General practice: some thoughts

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Family practice is perhaps the oldest form of modern medical practice. It also involves the largest number of medical professionals. In India, where around 70 per cent of health care is now delivered by the private sector, family physicians form the largest group of health care providers coming into first contact with the patient. In that sense, the scientific and ethical temper of this group of practitioners has a major impact on health care. Any attempt to change prevalent norms of medical practice should necessarily therefore grapple with the aspirations and concerns of family physicians.

Because of their close contact with the community, family physicians also occupy a crucial position in preventive and social aspects of health care, an important area for those who believe in a wider definition of ethics.

My personal impressions of family practice began very early in life as my mother has been a general practitioner for the last 40 years. I grew up in a setting in which most of our family friends were general practitioners (GPs). As is often described about general practice of the past, those were the times of family physicians who were simple and friendly, and who offered their services at a low cost and in a low-key style, in small clinics and without much of the marketing paraphernalia that now characterises medical care. A large number of GPs served the working class both directly and through the employees state insurance scheme and themselves led a middle-class lifestyle.

Decades later, as a specialist in Mumbai's private sector, I now interact with GPs at a different level. However, my impression of many GPs remains largely the same. In fact, as opposed to specialist practice, family practice still relies the least on marketing gimmicks and has the strongest doctor-patient bonds. GPs are the only source of immediate medical care to the millions in Mumbai's slums. In fact, because of their close bonds with the community, there are many examples of GPs becoming politically active and even becoming elected representatives. For example, trade unionist Datta Samant's interest in organising workers originated from his close interaction with quarry workers who were his patients. A few years ago, Dr Natu was elected as an MLA from Konkan in Maharashtra, based on his popularity as a family physician.

Some may perceive this rather 'simple' style of family practice as resistance to change. In my opinion, this simplicity is actually a strength. Such a patient-friendly and community- based form of practice can be an effective counter to the excesses of privatisation and market medicine that we are beginning to see with the emergence of hi-tech, specialist care. However, does family practice today play this role?

Fee-splitting

From the accompanying articles, it is obvious that there are many practices in contemporary medicine — perceived as examples of 'commercialisation' — in which family physicians are willing participants, along with the rest of the profession. There is no better example than what has been variously termed 'fee splitting', 'commisions', 'cut practice' or even 'referral fees'. It would not be an exaggeration to say that any discussion on the ethics of medical practice today inevitably veers towards this phenomenon. Although this practice involves many other players, any discussion on contemporary ethical dilemmas in family practice would be grossly incomplete without a look at this phenomenon.

It must be stated at the outset that the practice of giving commissions for referral of patients is not restricted to the GP-specialist interaction. It is now commonplace for commissions to be given by pathology laboratories, radiology establishments, equipment manufacturers and perhaps even institutions. In fact, even specialists practice a sophisticated form of commissions by referring patients to each other, often more as a 'return referral' than because there as a genuine need. Also, it is probably true that the idea of such commissions originated from aggressive specialists trying to increase their practice through commercial incentives.

One common justification of this practice is that such commissions are accepted in other professions (more precisely, trades) and in society in general; why should they be deemed wrong for the medical profession? Also, since we have accepted a privatised healthcare system in which healthcare providers decide how to charge patients for their services, what objection could one have if two of the players decide to share the fee?

These may be fair arguments in themselves, except that they assume that socially accepted rules for all professions apply to the medical profession as well. Historically, the medical profession has been given special privileges by society with the understanding that it has special responsibilities towards society. These include a commitment to provide affordable, quality care.

This is not to say that there is evidence that society objects to fee splitting. But then, has society been asked its opinion in any form? It has been argued that society need not be asked, since fee-splitting does not affect health care delivery. It is my contention, however, that such practices contribute to increased costs, and also affect the quality of care. When referrals are based mainly on commercial considerations, the merit of the referral (and in turn the quality of care) will suffer. Also, the battle for a share of the pie is reflected in an increased cost of care. Those who offer commissions increase their charges to maintain their share of the pie. Thus, this practice has definite implications for society.

