

GLOBALISATION, ECONOMICS AND PROFESSIONALISM

Chay-Hoon Tan¹ and Paul Macneill²

Affiliation:

¹Associate Professor, Department of Pharmacology, Associate, Centre for Medical Education, School of Medicine, National University of Singapore, Consultant Psychiatrist, National University Hospital

²Professor, Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney

Abstract

This paper presents an analysis of the effect of globalisation and attendant economic factors on the global practice of medicine, medical education, medical ethics and medical professionalism. The authors discuss the implications of these trends, citing case scenarios in the healthcare insurance, medical tourism, pharmaceutical industries, the educational systems as well as in clinical practice, to illustrate the impact of globalisation and economics on professionalism. Globalisation, on the one hand, offers benefits for the global practice of medicine and for medical education. On the other, globalisation can have negative effects, particularly when the main driver is to maximize profitability across national boundaries rather than concern for human well-being. Appraising the effect of globalisation on professionalism involves assessing its effects at the intrapersonal, interpersonal, and institutional levels, and its effects on society at large.

Keywords: clinical practice, economic factors, globalisation, interpersonal, intrapersonal, institutional, healthcare insurance, medical education, medical ethics, medical professionalism, medical tourism, pharmaceutical industries, practice of medicine, profitability

INTRODUCTION

Globalisation is a process of interaction and integration. The term ‘globalisation’ was popularised by many writers including Friedman (2005) who used the term globalisation to refer to the market place associated with business and industry. Globalisation has been however extended much further, by policies that have opened economies domestically and internationally.

This has been aided by technological innovations that have enhanced the speed and simplicity of communication and dramatically increased exchanges of knowledge and resources across the globe (REF). There are now fewer obstacles to the mobility of products and services across national borders (REF). The word ‘globalisation’ has spread extensively into many fields of human endeavour (REF). Inevitably, globalisation has affected medical practices as is evident from notions of ‘global healthcare’, and from the relative ease of crossing of national borders—for medically related activities—by the movement of medical staff, by pharmaceutical products (and the ‘off-shoring’ of clinical trials), and by ‘medical tourists’—seeking surgery, organ transplants, and even medical euthanasia. Globalisation has also influenced medical education, medical ethics and medical professionalism (Crone & Samaan 2013, Frenk et al. 2010).

Concerns about medicine and medical practice now need to be addressed globally. For example, to take just two relevant statements, Murray (2006) remarked that “*Physicians need to recommit themselves to the ‘fundamentals’ of medical professionalism due to ‘widespread threats’ to that professionalism*”. Mechanic (2008) reported that changes in the organization, economics, and technology of medical care have made it difficult to maintain competence to meet patients' expectations. Although neither speaker specifically addressed globalisation, the additional challenges to professionalism and competence arising from globalisation need to be addressed.

In this paper, we examine globalisation in relation to the practice of medicine and its effect on medical education.

1. ECONOMICS AND PROFESSIONALISM

A. INSURANCE

In the landmark study funded by the Carnegie Foundation in the early 1900s, Abraham Flexner described the underpinning of medical professionalism as knowledge used in an altruistic fashion, and based on a trust between the patient and the treating doctor. Flexner’s altruistic vision, however met confronting challenges brought about by societal change. The great depression in the 1920s led to a rise in employer-sponsored health insurance in the USA—a trend that was further fuelled by the “*ability of companies to take a full tax deduction for their costs*”. This trend was added to by a “*fee-for-service system, aided by aggressive new medical*

marketing” which “*encouraged use of the latest and the best*” (Wenger 2007). With costs covered almost totally by insurance, many patients demanded only the best and most expensive treatment. Furthermore, with “*corporate encouragement, hospitals began to compete with each other to deliver the latest and best, with proceduralists beginning to dominate both medicine and surgery*” (Wenger 2007). This trend of US healthcare and practice spread globally (Neill; Arnold 2005). US business expansion in healthcare services has become a global phenomenon (Health and Medical, 1997) and predominates over health concerns. For example, Tan and colleagues, (Tan et al 2008; Chong & Tan 2010) found that factors, such as insurance arrangements and the healthcare structure in a number of countries have become more significant in the prescription of psychotropic drugs than the drugs’ effectiveness.

