publication of media for the information and support of patients and / or the provision of counselling services”.
- Talia referred to previous WG discussions where we had talked about a narrow versus a broad definition for the term “Patient”, where “narrow” refers to the patient alone and “broad” refers to the patient plus patient organisations, caregivers, advocacy organisations, and all those who provide the learned knowledge and expertise of a disease from a first-hand experience. It is cumbersome to write out the list each time. Some sections may have been written with a narrow sense and some with a broad sense of the word, and therefore some parts of the guidance may need to be reworded accordingly.
- Stephen replied that the glossary team received input from quite a number of people especially for the “Patient” definition. He invited the WG to suggest a different approach for everyone’s consideration.
- Talia recommended removing “Family” from “Family caregiver” and simply using “Caregiver”. Stephen explained that a “Family caregiver” is often unpaid and is involved especially for patients with chronic diseases, whereas “Caregivers” can also be from external social services. We need to verify if we have a separate definition for “Caregiver”.
- François added that a “Family caregiver” will join a patient organisation and be eligible to represent patients, whereas a professional one would typically join a healthcare professional group.
- Talia asked whether it matters in the context of drug development if there is a full familial lineage to the caregiver in providing input. Is it considered? Stephen replied that it matters only in the area of consent. He did not see the value of separating family and non-family in the context of the PFDD. This definition is of NHC origin and we can modify it.
- With regard to chapter 5 on patient product labelling, Theo made the point that what we mean by “Label” and “Labelling” in regulatory terms may not be understandable to the lay person. The words “Label” and “Labelling” may be misunderstood by some readers, e.g. patients and most practising health professionals who regard the “Label” as something separate from the leaflets and other information; to them, “Labelling” is about what is on the package. Theo recommended that at the beginning of chapter five (or in a footnote) and in the glossary, we clarify what we mean by “Label”. Theo invited the patient representatives to give their views.

Patient involvement / engagement / participation / voice

- In the report, we use the terms "Patient involvement" and "Patient engagement" interchangeably at times but there are differences between how different regions use them:
    - Talia, Health Canada: We use patient involvement more than engagement but we do not have formal definitions. From how we speak of it, patient engagement has been traditionally the "talking", more ad hoc basis, whereas involvement is where patient are integrated into the process specifically; more hands on and aligned with PFDD. There is a distinction in terms of the level of integration.
    - François, EURORDIS: For us, involvement is more vague and loose. It includes both the passive and the active participation, but it is more on the passive mode, e.g. involving patients to disseminate documents to patient organisations. That is a way of involving patients but it is minimal and can mean anything. When you use the term engaging, there is a more active role in the engagement method than in any other involvement. When patients have an active role, then you can start talking about engagement. He reported having heard patients saying "I don't want to be involved, I want to be engaged".
    - Nathalie, EMA: Engagement is more important for us and what we do when we involve patients.
    - Regina, CHAIN, Uganda: When we look at engagement, it is mainly about working collaboratively to address issues affecting patients; we work together with them. Involvement is really about the patients being able to play a full part in the decision making, and all those issues that concern them to be able to influence decisions affecting their lives. It is also about patient empowerment.
- The original report title uses "Involvement".
- Maybe we can use "active involvement" or "high-quality involvement", or a third word?
- Stephen suggested considering what is already written in the report and the context.
- Talia suggested including a paragraph on this early in the report, recognizing that around the world the terms can be used interchangeably or used as distinct terms, explain both, and say "for this guidance, we're using the term X to mean ....?"[1]

Editorial matters

Report title and the regulatory aspect

- The editorial team discussed the below two titles – the original title and an alternative by Juan – and requested the WG's responses:
    - *Patient involvement in development and safe use of medicines*
    - *Patient involvement in development, approval, and safe use of medicines*

[1] [Post-meeting comment from Talia: This draft Literature Review deals with the use and scope issue and the term "patient involvement", and seems to be a good example of how the topic could be approached by the WG. References can be provided if needed.

"At this time, there is no commonly accepted definition of 'patient involvement' (13). The concept of involving patients in drug development takes on different names, as well as different definitions, on a case-by-case basis predicated on the specifications of the sponsor, regulator, patient or patient organization (13,14). In a search of the literature, 24 terms related to patient engagement were found, each with up to 7 different definitions (15). The divergent meanings across organizations has resulted in unidentifiable systemic goals for the inclusion of patients within the drug development process (8)…. Within the Canadian context, Health Canada currently has no formal definition of patient involvement in drug development. As such, "patient involvement" and "patient engagement" are often used interchangeably. Within this document, we will move forward adopting the term 'patient involvement' to convey the systemic integration of patient experiential knowledge into the drug development process to support or inform decision-making (12)."]

