tive to survey these 95 participants again to explore their postsurvey reflections and to see if their preferences for deactivation have remained stable.

While the authors conclude that the findings highlight the importance of including multiple patient-centered outcomes in advance care planning, we would also argue that difficult topics like ICD deactivation should be raised when patients have the time and emotional stability to consider complex information and reason through their preferences. This discussion could be part of an annual heart failure review. Recently, updated performance measures surrounding ICD implantation state that all eligible patients should receive “counseling” to determine if an ICD is right for them. Dodson et al give evidence that at least a portion of that “counseling” should include preparation for a possible time in the future when a person may wish to deactivate their ICD.

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RESEARCH LETTERS

The First 2 Years of the European Medicines Agency’s Policy on Access to Documents: Secret No Longer

On November 30, 2010, the regulatory agency for medications in Europe, the European Medicines Agency (EMA), announced a policy on access to “any document originated, received or held by the Agency.” The policy made a wide range of regulatory documents potentially accessible to anyone who asks for them, including clinical study reports. Documents are released without charge, primarily in PDF format, and made available via a web-based download. We used this policy and received 25,000 pages of previously unreleased clinical study reports on Roche’s oseltamivir phosphate (Tamiflu) trials, all unredacted. This formed the basis of our recent Cochrane review on neuraminidase inhibitors. The release of such documents contrasts with the approach of the US Food and Drug Administration (FDA), which similarly has a freedom of information policy but treats industry-sponsored clinical trial data as confidential and trade secret, denying public release on the grounds that disclosure could cause competitive harm to original study sponsors. We sought to inform discussion of access to clinical trial data by describing how the EMA’s policy is being used.

See Commentary on page 373

Methods. We requested from the EMA a log of all requests for documents handled under the Agency’s new policy (ie, since November 30, 2010) and received a table, dated November 19, 2012, of 457 requests containing details of each applicant’s affiliation (categorized by the EMA), a brief description of documents requested, the date the request was received, the date of last response from the EMA, and the disposition of the request (eg, pending, open, or closed; full, partial, or no access granted; and total pages released) (eAppendix; http://www.jamainternalmed.com). We summarized the information as follows: who requested information; what was requested; for partially fulfilled (part redacted) and fully fulfilled (unredacted) requests, how much was being released (as median number of pages per request and total per category of requestor’s affiliation); and time to release of information (as median days per request) by the
EMA. Because the request log represents a snapshot point in time, page counts in some cases represent only a partial fulfillment of a request. Time to first access of documents could not be determined because the information is not in the request log. We instead computed a time to access of the total number of pages thus far released. Institutional review board approval was not sought because no patients were involved in the study.

Results. The EMA received 455 requests for information (2 separate requests were received prior to, but handled under, the new policy)—178 requests during the first year and 277 in the second (eFigure; http://www.jamainternalmed.com). No information was provided about the number of unique requestors. There were 31 requests that were pending after a median 28 days (interquartile range [IQR], 6-55 days [range, 4-110 days]). Approximately one-quarter (124 of 457) of all requests were closed with no documents released. Ten of these had time expired (owing to a lack of response to the EMA’s request for clarification). Of the 302 requests that resulted in the release of documents, the median number of pages released per request was 81 pages (IQR, 17-825 pages [range, 1-254 251 pages]). Of 302 requests, 88 (29%) were released in full without redaction (304 876 pages). Median time to access of the total number of pages was 26 days (IQR, 16-60 days [range, 0-644 days]). Altogether, the EMA released 1,656,285 pages in the first 2 years of its policy. Requests made by the pharmaceutical industry, media, and legal affiliates were the majority of the 457 requests (Table). Requested materials varied widely, with at least 30 different types of EMA regulatory documents as well as data related to marketing authorization applications. The most frequently requested document types were assessment reports, dossiers, and clinical study reports. The largest releases were for clinical study reports for marketed, withdrawn, and never-approved medicines (at least 29 requests).