B. CLINICAL PRACTICE

The primary commitment of medicine is to serve patients' best interests. But this is difficult to maintain in the face of global shifts in the control of healthcare delivery either towards the state, or towards the corporate sector and individual interest (Casalina 2013). In addition, changes in the availability of health care services, both nationally and internationally, allow the rich to seek medical care where ever it can be found. This in turn leads to increased pressures to care for the rich at the expense of the poor. The lure of “*economic advantage has tested, and often undermined, practitioners’ commitments to core values of their professional*” (Faulconbridge & Muzio 2009). With an apparent rise in medical self-interest, societal attitudes have changed from respect to intensifying criticism REF. The medical profession is increasingly seen as concerned primarily about financial gain, lacking in adequate regulation of clinical behavior and skills, and lacking honesty in practice (Cruess & Cruess 2004’ Bernat 2014). The scenario below, drawn from a court case involving a Singaporean general surgeon specializing in cancer surgery, provides an extreme example of financial gain undermining core values of professionalism.

Scenario (Over-charging an International patient)

On 1st July 2013, “the highest court in Singapore dismissed an appeal by general surgeon Susan Lim against her conviction on charges of professional misconduct over the amount she charged a patient from the royal family of Brunei. In 2012, Dr Lim was found guilty of 94 charges of professional misconduct by a Singapore Medical Council . . . disciplinary committee for

charging about \$24 million for the services provided . . . for 110 treatment days” (Lum & Vijayan 2013).

Dr Lim had argued that she was free to charge fees according to market forces. However the High Court ruled that that there is “an ethical obligation” on the part of all doctors “to charge a fair and reasonable fee for their services.” The Court based its decision its view of the professions (particularly law and medicine) as primarily vocations rather than business enterprises. In effect, it mandated a return to fundamental values of the medical profession (Lim 2013).

This judgment may counter a tendency for the lure of financial gain to undermine professional values—at least in Singapore. Global health care, however, tends to advance medical practice as an economic enterprise. It enables free trade and promotes the use of the latest most expensive medical treatment. A survey in Beijing Children's Hospital found that more than 98% of the patients in the Outpatient Department, who were diagnosed with the common cold, were given antibiotics by physicians (Yang et al. 1993). A member of staff, working in a hospital in Beijing, highlighted a common practice of using expensive, imported intravenous antibiotics for fever in pediatric patients (personal communication 2013). These observations reflect poorly on the competency and professionalism of the treating doctors. The practice is, however, not restricted to China. It is a worldwide problem that doctors prescribe antibiotics inappropriately. In some cases intravenous antibiotics have been given to children who have had antibiotic-induced fever from earlier treatment in local clinics. The pandemic use of antibiotics non- pharmacologically is shaped by culture and economic factors (Avorn & Solomon 2000).

Scenario (professionalism of treating patients with end stage cancer)

A 45 year-old man with four children was in the terminal stage of a disseminating nasopharyngeal carcinoma. The metastasis affected both his eyes and ears and had led to a rapid deterioration in his health. The team of specialists in a public hospital had informed both patient and family that treatment was futile in his situation. In a private hospital, the approach of the oncologist was different. The oncologist offered state-of-the-art expensive treatment and the patient accepted, even though the family faced losing ownership of their home, in addition to the

inevitable demise of their father.

The private oncologist's reluctance to discuss the risks (both medical and financial), and the slim likelihood of any benefits from the treatment, raises serious questions about the oncologist's professional competence (Mohanti 2009). This case scenario stands in stark contrast to the expectations to be derived from Johnson (2014) about professionalism of oncologists and all physicians.

2. GLOBALISATION OF HEALTHCARE: MEDICAL TOURISM

Scenario (Medical tourism)

At Wockhardt Hospital in India, "Mr. Steeles, 60, a car dealer from Daphne, Alabama, had flown halfway around the world last month to save his heart [through a mitral valve repair] at a price he could pay. The article describes in great detail the dietician who selects Mr. Steele's meals, the dermatologist who comes as soon as he mentions an itch, and Mr. Steeles's "Royal Suite" with "cable TV, a computer, [and] a mini-refrigerator, where an attendant that afternoon stashed some ice cream, for when he felt hungry later." This treatment contrasts with the care given to a group of "day laborers who laid bricks and mixed cement for Bangalore's construction boom," many of whom "fell ill after drinking illegally brewed whisky; 150 died that day. (Sengupta 2008)

The delivery of global healthcare to international patients has spawned a growing and lucrative medical tourism industry, said to be worth US\$60 billion (Jones & Keith 2006; Gwee et al. 2013). Snyder et al. (2011) described the roles for medical professions in the tourism industry. An on-line UK-based publishing business for medical tourism is assisting in patient safety and medical professional issues in the healthcare industry (Youngman 2010). As a result, the public advertisement of medical services, which was once 'unethical,' has become more acceptable. While this is economically beneficial to the host country, the treating doctors and to health care institutions, it can also pose a potential source of conflict with the delivery of healthcare to the citizens of the host nation. This is an obvious way in which globalisation in health care may

impact on national health care systems. It raises ethical questions about marketing healthcare services across countries over the Internet and social media for economic gain.

