



IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Position Paper on Preserving Medical Professionalism in an Increasingly Commercial Healthcare Environment

April 2016

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Mission Statement

The role of the IMO is to **represent** doctors in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring, **efficient** and effective Health Service.



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“That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.”

George Bernard Shaw, *The Doctor's Dilemma* - 1909

Definitions of medical professionalism are frequently the subject of academic debate. The Hippocratic Oath stands as one of the earliest attempts to codify the moral and ethical standards to which a doctor should aspire in his or her treatment of patients, and reflects a foundation on which many centuries of medical culture has attempted to build. Some recent attempts to modernise the Hippocratic Oath include the *Declaration of Geneva*¹ by the World Medical Association in 1948 and *Medical Professionalism in the New Millennium – A Physician Charter*² published by the Medical Professionalism Project in 2002.

In Ireland, the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (which is currently under review)³, defines the standards of practice and behaviour which doctors in Ireland are required to meet to maintain the relationship of trust between the profession and society. The concepts of duty of care, placing the patients' needs ahead of the advantage of the physician, and the equal treatment of all are behaviours expected of good physicians from early times, and facilitate the strong level of trust the profession enjoys in society today.

The influence that commercialism and market forces in healthcare has on medical professionalism has risen time and again in the IMO. In the *Role of the Doctor in Ireland Paper 2007*⁴, the IMO cites a paper by Dr Jordan Cohen, former President of the Association of American Medical Colleges⁵, in which he draws a comparison of terms between professionalism and commercialism.

Professionalism	Commercialism
Doctor	Provider
Patient	Customer
Trust	Suspicion
Caring	Pandering
Services	Commodities
Values	Margins
Cures	Profits
Pride	Bonuses
<i>Primum non nocere</i>	<i>Caveat emptor</i>
Cohen, J. Professionalism in Medical Education, an American Perspective: From Evidence to Accountability in <i>Medical Education</i> , (2006) 40:p609	

1 World Medical Association (WMA), Declaration of Geneva, 1948 downloaded from <http://www.wma.net/en/30publications/10policies/g1/>

2 Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, Medical Professionalism in the New Millennium: A Physician Charter, *Ann Intern Med.* 2002;136(3):243-246

3 Medical Council of Ireland, Guide to Professional Conduct and Ethics for Registered Medical Practitioners, Dublin, 7th Ed. 2009.

4 Irish Medical Organisation (IMO), *The Role of the Doctor in Ireland*, Dublin, 2007

5 Cohen J. 'Professionalism in Medical Education, an American Perspective: From Evidence to Accountability', *Medical Education*, Vol. 40, Issue 7, July 2006, pp. 607-617.

Dr. Cohen stated that a degree of mutual exclusivity exists between medical professionalism and commercialism. While in ordinary commercial activity, consumers are encouraged to question the motives and claims of goods or service providers, such distrust is unsuited to a doctor-patient relationship that is conducive to improving the health outcomes of the patient. An increased focus on commercialism begets an increased focus on profitability, and could lead, he suggested, to the replacement of the physicians' mantra *primum non nocere*, or "first, do no harm", with the motto of consumerism *caveat emptor*, or "let the buyer beware".

In the *Role of the Doctor in Ireland* the IMO reaffirmed that

"The very nature of the doctor-patient relationship is not commercial and doctors defend their patients' reputations as persons undergoing medical care or treatment as opposed to persons purchasing goods or services".

IMO, Role of the Doctor in Ireland - 2007

The negative impact that a commercial healthcare environment can have on medical professionalism was further highlighted in the *IMO Position Paper on the Market Model of Healthcare - Caveat Emptor 2012*⁶. The IMO warned that

"Commercial imperatives conflict directly with the internationally affirmed values of professionalism to which doctors subscribe. ... doctors have a paramount responsibility to act in the best interest of their patients and at the same time be aware of the wider need to use limited healthcare resources efficiently and responsibly. A commercial competitive environment will inhibit doctors from reaching value judgements which are not in the interest of the patient or the State".

IMO, Market Model of Healthcare - Caveat Emptor 2012

While the IMO is aware of the potential conflict between commercialism and professionalism, at the same time doctors are required to work in a mixed public-private system healthcare system where almost half the population purchase private health insurance inpatient cover and pay out-of-pocket for GP care. The IMO wholly supports systems which protect the professionalism of doctors.

