# CORRESPONDENCE

## Problems with private pathology practice

I have read the article entitled 'Why I don't believe in referral commissions' by Arun Sheth (1). What struck me as odd about this piece was the fact that we now need to justify the 'right thing to do'. The very fact that doctors who don't give or take 'cuts' are a minority nowadays speaks badly enough of our 'noble' profession. But that we now need to find reasons and justifications for doing the proper things is truly a serious cause for introspection. It appears that a wrong done over and over again by a large number of people, and highly educated people at that, soon becomes the order of the day. Hence, doctors who 'don't fall in line' risk greater marginalisation from the mainstream. They take too long to establish themselves and some finally just give up and change professions. This is especially true for people like us who have dependent practices like pathology.

Let's look at some facts in the pathology 'business'. Technician-run laboratories are prepared to go to any lengths to secure their 'business'. Although it is degrading for qualified pathologists to compete with technicians, there is no other way because even top consultants accept these reports (sometimes even unsigned ones) from technicians. We even have a few technicians requesting us to report their peripheral smears or cytologies or even biopsies which means that even these investigations are sent to technicians' labs and not to pathologists. The flip side is that when it comes to the consultant's own relatives or friends they always come to a pathologist even for the simplest of tests. What's good enough for other patients is not so for the doctor's kith and kin.

Consortium-owned labs or group practice set-ups are the 'in' thing. Here, doctors invest money together in a diagnostic set-up and then send long lists of investigations for kickbacks and incentives. (From the layperson's point of view this is viewed as hunting in packs.) I think the main issue here is the percentage receivable, rather than what is necessary for the patient. It is one thing to make a project viable, quite another to burden the patient for your personal gain.

Then comes the choice of the patient to go to any lab. Due to the nexus that exists between the clinics and labs, unless a patient comes back with a report from a particular lab, he is subjected to another battery of tests with the explanation, 'These tests are wrong; why didn't you go to the other lab?' The poor patient fears the wrath of the doctor and does as he is told, in the process compromising his right to choose where he wants to go.

I have even heard of places where *rickshawallahs* and drugstore owners are roped in to direct patients. This absolutely unethical way of 'soliciting clients' just proves to what lengths we are now ready to go to succeed in our profession. It is even more depressing to think how the big reference labs have affected small private set-ups like mine to compete with their prices, especially when nobody cares about the quality of reports that these labs have to offer.

Thus, it is becoming very difficult to practise pathology in a clean manner. It is the patient who is being taken for granted all the time. I have managed so far to keep myself away from these practices but always get an 'explanation' from my male colleagues that it's because I am a woman and don't have to 'support' a family. I think we must take steps to create a space for ethical doctors to be able to earn a living while practising their professions with dignity and self-respect. In this, I feel the National Accreditation Body for Laboratories must play an important role and laboratories must be licensed and accredited.

Meanwhile, to those who wish to practise market-medicine, I wish you much happiness in your endeavours. But remember what Gibbon said: 'The first and indispensable requisite of happiness is a clear conscience, unsullied by the reproach or remembrance of an unworthy action.'

### Reference

1. Sheth A. Why I don't believe in referral commissions. *Issues in Medical Ethics* 2003;**11:**58–59.

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## Audits of electroconvulsive therapy

Waikar et al. (1), in their diatribe against ECT (electroconvulsive therapy) in general, and unmodified or direct ECT in particular, were shocked that our institutional ethics committee permitted an 11-year 'study' of unmodified ECT (2), where patients whose 'fearful refusal of a hazardous and life-threatening procedure' were 'considered as a mere symptom of insanity, and further treated with sedatives'. They were appalled that ECT was given to children, elderly and pregnant women. They contend that our report trivialised the 'horrific' physical complications with direct ECT and 'the costs of disability days following ECT'. They wonder 'why presumably rational scientists produce such irrational arguments to safeguard a scientifically dubious and highly hazardous procedure', concluding that it is because we 'make a lot of money by giving ECT'.