European Federation of Allergy and Airways Diseases Patients Associations

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Proposal for a regulation of the European Parliament and of the Council on medical devices[1]

Purpose

The European Federation of Allergy and Airways Diseases Patients' Associations (EFA) is a non-profit network of allergy, asthma and chronic obstructive pulmonary disease (COPD) patients' organisations, representing 35 national associations in 22 countries and over 400,000 patients in Europe. EFA is dedicated to making Europe a place where people with allergies, asthma and COPD have the right to best quality of care and safe environment, live uncompromised lives and are actively involved in all decisions influencing their health. This paper includes EFA's first comments on the main issues of the proposal and was sent out to EFA's network for comments and approval. Members positively responded and especially FEDERASMA and Association of Bulgarians with Bronchial Asthma (ABBA) were actively involved in the development of the document.

Medical devices are fundamental for patients with chronic diseases as they may increase life expectancy and quality of life on daily basis or in emergency situations, and empower patients to better manage their diseases contributing to patient-centred disease- and self- management. EFA representing patients with allergy, asthma and COPD, medical devices represent a high priority for us as the daily use/carry of some of these devices is essential for patients with respiratory diseases (e.g.: medical oxygen, inhalators) and for allergic people (e.g.: adrenaline auto-injectors). Studies show that both asthma and COPD patients feel that their inhaler device is an essential item and across all markets their device is rated at the top item that makes their lives better. As a result, and with the objective of fundamentally improving patients' safety and with potential to contribute to issues such as patients' empowerment,

[1] The text was proposed by the Commission in the framework of the package on innovation in health, together with the communication on safe, effective and innovative medical devices and *in vitro* diagnostic medical devices for the benefit of patients, consumers and healthcare professionals and with the proposal for a regulation on *in vitro* diagnostic medical devices (such as blood tests), previously regulated by directive 98/79/EC. The common horizontal aspects are aligned, but separate legal acts are necessary to cover specific issues to the different medical devices (*in vitro* and not).

quality of life and effective and easy delivery methods, our voice should be heard by European policy-makers and our involvement fostered in drafting the new rules.

Background

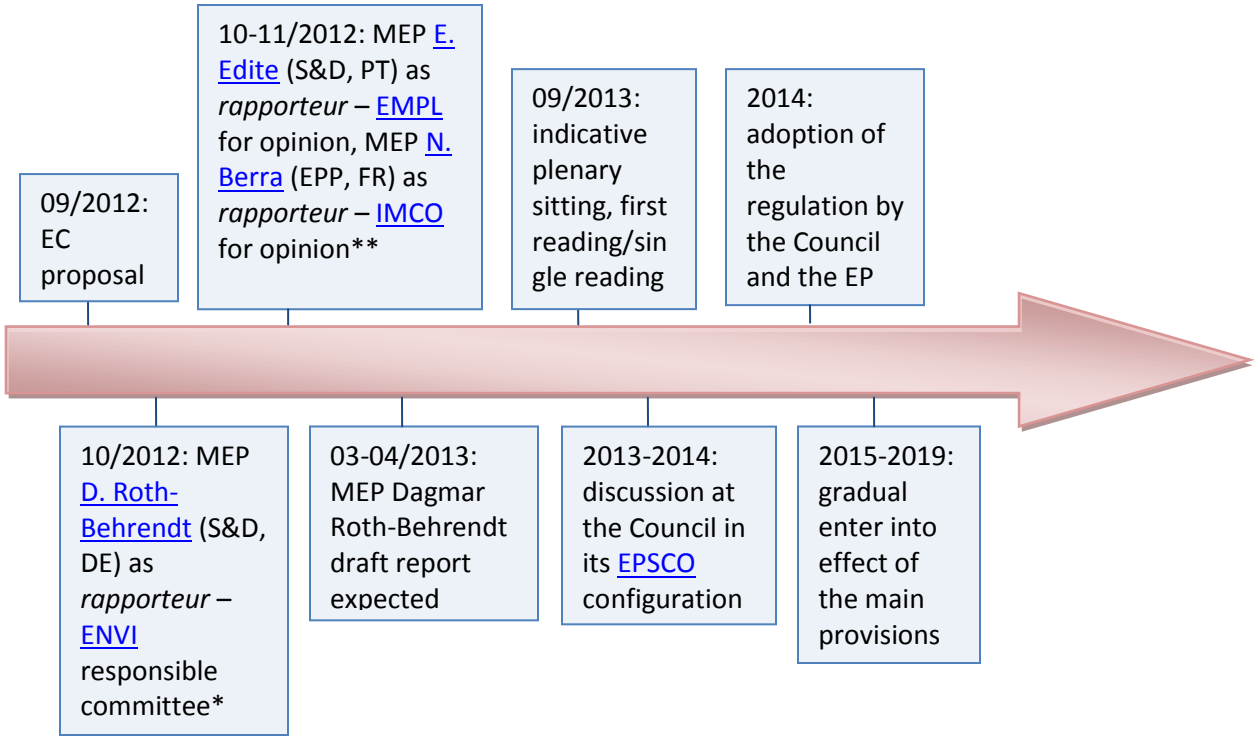
The proposal merges into a single regulation two directives adopted in the 1990s: Council directive 93/42/EEC on medical devices (divided into four classes of risk: class I, low risk, such as corrective glasses, class IIa, medium-low risk, such as dental filling material, class IIb, medium-high risk, such as X-ray machines, and class III, high risk, such as heart valves) and Council directive 90/385/EEC on active implantable medical devices (such as pacemakers, considered as class III medical devices). The existing regulatory framework being established more than 20 years ago, technological and scientific progress, the need to guarantee the functioning of the European Union (EU) single market undermined by the presence of gaps and uncertainties regarding certain products (such as invasive products for cosmetic purposes) and the necessity to increase patients' safety (especially after it was proved that medical devices on the market can be even dangerous despite the approval issued by regulators)[2] justify the Commission's proposal. **EFA believes that also the changing role of patients and the need for patients' empowerment to take active role in their care should be one of the key justifications underpinning the proposal.**

