

EMBARGOED UNTIL
THURSDAY, JANUARY 10, 2002 – 5PM

The Destruction of Medicine by Market Forces: Teaching Acquiescence or Resistance and Change?



Sidney M. Wolfe, MD

Medical schools have too often taught—actively, or passively by example—acquiescence to the increasing trends toward medicine as a business rather than teaching resistance to those trends in a manner consistent with medicine as a profession. A rapidly growing amount of research has documented the deleterious effects of this business model on doctors and/or patients. But except in rare instances, medical curricula for students or residents neither include in-depth discussions of such research nor map out strategies for resisting and reversing these dangerous trends, including encouraging more research in these areas. As we approach the 100th anniversary of the 1910 Flexner Report, which revolutionized and rationalized medical education, we must heed his admonition to apply the scientific method to all dimensions of medicine, including elucidating evidence for the destruction of medicine and medical education by market forces.

Ironically, the revolution in medical education occasioned by that report included the evidence-based elimination of a large number of poor-quality medical schools being run on a for-profit basis. The new model that evolved emphasized a non-commercial ethic of professionalism and service, but this model is now in jeopardy.

HEALTH SERVICES AND MEDICAL EDUCATION

Among developed countries, the United States is unique in having a substantial proportion of health services delivered by for-profit businesses. Research has documented that the quality of care is worse in for-profit HMOs, kidney dialysis centers, nursing homes, and hospitals than in nonprofits, just as Flexner documented poor-quality education in for-profit medical schools. We are also the only country in the world in which the predominant mode of health care delivery is for-profit managed care companies, squeezing doctors and patients into shorter visits and less care, in too many instances simply to pay CEOs and stockholders more. The managed care industry has driven teaching hospitals into an entrepreneurial response that undermines the critical missions of teaching as well as professionalism and service.

Resistance to these dangerous directions is needed to diminish the incursions of for-profit medical care. Research and teaching concerning the poorer quality of for-profit care would add to the atmosphere and strength of resistance.

But there are two concomitant and similarly unique aspects of this market-driven system, now caused and controlled by private insurance companies with an increasing amount of for-profit care. First is the failure to provide health care as a right to all citizens, leaving one seventh of our population, about 40 million people, without health insurance. Second is the failure of our government to provide low-cost medical education to all who are qualified to enter medical school because of the lack of an overall national policy to pay for medical education.

Medical schools should end the general silence on the absolute necessity for a single-payer, government-financed health insurance plan by teaching students its unique advantages. In addition, a coalition of medical students and faculty should be leading a national effort for government subsidy of a much larger part of medical education so that socioeconomic-class-based discrimination does not continue to pose barriers for many to attend medical school and so that medical teaching institutions and their faculties are on firmer financial footing, less dependent on commercial ventures. Another important advantage of a single government payer for all medical services would be to overcome the perpetual private health insurance industry's resistance to such a subsidy.

THE PHARMACEUTICAL INDUSTRY AND MEDICAL SCHOOLS

Another important area in which medical educators need to be offering much

more resistance involves the pharmaceutical industry. Medical journal articles that distort the actual results of clinical trials concerning drugs or other medical products, ghost-written articles, delayed articles, and publication bias as a result of industry pressure have led to guidelines endorsed by editors of 13 leading international medical journals. The cause was succinctly stated in the prologue to the guidelines. "As CROs (contract research organizations) and academic medical centers compete head to head for the opportunity to enroll patients in clinical trials, corporate sponsors have been able to dictate the terms of participation in the trial—terms that are not always in the best interests of academic investigators, the study participants, or the advancement of science generally."¹

But the publication step is at the end of the research process, and much damage can be done by then, especially because many of the most alarming findings of drug-company-sponsored research are not published. Medical schools should prohibit equity interest in drug companies by academic researchers who are doing clinical trials. The broader issue is that drug companies should fund clinical trials but have no control over their design and implementation, the interpretation of data, or publication. More than merely a change in journal publication policy is needed for this to occur, and medical schools need to be at the forefront of advocating such a change.