In this case, as a profession (perhaps through our professional organisations) it may become necessary toinform the public of the practice of 'fee-splitting', and also rationalise and structure the system. If we do not do

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this, the public may form its own impression as to the extent of this practice, and its logic. This may add substantially to the profession's already diminishing credibility.

Hierarchies

Another phenomenon relevant for our discussion, which is articulated in some of the accompanying articles, is the presence of a very strong established hierarchy in the medical profession. To an extent, this is a reflection of the economic hierarchy in society itself. Thus you have a pyramid with the urban super-specialist at the top, the rural family physician at the bottom, and other healthcare workers — including nurses, health workers and other staff — in between at various levels. This hierarchy is also expressed in the relationship between practitioners of modern medicine and of alternative systems.

This hierarchy manifests itself in various forms, starting from something as simple as dress and style codes. Three years ago, when I became a 'consultant' in the private sector I was advised by many well-meaning friends to start wearing a tie – advice I did not receive in all my years as an associate professor in a medical college. For some time, I was routinely stopped by the security guards at some hospitals, perhaps because without the proper attire I did not fit into their image of a new consultant. Interestingly, some family physicians of my parents' age now call me 'sir', perhaps a reflection of the same hierarchy.

On another level, this hierarchy has other implications leads to discrimination and conflicts. Why should a new young consultant just starting practice expect to earn — and actually earn — more than a rural GP who has spent his entire life in practice? In this hierarchy, it is also assumed that those with more glamorous skills are higher up and therefore must earn more. I remember a cardiac surgeon once explaining that the reason they charge more than other surgeons do is because their skills are more 'sophisticated'. This hierarchy often leaves individuals dissatisfied if they cannot attain the economic 'status' of their peers, pushing them into questionable practices which may not be in the interest of the patient.

Family practice like other sections is, also a victim of this hierarchy. The effort to project it as a specialisation could be an attempt to counter this hierarchy. Also, GPs' demand for a share of the patient's fees, which are currently heavily loaded in favour of specialists, is also perhaps an assertion against this hierarchy. Add to this the pressure on today's medical professionals to lead an upper middle-class lifestyle (with all its trappings), and the ground for fee-splitting has been laid. Also, given the scenario of a marketised healthcare system, which involves monetary transactions at every step, the practice of referral fees gains a certain natural acceptance.

Thus, those who feel morally indignant about the 'cut practice' could do well to understand that the roots of this and other controversial practices lie in an increasingly privatised health care system, which allows the market and the profession to arbitrarily determine how doctors are going to charge their patients. It may be pertinent to point out that such a system is perhaps unique to India. Even in the free market economies, medicine and user charges have state controls Given this background, it is unlikely that there are easy solutions to the ethical dilemmas posed by fee splitting, and appeals to morality will certainly not get us anywhere.

Need for a debate

On the other hand, a beginning could certainly be made on the premise that — whether we consider them wrong or right – we must break the conspiracy of silence surrounding such practices. Medical associations need to debate these practices internally. If the practice is deemed acceptable, they need to come out with rational guidelines. If it is felt to be undesirable, and the root causes of its wide prevalence can be identified, an effort must be made to tackle these. For example, if the inequity in the fees of specialists and family physicians is identified as one of the driving forces behind fee splitting, an effort could be made to rationalise the fee structure. This will not be easy, but it will certainly enhance the credibility of those associations which attempt this exercise.

Otherwise, as has happened in many other instances, the state will step in at some stage, in response to public pressure. Already there is evidence that the the state, the judiciary, consumer groups and the public in general are becoming increasingly impatient with the medical profession's inability to regulate itself including the fee structure. As a result, laws covering all aspects of practice, including fees, are imminent.

An alliance of individuals from all sections of the profession including family practitioners, who believe in self regulation as a social and ethical responsibility, can take the lead in starting this debate. On their part, the ethics movement and people's health movements must provide the platform.