On 26 September 2012, the European Commission adopted this proposal that fosters innovation and contributes to maintain the competitiveness of the medical devices sector,[3] while at the same time tightening and streamlining the controls to improve the safety of the devices placed on the EU market. The proposal is currently under ordinary legislative procedure at the European Parliament and the Council of the European Union, it is expected to be adopted by 2014, and its provisions will gradually enter into force from 2015 to 2019.

[2] Triggered by the scandal of the French manufacturer *Poly Implant Prothèse*, PIP, that used industrial silicone instead of medical grade silicone for breast implants for several years the European Parliament adopted a resolution on defective silicone gel breast implants made by the French company PIP calling on the Commission to develop an adequate legal framework to guarantee the safety of medical devices in Europe [European Parliament resolution of 14 June 2012 on defective silicone gel breast implants made by French company PIP, available at: http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2012-0262&language=EN&ring=B7-2012-0302 (consulted on 22 November 2012)].

[3] According to Eucomed, the European association representing medical technology industry, the medical devices' sector is highly innovative in Europe, with a market value of around 95 billion EUR every year [2009 Eucomed figures for the EU 27 Member States, Norway and Switzerland, available at: http://www.eucomed.org/medical-technology/facts-figures (consulted on 21 November 2012)].

Timeline of the regulation[4]



* Shadow *rapporteurs*: M. McGuinness (EPP, IE), H. Krahmer (ALDE, DE), M. Rivasi (Greens, FR), M. Yannakoudakis (ECR, UK), A. Sousa (GUE, PT)

** Shadow *rapporteurs*: V. M. Garcés Ramón (S&D, ES), A. Parvanova (ALDE, BG), H. Ruhle (Greens, DE), A. Fox (ECR, UK)

Legal basis

Article 114 of the Treaty on the Functioning of the European Union (TFEU): harmonisation of national rules for placing on the market and putting into service medical devices and their accessories on the EU internal market

Article 168(4)(c) of the TFEU: public health measures setting high standards of quality and safety for medicinal devices

[4] A more complete overview of the legislative procedure is available at: http://www.europarl.europa.eu/oeil/popups/ficheprocedure.do?reference=2012/0266%28COD%29&l=en (consulted on 8 January 2013). Basically, the Commission proposes; the European Parliament identifies a responsible committee that will draft the report and several committees that will give an opinion on this proposal; the Council will discuss the issue in its responsible configuration.

Both objectives of the regulation (ensuring the functioning of the internal market as regards medical devices and promoting a high level protection of human health by setting high standards of quality and safety for these devices) are **pursued simultaneously** and are **inseparable linked** in the proposal while **one not being secondary to the other**.

Difference with the current legislation: currently, because the harmonisation article is the only legal basis, devices that bear the CE marking can, in principle, move freely within the EU. With the proposed revision, it is necessary to take into account the protection of public health for all European patients and users.

Member States should be prevented from adopting diverging product regulations that will result in further fragmentation of the EU single market and unequal possibilities for access/availability to patients/users.

→ The Commission is empowered by the regulation to adopt delegated (article 290 of the TFEU) and implementing acts (article 291 of the TFEU).[5] The former ensures uniform application of the proposed regulation; the latter complements the regulatory framework for medical devices over time.

The proposed regulation applies to all 27 EU Member States, the three countries of the European Economic Area (EEA: Norway, Liechtenstein and Iceland), Switzerland and Turkey. The requirements also apply to the medical devices offered to persons in the EU by means of information society service (Internet sold medical devices) and to those devices that provide a diagnostic or therapeutic service to persons in the EU (e-health medical devices).

General content

Chapter I: Scope

The proposed regulation covers all medical devices other than *in vitro* diagnostic medical devices, and their accessories, for human use (merging two current directives).

Its scope is however extended to include some products that are not at present regulated by the two directives in question, such as:

[5] For example, it is the Commission that, by means of implementing acts, decides if a product should be considered as a medical device or as one of its accessories and therefore falls under the scope of the proposed regulation. Delegated acts may be adopted to amend in the light of technical progresses the general safety and performance requirements to place a device on the market (annex I), the elements in the technical documentation (annex II), the minimum content of the EU declaration of conformity (annex III), the minimum requirements needed for the assessment of medical devices performed by notified bodies (annex VI). More in general, Commission may adopt delegated acts to amend all annexes of the proposed regulation.

- Products manufactured utilising human tissues and cells, or their derivatives, that have undergone substantial manipulation (e.g.: syringes prefilled with human collagen);
- Implantable or other invasive products without a medical purpose that are similar to medical devices in terms of characteristics and risk profile (e.g.: implants for aesthetic purposes, non-corrective contact lenses).

