

Institute of Medicine Recommends Standards for Clinical Practice Guidelines; CT AG's Antitrust Investigation of IDSA's Lyme Guidelines Spurs Call for Reform

- Richard Wolfram, April 2011

At the end of March, the Institute of Medicine (IOM), the health arm of the congressionally chartered, independent National Academies in Washington, D.C., called for sweeping reform in the development of clinical practice guidelines (CPGs) in medicine. This is a significant development in itself because of CPGs' influence on medical decision-making and outcomes; but it is doubly important, for reasons that are only beginning to emerge, because it also underlines the potential application of legal principles of standard setting to CPGs in medicine.

Responding to a request by Congress in 2008 to study the best methods for developing CPGs, a special standards committee of the IOM issued eight proposed standards for developing CPGs and an accompanying 250-page report ("Clinical Practice Guidelines We Can Trust") (the "Report").¹ The National Academies (formerly known as the "National Academy of Sciences" and comprising the National Academy of Sciences, National Academy of Engineering, IOM and the National Research Council) are considered to be the nation's premier source of independent, expert advice on scientific, engineering and medical issues. The IOM's project therefore calls national attention to the far-reaching influence of CPGs in medicine today and to best practices for ensuring process integrity in the development of CPGs as clinical standards.

IOM Identifies Shortcomings in CPG Development. The central, organizing principle behind the IOM's CPG project is that "most guidelines used today suffer from shortcomings in development." (IOM Report Brief.) In particular, according to the committee, most guideline development groups (GDGs)

- fail to represent a variety of disciplines in drawing up guidelines,
- lack transparency in how they derive and rate their recommendations,
- have conflicts of interests on the part of GDG members, and
- are not subject to a thorough external review process.

The Report and proposed standards target these perceived shortcomings. The IOM's goal is to offer guideline users a mechanism to identify high quality, trustworthy guidelines, thereby enhancing medical decision-making and healthcare quality and results. As a means to attain this goal, the IOM in turn offers the eight proposed standards to help ensure the development of trustworthy CPGs.

The IOM's special standards committee recommends that the federal Department of Health and Human Services create a mechanism to identify trustworthy guidelines and, as a first step, that the National Guidelines Clearinghouse (a list of nearly 2,700 CPGs),

¹ The proposed standards, the Report and a Report Brief are available at <http://www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx>. There is a fee for downloading the Report.

which is part of the HHS Agency for Healthcare Research and Quality, no longer include guidelines whose development is “not sufficiently documented.”

Report Cites Lyme CPG Antitrust Investigation as Example. The Report cites various examples of the need for process integrity in the development of CPGs. Prominently featured among these examples, as a case study, are guidelines on the diagnosis and treatment of Lyme disease developed by the Infectious Disease Society of America (IDSA). (Report at 40-42). The development of the guidelines by the IDSA was the subject of an 18-month antitrust investigation and settlement in 2008 by the Connecticut Attorney General’s Office.² Pursuant to the settlement, the IDSA reconstituted its Lyme guideline panel under a procedure intended to eliminate any financial conflicts of interest; the new panel held a day-long public hearing on the science and subsequently upheld the guideline, by supermajority vote, based on a determination that the science supports the guideline.

Lyme Investigation Highlights Integrity in CPG Development, with Antitrust Implications. There are two ‘lines’ to the Lyme story of relevance here, one of them highlighted in the Report and the other, less apparent but likely to assume greater importance as more attention is focused on the issues raised by the IOM. Both lines stem from a common source: the nature of CPGs as standards that influence and may even determine medical decision-making and outcomes.

First, according to the IOM, the investigation “highlights the need for standardization and transparency in all aspects of systemic [sic] data collection and review, committee administration, and guideline development, so that questions about these issues do not detract from the science. GDGs must be aware of the many, varied observers who will consider their development processes, particularly when their recommendations are likely to be controversial.” (Report at 41.) Indeed, the AG’s investigation and settlement have served as a lightning rod (attracting widespread media attention) for such issues – along with conflicts of interest – in the development of CPGs.³

² See my previous posts and articles describing the matter, including “Connecticut Attorney General Investigation and Settlement Highlights Possible Applicability of Antitrust Standard Setting Law to the Development of Clinical Practice Guidelines,” *Antitrust Health Care Chronicle* (Health Care and Pharmaceuticals Committee, ABA Antitrust Section) (Nov. 2008) and *Health Lawyers Weekly*, Vol. VI, Issue 46 (American Health Lawyers Association) (Dec. 2008), and “Evidence-Based Clinical Guidelines: An Rx for Better Quality, an Opportunity for Exclusionary Conduct Under the Antitrust Laws, or a Little of Both,” *Connections* (American Health Lawyers Association) (Aug. 2010) (with M. Mattioli).

