An Uncommon Examination of a Generic Problem: Pliva Inc. v. Mensing and Its Effect on the Liability of Generic Drug Manufacturers

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Recommended Citation
I. INTRODUCTION

Imagine there was a generic version of a brand-name car. Now imagine that the makers of the generic car were allowed, by federal statute, to make the generic car because it was identical to the brand-name car in every way except its name and lower price. Additionally, federal regulation, interpreted by case law, allowed for the maker of the brand-name car to be held liable under a failure to warn theory, but disallowed the same for the generic car. Moreover, the maker of the generic car could not, by law, amend its user manual to warn about hazards of the usage of the car unless the makers of the brand-name did so first. This is a simplified illustration of the differences in liability and ability to warn consumers between brand-name and generic drugs.

The Food, Drug, and Cosmetic Act (“FDCA”) regulates all drugs, which necessarily includes generic and brand-name drugs. However, as the regulatory scheme currently stands, generic manufacturers cannot unilaterally alter their warning labels, as they must be identical to the brand-name warning labels. The Hatch-Waxman Act created this regulatory scheme. It was intended to, and has, accomplished the goal of increasing access to new drugs by allowing a generic drug company to enter the market by simply showing its drug to be identical to an already approved brand-name drug. However, as seen in recent cases, a plaintiff who is injured by a generic drug may have no recourse in a failure to warn tort claim because federal preemption prevents the generic manufacturer from complying with both state and federal law. Generic manufacturers have prevailed on the theory of impossibility preemption, arguing they are precluded from complying with federal and state law, because under federal law they cannot unilaterally strengthen their warning label, regardless of whether they are informed of adverse events. Recently, however, the possibility of a plaintiff prevailing on a theory of design defect has been raised as an alternative to hold generic manufacturers liable when a consumer is injured by their product. This Comment will discuss the controversy and possible solutions.

II. REGULATORY STRUCTURE

A. Background

The FDCA gives the FDA the power to regulate drugs. For the purposes of the FDCA, a “drug” is defined as, “intended for the use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals.” All drugs must be approved by the FDA prior to being distributed or marketed under the “new drug application” (“NDA”) procedure. The Drug Amendments of 1962 were the most important change in the FDCA’s drug regulatory framework, as they created a shift from premarket notification to premarket approval for safety and effectiveness. Prior to 1962, a drug manufacturer was required to submit a premarket notification NDA that would become effective after 60 days if the FDA did not oppose it. However, the 1962 FDCA Amendments fundamentally changed the NDA process to one of premarket approval, requiring multiple steps of clinical testing to demonstrate the drug’s safety and effectiveness prior to FDA approval.
the passage of these Amendments, the regulation of drugs became one of the most contentious and vital functions of the FDCA.14

A pioneer drug manufacturer is required to perform considerable clinical testing showing the drug is safe and effective.15 The NDA processes usually last between five to ten years, and for every 5,000 new chemical entities that begin, approximately only one will survive to be approved as a drug under an NDA.16 The cost of this process is borne exclusively by the brand-name manufacturer and averages almost $1 billion per drug.17

Prior to any human clinical testing, the brand-name manufacturer must show anticipated risks associated with the drug, based on pharmacological and toxicological data obtained from animal studies.18 The brand-name manufacturer is then required to conduct multiple stages of heavily regulated clinical testing investigations in human subjects that show whether the drug is effective and safe for use.19 While the NDA must show that the new drug is safe and effective, no drug has ever been shown to be completely safe.20 The broad safe and effective requirement has been interpreted by the FDA to mean that the benefits of the drug outweigh the risks.21

The new drug must conform to the labeling requirements of the FDCA.22 The FDA completely controls the drug label, which must contain adequate approved directions for use, warnings, side effects, contraindications, and effectiveness.23 Once the NDA has been approved, the drug is “listed” as an approved drug.24 After the NDA has been listed as an approved new drug, the manufacturer must maintain records of research on the drug and report any adverse effects.25 This includes annual reports detailing new information about the drug or unexpected complications that affect the safety or effectiveness of the drug.26

A notable process associated with the change in warning label is the “changes being effected” (“CBE”) process.27 Under certain conditions, the CBE process requires a brand-name manufacturer to unilaterally change the warning label without prior FDA approval.28 When a brand-name manufacturer becomes aware of the need for an additional warning label, it is required to add the new information to the labeling “as soon as there is reasonable evidence of a causal association” between the adverse event and the drug.29 Further, brand-name manufacturers must delete content from the warning label if it contains “false, misleading, or unsupported indications.”30 Additionally, under CBE, a brand-name manufacturer may strengthen the warning label regarding “a contraindication, warning, precaution, or adverse reaction,” which can include changes to dosage or administration of the drug.31

B. The Hatch-Waxman Act

The Drug Price Competition and Patent Term Restoration Act of 1984, also known as the Hatch-Waxman Act (“Act”), established a new FDA procedure for generic drugs to be approved based on the authorization of an equivalent pioneer drug, or brand-name drug, known as the abbreviated new drug application (“ANDA”).32 This Act was a compromise: manufacturers of generic drugs would no longer have to conduct and report the expensive clinical testing required of a pioneer drug, and in return pioneer drugs received extended patent exclusivity.33 ANDAs piggyback on a brand-name manufacturer’s NDA.34 An ANDA is required to show that the generic drug is the bioequivalent of the approved brand-name drug, also known as the “listed” drug.35 Additionally, an ANDA must provide a copy of the labeling for the “listed” brand-name drug, a copy of the proposed labeling for the ANDA, and a side-by-side comparison of the generic and brand-name drug.36 The “side by side” comparison between the generic and the brand-name drug emphasizes the fact that the generic and the brand-name drug must be identical in every way, including the formula and warning.37 Unlike a brand-name manufacturer, a generic manufacturer does not have to demonstrate the results of preclinical and clinical testing of safety and effectiveness.38 Notably, the labeling requirement for an ANDA requires the generic manufacturer to demonstrate that its labeling is identical to that of the brand-name manufacturer.39

The Act was enacted to advance two important public policies. First, Congress wanted to provide explicit patent protection and a period of market exclusivity for brand-name drug manufacturers.40
As brand–name manufacturers invest significant time and resources in the IN and NDA processes, Congress wished to provide an incentive for drug innovation. Second, Congress sought to encourage lower prices and availability of generic drugs after the brand–name patent protection and market exclusivity expired. Overall, this framework has successfully provided greater access to generics through lower prices and greater availability, but it is questionable whether it has provided a benefit to brand–name drug manufacturers.

