RU-486; Safe? Effective? Banned! Why Would the Food and Drug Administration Ban a Drug With Such Potential?

Mark A. Hernandez

Follow this and additional works at: http://elibrary.law.psu.edu/psilr

Part of the Food and Drug Law Commons, Health Law and Policy Commons, and the International Law Commons

Recommended Citation


Available at: http://elibrary.law.psu.edu/psilr/vol11/iss3/8

This Comment is brought to you for free and open access by Penn State Law eLibrary. It has been accepted for inclusion in Penn State International Law Review by an authorized administrator of Penn State Law eLibrary. For more information, please contact ram6023@psu.edu.
RU-486; Safe? Effective? Banned! Why Would the Food and Drug Administration Ban a Drug With Such Potential?*

I. Introduction

In 1973, the U.S. Supreme Court ruled that a woman has a fundamental right to terminate an unwanted pregnancy through abortion.\(^1\) Although individual states may regulate this right,\(^2\) to date, a woman may still legally obtain an abortion in the United States.

Leona Benten\(^3\) is a twenty-nine year old resident of California,\(^4\) who was faced with the difficult decision of whether or not to terminate her pregnancy. Ms. Benten underwent a surgical abortion under general anaesthesia in the mid-1980's and was weary of enduring the procedure a second time.

On July 1, 1992, customs officials met Ms. Benten at John F. Kennedy International Airport as she returned from London, England.\(^5\) Ms. Benten was found to be carrying one dose of the drug Mifepristone,\(^6\) commonly known as RU-486, which she had intended to use to end her unwanted pregnancy. RU-486 was banned by the Food and Drug Administration (FDA) from United States importation due to its health risks and, therefore, was seized from Ms. Benten's luggage by customs officials.

The United States Food and Drug Administration primarily seeks to ensure that new drugs are safe and effective for their proposed use in order to protect the general public's welfare. The Federal Food, Drug and Cosmetic Act (FDCA)\(^7\) requires that drugs be

* Several new developments have arisen regarding RU-486 between the time this Comment was originally written and the time it went into print. A note at the end of the comment highlights recent developments. will summarize the developments to date.

3. Leona Benten at the time, was in her seventh week of an unwanted pregnancy. After consulting with her gynecologist, Louise Tyrer, Ms. Benten was informed that she could terminate her pregnancy by medical means not involving surgery. After explaining the procedure, risks and side effects, Dr. Tyrer wrote Ms. Benten a prescription for one dose of RU 486 to end her pregnancy. Ms. Benten then traveled to London, where she had the prescription filled. See Benten v. Kessler, 799 F. Supp. 281 (E.D.N.Y. 1992).
6. Id.
proven safe and effective through scientific evidence before they are approved for commercial marketing within the United States. Recognizing the need which some individuals may have for immediate drug treatment, the FDA revised its Regulatory Procedures Manual creating the "personal use exception" for those who wish to obtain drugs that have not yet been approved in the United States. This exception allows for the importation of small doses of untested drugs from abroad for personal use. Included within this exception are drugs for all life-threatening or serious conditions, as well as drugs for less serious medical problems where the product "is not known to represent a significant health risk."

On July, 9, 1989, the FDA issued Import Alert 66-47 which stated that RU-486 was subject to "automatic detention" and that customs agents were to "automatically detain all shipments of unapproved abortifacient drugs" being imported into the United States. The Import Alert was issued because the FDA concluded that the intended use of abortifacients could pose safety risks to the user. RU-486 has been approved for use in numerous countries, but has not yet been introduced in the United States. The political controversy surrounding abortion in this country has stalled the introduction and testing of RU-486. This Comment discusses in Section II the drug RU-486, its health risks, and its possible uses; Section III examines the FDA’s approval system; Section IV discusses the drug approval system of Great Britain; Section V compares the United States system with that of Great Britain; Section VI discusses the drug approval systems of other countries; Section VII sets forth the reasons why RU-486 has not yet been approved for use in this country; and Section VIII discusses the recent history of RU-486 in the United States including Leona Benten’s unsuccessful attempt to challenge the FDA’s ban.

(current version at 21 U.S.C. §§ 301-392 (1982)).
9. In recent years, people who are critically ill with cancer or Acquired Immune Deficiency Syndrome (AIDS) are willing to try drugs that have not yet been approved in the United States in an effort to extend their life expectancy.
11. Id.
12. Id. (quoting the Food and Drug Administration Regulatory Procedure Manual).
13. Id. at 286. See also, THE AMERICAN LAWYER, Sept. 1992, at 101.
15. To date, RU-486 has been approved for use as an abortifacient in France, the United Kingdom, Sweden and China.
16. See Steven Miles, Mifepristone is a Pill That the U.S. Should Learn to Swallow, STAR TRIBUNE, Sept. 21, 1992, at 13A.
II. Mifepristone (RU-486)

A. Background of RU-486

RU-486 is a revolutionary contraceptive/abortifacient which gained notoriety in the late 1980's. The scientific and medical communities have identified RU-486 as one of the most effective and safe methods of terminating an abortion absent a surgical procedure.\(^7\)

Dr. Etienne-Emile Baulieu first synthesized RU-486 in 1980 while he was associated with the French drug company Roussel Uclaf.\(^8\) On September 27, 1989, Dr. Baulieu received the Albert Lasker Medical Research Award for the research and development associated with this new drug.\(^9\)

B. How RU-486 Works

The body of a pregnant woman secretes progesterone to prepare the uterus for the implantation and retention of a fertilized egg.\(^20\) RU-486 is “an antihormone, a synthetic chemical, that when taken within the first seven weeks of pregnancy induces an abortion by blocking the action of progesterone and prompting the uterus to shed the egg.”\(^21\) The entire procedure “involves the ingestion of 600 milligrams of Mifepristone on an empty stomach, followed forty-eight hours later by the ingestion of Cytotec [or another prostaglandin].”\(^22\) Prostaglandins cause contractions of the uterus, and are administered sequentially with RU-486 to increase the drug’s overall effectiveness.\(^23\)

