Whither medical ethics?

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(Editorial *note:* Dr. Anantharam is a senior and respected consultant surgeon. His repugnance of the depths to which the malpractice of medicine has sunk has found expression in this essay.)

The origins of malpractice

On reading the article by Dr. V. Murlidhar ***(Medical Ethics*** Vol. 1, no. ***2,*** pages 1-2, 1993-94) I feel compelled to offer my own experiences during practice in Bombay over the past twenty-five years. Any resemblance to persons living or dead is deliberate.

Paying commission by a consultant to the general practitioner has been firmly established in this city over the past fifteen years. The practice started in the form of parties thrown by the consultant for those referring patients to him. Whisky and other alcoholic drinks soon became vital ingredients on such occasions. Payment of cash followed and was made by the consultant after he had seen and treated a patient referred by the practitioner. The current system involves payment of a large sum to the practitioner as a deposit on the basis of which patients are referred. Failure to renew the deposit after the agreed number of referrals has been made by the practitioner puts an end to such referrals.

Worse was to follow. Here are examples of some current practices.

Fraudulent diagnosis, treatment:

Abdominal pain = appendicitis. All patients with pain in the abdomen are referred by a general practitioner to a particular surgeon at his nursing home. He, in turn, makes the uniform diagnosis of amoebic hepatitis with appendicitis. The patient is immediately admitted to the nursing home. The initial therapy is in the form of intravenous infusions of metronidazole. This costs the patient Rs. 3500. Rs. 900 is passed on to the referring practitioner. The patient is told of the need to get the vermiform appendix removed six weeks later. When the general practitioner visits the nursing home after this operation, the consultant hands him an envelope containing Rs. 1500.

The hernia that never existed. A particular surgeon is attached to a recruiting agency for jobs overseas. He makes a diagnosis of hernia in thirty of fifty individuals examined by him and indicates to them that unless they get the hernia treated, he would be forced to label them medically unfit. He offers to arrange surgery at a concessional rate. Each 'patient' is admitted to a nursing home where, under general anesthesia, the operation theater sister makes and sutures a skin incision in the inguinal region whilst the surgeon and anesthetist enjoy a cup of tea in the adjacent side room.

How to insert urinary calculi into a patient. A particular urologist insists on being present when his patient undergoes x-ray tests for urinary calculi. Whilst positioning the patient 'so as to get optimal pictures' he surreptitiously places a calculus in such a way that it casts a shadow in the region of the kidney. This single antero-posterior film is all he needs to make and demonstrate his diagnosis to patient and family and proceed to surgery.

Hijacking the patient: A child is referred by a general practitioner to a surgeon for circumcision. The surgeon asks for preoperative tests - complete blood count, analysis of urine.. bleeding time and clotting time. When the child emerges after the pathology tests. a 'well-wisher' accosts the parents and advises them to see another surgeon in the building housing the laboratory. This surgeon convinces the parents that an immediate operation is necessary and goes ahead with it. The original surgeon requesting the tests is neither consulted nor informed.

Operating when a fatal outcome is certain: A neurosurgeon is known to welcome patients with severe intracranial hemorrhage. Despite findings on clinical examination and computerised tomography of extensive deep cerebral and brainstem damage, he tells the relatives of the patient that he might just be able to save the patient's life by major intracranial surgery at a cost of Rs.20,000. The patient is then taken to the operation theater and kept there all night. He is brought out in the early morning with an endotracheal tube in place and declared dead. There are also instances where after collecting Ks. 20,000 - which appears to be his standard fee - he transfers the patient to a general hospital in a terminally ill state.

Why should we record these facts?

I was trained by teachers who excelled in ethical medical practice. I have striven to follow their examples and am fortunate in having earned not only my bread-and-butter but also peaceful sleep each night.

I am hurt and saddened that my profession is now worse than a trade for there is some honesty and decency even in commerce.

As I see patients ill-treated, fleeced and then sent to me at the Sion Hospital I wonder, 'Whither medical ethics?'

Silence will only worsen an already abysmal state. Placing facts before the public may prompt protests, careful monitoring of our deeds by watchdog agencies and public-spirited citizens. Perhaps - and I am very unsure of this - medicine will then return to its original purpose of healing the sick and benefiting mankind.

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