# An objective look at 'cut practice' in the medical profession

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### *Introduction*

All doctors qualified to practice modern medicine take the classical Hippocratic Oath before beginning their professional career. The idealistic values learned during the period of training get shaken up when the doctor steps out from a world of 'practice of medicine' to one of 'medical practice'. Here he sees 'practical' adjustments that he is required to make in his clinical and therapeutic decisions and encounters open offers of referral of patients for a predetermined and regularised practice of fee-sharing ('cut practice'). Since the schedule of charges for professional services is totally individualistic, the illegal and unaccounted fees to be given to the referring doctor usually get added on to the specialist's fees and are paid unknowingly by the patient.

How ethical is this practice? The subject is debated by doctors in social and academic get-togethers but a status quo has persisted with some doctors for and some against it.

### *Variations on the theme*

Cut practice occurs in many forms. I list some of them:

- Giving a share of fees to the referring doctor.
- Referring patients for unnecessary consultations or tests to ensure a kickback from the consultant or laboratory.
- Giving expensive gifts periodically to the referring doctor.
- Appointing junior specialists to a superspeciality hospital so that procedural work is always referred by them to you.
- Sponsoring of a conference or payment of travel expense by a company in return for the use of its equipment or prescription of its drugs.

If one reads the Hippocratic Oath carefully, there is no condemnation of the act of sharing one's fees with another doctor involved in the care of a particular patient. It is only by implication that the Oath stipulates that a doctor shall charge a reasonable fee and will not increase it for sharing it in order to obtain a larger number of referrals.

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### *Basis for charging fees*

***Every*** doctor determines his/her professional fees on the basis of experience, wisdom and self-perception of the level of skills required for a particular treatment. Fees thus vary widely from doctor to doctor. Hence a particular amount cannot be termed 'unreasonable' as long as the patient is aware of the sum to be paid before the service is rendered. What the treating doctor does with the fee after it is received by him is entirely and solely his concern and the patient or any other person has no say in it. Hence if a doctor decides to give a portion of his fees to another person (medical or nonmedical) it is entirely legal and ethical to do so provided this is done openly and after obtaining a receipt.

However such disbursements occur only in theory. In actual practice the referral pattern is based more on the fact that a particular doctor is ready to split his fees rather than that he is the best qualified to render a particular treatment. Several malpractices accompany such referrals. The limitations and scope of a particular procedure are not fully explained in advance. Patients are admitted to a hospital or nursing home in spite of the fact that the place is not adequately equipped to impart a standard of medical care available at another place in the area. Patients are referred to manifestly substandard laboratories. Reports from such laboratories are manipulated to suit the requirements of the referring physician.

Various specialised procedures - such as endoscopy, angiography, angioplasty - form lucrative sources of income and are therefore frequently advised even when the stated indications are not scientifically valid. (At times it is difficult for a doctor to say that the procedure advised by another was not required because on most such issues, opinions published in the medical literature support both points of view. There is truly no substitute for one's own competence and conscience acting as an internal judge and counsel.)

### *A malpractice that has come to stay*

Pernicious as it is, cut-practice has come to stay. ***The medical*** profession itself has nurtured it. Indiscriminate proliferation of medical colleges with open and shameless support of those in power is adding hundreds of inadequately trained medical graduates every year to the pool of practicing doctors. A large majority of these are concentrated in urban areas with attendant intense com-

petition and battle for survival which favour cut-practice.

In the absence of a clear, logical, bold and community oriented health care policy on the part of the government and a lobby of strong, honest, clear thinkers representing the medical profession in the corridors of power, the present situation is unlikely to change in the near future.

***Some practical alternatives***

- All financial transactions between doctor and patient must be above board with receipts being provided to the patient.
- Each general practitioner must charge a publicly stated fee from the patient for the act of medical examination, making a diagnosis and recommending appropriate treatment or referral to an appropriate consultant or hospital.
- A fixed percentage of the specialist's fees for procedures should be openly given to the family doctor on the ground that the latter will offer follow up care to the patient at his home after the procedure. This measure also transfers legal responsibility on to the family doctor for competent medical care.
- A body of experts in each hospital or nursing home should monitor the performance of various procedures to ensure that they are based on scientifically valid indications.
- Health insurance should be made compulsory and fees for various examinations, procedures, visits, etc. should be fixed from time to time by a committee of professionals consisting of representatives from the medical bodies, insurance companies, government and the legal profession.
- Medical councils at central and state levels should be given adequate powers to punish erring doctors even without a formal complaint. At present positions on such councils are used only to enhance one's prestige and members of the councils are almost completely incompetent.
- The annual output of medical graduates should be governed by actuarial data like annual loss of practicing doctors, density of doctors in a given area, the local population and its medical needs and so on. If an area has a supersaturated doctor/population ratio in a given speciality then the redundant doctors should be made to relocate to another suitable area.
- The monthly salary and other benefits of full time doctors especially in teaching hospitals should be such that they are able to maintain a decent standard of living commensurate with their position and seniority. There will then be no need or incentive for unethical ways of earning extra income. The present pay structure is insultingly low in this respect.
- Compulsory attendance by general practitioners and consultants at continuing medical education programmes will help to bring about uniformity of approach in management.
- An increased general awareness and education in society and fear of consumer courts will certainly act as an external deterrent as in Western countries.