C. Effectiveness of RU-486

The medical community viewed RU-486 as a medical breakthrough, offering women a safe and effective manner of terminating an unwanted pregnancy without having to undergo surgery.\(^24\) Each year approximately 1.6 million women in the United States undergo elective abortions.\(^25\) Surgical abortion is the most commonly used al-

---

\(^23\) See Chapman, supra note 21, at Z13.
\(^24\) See Miles, supra note 16, at 13A; see also Grimes, supra note 17, at 5.
\(^25\) See Grimes, supra note 17, at 5.
ternative method of terminating a pregnancy and requires anesthesia so that a woman’s uterus may be dilated, scrubbed and evacuated. Women who have terminated pregnancies through surgical abortion and clinical trials of RU-486 reported that the abortion with RU-486 was “two thousand times better” and “far less violent” than the surgical alternative.

Roussel Uclaf noted that RU-486 is eighty-five percent effective when taken alone. When taken in conjunction with a prostaglandin, the drug’s effectiveness increases to ninety-six percent.

D. Safety of RU-486

RU-486 was approved for use in France in 1988. Since then, over 110,000 women have safely used the contraceptive/abortifacient. The drug induces bleeding comparable to a menstrual period for approximately one week, and a few patients feel slight nausea and cramps. The drug remains in the body for only forty-eight hours, and the side effects are “short-lived.”

E. Other Possible Uses for RU-486

Recently, RU-486 was found to be 100 percent effective when used as a “morning-after” contraceptive. “The standard morning-after pill, a high dose version of the oral contraceptive, is given up

27. The procedure for a surgical abortion are generally not recommended until the eighth week of pregnancy and requires the uterus be dilated so that the vagina, vulva and cervix can to be scrubbed. The cervix is then dilated to allow for the evacuation of the uterus. To do so, a suction curette aspirator is inserted into the uterus to remove the placenta or fetal parts. Any remaining parts of the placenta or fetus must then be removed with a sharp curet to avoid continued bleeding and infection. See id. n.2 (citing ROSCOE N. GRAY, ATTORNEY’S TEXTBOOK OF MEDICINE P 311.84(I) (3d ed. 1991)).
28. For a short period of time, RU-486 was being tested in California until Roussel Uclaf ceased supplying the drug in the United States due to the hostile environment of the abortion issue. See Miles, supra note 16, at 5.
29. See Herman, supra note 20, at Z12.
30. Id.
32. See Hilts, supra note 5, at A12.
35. Glasgow researchers administered either RU-486 or the standard morning-after pill to eight hundred women who sought emergency help after having unprotected intercourse or contraceptive failure. Of the women who received RU-486, none became pregnant and fewer suffered from nausea in comparison to the standard morning-after pill. Peter Pallot, Morning-After Birth Pill Proves 100pc Effective, THE DAILY TELEGRAPH, Oct. 9, 1992, at 7.
36. The most common morning-after pill used by doctors is Ovral. The usual dosage for this emergency treatment to prevent pregnancy requires the administering of two pills taken as soon after intercourse as possible followed by two additional pills 12 hours later. Dr. Howard Seiden, ’Morning-after pill’ RU 486 Should Not Be Blocked, THE GAZETTE (Montreal), Oct.
to seventy-two hours after unprotected intercourse or after contraceptive failure. "Morning-after" birth control pills are administered primarily in Planned Parenthood clinics, emergency rooms treating sexually assaulted women, and college health clinics as protection from becoming pregnant. RU-486, when used as a "morning-after" contraceptive, as opposed to an abortifacient, is believed to prevent the implantation of a fertilized egg in the uterine wall.

Other options for emergency postcoital or "morning-after" contraceptives are the insertion of a copper-type intrauterine device (IUD) or the administering of the drug Danazol (Cyclomen). The drawbacks to these alternatives are the side effects of the IUD, and the failure rate of Danazol. RU-486 has also shown promise as a treatment for brain tumors, endometriosis and depression as well as breast, ovarian and prostate cancer. Experts noted that RU-486 may also be used to treat several other diseases including glaucoma, adrenal cancer and Acquired Immune Deficiency Syndrome (AIDS). Dr. Steven Grunberg of the University of Southern California stated that 200 patients are currently being chosen for a new study using RU-486 as a treatment for benign brain tumors that can cause seizures, blindness and paralysis.

III. The Food and Drug Administration
   A. History and Development of the FDA

   The FDA, established in 1927, was originally known as the Food, Drug and Insecticide Administration. In 1931 the name was changed to the Food and Drug Administration.

   Before 1906, no governmental body regulated the sale of drugs in the United States. Moreover, during the next thirty-two years, all attempts to regulate drug sales were ineffective. Unfortunately, it

31. 1992, (Living Section), at 5.
40.  See Dr. Howard Seiden, This Country Should Allow Women Access to RU 486, TORONTO STAR, Oct. 29, 1992, (Life Section), at 3.
41.  Insertion of the IUD can cause pain and bleeding and can on rare occasion cause perforation of the uterus, pelvic infections which may result in permanent infertility as well as heavier and more crampy periods. Id.
42.  Reports on the failure rate of Danazol have been as high as 10 percent. Id.
44.  RU-486 Will Be Tested On Brain Tumor Patients, CHICAGO TRIBUNE, Oct. 16, 1992, at 7.
45.  Id.
47.  Id., see also Myron L. Marlin, Treatment INDs: A Faster Route to Drug Approval,
took a tragedy for Congress to pass the 1938 Food, Drug and Cosmetic Act to regulate the sale of drugs. In 1938, more than one hundred children died from ingesting a liquid sulfa drug called Elixir of Sulfanilamide. Massengill Company, in formulating this liquid sulfa drug, used “diethylene glycol” as a solvent without first testing the chemical’s safety. After distribution to the public, the drug later proved extremely toxic.

