Unholy nexuses in general medical practice

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It is a matter of concern that general medical practice as it should be is slowly disappearing in our country, especially in the urban areas. There are many reasons for this. Specialisation has a glamour and prestige attached to it, as a result of which specialists also make more money than do general practitioners (GPs). GPs also have (well founded) fears of professional isolation as they work in the community and specialists from institutions. There are no clear-cut geographical distinctions between the work of GPs and specialists; in many areas specialists have taken over work that GPs should be doing by right. This particularly true of obstetrics, minor surgery, most of paediatrics, quite a bit of ophthalmology, ENT and psychiatry

There was a time that GPs provided all these services, led fairly fulfilling lives and were respected for their service to the community. They could also make a reasonable living without resorting to the dubious practices which have now crept into their arena. It is no consolation to know that these unhealthy practices exist in specialities as well.

To some extent one can blame the general lowering of standards of ethics in all spheres of public life. After all, doctors are products of the same society. However, certain trends have contributed to the moral and professional degradation of medical practice in general and general medical practice in particular.

Fee splitting

This appears to be the norm rather than the exception in the country's major metropolises. No one is willing to talk openly about this practice, and I suspect the reason is that most are a party to it. Nevertheless fee splitting exists and, if I may use the word, 'flourishing'. There are various ways in which it is done. Let us take these one by one.

Laboratories and hospitals pay referring doctors (both general practitioners and consultants). The percentage of payment can be 10 per cent to 20 per cent or more of the total charges. This is usually paid in cash, in which case it is unaccounted, but it is also paid openly by cheques. If a doctor were to tell these institutions not to pay him but deduct the amount from the patient's bill, most will not oblige. That is the reason some of my colleagues put forth for accepting this consideration. I know one of them ploughs it back into his charity work. This places GPs in a dilemma (consultants too). If they direct the patient to a diagnostic centre that agrees to their terms and gives the patient the benefit, it may be inconvenient for the patient, besides which they may also have to explain their choice. This can be awkward and patients may not believe them.

Consultants also pay general practitioners a percentage of their fee. I believe this practice exists but I don't know the extent of this practice.

Then, pharmaceutical companies pay doctors, in kind or otherwise. This type of fee splitting is widely prevalent and no doctor is exempt from this. All of us including myself have attended continuing medical education programmes supported by pharmaceutical companies. But the practice extends beyond such sponsorship. Selected doctors are wined and dined and even taken out of town to attend professional conferences with private pleasures thrown in. The question is how far we can go in accepting such sponsorships.

Recently we (the Indian Association of General Practitioners, a 25-year-old body of Bangalore-based GPs) introduced the concept of 'paying for your learning' in our monthly CME programmes. A separate register was kept where doctors attending the programme paid an amount of money which was not fixed. Many people pay, but many don't as we have intentionally kept it optional for the present. This takes care of some of our expenses we are still dependent on sponsorship. Ideally there should be no sponsorship and we should pay for our learning.

I know of no GP who can really afford to stay out of town in a reasonably good hotel and attend, on an annual basis, the conferences which are so essential to update oneself. The few conferences that they attend once in a blue moon are a financial strain. When an offer comes from a pharmaceutical company to host them and perhaps their families, will you blame them if they accept? In any case, such offers usually come to the consultants, not the GP. Then how do we educate ourselves? The only solution is to organise such programmes locally with local resources as we are doing in Bangalore. They are still not entirely free of sponsorship, but we are heading slowly in that direction.

Let us see where this pernicious nexus is taking us. Doctors who take these kickbacks will always be on the lookout for patients whom they can send for investigations, interventions or hospital admission. Their abilities to think, diagnose and treat the patient erode over the years and they become qualified referral clerks and qualified quacks. Patient end up paying more, without knowing that some of this money is going back to the referring doctors. There is a widespread suspicion that the profession is not playing fair. This will eventually become common knowledge and the vestige of respect that the profession commands today will go. Doctors who don't split fees will be bracketed with those who do, and the entire profession will come to disrepute. Patients will be afraid to come to us, fearing that we will unnecessarily prescribe tests and perhaps even create illnesses where none exist. Doctors who accept the hospitality of pharmaceutical companies and/or equipment manufacturers are beholden to use and prescribe these products. They may of good quality but the expenditure incurred on hosting the doctors is built into the cost of the item and the end user, the patient ultimately pays.