REVIEW OF THE LITERATURE

Although the pharmaceutical industry has been singled out as the main focus of potential conflict of interest in the medical literature, an almost universal source of potential conflict of interest in systems with elements of private health care is that of personal financial reward to individual practitioners and groups of doctors, in terms of patterns of assessment, treatment, equity and under/over-treatment. An increasingly sophisticated view of medical professionalism recognises a range of internal and external determinants of professional behaviour. Moving from a basis that focussed on individual motives and behaviours, the focus on professionalism has moved from changing individuals to modifying the underlying structural and environmental forces that shape social actors and actions⁷.

The Pharmaceutical Industry and Conflict of Interest

Many years of training provides doctors with a unique range of clinical skills, experience and knowledge that enables doctors to provide optimal advice, care and treatment to patients based on the clinical symptoms that present. Care of the patient is a primary concern and a doctor is expected to put the interests of the patient before his/her own, to the greatest extent possible, but is not obliged to totally efface his/her own interests⁸.

The marketing and commercial activities of pharmaceutical companies deliberately aim to influence the prescribing habits of physicians. At the same time collaboration is needed between pharmaceutical industry and physicians for the advancement and development of drug therapies.

6 IMO Position Paper on the Market Model of Healthcare – Caveat Emptor, Dublin 2012 available at <http://www.imo.ie/policy-international-affair/documents/imo-submissions-archive/IMO-Position-Paper-on-the-Market-Model-of-Healthcare-Caveat-Emptor.pdf>

7 Hafferty FW, Levinson D. Moving beyond nostalgia and motives: towards a complexity science view of medical professionalism. *Perspect Biol Med*. 2008 Autumn;51(4):599-615.

8 Morreim EH. Balancing act: the new medical ethics of medicine's new economics. Springer Science & Business Media; 2007 Aug 20.

In the USA, the pharmaceutical industry spends approximately \$24 billion annually on marketing to physicians.⁹ Published in the Journal of the American Medical Association, Dr. Ashley Wazana collated a large quantity of research that had been conducted on how interactions between pharmaceutical companies' sales representatives and doctors affected physician behaviour. The results revealed numerous worrying correlations: having received a gift and the number of gifts received predicted the likelihood of belief that pharmaceutical representatives have not impacted on prescribing behaviour; accepting samples was associated with awareness, preference, and rapid prescription of a new drug; accepting funding to attend a symposium was independently associated with increased formulary addition requests for the sponsor's drug; resident exposure to pharmaceutical representative speakers at lunch rounds was associated with dissemination and learning of inaccurate information about a sponsor's and competitor's drug; and accepting a pharmaceutical company honorarium to present data on a new therapy and receiving research support were independently associated with a formulary addition request for the sponsor's drug.¹⁰

The potential for conflicts of interest is also apparent in academic research. Studies into the effect of sponsorship of biomedical research has found that, not only are financial relationships among industry, biomedical researchers, and academic institutions widespread, but show a statistically significant association between industry sponsorship and pro-industry conclusions.¹¹

Incentives to Over-treat, Under-treat and Steer Care in a Particular Direction

Key principles of good medical practice include searching for the best evidence to guide clinical professional practice as well exercising good judgement and communicating sound clinical advice to patients¹². Referrals should be based on an objective assessment of the quality of service or of the physician to whom the patient is being referred.¹³ While doctors have a paramount duty to act in the best interests of their patient healthcare is a limited resource and doctors are also required to balance that duty of care with the wider need to use those resources responsibly and efficiently¹⁴.

Fee for service payments allow health services to be divided into discreet saleable units. While this has the advantage of forcing healthcare providers to cost their care, in a healthcare market where profit takes priority over patient care, healthcare providers can be incentivised to over-treat patients rather than minimise treatment or prevent disease, to steer care in a particular direction or to "cherry-pick" more profitable care while leaving more complex and less profitable care to the public sector. Other commercial factors can also lead to over-treatment. Advertisement of healthcare services can raise patient expectations and demands for care while moral hazard can cause both patients to consume more care and physicians to prescribe more care in the knowledge that the insurance company will pick up the bill.