In that same year, Congress passed the Food, Drug and Cosmetic Act, giving the FDA authority to regulate “all drugs and vaccines sold in interstate commerce.” The act also required that drug manufacturers submit a new drug application (NDA) to the FDA prior to marketing the drug in interstate commerce.

It took yet another disaster to bring about more stringent changes in the FDA’s regulation of drugs. In 1961 Thalidomide was determined to cause deformities in the children of European women who took the drug during pregnancy. Although U.S. doctors did not prescribe Thalidomide because it never received FDA approval, the drug was distributed to over one thousand women as an investigational new drug. This distribution resulted in seventeen cases of children born with deformities in the United States. In response to this tragedy, Congress passed the Kefauver-Harris Amendments to the Food, Drug and Cosmetics Act.

The new amendments required drug manufacturers to submit to the FDA data from adequate clinical studies proving that “substantial evidence” exists that a drug is safe and effective for its intended use. The Act defined the term “substantial evidence” as meaning evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved, on the basis of which it could fairly and responsibly be concluded by such experts that the drug will have the effect it purports or is represented to have under the conditions of use prescribed, recommended, or suggested in the label-
Although, this “definition” did not give drug manufacturers guidance, “towards the end of the 1960s, it became apparent that the pharmaceutical industry had accepted a formula under which the FDA required rigorous statistical testing procedures.” The new amendments also made it possible to hold manufacturers criminally liable for failing to notify the FDA of new adverse findings. Approval of the drugs could also be suspended, and later withdrawn, if the FDA found that use of the drug presented an imminent hazard to the public.

**B. New Drug Development and Approval**

Generally, it is not well known that the FDA does not discover or test new drugs. The FDA reviews the data and proposals of drug manufacturers who test and seek to market drugs within the United States. “Traditionally, the FDA does not become involved in drug development until the sponsor, usually a pharmaceutical company, decides that a potentially useful new drug has been studied sufficiently through laboratory and animal tests to justify the risks of administration to humans.”

The sponsor of the new drug files an Investigational New Drug (IND) application with the FDA to request a license which ex-

---

60. Id.
63. Id.
64. Id.
65. There are currently three forms of FDA licensing included under an IND application. They are: 1) the standard IND (discussed more in depth infra text pp. 8-9), 2) the “compassionate IND” license, and 3) the “treatment IND” license. See Myers, supra note 46, at 313-18.

The “compassionate IND” license is “a discretionary permit allowing a patient with an untreatable terminal illness that is unresponsive to any approved therapy to use an unapproved drug in a particular way.” Id. at 315. This license has allowed many doctors to prescribe unapproved drugs to patients suffering from cancer, epilepsy and Acquired Immune Deficiency Syndrome (AIDS), but a drawback is that the applicant must demonstrate that the “benefits in question outweigh the risks . . . .” Robert Craig Waters, Obtaining Experimental Drugs for Severely Ill Clients: The Dilemma Caused by AIDS, FLA. B. J., May 1989, at 8. Other drawbacks with compassionate IND’s is the requirements of “extensive recordkeeping, the development of extensive protocols, and . . . regulations that often may render the therapy in question too expensive. For instance, manufactures must supply the drug or therapy without charge.” Id.

The third type of licensing program, the “treatment IND,” was established in June 1987 and is “based on the premise that there are times when an experimental drug shows such promise — especially for a life-threatening condition for which there is no other hope — that it seems unacceptable to withhold it from desperate patients.” Frank E. Young, Experimental Drugs for the Desperately Ill: A Progress Report, FDA CONSUMER, May 1988, at 2. Treatment IND’s can be more widely used, by allowing the prescription to a class of patients rather
empts the sponsor from the FDCA's prohibition of the movement of unapproved drugs throughout the United States. The standard IND application must include all information gained from laboratory and animal studies conducted and must outline a plan of investigation, detailing the protocols proposed for anticipated clinical testing.

Once a sponsor files a standard IND application, the FDA has thirty days to review the submitted testing results and determine whether or not it is reasonably safe to allow the proposed clinical studies to commence. After review, "if the sponsor has submitted sufficient information to demonstrate that the drug appears reasonably safe for initial, limited testing in humans, the clinical trials may begin." After approving the standard IND application, the FDA retains the authority to stop the clinical testing if the preliminary results are not satisfactory. Complete testing of standard IND's can take anywhere from two to ten years.

When the sponsor of a standard IND judges that sufficient data exists to demonstrate that the safety and efficacy of that drug exists for its proposed purpose, a new drug application (NDA) is filed with the FDA. This application contains all the results and analysis relevant to human use from the IND clinical studies. If FDA approval is granted, the sponsor may market the new drug so long as safety reports are submitted to the FDA on a regular basis.

than individuals, but many restrictions remain on the drugs that qualify for the treatment IND. See Myers, supra note 46, at 316. Some of the regulatory requirements for the treatment IND include: "(1) there are no satisfactory alternative treatment for the disease, (2) the drug is under investigation in clinical trials under an FDA-approved IND, and (3) the sponsor of the clinical trial is actively seeking approval from the FDA for marketing the new drug—an NDA." Id. n.49 (citing H.R. Rep. No. 1092, 100th Cong., 2d Sess. 28 (1988). In addition, "scientific evidence must provide a reasonable basis for concluding (1) that the drug may be effective and (2) that it would not expose the patient to significant risk of additional illness or injury." Id.