Comment. Since November 2010, the EMA has released many kinds of documents to a variety of applicants. Industry made the most requests and received the most pages (491,989). Health care professionals and the general public were far smaller beneficiaries, perhaps because of ignorance of the policy change and unfamiliarity with its use. Twenty-seven percent of requests were not granted access, sometimes simply because of nonapplicability (documents not held by the EMA) or time expiration (no response to the EMA’s request for clarification). Limitations of this study include an inability to calculate the proportion of pages redacted. We only know that 71% of requests included at least 1 redaction, but in our experience with the release of clinical study reports, the redactions were minor and of no impact to interpretation of text, eg, redaction of patients’ date of birth. Other limitations included possible misclassification of requests (eg, “industry” could request through “legal”); lack of knowledge of intended use of documents (the EMA is not legally allowed to query the purpose for which requests are made); and an inability to judge the long-term impact of EMA’s policy (eg, competitive harm to trial sponsors). In the future, the EMA is likely to release more clinical trial data. While this study evaluated EMA’s “reactive” disclosure policy, on January 1, 2014, the agency also intends to start a “proactive” policy on publication of clinical trial data.5

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Table. Requests for Documents Handled Under the European Medicines Agency’s Policy Announced on November 30, 2010 (as of November 19, 2012)

<table>
<thead>
<tr>
<th>Requestor’s Affiliation</th>
<th>Totala</th>
<th>Pendingb</th>
<th>No Accessb</th>
<th>Access Grantedb</th>
<th>Time to Access, d</th>
<th>Length Released, Pages per Request</th>
<th>Total Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry</td>
<td>149(33)</td>
<td>6 (4)</td>
<td>46 (31)</td>
<td>97 (65)</td>
<td>25 (18-60)</td>
<td>78 (13-919)</td>
<td>491 989</td>
</tr>
<tr>
<td>Media</td>
<td>84 (18)</td>
<td>5 (6)</td>
<td>20 (24)</td>
<td>59 (70)</td>
<td>26 (13-40)</td>
<td>64 (17-358)</td>
<td>380 563</td>
</tr>
<tr>
<td>Legal</td>
<td>71 (16)</td>
<td>6 (8)</td>
<td>15 (21)</td>
<td>50 (70)</td>
<td>37 (21-112)</td>
<td>49 (14-1244)</td>
<td>274 163</td>
</tr>
<tr>
<td>Academia</td>
<td>38 (8)</td>
<td>6 (16)</td>
<td>7 (18)</td>
<td>25 (66)</td>
<td>30 (19-68)</td>
<td>210 (41-2796)</td>
<td>286 045</td>
</tr>
<tr>
<td>General public</td>
<td>31 (7)</td>
<td>1 (3)</td>
<td>8 (26)</td>
<td>22 (71)</td>
<td>31 (16-62)</td>
<td>183 (32-1873)</td>
<td>134 782</td>
</tr>
<tr>
<td>Institution</td>
<td>28 (6)</td>
<td>1 (4)</td>
<td>13 (46)</td>
<td>14 (50)</td>
<td>21 (15-35)</td>
<td>48 (6-167)</td>
<td>17 620</td>
</tr>
<tr>
<td>Consultant</td>
<td>27 (6)</td>
<td>5 (19)</td>
<td>4 (15)</td>
<td>18 (67)</td>
<td>27 (14-62)</td>
<td>75 (25-299)</td>
<td>45 982</td>
</tr>
<tr>
<td>Health care professional</td>
<td>16 (4)</td>
<td>1 (6)</td>
<td>6 (38)</td>
<td>9 (56)</td>
<td>20 (19-24)</td>
<td>89 (25-1534)</td>
<td>18 795</td>
</tr>
<tr>
<td>Patients’ organization</td>
<td>9 (2)</td>
<td>0</td>
<td>3 (33)</td>
<td>6 (67)</td>
<td>51 (4-183)</td>
<td>404 (404-1018)</td>
<td>5942</td>
</tr>
<tr>
<td>Financial sector</td>
<td>4 (1)</td>
<td>0</td>
<td>2 (50)</td>
<td>2 (50)</td>
<td>33 (1-64)</td>
<td>202 (2-402)</td>
<td>404</td>
</tr>
<tr>
<td>Total</td>
<td>457</td>
<td>31 (7)</td>
<td>124 (27)</td>
<td>302 (66)</td>
<td>26 (16-60)</td>
<td>81 (17-825)</td>
<td>1 656 285</td>
</tr>
</tbody>
</table>

