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From Scientist to Analyst to Strategist

Aharon (Ronny) Gal Talks with Ken Herrmann and Johannes Czernin About Leadership in Multinational Pharma

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Ken Herrmann, MD, MBA, from the Universitätsklinikum Essen (Germany), and Johannes Czernin, MD, from the David Geffen School of Medicine at UCLA, talked with Aharon (Ronny) Gal, PhD, about his career across a range of scientific, analytic, consulting, and leadership positions. Dr. Gal is Chief Strategy & Growth officer and a member of the executive committee of Novartis AG, responsible for end-to-end portfolio strategy to support the company's long-term growth, including oversight of corporate strategy, research and development portfolio strategy, and business development. He earned his PhD in biochemistry from the Massachusetts Institute of Technology (MIT; Boston) and began his career with the Boston Consulting Group (MA), where he focused primarily on health care. In 2004 he became the senior analyst covering the U.S. biopharmaceutical industry at Sanford Bernstein (New York, NY), a research and brokerage firm, where he held positions of increasing responsibility. In 2022 he accepted his current position at Novartis, bringing more than 20 years of experience in the life sciences industry. As a thought leader in the health care sector, he is recognized for insightful thematic research across therapeutic areas, technology platforms, and key industry topics, such as U.S. health care reform.

Dr. Czernin: *Ronny, thank you for speaking with us. Tell our readers briefly about your background. What did you do before you joined Novartis?*

Dr. Gal: Thanks for the opportunity to have this discussion. I have been with Novartis for more than 2 years as head of Strategy & Growth, a division that provides decision support for the executive committee on internal developments and external acquisitions. Before joining Novartis, I was on Wall Street for 17 years analyzing drugs and therapeutic areas of pharmaceutical companies. Prior to that, I was a strategic consultant with the Boston Consulting Group for 6 years. I received a doctorate in biochemistry from MIT. I've had a varied career—from the bench to strategic consultant to Wall Street analyst and now to pharmaceutical industry executive.

Dr. Herrmann: *This sounds very unusual. In sports, one starts as a professional and then moves to the sidelines and begins to analyze. Your career was the other way around. You were first an analyst and now are a professional driving the company.*

Dr. Gal: In a way it is somewhat unusual. However, within the past 2 years, we've seen other companies following our example and hiring people with backgrounds similar to mine. The idea of finding somebody who looks at multiple companies and bringing them in to look at things from a different angle is a good way to generate new ideas. I can tell you it's been a fascinating couple of years.

Aharon (Ronny) Gal, PhD

Dr. Herrmann: *Speaking of new ideas, a major pillar of the Novartis strategy in cancer care is RPT. Of course, as nuclear medicine specialists, this is one of the things about which we care most. What are the new ideas you bring to RPT development?*

Dr. Gal: Let me be clear: I have not invented anything in RPT myself. What I try and do is help advance ideas that were created elsewhere. RPT is a very important area, and the industry is trying to accelerate drug development to make therapies more affordable and accessible for patients across the world.

Dr. Czernin: *Are there ways to accelerate the drug development process? In the context of the good-but-not-optimized response rates to RPTs (currently about 50%), how can we accelerate the development of combination therapies?*

Dr. Gal: First, we need to understand reasons for nonresponse or partial response. Another idea is to use multiple modalities in an attempt to address the same target. Without disclosing proprietary information, we are addressing targets with both RPT and additional modalities. We are analyzing whether there are additive benefits versus synergistic benefits. And we are trying to test combinations earlier in development. Some of this is happening in prostate cancer.

Dr. Herrmann: *A lot of targets are the same for RPT and antibody–drug conjugates (ADCs). Some in industry believe that we should go for one or the other rather than both. What is your personal reasoning there? And if we have both ADCs and RPTs on the same target, how do you see the sequencing?*

Dr. Gal: RPTs and ADCs have different strengths and weaknesses. In my mind, there is certainly room to try combinations of the two, either sequentially or simultaneously, if the safety profile is tolerable. You can also think about trials in which the patient first receives several rounds of RPT and then an ADC or naked antibody. We can think about the combination of both of those, depending on tumor type and composition, penetrability of antibodies, and durability of effect. Twenty years ago, when we conducted a trial, we demonstrated only that the drug worked in the

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disease area. Now and in the future we need to do follow-up trials that try different sequences and different combinations in tumor types with proven single-drug efficiency.

Dr. Czernin: *Do you have your own basic, fundamental scientists who try to understand resistance on every level, from optimization of drug delivery to innate resistance mechanisms? Or do you outsource these preclinical experiments to academia?*

Dr. Gal: We do both. We certainly have internal teams that look at this, but the notion that we have some sort of monopoly on smart thinking or even the best understanding of how a patient responds is simply not true. We rely extensively on a network of collaborators. Assuming some of your readers are professors in academia, I encourage them to reach out to Novartis to start discussions about potential collaboration efforts.

Dr. Herrmann: *When you joined the company, logistics were more complex for RPTs than ADCs. What are the lessons learned?*

Dr. Gal: We have focused on manufacturing capabilities. Our view is that the challenges associated with the first generation of a new cancer treatment modality may be mitigated through production and distribution. We certainly have not solved all the issues involved, but we have a network of supply today to deliver RPTs in North America and Europe with very high reliability rates. Our internal customer supply on-time rates for Pluvicto are basically the same as for non-RPTs.