66. See Cooper, supra note 62, at 329-330; see generally 21 C.F.R. § 312 (1991) (describing the FDA's method of processing investigational new drug applications). In addition to the IND application, the sponsor of the drug must also include documents which describe all "studies to be conducted, provide the identities of those sponsoring the tests, include protocols detailing the course of the study, offer chemical, physiological or biological character of the drug substance, list the previous human experience with the investigational drug, and furnish any other relevant information requested by the FDA." Myron L. Marlin, Treatment INDs: A Faster Route to Drug Approval, 39 AM. U. L. REV. 171, 179 n.64 (1989) (citing 21 C.F.R. § 312.23 (1989)).

67. See Myers, supra note 46, at 313.
68. See Cooper, supra note 62, at 330 (citing 21 C.F.R. § 312.35(a) (1989)).
69. Id.
70. Id.
71. See Myers, supra note 46, at 313.
72. See Cooper, supra note 62, at 330.
73. Id.
74. Id. (citing 21 C.F.R. § 314.80-81 (1989)).
C. Effect of the New Experimental Drug Approval Process

The experimental drug approval process had many positive effects. Primarily, the safety and effectiveness of these new regulations boosted consumer confidence and security in drugs marketed within the United States, as well as prevented the "proliferation of medically dubious products." However, the positive benefits of the amended process are often overlooked in the light of the criticisms the FDA regulations have received in recent times.

While introducing and marketing a new drug, a sponsor must cope with extremely high costs as well as long delays. The most significant adverse effect of the new regulations is the "drug lag," defined as "the decrease in new drug innovation and marketing that results from the strict regulatory climate at the FDA." "Beginning in 1972, several studies indicated that the United States had lost its lead in marketing new medicines and that breakthrough drugs—those that show new promise in treating serious or life-threatening diseases—had come to be available much sooner in other countries.""In 1973 William Wardell published a series of studies comparing drug introductions in Great Britain with those in the United States between 1962 and 1971. The outcome of these studies showed that "approximately fifty percent more drugs were introduced in Great Britain between the years 1962 and 1971, than in the United States."recognizing the problems associated with the drug lag, the FDA attempted to reduce delays. In cooperation with other drug regulatory agencies, the FDA focused on the acceptance of foreign clinical data. This process entails communication between drug regulatory agencies on an international scale. Communication of drug information is significant "because it relates to the very basis of the value of pharmacotherapy in health care: the effective use of drugs depends on the accurate and comprehensive communication and understanding about them."
The acceptance of foreign clinical data dates back to 1962 when the FDA advised the pharmaceutical industry that foreign clinical data meeting the standards of adequate and well-controlled studies was acceptable, but could only be used as supplemental information for proof of a drug's safety and efficacy.84

"It was not until 1975 that the FDA accepted foreign clinical studies as primary evidence of a drug's safety and efficacy. But even at this time, before the FDA would accept the foreign clinical data, the drug in question must have been for a major health gain, an uncommon disease, or must have had a strikingly favorable benefit/risk ratio."85 The FDA currently recognizes two categories concerning the acceptability of foreign clinical data: 1) foreign clinical studies not conducted under an investigational new drug application (IND) and 2) marketing approval based solely on foreign clinical data.86


85. Id. (citing Lisook, FDA Investigation of Clinical Studies: Policy and Procedure, Paper presented at the Third Annual European Symposium, Good Clinical Practice in Europe, Copenhagen Denmark at 14 (Mar. 3, 1989)).

86. See Gorski, supra note 81, at 334. John Gorski has summarized the recognized categories as follows:

1. Foreign Clinical Studies Not Conducted Under an IND.

In general, FDA accepts foreign clinical studies not conducted under an IND if the studies are "well designed, well conducted, performed by qualified investigators, and conducted in accordance with ethical principles acceptable to the world community." Studies meeting these criteria may be used to support clinical investigations and/or marketing approval in the United States. A sponsor who wishes to rely on foreign clinical studies to support an IND or to support a new drug application ("NDA") must submit the following information to the FDA:

(1) A description of the investigator's qualifications;
(2) A description of the research facilities;
(3) A detailed summary of the protocol and results of the study, and should FDA request, case records maintained by the investigator or additional background data such as hospital or other institutional records;
(4) A description of the drug substance and drug product used in the study, including a description of components, formulation, specifications and bioavailability of the specific drug product used in the clinical study, if available; and
(5) If the study is intended to support the effectiveness of a drug product, information showing that the study is adequate and well controlled.

2. Marketing Approval Based Solely on Foreign Clinical Data

The FDA has also promulgated standards under which foreign data can be used as the sole basis for marketing approval. A new drug based solely on foreign clinical data may be approved if:

(1) The foreign clinical data are applicable to U.S. population and U.S. medical practice;
(2) The studies have been performed by clinical investigators of recognized competence; and
(3) The data may be considered valid without the need for an on-site inspection by FDA or, if FDA considers such an inspection to be necessary, FDA is able to validate the data through an on-site inspection or
IV. Drug Approval in Great Britain

A. History and Development

Although both Great Britain and the United States imposed similarly high standards of medical practice and training and had research-intensive drug industries, the two countries' regulatory systems differed significantly between 1962 and 1971.87

As in the United States, premarket safety reviews of new drugs did not begin in Great Britain until the Thalidomide tragedy of 1961.88 In 1963, the Committee on Safety of Drugs (CSD), a central regulatory agency, was created to review toxicity data on new drugs, results of clinical trials, and postmarket adverse reactions.89 However, the premarket review system was voluntary rather than mandatory.

