

KEEPING THE LABEL OUT OF THE CASE

By Mark Herrmann and Pearson Bownas*

I. INTRODUCTION

The FDA approves prescription drugs and medical devices for only the specific uses indicated in the labeling materials that the manufacturer submits in the approval process. A physician may determine, however, that a use not indicated in the FDA-approved labeling – *i.e.*, an “off-label” use – would benefit a patient. In medical malpractice cases involving an “off-label” use, the drug’s or device’s label should not be admitted as evidence of the standard of care or the physician’s alleged breach of the standard of care.

II. “OFF-LABEL” USE EXPLAINED

A. The FDA Approves Drugs And Devices For Only Specified “Intended Uses.”

Prescription drugs and certain medical devices cannot be sold and marketed unless they are approved by the United States Food and Drug Administration (“FDA”).¹ The FDA approval regimes for drugs and medical devices require manufacturers to submit proposed labeling.² This labeling must include, among other things, indications for the product’s use, such as the conditions the product is indicated to treat and information about the population for which the product is indicated for use, and administration and dosage information.³ When the FDA approves a drug or device for sale and marketing, it does so only with respect to the indicated uses.⁴

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¹ See, e.g., 21 U.S.C. §§ 355 (drugs), 360e (devices) (2007). A comprehensive discussion of the FDA drug and device approval regimes is found in James M. Beck and Elizabeth D. Azari, *FDA, Off-Label Use, and Informed Consent: Debunking Myths and Misconceptions*, 53 FOOD AND DRUG L.J. 71, 72-76 (1998). The evolution of the FDA’s regulatory authority is traced in Katherine A. Helm, *Protecting Public Health From Outside The Physician’s Office: A Century Of FDA Regulation From Drug Safety Labeling To Off-Label Drug Promotion*, 18 FORDHAM INTELL. PROP. MEDIA & ENT. L.J. 117, 124-146 (2007).

² See, e.g., 21 U.S.C. §§ 355(b)(1) (drugs), 360e(c)(1)(F) (devices) (2007); 21 C.F.R. § 314.50 (drugs) (2007).

³ See, e.g., 21 C.F.R. §§ 201.56(d)(1), 201.57(c)(2)-(3) (drugs), 801.109 (devices) (2007).

⁴ See, e.g., 21 U.S.C. §§ 355(d) (drugs), 360e(d)(1)(A)(ii), 360e(d)(2)(A)-(B) (devices) (2007). See also, e.g., Notice, Decision in *Washington Legal Foundation v. Henney*, 65 Fed. Reg. 14,286, 14,286 (Mar. 16, 2000) (“When FDA approves a drug or medical device, the agency approves the product for each use set out in the product’s approved labeling.”). “If there is a

The FDA-approved label may also include “contraindications,” and “warnings and precautions.” A “contraindication” is a “situation[] in which the drug should not be used because the risk of use . . . clearly outweighs any possible therapeutic benefit.”⁵ “Warnings and precautions” are descriptions of “clinically significant adverse reactions . . . , other potential safety hazards . . . , limitations in use imposed by them . . . and steps that should be taken if they occur,” as well as any other “information regarding any special care to be exercised by the practitioner for safe and effective use of the drug”⁶

The analysis in this chapter is limited to “off-label” uses that are not contraindicated, warned against, or identified by a precaution. In a medical malpractice action involving a use that is contraindicated, for example, the FDA-approved label should be admissible because the FDA has analyzed that very use and concluded that the risk is unacceptable.⁷ In an action involving a use as to which the FDA-approved label is silent, by contrast, the FDA has not reached that conclusion; the FDA may simply not have been asked to consider the use. The label is therefore irrelevant to determining whether that use satisfies the standard of care.

B. Physicians May Find Beneficial “Off-Label” Uses.

Although the FDA approves drugs and medical devices for only the uses indicated in the product labeling, drugs and devices may have other, “off-label,” beneficial uses.⁸ For example, physicians may use a drug or device to treat a disease other than the one (or ones) the drug or device was approved to treat.⁹ Physicians may prescribe a drug or device for a person outside

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common belief that [a] drug may be effective for a certain use or if there is a common use of the drug for a condition, but the preponderance of evidence related to the use or condition shows that the drug is ineffective or that the therapeutic benefits . . . do not generally outweigh its risks, FDA may require [a statement] that there is a lack of evidence that the drug is effective or safe for that use or condition.” 21 C.F.R. § 201.57(c)(2)(ii) (2007).

⁵ 21 C.F.R. § 201.57(c)(5) (2007).

⁶ *Id.* § 201.57(c)(6)(i)-(ii).

⁷ For the same reason, in a medical malpractice case involving a use indicated in the FDA-approved label, the prescribing physician should be allowed to offer the label as evidence that the FDA has considered that use and determined it to be safe and effective. *See* James R. Bird, *Package Inserts for Prescription Drugs as Evidence in Medical Malpractice Suits*, 44 U. CHI. LAW REV. 398, 445-46 (1977) (suggesting that “the cautious bias of the FDA may make inserts more reliable as defensive than as offensive evidence”). This chapter does not address what, if any, evidence plaintiffs may offer to try to offset that showing.

⁸ *See, e.g.*, “Off-label drugs and medical devices: Get the facts,” <http://www.mayoclinic.com/health/off-label/DI00088> (hereinafter “Mayo Clinic Off-Label Web Page”).

⁹ *Id.*

the approved patient population.¹⁰ Physicians may also administer drugs by different routes, or in different doses or frequency, than approved by the FDA.¹¹

C. “Off-Label” Use Is Widespread.

“Off-label” use of drugs and medical devices is common. Between twenty-five and sixty percent of all prescriptions written may be for “off-label” uses.¹² For some conditions, the percentage is even higher. One report estimates that sixty-five percent of all cancer drug use is “off-label.”¹³ Other estimates include seventy percent of kidney dialysis patients using their equipment “off-label,”¹⁴ and more than eighty percent of AIDS patients being treated with at least one “off-label” use.¹⁵

¹⁰ *Id.*

¹¹ *Id.*; Lars Noah, *Constraints on the Off-Label Uses of Prescription Drug Products*, 16 J. OF PRODS. & TOXICS LIAB. 139, 140-41 (1994).

¹² Beck and Azari, *supra* note 1, at 80 & n.73 (citing sources); Noah, *supra* note 11, at 139 & nn. 1-2 (citing sources).

