COMMENTARY

House of Medicine for Rent

Peter A. Swenson, PhD

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Organized medicine has come a long way since the founding of the American Medical Association (AMA) in 1847. For conflicts of interest, the journey has been a downhill slide.

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At its inception, the AMA declared that it was “reprehensible" for physicians to attest to the efficacy of patent medicines or in any way to promote their use. Holding a patent for any drug or surgical device was "derogatory to professional character" for doctors. Accepting money to shill for industrial patent holders was a breach of ethics.

Starting in the 1920s, organized medicine, including hundreds of specialty societies, discarded this staunch defiance of commercialism for wary collaboration and ultimately a full embrace of support from the pharmaceutical and medical device industries.

Today, the threadbare remnant of organized medicine's original stance is a weak principle of "transparency" about the flow of money and influence from industry into medical practice. But organized medicine doesn't even hold itself to that flimsy standard.

Anyone can now go to the federal government's Open Payments website to see what individual physicians receive from industry. And as of 2022, what physician assistants and specialty nurses get is also being exposed to sunshine's supposed disinfecting properties. Even money flowing from industry to academic medical centers is reported — but the same isn't true for their professional societies. Why not?

The human and economic costs of medicine's commercial entanglements are huge: overdiagnosis, overuse, overmedicalization — and therefore potential doings of harm. Because medical societies actively contribute to the bustling business of continuing medical education, the promulgation of clinical guidelines, and publication of educational material on drug and device therapies, they potentially share responsibility for overpriced and often meretricious drugs, often used for poorly studied off-label indications, contributing to clinical risks and massive waste.

The grossest example of economically compromised organized medicine was exposed in the US Senate's 2017 investigation of the opioid epidemic. The public learned how Purdue Pharma and Johnson & Johnson spent close to $9 million between 2012 and 2017 on physician and patient organizations (like the American Pain Society) that together broadcasted the unfounded claim that opiates prescribed for pain rarely led to addiction.

The medical-industrial complex's laser focus on expensive medicinal therapies and surgical interventions means neglect of prevention and the social causes of disease in medical organizations' educational and lobbying activities. For example, out of around 300 scientific sessions of the upcoming 2022 meeting of the American College of Cardiology (ACC), only seven concern lifestyle and other nonmedicinal modes of prevention. By contrast, there were at least 38 sessions sponsored by pharmaceutical and medical device corporations on clinical uses of their products are planned.

From Arm's Length to Ready Embrace

The opioid crisis exposed only the scandalous tip of a deeply rooted problem that was long in the making.

Early in the 20th century, AMA executive and *JAMA* editor George H. Simmons treated drug companies "with suspicion and grave doubt, like diplomats working on an armistice." Simmons told his successor, Morris Fishbein, that negotiating with pharmaceutical manufacturers to clean up their specious advertising was "about the same as Faust trying to make a deal with Mephistopheles."

Under Simmons, the AMA succeeded in imposing some ethical standards for industry access to *JAMA*'s advertising pages. It actively lobbied for passage of the Pure Food and Drugs Act of 1906. But after 1924, under Fishbein, the downward slide began. In 1938, the AMA watched passively as lay forces pushed for another major drug law reform, the Federal Food, Drug, and Cosmetic Act, which demanded proof of safety before marketing.

In the early 1940s, Fishbein helped raise $1 million for a massive "National Physicians Committee" campaign to fight national health insurance and therefore preserve the "American system of medicine." But the committee was mislabeled —about 90% of its funding came from Hoffman-Laroche and other huge drug companies.

"Captive and Beholden"

In the 1950s, the AMA and the drug industry became fully enmeshed. *JAMA* relaxed its control on advertising to increase its revenue. A revolving door opened between the two. The Pharmaceutical Association of America (PMA) rewarded Austin Smith, who had succeeded Fishbein in 1949, with its presidency. In 1963, after Smith moved on to a more lucrative job as president of Parke-Davis, the PMA replaced him with C. Joseph Stetler, the AMA's executive vice president.

Money circled back. In the early 1960s, 17 of the largest drug firms gave nearly $1 million to the AMA's lobbying arm to help it fight Medicare, in part out of fear of federal controls on drug pricing.

In 1962, the AMA testified along with the PMA against a proposed amendment to the 1906 Food and Drug Act that demanded that new drugs show efficacy, not just safety, in controlled clinical studies. The AMA argued that individual clinicians didn't need government advice on what worked or didn't. It also backed the drug industry's successful objections to provisions breaking its monopoly pricing power.

The unholy alliance was cemented in the early 1970s. In 1971, the AMA dropped from its ethical code its historic disapproval of medicine patents held by physicians. The next year, it shut down its semi-independent Council on Drugs that had issued advice on hundreds of products on the market to help bewildered clinicians separate good from useless — or worse — medications. The council had damned many profitable drugs as "not recommended" or even "irrational."

In 1973, John Adriani, the chair of the now-disbanded council, indignantly explained to Congress that the AMA was "captive of, and beholden to, the pharmaceutical industry."

Rental Payments

The ties have only grown tighter. Over the last 40 years, medical specialty societies have eclipsed the AMA in overall importance and political muscle.

Much of their growth in revenues and activities was funded by industry. In a 2008 Medscape article, Lawrence Grouse, a disaffected insider in the ranks of organized medicine, estimated that many specialty societies received almost 80% of their revenue from industry for grants-in-aid, project grants, educational enterprises, donations to their spin-off foundations, and in-kind contributions. He had to estimate because of the organizations' secrecy.

Since then, nothing has changed. In 2019, for example, membership dues accounted for only about 13% of the almost $150 million that the ACC and its foundation took in. That most of the remaining revenue came from industry can be inferred from the fact that in 2018, 22 of the ACC's 26 leaders had financial ties with industry totaling almost $23 million. In fact, around 80% of specialty society leaders in the 10 costliest areas of medicine, including cardiology, had financial ties with industry. For those with ties, the median reward was about $30,000. For leaders of the American Society of Clinical Oncology with such ties, the median was a little over $500,000.

What remains today of the 19th century AMA ethics against entanglement with medical industries? Nothing but a lukewarm endorsement of the need for transparency about which medical practitioners get what from whom. Tellingly, the forceful implementation of that principle had to be pushed for by a coalition of outsiders to organized medicine, including powerful politicians, in the form of the Physician Payments Sunshine Act, which was passed in 2010 as part of the Affordable Care Act.

Of course, keeping money out of medicine is impossible and probably not even desirable, given the relative scarcity of federal funding for medical research, continuing medical education, and clinical guideline formulation. But we must do something to restore balance to the system.

Medical reformers have offered various solutions to organized medicine's pervasive conflicts of interest, including a total divorce from industry. Those will be slow in coming. An intermediate fix, albeit an insufficient one, would be for the law to subject the entanglements to critical scrutiny by the public and the medical profession at large.

But considering the likely opposition to forced reporting and public disclosure, even new federal regulations or congressional action will be hard to achieve. Between 1998 and 2021, the AMA was the fourth largest spender on federal lobbying among trade associations and major corporations — doling out more than $462 million during that period. Without a countervailing alliance of lay forces and reform-minded physicians to force disclosure, the armada of specialty societies and industry powerhouses will continue to have unchecked power and political clout. And that's a prescription for bad medicine.

Peter A. Swenson, PhD, is the C.M. Saden Professor of Political Science at Yale University, New Haven, Connecticut, and a prize-winning author on the political history of healthcare and the welfare state. His latest book is Disorder: A History of Reform, Reaction, and Money in American Medicine *(Yale University Press, 2021).*

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