In an effort to encourage drug manufacturers to utilize the premarket review system, "the Association of the British Pharmaceutical Industry and the Proprietary Association of Great Britain both agreed that their members would not undertake or market new medicines contrary to the advice of the CSD."90 These efforts forced all of the major drug manufacturers to comply with the approval system because the majority of their domestic trade was with the National Health Service and doctors.91 While most of the large drug manufacturers complied with the voluntary premarket review regulations, a number of smaller and less reputable drug manufacturers refused. This action exemplifies just one circumstance which led to the enactment of more comprehensive, mandatory provisions for regulating drugs.92

B. The Medicines Act

In 1971, the Medicines Act of 1968 (Medicines Act) went into effect and now represents the primary mechanism for prescription drug regulation in Great Britain.93 Similar to the U.S. Food and

---

other appropriate means.

If an application fails to meet any of these criteria, it will not be approved on the foreign clinical data alone . . . . The three criteria listed immediately above are only relevant if a foreign clinical trial is pivotal for FDA approval (for example, one of only two clinical trials showing effectiveness). If U.S. data exists which is convincing per se, and foreign trials confirm the U.S. data, then FDA is not overly concerned about the foreign data . . . .

Id. at 334-36.

88. Id.
89. Id.
90. See Teff, supra note 59, at 575.
91. Id.
92. Id.
93. See Dillman, supra note 76, at 932.
Drug Administration, one of the Medicines Act's primary purposes is to "lessen the consumer's vulnerability in the face of dubious marketing techniques." To fulfill this purpose, the Medicines Act imposed safety and efficacy requirements, introduced restrictions on the advertising and promotion of drugs and also introduced provisions to improve quality control and establish a system for the licensing and inspection of manufacturing premises. "The Medicines Act established compulsory licensing of drugs through a licensing authority composed of British health ministers, including the Secretary of State for Social Services, the Secretaries of State for Wales and Scotland, and the Department of Health and Social Services for Northern Ireland." Clinical Trial Certificates (CTC's), which allow drugs to be administered to human beings, and Product Licenses (PL's), which allow drug marketing, are issued by the Medicines Division of the Department of Health and Social Services.

In making drug approval decisions, the Medicines Division of Health and Social Services is advised by the Committee on the Safety of Medicines (CSM) and the Committee on the Review of Medicines (CRM). The CSM is the organization responsible for the safety, quality and effectiveness of all new drug compounds; the CRM is the organization responsible for drugs in use as of 1975.

Postmarketing surveillance of prescription drugs is done through the "yellow card" system. The "yellow card" system works through the cooperation of doctors returning postage-paid postcards to the CSM when adverse reactions to drugs are reported.

In 1985 tests began on RU-486 in United Kingdom. In July of 1991 the drug was approved for use in Britain, primarily because the British drug approval system is less political than others.

V. Differences in Drug Approval; United States v. Great Britain

Although similar, drug approval in the United States has several distinctions from Great Britain's process. Congressional regula-
tion of drug approval is more formal than the English system. "Yet the British approval process has been characterized as scientific rather than political in comparison with that of the United States." The main difference between the two systems is the regulatory philosophy of each.

The FDA's main concern is to test drugs for adverse effects prior to the drugs being marketed to the general public. The FDA begins reviewing drugs very early and gives less emphasis to postmarketing review. Through extensive testing, "the FDA attempts to discover information relating to adverse drug reactions, effectiveness, and long-term toxicity in premarketing screening."

In contrast, Great Britain maintains the premise that no drug is one hundred percent safe, and that no matter how long a drug is tested, there will always be a chance that adverse side effects may occur. Great Britain, therefore, stresses postmarketing monitoring for these possible adverse reactions. "Although short-term testing may uncover most negative side effects, only long-term experience with a large, widely varied population will reveal the rare, and possibly more serious, reactions." As a result, drugs are approved in Great Britain on an average of two years sooner than in the United States.

Another major difference between the two systems is Great Britain's use of apolitical committees in the drug approval process. These committees are independent from both government and drug industry influence, allowing scientific evaluation of new drugs without undue influence from governmental bureaucracy or industrial pressure.

106. See Teff, supra note 59, at 579.
108. See Teff, supra note 59, at 579.
109. Id.
110. Id.
112. See Teff, supra note 59, at 579.
113. Id.
115. See Wall, supra note 107, at 325.
116. See Dillman, supra note 76, at 933-34.
117. Id.
VI. Other Countries

A. Sweden

In October of 1992 the Swedish authorities approved the use of RU-486, allowing the drug to be prescribed only by doctors. The Swedish approach to drug regulation shows a cautiousness toward the approval of new drugs that rivals the United States. Sweden, like Great Britain, uses a nationalized health care system to conduct postmarketing surveillance for adverse effects associated with new drugs. However, unlike Great Britain, “the philosophy of Swedish nationalized health care permeates decision making by the National Board of Health and Welfare (NBHW).”

Until 1980, Sweden traditionally allowed human testing of new drugs with only mandating a notice requirement. In 1980, Swedish authorities adopted a proposal which restricted the approval criteria, imposing requirements similar to those of the United States and Great Britain.

B. France

The Office of Pharmaceutical Control, which reports to the Minister of Public Health, is the regulating agency of France. France historically has not regulated consumer protection as comprehensively as the United States, but, over the last fifteen years, the regulation has grown more stringent.

In France, to market products that may put the life or health of consumers at risk, a manufacturer must obtain a “visa” or authorization from the Office of Pharmaceutical Control. Authorization is granted for medical drugs only when drug companies establish that the drug is manufactured under high standards and that it is harmless to consumers. This marketing authorization is only temporary and must be renewed periodically.