C. Implications
The Hatch-Waxman Act is a friend of patients who wish to obtain reasonably priced drugs, however, the preemptive effects of the Act, as interpreted by caselaw, are a terrible foe. The Act allows a generic drug company to file an ANDA to obtain expedited approval of a generic drug that is identical to a brand-name drug. As an incentive for generic drug manufacturers to create more affordable alternatives to brand–name drugs, the Act also provides the first successful ANDA filer with a 180 day period in which that generic manufacturer is the exclusive manufacturer of the particular generic drug sold. During the exclusive marketing period, generic manufacturers typically price their drugs only slightly less — about five percent — than the brand–name counterpart. However, when a second generic company enters the market, the price drops an average of fifty percent. This achieves one of the goals of the Hatch-Waxman Act because when multiple generic drug companies enter the market drug prices are lowered and a wider array of drugs are available to more patients. However, this lower price may come with the cost of unintended consequences due to the Supreme Court’s recent holding in PLIVA Inc. v. Mensing. A patient who is injured after receiving a generic substitute for a brand–name drug dispensed by the pharmacist, even though the patient may be unaware the pharmacist dispensed a generic drug, will unlikely be able to recover damages for a failure to warn cause of action against a generic drug manufacturer. The Act has been criticized for creating this statutory dilemma due to federal preemption in state failure to warn cases. Therefore, while the Hatch-Waxman Act improves accessibility to otherwise high priced drugs it does so with the consequence of precluding injured patients from recovering damages if they are harmed by a generic drug.

III. CASE LAW: FAILURE TO WARN, FEDERAL PREEMPTION, AND DESIGN DEFECT LIABILITY
A. Wyeth v. Levine: Brand–name manufacturers may be held liable under failure to warn.
Wyeth v. Levine involved a state cause of action for failure to warn and federal preemption. Diana Levine was administered Phenergan through the now notorious “IV-push” method. The drug entered her artery, caused gangrene, and as a result, her arm was amputated. Levine filed suit against the maker of the brand–name drug Phenergan on the theory of common law failure to warn negligence and strict liability. She alleged that Phenergan was not reasonably safe for the “IV-push” method and that its labeling failed to reasonably warn physicians of the foreseeable risks of gangrene and amputation when this method is used. Finally, Levine alleged that the risks of losing a limb outweighed the therapeutic benefits of Phenergan when administered through the “IV-push” method. Wyeth alleged that Levine’s claim was federally preempted, arguing that the FDCA establishes “both a floor and a ceiling” for a drug’s label. Wyeth pointed to the preamble of a 2006 federal regulation governing the prescription drug labels as evidence that FDA approval of labeling explicitly preempts conflicting or contrary state law.

The Supreme Court held that Phenergan’s label did not contain an adequate warning for its administration through the “IV-push” method and that the federal regulation did not preempt the state law tort claim. The Court stated that Wyeth had a duty to provide a warning of the risk associated with the “IV-push” method, and could have done so through the CBE process. The Court emphasized that a central premise of the FDCA is that the drug manufacturer retains liability for its label at all times. Moreover, the Court pointed to the CBE regulations as proof that the manufacturer is ultimately responsible for its label as a safety precaution.
The Supreme Court rejected Wyeth's argument that FDA regulations explicitly preempt state law. It stated that Congress has not authorized the FDA to directly preempt state law and that the Supreme Court has never deferred to an agency's conclusion that its regulations preempt state law. The Court stated that the 2006 preamble to the regulation was insufficient to prove that the FDA and Congress intended all FDA regulations to preempt state law. Moreover, the Court refused to accord the preamble any deference, and criticized it as a procedural failure, stating that the FDA finalized the rule without input from the states, "articulat[ing] a sweeping position on the FDCA's pre-emptive effect in the regulatory preamble." 

The Supreme Court emphasized that Congress did not intend for the FDCA to preempt state tort suits. The Court further noted that the FDA has limited resources to monitor the 11,000 approved drugs, and therefore, state tort suits are an important means of discovering drug defects and motivating people to come forward for compensation. Also, state tort suits support the assertion that the manufacturer bears the ultimate responsibility for a drug's label. Finally, although Wyeth was a brand-name manufacturer, the Court did not make a distinction between brand-name and generic manufacturers, stating that a drug manufacturer bears responsibility for its labeling "at all times."

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B. PLIVA Inc. v. Mensing: Federal law preempts state tort claims against generic manufacturers, who cannot unilaterally change a warning label.

In PLIVA Inc. v. Mensing, patients alleged that PLIVA Inc., the generic manufacturer of metoclopramide (brand-name Reglan), a drug used for stomach disorders, knew or should have known that the drug had a high risk of causing tardive dyskinesia, a permanent neurological disorder. Gladys Mensing and Julie Demahy were prescribed the brand-name Reglan, but were given the generic metoclopramide by their pharmacists as a less expensive generic alternative. The generic version of metoclopramide was approved pursuant to the Hatch-Waxman Act that allows the FDA to approve generic drugs that are identical to a brand-name version. Both women took the drug as directed for a period of years, and both developed tardive dyskinesia.

