Health professionals as vendors: the commercial erosion of evidence and ethics

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With the discussion paper from the ongoing *Review of Pharmacy Remuneration and Regulation* still open for public input, there is an opportunity to reflect on how the services currently delivered by community-based pharmacies in Australia can be improved.

Some of the questions up for discussion concern the ways in which pharmacists and patients navigate pharmacists' dual roles as retailers and dispensers.

In the post below, bioethicists Wendy Lipworth, Christopher Mayes and Ian Kerridge discuss what is at stake when therapeutic and commercial boundaries are blurred, and deliver a warning to other health professionals who might consider the addition of merchandising to their professional portfolios.

Dr Wendy Lipworth, Dr Christopher Mayes and Professor Ian Kerridge write:

A national *Review of Pharmacy Remuneration and Regulation* is currently underway. The review, initiated by Federal Health Minister Susan Ley and led by Productivity Commissioner, Professor Stephen King, is part of the of Sixth Community Pharmacy Agreement between the Commonwealth and the Pharmacy Guild of Australia.

Balancing activities and roles

In July this year, the Review panel released a Discussion Paper, asking stakeholders to consider a wide range of issues affecting the community pharmacy sector in Australia. Among these, stakeholders were asked to reflect upon whether there should be limits to pharmacists' retail or "front of shop" (as distinct from dispensing) activities and whether Government funding should take this balance into account.

Underpinning these questions were concerns about "the possible conflict of interest between the 'retail' and 'health care' environment" (page 25), the "tension between treating consumers as customers or patients" (page 47), and whether "the 'retail environment' within which community pharmacy operates detract(s) from health care objectives" (page 47).

More specific concerns were raised about the revenue generated from the sale of over-the-counter (OTC) medicines and complementary products. It was noted that many of these products "do not have evidence-based health benefits" and that their sale in a pharmacy setting "may misinform consumers of their effectiveness and undermine the professional integrity of community pharmacists"(page 47).

In response, George Tambassis, National President of the Pharmacy Guild of Australia, was quoted in the *Sydney Morning Herald* as saying that attempts to limit or otherwise disincentivise front of shop activities were simply ideologically-driven, and would dismantle a good system—which he defined on the basis of positive customer satisfaction surveys and the high level of trust in pharmacy professionals.

Professional standing, public good

We believe that Tambassis is wrong on a number of counts. First, simply labelling an argument as "ideological" is not a sufficient basis for its refutation. Indeed, complaints that arguments are "ideological" are usually themselves ideological. Second, the fact that there are high levels of trust in a particular professional group does not mean that the trust is informed or valid (i.e. reflective of the fact that pharmacists genuinely have their customers' best interests at heart) – or that this trust cannot be eroded. Third, while customer satisfaction may be a valid measure of commercial or professional transactions, these ratings do not necessarily reflect the quality of professional care or the impact of transactions on health and wellbeing.

The fundamental error that Tambassis makes is that he fails to understand the moral anxiety that underpins the questions posed in the Discussion Paper—that commercial activities of pharmacists and pharmacies might ultimately undermine both their professional standing and their contribution to public goods. (1)

Professionals are thought to possess skills that carry with them moral duties that go beyond economic transactions. As a result, relationships between professionals and those to whom they have a duty are expected to be based on trust and fidelity, as opposed to an economic

exchange between a customer and provider.(2) In the case of health care, the professional duty is towards patients and the public, and the concern—expressed implicitly in the discussion paper—is that private economic interest will skew and undermine these duties. While this may not lead to the unravelling of society (as Emile Durkheim argued in the 1890s(3)), the erosion of trust in health care professionals is likely to have impacts on patient wellbeing and public health that may well not show up in 'customer satisfaction surveys'.

Lessons for the medical profession

It would be easy for doctors reading about the *Pharmacy Remuneration and Regulation Review* to feel morally superior to pharmacists, and not vulnerable to the same criticisms. From classical times, doctors have made an effort to distinguish themselves from other health professionals by emphasising their *episteme* and ethics—i.e. their understanding of illness and commitment to patient care. While doctors have always sold their services, in general it has been other professional groups, most notably apothecaries, who have manufactured and sold medical products.

Over the past 50 years, however, this separation has become progressively eroded as doctors now frequently engage with, and benefit financially from, their interactions with industry in both research and clinical settings. The most obvious example of this—and the one that has attracted the greatest attention—is the relationships that medical professionals have with the pharmaceutical industry. Another example is the growing number of doctors practicing "integrative medicine", some of whom also sell supplements and various other kinds of complementary and alternative medicines (CAMs).

It is difficult to demonstrate conclusively that patients are harmed by doctors who have financial interests in pharmaceutical companies or CAM products; for this, we have to rely on a body of indirect evidence that doctors and researchers who interact with industry demonstrate attitudes and behaviours that are not always in the best interests of patients or the public.

The same is not, however, true of the increasing number of doctors manufacturing, selling and administering unproven stem cell "therapies" for conditions as diverse as osteoarthritis, cerebral palsy, multiple sclerosis, and dementia. This point needs no justification beyond the recent case of Sheila Drysdale, an Australian woman who died from bleeding associated with a liposuction procedure that was being undertaken solely in order to extract stem cells to "treat" her dementia.

None of this is meant to demonise doctors who earn a living, who innovate, and who interact (in limited ways) with health-related industries (to do so would be simply play into George Tambassis's point about "ideology"). However, we do believe that the medical profession needs to take seriously the inevitable conflict of interest that occurs in the context of medical merchandising.

The debate about pharmacists' professional roles and responsibilities should prompt doctors to look closely at at the ways in which the boundaries between profiting from time, skills and services, and profiting from products, are currently being blurred.

References unavailable online:

1. Friedson E. Theory and the Professions. *Indiana Law Journal* 1989; 64: 423-433.
2. Macdonald K. The Sociology of Professions. London: Sage, 1999.
3. Durkheim E. Professional ethics and civic morals. London: Routledge, 2013

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