In the US physician investment in hospital outpatient and diagnostic facilities has been found to influence the direction and volume of referral.¹⁵ Self-referral and fee-splitting culminated in the enactment of a series of federal legislation between 1989 and 2007 known as "Stark Law" that generally outlawed the referral of Medicare or Medicaid patients to a facility owned by a physician or immediate family member of a physician.

9 The Pew Charitable Trusts, *Persuading the Prescribers: Pharmaceutical Industry Marketing and its Influence on Physicians and Patients*, November 2013, [accessed at <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2013/11/11/persuading-the-prescribers-pharmaceutical-industry-marketing-and-its-influence-on-physicians-and-patients> at 11:47 on 6 February 2015]

10 A. Wazana, 'Physicians and the pharmaceutical industry: is a gift ever just a gift?', *JAMA*, Vol. 283, Issue 3, January 2000, pp. 373-380.

11 Bekelman J E, Li, Y, Gross C P, 'Scope and Impact of Financial Conflicts of Interest in Biomedical Research', *JAMA*, Vol. 289, Issue 4, January 2003, pp. 454-465.

12 Medical Council 2009 op cit

13 WMA, Statement on Conflict of Interest 2009 [available at <http://www.wma.net/en/30publications/10policies/i3/>]

14 Medical Council 2009 op cit

15 Lo B, and Field M J, (eds.), *Conflict of Interest in Medical Research, Education, and Practice*, Washington (DC), 2009, 6. *Conflicts of Interest and Medical Practice*, [available at <http://www.ncbi.nlm.nih.gov/books/NBK22944/> accessed on 27 February 2015].

Similarly in Australia corporatisation and vertical integration of primary care and diagnostic facilities has had a similar effect. A recent report on the Corporatisation of General Practice published by the Australian Department of Health and Ageing¹⁶ highlights a number of studies which show how the profit motive and corporate pressure has influenced the direction of referrals between vertically integrated primary care and diagnostic facilities.

At home the National Treatment Purchase Fund (NTPF), an initiative to address waiting lists through the purchase of elective care from the private sector, led to cherry picking¹⁷ and the purchasing of elective care from the private sector at a price substantially higher than in the public sector.¹⁸

The Inverse Care law

A commitment to social justice, equality of care and the just distribution of resources are also key tenets of medical professionalism.

The Inverse care law coined by Julian Hart in 1971¹⁹, states that the availability of good medical care tends to vary inversely with the need of the population served and the wealthier and healthier sections of society tend to be better served than the poorer and sicker sections of the population. Hart suggested that this inequality in the treatment of patients is driven by profit.

Throughout academic literature, stemming from a variety of countries, differences have been observed between the rates of specific treatments provided to private and public patients. Despite no differences in treatment preferences, private patients in Brazil were noted to have received almost twice as many caesarean sections as their public counterparts²⁰, and private patients were more likely to receive a coronary angiography than comparators within the public system in Australia.²¹ Furthermore in the US it has been observed that doctors operating in high-spending regions see their patients more frequently and are more likely to recommend medically unnecessary tests and treatments than doctors in low-spending regions.²²

Literature from Ireland has shown similar results. A study of public versus private obstetric care within the same hospital setting found that compared with public patients, private patients had higher rates of operative deliveries that were not fully accounted for by medical or obstetric risk.²³

DOCTORS' VIEWS ON COMMERCIALISM IN IRELAND

In preparing this position paper the IMO held a workshop and carried out a survey of IMO members to gauge the views of members on this important topic. It is not surprising that four out of five doctors who responded to our survey agree that commercialism is a reality that is increasingly forced on the medical profession however from discussions at the workshop and from the open-ended questions in the survey it is apparent that *"the issue is not so black and white and there are many grey areas"*. There are many commercial market factors within the health system that impact on doctor behaviour and not all commercial activity is negative. Comments made from doctors are in italics.

16 Medicare Financing and Analysis Branch, State of Corporatisation - A Report on the Corporatisation of General Practices in Australia, Department of Health and Ageing, February 2012

17 IMO Submission to the DOH Value for Money and Policy Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals 2009

18 Auditor General Annual Report 2008 [http://www.audgen.gov.ie/documents/annualreports/2008/Appropriation_Account_2008Rev1.pdf]

19 Tudor Hart J. The Inverse Care Law. *Lancet* 1971; i :405–12

20 Potter J E, et al., 'Unwanted caesarean sections among public and private patients in Brazil: prospective study', *British Medical Journal*, November 2001, *BMJ* 2001;323:1155;

21 Robertson I K, and Richardson J R, 'Coronary angiography and coronary artery revascularisation rates in public and private hospital patients after acute myocardial infarction', *Medical Journal of Australia*, Vol. 173, Issue 6, September 2000, pp. 291-295.