The Supreme Court deferred to the FDA's interpretation of the Hatch-Waxman Act and held that a generic drug label may only display warnings contained in the equivalent brand-name drug label. The Supreme Court concluded that because PLIVA Inc. was a generic drug manufacturer, the CBE process was not available to make the type of change required by state law. Thus, the state tort claim based on a failure to warn was preempted because federal statutes do not allow a generic manufacturer to independently change its label. The Court distinguished Wyeth, stating that in Wyeth the manufacturer was a brand-name manufacturer who had the power to unilaterally change its label without FDA approval. The Court acknowledged that the difference between Wyeth and this case seemed trivial as the only difference was that the manufacturer in Wyeth was a brand-name, while the manufacturer in this case was a generic. Nevertheless, the Court stated that the way the statute was written caused a preemption issue that must give way to federal law under the Supremacy Clause.

C. Bartlett v. Mutual Pharmaceutical Co.: Generic manufacturers may be held liable under a theory of design defect

While a plaintiff may not be able to recover from a generic drug manufacturer under a failure to warn theory of liability, Bartlett v. Mutual Pharmaceutical Co. provides hope for a plaintiff to prevail under a design defect theory of liability. This requires a paradigm shift however, as the CBE process is irrelevant in the design defect context. In the design defect context, whether the manufacturer is brand-name or generic is unimportant. Nevertheless, the design defect theory of liability as applied to generic drug manufacturers is important because it provides a potential alternative theory of liability when a plaintiff cannot otherwise prevail under a failure to warn theory of liability.

In Bartlett v. Mutual Pharmaceutical Co., the First Circuit rejected a preemption claim in response to a state tort claim similar to that in PLIVA Inc. v. Mensing, holding that federal law does not preempt state law design-defect claims. Karen Bartlett brought a strict products liability state tort claim for
failure to warn against a generic drug manufacturer of sulindac.9 Sulindac is a generic non-steroidal anti-inflammatory drug ("NSAID"), manufactured by Mutual Pharmaceutical Company ("Mutual").90 In rare cases, sulindac can cause Stevens–Johnson Syndrome91 or toxic epidermal necrolysis ("SJS/TEN").92 Bartlett’s doctor prescribed Bartlett the brand-name Clinoril for shoulder pain, and her pharmacist dispensed the generic sulindac.93 Bartlett’s reaction to sulindac was severe.94 Sixty to sixty-five percent of her body was covered in open-wound skin lesions.95 She spent over 50 days in the burn unit and her reaction resulted in permanent near-blindness and severe disfigurement.96

Bartlett argued that sulindac’s risks outweighed its benefits, which made the product unreasonably dangerous even though the FDA approved the "safety and effectiveness" of the brand-name version, Clinoril.97 The court held that it was proper for Bartlett to show that sulindac was "in a defective condition" and it was "unreasonably dangerous," even though it was approved by the FDA.98 The court noted that Mutual could have avoided liability had it shown that sulindac was unavoidably unsafe but nonetheless very useful.99

The design defect theory of liability presents an alternative to the indirect process suggested in PLIVA, of placing the burden on the generic manufacturer and the FDA to convince the brand-name manufacturer to strengthen the warning label. The court in Bartlett stated that "although Mutual cannot legally make sulindac in another composition, . . . it certainly can choose not to make the drug at all; and the [FDCA] might permit states to tell [a manufacturer] it ought not be doing so if risk-benefit analysis weights against the drug, despite what the Supreme Court made of similar arguments in the labeling context."100 Instead, under a design defect theory of liability, perhaps the FDCA could be interpreted to reserve to the states the power to tell a drug manufacturer that it should not be selling a drug if the risk benefit calculus is unacceptable.101

The analysis in Wyeth v. Levine lends support to using a design defect theory of liability.102 Because state tort suits motivate manufacturers to strengthen their label, and the FDA does not have adequate resources to monitor the thousands of drugs on the market, state tort suits are an important enforcement mechanism.103 Strict liability in a state tort action for design defect could add another layer of enforcement.104 Additionally, this mechanism could provide a patient who is injured by a generic drug an alternative course of action: strict liability for a design defect without regard to the fact that the FDA approved the drug as "safe and effective."105

The Supreme Court granted certiorari to Bartlett, to resolve the issue of whether federal law preempts state law design-defect claims.106 Petitioner Mutual argues that Bartlett is an outlier case, and regardless of what a state tort claim is called, courts have recognized that state law must yield.107 The Generic Pharmaceutical Association, in its amicus curiae brief in support of Mutual, argues that if the mere ability of a manufacturer to withdraw a product from the market was sufficient to defeat preemption, it is unclear when the Supremacy Clause would have any force.108 Conversely, Respondent Bartlett argues that nothing in federal law precludes Mutual from complying with state law as federal law does not require manufacturers to sell sulindac and Mutual’s decision to manufacture it is entirely its own.109 Bartlett further states there is no conflict of law under PLIVA, Inc., because this case involves design defect, while PLIVA, Inc., involved failure to warn, an entirely different cause of action.110 In their amicus curiae brief in support of Bartlett, American Association for Justice, and Public Justice argue that Congress did not intend to deprive compensation to individuals who are injured by drugs, and design defect claims complement the objectives of the FDCA of approving only safe and effective drugs.111

IV. RECOMMENDATIONS

Different suggestions have been made for how to fix the paradox of the Hatch-Waxman Act’s unintended consequence of denying any liability to patients injured by generic drugs.112 However, as stated in Bartlett,113 a better alternative may be to empower states, through the judicial means of state torts suits, to disallow any company from selling a drug with questionable safety and effectiveness “if risk-benefit analysis weights against the drug.”114 This could provide a plaintiff with a strict liability design defect case theory against a generic manufacturer.115
Alternatively, the Hatch-Waxman Act could be amended to explicitly state that the burden is placed on manufacturers of equivalent drugs to monitor the labels and safety of both the generic version of the brand-name version through a modified market share liability scheme.\(^\text{116}\)

