

# David R. Parkinson, MD

Senior Vice President, Oncology R&D, Biogen Idec

by Nancy J. Ciancaglini



David R. Parkinson, MD

M.D. Anderson Cancer Center, University of Texas, Houston, Tex., and at New England Medical Center, Tufts University School of Medicine, Boston, Mass.

His numerous professional affiliations include currently serving as a member of the National Cancer Policy Forum of the Institute of Medicine, on the FDA's Science Board, and on the Board of Directors of the American Association for Cancer Research. Dr. Parkinson is married with two children, lives in La Jolla, Calif., and works in nearby San Diego.

David R. Parkinson, MD, joined Biogen Idec in March 2006 as Senior Vice President, Oncology Research and Development, and oversees all oncology discovery research efforts and the development of the oncology pipeline for the company.

Before Biogen Idec, Dr. Parkinson held senior oncology positions at Amgen and Novartis, where he was responsible for clinical development activities leading to a series of successful global drug registrations for important cancer therapeutics, including Gleevec® [imatinib mesylate; Novartis], Zometa® [zoledronic acid; Novartis], Femara® [letrozole; Novartis], and Vectibix™ [panitumumab; Amgen].

Prior to working in industry, Dr. Parkinson served as Chief of the Investigational Drug Board and then Acting Associate Director of the Cancer Therapy Evaluation Program (CTEP) while at the National Cancer Institute (NCI) from 1990-1997. Earlier in his career, he held academic positions at

In the Q&A that follows, Dr. David R. Parkinson, whose career includes work in academia, the public sector and industry, tells us about oncology drug development at Biogen Idec and how

his R&D team fits into the big picture there, gives us his insight on the industry, and more. We even find out who he most admires.

*“The sheer number of new agents, and the finite number of clinical investigators increase the necessity of operating globally...”*

**OBR:** *Before Biogen Idec, you were at Amgen and Novartis. What’s changed over the last 5 to 10 years in determining how the industry shapes oncology drug discovery and development programs?*

**DP:** From a number of perspectives, oncology drug development has changed greatly. The remarkable progress in our understanding of the pathophysiology of cancer reveals new insights into the successes and failures of current anti-cancer agents, and presents an ever-expanding range of potential new targets and treatment approaches for therapeutics development.

In parallel with the biological progress, is the advance of technologies for generating therapeutic agents against these targets, whether small molecules, engineered antibodies, or recombinant proteins. Similar technological advances are allowing us to more accurately characterize the biology of tumors from individual patients, to better understand the relationship between underlying pathophysiology and response to biologically-targeted agents.

This process is leading to the reclassification of cancers in ways more meaningful for the application of the new classes of therapeutics. An irony is that just as these advances are broadening the possibilities for therapeutics development, numerous practical issues make the actual development of new therapeutics increasingly challenging. These range from the increased bureaucratic burdens associated with the actual conduct of trials—increasing delays and obstacles related to contract and intellectual property language in arrangements with trial sites as well as the remarkable hurdles to the conduct of clinical research resulting from the privacy initiatives enacted within the US in recent years.

The sheer number of new agents, and the finite number of clinical investigators willing and able to conduct clinical trials, conspire to make the conduct of trials more difficult, and increase the necessity of operating globally. Finally, the pace of change in oncology clinical practice, while reflecting progress in cancer

treatment, brings significant complexities in the design and conduct of registration-directed clinical programs, made even more complex by the increasing and appropriate need for such programs to establish a societal niche for the new therapeutic through the conduct of quality-of-life and pharmacoeconomic studies.

Cancer, as an area of significant continuing unmet medical need, still represents a perceived major area of opportunity for the drug development industry. However, it is my belief that, as a drug development community, we need to work together to decrease some of the difficulties I’ve referred to in order to maintain oncology as a preferred area for therapeutics development.

**OBR:** *How have your professional affiliations in the public sector, 7 years at the National Cancer Institute (NCI) for example, influenced or benefited what you do now? Is there any downside there?*

**DP:** I still recall with great pride and sense of accomplishment the years I spent at the NCI. The pharmaceutical and biotechnology industry’s interest and capabilities in oncology drug development were not what they are today—we, in the Investigational Drug Branch and the Cancer Therapy Evaluation Program, were able to bring together clinical investigators with potentially interesting agents from NCI or from industry. This led to drugs including TAXOL® [paclitaxel; Bristol-Myers Squibb] and trans-retinoic acid.

Our supply of investigational and approved agents to the cooperative groups led to the range of studies which represent the cornerstones of current medical oncology. They were great years and I still keep in contact with my former NCI colleagues as well as the community of national and international clinical

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