In 1982, the French government “established the National Commission on Drug Monitoring to facilitate the gathering of data on adverse reactions to drugs subject to authorization. Its primary

119. See Wall, supra note 107, at 327.
120. Id.
121. Id.
122. Id.
123. Id.
125. Id. at 401.
126. Id. at 402.
127. Id.
128. Id.
functions include 'compiling and evaluating information on the unexpected or toxic effects of medicaments.'

The French authorization system requires a manufacturer of a new drug to conduct clinical investigations in France, on French citizens before the drug will be granted marketing approval. The French government controls and pays for drug costs as part of its national social security system. "Because it ultimately subsidizes the cost of drugs to the French consumer, the French government has taken steps to encourage the pharmaceutical industry to establish research operations and manufacturing in France, rather than to continue to import drugs from abroad."

On September 23, 1988, France's Health Minister, Claude Evin, announced that RU-486 was granted marketing approval. Professor Jean-Michel Alexandre, President of the Medical Sales Commission, stated in a news conference that experiments conducted with RU-486 showed a more than ninety-five percent success rate in women administered the drug.

For more than one month, French women who wished to obtain the drug to terminate a pregnancy could do so from doctors in specialized family planning centers. However, on October 26, 1988, Roussel Uclaf withdrew RU-486 from the French drug market after receiving what it called "an emotional response from parts of French and foreign public opinion." Pierre Joly, Vice-Chairman of Roussel Uclaf, stated that the company had received threats of boycotts of Roussel Uclaf drugs as well as anonymous threats of violence aimed at the wives and children of the company's executives. Although these threats were anonymous, Health Minister Claude Evin suspected that it was the work of the same militant Catholics and anti-abortionists who in the early 1970's campaigned against the abortion law.

Two days later, Mr. Evin told French television that "[f]rom the moment government approval for the drug was granted . . . RU 486 became the the [sic] moral property of women, not the property

130. Id. at 403.
131. Id.
132. Id. at 404 (citing Kruezer, International Drug Registration, 43 FOOD DRUG COSM. L.J. 559, 560 (1988)).
133. France Becomes First Western Nation to Approve Abortion Pill, supra note 31, at 4.
134. Id.
135. Id.
137. Id.
138. Id.
of the drug company.” Mr. Evin ordered Roussel Uclaf to ignore the anonymous threats and to continue marketing the drug.

VII. Why RU-486 is Unavailable in the United States

There are numerous reasons why RU-486 is not available in the United States. These include the FDA ban on the importation of the drug for personal use, President Bush’s hostile attitude towards abortion, boycott threats from anti-abortion organizations, Roussel Uclaf’s unwillingness to supply the drug to the United States as well as the exorbitant costs involved in introducing and marketing a new drug.

A. President Bush and Politics in the FDA

Over the past four years, the Bush Administration had a hostile attitude towards abortion. This position was evident by President Bush’s “gag-rule” which prohibited abortion counselling at federally financed family planning clinics.

Because of the Bush Administration’s objections to abortion, the FDA indicated that it would not approve clinical trials of RU-486. With this attitude from the FDA, pharmaceutical companies were reluctant to begin the long, expensive FDA approval process.

B. Roussel Uclaf’s Reluctance

With the resistance Roussel Uclaf experienced soon after marketing RU-486 in France, the company stated that it would not sell RU-486 in countries where the social climate remains hostile toward abortion. Since anti-abortion groups in the United States threatened to boycott all products of any drug company attempting to market RU-486, no pharmaceutical companies have ventured to market the drug. Even if Roussel Uclaf were willing to market the drug in the United States, the company would have a difficult time

139. Id.
140. Id.
141. See infra text pp. 22-23.
142. On the day of the 1992 Presidential election, a federal appellate court invalidated the “gag-rule.” Since President Clinton’s Administration is not expected to appeal this decision to the United States Supreme Court, the regulation should become moot. See Sara Engram, Clinton Era Means Reproductive Freedom For Women, TORONTO STAR, Nov. 9, 1992, at D1.
145. See Herman, supra note 20, at Z13.
146. The Upjohn company has closed its reproductive research unit, removed one abortion drug from the market and decided not to market another. This is partially due to a nationwide boycott from 1983 to 1985 of Upjohn products, including Nuprin, Motrin, and Unicap vitamins. See Lees, supra note 34, at 1122.
finding an American company willing to be a licensed partner for
distribution.147 Even Roussel Uclaf’s United States subsidiary, lo-
cated in Somerville, New Jersey, declined to market the drug.148
Some experts on the politics of abortion have stated that “Roussel
Uclaf will not try to sell RU486 in the United States until there is a
President who favors abortion rights.”149 Until Roussel Uclaf seeks
to introduce the drug in the United States, the FDA is not required
to review it.

C. Economic Difficulties

A drug manufacturer wishing to market RU-486 in the United
States would have a market of approximately $200-250 million per
year available.150 However, the possibility of boycotts prevents larger
drug manufacturers from marketing RU-486. The market available
for RU-486 is minuscule when compared with the markets for anti-
biotics, anti-hypertension and anti-arthritic drugs which are worth
billions of dollars.151

A smaller drug company, with fewer products, would not be as
severely affected by a boycott.152 However, because the preparation
of new drugs for marketing takes many years and can cost a drug
manufacturer several million dollars in clinical tests and legal
fees,153 smaller drug companies do not have the economic and legal
resources necessary to sustain the drug’s manufacture. Readying
RU-486 for FDA approval could cost anywhere from $50-100 mil-

147. See Herman, supra note 20, at Z12.
148. Id.
149. See Lewin, supra note 144, at D16.
150. See Arnold Abrams, Politics, Profits And a New Pill; U.S. Women May Never
Have Access to RU 486 For Abortions, NEWSDAY, Dec. 13, 1988, (Discovery Section), at 6.
151. Id.
152. See Chapman, supra note 21, at Z13.
153. Id.
154. Id.
155. Id.
156. In 1985, a jury awarded a Georgia woman $4.7 million dollars in damages for a
claim that a spermicide made by Ortho Pharmaceuticals was the cause of her child’s birth
defects. See id.
VIII. Recent History

