Brigham and Women's Hospital
Founding Member, Mass General Brigham

HARVARD MEDICAL SCHOOL

MULTI-REGIONAL CLINICAL TRIALS
THE MRCT CENTER of BRIGHAM AND WOMEN'S HOSPITAL and HARVARD

Submitted April 29, 2024

Re: **Docket No. FDA–2016–D–3561**
Collection of Race and Ethnicity Data in Clinical Trials and Clinical Studies for FDA-Regulated Medical Products

To whom it may concern:

The Multi-Regional Clinical Trials Center of Brigham and Women's Hospital and Harvard (MRCT Center) appreciates the opportunity to comment on the Food and Drug Administration's ("FDA's" or "the Agency's") Draft Guidance for industry entitled, "*Collection of Race and Ethnicity Data in Clinical Trials and Clinical Studies for FDA-Regulated Medical Products*," published at 89 Fed. Reg. 5911-13 (Jan. 30, 2024) (the "Draft Guidance"). Guidance on this topic is timely, welcome, and important to stakeholders across the clinical research enterprise.

The MRCT Center is a research and policy center that seeks to improve the ethics, conduct, oversight, and regulatory environment of international, multi-site clinical trials. Founded in 2009, it functions as an independent convener to engage diverse stakeholders from industry, academia, patients and patient advocacy groups, non-profit organizations, and global regulatory agencies. The MRCT Center focuses on pre-competitive issues, to identify challenges and to deliver ethical, actionable, and practical solutions for the global clinical trial enterprise. The responsibility for the content of this document rests with the leadership of the MRCT Center, not with its collaborators nor with the institutions with which its authors are affiliated.[1]

The MRCT Center applauds the broader effort across the Department of Health and Human Services to promote diversity and representation across clinical research and the development of the Draft Guidance in particular. We appreciate that the Draft Guidance is clear, concise, and straightforward to implement procedurally. Conceptually, however, the Draft Guidance may be incomplete. We offer the comments below to promote more complete guidance on an incredibly complex issue.

Before commenting on the specifics included in the draft guidance, we appreciate that FDA has already indicated that it will revise FDA guidance in the event that the Office of Management and Budget (OMB) Statistical Policy Directive (SPD) No. 15 (Policy Directive 15) is revised. OMB published a revised SPD 15 at 89 Fed. Reg. 22182-96 (Mar. 29, 2024). Consequently, several elements of the Draft Guidance will require substantial revision to comply with the revised OMB standard. We, therefore, restrict our comments to some issues of overriding importance and not to the specifics of the differences between the two federal agencies as we presume that FDA final guidance will not be inconsistent with OMB.

[1] Brigham and Women's Hospital, Mass General Brigham, Harvard Medical School, and Harvard University.

Smith Center #771, 1350 Massachusetts Ave, Cambridge, MA 02138 75 Francis Street, Boston, MA 02115
Tel: 617-827-7413 | Email: bbierer@bwh.harvard.edu www.MRCTCenter.org

Overall Comments

1. The FDA draft guidance gives some reasons why the study of diverse populations is important, but further elucidation in the guidance would be well-received, particularly given the fact that race and ethnicity are not biological variables.
    - What should sponsors and sponsor-investigators do with these data?
2. We encourage FDA to include guidance on the importance of reporting geographic heritage as well as genetic ancestry. These elements correlate with pharmacogenetic and pharmacodynamic differences with greater fidelity than race and ethnicity.
3. As noted in the Draft Guidance, race and ethnicity categories are "not anthropologically or scientifically based designations, but instead are categories that describe the sociocultural construct of our society." (p 4, ln 103-04) Through this lens, we support self-reporting (p 5, ln 140-49) and the ability of "individuals [to] be permitted to designate a multiracial identity" (p 5, ln 143).
    - How should multi-race categories be reported and how should they be incorporated into the statistical analysis?
4. The requirement for self-identification will help mitigate implicit biases and yield data that more closely reflect the "sociocultural construct of our society."
5. We recommend FDA clarify whether and when individual data on race and ethnicity that were collected in the past can be used and when it must be collected anew or verified contemporaneously. Further, clarifying when data contained within the electronic medical record can be relied upon would be helpful. If such data can be used for real-world data (RWD) in support of regulatory submissions generally, can it be used in pre-approval settings?
6. We appreciate the inclusion of Middle Eastern or North African ("MENA") as an option in the OMB SPD 15, and we assume that revised FDA guidance will be modified to reflect this option.
7. Similarly, we appreciate that the revised FDA guidance will allow for a single question over the current two-question format, and the further delineations of these categories as referenced in OMB SPD 15. We believe that certain amplifications of the OMB SPD 15 directive should be considered by FDA:
    - Resolution or convergence of international/global regulations and perspectives
        i. How will these "count" towards the FDA categories? Is there a difference, for instance, between Chinese Americans in the US and Chinese people living in China?
        ii. Will and how will outside US participants be recognized in FDA-required reporting expectations or requirements?
        iii. How should statistical analyses be adapted for populations from which these categories are not collected (e.g., decline to or are unable to provide, considered against national regulations to collect, etc.)?

- How should members of indigenous populations outside the US be categorized? Should indigenous populations in Canada, Latin America, Australia, and New Zealand, among others, be considered?
- Recognition of the potential inherent complexity of "Black or African American" is important.

8. Were local healthcare and/or local participant perspectives collected and considered?

We note that there remain open opportunities for FDA to consider and provide guidance on a number of additional issues (e.g., social determinants of health) and populations (e.g., sexual orientation and gender identity) as additional important considerations of representativeness in determining medicines safety and efficacy.

The MRCT Center is thankful for the opportunity to comment on this Draft Guidance document. We reiterate our support for revising the means by which race and ethnicity data are collected, and we would welcome any opportunity to discuss.

Please feel free to contact the MRCT Center (bbierer@bwh.harvard.edu or sawhite@bwh.harvard.edu if we can be helpful or if you wish to discuss.

Respectfully submitted,

Barbara E Bierer, MD
Faculty Director, MRCT Center

Sarah A White, MPH
Executive Director