22 Sirovich B, et al., 'Discretionary Decision Making By Primary Care Physicians And The Cost Of U.S. Health Care', *Health Affairs*, Vol. 27, Issue 3, May 2008, pp. 813-823.

23 Murphy DJ, Fahey T, A retrospective cohort study of mode of delivery among public and private patients in an integrated maternity hospital setting. *BMJ Open* 2013;3:e003865.doi:10.1136/bmjopen-2013-003865

Labour Market Forces

In the first instance, while doctors are expected to put the interests of their patients before their own pecuniary interests, in reality the medical profession balances the responsibility to patients and to society against the desire for an appropriate standard of living. In Ireland, as elsewhere, the terms and conditions of employment for medical professionals are subject to market forces. Highly qualified medical professionals are a scarce resource and with approximately 300 consultant posts unfilled in the HSE and difficulties in filling posts in general practice demand for physicians outweighs supply. In addition the employment market for healthcare professionals competes with other healthcare markets, primarily other English speaking markets such as the UK, USA, Canada, Australia and New Zealand.

“the employment market sets the level of remuneration of doctors”

Physician Interactions with the Pharmaceutical Industry

Ireland is the primary location for international pharmaceutical and medical technology investment in Europe with many of the top global companies in these sectors are located in Ireland.²⁴ Both industries employ approximately 25,000 people each with many more employed in related services. Preliminary figures show that exports of medical and pharmaceutical products exceeded €30 billion in 2015 representing 27% of Irish exports.²⁵

It is not known how much the pharmaceutical and medical device industries spend on advertising and promotion in Ireland, however, sales of medical goods, including pharmaceuticals and therapeutic appliances, in 2013 amounted to €2.8 billion or 15% of total healthcare expenditure in Ireland.²⁶ Close collaboration with healthcare professionals is vital to the pharmaceutical industry in order to inform healthcare professionals and seek feedback on their latest products. The pharmaceutical industry supports medical research, educational meetings, expert-led forums and attendance at conferences and scientific meetings.²⁷

A number of measures have been implemented in an attempt to improve transparency and address any potential conflict of interest. Direct conflict of interest is removed by a separation of the prescriber and dispenser role. Under the Pharmacy Act 2007 physician investment in retail pharmacy and vice-versa or the sharing of a premises is considered professional misconduct. The advertising and promotion of pharmaceuticals including the provision of gifts and hospitality are restricted under the Medicinal Products (Control of Advertising) Regulations 2007 and supplemented by a number of voluntary industry codes of practice. The Medical Council has clear guidelines in place to support transparency between the medical profession and the pharmaceutical industry requiring doctors to declare any potential conflicts of interest and limiting the influence of the pharmaceutical industry on educational events and material. From this year the pharmaceutical industry will begin publishing all transfers of value from pharmaceutical companies to healthcare professionals.

Despite the measures implemented half of doctors surveyed agree that “there are few independent sources of information with regard to new drug therapies”. A number of reliable independent sources of information were cited, such as *Prescrire* and the *Drugs and Therapeutics Bulletin*, however, many doctors feel that pharmaceutical sales representatives, promotional material and even magazines, journals and news reports could be biased. Of particular concern to doctors is the role of pharmaceutical companies in the sponsorship of educational events.