A. The Personal Use Exception

The FDA possesses the authority to prohibit the importation of drugs that are not approved pursuant to the laborious regulation process. The FDA also possesses the authority to permit the importation of drugs not yet approved. On July 20, 1988, the FDA initiated a pilot program that, if successful, would revise the Regulatory Procedure Manual (RPM) Chapter 9-71 to allow persons suffering from cancer and AIDS to import small doses of unapproved drugs for their own personal use. On September 26, 1988, the FDA issued Import Alert 66-813, stating that "the July 20, 1988, pilot program on mail importations did not apply to RU486, presumably because the drug has nothing to do with the treatment of AIDS or cancer." On February 1, 1989, the FDA deemed the mail importation pilot program a success and formally revised the agency's RPM. The revision not only expanded the pilot program from mail order imports to include imports in personal luggage, but it also included drugs for "all life-threatening or serious conditions whether or not AIDS-related or the result of cancer, as well as less than serious medical conditions where the product 'is not known to represent a significant health risk.' This revision became known as the "personal use exception."

160. Id.
161. Id. at *11 (quoting the Food and Drug Administration Regulatory Procedure Manual).
162. Id. The RPM reads in pertinent part:

In deciding whether to exercise discretion to allow personal shipments of drugs or devices, FDA personnel should consider a more permissive policy in the following situations:

[When] the intended use is appropriately identified, such use is not for treatment of a serious condition and the product is not known to represent a significant health risk; or when

1. the intended use is unapproved and for a serious condition for which effective treatment may not be available domestically either through commercial or clinical means;
2. there is no known commercialization or promotion to persons residing in the United States by those involved in the distribution of the product at issue;
3. the product is considered not to represent an unreasonable risk; and
4. the individual seeking to import the product affirms in writing that it is for the patient's own personal use (generally not more than three months supply) and provides the name and address of the doctor licensed in the U.S. responsible for his or her treatment with the product or provides evidence that the product is for the continuation of a treatment begun in a foreign country.

Id. at *11-12 (quoting the FDA Regulatory Procedure Manual) (emphasis added).
B. Import Alert 66-47

The “personal use exception,” in effect, nullified Import Alert 66-813 by allowing the importation of drugs whether or not the use was AIDS or cancer related. Shortly thereafter, the FDA was criticized for failing to exclude RU-486 from the “personal use exception.” Just a few months after the “personal use exception” went into effect, the Commissioner of the FDA began receiving correspondence from several United States legislators voicing their disapproval of allowing the importation of RU-486.\textsuperscript{163}

On June 6, 1989, the FDA issued Import Alert 66-47, which concluded that the importation of unapproved abortifacients was inappropriate for release under the personal importation policy.\textsuperscript{164} The Import Alert states that RU-486 could pose a risk to the safety of the user and should therefore be subject to automatic detention by customs officials.\textsuperscript{165}

The FDA Import Alert represents a mechanism for stopping improperly labeled or otherwise nonconforming drugs from importation into the United States.\textsuperscript{166} By issuing an import alert, the FDA “can hold a product for review, then presumptively deny entry.”\textsuperscript{167}

C. Ms. Leona Benten

Ms. Benten, a politically active feminist, volunteered to be the test plaintiff to challenge the FDA’s ban on RU-486.\textsuperscript{168} Ms. Benten contacted friends at the Woman’s Clinic in Oakland, CA, regarding an abortion, who put her in touch with the Abortion Rights Mobili-

\begin{footnotes}
\item[163] See Benten v. Kessler, 799 F. Supp. at 285-86. Judge Sifton states in his opinion that on May 5, 1989, Congressmen Robert K. Dornan, Henry Hyde, and John LaFalce sent a letter to the then Commissioner of the FDA expressing their concern that RU-486 was not listed as one of the drugs specifically excluded from importation in a 1988 article in American Health, entitled “Mail Order Drugs From Abroad.” Pertinent portions of that letter state: We are aware of the September 26, 1988 memo signed by Burton I. Love [Alert 66-813] but we have seen no official statement from you confirming the ban on RU 486. The U.S. government should not be involved in abetting abortion. This includes regulations that would allow the use of abortifacients such as RU 486. . . . How could the FDA possibly allow it to be purchased through mail order?!
\item[164] See id. at 286.
\item[165] Id. Judge Sifton held in Benten, that Import Alert 66-47 was issued “not from any bona fide concern for safety of users of the drug, but on political considerations having no place in FDA decisions on health and safety.” Id. The Judge came to this conclusion after observing the differing rationales offered by the FDA, the influential correspondence directed to the then Commissioner, and the limited time taken by the FDA to consider the issue. Id. at n.3.
\item[167] Id.
\end{footnotes}
zation. For months, the Abortion Rights Mobilization had been trying to obtain RU-486 and a young woman willing and suitable to test the FDA’s ban.76

For many years, Ms. Benten actively voiced her opinion on such issues as abortion rights, prisoner’s rights, lesbian rights, AIDS education and women in nontraditional jobs.77 Ms. Benten volunteered to import RU-486 from England to force a court challenge “so that women [could] benefit from [the] drug.”78

On July 1, 1992, customs officials, after receiving notification by the Abortion Rights Mobilization of their plan to import the drug, seized twelve RU-486 pills from Ms. Benten at John F. Kennedy International Airport.79

D. Benten v. Kessler74

Shortly after the RU-486 pills were seized, Ms. Benten initiated an action against Mr. David Kessler, the Commissioner of the FDA, challenging the FDA’s ban of RU-486. In her complaint, Ms. Benten alleged that the FDA illegally promulgated the ban on importation of RU-486 and sought to secure the return of the drug as well as enjoin the enforcement of the ban.75