¹³ Gen. Accounting Office, GAO/PEMD-91-14, Report To The Chairman, Comm. On Labor And Human Resources, U.S. Senate, “Off-Label Drugs: Reimbursement Policies Constrain Physician In Their Choice Of Cancer Therapies,” at 13 (1991) (hereinafter “GAO Report”). *See also, e.g.*, Editorial, *The off-label use of drugs in oncology: a position paper by the European Society for Medical Oncology*, 18 ANNALS OF ONCOLOGY, 1923-25 (2007) (“The off-label use of drugs in oncology has been estimated to reach 50%, or even more.”).

¹⁴ “FDA and Dialyzer Makers Spar Over Device Reuse,” Food & Drug Letter, Apr. 8, 1994.

¹⁵ Carol Brosgart, et al., *Off-Label Use In Human Immunodeficiency Virus Disease*, 12 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUMAN RETROVIROLOGY 56, 57-58 (1996). Other examples of conditions with standard “off-label” use treatments have included heart and circulatory disease, osteoporosis, spinal injuries requiring fusion surgery, and incontinence. Beck and Azari, *supra* note 1, at 80 & nn. 78-80 (citing sources). Because historically drugs were rarely tested on children, the FDA rarely had the data necessary to approve drugs for use on children, so as many as eighty percent of prescriptions written for children were for “off-label” uses. *See, e.g.*, Lauren H. Breslow, *The Best Pharmaceuticals For Children Act of 2002: The Rise Of The Voluntary Incentive Structure And Congressional Refusal To Require Pediatric Testing*, 40 HARV. J. ON LEGIS. 133, 135-44 (2003) (analyzing reasons for scarcity of pediatric clinical drug trials); Doriane Lambelet Coleman, *The Legal Ethics of Pediatric Research*, 57 DUKE L.J. 517 (2007) (same); Sidney A. Shapiro, *Limiting Physician Freedom To Prescribe A Drug For Any Purpose: The Need For FDA Regulation*, 73 NW. U. L. REV. 801, 809-10 n. 58 (1979) (citing sources); Beck and Azari, *supra* note 1, at 80 n. 81 (citing Robert Levine, ETHICS AND REGULATION OF CLINICAL RESEARCH 239, 241 (2d ed. 1986)); Statement of Sarah F. Jagger, Director of Health Services Quality and Public Health Issues, Health, Education, and Human Services Division, Gen. Accounting Office, Before the Subcomm. on Human Resources and Intergovernmental Relations, Comm. on Gov’t Reform and Oversight, U.S. House of Rep., GAO/T-HEHS-96-212, “Prescription Drugs: Implications of Drug Labeling and Off-Label

III. THE FDA-APPROVED DRUG OR DEVICE LABEL SHOULD NOT BE ADMITTED IN AN “OFF-LABEL” USE CASE

Virtually all medical treatments carry some degree of risk.¹⁶ When a physician treats a patient with an “off-label” use and the patient is injured in the course of that treatment, the patient may sue and contend that the “off-label” use was, in and of itself, a violation of the standard of care – *i.e.*, negligence.¹⁷ And the patient will undoubtedly try to introduce the drug’s or device’s label as evidence of the physician’s alleged negligence.

One recent case reports that “[v]irtually every court addressing [the] question has concluded that the drug’s labeling and PDR reference are relevant to the standard of care issue.”¹⁸ “Several jurisdictions, believing drug manufacturers to be uniquely knowledgeable about the proper use of their products, have held that a drug’s labeling or its parallel PDR reference amounts to *prima facie* evidence of the standard of care as far as the use of that drug is concerned.”¹⁹ “However, a majority of jurisdictions have determined that a prescription drug’s labeling or parallel PDR reference is admissible to prove the standard of care, but only if the plaintiff also introduces other expert testimony regarding the standard of care.”²⁰

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Use,” at 3 n.6 (Sept. 12, 1996) (hereinafter “Jagger Statement”), available at <http://www.gao.gov/archive/1996/he96212t.pdf>. Since 1997, Congress has passed a series of measures to increase pediatric testing and labeling of drugs and devices. Pub. L. No. 105-115, Tit. I, Subtit. B, § 111, 111 Stat. 2305-09 (1997) (codified as amended at 21 U.S.C. § 355a); Pub. L. No. 107-109, §§ 4-11, 115 Stat. 1411-16 (2002); Pub. L. No. 108-155, § 2, 117 Stat. 1936-41 (2003) (codified at 21 U.S.C. § 355c); Pub. L. No. 110-85, Title III, § 302, 121 Stat. 859-60 (codified at 21 U.S.C. § 360e-1), Title IV, § 402, 121 Stat. 866-75 (codified at 21 U.S.C. § 355c), Title V, § 502, 121 Stat. 876-86 (2007) (codified at 21 U.S.C. § 355a). These measures, however, have been voluntary, subject to waiver, and/or applied primarily to new drugs and devices, and some of the provisions are relatively new. Thus, it is not clear that they have significantly affected the frequency of “off-label” pediatric uses.

¹⁶ See, e.g., “Information for Consumers: Side Effects,” http://www.fda.gov/cder/info/consumer_safety.htm (“All medicines have benefits and risks.”).

¹⁷ See Paul D. Rheingold and David B. Rheingold, *Offense or Defense? Managing the off-label use claim*, 37 TRIAL 52, 52-55 (Mar. 2001) (“Lawyers who represent plaintiffs injured by drugs or medical devices are increasingly encountering what is known as the ‘off-label’ use claim.”).

¹⁸ *Richardson v. Miller*, 44 S.W.3d 1, 15 (Tenn. Ct. App. 2001). “PDR” refers to the Physicians’ Desk Reference, “an encyclopedia of medications written and published annually and provided to all practicing physicians.” *Id.* at 11. “The PDR contains the same information drug manufacturers are required to include in their package insert labeling.” *Id.*; 21 C.F.R. § 201.100(c)-(d) (2007).

¹⁹ *Id.* at 16 (citing cases).

²⁰ *Id.* The treatment of drug and device labels in medical malpractice cases is also discussed in Bird, *supra* note 7, and David C. Minneman, Annotation, *Medical Malpractice:*

Both rationales for admitting drug and device labeling in “off-label” use cases are incorrect. FDA-approved drug and device labeling is not relevant evidence of the standard of medical care. And even if the labeling offered *some* evidence of that standard, the risk of confusion, prejudice, and undue waste of time would substantially outweigh that marginal relevance.