24 Enterprise Ireland, Pharmaceutical Sector Profile, [downloaded from <https://www.enterprise-ireland.com/en/Source-a-Product-or-Service-from-Ireland/Sector-and-Company-Directories/Pharmaceutical-Sector-Profile.pdf>] and Medical Devices Sector Profile [downloaded from <https://www.enterprise-ireland.com/en/Source-a-Product-or-Service-from-Ireland/Sector-and-Company-Directories/Medical-Devices-Sector-Profile.pdf>]

25 Central Statistics Office (CSO), Goods Exports and Imports December 2015 [downloaded from <http://www.cso.ie/en/releasesandpublications/er/gei/goodsexportsandimportsdecember2015/>]

26 CSO Ireland's Health System of Accounts Annual Results 2013 [downloaded from <http://www.cso.ie/en/releasesandpublications/er/sha/systemofhealthaccounts2013/>]

27 Irish Pharmaceutical Healthcare Association, Bringing Health and Growth to Ireland. How the pharmaceutical industry helps patients, the health service and the economy 2014

“there is a clear lack of regulation of industry and pharma reps in hospitals. There is a clear conflict of interest of pharma companies sponsoring educational meetings for doctors in public hospitals”

Many doctors believe that the pharmaceutical industry has too much influence on Irish medicine and that pharmaceutical therapies are promoted above non-pharmaceutical treatment.

“Pharma companies are too involved in medicine. From research to hospitals they are silent decision makers”.

“Pharmaceutical company influence means promotional materials are everywhere and management don’t support non drug approaches...knock-on is under-development of non-drug treatment facilities and staff eg. psychotherapists, OTs, SLTs, physios. Huge factor in mental health”

Many doctors believe that there is a need for greater enforcement of guidelines relating to the sponsorship of educational events.

“reinforcing of restraints on medical education is sorely needed”

Affordability of Pharmaceutical Care

Affordability of pharmaceutical care is an issue both for the state and individuals. Per capita spending on pharmaceuticals in Ireland is 30% above the OECD average²⁸. In an effort to reduce government expenditure on drugs out-of-pocket payments for pharmaceutical care have risen substantially. Prescription charges for medical card patients introduced in 2010 now stand at €2.50 per item (capped at €25 per month) and those without a full medical card face charges of up to €144 per month for prescription drugs under the Drugs Payment Scheme. Doctors are concerned that due to the high level of out-of-pocket payments for medicines many patients are not adhering to treatment.

“Where patients pay out-of-pocket for medication, they may not adhere to treatment resulting in a worsening of their condition and re-attendance... there can be an element of doctor rationing and self-rationing of care”

76% of doctors who responded to our survey agree with the statement “I am obliged to consider my patients’ financial circumstances when discussing options for care”. Many doctors support the work of HIOA and the National Centre for Pharmacoeconomics in health technology assessment and pharmacoeconomic assessment but consider that there is insufficient information available to them on the cost-effectiveness of new medicines and technologies compared with those already existing in the market.

Incentives to Over-treat in Private Healthcare

Despite a sharp drop during the recession, approximately 46% of the population or 2.1 million people hold private health insurance inpatient plans. Three private health insurers now operate in the Irish health insurance market and there are approximately twenty private hospitals providing acute and mental health services in Ireland. Private health insurance also covers private consultant fees and per diem charges in public hospital. Since 2014 charges are now levied from all patients admitted to a public hospital with private health insurance regardless of whether they are accommodated in a designated private bed or not. In 2013 expenditure from voluntary health insurance schemes amounted to €2.1 billion or 11.8% of total health expenditure.²⁹ While some doctors work in private practice or public practice only, most doctors in Ireland treat a mixture of public and private patients. Consultants depending on their contract may treat private patients in a public hospital or may have a private practice off the hospital site. With just 48.6% of the population covered by a Medical Card or GP Visit card, most GPs also have a mixed public and private practice.

28 OECD Health at a Glance 2015 – How does Ireland compare? [downloaded from <http://www.oecd.org/ireland/Health-at-a-Glance-2015-Key-Findings-IRELAND.pdf>]

29 CSO Ireland’s Health System of Accounts Annual Results 2013 [downloaded from <http://www.cso.ie/en/releasesandpublications/er/sha/systemofhealthaccounts2013/>]

Eight out of ten doctors who responded to our survey agree that “private care can lead to over investigation” and nine out of ten doctors agree that “patients perceive private care to be better than public care”. Of particular concern to doctors is supplier induced demand created by the advertising of health screening services advertised by major private institutions and the inter-referral of patients within private hospitals. Doctors are concerned about the lack of evidence supporting some health checks and screening procedures, as well as cross-referrals leading to the over-treatment by doctors of the “worried well”. Doctors feel that patients should be made aware of both the health consequences of over-exposure to radiation and the impact unnecessary diagnostics procedures have on health insurance premiums.