3. GLOBALISATION AND MEDICAL EDUCATION

The adoption across many countries of common standards for teaching and assessment—including standards for clinical teaching as well as professionalism—from sources such as ACGME, Scottish Doctor, and CanMEDs, has influenced the curricula of medical schools in many countries (Tarpley et al 2013, Dewhurst et al 2009, Henry et al 2013). This, along with increasing efforts of medical schools to raise their international ratings, has led medical schools toward common standards. More importantly common standards have allowed for trans-national training of both undergraduate and postgraduate medical professionals as well as for the movement of medical teachers across the globe.

However, the impact of globalisation on medical education needs to be evaluated in terms of its benefits and potential harms. Medical education has become a business enterprise. Several medical schools in the USA, the UK and Australia have entered into partnerships with hospitals, institutions and medical schools outside of their own country (Tsai 2012). These partnerships take different forms. In some cases a ‘brand’ is ‘purchased’ to enhance the prestige of the purchaser. Other situations involve the sale and purchase of curriculum packages and assessment tools. Human resources such as teaching faculty may also be included in the agreement. Another model is the “*co-branding*” and ““*off-shoring*’ of a whole medical school” as epitomized by the new Weill Cornell Medical College in Qatar at a contractual cost of USD750 million for 11 years. (Hodges 2009). Green (2007) commented that the Cornell-Qatar partnership “*is a revenue stream*”. In another example, the Medical Education Partnership Initiative provided \$130-million over 5 years to 13 African medical schools from the U.S. government (Omasawa 2014). These are considerable sums of money and draw attention to the business motivation behind globalisation. The arrangements, however, may come at some hidden cost to the host countries. Medical educators from ‘partner’ medical institutions are more likely to conform to imported educational approaches and standards of practice which may not be appropriate in the host country (Ho et al. 2011). The quality of the medical institutions can be heavily compromised in Lim’s view (Lim 2008; Lum 2011). There are also serious concerns about the effect on the

professionalism and attitudes of medical students in an environment of “*overemphasis on the economic aspects of globalisation*” (Hodges 2009).

4. GLOBALISATION AND THE PHARMACEUTICAL INDUSTRY

The availability of drugs and priorities in developing new drug treatment is largely in the hands of the pharmaceutical industry. This would not be an issue if pharmaceutical companies were primarily focused on alleviating suffering by promoting and distributing effective drugs targeted at major sources of disease and suffering, and by supporting research into new treatment in areas of need. The problem, however, is that industry is largely dominated by for-profit companies. Marcia Angell (former Editor of the *New England Journal of Medicine*), in her book *The Truth About the Drug Companies* (and a previous article with the same title) makes a strong case for claiming that the industry is dominated by the profit motive (Angell 2004a; Angell 2004b; Hoey 2004). She traces the rapid rise of big Pharma back to legislation, favorable to drug companies, which was enacted in the USA in the 1980s (during the Ronald Reagan’s presidential era). That legislation allowed companies to extract enormous profits for many years from drugs over which they were given monopolistic control (through patents and monopoly rights over brand name drugs) and to maintain their profit stream through subsequent legislative extensions to the life of patents.

Big Pharma—the collective name for ten or more very large multinational companies—have enormous wealth and political power. The global pharmaceutical market was estimated ten years ago at about US\$20 billion per annum although, when all drug expenditure is taken into account, it can be as much as \$400 billion (Angell 2004a; Angell 2004b).

The concerns about the power and influence of drug companies are exacerbated by globalisation and the influence of companies across national borders. In Australia, for example, which has a well-established drug evaluation program that limits the extent to which drugs can be subsidised by the national health system, drug companies have challenged decisions of the Pharmaceutical Benefits Advisory Committee (e.g. in not admitting new drugs when an equivalent generic drug

was available) arguing that the decisions are constraints on free trade (Quiggin 2010). There is further concern that a new Trans Pacific Partnership will add to the pressure (Sheftalovich 2015).

Whilst John Le Carré's novel *The Constant Gardener* presented an extreme (fictional) account of corrupt behavior by pharmaceutical companies, it is apparent that there have been many instances of corruption in reality (Croeger, 2014). To cite just one example, GlaxoSmithKline (GSK) received a record of \$489 million fine for paying bribes to doctors to use their drugs (Jourdan & Hirschler, 2014). The questions are how did GSK get the doctors to order its products? And what has happened to the medical professionalism of doctors? It appears that part of the answer is that doctors' professionalism has been compromised by the influence and power of the pharmaceutical industry.