EFA comment: although EFA is focused on patients with asthma, allergy and COPD, this provision that includes others than strictly medical devices is **welcomed** as far as it enhances the protection of Europeans' health and ensures a better level of safety. In addition, it may cover also possible new devices, in favour of asthmatic/allergic/COPD patients, that might be invented afterwards.

On the other hand, in order to ensure harmonisation of the rules at the EU level, some products that are considered as medical devices in Member States and not in others are excluded from the scope of the proposed regulation.

Distinction between medical device and medicinal product: in general, the proposed regulation should apply to medical devices intended to administer a medicinal product. However, when the resulting product is a **single integral product intended exclusively for use in the given combination and not reusable**, it will be governed by the provision of the legislation on medicinal products. The general safety and performance requirements set out in annex I of the proposed regulation should nonetheless be respected as far as the device part is concerned.

It is difficult to draw the line between medicinal products and medical devices in the cases of **products composed of substances or combination of substances** that are intended to be ingested, **inhaled** or administered rectally or vaginally and that are **absorbed by or dispersed in the human body**. To ensure a high level of safety of these products regardless of their qualification, they are classified in the highest risk class of medical devices and they should comply with the requirement set out in annex I of the legislation on medicinal products.

EFA comment: the objective of the Commission is to guarantee a high level of safety for patients using these devices, but a **clarification**, for example through guidelines, is needed on the specific characteristics of these devices that cannot easily fit into one definition or the other.

EFA may be particularly interested in those products; especially if we think about possible future scientific developments that allow certain devices with products to be inhaled directly (nanomaterials) and that could treat respiratory diseases. Also patients need to understand under which regulation a device they might be using falls under in view of reporting defects to the right place.

Recital 8 says that it is the responsibility of the Member States to decide whether or not a product falls under the scope of the proposed regulation on a case-by-case basis and that the Commission may issue EU-wide decisions in some cases when it is particularly difficult to distinguish between medical devices and other products (i.e., cosmetics or medicinal products). Article 3 then states that the Commission

may decide by means of implementing acts on the regulatory status of a product, at the request of a Member State or on its own initiative.

EFA comment: the provisions are not crystal clear, it should be **better specified** whether the final decision rests with the Commission or with the Member States. Indeed, the text as it is proposed gives discretion to the Commission to decide whether or not intervene in case of contrast between Member States (or to the Member States to ask the Commission to intervene). Instead, in such cases, the Commission should always take EU-wide decisions.

The same level of protection of EU citizens and performance of a device should be applied everywhere in the European Union. As a consequence, what is considered medical device in a Member State (and therefore needs to respect the safety and performance requirements) should be considered in the same way in the other countries where the proposed regulation applies. Otherwise this leaves patients/users in a strange situation, especially with open borders to work and live in another EU Member State. In addition, if one item might be considered as medical device in some countries and not in others, the risk is to cause a breach of the EU single market. More clarity is also useful for understanding which reporting system should be used.

Although the issue of **pricing and reimbursement** is a national topic, access to safe medical devices should be guaranteed to everyone. In Bulgaria, for example, oxygen concentrators are not reimbursed and patients with COPD have to buy them by themselves. As their average price amounts to 1,000 EUR and an average salary in Bulgaria corresponds to 400 EUR, they end up buying second hand oxygen concentrators that no one can guarantee.

Chapter II: Placing on the market

Medical devices may be placed on the EU internal market if they meet the **general safety and performance requirements** set in annex I of the proposed regulation, if the **technical documentation** has been drawn up and a **clinical evaluation** carried out by manufacturers.[6] Such evaluation and its documentation should be **constantly updated** with data obtained from the implementation of the manufacturer's **post-market surveillance plan**.

[6] Where there are no harmonised standards already in place at the EU level, the Commission may adopt, by means of implementing acts, common technical specifications (CTS) to further specify the requirements set out in annex I, as well as the technical documentation set out in annex II and the clinical evaluation and post-market clinical follow-up set out in annex III.
If a manufacturer does not have a registered place of business in a Member State should designate a **single authorised representative** that keeps the contact with the authorities. This representative has duties, such as inform the manufacturers of any complains related to the devices they place on the market and terminate the mandate if the manufacturers do not follow the provisions of the proposed regulation (and later on inform the authorities). Manufacturers need to provide access to the documentation in at least one official language of the EU. Manufacturers and authorised representatives need to appoint a person responsible for regulatory compliance (novelty of the new proposed regulation, parallelism with the legislation on medicinal products).

EFA comment: the requirements set in annex I are both general and specific regarding design and construction of the devices. A provision that requests **patients' participation** in any further revision of these requirements (at least of the general ones) should be inserted in the proposal.

Patients are the ones using the devices in their daily lives and they know better than others what it means and which kind of risks they are willing to take to have benefits in exchange. Therefore, they should be consulted when the risk-benefit balance is defined (as it is the case in annex I general requirements).

When the conformity assessment procedure has been completed, manufacturers can draft an **EU declaration of conformity** and affix the **CE** marking.[7] This marking should be visible, legible and indelible and affixed to the device or its sterile pack.