“The advertisement of independent sectors for non-evidence-based activity (health checks) exposes persons to excessive medical care, including over-diagnosis and over-treatment. I think of cases of perfectly healthy people receiving ionising radiation.”

“advertising from the main private institutions sets an expectation among all our patients to expect investigation when it might be unnecessary”

Concerns are not related solely to secondary care but also to corporate providers of primary care services and diagnostic facilities and the potential for conflict of interest that can arise.

Doctors are also concerned that private health insurance companies do not always promote evidence-based care. Seven out of ten doctors also agree that insurance companies are increasingly dictating the delivery of care. IMO doctors feel that private health insurance reimbursement favours admission to hospital above day treatment, outpatient care or care in the community.

“insurance cover for in-patient procedures reduces incentive to move to day case/outpatient procedures”

Many doctors are critical of reimbursement procedures by health insurance companies and their willingness to reimburse more expensive MRIs over less expensive diagnostic procedures such as a CT scan or X-ray, whether the tests are clinically indicated or not. Doctors are also concerned about telemedicine services provided by health insurance companies.

Inequity and the Mixed Public-Private System

However for many doctors private care is not always a negative. Public healthcare is significantly underfunded in Ireland and in the majority of cases private care provides access to a range of services that are not available in the public system.

“We need to differentiate between commercialism and service...not all private medicine is ‘bad’ – a lot provides a service that doesn’t exist in the public system”

Between 2009 and 2014 public health service expenditure fell by 20% per person, while demand on public services has increased as a result of both population growth and an ageing population. In the same period both staff numbers in the HSE and the number of acute beds fell by approximately 13%. As a result, unprecedented numbers of people are treated on trolleys in our emergency departments and wards and long waiting lists for outpatient appointments and inpatient elective procedures. Pressures to keep within budget has led to rolling theatre closures and regular cancellation of elective procedures.

Under-resourcing and long waiting lists for public hospital care impact on doctors’ and patients’ decision making and have led to increased reliance on the private sector and a widening of the two-tier system. Seven out of ten doctors agree with the statement that “private care means more timely care. If patients can afford it I urge them to consider private care”. However for many doctors demand for private care is driven by the under-funding and mismanagement of resources in the public healthcare system.

“due to the dysfunctional nature of our public system and the under-supply and over-demand for healthcare in our hospitals people are forced into purchasing private health insurance just to ensure timely care”

“the two-tier system gets worse and worse. I now have medical card patients paying to see private consultants as public lists are indefensibly long”

However eight out of ten doctors agree that “if patients require urgent or complex care I am more likely to refer them to a public hospital” and many doctors are of the view that private care was not suitable for all patients.

“[private care is] timely if your illness fits private eg. younger, fitter patients with elective issues or buying a one-off scan for a single issue”

“when there is a commercial contract to send patients from the public system to the private... the onus falls on doctors to make sure the “right patient” is moved to the private system. Less complex, few comorbidities, not confused or elderly dependent or addicts or homeless. Not simple for doctors. Leaves all the difficult and expensive patients [in the public system].

“private care is of little benefit in psychiatry because it cannot deliver a community team in a patient’s local area with in-depth knowledge of local community resources and supports ...”

Private healthcare provision can foster innovation and improvements to the quality and effectiveness of care. For some doctors the public health system cannot afford expensive new technology and treatments and innovative quality of care should be rewarded.

“Medical advances are too costly for governments to pay for”

“Healthcare demands are increasing all the time and a combination of public and private offerings are needed. Profitable efficient healthcare serves both patients and medical practitioners.”

Many doctors believe that some commercial practices could be of benefit within the public sector. In particular, an understanding of the cost of procedures could support decision making and the efficiencies in the delivery of care.

“An understanding of the cost of diagnostics, treatments and procedures can support doctors in everyday decision making. Particularly in an era of public resource constraints doctors should have an understanding of the level of resources available to them.”

The HSE is currently rolling out a system of money follows the patient of activity-based funding (ABF) for funding hospital care in an effort to improve efficiency and increase transparency in healthcare funding. Doctors are concerned though that with the introduction of ABF, hospitals serving older populations may be underfunded or biased towards patients requiring less resources.