Dr. Herrmann: *Novartis is currently the front-runner in the field of theranostics. There are now several competitors, which is good. What is the next big thing?*

Dr. Gal: This is a competitive field, with 4 or 5 large pharma companies that have committed several billion dollars of investment. We started first and will certainly make an effort to keep delivering for patients in our selected area of oncology. However, we are not going to do everything; nor should we. At Novartis, we are using 2 approaches. One is testing RPT against a whole new set of targets. Second, we are trying to develop best-in-class RPT alternatives to antibody, ADC, cell therapy, and other approaches. Internally, we have put together the capability to develop molecules through our own organization. We've also had a couple of public transactions with companies that are able to generate peptides for us. In addition, we acquired a company, Mariana Oncology, about which we are quite excited. So again, to the extent that some of your readers have new molecules in their labs, please contact us and we will be happy to take a deeper look at their work.

Dr. Herrmann: *Novartis is a great company when it comes to executing phase II and III clinical trials but is less well known for early intellectual property development.*

Dr. Gal: Large pharma companies are not necessarily the fastest. They're not built for speed. The decision-making cycles are slower, because more people need to be involved in a decision. Conversely, when you have CEOs who are also scientists and have the capability to get the funding on their own, decisions are faster. On the other hand, even in early trials, data packages from big pharma are inherently superior. Often, when we talk to small companies and ask them about their data packages, we discover missing components. The benefit Novartis currently brings to a small company or a physician who is developing is two-fold: this consistency of robust work early on and the ability to scale up the chemistry, manufacturing, and controls (CMC) side of the package in a much more robust way than small companies can typically do.

Dr. Czernin: *You've commented on how best to innovate and move things forward. Isn't a very important component of market development also expansion of the patient cohorts that can be treated with existing RPTs? For example, we're all anxiously awaiting the FDA response to the PSMAfore trial results (Phase III study on ^{177}Lu-PSMA-617 treatment), because approval in this indication would lead to a change in what we can do.*

Dr. Gal: The earlier question was about how we compete and how we think about our early-stage pipeline, whereas this question is much more to the core of what Novartis and other large pharma companies have the capability to do, which is to take a drug that has passed proof-of-concept and enable broad access to it. Some of the benefits of RPT, a generally well-tolerated therapy, are useful for early patients who may not be expected to tolerate a therapy with a significant adverse reactions profile. We are now working very hard on expanding the reach of RPT beyond those tertiary medical centers where a lot of the end-stage patients are treated. We need to broaden access for patients being treated outside of the larger clinical medical centers. So, by being early on in the development of RPT, we are trying to move the therapy at the speed at which the organizational feasibility of the industry of your partners works. We have to properly move the patients, the hospitals, and the regulators, both federal and local. And we have to get the patients comfortable. You can move only as fast as the slowest link.

"We are now working very hard on expanding the reach of radiopharmaceutical therapy (RPT) beyond those tertiary medical centers where a lot of the end-stage patients are treated. We need to broaden access for patients being treated outside of the larger clinical medical centers."

Dr. Herrmann: *One issue is the toxicity profile, which is superior for lutetium compared with actinium (at least for PSMA). Are you concerned that once ^{225}Ac-PSMA is deployed to earlier lines, this may damage the reputation of RPT?*

Dr. Gal: We will start in settings where the benefit–risk is expected to be positive given the options available for the patients. That's a natural way to test an agent such as actinium.

Dr. Herrmann: *What about the scale-up when you look at revenues? Pluvicto is now at $350 million per quarter, which means it's a billion-dollar drug. It's still not much higher than Sandostatin, which is 30 years old and off patent. The increase is not as much as we would have expected and may be due to lower than expected referral numbers in the United States. How can you promote patient referral in the United States?*

Dr. Gal: We are putting a lot of management time and thinking into this. In addition, a large part of this issue is physician-to-physician advocacy.

Dr. Czernin: *I think that an underestimated lobbying group here would be the patients. They all underwent chemotherapy with a much more challenging side effect profile. And they ask, "Why didn't I have this before? Why did I continue my chemotherapy when the prostate-specific antigen was still rising?" I think patients are getting very smart about it, and with social media they are aware that this is a good new thing. Maybe they are a little bit underutilized right now across the board.*

Dr. Gal: Although in Europe we are not allowed to communicate directly with patients, we can reach patients in the United States directly through advertisements. In fact, Novartis recently began direct-to-consumer advertising in the United States to help educate patients.

Dr. Czernin: *We are coming to the end of this very stimulating discussion. What would you advise young people to do with their lives if they are in the life sciences and want to embark on a career in big pharma, small pharma, or medicine?*

Dr. Gal: I'll share 2 thoughts. First, you're not defined by your education, by your current job, or even by your current skill set. These are things that you build over time. You should keep your eyes open to other careers or other jobs. We are now living longer and have longer careers. We should be willing over our lifetimes to try 2 or 3 different careers. I certainly did that, and it benefited me. The sum of my experiences has made me intellectually richer as a person and also more of a benefit to an employer. I don't think about a job based primarily on the nature of the employer. To some extent it's very much related to the group of people that you work with and the kinds of tasks that you are given. What I find as the central thread across my career is that I have always done better when I worked with a small group of excellent people. It has challenged me and made me work better, and I have always liked jobs or positions that require a lot of problem solving. That central thread is the second piece of advice. Find jobs that you love and roles that fit well with your personality. People ask me if I need vacations to recharge. I don't, because I recharge by being at work. If you discover that you're in a job where you can't wait for the weekend, then you probably are not in the right position or right career for your personality. So that's the 2 elements: be willing to try various jobs and find roles that you really enjoy doing.

Dr. Herrmann: *This was a great pleasure. Thank you for sharing your experience and insights with our readers.*