Other responsibilities of the manufacturers include the institution and update of a **quality management system** and a **post-market surveillance plan**, both proportionate to the risk class of the device they produce. The post-market surveillance plan, in particular, sets out the process for collecting, recording and investigating complaints and reports from healthcare professionals, patients or users on suspected incidents related to the device, keeping a register of non-conforming products and products recalls or withdrawals. Part of this plan should be the post-market clinical follow-up. Manufacturers should take all the necessary actions to bring the product into conformity (if they believe it is not), withdraw it or recall it, and inform the distributors.

EFA comment: EFA **welcomes** the streamlining of post-marketing surveillance and possibility for direct patient reporting on any incidents on the device, alongside of healthcare professionals and other users, with that in use for medicines.

Patients with allergy and respiratory diseases are very active when it comes to the devices they use, especially if they are to help treat life-threatening events, such as serious exacerbations in COPD, asthma attacks or anaphylactic reactions in allergy. This kind of information will also help to understand the needs and further develop existing and new innovative devices.

Manufacturers should also provide **information** in an official EU language that is easily understandable for the user or patient. In the specific case of implantable devices, manufacturers should make available to patients **implant cards** with all the information on the device, on how to identify it and on ways to act (for example indications as to whether or not the device is compatible with certain diagnostic devices or with scanners used for security controls).

EFA comment: EFA **welcomes** this provision as appropriate patient-friendly information prevents the occurrence of users' errors that can cause medical device incidents and therefore

[7] This certificate, together with the technical documentation should be made available to authorities by manufacturers for five years after the last device interested by these documents was sold and for 15 years in case of implantable medical devices.

--------> **EFA comment:** this provision is particularly **positive** as it aims at enhancing patients' safety by requesting transparency and continuity.

improves patients' safety. Moreover, informed patients are more likely to report any issues they have with the devices and act correctly in case of defect. This information should include advice on what to do in special situations, such as corrective actions to take in case of defects. Information to the public must be supplied in the local language of the country the device is sold.

Patients and their organisations should be involved in developing **guidelines** for information on medical devices to patients to ensure that it corresponds to their needs. In line with the provisions of the medicinal products legislation, patient/lay **review** of the information supplied to users should be foreseen in order for the device to be used correctly.

Implant cards should be supplied **before** the patients are implanted to help them make better informed and more conscious choices.

Importers shall ensure that the devices they import are in conformity with the requirements of the regulation and they need to check that the manufacturers' duties are respected (including the designation of an authorised representative). Once they import the devices, these come under their responsibilities (e.g.: storage and transport conditions do not need to jeopardise the safety of the devices). They should recall or withdraw the devices if they believe these are not in conformity with the regulation once the manufacturer and the authorised representative are informed. Distributors need to check as well that the provisions of the proposed regulation are respected by manufacturers or importers.

Therefore, manufacturers/importers/distributors have the following major common duties:

- Check the provisions are respected; and
- Do not put the device on the market, recall or withdraw the device if it does not respect the regulation's requirements.

Manufacturers' duties can apply to importers and/or distributors when the latter make available the device under their trademark, they change the intended purpose of the device and/or they modify (substantially) a device already placed on the market.

EFA comment: EFA **welcomes** the "safety chain" for devices, with all the actors of the supply chain having their own responsibility.

Reprocessing of single-use devices is considered as manufacture of new devices so that the reprocessors must satisfy the obligations incumbent on manufacturers. The reprocessing of single-use devices for critical use (e.g.: device for surgically invasive procedures) can be carried out only if considered safe according to the latest scientific evidence, and the European Commission will establish a list of those devices that may be reprocessed.

For all devices, Member States are allowed to have national provisions that ban the practice of reprocessing for their territory, and they can refuse access to the market to reprocessed single use devices on public health grounds. This information will be made publicly available by the Commission.

EFA comment: the reprocessing of single-use devices is crucial for EFA as it may refer for example to the adrenaline injectors (that can be used only once). Although this may represent an apparent danger to patients' safety, it needs to be specified that when they are reprocessed, these devices need to go through the same procedure applicable to medical devices that have to be firstly placed on the market. Lives are at stake, and often those of children. Therefore, they need to prove that all the safety requirements of the regulation are respected. To guarantee the same level of EU citizens' protection, the Commission should draft EU-wide **guidelines** on clear, legally binding procedures that evaluate the potential risk for patients.

The proposed regulation defines medical devices for critical use as single-use device intended to be used for surgically invasive medical procedures. This definition does not take into account the severity of the disease that is treated by the device and should be **modified** accordingly. EFA is particularly concerned because of adrenaline injectors. They can save life and if they have to be reprocessed, the same clear procedures that evaluate the potential risks for patients should be followed. However, it is not clear whether they have to be considered as surgically invasive devices or not. Annex VII defines these devices both as those that penetrate inside the body through the surface of the body, with the aid or in the context of a surgical operation and those that produce penetration other than through a body orifice.

Chapter III: Transparency

Economic operators must be able to identify who supplied them and to whom they have supplied medical devices. To allow such identification within the supply chain and traceability of the devices, all medical devices placed on the market should bear a **Unique Device Identification (UDI)** on their labels (novelty).[8]

EFA comment: the UDI represents a **positive** novelty as it is essential to guarantee the traceability for vigilance and post-market surveillance. This is fantastic news for patients as if a serious incident happens, it is important to be able to trace back and conversely, in case of a safety alert, use this code as a reference.