Abbreviation: IQR, interquartile range.

aData are given as number of requests (proportion of total, overall).

bData are given as number of requests (proportion of total, per category).
Author Contributions: Dr Doshi had full access to the request log file used in the study and takes responsibility for the accuracy of the data analysis. Study concept and design: Doshi and Jefferson. Acquisition of data: Doshi. Analysis and interpretation of data: Doshi and Jefferson. Drafting of the manuscript: Doshi and Jefferson. Critical revision of the manuscript for important intellectual content: Doshi and Jefferson. Statistical analysis: Doshi.

Conflict of Interest Disclosure: Dr Doshi received £1500 from the European Respiratory Society in support of his travel to the society’s September 2012 annual congress, where he gave an invited talk on oseltamivir. Dr Jefferson receives royalties from his books published by Blackwells and Il Pensiero Scientifico Editore, none of which are on clinical study reports. In 2011-2012, Dr Jefferson acted as an expert witness in a litigation case related to an antiviral (oseltamivir phosphate; Tamiflu [Roche]). Dr Jefferson is on a legal retainer for expert advice on litigation for influenza vaccines in health care workers. Drs Doshi and Jefferson also personally know some European regulators who share an interest in this topic.

Funding/Support: Both authors are co-recipients of a UK National Institute for Health Research grant to carry out a Cochrane review of neuraminidase inhibitors (http://www.hta.ac.uk/2352). Dr Doshi is funded by an institutional training grant from the Agency for Healthcare Research and Quality (#T32HS019488).

Online-Only Material: The eAppendix and eFigure are available at http://www.jamainternalmed.com.

Additional Contributions: David Mackay, BVetMed, MSc, PhD, MRCS, of the European Medicines Agency, closely reviewed the manuscript for accuracy and provided many clarifications about the EMA’s policy. Dr Mackay received no compensation for his assistance.

2. Rodwin MA, Abramson JD. Clinical trial data as a public good. JAMA. 2012;308(9):871-872.

Using Information Technology to Improve the Monitoring of Outpatient Prescribing

Adverse drug events (ADEs) and medication nonadherence are common and reduce the potential benefit of medications. Adverse drug events, defined as poor health outcomes caused by medications, occur in up to 25% of ambulatory care patients prescribed a medication. Medication nonadherence, defined as patients not taking their medications as directed, can occur in 25% of new prescriptions. Improved monitoring and communication could reduce ADEs and nonadherence to minimize medication-associated problems.

See Invited Commentary at end of letter

We designed the ISTOP-ADE system (Figure), an information technology–based approach to monitor ambulatory patients receiving incident prescriptions. This system automatically called patients 3 and 17 days following a prescription and allowed patients to request a pharmacist phone call. The purpose of this study was to determine this approach’s potential effectiveness.

Methods. We conducted a prospective cohort study of patients receiving incident prescriptions from 1 of 76 primary care physicians in Montreal and Quebec City, Canada. Practices were selected if they used the Medical Office of the 21st Century web-based electronic prescribing and integrated drug management system. Eligible pa-

Figure. Graphic representation of data flow through the ISTOP monitoring system. (1) At the time of prescription, primary care physicians receive electronic prompt identifying eligible patients; this information is based on a query of the patient’s prescription history within the clinical data repository. (2) When the patient’s eligibility is confirmed and the patient consents, primary care physicians enroll consenting patients into the program. (3) The system’s electronic health record (Medical Office of the 21st Century web-based electronic prescribing and integrated drug management [MOXXI] system) passes data to the interactive voice response system (IVRS) to queue automated follow-up calls. (4) The IVRS calls patients and administers the questionnaire on days 3 and 17 after the prescription; the questionnaire consists of 4 simple questions soliciting “yes” or “no” answers (med indicates the subject prescription medication). (5) The IVRS passes patient response data to MOXXI to update the electronic health record. (6) The IVRS sends an e-mail to the study pharmacist if responses by the patient indicate that follow-up is required. (7) The pharmacist personally contacts patients and documents information in the MOXXI system.