³ In my view, the IOM’s discussion of the Lyme investigation includes some inaccuracies and mischaracterization, which nonetheless do not appreciably diminish the Report’s recognition of the matter’s importance as an example of the need for CPG reform. For instance:

- contrary to the Report, the AG did not “file an antitrust lawsuit” but rather conducted an antitrust-based civil investigation;
- the Report cites (without endorsement) commentaries “describ[ing] this case as a politicization of professional practice guidelines” but the Report fails to cite a response in the *Journal of the American Medical Association* rejecting such claims and explaining why the inquiry was legally well-founded (*available at www.rwolframlex.com*); and

A second aspect of the investigation, which the Report mentions but does not explain, is its legal underpinning in antitrust. Various complainants in the investigation, which I represented as antitrust counsel in collaboration with co-counsel, alleged antitrust violations in the creation and implementation of the Lyme guidelines by the IDSA. We presented a putative case to the AG alleging process abuse in the development of the guidelines by financially interested panelists, and implementation of the guidelines by the IDSA, with harm to competition for treatment modalities and resulting financial (and other) injury to both patients and physicians. It may be reasonably inferred that the threat of bringing and winning such a case reinforced the AG's ability to reach a settlement with the IDSA. At the heart of such a case lay the principle that where CPG panelists are financially interested in the outcome of the guidelines, the guideline development may be properly characterized as an organized process of competition for a standard which pre-empts market choice. If such guideline development, *qua* standard setting, is distorted to favor one interest over another, then the process may well cross the line from pure medical/scientific endeavor to one, just like standard setting in a more conventional commercial context, with commercial consequences and attendant antitrust implications.

Most CPGs are Industry-Funded – therefore “Commercial.” Furthermore, the likely commercial character of CPGs is neither speculative nor hypothetical. As the IOM reports:

[M]any CPG experts and practicing clinicians increasingly regard the scientific evidence base [supporting CPGs] with suspicion for a variety of reasons, including . . . *the dominance of industry-funded research and guideline development.*” [For instance, a] 2005 study found that industry sponsored approximately 75% of clinical trials published in *The Lancet*, *New England Journal of Medicine*, and *Journal of the American Medical Association* Two-thirds of this industry-sponsored published research is directly conducted by profit-making research companies and one third by academic medical centers. Furthermore, even high-quality commercial clinical investigations (e.g., those included in Cochrane Reviews) are 5.3 times more likely to endorse their sponsors’ products than non-commercially funded studies of identical products [Report at 40, emphasis added.]

While holding that “[GDGs] optimally comprise members without conflict of interest,” the Report also acknowledges that financially interested panelists may not only be inevitable but also desirable; thus, it notes that “in some circumstances, a [GDG] may not be able to perform its work without members who have conflicts of interest – for

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- the Report’s phrasing of the properly identified “need for standardization and transparency in all aspects of systemic data collection and review, committee administration, and guideline development, so that *questions* about these issues do not detract from the science” (Report at 41, emphasis added), plainly but incorrectly suggests that it is *questions* about these issues, rather than possible deficiencies in the guideline development process itself, which detract from the science; yet surely the point of the Report is, instead, that it is the possible deficiencies, rather than the allegations about them, which may undermine the scientific purpose of CPG development.

example, relevant clinical specialists who receive a substantial portion of their incomes from services pertinent to the guideline.” (Report Brief at 2.) These same specialists may sometimes have the most expertise on the subject; and their contribution to CPG development may thus be desirable and beneficial, *provided* their concurrent financial interests are not allowed to dominate that process. As one solution to this particularly thorny problem, the IOM proposes that guideline development panelists with conflicts of interest not represent more than a minority of the group. (Id.)

The issuance of the IOM Report and proposed standards announces high-level attention to this critical area of health care practice and policy – and the Lyme matter is duly cited as emblematic of the need for reform. These issues are looming larger in health care and antitrust. Participants and other interested parties in clinical practice guideline development would be well advised to study and heed the advice and conclusions of the IOM, not only for the obvious benefit of improving CPGs but also in order to safely navigate the less obvious antitrust perils of guideline development as commercial standard setting.