- There were many viewpoints:
    - Talia commented that regulators do not have the authority to delegate decision making over approval and we do not want to raise expectations to suggest that patients would be able to participate in the final decision making. Ken supported this.
    - We would like to express that patient input is an integral part of the regulatory decision making process, it informs decision making, even if patients do not ultimately have the final say. Patients are involved in more than the clinical programme and in the post marketing aspects.
    - Nathalie suggested using “the full regulatory lifecycle”.
    - Talia supported reflecting the “whole drug lifecycle”.
    - How about “assessment”? This is a little more nuanced and maybe captures more of the process. "Assessment" could cause confusion due to its use in "health technology assessment” in the context of reimbursement / coverage.
    - Ken suggested that we look at the differences among countries regarding patient participation in the approval process. He was not sure whether the term assessment can describe that situation.
    - How about "evaluation"? After regulatory approval, there are of course other potential barriers (HTA, approved lists, formularies...), and therefore “evaluation” sounds good.
    - Another title option was proposed:
      High-quality involvement of patients in the development, evaluation and safe use of medicines
    - Dinesh commented that the above covers it well but we would need something concise. We could do without “high quality” since we would expect this.
    - Lembit agreed that “approval” is more direct and has more legal implications. Evaluation or assessment are more about the process, not the final decision making.
- Lembit concluded that we have no consensus at this time.
- He reflected that when we put together the title originally, the interpretation of development was probably wider than some people see it. The thinking was that development encompasses everything from early product development, with continued assessment postmarketing, and fine-tuning afterwards. Nowadays, more and more products are put on the market with some sort of regulatory approval with very limited data, with huge obligations to the developers to generate more data after the approval phase (e.g. a conditional approval or emergency approval) and a lot of the work needs to be done afterwards. So, the product development is a continuum throughout the whole lifecycle. It is like a biological human being that keeps developing until death. We have continuous assessment and reassessment.
- Ken felt the term “lifecycle” describes the entire drug development and safety management because the word includes the approval process, the review process, the assessment, and maybe even withdrawal from the market.
- Following the discussion, Lembit added another option:
    - *Patient involvement in the drug development lifecycle and the safe use of medicines*
- [Post-meeting comment: the discussion continued over email:
    - Talia proposed using “market authorization”. François remarked that this covers the benefit/risk evaluation, and possibly withdrawals, but not completely all regulatory actions where patients can be engaged e.g. pharmacovigilance, shortages, batch recalls etc.
    - François proposed:
    - *Patient engagement in the development, regulation and safe use of medicines*
    - *Patient involvement in the development, regulation and safe use of medicine*
    - The above option was supported by Lembit, Nikos, Stella, Kaisa, and Talia, who said it is user-friendly, has the desired scope, and while remaining in the spirit of the initial title change proposed by Juan.

- Annemiek agreed with François' proposal, although believed there is some overlap in the various phases as "development" covers activities concerned with building the dossier required for regulatory approval, e.g. guided via scientific advice, regulatory guidelines, etc., and "safe use" covers the part after approval with pharmacovigilance, communication aspects in case of calamities, among others. Different stakeholders are involved throughout all of the phases and may engage patients in specific activities. She recalled earlier discussions on the title, where we wanted to mark a phase before and one after market authorization, and in that light, the regulatory approval merely marks a point in time. The type of patient engagement activities plus roles of patient organisations will vary depending on whether it is before or after a product has entered the market. She was not sure whether we would really miss something if we leave out "regulation".
- Dinesh agreed with François' "involvement" suggestion above. Regulation is a good concept to include, since it is such a critical step, but he wondered if the title implies a more limited role than we would like to convey, and if the term "safe use" is too light for the challenges to overcome after a medicine receives regulatory approval:
    - Procurement, which may involve assessment by health technology bodies or similar;
    - Introduction of the medicine into authoritative treatment guidelines and formularies;
    - Creating awareness of the medicine's role among healthcare providers;
    - Providing patients and healthcare providers the tools to ensure that the medicine is used appropriately and safely.

  There is no clear answer on how to elegantly encapsulate these ideas into a short title. Dinesh offered two suggestions:
- *Patient involvement in establishing safe use of medicines*
- *Patient involvement in the safe use of medicines: from development to community use*

  Dinesh said his thoughts are influenced by the role of South Africa's Treatment Action Campaign (street action and education to make HIV therapy available to the population) and his work in the area of formularies and essential medicines lists.
- Meredith valued Dinesh's points, and Meredith and Christine prefer his first option; in Meredith's view it is simpler and more succinct.]

Chapter titles

- The chapter titles need to be shorter and form a set.
- Below are the original titles, and underneath, a proposed revised set.