Manufacturers/authorised representatives and importers must register themselves and the devices they place on the market in a **central EU database** (further development of the European Databank on Medical Devices – Eudamed – set up in 2010). A large part of the information contained in the database will become public available (novelty: currently the information is accessible only by Member States' competent authorities). According to the Commission's proposal, this database will increase transparency and, at the same time, reduce economic costs and administrative burdens for economic operators following the emerging of different national databases with divergent requirements that were hampering the EU internal market and indeed transparency.

[8] This will be implemented gradually and proportionate to the risk class of the device.

Manufacturers of high-risk devices should draft a **summary of safety and performance** with key elements on the supporting clinical data (novelty).

EFA comment: the summary of safety and performance should be **publicly** available and written in a language **easily** understandable by users, healthcare professionals and patients (the local language of the country the device is sold).

Chapter IV: Notified bodies

The existing differences as regards the **designation and monitoring of notified bodies** (independent bodies assessing the conformity of the medical devices) on the one hand and the **quality and depth of the conformity assessment** they perform (especially in the case of the clinical evaluation) on the other hand result in inequalities between EU Member States as far as health, safety, possibilities for access for devices and confidence of citizens in the system are concerned.

Stricter and detailed criteria to designate and monitor notified bodies are laid down in annex VI of the new proposed regulation (novelty).[9] In addition to this, the proposal increases the powers of the notified bodies and specifies the rules according to which notified bodies perform their assessments. These notified bodies have the right and duty to carry out unannounced factory inspections and to conduct physical or laboratory tests on the devices (novelty). Surveillance assessment must be regularly conducted by notified bodies after initial certification. The personnel involved in the assessment of medical devices should rotate to guarantee a balance between the need to have knowledge and experience as well as objectivity and neutrality.

Chapter V: Classification and conformity assessment

The proposed regulation maintains the classification in four classes of risk, but the classification rules (laid down in annex VII) have been adapted to technical progress and experience gained from market

[9] Member States authorities are still the ones deciding on the notified bodies, including their subcontractors and subsidiaries. These authorities should be independent and peer-reviewed every second year. The results of this review should be communicated to the Commission and the other Member States and a summary made available to the public at large. The decisions of the national authorities, in addition, are reviewed by joint assessment teams with experts from other Member States and the Commission and the final recommendations regarding the bodies are issued by the Medical Device Coordination Group. As a result, the subsidiarity principle is respected and, at the same time, an effective control at the EU level is ensured.
The national authorities shall suspend, restrict and fully or partially withdraw the notification if the notified bodies do not meet anymore the requirements of the proposed regulation. The Commission and the Member States should be informed accordingly. When these authorities fail to do so, the Commission may do this by means of implementing acts. The Commission shall ensure the exchange of best practices among national authorities and appropriate cooperation and coordination among notified bodies. Member States shall levy fees on applicants and notified bodies to cover the costs of the national authorities and such fees should be regulated by the Commission at the EU level through delegated acts.

surveillance. The Commission by means of delegated acts my decide to change the classification criteria or decide that a device should, by way of derogation from these criteria, be classified in another class. In case of dispute between manufacturers and notified bodies on the class of the device, the competent authority will be referred to, and it must notify both the Commission and the Medical Device Coordination Group (MDCG, an expert committee made up of members appointed by the Member States due to their role and experience in the field of medical devices and chaired by the Commission). The implantable medical devices are considered as high risk ones.

EFA comment: as patients are the ones taking risks, their expertise and vision should be taken into account. Therefore, provisions requiring the Commission to involve patients when changing the classification criteria should be involved, as well as **patients' involvement** should be foreseen at the national level by the competent authorities responsible for deciding on the classification of a medical device in case of disputes between manufacturers and notified bodies.

The classification of the medical devices determines the applicable **conformity assessment procedure** (laid down in annexes VIII to X):[10]

- For class I (low risk) medical devices, the conformity assessment may be carried out by the **manufacturers**, simply by issuing the EU declaration of conformity. When these devices are placed on the market in sterile conditions or have a measuring function, notified bodies play a role in verifying the aspects related to the measuring function and the sterilisation process;
- For class IIa (low/medium risk) and IIb (medium/high risk) medical devices, **notified bodies** are involved in a way proportionate to the risk of the device: they need to check the quality management system, and the technical documentation on a representative basis;
- For class III (high risk) medical devices, prior approval of the design or of the type of the device and of the quality management system by **notified bodies** is required before these are placed on the market. In the case of new applications for conformity assessments for class III medical devices, the notified bodies need to notify the Commission and the Medical Device Coordination Group that, on scientifically valid health grounds, can request the body to submit a preliminary assessment and then give comments on that before the certificate is granted (**scrutiny procedure**).[11]

EFA comment: although the scrutiny procedure is the exception rather than the rule, it allows the authorities to have a deeper look into the high risk class medical devices before these are placed on the market and therefore ensures a high level of protection and safety. **Patients'**

[10] Manufacturers of custom-made medical devices are subject to a specific procedure (laid down in annex XI) that does not involve notified bodies.

[11] The Commission may decide by means of implementing acts if this procedure is applicable to other medical devices than those classified under class III (on the basis of, *inter alia*, the novelty of the device, an increased rate of serious incidents reported, significant discrepancies in the conformity assessments carried out by different notified bodies on similar devices).

views should be taken into account in this new procedure, alongside with those of healthcare professionals.

