The March/April issue of *Pediatric Dentistry* will publish an article with the clunky title: “Pediatric dentists’ knowledge concerning the Physician Payment Sunshine Act and their predictions of its effects on their interactions with industry and its impact on patient care.” Why did the Academy’s journal publish such a wonky piece co-authored by a first-year medical student and me, an old academic physician specializing in blood diseases and who has principally engaged in basic cellular research? The answer is the product of two stories.

The first story is that I’m married to Kerry Maguire, a general dentist with a public health degree. A decade and a half ago, as professional relations director at Tom’s of Maine Company (no relation to me), she introduced Tom’s kid-friendly “Silly Strawberry” toothpaste to pediatric dentists in the exhibit halls of AAPD meetings. There she got to know many Academy members. More recently, she has been running ForsythKids, a school-based dental program of Boston’s Forsyth Dental Institute. Although she is not a card-carrying pediatric dentist, her clinical practice involves youngsters, and she kept up her AAPD meeting attendance. In 2014, the Academy elected her to its board of directors as Affiliate Trustee.

Always up for a good party, I’ve accompanied Kerry to many an AAPD gathering and, as a kind of AAPD mascot, have gotten to know the good folks in the organization’s membership including many of its leaders.

The second—and longer story—is that over my almost half-century career health care has improved markedly. We live on average 10 years longer. Death from cardiovascular disease—the number one killer—has decreased by 60 percent. Cancer mortality is at an all-time low. I observed HIV/AIDS transform from a potential public health disaster to a livable condition, even in sub-Saharan Zambia where Kerry and I do volunteer work. Thanks to medications and joint replacements we rarely see people incapacitated with arthritis. As evidenced by the hardware my prosthodontist has replaced in my mouth, dentistry must have improved a lot as well.

During the first third of my career I thought that such progress was entirely the result of academic nerds like me, panhandling the government and public charities for grants. We used those funds for impressive research work that we published in prestigious medical journals. Of course I knew that the drugs and devices actually came from private companies but, hey, they just hijacked university discoveries and made big bucks off of them.

But in 1987, when I joined the scientific advisory board of the pioneering biotechnology company, Biogen, I realized how clueless I had been. Here’s what I learned.

The vast preponderance—over 85 percent—of the drugs and devices responsible for the incredible progress summarized above arises from private industry—and with good reason. Only industry has the financial resources, the skill sets and the culture to bring medical products to patients. Two-thirds of biomedical research investment is in the private sector, and getting a new drug approved by the FDA costs over $2.5 billion. The reason for this high cost is that biology is a tough customer: 90 percent of drug development projects that look promising in laboratories fail in clinical trials.

Most of the requirements for product development, determining that a drug or device is safe, formulation and packaging, quality control, manufacturing and myriad others only take place in industry. And most academics aren’t really interested in solving practical problems. They obtain grants, publications and promotions by impressing one another with their experimental cleverness and novelty for novelty’s sake.

To be sure, this behavior advances knowledge, and most health care innovations can be traced to some scientific discovery. But the connection is far from straightforward and involves much trial and error with forward and backward steps.

Acquiring these insights has enabled me to parallel my academic activities with efforts to innovate. I have been working for decades to develop an improved method for storing blood platelets procured for transfusion and for preventing lethal complications of injury and inflammation by measuring and replacing a blood protein called gelsolin that I discovered and that becomes depleted in those conditions.

Timing is everything, and just as I learned these facts about health care innovation, a disorder I call “administralgia” abruptly appeared. University officials, embarrassed by media reports alleging misconduct by faculty engaged in industry-sponsored research, panicked. The accusations—ultimately discredited—elicited a deadly combination of imagination and intellect divorced from experience to legitimize the theory that industry funding corrupts academic research. Specifically, researchers supposedly distort results to please corporate sponsors. The idea that such corruption—that operates under the code term “conflict of interest”—exists became prevailing wisdom and launched regulations requiring disclosure, management or elimination of industry research relationships. I refer to this belief system as “the conflict-of-interest narrative.”

Over the next decade and a half I documented that these ideas were not grounded in facts and sound logic. In 2003, when more media reports abused honorable colleagues because of their industry relationships, I went public. I wrote Op Ed articles published in *Forbes* and *The Wall Street Journal* and managed to publish a detailed paper in *The New England Journal of Medicine* discrediting the research corruption allegations as purely theoretical and unsupported by facts.

I naively assumed that as a result of my efforts academic officials would back off on their rules. Instead, within months of my *New England Journal* publication, an article appeared in *The Journal of the American Medical Association* (JAMA) that moved the conflict-of-interest narrative beyond research into every nook and cranny of health care. The article, authored by medical bureaucrats, advocated restricting or eliminating every method companies apply to educating health care providers about their products. Topping the marketing ban list was company represen-

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**Sunscreen for Pediatric Dentists**

*By Thomas P. Stossel, M.D., M.D. (Hon)*

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tatives visiting health care professionals (detailing) and providing them with product samples, product reminder items (sticky pads, mugs, pens) and meals. Also included was corporate sponsorship of continuing education and, especially, health care providers speaking about products to fellow practitioners in pleasant surroundings such as resorts or restaurants.