There has been an increase in deals between medical schools and pharmaceutical or medical device manufacturers to develop products under exclusive arrangements that will generate income for the medical schools and faculty members. The formation of small companies involving faculty to develop products is, at the least, a drain on teaching and other non-commercializable research efforts.

There is good evidence that money from drug companies or contacts with them can influence faculty decisions re-

garding hospital formulary additions. There is also widespread drug company funding of hospital rounds, and contact with drug reps is allowed in many academic medical teaching centers. Attendance at free drug-company-sponsored dinners, sports events, and thinly disguised marketing efforts labeled as research are often viewed as an acceptable norm. Contrary to a recent statement by former AMA President Alan Nelson, MD, that "Ongoing interaction and strong communication between physicians and [the pharmaceutical] industry is vital for good patient care,"² many of the best physicians have little if any contact with this industry.

The need for resistance to these influences has been articulated by the eminent medical historian and ethicist, David Rothman: "Medical training should not include acquiring a sense of entitlement to the largesse of drug companies. . . . Medical schools should . . . prohibit all gifts from drug companies to students. . . . Teaching hospitals should proscribe drug company sponsorship of lunches, conferences, and travel for residents."³

An extensive collection of references and slides of published articles refuting the notion that there can be, in the context of the relationship between drug companies and physicians, a truly free lunch, is available on the Internet and is frequently updated. Bob Goodman, of Columbia University College of Physicians and Surgeons, the founder of the *No Free Lunch* Web site, (www.nofreelunch.org), is currently developing, with several colleagues, a curriculum for use with medical students and residents to review this evidence and teach resistance to the "free lunch" concept.

Other educational efforts to counter drug-industry influences on prescribing practices could include teaching students and residents a process for the evaluation of newly emerging or older prescription drugs that utilizes publicly available information from the FDA

Web site, (www.fda.gov), or other information available from the FDA through the Freedom of Information Act.⁴

The CDER Freedom of Information Web page is located at (www.fda.gov/cder/foi/index.htm). The link can then be made to New Drug Approval Packages. These documents are the reviews by FDA scientists of the data submitted by a manufacturer to support the approval of a new drug and include reviews of clinical trials. A direct link can be made to the new-drug approval packages at (www.fda.gov/cder/foi/nda/index.htm).

FDA scientific reviews are also available for drugs not yet approved that go before public advisory committees. These reviews are known as briefing information. In general, briefing information is not as complete as approval packages and focuses mainly on efficacy and safety. Briefing information is organized by the year and by the name of the advisory committee undertaking the review. This information can be accessed at (www.fda.gov/ohrms/dockets/ac/acmenu.htm). It will also be necessary to know the date of the advisory committee meeting.

This site (www.fda.gov/ohrms/dockets/ac/acmenu.htm) also allows a link to the transcripts of advisory committee meetings, which are organized in the same manner as the briefing information.

Reports made to the FDA's adverse-drug-reaction-reporting system (Med-Watch) can be purchased from the U.S. Department of Commerce's National Technical Information Service (NTIS) on CD ROM. Data are available back to 1969. The NTIS's Web site is located at (www.ntis.gov/). A direct link to descriptions of this information is (<http://neptune.fedworld.gov/cgi-bin/waisgate>).

These sources often provide data concerning safety and efficacy unfavorable to the drug's approval, data that are often never published or are published in ways that distort the results.

Medical schools are mainly silent on

the need for drug-company price controls or negotiated prices, having bought into the misleading arguments that unless Americans pay about twice as much for pharmaceuticals as do citizens of other developed countries, the industry—the most profitable among major American industries—will not have enough money to do important research and develop new pharmaceuticals. A recent report by Public Citizen's Congress Watch casts serious doubt on the validity of these industry claims (<http://dev.citizen.org/documents/ACFDC.PDF>). There is a need for medical schools to advocate government price controls or negotiated prices as the only way prescription drug benefits—for Medicare or for everyone—would be affordable. Medical school ties with drug companies are probably another deterrent to advocacy for these price controls.