A. Allow risk-benefit analysis in a design defect case against a generic manufacturer.

In Wyeth v. Levine, the Court rejected the idea that the FDA retains the burden of proper labeling for a drug at all times.\(^\text{117}\) In fact, the Court stated that “it has remained a central premise of federal drug regulation that the manufacturer bears responsibility for the content of its label at all times.”\(^\text{118}\) The Court provided evidence for this statement by referring to the CBE changes established in 2007 that allow the FDA to order manufacturers to revise their labels.\(^\text{119}\) The Court stated that under the CBE process, Congress granted the FDA the authority to allow brand-name drug manufacturers to unilaterally strengthen their warning labels.\(^\text{120}\) In doing so, Congress reaffirmed the manufacturer’s obligation to increase label warnings when necessary.\(^\text{121}\) This reflects the manufacturer’s ultimate responsibility for its label by providing a mechanism for adding safety information to the label prior to FDA approval.\(^\text{122}\) Therefore, in Wyeth, the Court held that Wyeth had a duty to provide a warning that “adequately described the risk” of Phenergan.\(^\text{123}\)

Interestingly, the Court in Wyeth did not make a distinction between generic and brand-name manufacturer’s responsibilities with regard to the content of a warning label.\(^\text{124}\) The Court in PLIVA Inc. v. Mensing distinguished Wyeth, stating that in Wyeth, the manufacturer was a brand-name manufacturer who had the power to unilaterally change its label without FDA approval.\(^\text{125}\) In fact, the Court in Wyeth emphasized the reasons why it is almost exclusively the manufacturer’s responsibility for post-market surveillance of a drug.\(^\text{126}\) The Court stated that the FDA has limited resources with which to monitor the 11,000 drugs currently on the market.\(^\text{127}\) Second, manufacturers have a large advantage over the FDA regarding access to information and awareness of new adverse effects.\(^\text{128}\) Finally, it is more likely that consumers will contact the manufacturer of the drug rather than the FDA in order to obtain financial compensation.\(^\text{129}\) It is clear that the burden of retaining responsibility for monitoring the drug even after it is on the market applies equally to brand-name and generic manufacturers.\(^\text{130}\)

When the Court in PLIVA distinguished Wyeth as a case about a generic drug manufacturer, it could not have meant that these requirements for post-market surveillance do not apply to generic manufacturers.\(^\text{131}\) In fact, the Court in Wyeth stated that “the FDA’s views are ‘controlling unless plainly erroneous or inconsistent with the regulation[s]’ or there is any other reason to doubt that they reflect the FDA’s fair and considered judgment.”\(^\text{132}\) Thus, as the FDA has determined that it is almost exclusively the manufacturer’s responsibility to conduct post-market surveillance, surely this must apply to generic drug companies, as they are also drug manufacturers.\(^\text{133}\) The entry of many new generic drugs on the market due to the Hatch-Waxman Act, and the small amount of resources available for the FDA to monitor the more than ten thousand drugs on the market remain controlling factors even when the plaintiff happens to be a generic manufacturer.\(^\text{134}\)

As in Bartlett, it therefore seems that a plaintiff in a state tort suit against a generic drug manufacturer may be able to prevail on a design defect theory of liability.\(^\text{135}\) This is because the generic manufacturer has a duty to weigh the risks and benefits of producing the drug, and it can be held liable for choosing to make an unreasonably dangerous product.\(^\text{136}\) Even though the FDA had never withdrawn its “safe and effective” approval of the drug, the manufacturer could nonetheless be held liable for making a product with risks of harm that outweigh the benefits.\(^\text{137}\) Under this scheme, state juries would be allowed to second guess the FDA’s approval as an additional layer of oversight for manufacturers.\(^\text{138}\) Accordingly, manufacturers would have to give careful thought as to whether they ought to be making the drug at all.\(^\text{139}\)

The Supreme Court has not yet ruled on the applicability of design defect claims in cases such as the federal preemption claims in PLIVA.\(^\text{140}\) However, the Supreme Court noted that the result in PLIVA was “unfortunate,” “bizarre” and “unusual.”\(^\text{141}\) Therefore, the Supreme Court may be likely to uphold
a tort claim against a generic drug manufacturer under the design defect theory of liability.\textsuperscript{142}

B. Require manufacturers of equivalent drugs to monitor the generic and brand–name version under a modified shared market liability theory.

The Court in PLIVA noted the bizarre outcome of Mensing's state tort claim due to FDA regulations.\textsuperscript{143} Had Mensing been given the brand–name Reglan instead of the generic version metoclopramide, she would have prevailed in her case against the brand–name manufacturer.\textsuperscript{144} Mensing was given metoclopramide at the discretion of her pharmacist.\textsuperscript{145} It is unlikely that most consumers of generic drugs would know the minutiae of FDCA regulations well enough to ask for the brand–name version as an assurance they would succeed in a failure to warn claim. Further, many insurance plans require that prescriptions be filled by generic drugs. Therefore, as the current system provides incentives for making generic drugs more available and less expensive to increase accessibility to important medicines, it also follows that the drug companies responsible for creating increased access should be held responsible if their products cause harm.\textsuperscript{146}

As the regulations currently stand, generic manufacturers cannot independently change the label warnings as a brand–name manufacturer is able to do.\textsuperscript{147} To remedy this, Congress could amend 21 C.F.R. §§ 314.70 and 314.97 to allow generic drug manufacturers to be able to unilaterally strengthen their warning labels.\textsuperscript{148} However, this could possibly lead to consumer confusion as the same drug could contain different warnings.\textsuperscript{149}