A. The FDA-Approved Label Is Not Relevant Evidence Of The Standard Of Care.

The plaintiff in a medical malpractice action must prove that the physician failed to meet the standard of care, which in most jurisdictions is the level of skill and knowledge possessed by medical professionals in the same or a similar community.²¹ Only evidence that is relevant to establishing the standard of care should be admitted in the plaintiff’s case.²² The FDA-approved label is not relevant evidence of the standard of care in an “off-label” use case, for several reasons.

1. The FDA And Manufacturers Are Not Local Medical Practice Standard-Bearers.

Drug and device labeling is a creature of federal regulatory law. The FDA, the creature’s master, has repeatedly said it does not regulate the practice of medicine.²³ Accordingly, the FDA

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Drug Manufacturer’s Package Insert Recommendations As Evidence Of Standard Of Care, 82 A.L.R. 4th 166 (1990).

²¹ See, e.g., RESTATEMENT (SECOND) OF THE LAW OF TORTS § 299A (“one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities”).

²² Evidence is “relevant” if it makes the existence of a consequential fact more probable or less probable than it would be without the evidence. See, e.g., Fed. R. Evid. 401. Irrelevant evidence is inadmissible. See, e.g., Fed. R. Evid. 402.

²³ See, e.g., Statement of William B. Schultz, Deputy Commissioner for Policy, FDA, Before the Comm. on Labor and Human Resources, U.S. Senate (Feb. 22, 1996), available at <http://www.fda.gov/ola/1996/s1447.html> (“the legislative history of the Federal Food, Drug, and Cosmetic Act . . . indicates that Congress did not intend FDA to interfere with the practice of medicine;” “once a drug is approved for marketing, FDA does not generally regulate how, and for what uses, physicians prescribe that drug”); “Use of Drugs for Unapproved Indications: Legal Responsibility,” FDA Drug Bulletin (Oct. 1972) (hereinafter “1972 FDA Drug Bulletin”) (“Congress did not intend the [FDA] to interfere with medical practice.”), reprinted in *Information – Select Item from the FDA Drug Bulletin*, 117 Cal. Med. 80, 80 (1972); Legal Status Of Approved Labeling For Prescription Drugs; Prescribing For Uses Unapproved By The Food And Drug Administration, 37 Fed. Reg. 16,503, 16,503 (proposed Aug. 15, 1972) (noting that legislative history of Federal Food, Drug, and Cosmetic Act includes “repeated statements that Congress did not intend the [FDA] to interfere with medical practices and references to the understanding that the bill did not purport to regulate the practice of medicine as between the

has repeatedly confirmed that the absence of a particular use from a drug’s or device’s approved label has no legal effect on a physician’s ability to put the drug or device to that use:

- In a 1972 rulemaking proposal, the FDA stated that a “physician may, as part of the practice of medicine, lawfully prescribe a different dosage for his patient, or may otherwise vary the conditions of use from those approved in the package insert”²⁴ Thus, “labeling is not intended either to preclude the physician from using his best judgment in the interest of the patient, or to impose liability if he does not follow the package insert.”²⁵
- In a 1982 Drug Bulletin, the FDA stated that federal law “does not . . . limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling.”²⁶
- In a 1994 request for public comment, the FDA said it “has long recognized that physicians and other health care professionals may prescribe approved therapies for unapproved uses.”²⁷ The same document

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physician and the patient”); Peter H. Rheinstein, *Drug Labeling as a Standard for Medical Care*, 4 J. LEGAL MED. 22, 24 (1976) (former director of FDA advertising division explained that “differences between” drug labeling and “accepted medical practice represents the difference between the rigorous proof” the FDA “must demand and the clinical judgment of a physician based on his training, experience, and skill as related to the needs of his individual patient;” “[o]ne cannot be taken as a standard for the other”). The United States Supreme Court has reached the same conclusion. *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341, 350 (2001) (“‘off-label’ usage of medical devices (use of a device for some other purpose than that for which it has been approved by the FDA) is an accepted and necessary corollary of the FDA’s mission to regulate in this area without directly interfering with the practice of medicine”); *Linder v. United States*, 268 U.S. 5, 18 (1925) (“direct control of medical practice in the State is beyond the power of the federal government”).

²⁴ Legal Status Of Approved Labeling For Prescription Drugs; Prescribing For Uses Unapproved By The Food And Drug Administration, 37 Fed. Reg. 16,503, 16,503 (proposed Aug. 15, 1972); *see also* 1972 FDA Drug Bulletin (similar), reprinted in 117 Cal. Med. at 80.

²⁵ 1972 FDA Drug Bulletin, reprinted in 117 Cal. Med. at 81. Notwithstanding this clear statement that an “off-label” use will not lead to liability, the FDA also said in the same document that “*labeling*, along with medical articles, texts, and expert opinion, *may constitute evidence of the proper practice of medicine*” *Id.* (emphasis added).

²⁶ 12 FDA Drug Bulletin, No. 1, at 5 (Apr. 1982).

²⁷ Citizen Petition Regarding the Food and Drug Administration’s Policy on Promotion of Unapproved Uses of Approved Drugs and Devices; Request for Comments, 59 Fed. Reg. 59,820, 59,825 (Nov. 18, 1994).

notes that the FDA and its representatives “have restated this policy on numerous occasions.”²⁸

- In a brief filed in federal court in 1995, the FDA commissioner (sued in his official capacity) said that the FDA “has long recognized the important role that some unapproved uses may play in the practice of medicine.”²⁹
- In a February 2008 draft report, the FDA stated that “[o]nce a drug or medical device has been approved or cleared by FDA, generally healthcare professionals may lawfully use or prescribe that product for uses or treatment regimens that are not included in the product’s approved labeling.”³⁰

Congress, too, recognizes that “off-label” uses are not *per se* improper. Federal law provides that “[n]othing in [the Federal Food, Drug, and Cosmetic Act] shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship.”³¹ Congress also requires government insurance programs to pay for certain “off-label” uses.³²

²⁸ *Id.* at 59,821.

