TESTIMONY OF JACK RUSLEY

TO
SENATE SELECT COMMITTEE ON AGING

HERB KOHL, CHAIR
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My name is Jack Rusley and I am a fourth year medical student at the Alpert Medical School of Brown University, in Providence, Rhode Island. I am also a national leader in the American Medical Student Organization, or AMSA, where I am the current director of the PharmFree Scorecard, a rigorous, comprehensive assessment of industry-medicine interaction and conflict of interest policies at academic medical centers across the United States.[1]

I am here today to provide a perspective from a large and growing group of physicians-in-training regarding the relationship between the pharmaceutical and device industries and the medical profession. My organization and I believe the following:

1) Disclosure is an important *first step* in bringing transparency to industry-medicine relations
2) Continuing medical education, or CME, must be *free from industry funding*
3) Medical research must *directly serve the public good* over industry profits

With 62,000 members, AMSA is the oldest and largest independent association of physicians-in-training in the US, and has a long history of activism around health care issues that affect our current and future patients. In fact, AMSA was the first national organization of health care professionals to end industry advertising in or sponsorship of all meetings and publications in 2001. AMSA began its PharmFree Campaign in 2002 to educate ourselves and others about the impacts of conflicts of interest. The first Scorecard was launched in 2007, and throughout this time, AMSA has been a leader in the movement to promote evidence-based prescribing and access to medicines while preserving true pharmaceutical innovation.[2]

Right about now, you may be wondering, "why do students care about these issues, and what do they have to contribute to this debate?" As long as there have been students, there have been young people not yet tinged with the streak of cynicism who will challenge the status quo. Students are not as tangled in the financial and administrative webs as are our physician mentors, and are therefore more able to be passionate and powerful advocates for our patients and the health care system we want to inherit.

A generation ago, these qualities of student activists were less present, and medical students were known for their docility and acceptance of authority. I've had the privilege to work with students from all over the country that have flipped this model on its head. Instead of accepting and repeating the questionable ethical practice of their elders, they take the lead to create a new conversation about industry-medicine interaction, often at the risk to their academic record.

A group of such students in their first year at Harvard sat in class one day last spring, listening to a faculty member lecture about treatment options for a rare and deadly form of cancer. When this faculty member advocated for the use of a new, less-researched, and expensive drug to be the first-line treatment for this cancer over well-studied, effective, and cheaper alternatives, the students wondered why. They googled him and discovered he was a paid consultant for the drug company that makes the expensive new drug, yet had not disclosed this fact during his presentation. After negotiations with the

administration, a large group of students rallied to call for increased transparency of industry-medicine interactions and an end to conflicts-of-interest in their medical education. This is no small request – Harvard and its affiliated hospitals represent one of the largest and most complex industry-medicine interactions in the nation, and the medical school received a failing grade on the 2008 Scorecard because they had submitted no policy. The students asked national AMSA leaders for help, and I was one of those who helped them organize this protest. I was also present to see a group Pfizer employees nearby. What I did not know until the story was published in the New York Times,[3] was that one of whom had taken a picture of us with his phone, apparently for "personal use" according to a company spokesperson.[4] Under increasing scrutiny by students, the press, and your colleague Senator Grassley, Harvard agreed to require faculty disclosure and is now reviewing its policies. This year, Harvard received a grade of B on the Scorecard.[5]

This story became a symbol of a larger movement among students across the country, one that has been growing for years and is only now receiving due attention. It is a movement rooted in the desire to learn the best, most scientifically sound, evidence-based treatments for our future patients.

I would like to directly address some of the arguments and misconceptions from the other side of this debate. The first is that AMSA and our partners in this movement are anti-pharma, anti-research, or anti-innovation. Quite the opposite. Industry-medicine interaction has in the past and can in the future result in innovative and life-saving therapies. We want more, well-designed, unbiased research to create truly innovative drugs and devices.