Judge Charles P. Sifton, sitting for the Federal Eastern District Court of New York, held that the United States Customs Officials and the FDA proceeded illegally when they confiscated the pills and ordered the release of the drug to Ms. Benten.76 Judge Sifton also denied Ms. Benten’s broader request for a preliminary injunction against enforcement of the ban.77

In concluding that the FDA proceeded illegally, Judge Sifton stated that “[t]his was a lawsuit waiting to happen. The record . . . reveals a history of political and bureaucratic timidity mixed with well-intentioned blundering in dealing with two of the most charged and significant issues of our time: AIDS and abortion.”78 Adoption of the “personal use exception” by the FDA was without the required notice of the rulemaking and opportunity for comments by

169. Id.
171. See Lewin, supra note 168, at 1.
172. See Hilts, supra note 5, at 12.
173. Id.
175. See generally, id.
176. Id. at 283.
177. See id. Judge Sifton held that whether or not the drug should be available in the United States was not before the Court and should be heard by the agency assigned the task of reviewing such matters. Id.
Ms. Benten took “advantage of this sink of illegality to relieve her own understandable anxieties over employing surgical procedures to end her unwanted pregnancy.”

Ms. Benten's victory was short lived. Before the pills could be returned to Ms. Benten, the United States Court of Appeals for the Second Circuit in Manhattan stayed Judge Sifton's order. Ms. Benten immediately filed an emergency request with the United States Supreme Court to uphold Judge Sifton's order and overrule the Appellate Court's stay. Ms. Benten filed for emergency review because she had only a few days left to terminate her pregnancy through the use of the pills. Justice Clarence Thomas took the appeal and asked the Justice Department to submit its argument so he could make an expedited decision.

On July 18, 1992, the last day Ms. Benten could be assured that the pills would terminate her pregnancy, the United States Supreme Court, in a seven to two decision, refused to order the Federal Government to return the RU-486 pills. The unofficial Supreme Court decision stated that “the petitioners failed to demonstrate substantial likelihood of success on the merits of the claim that an administrative document instructing enforcement officials to seize the drug was promulgated without notice-and-comment procedures assertedly required under both the Administrative Procedure Act and FDA regulations.”

Further supporting the claim that the FDA allowed political influence to color their decision to ban RU-486 for use as an abortifacient, the FDA recently allowed Mr. John David Grow to import small amounts of the drug for his personal use. Mr. Grow suffers from an aggressive recurrent meningioma (a tumor of the lining of the brain) and was granted approval by the FDA to use the drug as an experimental treatment.

179. See id. at 285.
180. Id. at 286.
181. Id. at 283.
184. See id.
185. See id.
188. Id.
IX. Conclusion

To date, RU-486 may not be imported into the United States to terminate an unwanted pregnancy. As seen in the past, prohibition is not effective as a deterrent. If American women are determined to obtain RU-486, the FDA's ban will not stop their pursuit.

This ban may lead to the creation of a dangerous black market for the drug. The drug may be smuggled into this country, as are other drugs such as cocaine and heroine; some may try to reproduce the drug in underground laboratories which could lead to a similar, but dangerous chemical compound; and yet others may intentionally sell drugs purposefully misrepresented as RU-486 to profit from those women who are desperate enough to buy the drug on an illegal market.

Women must make the difficult decision whether or not to terminate an unwanted pregnancy. A woman must consider, as part of this decision, the dangers associated with surgical abortions as well as possible political pressures from anti-abortion groups.

RU-486 simplifies this difficult decision. It offers women a safe alternative to surgical abortions and, at the same time, offer more privacy through administering the drug in doctors' offices or even the woman's home.

The FDA must put aside the politics associated with the abortion debate and focus on RU-486's safety. If the benefits offered by this drug outweigh the risks, it should be marketed within the United States.

The future of RU-486 is uncertain, but there is hope. On November 3, 1992, former Governor of Arkansas, Mr. Bill Clinton was elected President of the United States, defeating the incumbent, George Bush. President Clinton believes a woman should have a choice in deciding whether or not to have an abortion. On his campaign trail, President Clinton called on the FDA to stop playing politics with RU-486. Dr. Sharon Camp of the Washington-based Population Crisis Centre predicts that with Mr. Clinton in the White House, RU-486 will be available in the United States within the next five years.*

Mark A. Hernandez

189. See Michael K. Frisby, Clinton's Currency Rises with the Polls; Democrats Jump on Bandwagon as Public Responds; Campaign '92, B. Globe, July 29, 1992, at 10.
190. See Engram, supra note 142, at 1.
* Since taking office, President Clinton has changed the political atmosphere pertaining to RU-486 and abortion in general. In January, President Clinton directed the Secretary of Health and Human Services to instruct the FDA to determine whether the current ban on RU-486 is justified, and to rescind the ban if there is no basis for it.
In March Roussel-Uclaf announced that President Clinton had shown an interest in making RU-486 available to American women, and it would therefore supply the drug for clinical
testing in the United States. In April, Roussel-Uclaf agreed to license RU-486 to the Population Council, a not-for-profit research organization located in New York. The Population Council plans to sponsor clinical trials involving approximately 2,000 women in the United States and would also sponsor an application to the FDA for approval to market the drug. The Population Council plans to raise four million dollars for the sponsorships and hopes to have the drug approved for marketing in the United States within two years.

Recently, England’s Dept of Health authorized the Marie Stopes Health Clinic to offer RU-486 to American women who travel to England & pay $600 to terminate their pregnancy. Planned Parenthood believes the decision signals a warming trend toward RU-486 generally.”