²⁹ *Wash. Legal Found. v. Kessler*, 880 F. Supp. 26, 28 n.1 (D.D.C. 1995) (quoting FDA commissioner’s brief). Curiously, in a later proceeding, the FDA attempted to downplay the scope of “off-label” use and took the position that it merely “accepts the practice of off-label use by physicians as part of its enforcement discretion.” *Wash. Legal Found. v. Friedman*, 13 F. Supp. 2d 51, 55-56 (D.D.C. 1998), *vacated on other grounds sub nom. Wash. Legal Found. v. Henney*, 202 F.3d 331 (D.C. Cir. 2000). The court was skeptical “whether the FDA could currently regulate this aspect of the practice of medicine if it wished to do so.” *Id.*

³⁰ FDA, Guidance for Industry: Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices, Draft Guidance, at 3-4 (Feb. 2008) (hereinafter “FDA Draft Guidance”), available at <http://www.fda.gov/OHRMS/DOCKETS/98fr/FDA-2008-D-0053-gdl.pdf>. It is particularly anomalous to admit the version of a drug’s labeling taken from the PDR, as some courts have done, because that publication itself recognizes that the FDA-approved labeling it contains does not “limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may choose to prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling.” PHYSICIANS’ DESK REFERENCE, Foreword (62d ed. 2008).

³¹ 21 U.S.C. § 396 (2007).

³² *E.g.*, 42 U.S.C. § 1395x(t)(2)(A)-(B) (2007) (requiring Medicare to reimburse for off-label indications supported by specified medical publications).

Not surprisingly, federal courts³³ and state courts³⁴ are in accord. And, like Congress, many state legislatures have at least tacitly approved certain “off-label” uses by requiring insurance companies to cover them.³⁵

³³ See, e.g., *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341, 350 (2001); *Ortho Pharm. Corp. v. Cosprophar, Inc.*, 32 F.3d 690, 692 (2d Cir. 1994) (“the FDA permits doctors to prescribe drugs for ‘off-label’ uses”); *Weaver v. Reagen*, 886 F.2d 194, 198 (8th Cir. 1989) (“Thus, the fact that FDA has not approved labeling of a drug for a particular use does not necessarily bear on those uses of the drug that are established within the medical and scientific community as medically appropriate.”); *Schultz v. AstraZeneca Pharms., L.P.*, No. C 06-6681 CW, 2006 WL 3797932, at *4 (N.D. Cal. Dec. 22, 2006) (citing approvingly to cases “indicat[ing] that a mere allegation of ‘off-label’ use with nothing more would not be sufficient to state a claim for professional negligence”); *Organon Inc. v. Teva Pharms., Inc.*, 244 F. Supp. 2d 370, 375 n.8 (D.N.J. 2002) (“A use can only be put in the drug’s packaging insert if it is FDA-approved. However, [the drug] can lawfully be prescribed by doctors for off-label uses.”); *Alexander v. Smith & Nephew, P.L.C.*, 98 F. Supp. 2d 1310, 1321 (N.D. Okla. 2000) (“While the FDA regulates the manner in which [the manufacturer] markets [a] device, it does not regulate a physician’s decision to use the device for another, ‘off-label’ use.”); *Parks v. Danek Med., Inc.*, No. 2:95 CV 206, 1999 WL 1129706, at *3 (N.D. Ind. June 17, 1999) (“‘Off-label’ use is both legal and widespread.”) (citing *Hill v. Danek Med. Inc.*, No. 4:96-CV-177-H1, 1998 WL 1048182, at *6 (E.D.N.C. Sept. 10, 1998), *In re Orthopedic Bone Screw Prod. Liab. Litig.*, No. 1014, 9408-0002, 1996 WL 107556, at *4-*5 (E.D. Pa. Mar. 8, 1996), and *West v. Danek Med., Inc.*, No. CIV-97-575-T, 1998 WL 1041327, at *4 (W.D. Okla. Dec. 28, 1998)); *Holland v. Smith & Nephew Richards, Inc.*, 100 F. Supp. 2d 53, 56 (D. Mass. 1999) (“The mere fact that the FDA has not cleared a product for a particular use does not mean that the product is not in fact suitable for that purpose; it simply means that the FDA has not cleared it.”); *Wheat v. Sofamor*, 46 F. Supp. 2d 1351, 1365 (N.D. Ga. 1999) (“a physician is permitted to use an FDA approved device for an unapproved use”); *Sita v. Danek Med, Inc.*, 43 F. Supp. 2d 245, 262-63 (E.D.N.Y. 1999) (“Off-label use of a medical product is not illegal.”); *Baker v. Danek Med.*, 35 F. Supp. 2d 865, 873 (N.D. Fla. 1998) (“if a product is legally marketed for a certain use . . . , doctors do not violate the FDCA by prescribing the product for a different use”); *Friedman*, 13 F. Supp. 2d at 55 (“off-label use of FDA-approved drugs by physicians is an established aspect of the modern practice of medicine”); *Kessler*, 880 F. Supp. at 28 n.1 (“it is not unlawful for doctors to employ or prescribe medical products for ‘unapproved’ uses”); *United States v. Evers*, 453 F. Supp. 1141, 1144, 1150 (M.D. Ala. 1978) (answering negatively “the question of whether a licensed physician may be enjoined from prescribing for his patients a drug of which the package insert is silent as to whether the drug is indicated or contraindicated for the patient’s illness,” because “[w]hen physicians go beyond the directions given in the package insert it does not mean they are acting illegally or unethically”), *aff’d*, 643 F.2d 1043 (5th Cir. 1981).

³⁴ See, e.g., *Sita v. Long Island Jewish-Hillside Med. Ctr.*, 803 N.Y.S.2d 112, 114 (N.Y. App. Div. 2005) (“Although marketing and promotion of the pedicle screw system was not approved by the [FDA] for treating the injured plaintiff’s condition, this does not prevent a physician from using the system in an ‘off-label’ manner.”) (citations omitted); *State Bd. of Reg. for the Healing Arts v. McDonagh*, 123 S.W.3d 146, 150 (Mo. 2004) (“non-FDA-approved, or ‘off-label,’ use of medications by physicians is not prohibited by the FDA and is generally accepted in the medical profession”); *Zbras v. St. Vincent’s Med. Ctr.*, No. CV950323593, 2002

Moreover, the FDA's information-gathering role in the approval process is largely passive and static, relying on only data that exists when approval is sought and that the manufacturer chooses to submit.³⁶ The FDA has acknowledged those limitations: "Physicians