Manufacturers may decide to apply a conformity assessment procedure applicable to device of a higher class (additional control that enhances the safety of the devices). The certificate notified bodies released may not last more than five years.

Chapter VI: Clinical evaluation

Manufacturers have key obligations as regards the **clinical evaluation** to demonstrate the safety and performance of their devices: they have to analyse the relevant scientific literature and the results of all clinical investigations performed, and the outcome of this analysis shall be documented in a clinical evaluation report. Annex XIII presents more in detail the pre-market clinical evaluation and post-market clinical follow-up, while annex XIV focuses on the requirements for clinical investigation.[12]

EFA comment: an issue that should be underlined in the clinical evaluation refers to the issue of **generics**. In particular, for our disease area, we may present the Italian example, where AIFA (the Italian Medicines Agency) checks and approves any branded drug together with the device supplied for spraying it to grant that the right quantity of necessary drug is dispensed. In view of generic drugs expansion also in the field of asthma and respiratory diseases care, the new rules ought to foresee that medical devices for spraying drugs are tested, checking their effectiveness, together with any of the drugs with which they might be utilised.

Link with the proposed clinical trial legislation: for all commercial clinical investigations that pursue regulatory purposes (obtaining or confirming regulatory approval for market access) the concept of sponsor is introduced and aligned with the definition given in the proposed clinical trial legislation.[13] The sponsor must submit an application to confirm that there are no health and safety or ethical aspects that would oppose the clinical investigation.[14] The **sponsor** shall report to all interested Member States **every serious adverse event, every device deficiency and every new finding** in relation to the medical device.

[12] Clinical investigation is the equivalent of clinical trials as regards medical devices. The clinical investigation shall assess whether the medical device is suitable for its specific purpose, whether it achieves the objective specified by the manufacturers and the risk-benefit balance for patients.

[13] In the case the sponsor is different from the manufacturer, and when it is not established in the EU territory, a contact person should be appointed.

[14] Clinical investigations shall be designed and conducted in a way that the rights, safety and well-being of the subjects are protected and that the clinical data generated are going to be reliable and robust. The rules on clinical investigations should be in line with major international guidance in this field, such as the international standard on good clinical practice for clinical investigations of medical devices for human subjects and the most recent version of the World Medical Association Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects, to ensure that clinical investigations conducted in the Union are accepted elsewhere and that clinical investigations conducted outside the Union in accordance with international guidelines can be accepted under this regulation.

Every clinical investigation must be registered in a **public accessible electronic system** set up by the Commission that should interoperate with the proposed EU database on clinical trials. To guarantee the protection of personal data and commercially sensitive information, confidentiality is necessary in some cases. Through this electronic system, **Member States** should let the other Member States and the Commission know when a clinical investigation has been **refused, suspended or terminated**. The **sponsor** should communicate to the interested Member States when a clinical investigation has been **temporarily halted for safety grounds**. Within one year from the end of the clinical investigation, the sponsor shall submit to the Member States concerned a summary of the results of the clinical investigation (**clinical investigation report**). Nothing is mentioned concerning the general public.

EFA comment: Member States should make **publicly** available all the information regarding the clinical investigations' results, as well as refusals, suspensions and terminations. It is important that all information regarding patients' safety is clearly made public.

In the case of multinational clinical investigations, there will be a **single application** (there will be a single identification number for every clinical investigation) submitted through the electronic system set up by the Commission and will be assessed by the interested Member States under the direction of a **coordinating Member State**. This Member State will be assisted by the Commission's secretariat and will be responsible for drafting the **report on the results of the coordinated assessment (first phase)**. Intrinsically national, local and ethical aspects (such as the liability, the information to patients and the informed consent) are still **assessed at the Member State's level (second phase)** that ultimately decide whether the clinical investigation is authorised or not. Member States that decide to "opt-out" from a clinical investigation need to let the other Member States and the Commission know, but there is no mention of the general public in the proposal. The people assessing the application (both during the first and the second phase) need to have the necessary qualifications and experience, to be independent and without conflict of interest. At least one person whose primary area of interest is non-scientific shall be taken into account, as well as the view of at least one **patient**.

EFA comment: in line with the clinical trials new proposed legislation, there is a provision requiring that the application is assessed by at least one patient. This enhances patients' involvement and participation in the decision-making influencing their health and is a positive step forward compared to the past. However, a **clear** definition of what is intended for patient is needed as there are great divergences between Member States at the moment regarding patients' participation in these assessments. In addition to that, **patients' views** should be taken into account both while assessing the application and while submitting it. This means that applications for clinical investigations should be patient-centred. Indeed, although the proposed regulation says that clinical investigation "shall be designed and conducted in a way that the rights, safety and well-being of the subjects participating [in it] are protected and that the clinical data generated...are going to be reliable and robust", nothing is mentioned about the performance that is relevant for patients.

As for the clinical trials legislation, at least the basic core principles of the informed consent and information to patients should be assessed **jointly** by all Member States interested and not at the national level. Member States that "opt-out" should make their reasons **publicly** available.

As for the clinical trials legislation, Member States may decide who is responsible for deciding on the approval of clinical investigations. There is **no more a legally required dualism of bodies (national competent authorities and ethics bodies)**.