Alternatively, Congress could amend the FDCA to explicitly place the burden on the manufacturers of equivalent brand–name and generic drugs to monitor their version of the listed drug and assess damages under a modified version of the shared market liability theory.\textsuperscript{150} The concept of market share liability was first introduced in Sindell v. Abbott Laboratories.\textsuperscript{151} Judith Sindell brought a state tort action, on behalf of herself and others, against Abbott Laboratories and other companies who manufactured the drug diethylstilbestrol ("DES").\textsuperscript{152} DES was a synthetic version of estrogen, taken by pregnant women to prevent miscarriages between 1941 and 1971.\textsuperscript{153} DES posed a high risk, and indeed caused cancerous vaginal and cervical growths in thousands of daughters whose mothers took the drug during pregnancy.\textsuperscript{154} The cancer and growths spread quickly and required painful and frequent surgeries and medical procedures.\textsuperscript{155} During the period in which DES was marketed, the makers of the drug knew, or should have known of the risk of cancer, as well as the drug's ineffectiveness at preventing miscarriages.\textsuperscript{156} Despite evidence showing that DES was not safe or effective, its makers continued to produce it and market it as a miscarriage preventative.\textsuperscript{157} Sindell's mother took DES as a miscarriage preventative, and as a result, Sindell developed a malignant bladder and adenosis.\textsuperscript{158}

Sindell argued, and the Supreme Court of California agreed, that each of the defendants were jointly liable as they acted in concert, on the basis of express and implied agreements, and in reliance upon the FDA's approval and each other's testing and marketing methods.\textsuperscript{159} The court emphasized that it was of great importance that the drugs each company produced were fungible, meaning the drugs are identical as to be freely exchangeable.\textsuperscript{160} Thus, the court held that each manufacturer's liability would be equivalent to the share of the market it held at the time the drug was taken.\textsuperscript{161} However, if a manufacturer could prove that it did not, or could not have manufactured the drug at issue in the case, it would not be liable for damages.\textsuperscript{162} Therefore, if a plaintiff knew which manufacturer produced the drug that caused the harm, market share liability was precluded.\textsuperscript{163}

To apply the market share liability theory to a failure to warn case against a generic drug manufacturer, the theory would need to be modified. The requirement that the plaintiff be unaware of exactly what manufacturer caused the harm would need to be eliminated, as the person who is injured by a generic drug is aware of what company manufactured the drug.\textsuperscript{164} This way, a patient who is injured by a generic drug would have a course of action against all of the drug companies who make the drug, regardless of whether they are generic or brand–name manufacturers.\textsuperscript{165} Under this framework, the drug company would have to pay the percentage of damages equal to its percentage of the market it occupies for the drug it is selling.\textsuperscript{166} The policy

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behind this is that all manufacturers of a drug that is potentially very dangerous should be responsible for the effects thereof. In this manner, drug companies would have an incentive for working together with and sharing improved technology and knowledge of adverse events. It would likely create cooperation between drug companies that manufacture bioequivalent drugs, brand-name or generic, as each would have an incentive to account for all risks, as all would be responsible if a person is injured due to a failure to warn.

V. CONCLUSION

It is inherently unfair that a patient who receives a drug from a pharmacist who made a decision to substitute a generic version of a drug for a brand-name version will be unable to prevail in a failure to warn tort case, despite how horrific their damages are. The Hatch-Waxman Act provides incentives for generic drug companies to enter the market for the laudable goal of increasing access to new drugs. However, the federal regulations that implement the Act require that the labeling of the generic drug be identical to that of the brand-name drug. This creates the unintended consequence of prohibiting a generic drug manufacturer from strengthening its warning label, regardless of how many documented cases it receives of adverse effects. Further, due to federal preemption, the Supreme Court has held that generic manufacturers cannot warn against adverse effects without the brand-name manufacturer doing so first.

Moreover, as federal regulations currently stand, a brand-name manufacturer has no duty to change its label even in response to pleas from a generic drug manufacturer. This leads to the real world consequence of severely injured patients being left with no form of recourse against a company whose product injured them. To remedy this problem, the FDCA could be amended to allow courts to conduct risk-benefit analysis of the reasonable safety of the drug itself, and expressly state that failure to warn and design defects claims are not federally preempted. In this way, a generic manufacturer could be held liable under a theory of design defect in products liability, rather than under a theory of failure to warn. This would force generic manufacturers to consider whether they ought to be making a drug with severe adverse effects. However, it would be preferable to amend FDCA to allow generic manufacturers to change their warnings, as this would allow some drugs that would potentially be taken off the market under the design defect theory would to remain on the market.

Alternatively, Congress could amend the FDCA to explicitly place the burden on manufacturers who manufacture equivalently identical drugs to monitor each other through a modified market share liability scheme. Under this scheme, all manufacturers of a bioequivalent drug would be held liable for damages caused by that drug in proportion to their share of the market of the drug. This would cause the market to police itself, independently checking the warning label, and creating a sense of urgency in the brand-name drug to change its label in response to reporting of adverse events. In either case, Congress must act to provide individuals who are injured by generic drugs with an avenue of recourse.

See generally 21 U.S.C. § 355 (2006); P.L. 75-717 (1938) (as amended by P.L. 112-144 (July 9, 2012)).


3 See id.


5 See PLIVA Inc. v. Mensing, 131 S. Ct. 2567, 2581 (2011) (holding state tort law is preempted by federal law under the Supremacy Clause, thus precluding a failure to warn claim against a generic manufacturer); Bartlett v. Mut. Pharm. Co., 678 F.3d 30, 37-38 (1st Cir. 2012) (ruling for the patient under a products liability theory, realizing that a failure to warn theory is likely to fail).

6 See PLIVA Inc., 131 S. Ct. at 2581; Bartlett, 678 F.23 at 37.

7 See Bartlett, 678 F.3d at 35, 37.


10 See 21 U.S.C. § 355(a). While federal law only applies to drugs within interstate commerce, the FDCA has been interpreted broadly to include all drugs marketed or manufactured in the United States; see Food & Drug Admin., Compliance Policy Guide § 440.100, Marketed New Drugs Without Approved NDAs and ANDAs (2011), available at http://www.fda.gov/ICECI/ComplianceManuals/CompliancePolicyGuidanceManual/ucm074382.htm.