Despite receiving a loving endorsement from *The New York Times*, the *JAMA* publication is a paragon of speculation and misrepresentation. While superficially plausible, its insinuation that marketing results in prescribing of unnecessary, unnecessarily expensive and unsafe brand products is unproven. Worse, the piece baldly claimed that empirical evidence supported that industry marketing impairs patient care; no such data exists.

The *JAMA* travesty was the culmination of an outpouring of books and articles in health care journals demonizing the medical products industry. At the same time, the media reported on huge fines drug and device companies paid federal prosecutors to settle charges of illegal (off-label) marketing. This perfect storm ushered in a new wave of conflict-of-interest regulation responsive to all of the *JAMA* recommendations. These regulations are now in force in most academic health centers, state governments and even in private medical practices.

I continued to write and speak against the conflict-of-interest narrative, and a few colleagues emerged who joined me. But it was to no avail; conflict-of-interest rules concerning health care research, education and practice are etched in stone. Since the topic is as complicated as health care itself, I decided it required an in-depth analysis that I completed in the form of a book published by Rowman and Littlefield last spring entitled *Pharmaphobia: How the Conflict of Interest Myth Undermines American Medical Innovation*. It covers the history of medical innovation, the emergence of the conflict-of-interest narrative and how the narrative’s assertions are false. In particular, it explains how the off-label marketing settlements are not examples of fraud but rather the result of clever legal engineering. It argues that conflict-of-interest regulation is bad for health care. I can’t do justice to the heavily referenced 350-page effort here other than to cover a few points that relate this story to the *Pediatric Dentistry* article.

One class of promoters of the conflict-of-interest narrative I refer to as “instigators.” They include academics that advance their careers documenting what they claim to be evidence for deleterious effects of conflict of interest. The media sells copy with corruption allegations, and lawyers profit whether suing, defending or teaching regulatory compliance to health care professionals. University officials, while talking a good game about innovation, care far more about scandal avoidance. Professional journal managers try to elevate the cache value of their products by discrediting industry marketing, despite the fact that such marketing is based on FDA-vetted information that is far more rigorous and reliable than what journals publish.

But the most relevant instigator for our story is Senator Charles Grassley (R-IA). He, along with former Senator Herbert Kohl (D-WI) filed legislation ultimately encompassed in the Affordable Care Act that mandates that companies must report all payments in cash or kind of $10 or more to health care providers to the Center for Medicare and Medicaid Services (CMS) for disclosure on a publicly accessible website. This “Sunshine Act” is the topic of the *Pediatric Dentistry* article.

The measly reportable sum essentially means that all transactions get reported. Why is the amount so low? The reason is a particularly inane and insulting element of the conflict-of-interest narrative—an intuitively unlikely idea that “social science research” has established that even trivial payments cloud clinical judgment. It also takes energy from an animus against profit in health care (that is probably less prevalent among dentists compared to other providers).

When the Act implemented in mid-2014, the AAPD leadership, knowing my interest in the subject, asked if I would write something for this publication. My response was that some data rather than just my opinions might be a stronger statement. That is how the *Pediatric Dentistry* exercise arose.

David Barton, my then policy research assistant and I constructed a survey that queried AAPD members’ familiarity with the law, the extent to which they currently participated in activities involving industry that the conflict-of-interest narrative deems objectionable, their opinion regarding whether the law would influence such participation and if their altering such participation would affect their ability to provide good patient care.

The principal problem we encountered was a low response rate that despite statistical wizardry always raises questions of validity. But I think nevertheless that the results were predictable. The majority of respondents reported little or no familiarity with law, that they currently have interactions with industry but that now learning about the law, they would back away from them; and that doing so would compromise patient care. Only a handful of respondents rendered answers that reflected a favorable opinion concerning the conflict-of-interest narrative.

Despite the low response rate, and the fact that what respondents say they intend to do doesn’t necessarily happen, the survey results seem reasonable; busy practitioners who fundamentally care about their patients don’t have time for policy surveys. They get that what industry provides them is valuable. They don’t like the idea of possibly being ostracized for industry relationships but, if they react by discontinuing them, they also understand that it might compromise patient care. As a result of the survey, pediatric dentists are the first health care professionals to weigh in regarding the law. As caregivers on the front lines, their opinions have credibility.

Since completion of the survey, CMS has continued to report industry payments to health care professionals. The vast majority of them are very small. The few large ones predominantly go to researchers. Early on, the media tried to embarrass recipients of large sums, but such harassment has largely subsided. No evidence indicates that the public in general or patients in particular care about these payments.

In my opinion, the Sunshine Act accomplishes nothing other than to divert scarce resources from health care research and education to compliance. I’m not hopeful of repeal, because unfamiliarity with it and more salient deficiencies of other aspects of the ACA take precedence. But I do hope that this effort will convince pediatric dentists they can shed any guilt because of taking advantage of industry’s contributions to care of their patients and that they will continue to exploit that advantage.

I welcome comments from the AAPD Membership.

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*Editor’s Note: For further background on The Sunshine Act, see http://www.pediatricdentistrytoday.org/2013/November/XLIX/6/news/article/304/.*