The great divide: 'Private' versus 'general' patients

The differential treatment between 'paying' and 'general' patients is obvious in a hospital which provides both services

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Working in a hospital where patients are dichotomised into "general" or non-paying and "private" or paying patients brings up some interesting questions and has stimulated my thoughts on this issue. Most hospitals in India belong exclusively to either the private or public sector. Such a stark contrast within one hospital is therefore unique.

Let me illustrate with a typical case history. X is a non-Bombayite, hailing from one of the Northern states, who has been referred to this large hospital in Mumbai. He walks into the hospital accompanied by two relatives from his home town, with a lot of hope, and becomes a general patient. He expresses a wish to meet the doctor to whom he has been referred, and is informed by the junior doctor that consultants see private patients; the best way to get a consultant to see him is to become a private patient.

However, X has been told that the only hope of treating his disease is this hospital, so he holds every doctor he encounters in great awe. He is seen by a junior member of the staff (usually a resident doctor) in the outpatient department, and is asked to get a string of investigations done. So far so good. X's morale is boosted; things are moving in the right direction for him at last.

The process of getting investigations continues much longer than he had expected. Finally he is told that it has been proven that he has a malignancy and needs surgery. What a relief, he thinks to himself. At least he can have the surgery now — but will the senior doctors at least see him once before the surgery? He is once again reminded that they are being consulted, and that they do not have the time to see him as they are busy tending to more important matters.

By now he has had a good taste of this discrimination, right from having his blood tested to having an endoscopy performed by the same junior doctor. He has had the privilege to catch a glimpse of the elusive consultant, who does not seem to register his presence at all. He visits the outpatient department once a week to get a date finalised for surgery — it has been three months now. He watches himself withering away; the weekly injections have hastened the worsening of his condition; they seem to be just eye-wash to buy some time for surgery.

> The message to patients and all involved in their management: "wealth is health"

Along the way, the realisation slowly dawns upon him that if he were a private patient he would have been operated upon by now — and it would have been more economical to do so than to live in Bombay with two relatives for more than two months.

He goes to the outpatient department once more, now reduced to half the size of what he was when he first came to the hospital — and is asked to get the investigations repeated to monitor the disease's progress, since it has been quite some time since he was first assessed. This report shows that the disease has advanced considerably. He is declared inoperable, given painkillers and sent home.

Contrast this scenario, with that of a patient Y with a similar disease -- except that he can afford private treatment. He is seen by the consultant the very next day and is investigated completely within a week. In a month's time, he has been operated upon and is on his way to a speedy recovery. The treating doctor tells him he was lucky to have the disease detected early and removed in time!

These illustrations may be extreme examples but are not uncommon occurrences in hospitals with such a dichotomous system. The message is conveyed loud and clear, to patients, and all those involved in their management: "wealth is health". Of course, one may argue that there is nothing wrong in that. We live in a consumerist society, and market principles guide all spheres of life, including medical care. However, is this justifiable?

There are several issues involved in such a dichotomised system of practicing medicine. The very act of treating two individuals with a similar disease in a different way goes against the scientific and ethical principles which are supposed to be the guiding forces in the practice of medicine. The practice of wooing the paying patient goes against the professional virtues of honesty, accountability and respect for the patient irrespective of his social status. People will lose all confidence in the doctor when profit is the driving force of medical practice.

This affects medical education and training as well, when such hospitals run teaching programs and award degrees and diplomas. Doctors spending most of their day furthering their private practice have little time for formal teaching. Most work done by junior doctors is unsupervised. Consultants rarely see general patients and never perform surgeries or procedures on them. As a result, general patients are always at the mercy of relatively inexperienced junior residents.

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When the same consultant who is brusque and busy when walking past patients in the general wards is full of politeness and charm with private patients, this inculcates commercial values in the junior faculty, as they see their role models pandering only to the well-to-do.

Though the proportion of general and private beds and operation tables is supposed to be commensurate with the number of patients seen in such hospitals, this fair distribution is not strictly enforced. The waiting period for a definitive procedure like surgery therefore is not the same for paying and non-paying patients.

I recently had the opportunity to observe paying and non-paying patients under the same roof during a year's stint at a liver transplantation unit in the UK. The waiting lists of patients needing a liver transplant were prepared according to their medical urgency, not their payment status. This practice was strictly monitored and enforced. In fact, private paying patients from abroad were at the bottom of the waiting list, and in a sense transplanted last.

It can be argued that it is difficult to ensure an equitable distribution of health services unless we have some form of socialised medicine. Also, in predominantly private hospitals the few general beds are rarely accessible to poor patients since they are being used by private patients.

One could argue that the private patient, who is paying heavily for his health care, deserves the best -- better than another who does not pay at all or less. And educational institutions depend by and large on paying patients for their resources. Finally, the very survival of several such institutes depends on the paying patients. The relatively higher cost of treating the poor, and the possibly lower success rates, create a conflict between cost-effective allocation of limited resources and ethical practice of medicine.

The solution needs far-reaching changes in the entire medical system, as we as medical professional perpetuate the class divide in society in our day-to-day practice. However rational and ethical principles demand that the following guidelines be enforced:

♦ There should be a regular auditing of the number of procedures performed on all patients -general and private — the number of ward/ICU beds occupied, the precise nature of disease, nature of treatment, waiting period, and outcome. A fixed ratio of general to private patients must be enforced especially when it comes to procedures. Any glaring disparities should be accounted for.

♦ Consultant staff must be required to assess all patients at least once before a final decision on the case is made.

♦ There should be a mechanism of direct supervision by the senior doctors concerned of the work done by the junior doctors.

♦ All hospitals should have a functioning patient redressal forum made up of members of the senior faculty, a social worker, member of the junior staff and the head of the institution.

♦ All such hospitals should be required to hold a minimum number of teaching sessions.

Even if one accepts that the market economy has come to stay, efforts can be made to treat patients on the merit of their disease, not their paying capacity. A more fundamental change can come about only by changing attitudes of senior doctors who serve as role models for the junior staff and help shape the attitudes they will carry for life.

Suggested reading

1. McArthur JH, Moore FD. The two cultures and the health care revolution. Commerce and professionalism in medical care. *JAMA* 1997; 277(12): 985-989.
2. Braithwaite SS. The courtship of the paying patient *J Clin Ethics* 1993; 4(2): 124-133.

X-raying the radiologist

It's a little over a hundred years ago
That Wilhelm Roentgen discovered
the hitherto unknown rays
That passed through living tissue
including bone,
To cast a shadow on film.

Over-enthusiasm and carelessness,
however,
Soon showed up the darker side of
this mixed blessing,
As radiation dermatitis was followed
by cancer,
Leading to amputations
that were, at times, too late.

Worse, the breast and bone marrow,
Sensitive to the carcinogenic action
of ionising radiation,
Spawned carcinoma and leukaemia
As diagnostic tool turned into
pathogenic enemy.

Many radiologists, however,
Continue to use this money-spinning
engine,
Touting 'early detection screening
programmes'
For the very disease produced by
these deadly rays.

Few follow guidelines for safety
Laid down by BARC,
Exposing hapless patients
To death-dealing doses.

Who will ensure continued vigilance
Or sincere implementation
Of rules and regulations,
Proper maintenance,
careful shielding?

Will the body radiologic
Awaken to this crying need,
Or will the cry, once again, be
Caveat emptor *- let the buyer*
beware?

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