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WL 31018547, at * 2 (Conn. Super. Ct. Aug. 7, 2002) ("an off-label use of a medical device is not prohibited"), *aff'd*, 880 A.2d 999 (Conn. App. Ct. 2005); *Blazoski v. Cook*, 787 A.2d 910, 920 (N.J. Super. Ct. App. Div. 2002) ("In essence, physicians have the right, exercising reasonable medical judgment, to use medical devices for off-label purposes that are not FDA approved, provided that the FDA has approved the device for some other purpose."); *Southard v. Temple Univ. Hosp.*, 781 A.2d 101, 104 (Pa. 2001) ("The FDA does not preclude off-label use of medical devices. To the contrary, while the FDA regulates the marketing and labeling of medical devices, it does not purport to interfere with the practice of medicine."); *Baker v. Smith & Nephew Richards, Inc.*, No. 95-58737, 1999 WL 811334, at *6 (Tex. Dist. Ct. June 7, 1999) ("'off-label use' is a common part of the practice of medicine which the FDA does not regulate"), *aff'd sub nom. McMahan v. Smith & Nephew Richards, Inc.*, No. 14-99-00616-CV, 2000 WL 991697 (Tex. App. July 20, 2000); *Morlino v. Med. Ctr. of Ocean County*, 706 A.2d 721, 730 (N.J. 1998) (holding that, "[t]o confine the treatment choices to those expressly permitted in the PDR would be too restrictive" and "would be inconsistent with the FDA's position that physicians are not bound by PDR recommendations"); *Staudt v. Froedtert Mem. Lutheran Hosp.*, 580 N.W.2d 361, 363 (Wis. Ct. App. 1998) ("Once a drug or device has been approved for any purpose, physicians may use that drug or device for purposes that have not been approved."); *Piazza v. Myers*, No. 1914, 1997 WL 1133693, at *3 (Pa. Comm. Pl. Apr. 18, 1997) ("a physician is free to use a medical device for a purpose not approved by the FDA if, in that physician's best medical judgment, such use will benefit the patient"); *Klein v. Biscup*, 109 Ohio App. 3d 855, 864 (Ohio Ct. App. 1996) ("the decision whether to use a drug for an off-label purpose is a matter of medical judgment, not of regulatory approval;" "the off-label use of a medical device is also a matter of medical judgment").

³⁵ *E.g.*, Ala. Code § 27-1-10.1; Cal. Ins. Code § 10123.195(a); Cal. Health & Safety Code § 1367.21(a); Conn. Gen. Stat. §§ 38a-492b(a), 38a-518b(a); Fla. Stat. Ann. § 627.4239; Ga. Code Ann. §§ 33.24-59.11, 33-53-2; 5 Ill. Comp. Stat. 375/6.4; 215 Ill. Comp. Stat. 125/4-6.3; Ind. Code Ann. § 27-8-20-7; Kan. Stat. Ann. § 40-2,168; 24 Maine Rev. Stat. Ann. §§ 2320-F, 2320-G, 2745-E, 2745-F, 2837-F, 2837-G, 4234-D, 4234-E; Md. Code Ann. Ins. §§ 15-804, 15-827; Mass. Gen. Laws Ann. ch. 175, §§ 47k, 47o, ch. 176A, §§ 8N, 8Q; ch. 176B, §§ 4N, 4P; ch. 176G, § 4G; Mich. Comp. Laws Ann. §§ 500.3406e, 500.3406q, 500.3616a, 550.1416c; Minn. Stat. Ann. § 62Q.525; Mo. Stat. §§ 376.429, 376.1361; N.H. Rev. Stat. §§ 415:6-g, 415:18-j; N.C. Gen. State. §§ 58-67-78, 58-51-59; N.J. Stat. Ann. § 26:1A-36.9(e); N.D. Cent. Code § 26.1-36-06.1; Ohio Rev. Code Ann. § 1751.66; Okla. Stat. Ann. tit. 63, §§ 1-2604, 1-2605; R.I. Gen. Laws §§ 27-55-2, 27-55-3; S.C. Code Ann. §§ 38-71-275, 58-17-101; Va. Code Ann. 38.2-3407.5; Vt. Stat. Ann. § 4100e.

³⁶ An FDA official has observed that, in some cases, the existing data regarding an "off-label" use is sufficiently comprehensive that the use "could be approved by the FDA if the sponsor would simply compile the existing literature and submit it to us." Statement of William

clearly have access to new information on drugs through the medical literature, scientific meetings, postgraduate courses, and professional contacts with colleagues. The package insert is not intended under the law to serve as a totally current repository of all such information.”³⁷

Drug and device manufacturers, too, are not attempting to define the standard of care in any particular (or every) community. They prepare labeling to get their products approved and to market.³⁸ Thus, courts have found that “[t]he purposes behind the [manufacturer’s labeling] render its contents ill-suited to serve as prima facie evidence of a standard of care; they seek to cover a wide range of concerns not always directed at a diagnosis and course of treatment.”³⁹

(continued...)

B. Schultz, Deputy Commissioner for Policy, FDA, Before the Comm. on Labor and Human Resources, U.S. Senate (Feb. 22, 1996), available at <http://www.fda.gov/ola/1996/s1447.html>.

³⁷ Labeling for Prescription Drugs Used in Man: Proposed Format of Prescription-Drug Advertisements, 40 Fed. Reg. 15,392, 15,393-94 (proposed Apr. 7, 1975). Courts have recognized the limitation, too. *See, e.g., Evers*, 453 F. Supp. at 1149 (“It is well-recognized that a package insert may not contain the most up-to-date information about a drug.”). These statements apply to “off-label” uses that may in fact be supported by medical and scientific data but nevertheless remain “off-label.” After the FDA approves a drug or device for an indicated use, the FDA continues to monitor adverse events and may withdraw its approval if it determines that the drug or device is not safe for that use. *See, e.g.,* 21 C.F.R. §§ 314.80, 314.150 (2007). The FDA, however, will not act to approve a new use unless the manufacturer asks it to and submits the appropriate supporting information. *See supra* note 36 and accompanying text.

³⁸ *E.g., Arnold v. Lee*, No. 05-0651, 2006 WL 1410161, at *4 (Iowa Ct. App. May 24, 2006) (“a manufacturer has its own reasons for the information contained in the package inserts,” which “are not limited to altruism or the education of the medical community”); *Morlino*, 706 A.2d at 729 (“drug manufacturers do not design package inserts and PDR entries to establish a standard of medical care,” but for other reasons, “including compliance with FDA requirements, advertisement, the provision of useful information to physicians, and an attempt to limit the manufacturer’s liability”); *Thompson v. Carter*, 518 So. 2d 609, 612 (Miss. 1987) (similar). *See also* Bird, *supra* note 7, at 416 (reporting that the American Medical Association “has repeatedly alleged that inserts are an inadequate standard for medical practice, pointing to the inconsistent purposes served by the document – advertising for the manufacturer, regulation by the government, and information for the doctor”).