12 HUTT ET AL., supra note 11, at 577.

13 See id.

14 See id. (stating it takes 10 to 15 years to develop the chemical that will become the drug, about five out of every five thousand chemicals reach the clinical testing stage, and the average cost of the NDA process is about $1 billion).


16 HUTT ET AL., supra note 11, at 677.


18 See 21 C.F.R. § 312.23(a)(8).


20 See Peter Barton Hutt, The Regulation of Drug Products by the United States Food and Drug Administration, in FOOD & DRUG LAW: CASES AND MATERIALS 677 (3d ed. 2007) (noting the FDA has exercised discretion in assessing the requirements to show safety and effectiveness).

21 See id.


24 See 21 U.S.C. § 355(b)(1), (j)(7)(A)(ii). When the FDA approves an NDA it publishes a listing of the drug in Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the “Orange Book.”


26 See 21 C.F.R. §§ 314.80, 314.81, 314.98.

27 See 21 C.F.R. § 314.70(c)(6)(ii).

28 See id.

29 See 21 C.F.R. § 314.57(c)(6).

30 See 21 C.F.R. § 314.70(c)(6)(iii)(D).

31 See 21 C.F.R. § 314.70(c)(6)(iii)(A), (C)-(D); Perry v. Novartis Pharm. Corp., 456 F. Supp. 2d 678, 686 (E.D. Pa. 2006) (stating letters to doctors are not labeling changes and are not prohibited by labeling regulations). But see 21 C.F.R. § 202.1(1)(2) (according to FDA labeling regulations, letters to doctors can be considered as labeling for a drug).


35 See 21 U.S.C. § 355(j); 27 U.S.C. § 271(e)(1); 21 C.F.R. § 320.1(e) defining bioequivalence as the absence of a significant difference in the rate and extent of the active ingredient’s effects when administered at the same dose under similar conditions).

36 See 21 C.F.R. § 314.94.

37 See 21 U.S.C. § 355(j); C.F.R. § 314.94(a)(8)(i), (iv) (except in the case of inert ingredients, which are not required to be identical to the listed drug).


39 See 21 U.S.C. § 355(j)(2)(v) (except for changes required because of differences approved under petition or because the new drug and the listed drug are produced or distributed by different manufacturers).

40 See Hearings, supra note 4.

41 See e.g., id.

42 See id.

43 See id. (“Since 1984, over 10,000 generic drugs have entered the market, and generics now account for close to fifty percent of prescriptions filled.”); HUTT ET AL., supra note 11, at 764 (raising the concern that pioneer drugs are being displaced by generic drugs and fewer pioneer drugs are being approved by the FDA).


47 See FDA Study, supra note 46.

48 See Hutt, supra note 32, at 11.


50 See Eli Lilly & Co. v. Medtronic Inc., 496 U.S. 661, 679 (emphasizing that the Act is not an “elegant piece of statutory craftsmanship,” and it creates a “good deal of legal imprecision”); cf. PLIVA Inc., 131 S. CT. 2567, 2581 (describing the effects of the Act on state tort liability as unfortunate, unusual and bizarre); see also 21 U.S.C. § 355(j)(2)(v) Congress based the framework on the generic-brand and name-brand being identical in all meaningful aspects, thus federal law preempts state law that requires the generic manufacturer to unilaterally change the label by adding a warning).


52 See Wyeth, 555 U.S. at 559 (the “IV-push” method involves directly injecting the drug into the patient’s vein, as opposed to the “IV-drip” method which involves the drug slowly entering through an intravenous hanging bag with saline solution).

53 See id.

54 See id. at 560.

55 See id. (advocating that the label should have instructed providers to prefer the “IV-drip” method over the “IV-push” method).

56 See id. (asserting a cost-benefit analysis also used in a products liability theory of recovery).

57 See id. at 560, 573 (asserting that once FDA has approved a label, a state may not deem that it is inadequate, even if there is evidence the FDA considered the strengthened warning at issue).

58 See id. at 575 (citing Requirements on Content and
Supremacy Clause in order to create similar pre-emption

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market). (continue to monitor a drug even after it is approved for the reasonable evidence of an association of a serious hazard e.g., adequate label and with ensuring that its warnings remainauerful (reiterating that manufacturers retain their responsibility to maintain and update drug labels).

See Wyeth, 555 U.S. at 571.

See id. at 576–78.

See id.

See id. (citing Requirements on Content and Format of Labeling for Human Prescription Drugs and Biologics; Requirements for Prescription Drug Product Labels, 65 Fed. Reg. 81082, 81103 (codified at 21 C.F.R. pt. 201) (“this proposed law does not preempt state law.”)).

See id. at 577 (citing Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944)) (“the weight we accord the agency’s explanation of state law’s impact on the federal scheme depends on its thoroughness, consistency, and persuasiveness.”).

See id. at 578.

See id.

See id. at 578–79.

Id. at 570–71 (“It is charged both with crafting an adequate label and with ensuring that its warnings remain adequate as long as the drug remains on the market.”); see e.g., 21 C.F.R. § 201.80(e) (stating a manufacturer must revise its label “to include a warning as soon as there is reasonable evidence of an association of a serious hazard with a drug”); § 314.80(b) (requiring manufacturers to continue to monitor a drug even after it is approved for the market).


Id. at 2569.

Id. at 2572.


PLIVA Inc., 131 S. Ct. at 2572.

See id.

See id. at 2574–75; see also Erwin Chemerinsky, A Devastating Decision, 47 TRIAL, 54, 54 (Sept. 2011).

See PLIVA, Inc., 131 S. Ct. at 2576.

See id. at 2577–78.

See id. at 2581.

See id. (lamenting the “unfortunate hand” dealt to Mensing by federal drug regulations).