Chapter titles at the moment
Ch 2: The landscape of patient engagement in the development and safe use of medicines
Ch 3: Guiding principles for patient engagement
Ch 4: Patient involvement in advancing treatments for their disease
Ch 5: Principles for patient involvement in patient product labelling
Ch 6: Opportunities for patient involvement in additional risk minimisation
Ch 7: Guiding principles for patient engagement in the development and use of safety and effectiveness data
Ch 8: Patient involvement in developing time-bound safety communication on medicinal products
Ch 9: Challenges and opportunities for patient involvement in resource-limited settings
Ch 10: Guiding principles for patient participation in therapeutic decision-making: Patient and public involvement in clinical practice guidelines
Ch 11: Pandemic effects and patient care: Lessons learned

Proposed chapter titles

Ch 2: Landscape

Ch 3: Guiding principles

Ch 4: Advancing treatments

Ch 5: Product labelling

Ch 6: Additional risk minimisation

Ch 7: Safety and effectiveness data

Ch 8: Time-bound safety communications

Ch 9: Resource-limited settings

Ch 10: Clinical practice

Ch 11: Pandemic effects and lessons learned

Comments

- Several WG members confirmed a preference for the shorter set and supported the wording.
- Lembit mentioned an option whereby each title could link with the report title to be completed with "… patient involvement in the development and safe use of medicines" (or the final wording chosen).
- There were some suggestions made specific to chapters:
    - Dinesh suggested "Ch. 11: Lessons from the pandemic" and Jamie added that it should specifically reference the SARS CoV-2 pandemic unless we include historical pandemic examples such as H1N1 etc. Stephen suggested removing "lessons learned" and having simply "pandemic effects", "Covid-19", "SARS CoV-2", or "pandemic effects and the patient voice", so that the title does not just question what the pandemic did to patient care in general but looks more at the patient voice.
    - François suggested swapping over chapters 6 and 7, so that we have first chapter 7 on "Safety and effectiveness data" followed by chapter 6 on "Additional risk minimisation", because it is only once you have the safety and effectiveness data that you can discuss and present additional risk minimization measures.
    - Regina highlighted that the resource-limited settings title would need to reflect also the focus on challenges and opportunities.
- Alex suggested picking up on the definitions of patient involvement/engagement/participation in the report introduction and the chapter introductions.
- Lembit suggested for all to digest and invited the other chapter leads to also make propositions.

Editing the full report

- Due to the pandemic, it has taken time for some of the chapters to reach maturity and for the editorial team to really start to work on its task. Many chapters have been edited as individual units in terms of their structure, flow, style, and length etc., but we also need to consider the report as a whole and focus on removing duplication, having the chapters work together coherently, ensuring that we cover the different topics at the same sort of depth, and looking at indexing and cross-referencing.
- We are hoping to be able to re-distribute a revised draft report towards the end of August.
- Additions to the abbreviations, acronyms and index words are welcome.
- Talia requested that the editorial team provide progress updates to enable preparing the report roll out. Any centralized messaging will also be helpful.

Public consultation

- The public consultation was originally intended for July, but we have been held back due to some chapters, and early September would now seem more realistic. François supported this as most patients will not be reactive in August.
- The timings also depend on the glossary team finalising the 50+ terms and definitions for sharing with the full WG.
- Lembit proposed that the full WG delegate the decision making on when to progress to the five-week public consultation period to the editorial team in order to make the procedure easier. No objections were voiced and Corinna confirmed her approval in writing. [Post-meeting comment: approval was received in writing from Marilyn and Pujita in advance of the meeting.]
- This public consultation period will serve for the full WG as an opportunity to provide comments.
- The public consultation will rely heavily on the WG members' networks, e.g. patient organisations, social media networks, and other channels, for disseminating / promoting the public consultation opportunity. Annemiek offered to support this within the EUPATI community.
- Feedback will be captured in a structured manner to ease the editorial team handling the comments afterwards.

Closing statements

Lembit thanked everyone for their time and warmly commended all for their contributions.

Working group structure

		Group 1 **Chair: Juan, co-chair: Kerry**				**Group 2** **Chair: Meredith, co-chair Stefan**						
Foreword	**Preface?**	**Ch. 1**	**Ch. 2**	**Ch. 3**	**Ch. 4**	**Ch. 5**	**Ch. 6**	**Ch. 7**	**Ch. 8**	**Ch. 9**	**Ch. 10**	**Ch. 11**
Alison	**Meredith**	**Theresa**	**Elisabeth**	**Charles**	**Marilyn**	**Meredith**	**Cheryl**	**Alex**	**Stefan**	**Dinesh**	**Corinna**	**Stephen**
	Stephen		Talia	**Annemiek**	Becky	Ton	Stephen	Linda	Linda	Regina		**François**
			Theresa	Matthias	Christine	Panos	Leanne	Kaisa	Marie	Shanthi		Fatima
			Shanthi	Regina	Theresa	Patient rep. to review	Peter	Peter	Sabine	Lembit		Lembit
			Kerry		Kerry		Judy	Elisabeth	Ravi	Ratna		Meredith
			Ken		François		Stella	Ravi	Elisabeth	Kawaldip		Nathalie
					Pujita (maternity leave)		Nikos	Manal	Fatima	Javier		Panos
					Kaisa to review		Jun	Patrick	Kerry to review	Manal		Peter
							Shinji	Leo				Ton
							Jamie					
Glossary team **Stephen** Elisabeth, Panos, Sanna, Stella, and Pujita (maternity leave)												
Implementation strategy team Christine, Elisabeth, Meredith, Peter and Talia												
Editorial team Annemiek, Cheryl, Dinesh, Elisabeth, François, Meredith, Panos, Stella, Stephen, and Theo												