³⁹ *Spensieri v. Lasky*, 723 N.E.2d 544, 548 (N.Y. 1999) (citation omitted). *See also, e.g., Blazoski*, 787 A.2d at 919 (finding that drug and device labeling addresses regulatory and administrative issues and does not address “medical issues”); *Morlino*, 706 A.2d at 729; *Bissett v. Renna*, 710 A.2d 404, 407 (N.H. 1998) (“We find that the PDR, by itself, is insufficient to establish the standard of care required of the defendant.”); *Ramon v. Farr*, 770 P.2d 131, 135 (Utah 1989) (holding that “manufacturers’ inserts and parallel P.D.R. entries do not by themselves set the standard of care, even as a prima facie matter”); *Webb v. Jorns*, 530 S.W.2d 847, 856 (Tex. App. 1975) (“The manufacturer, probably a corporation, but in any event someone not proved to have been a medical expert, could not by its literature have established any medical standard for its use for purposes of trial in a court of law.”).

2. There Are Many Reasons Unrelated To Standards Of Care Why A Use May Not Be Indicated In A Label.

The indicated uses in a drug's or device's FDA-approved labeling are not evidence that another use is outside the standard of care, because there are many compelling reasons why a widely accepted and demonstrably safe and effective use for a drug or device may be omitted.

For one, science advances more quickly than regulation.⁴⁰ Physicians may discover the benefits of an "off-label" use, and share those benefits with others, through journals, presentations, and professional associations, long before the FDA approves the use.⁴¹

Even if science and regulation advanced at the same rate, there are several reasons why much standard of care medicine would still not be reflected in drug or device labeling.⁴² First, "[b]ecause of the time and expense of obtaining FDA approval of new uses for an already approved drug, drug manufacturers frequently do not voluntarily request FDA approval for a new use unless the change in labeling will pay for itself in increased profits."⁴³ Self-funding label changes are particularly unlikely when the drug's or device's patent is nearing expiration

⁴⁰ *E.g.*, Shapiro, *supra*, note 15, at 811 (observing that "off-label" uses "are unlikely ever to be eliminated since there is an unavoidable lag between the time a new use for a drug is discovered and the time that use is approved by the FDA"). Indeed, a manufacturer may not even start the testing required to support FDA approval for a new use until after that use becomes the medically-accepted standard. *Id.*

⁴¹ 12 FDA Drug Bulletin, No. 1, at 5 (Apr. 1982) ("Valid new uses for drugs already on the market are often first discovered through serendipitous observations and therapeutic innovations, subsequently confirmed by well-planned and executed clinical investigations." "Before such advances can be added to the approved labeling, however, data substantiating the effectiveness of a new use or regimen must be submitted by the manufacturer to FDA for evaluation. This may take time and, without the initiative of the drug manufacturer whose product is involved, may never occur.").

⁴² Stuart L. Nightingale, M.D., Office of the Secretary, U.S. Department of Health and Human Services, Editorial, *Off-Label Use of Prescription Drugs*, AMERICAN FAMILY PHYSICIAN (Aug. 1, 2003), available at <http://www.aafp.org/aft/20030801/editorials.html>.

⁴³ *Richardson*, 44 S.W.3d at 12. *See also, e.g., Evers*, 453 F. Supp. at 1150 ("The manufacturer may not have sufficient commercial interests or financial wherewithal to warrant following the necessary procedures to obtain FDA approval for the additional use of the drug.") The General Accounting Office similarly observed that, when an "off-label" use is proven effective, "the manufacturer can ask the FDA to make a formal change in the label that would reflect the expanded benefits of the drug. However, representatives from the pharmaceutical industry characterize this process as cumbersome, time-consuming, and expensive compared to the payoff for a company." GAO Report at 11 n.2.

(thus exposing the drug or device to generic competition),⁴⁴ and when the market for the “off-label” use is small.⁴⁵

Second, drug and device manufacturers have limited research and development dollars, and they may decide those dollars are better spent pursuing groundbreaking new therapies than seeking approval for new uses of products already being sold.⁴⁶

Third, the same concept of limited resources may make it difficult for manufacturers to find researchers willing to perform the clinical trials necessary to obtain FDA approval for the new use. When the “off-label” use to be investigated is already widely accepted, researchers may find the investigation to be “at least uninteresting, if not a waste of time.”⁴⁷

Fourth, when the “off-label” use is already widely accepted as beneficial, the availability of researchers may also be limited by ethical restraints: “the conflict between the patient’s therapeutic needs and the needs of the experimental trial [such as supplying placebos to the control group of afflicted subjects] poses ethical problems which may deter a physician from acting as an investigator.”⁴⁸

Fifth, when the “off-label” use is already the standard of care for a particular disease or condition, it may be difficult to find a traditional control group, because most people afflicted with the disease or condition are already receiving the “off-label” treatment that is to be studied.⁴⁹

Sixth, if a manufacturer seeks approval for a new use, the FDA may choose to revisit the entire label.⁵⁰ If the original label resulted from compromise between the manufacturer and the FDA, the manufacturer may wish not to reopen these negotiations.⁵¹

⁴⁴ GAO Report at 11 n.2 (“In addition, generic drug manufacturers can typically market the same drug at a reduced price after the patent expires; thus, the drug developer has little incentive to expend resources on testing the effectiveness of a drug against off-label indications.”).

⁴⁵ See, e.g., Beck and Azari, *supra* note 1, at 80 n.80 (“Most diseases afflicting fewer than 200,000 Americans are ‘totally without’ FDA-labeled treatment.”); see also Shapiro, *supra* note 15, at 811-12 (“The fact that the manufacturer is already benefiting from sales attributable to the unapproved use may also contribute to its lack of incentive to seek FDA approval.”). When the disease or condition is rare, it may also be difficult to enroll enough subjects in a clinical trial to obtain meaningful results. Jennifer A. Henderson and John J. Smith, *Realizing The Potential For Biomarkers In Imaging: Background And Legal Basis*, 60 FOOD & DRUG L.J. 511, 515 (2005). In the 1983 Orphan Drug Act, Congress sought to reduce the cost of, and provide financial incentives for, developing and obtaining FDA approval of drugs for use in treating rare diseases and conditions. Pub. L. No. 97-414, 96 Stat. 2049-66 (1983) (codified in pertinent part as amended at 21 U.S.C. §§ 360aa-360ee).

⁴⁶ Noah, *supra* note 11, at 145.

⁴⁷ David A. Kessler, *Regulating The Prescribing Of Human Drugs For Nonapproved Uses Under The Food, Drug, and Cosmetic Act*, 15 HARV. J. ON LEGIS. 693, 730 (1978).