EFA comment: the Commission prefers to avoid mentioning the distinction between national competent authorities and ethics committees and leaves the Member States responsible for deciding whether the assessment (both during the first and the second phase) should be carried out by the former or the latter. Although ethics committees see this provision as a limit (not mentioning ethics committees could let Member States free to decide whether or not these bodies are necessary at the national level), the idea behind the proposal is to avoid harmonising something (ethics committees) that cannot be done at the EU level due to major divergences. Following the future entry into force of this provision, ethics bodies will be involved in the assessment of both phases one and two and they will be forced to restructure their way of functioning (they should meet more often than once per month and cooperate more closely with the other ethics committees in the EU).

This provision streamlines their functioning, but it should made **clear** that this avoidance does not mean less protection for patients while assessing the clinical investigations.

By implementing acts the Commission may harmonise, among others, the forms used to report adverse reactions and devices deficiency, the forms to apply for clinical investigations and their assessments, the forms for the notification of the post-market clinical follow-up.

Chapter VII: Vigilance and market surveillance

A well-functioning system of vigilance is fundamental as some medical devices (those implanted or those that are supposed to operate for ages or decades, but in our disease areas also devices with a shorter life) may present complications only after a certain period of time.

Manufacturers shall report **every incident occurred and every field safety corrective action** (actions taken by the manufacturer for technical or medical reasons to prevent or reduce the risk of serious incidents) they have been taken to reduce its impact via an **EU portal**.[15] The incidents and the corrective measures adopted at the level of a single Member State are evaluated centrally by the competent authority of the Member State in question (possibly in collaboration with the manufacturer). This information will be automatically forwarded to all responsible national authorities. When the same

[15] The manufacturers have 15 days to submit the report from the moment where the incident occurs and the causal relationship with the medical devices is identified. They may submit an incomplete report followed by a complete one to respect the deadline and do not delay any further actions to safeguard patients' safety.

incident occurred in several Member States or the same corrective action has been taken, a coordinating authority (supported by the Commission's secretariat) will lead the analysis of the case.

EFA comment: differently from the EU pharmacovigilance system, there is not a single EU agency, as the European Medicines Agency (EMA), that carries out a risk assessment. This can cause a difference of treatment among Member States of the EU. However, EMA has to be informed in the case of incidents and field safety corrective actions related to a substance that, if used separately, would be considered to be a medicinal product. A more **coordinated response** is needed where an important issue that threatens patients' safety is detected or suspected and a system that is involving patients should be developed.

Member States should take all appropriate measures to encourage **healthcare professionals, patients and consumers** to report to their competent authorities suspected serious incidents. These reports should be recorded centrally at the **national level** and manufacturers should be informed of any suspected serious incident that has been reported. Standard web-based structures forms for reporting should be developed by EU Member States,[16] and the Commission shall ensure that everyone interested has appropriate levels of access to the electronic system. A statement will be included in the instructions for use, as it is now for medicinal products.

EFA comment: as for the pharmacovigilance legislation, only manufacturers are obliged to report suspected serious incidents, while healthcare professionals, patients and consumers are encouraged. Differently from the pharmacovigilance system, Member States should only provide a web-based system to report suspected serious incidents. This could represent a limit for some patients and consumers that may not have access to the web or necessary experience in using such tools. Although the provision says that the Commission has to ensure adequate levels of access to the electronic system, it is not clear how this can actually happen. Hence, another **format for reporting** should be foreseen by the national authorities. As for the medicinal products, it should be possible to report incidents to patients also to **pharmacies**, which should have access to the electronic system.

The way and language information is given to patients, as well as the existing different Member States' systems need to be **consulted** with patients, as it happens for example with the Eudravigilance user group. **Campaigns** should be carried out to raise awareness of citizens on the issue. In addition, **all** incidents, including those caused by users' errors, should be collected. This kind of information would also be very useful for patients.

Manufacturers shall ensure that users of the medical devices are informed without delay of the corrective actions taken through a so called **field safety notice**. Manufacturers of devices classified in class IIb and III shall report **all significant increase in the frequency and severity of incidents** that are not considered as serious or of expected undesirable side-effects.

[16] Member States will have to follow the harmonisation rules that may be decided by the Commissions by means of implementing acts.

EFA comment: both these provisions are **positive** as they concern the guarantee of patient's safety and access and transparency of information.

Vigilance system

The reporting of serious adverse events during clinical investigations and the reporting of serious incidents occurring after a medical device has been placed on the market should be clearly distinguished to avoid double reporting.

As regards **market surveillance**, the proposed regulation clarifies the rights and obligations of national authorities and ensures effective coordination among them at the EU level. Information on market surveillance may be collated in an **electronic system** set up by the Commission in collaboration with the Member States.

The **competent authorities** shall carry out an **evaluation** (see chapter VI) when, on the basis of vigilance data and other information, they have sufficient reasons to believe that a device presents a risk to the health or safety of the users. If the device is found to be in breach of the requirements of the proposed regulation, the relevant economic operators should take all necessary measures within a certain period of time, proportionate to the risk. When it does not happen, competent authorities may **prohibit, restrict, withdraw or recall** the device available on the EU single market. It is possible that a Member State raises objections against provisional measures adopted by another Member States or that the Commission finds these provisions to be contrary to the EU law.

Member States have the possibility to adopt **preventive measures** to protect the health of their citizens and therefore not making available on their market or putting into service the medical device after the performance of an evaluation without waiting for the actions of the economic operators. The Commissions should assess these measures and decide on them by means of implementing acts.