“activity-based funding mechanisms do not take into account patients with mixed complexities and can bias the types of patients hospitals want to admit”

Trust and the Promotion of Transparency

Doctors work at the coalface of the health service and every day make clinical decisions based on scientific evidence and international best practice. Frequently major changes to healthcare policy are guided by economic or political imperatives without any evidence of improvement to quality of care or patient outcomes.

Patients trust their doctors to make decisions that are to the greatest extent possible in the patients’ interests and which minimize as far as possible commercial, political, or other concerns. A recent poll conducted by Amárach Research, on behalf of the Medical Council of Ireland, found that doctors continue to be the

most trusted profession in Ireland.³⁰ While 91% of adults in Ireland state that they trust their doctor to tell the truth, this figure is decidedly lower in the USA, where just 58% have expressed the same trust.³¹ While the components of trust in a given profession are complex and diverse, studies have established that the commercialisation of medicine acts as a barrier to trust and a strong doctor-patient relationship.³² The USA, where a commercially-driven market model of medicine has been in place for many decades, demonstrates the pitfalls of increasing commercial pressures in the field of medicine on trust in the medical profession.

Maintaining that trust in the medical profession is crucial to a caring efficient and effective healthcare service.

Recognising conflict of interest and being transparent about potential conflict of interest is vital to the integrity of medical professionals. 84% of doctors surveyed agree that “doctors should be better informed on how to recognise and be transparent about conflicts of interest”. Commercialism is a reality of modern healthcare delivery whether in a publicly funded universal healthcare system or a mixed public and private system as currently exists, however incentives that have the potential to impact on medical professionalism can be reduced. Protecting the unique doctor-patient relationship is in the interest of doctors, patients and the state. In order to preserve medical professionalism in an increasingly commercial healthcare environment the IMO recommends a number of measures as follows:

IMO Recommendations

Reducing Commercial Influence on Medical Professionalism

- **In order to reduce reliance on the private sector the public healthcare system must be appropriately resourced to meet current and future healthcare demand;**
- **Greater use of pharmacoeconomic assessment and health technology assessment should be made by the public sector;**
- **Appropriate non-directional educational material on new pharmaceutical therapies should be provided;**
- **The rollout of activity-based funding must**
 - **ensure that diagnostic related payments are adequately costed,**
 - **allow for complex patients with multiple co-morbidities,**
 - **encourage appropriate care in the appropriate setting;**
- **Private healthcare facilities should be subject to the same standards and oversight as public hospitals**
 - **Licences for private healthcare facilities should be awarded on the basis of provision of evidence based healthcare services,**
 - **Advertising standards for healthcare facilities should be developed and strictly enforced;**
- **Employment contracts in the public or private sector should support and promote the role of the doctor and should not include incentives to meet profit targets at the expense of patient safety and quality of care;**

Recognising and Declaring Conflict of Interest

- **Medical ethics, including conflict of interest and the potential impact of private and public medicine on medical professionalism, should be promoted in undergraduate, post-graduate and CPD educational programmes;**

30 Medical Council, Survey of Public Attitudes to Doctors’ Professionalism, July 2015

31 Blendon, R J, Benson J M, and Hero J O, ‘Public Trust in Physicians — U.S. Medicine in International Perspective’, *The New England Journal of Medicine*, Vol. 371, October 2014, pp. 1570-1572.

32 Banerjee, A, and Sanyal, D, ‘Dynamics of doctor–patient relationship: A cross-sectional study on concordance, trust, and patient enablement’, *Journal of Family and Community Medicine*, Vol. 19, Issue 1, April 2012, pp. 12-19.



- **While recognising the role of industry in the research and development of new therapies, medical council guidelines on industry sponsorship of educational events should be strictly adhered to;**
- **There should be routine registration of conflicts of interest in advocacy, education and academia;**
- **Medical journals should ensure conflict of interest statements are published for all submitted articles;**
- **When referring patients, doctors should openly declare any financial interest they have in private healthcare facilities;**
- **Clinical guidelines for care should be developed and applied where possible across public and private patients. Guidelines should be flexible to support innovation and improvements to patient outcomes and quality of care;**
- **When carrying out clinical audit doctors should pay careful attention to potential disparities between public and private patient care.**

Position Papers published by the Irish Medical Organisation are available on www.imo.ie

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