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Why People Who Influence Research Are Popular in Pharma Boardrooms

ByEd Silverman

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After years of considerable hand wringing over the financial ties between physicians and drug makers, another set of relationships is starting to draw notice – the people who play leading roles at academic medical centers while also serving as board members for pharmaceutical companies.

A new research paper found that nearly 40 percent of drug makers worldwide – and nearly every U.S. pharmaceutical manufacturer – had at least one board member who simultaneously served in a leadership position at such centers in 2012. These included chief executives, clinical department chairs, division directors, medical school deans, hospital boards of directors and university presidents.

Why might this matter?

The dual roles may create conflicts because these individuals “wield considerable influence over research, clinical and educational missions” at the same time they are chartered with promoting the fortunes of a drug maker, according to the paper in the Journal of the American Medical Association, or JAMA. The board members, by the way, were compensated an average of $312,564 in 2012 by the drug makers.

“There are a number of decisions these individuals may make about where resources are placed, the

policies and regulations, what is taught, that are critical," says co-author Walid Gellad, an assistant professor of medicine at the University of Pittsburgh. "So any time we talk about a potential conflict, we need to consider these scenarios where the role at one institution may affect the role at the other institution. The possibilities [for conflicts] are real."

The issue is being raised at a time when the U.S. government is starting to require the pharmaceutical industry to disclose payments made to physicians, in response to concerns that financial ties may unduly influence medical practice and research. The U.S. Physician Payment Sunshine Act goes into effect this year following a long-running Senate probe into relationships between drug makers and doctors.

In the JAMA paper, the researchers found that 19 of the 50 largest drug makers had at least one board member who also held a leadership position at a U.S. academic medical center, including 16 of 17 U.S. companies. And 18 industry board members, or 3 percent of all board members, held 21 clinical or administrative leadership positions at centers; these included two university presidents, six deans, six hospital or health system executive officers and seven clinical department chairs.

The drug makers whose board members represented the largest number of academic medical centers included Johnson & Johnson, Gilead Sciences and Pfizer. A Gilead spokeswoman declined to comment and a Pfizer spokeswoman sent us this: "The leaders of academic medical centers knowledge of the crucial role of research in drug discovery and development and deep understanding of science and medicine are invaluable in our quest to deliver innovative therapies to patients."

A J&J spokesman wrote us that board members are chartered with overseeing decisions affecting product development. So "it naturally follows that our board seeks as directors, and our shareholders expect our board to comprise, not only active and former executives of other public companies, but also leaders of major complex organizations, including scientific, government, educational and other non-profit institutions, as well as widely recognized leaders in the fields of medicine or biological sciences, including those who have received the most prestigious awards and honors in their field."

This is not the first time that interlocking relationships between the pharmaceutical industry and academic medical centers have come to the fore. In 2007, a JAMA study found that 60% of department chairs at academic medical centers and university hospitals had some form of relationship with industry, such as serving as a paid consultant or scientific advisory board member.

Last month, a JAMA viewpoint piece also raised concerns about overlapping roles involving pharma company board members and academic medical center leaders and advocated for ending such relationships, except when there is a "compelling institutional interest," such as equity partnership between the academic medical center and the drug maker that binds their financial success together. An example might be when the individual founded an academic health system start-up based on his or her intellectual property.

"Having a fiduciary responsibility to two separate entities is, at best, a very difficult situation. Will the leader direct business inappropriately to the outside company on whose board he or she sits? Will the leaders inappropriately use information about the institution he or she leads to influence decisions by the outside corporation?" asked the three academic researchers who authored the essay.

What to do? Something between mere disclosure and a complete ban is likely to have merit, according to Arthur Caplan, the director of the division of medical ethics at the NYU Langone Medical Center. "To be credible, they have to look as if they're not beholden to any interest or group or sector. At the same time, they want connections for fundraising and advancing the agendas of their institutions. But they're

walking a fine line. One way to handle this would be for a professional group to come up with some clear cases to develop guideposts that can be used for determining a level of acceptability."

In an email, Ann Bonham, the chief scientific officer at the Association of American Medical Colleges, sent us this statement: "AAMC has recommended that all institutions adopt institutional conflict of interest policies that govern the review of certain financial interests held by the institution itself or by institutional officials, and has developed a model policy on institutional conflicts of interest that focuses on the careful review of those financial interests."