Chapters VIII and IX: Governance

Member States are responsible to designate the competent authorities for the implementation of the regulation. Such authorities should cooperate with each other and the Commission, and they will be

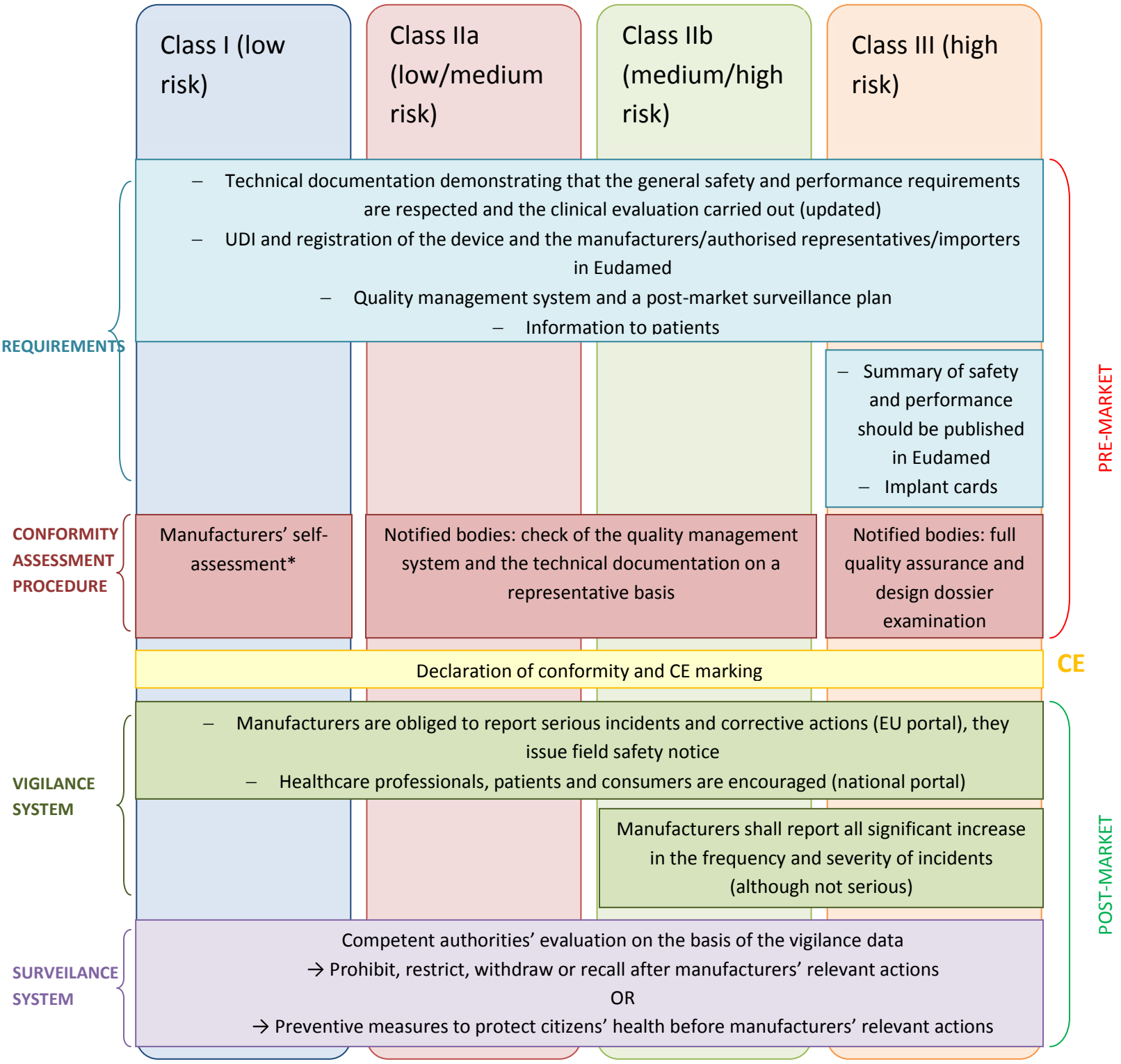
supported by the Medical Device Coordination Group, composed of members appointed by them and chaired by the Commission. By means of implementing acts, the Commission may designate **EU reference laboratories** that provide scientific and technical expertise, create a network of national reference laboratories and therefore share best practices at the national level. These laboratories may be granted a Union financial contribution and they impose fees on Member States when they request scientific or technical assistance. These laboratories are subjected to controls by the Commission, including on-site visits and audits. Member States may levy fees for the activities set out in the proposed regulation.

EFA comment: these measures could be improved. First of all, the involvement of **patients** and patients' representatives in the MDCG is very limited as they could be invited, where appropriate, in the capacity of observers to take part in standing or temporary sub-groups. In addition, the extended role of the **EMA** is not taken into account. By doing that, the intergovernmental aspects outweigh the Union ones.

Key features of the EMA model include the following points:

- Patients' representatives are involved in decision making bodies such as the management board, and in scientific committees;
- Patient and consumers have a dedicated body that meets regularly and give input on issues that are essential for the patient perspective;
- The involvement of patient representatives is planned and set within a clear framework;
- EMA has a plan for training and capacity-building for patient representatives.

EU regulatory framework



* Notified bodies play a role when these devices are placed on the market in sterile conditions or have a measuring function.