MEDICAL SCHOOL COURSES IN RESEARCH-BASED ACTIVISM

In many ways, the public is more educated about the evils and dangers of market medicine than is the medical profession. In order for a joint effort of doctors, working with patients, to succeed in supplanting the current market-based system and restoring professionalism to medicine and to the doctor-patient relationship, there needs to be a radical shift in medical education to include such information.

We in the Public Citizen Health Research Group have been involved in helping to start several medical school courses in research-based activism that provide students with examples of evidence about such problems with our health care system. In some courses, students are taught to design protocols or even execute research projects that would add information and presumably help to cause changes in these areas. Information about one of the first such courses, at Case Western Reserve Uni-

versity School of Medicine, is available on a Web site that is being expanded to include information about other such courses at Johns Hopkins, NYU, and other schools, www.citizen.org/hrg/activistcourses.

Over the 30 years since the Health Research Group was begun, 20 medical students and 11 residents in preventive medicine have done rotations with us, lasting from two months to a year. In addition, we have collaborated with 35 post-residency physicians since 1996 on research-based activism projects. Many of the projects they worked on have resulted in bans or warnings on prescription drugs and restrictions in the amounts of dangerous chemicals workers are exposed to. The results of some of these projects have been published, and our Web site, (www.citizen.org/hrg), includes the full details of many of the most recent efforts at research-based change.

CONCLUSION

As long as the predominant vision of medical educators is acquiescence to market forces instead of resistance and constructive change, market medicine will thrive, to the detriment of doctors and patients alike, and medicine, as a profession, will suffer, along with the simultaneous erosion of the doctor-patient relationship.

Flexner taught evidence-based resistance and change. The lesson of the elimination of for-profit medical schools must not be lost, and a concerted effort by medical educators and our students and residents as well as patients to eliminate all for-profit health services and to reduce medical school dependence on commercial activities must be undertaken.

Sidney M. Wolfe, MD

Dr. Wolfe is director of the Public Citizen Health Research Group, Washington, D.C.

REFERENCES AND NOTE

1. Davidoff F, DeAngelis CD, Drazen JM, et al. Sponsorship, authorship, and accountability. *N Engl J Med* 2001;345:825-7.
 2. Nelson AR. When to accept and when not to accept: a few thoughts about gifts to physicians from industry. (<http://www.ama-assn.org/ama/pub/article/5310-5094.html>). Accessed 11/18/01. American Medical Association, Chicago, Illinois.
 3. Rothman DJ. Medical professionalism focusing on the real issues. *N Engl J Med*. 2000;342:1284-6.
 4. The Food and Drug Administration's (FDA's) Center for Drug Evaluation and Research (CDER) maintains a Freedom of Information Web page that allows public access to three important sources of drug information: (1) new drug approval packages; (2) new drug review documents that will be discussed before public advisory committee meetings; and (3) transcripts of public advisory committee meetings. The CDER Freedom of Information Web page is located at (www.fda.gov/cder/foi/index.htm). The link can then be made to New Drug Approval Packages. These documents are the reviews by FDA scientists of the data submitted by a manufacturer to support the approval of a new drug and include reviews of clinical trials. A direct link can be made to the new-drug approval packages at (www.fda.gov/cder/foi/nda/index.htm).
- FDA scientific reviews are also available for drugs not yet approved that go before public advisory committees. These reviews are known as briefing information. In general, briefing information is not as complete as approval packages and focuses mainly on efficacy and safety. Briefing information is organized by the year and by the name of the advisory committee undertaking the review. This information can be accessed at (www.fda.gov/ohrms/dockets/ac/acmenu.htm). It will also be necessary to know the date of the advisory committee meeting.
- This site (www.fda.gov/ohrms/dockets/ac/acmenu.htm) also allows a link to the transcripts of advisory committee meetings, which are organized in the same manner as the briefing information.
- Reports made to the FDA's adverse-drug-reaction-reporting system (MedWatch) can be purchased from the U.S. Department of Commerce's National Technical Information Service (NTIS) on CD ROM. Data are available back to 1969. The NTIS's Web site is located at (www.ntis.gov/). A direct link to descriptions of this information is (<http://neptune.fedworld.gov/cgi-bin/waisgate:waisdocid=1775605823+6+0+0&waisaction=retrieve>).