There are also concerns about trans-national clinical trials of drugs (Lang & Siribaddana 2012). The availability of a large drug-naïve patient population and well-trained medical professionals, coupled with sophisticated technological infrastructure, has made developing countries like India attractive destinations for conducting global clinical trials. Jayaraman (2004) reported that many clinical trials are conducted in a "*rash and risky*" manner, which raises questions about the professionalism of the investigators and their regulatory bodies.

A major issue is that most of the marketing efforts of pharmaceutical companies are "*focused on influencing doctors, since they must write the prescriptions*" (Angell 2004a). For this reason, multi-national drug companies have directed their marketing efforts at doctors and have been lavish in supporting them with travel, research grants and gifts (Macneill, et al. 2010; McNeill 2006a; McNeill 2006b; Henry 2005; Doran 2006).

A. The power of the pharmaceutical industry

The consequences of the global influence of drug companies are enormous. These include the growing cost of medical treatment to which pharmaceutical products contribute the greatest proportion. Yet "prices are much higher for precisely the people who most need the drugs and can least afford them". Angell accuses the pharmaceutical industry of "rapacious pricing and other dubious practices" and claims that the "prices drug companies charge have little relationship to the costs of making the drugs and could be cut dramatically without coming

anywhere close to threatening R&D” (Angell 2004a). Whilst the health professions (nursing, pharmacy and other contributing professions), within individual countries, have very little power to influence these practices, they directly impinge on their professionalism by distorting the ability of the professions to put the health of patients ahead of all other considerations. Globally, we as citizens have allowed drug companies to predominate in putting profit ahead of health.

B. Independence of medical schools

A principal concern is that the independence of the medical profession, and medical schools, have been compromised through their relationships with big Pharma—a relationship which has “transformed the ethos of medical schools and teaching hospitals” (Angell 2004a). Medical schools have become dependent on the pharmaceutical industry to support research and, in many cases, for direct support in capital development. It becomes increasingly difficult to maintain independence, let alone a critical stance, at the risk of losing significant funding. And for many reasons, as Angell points out, there “has been a growing pro-industry bias in medical research—exactly where such bias doesn’t belong.”

What can be done?

Angell makes a number of propositions to counter the undue influence of drug companies on the cost and provision of drugs and on their undue influence on the medical profession and medical education (Angell 2004b). Many of these are aimed at the need to “break the dependence of the medical profession on the industry. She also advocates that *“citizens should know what is really going on. Contrary to the industry’s public relations, they don’t get what they pay for. The fact is that this industry is taking us for a ride, and there will be no real reform without an aroused and determined public to make it happen”* (Angell 2004a). Medical doctors, however, need to be independent in their judgment and should treat the claims of pharmaceutical companies with skepticism. They have a professional obligation to put the interests of their patients, and the health of the community, above all other interests. Reddi (2013) described new guidelines for the disclosure of industry financial ties and modeling professionalism during medical education.

CONCLUSION

Globalisation has its benefits in creating a more cohesive world with more porous borders, but it has blurred the definition and practice of medical professionalism. Proponents of globalisation argue that it allows poor countries and their citizens to develop economically and raise their standards of living. Harden (2006) suggests globalization is the way to go for future Medical education. Opponents of globalisation claim that the creation of an unfettered international free market has benefited multinational corporations in the Western world at the expense of local enterprises, local cultures and common people. In assessing globalisation's effect on professionalism, there is a need for appraisal at the intrapersonal, interpersonal, and institutional levels and for evaluation of its effect on society at large (Brian 2011). Profession must recapture for itself the critical function of what constitutes excellence (Heller 2012) and aligning the goals of the organization and instill cultural change and improve professionalism (Updegraff 2013).

TAKE HOME MESSAGE

Globalisation comes with some benefits for the global practice of medicine and for medical education. Globalisation, however, has negative effects. It is driven, in part, by pressures to maximize profitability across national boundaries. It has added to tendencies for profit (and economic considerations) to predominate over concern for human well-being. Between countries, there are fewer controls and safeguards. As a consequence, medical professionalism and medical education have major challenges in maintaining patient welfare as the primary commitment. Whilst the benefits of globalisation are many and welcome, the harms are also considerable. Governments and their various institutions of health should be alert to these and put adequate safeguards in place to ensure that the profit motive is not permitted to undermine other major priorities of national importance, including priorities of health and education.

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