Second, some think disclosure policies and conflict of interest regulations, such as the "Sunshine Act" (S.301, introduced by Chairman Kohl and Senator Grassley) are "red light restrictions" that would stifle research, limit continuing medical educational opportunities, and demean physicians. In fact, the Sunshine Act would do none of these things. If this "chilling effect" does occur and faculty stop interacting with industry out of embarrassment, perhaps these relationships were not appropriate in the first place. There are many examples of academic medical centers ending industry sponsorship without the world ending, and even with positive results.[6] What about the classic "bad apples" argument, that there are a few rouge physicians out there taking all the gifts and advising 18 different companies? There is no evidence to support this claim, whereas the evidence for a system of widespread influence peddling is extensive.[7] Social science research clearly shows that influence is an unconscious, powerful force that is most effective in those who think they cannot be influenced.[8] Disclosure, like that provided by the Sunshine Act, is a first-step toward bringing transparency to industry-medicine interactions.

Third, the pro-industry side argues that industry-sponsored CME and speakers bureaus provide an important source of information for physicians who may not otherwise receive it. According to the Accreditation Council of Continuing Medical Education, in 2005, industry spent $1.1 billion on sponsoring CME, which accounted for 50% of all CME

funding.[9] Multiple studies in peer-reviewed journals make it clear that industry-sponsored CME is biased in favor of the sponsors' products.[10,11] Far from preserving and building the reputations of faculty members, speakers bureaus (where industry pays key opinion leaders who are physician experts are paid by industry to speak to their peers) can effectively turn them into salespeople.[12] Unlike laywers, physicians are one of the few groups of professionals that does not pay for their own continuing education. It is time we did, ended industry-sponsored CME, and stopped relying on industry to tell us what to think.

Finally, a common refrain from the other side is that there is no evidence that industry-medicine interaction does harm to patients, yet there are many examples of the positive results of this relationship (i.e. vaccine development). Again, we do not dispute that incredibly useful and lifesaving products have been created by industry with the support of physicians and researchers in academia. However, this narrow view ignores the larger picture: that the goal of medical research should be the service of the public good not industry profits.

The pharmaceutical industry alone, even without the device industry, is still one of the most profitable industries in the world: their profits are $26.2 billion annually and they rank number one among all industries on all measures, including return on revenues, equity, and assets.[13] However, all of the top five companies allocate a higher proportion of their revenue to net profit than to research and development.[14] It is no surprise that there are fewer and fewer truly innovative products, meaning for every new miracle drug there are a much larger number of new drugs with similar profiles and effects as their alternatives, also called "me-too" drugs. Only 2% of new drugs developed in the past 25 years constituted an important therapeutic innovation – meaning they were significantly different from and better than what we already had – while 90% offered no real benefit over existing drugs.[15] Much of the new drug research (and all the expenses involved) occurs in academic medical centers funded by taxpayers through the National Institutes of Health.[16] In the meantime, diseases like tuberculosis with the greatest burden occur in developing nations where we continues to use 20 year old drugs because there is "insufficient market share" to justify research and development of new therapies.[17] Only when drugs and devices are designed, sold, and distributed in such a way to maximize benefit to people, not return to shareholders, will the industry-medicine interaction thrive.

Despite its occasional successes, the profit-driven model of research, development, and marketing is broken and we need a new model of industry-medicine interface. Fortunately, there are many alternative models for this interaction. From Equitable Access Licensing,[18] to promotion of neglected disease research, to public-private partnerships such as those forged by the Clinton Foundation to lower the prices of antiretroviral therapy,[19] individuals and organizations are finding ways to bridge the industry-medicine divide that are beneficial for both and conflicting for neither. Until we find a model that works, we need more oversight and transparency, not more secrecy and opportunities for abuse. We believe that strong, regulated collaboration between industry and academic medical centers is necessary for the development of innovated drugs and devices, but it is not sufficient. We need novel sources of drug research funding, a

stronger FDA with a more efficient drug approval process, and increased funding for the National Institutes for Health.