⁴⁸ *Id.*; Henderson and Smith, *supra* note 45, at 515.

⁴⁹ Henderson and Smith, *supra* note 45, at 515-16.

⁵⁰ Shapiro, *supra* note 15, at 812 n.77; Kessler, *supra* note 47, at 723-24.

Congress' efforts to induce manufacturers to seek FDA approval for "off-label" uses have not entirely cured these disincentives. Although manufacturers are not permitted to market a drug for an "off-label" use, the 1997 Food and Drug Administration Modernization Act allowed manufacturers to disseminate certain scientific literature about an "off-label" use if the manufacturer had submitted, or certified that it would submit, a supplemental application seeking FDA approval for the use.⁵² The statute, however, allowed manufacturers to disseminate information without submitting, or promising to submit, a supplemental application when it would be "economically prohibitive . . . to conduct the studies necessary to submit a supplemental application for the ['off-label'] use."⁵³ And, of course, manufacturers willing to rely on the medical community to spread the word about a particular "off-label" use would not subject themselves to this rule. Moreover, this provision and its implementing regulations expired in 2006.⁵⁴ The FDA has recently proposed a "draft" guidance statement on the topic for public comment.⁵⁵ That draft would continue to permit manufacturers to disseminate certain types of literature about "off-label" uses,⁵⁶ but without requiring manufacturers to submit, or promise to submit, a supplemental application for FDA approval of those uses.⁵⁷

Thus, there are many reasons – unrelated to the standard of care – why certain uses of a drug or device would not be indicated in the FDA-approved labeling.

3. "Off-Label" Use May Actually Be The Standard Of Care.

An FDA-approved label should not be admissible as evidence of the standard of care because the FDA, as well as leading medical authorities and courts, have recognized that an "off-

(continued...)

⁵¹ Shapiro, *supra* note 15, at 812 n.77.

⁵² Pub. L. No. 105-115, Title IV, § 401(a), 111 Stat. 2356-63 (1997) (codified at 21 U.S.C. §§ 360aaa-360aaa-6).

⁵³ 21 C.F.R. § 99.205(b) (2007). To qualify for this exemption, the manufacturer must explain why the data in the disseminated study are not sufficient to support the supplemental application and present evidence that the cost of the studies necessary to support the supplemental application exceeds the expected net revenues from the "off-label" use. *Id.* § 99.205(b)(1)(i)-(ii).

⁵⁴ Pub. L. 105-115, Title IV, § 401(e), 111 Stat. 2364 (1997). *See also* Notice, Draft Guidance for Industry on Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices; Availability, 73 Fed. Reg. 9342 (Feb. 20, 2008).

⁵⁵ FDA Draft Guidance. Guidance documents "describe the [FDA]'s interpretation of or policy on a regulatory issue" and "represent the [FDA]'s current thinking." 21 C.F.R. § 10.115(a), (d)(3) (2007). They "do not establish legally enforceable rights or responsibilities." *Id.* § C.F.R. 10.115(d)(1).

⁵⁶ FDA Draft Guidance at 4-6.

⁵⁷ *Id.* at 4-7 & n.6.

label” use may well be the safest, most effective, state-of-the-art treatment and, indeed, may itself constitute the standard of care. For example:

- The FDA, in a draft report, observes that “off-label” uses “may even constitute a medically recognized standard of care.”⁵⁸
- The GAO’s Director of Health Services Quality and Public Health Issues testified to a congressional subcommittee that “a drug given off-label may have been proven to be safer and more beneficial than any drug labeled for that disease.”⁵⁹
- The National Cancer Institute has stated that “[f]requently the standard of care for a particular type or stage of cancer involves the off-label use of one or more drugs.”⁶⁰
- The Mayo Clinic takes the position that “it is even possible that for a specific form of cancer, a drug given off-label may have been proven to be more beneficial than any drug labeled for that cancer.”⁶¹
- Courts have found that “[b]ecause the pace of medical discovery runs ahead of the FDA’s regulatory machinery, the off-label use of some drugs is frequently considered to be ‘state-of-the-art’ treatment.” “In some circumstances, an off-label use of a particular drug or device may even define the standard of care.”⁶²
- The vice president of the American Medical Association is quoted as saying that, “[i]n some cases, if you didn’t use the drug in the off-label way, you’d be guilty of malpractice.”⁶³
- The American Academy of Pediatrics’ Committee on Drugs cautioned that “a physician could be held liable (in a malpractice action) for a departure from accepted standards of medical care if he denied a patient something that was potentially the best treatment solely because the use was not included in the official labeling of the drug.”⁶⁴

⁵⁸ *Id.* at 4.

⁵⁹ Jagger Statement at 3.

⁶⁰ Nat’l Cancer Inst., Understanding the Approval Process for New Cancer Treatments, <http://www.cancer.gov/clinicaltrials/learning/approval-process-for-cancer-drugs>.

⁶¹ Mayo Clinic Off-Label Web Page.

⁶² *Richardson*, 44 S.W.3d at 13 n.11.

⁶³ Fran Kritz, FDA Seeks to Add Drugs’ Uses to Labels, Wash. Post, Mar. 29, 1997, Health Section, at 11.

⁶⁴ *Unapproved Uses of Approved Drugs: The Physician, the Package Insert, and the FDA*, 62 PEDIATRICS 262, 262-63 (1978).

Neither the FDA nor manufacturers intend to set the standard of care for medical malpractice purposes in drug and device labeling. There are many reasons why uses that conform to the standard of care may be omitted from an FDA-approved label. An FDA-approved label's silence as to a particular use is therefore evidence of nothing in an "off-label" medical malpractice case.

B. Admitting Drug And Device Labels Poses A Substantial Risk Of Prejudice And Confusion.

Some courts have admitted FDA-approved drug and device labels as "some evidence" of the standard of care.⁶⁵ For all the reasons explained above, those courts decided wrongly. But even if FDA-approved labels had *some* evidentiary value in an "off-label" use case, that value would be outweighed by the significant risk of prejudice, confusion, and time-wasting.⁶⁶

Indeed, just the terminology associated with "off-label" use poses the risk of prejudice and confusion. Uses of drugs and devices not indicated on the drug's or device's labeling can be called "unapproved," "unlabeled," "off-label," or "extra-label."⁶⁷ As the FDA itself recognized, "[t]he term 'unapproved uses'[, for example,] is, to some extent, misleading. It includes a variety of situations ranging from unstudied to thoroughly investigated drug uses."⁶⁸

Consumer survey data confirm these risks. According to a 2006 Wall Street Journal/Harris Interactive Health-Care Poll, fifty percent of adults in the United States (out of 3,018 surveyed) believe that, once a drug is approved by the FDA, a physician may prescribe the drug for only the FDA-approved uses; another twenty-five percent were unsure.⁶⁹ A trial laden with references to "unapproved" uses would also inappropriately pander to jurors' views that "off-label" uses should not be permitted. The same survey found that nearly half (forty-eight percent) of respondents believe that physicians should not be allowed to prescribe a drug to treat diseases other than the diseases indicated in the FDA-approved labeling for that drug.⁷⁰ More

⁶⁵ See *supra* note 20 and accompanying text.