See id. (observing the “bizarre” result of the FDA regulations but concluding: “We will not distort the Supremacy Clause in order to create similar pre-emption across a dissimilar statutory scheme.”).

See generally 678 F. 3d 30, 35 (1st Cir. 2012). Notably, the Supreme Court left the door open for alternative interpretations when it stated that it did not resolve the issue of whether federal law placed a burden on the generic manufacturers to ask for the FDA’s assistance in convincing the brand-name manufacturer to adopt a stronger warning label. See PLIVA, Inc., 131 S. Ct. at 2577.

See 21 C.F.R. § 314.70(c)(6)(iii); PLIVA, Inc., 131 S. Ct. at 2576.

See Transcript of Oral Argument at 3–5, Mutual Pharm. Co. v. Bartlett, 133 S. Ct. 694 (2012)(No. 12-142), But see Brief for Petitioner at 48 Mutual Pharm. Co. v. Bartlett, 133 S. Ct. 694 (2012) (No. 12-142) (arguing that the purposes of the Hatch-Waxman Act would be frustrated if the design defect theory of liability were to stand).


678 F.3d 30 (1st Cir. 2012).

Id. at 38; See First Circuit Rejects Preemption Argument in Generic Drug Design Defect Case, 21 FDA ENFORCEMENT MANUAL NEWSL. (June 2012).

Bartlett, 678 F.3d at 34. The brand name of sulindac is Clinoril. Sulindac, PUBMEDHEALTH (last updated Sept. 1, 2010), http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH000529/

Bartlett, 678 F.3d at 34.

A skin disorder that is thought to occur in response to medications, infections, or illness. It is also known as Erythema Multiforme. The symptoms include painful symmetrical skin lesions that cause complete deterioration of the affected skin. SJS/TEN has high death rates and lesions cover a significant portion of the body. Erythema Multiforme, MEDLINEPLUS (last updated Oct. 10, 2010), http://www.nlm.nih.gov/medlineplus/ency/article/000851.htm.

See Bartlett, 678 F.3d at 34.

Id.; Transcript of Oral Argument at 10–11, Mutual Pharm. Co. v. Bartlett, 133 S. Ct. 694 (2012) (No. 12-142); cf. 21 C.F.R. § 320.1(e) (as the drugs are required to be bioequivalent, the generic drug sulindac would have posed the same risk as the brand–name version, Clinoril).

See Bartlett, 678 F.3d at 34.

Id.

See id. at 43 (describing Bartlett’s injuries including esophageal, vaginal, eye, and lung burns as “truly horrific” and “hell on earth”).

See id. at 34–35; 21 U.S.C. §§ 355(b)(1), (d), (j)(2)(a) (allowing a generic drug manufacturer to gain approval of a generic drug as “safe and effective” if it is virtually identical to a previously approved brand–name drug).

Bartlett, 678 F.3d at 35.

Id. at 36.

See id. at 37.

See id.

See Wyeth v. Levine, 555 U.S. 555, 575 (2009) (announcing that Congress did not intend FDA oversight to be the only way to ensure compliance with drug safety and effectiveness); Transcript of Oral Argument at 18, Mut. Pharm. Co. v. Bartlett, 133 S. Ct. 694 (2012) (No. 12-142) (stating the analysis implies the manufacturer could simply stop selling the dangerous product).

See Wyeth, 555 U.S. at 575.

Cf. id. at 575.
105 Bartlett, 678 F.3d at 37–38.


113 678 F.3d 30, 37 (1st. Cir. 2012).

114 Id.

115 See e.g., id. at 36–37. (stating it was proper for the plaintiff to show the generic drug was unreasonably dangerous and perhaps it should not be manufactured at all).

116 Cf PLIVA Inc v. Mensing, 131 S. Ct. 2567, 2577 (2011) (leaving the door open as to whether it is the generic manufacturer's responsibility to persuade the brand-name manufacturer to strengthen its label).


118 Id. at 571.

119 See id.

120 See id. at 571; 21 C.F.R. §§ 314.70, 601.12.

121 See Wyeth, 555 U.S. at 571; 21 C.F.R. §§ 314.70, 601.12.

122 Wyeth, 555 U.S. at 571; see 21 C.F.R. §§ 314.70, 601.12.

123 Wyeth, 555 U.S. at 571.

124 See id.

125 See PLIVA Inc v. Mensing, 131 S. Ct. 2567, 2581 (2011).

126 Id. at 578–79.

127 Id.

128 See id.

129 See id.

130 See id. at 571; PLIVA Inc v. Mensing, 131 S. Ct. 2567, 2576 (2011); U.S. DEPT. OF HEALTH & HUMAN SERVS., FOOD & DRUG ADMIN, Drug Applications and Current Good Manufacturing Regulations, (last updated Sept, 7, 2012), http://www.fda.gov/drugs/developmentapprovalprocess/manufacturing/ucm090016.htm (stating that FDA may not approve NDAs from companies who have been cited for failing to adhere to current good manufacturing practices).

131 Cf. PLIVA Inc., 131 S. Ct. at 2576 (citing Wyeth, 555 U.S. at 570–571) (a generic-brand drug manufacturer retains responsibility for its drug labeling at all times precisely because it is a drug manufacturer).


133 See e.g., PLIVA Inc., 131 S. Ct. at 2576; Auer, 519 U.S. at 461–462.

134 See Wyeth, 555 U.S. at 571; 21 C.F.R. §§ 314.70, 601.12.

135 See Bartlett v. Mutual Pharm. Co. 678 F.3d 30, 36 (1st Cir. 2012).

136 See id. at 36–37.

137 See id. at 34–35.

138 E.g. id. at 37 (citing Wyeth, 555 U.S. at 575 (“state law serves as a ‘complementary form of drug regulation’”)).

139 See id. at 37–38 (suggesting the generic manufacturer perform additional risk–benefit analysis).

140 See id. at 36. See generally PLIVA Inc v. Mensing, 131 S. Ct. 2567, 2581 (2011).

141 See PLIVA Inc., 131 S. Ct. at 2581.

142 See id. at 4 (stating the Supreme Court would be less likely to deprive Bartlett of her only “remaining avenue of relief”).