Hospitals and diagnostic centres with crores of rupees invested will adopt or adopting aggressive marketing techniques to entice more and more doctors into this path

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of easy money. A cardiologist friend of mine bemoaned that people will treat us as traders not professionals. I am afraid this is already so. Salespeople employed by diagnostic centres and hospitals are approaching us with proposals. Recently I informed one such young woman that what she was proposing was wrong, and also explained why this was so. Unfortunately I failed to convince her. She felt it was an excellent business proposition and I was foolish (or naïve?) to refuse it.

I put up a query in our website's forum board (www.iagponline.com) asking doctors whether it is justifiable for hospitals to give a percentage back to the referring doctor. It is nearly three weeks and not a single doctor has responded. This silence speaks volumes.

The major casualty is our self respect as professionals. These practices bring us down from the high moral ground that this profession occupies – or occupied. Already, when a doctor prescribes a procedure or treatment, the patient doubts if it is really needed. There is a justifiable suspicion that such procedures are suggested to help doctors and institutions, not patients.

What are the remedies? Can fee splitting be made legal in the sense that the patient knows he is paying an indirect commission to the referring doctor? Is this going to solve the moral issues of right and wrong? Pharmaceutical companies can make public their expenditure on individual doctors and associations of doctors. Will this expose help? I have no easy answers to these but current trends make me extremely uncomfortable.

Unwanted treatment and investigations

This is another issue that is causing harm to our image. Medication and Investigation are linked to effective patient management. Unfortunately they are also linked to our income, and strangely, to the psyche of our patients and doctors.

Let us take the example of a new patient who comes to me with a cough as the presenting symptom. I find there is normal air entry into his lungs, no abnormal chest sounds, normal peak flow rate, normal ear, nose, throat and my logical conclusion should be that the patient has an allergic cough and it is probably self limiting. I also know of the recent *BMJ* article debunking most cough syrups containing antihistamines as next to useless. So if I am honest, I will explain to the patient that the illness is likely to be self limiting nature, advise him that no treatment is required at present, and request him to return if he gets worse, develops fever or his sleep gets disturbed. Then the treatment will be with inhaled corticosteroids or antibiotics. If my practice has an element of consultation then I will collect a fee for this service. The patient then thanks me and will promptly go to another doctor.

Let us assume that this doctor is well informed. He will, after examination, dispense some medicine or give one of the many cough syrup samples he has with him, or prescribe one of these syrups. He is also likely to give an injection of vitamin B complex. If the patient has the fortune or misfortune of going to a consultant, he will most likely get a prescription for a cough syrup and a note to get a chest x-ray and blood studies. What is dispensing and injections for a GP is investigations for a consultant. Most cases both are unnecessary but the patient is likely to be more satisfied with that than what I did. I leave it to the readers to guess who made more money.

Many of us do this instead of educating patients. Generations of doctors have kept the whole nation ignorant of basic health matters. If I want to be uncharitable I would say that in their ignorance lies our prosperity. A well informed patient will demand treatment after being informed, and explaining a problem will mean spending lot more time. This will mean seeing fewer patients and maybe less money. The ignorant patient who believes in the magical powers of an injection or the diagnostic accuracy of the X-ray will only be satisfied if these are done.

Based on these facts a huge industry has sprung up which manufactures equipment and drugs used mostly for placebo value. Go and see any diagnostic centre and evaluate 100 consecutive X-rays and I guarantee that not even 10 per cent of them will be abnormal. I will not be far wrong if I stretch this to almost all investigations which will include CT scans and TMTs and may be even angiograms.

Should we the medical community allow the perpetuation of such unethical practices? Should we continue to take ethical shelter under the garb of patient satisfaction? Or should we try and educate patients? Is it impossible to earn a reasonably honest and decent living without resorting to these methods?

Unethical therapists

The writer who works with a Delhi-based telephone helpline on reproductive and sexual health reports on callers' feedback on mental health professionals. A caller says she feels suicidal *after* meeting her therapist. A couples therapist advises the husband to be physically aggressive in sex, tells a woman client who doesn't want children that she is not 'normal'. "It is frustrating to know that these unethical, insensitive and incompetent professionals continue damaging people and are not held accountable. They need to be exposed and tried by a peer committee of credible mental health professionals."

Deo SS. 'Save me from my therapist…' *AAINA mental health advocacy newsletter* 2001; 1: 17.