For all these reasons, hundreds of medical students across the country have taken this simple pledge:

I am committed to the practice of medicine in the best interests of patients and to the pursuit of an education that is based on the best available evidence, rather than on advertising or promotion.

I, therefore, pledge to accept no money, gifts, or hospitality from the pharmaceutical industry; to seek unbiased sources of information and not rely on information disseminated by drug companies; and to avoid conflicts of interest in my medical education and practice.

Thank you very much for this opportunity to share this perspective.

REFERENCES

[1] AMSA PharmFree Scorecard 2009. Methodology (online), http://www.amsascorecard.org/methodology, Reston, VA: American Medical Student Association, accessed 28 July 2009.
[2] Moghimi Y, 2006. The ‘‘PharmFree’’ campaign: Educating medical students about industry influence. PLoS Med 3: e30.
[3] Willson D, 2009. Harvard Medical School in Ethics Quandary. New York Times. 2 March 2009. http://www.nytimes.com/2009/03/03/business/03medschool.html?_r=1&scp=5&sq=pfizer%20harvard%20students%20&st=cse.
[4] Wilson D, 2009. Pfizer Worker Photographes Protesters at Harvard. New York Times. 2 March 2009. http://www.nytimes.com/2009/03/03/business/03pfizer.html?scp=3&sq=pfizer%20harvard%20students%20&st=cse
[5] AMSA PharmFree Scorecard 2009. Conflict of Interest Policies at Academic Medical Centers (online), http://www.amsascorecard.org, Reston, VA: American Medical Student Association, accessed 28 July 2009.
[6] Prescription Project, 2008. Toolkit on Continuing Medical Education. Online. http://www.prescriptionproject.org/tools/solutions_resources/files/0011.pdf. Accesed 28 July 2009.
[7] Healthy Skepticism Library, Topic: Influence, 2009. http://www.healthyskepticism.org/library/topics/influence.php, accessed 29 July 2009.
[8] Dana J, Loewenstein G. A Social Science Perspective on Gifts to Physicians from Industry. JAMA. 9 July 2003, 290(2).
[9] Accreditation Council for Continuing Medical Education 2005 Annual Report.
[10] Relman, A. Separating Continuing Medical Education from Pharmaceutical Marketing. JAMA. 2001; 185: 2009-2012.
[11] Steinbrook, R. “Commercial support and continuing medical education.” NEJM 352(3):534-535. 2005
[12] Carlat D. Dr. Drug Rep. New York Times Magazine. 25 Nov 2007. Available online at http://www.nytimes.com/2007/11/25/magazine/25memoir-t.html?scp=1&sq=dr%20drug%20rep&st=cse.
[13] *1999 Fortune 500 Industry Snapshot: Pharmaceuticals*, 1999. Available online at atwww.pathfinder.com/fortune/fortune500/ind21.html.
[14] Merck, Johnson & Johnson, Bristol-Myers Squibb, Pfizer, and American Home Products; rank based on sales from *Fortune* 500 list. The range of revenue allocated to R&D was between 9% - 16.8%; net income

ranged from 13% - 25%, according to each company's 1998 Annual Report. Calculation by Public Citizen for article entitled "Pharmaceutical Industry's Propoganda Campaign against the Prescription Drug Fairness for Seniors Act." Available online at http://www.citizen.org/congress/reform/drug_industry/articles.cfm?ID=935.

[15] International Society of Drug Bulletins. ISDB Declaration on therapeutic advance in the use of medicines. Nov 2001. Available online at http://www.prescrire.org/docus/ISDBTherapAdvanceEN.pdf.

[16] Angell, M. The truth about the drug companies: how they deceive us and what to do about it. New York, NY. Random House, 2004.

[17] Access to medicines is a large and complex issue beyond the scope of this document. For more information, please see www.pharmfree.org/access/.

[18] Chokshi DA, 2006. Improving access to medicines in poor countries: The role of universities. PLoS Med 3(6): e136.

[19] For more information, see http://www.clintonfoundation.org/what-we-do/clinton-hiv-aids-initiative/what-we-ve-accomplished.