143 See id. at 2581.

144 See id.

145 See PLIVA Inc., at 2574–75.

146 See Hearings, supra note 4 (noting the multiple objectives of the Hatch-Waxman Act of encouraging innovation while maintaining FDA's high standards of safety and effectiveness); PLIVA Inc., 131 S. Ct. at 2576 (citing Wyeth, 555 U.S. at 570–571) (asserting a drug manufacturer, without regard to whether it is brand-name or generic, retains responsibility for its drug labeling at all times).

147 See 21 U.S.C. § 355(j)(2)(v) (stating that the generic label must be identical to the brand-name label).

148 See Duncan, supra note 112, at 209 (suggesting the amendment of federal regulations to allow generic manufacturers to be able to change their labels); Transcript of Oral Argument at 11–12, Mutual Pharm. Co. v. Bartlett, 133 S. Ct. 694 (2012) (No. 12-142) (discussing the possibility of a strict liability regime similar to the vaccine compensation program). But see 21 U.S.C § 355(j) (requiring the generic label to be identical to the brand-name label).

149 See Duncan, supra note 112, at 209 (noting that any remotely dangerous condition associated with the drug could be listed as a warning, and could cause confusion even between different generic-brand drugs); 21 U.S.C. § 355(j)(2)(A)(2006).


151 See id.

152 See id. at 925.
Sutowski v. Eli Lilly
676 S.W.2d
N.W.2d 67, 76
337 (111. 1990)
is fungible.
market share liability regardless of whether the product
nonfungible products). Some states have refused to apply
rendering them nonfungible); Rostron,
But see
Collins v. Eli Lilly
Martin v. Abbott Labs.,
Biological, Inc.,
liability theory to fungible products.
Sindell,
plaintiffs could identify those who caused the harm). Since
2d 259, 263
(1st Dist. 1996).
Sindell, 607 P.2d at 938.
See id.
See id.; Edwards v. A.L. Lease & Co., 54 Cal. Rptr. 2d 259, 263 (1st Dist. 1996) (dismissing the case because plaintiffs could identify those who caused the harm). Since Sindell, courts have generally only applied the market share liability theory to fungible products. See Smith v. Cutter Biological, Inc., 823 P.2d 717, 724 (Haw. 1991); Hymowitz v. Eli Lilly & Co., 539 N.E.2d 1069, 1081 (N.Y. 1989); Martin v. Abbott Labs., 689 P.2d 368, 381 (Wash. 1984); Collins v. Eli Lilly & Co., 342 N.W.2d 37, 44 (Wis. 1984), But see Skipworth v. Lead Indus. Ass’n, 690 A.2d 169, 172-73 (Pa. 1997) (rejecting market share liability for lead paint as different colors contain varying amounts of lead rendering them nonfungible); Rostron, supra note 112, at 154 (arguing market share liability should be applied to nonfungible products). Some states have refused to apply market share liability regardless of whether the product is fungible. See Smith v. Eli Lilly & Co., 560 N.E.2d 324, 337 (Ill. 1990) (Illinois); Mulcahy v. Eli Lilly & Co., 386 N.W.2d 67, 76 (Iowa 1986) (Iowa); Zafft v. Eli Lilly & Co., 676 S.W.2d 241, 247 (Mo. 1984) (en banc) (Missouri); Sutowski v. Eli Lilly & Co., 696 N.E.2d 187, 192 (Ohio 1998) (Ohio); Gorman v. Abbott Labs., 599 A.2d 1364, 1364 (R.I. 1991) (Rhode Island). However, other states have chosen not to explicitly accept market share liability, but indicate that if they were to, it would only be applicable to fungible products. See, e.g., Black v. Abex Corp., 603 N.W.2d 182, 189 (N.D. 1999) (declining to adopt market share liability but nonetheless stating that plaintiff would have had to prove fungibility); Case v. Fibreboard Corp., 743 P.2d 1062, 1065, 1067 (Okla. 1987) (declining to adopt market share ability but stating it is of importance that the drugs in Sindell were fungible as it was produced from a single formula and used for a singular purpose). Market share liability provides a meaningful way to hold manufacturers who produce harmful products liable for injuries the product causes. See Sindell, 607 P.2d at 926; Rostron, supra note 112, at 158 (citing Symposium, The Problem of the Indeterminate Defendant: Market Share Liability Theory: Hymowitz v. Eli Lilly & Co., 55 Brook. L. Rev. 863 (1989).
E.g., Bartlett v. Mut. Pharm. Co., 678 F.3d 30, 34 (1st Cir. 2012) (plaintiffs could identify the drug they took as sulindac and the manufacturer as Mutual Pharmaceutical Company); PLIVA Inc. v. Mensing, 131 S. Ct. 2567, 2581 (2011) (plaintiffs could identify the drug they took as metoclopramide and the manufacturer as PLIVA Inc.); Edwards v. A.L. Lease & Co., 54 Cal. Rptr. 2d 259, 262 (1st Dist. 1996) (case dismissed because the plaintiffs could identify those who caused the harm). But see Sindell, 607 P.2d at 927-28 (plaintiffs were unable to identify the manufacturer of the DES their mother took); Abel v. Eli Lilly & Co., 343 N.W.2d 164, 168 (Mich. 1984) (plaintiffs were unable to identify the manufacturer, and thus could use the market share liability theory).
Compare PLIVA Inc., 131 S. Ct. at 2575-77 (finding impossibility preemption and thus no generic manufacturer liability), with Sindell, 607 P.2d at 936-37 (allowing a shared market share liability scheme).
See Sindell, 607 P.2d at 611-12.
See Rostron, supra note 112, at 158.
See id.