⁶⁶ See, e.g., Fed. R. Evid. 403.

⁶⁷ Citizen Petition Regarding the Food and Drug Administration's Policy on Promotion of Unapproved Uses of Approved Drugs and Devices; Request for Comments, 59 Fed. Reg. 59,820, 59,820 (Nov. 18, 1994).

⁶⁸ 12 FDA Drug Bulletin, No. 1, at 5 (Apr. 1982).

⁶⁹ "U.S. Adults Ambivalent About the Risks and Benefits of Off-Label Prescription Drug Use," available at <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=1126>. The specific question posed was: "The Food and Drug Administration (FDA) approves new prescription drugs for use only after medical research has found that they are safe and effective for treating specific diseases. Which of the following do you think is true?" The available responses (and response rates) were: "Once a drug is approved, a doctor can prescribe it only for the diseases for which it has been approved by the FDA" (50%); "Once a drug is approved, a doctor can prescribe it for any disease, including those for which it has not been approved" (26%); and "Not sure" (25%). The percentages total more than one hundred due to rounding. *Id.*

⁷⁰ The specific question posed was: "Do you think doctors should or should not be allowed to prescribe a drug for diseases for which that drug has not been approved by the FDA?"

respondents disagreed (forty-six percent) than agreed (forty-five percent) that “[d]octors should be allowed to decide which prescription drug treatments to use with their patients regardless of what diseases they have or have not been approved for by the FDA.”⁷¹ “When it comes to using prescription drugs for unapproved diseases,” more respondents believed that “[i]n most cases the risks outweigh the benefits” (thirty-four percent) than believed that “[i]n most cases the benefits outweigh the risks” (thirty-one percent).⁷² And sixty-two percent of respondents agreed that “[p]rescription drug use for unapproved medical conditions should be prohibited except as part of the clinical research trial.”⁷³

These 2006 results confirm the results of a similar survey conducted in 2004.⁷⁴ Together, these surveys demonstrate that public misconception and distrust about “off-label” use is common and deep-seated.

At least one court has, without the benefit of this type of survey data, concluded that the risk of confusion and prejudice could be adequately addressed through cross-examination and jury instructions.⁷⁵ But if either of those were a panacea, then Federal Rule of Evidence 403 and its state law analogues, which exclude evidence likely to confuse and more prejudicial than probative, would not be necessary. And the Harris Poll results demonstrate the sort of “widely held prejudice” that courts have relied on to exclude evidence under those rules.⁷⁶

(continued...)

The available responses (and response rates) were: “Should be allowed” (27%); “Should not be allowed” (48%); “Not sure” (24%). The percentages total more than one hundred due to rounding. *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ In the 2004 survey, which asked the same questions as the 2006 survey, fifty-one percent of adults from the United States (out of 2,148 surveyed) believed that “[o]nce a drug is approved, a doctor can prescribe it only for the diseases for which it has been approved by the FDA.” Many People Think That Drugs Should Only Be Prescribed Per FDA-Approved Use, Not for Off-Label Use, available at http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI-Health-CarePoll2004vol3_iss11.pdf. Thirty-one percent believed a doctor could prescribe a drug for any use. *Id.* Forty-eight percent believed doctors should not be allowed to prescribe drugs for “off-label” uses; thirty-one percent believed doctors should be allowed. *Id.* The chairman of the Harris Poll observed that these results indicated “massive public ignorance of ‘off-label prescribing,’” and that, notwithstanding the “several strong arguments in favor of off-label prescribing, . . . these data suggest that it is a potentially risky issue for both physicians and the pharmaceutical industry . . .” *Id.*

⁷⁵ *Richardson*, 44 S.W.3d at 22.

⁷⁶ *See, e.g., United States v. Kott*, No. 3:07-cr-00056 JWS, 2007 WL 2461930, at *2 (D. Alaska, Aug. 28, 2007) (excluding evidence that legislator had filed previous false *per diem* claims because it “would tend to support the widely held prejudice that many legislators are entirely corrupt”).

Evidence that a particular use is “off-label” should also be excluded to avoid wasting time.⁷⁷ Consider, for example, the case in which the plaintiff relies exclusively on the “off-label” nature of the use as proof of malpractice. If the physician’s expert witness will testify that the “off-label” use was, in fact, the state-of-the-art treatment, and the judge will instruct the jury that an “off-label” use is not negligence *per se*, then the label would come in, only for the physician and court to try to erase any effect it may have on the jurors. This wastes time; it also risks confusing the jurors.

Even if the plaintiff offered expert testimony in addition to the product label to establish the standard of care, admitting the label would waste time. In a field such as oncology, for example, where the majority of treatments are “off label,”⁷⁸ the plaintiff would offer the label, and the defense expert would testify that the majority of treatments are “off-label,” so the label is far removed from the standard of care. The physician in that type of case may or may not have committed malpractice, but admitting the label consumes time without giving the jury useful information.

IV. CONCLUSION

Drug and device labels reflect competing regulatory and commercial interests. Because they are frozen in time, they may not reflect advances in the medical state-of-the-art. The FDA itself has repeatedly recognized that “off-label” uses are generally allowed and may in fact be the standard of care. Thus, the absence of a use from an FDA-approved label proves nothing about the standard of care or a physician’s adherence to that standard when he or she employs that “off-label” use. Allowing plaintiffs in “off-label” medical malpractice cases to introduce evidence that the use in question was “off-label,” “unapproved,” or “unauthorized” unfairly appeals to commonly held misconceptions about the effect of FDA approval. Defendants in these types of cases must know and use all the arguments available to oppose the admission of this “off-label” evidence.

⁷⁷ See Fed. R. Civ. P. 403.

⁷⁸ See *supra* note 15 and accompanying text.