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Doctors' Fees

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"Three faces wears the doctor: when first sought -
An angel's! And a god's, when the cure half wrought;
But when that cure complete he seeks his fees,
The devil then looks less terrible than he."
- Enricus Cordus (1486-1535)

How much is the relief of suffering or the saving of a life worth? There is no formula set in stone, although the oldest known code of laws, that of Hammurabi of Babylon (circa 2250 B.C.) did include a scale of fees regulating the payment of physicians. Excerpt: *"If a physician sets a broken bone for a gentleman or cures his diseased bowels, the patient shall give five shekels of silver to the physician. If he be a slave, the owner shall give two shekels to the physician..."*[1]

For the most part of history though, remuneration for physicians was not as strictly regulated. The ancient Egyptians expressed their gratitude with bartered goods or services[2]. Hippocrates advised making no excessive demands, but to take into account the means and income of the patient[3]. For curing the two daughters of king Proteus of Argos of their fits of hysteria, Melampus was given the hand of one of them and a third of the kingdom[4]. An inscription on the island of Cos records the granting of an honorary decree - 'a crown of gold' - to Metrodorus "who during twenty years as a public physician, has saved many citizens, and now lives in poverty, having refused from them any fees"[5].

Western-style medical practice in modern-day Singapore may have come a long way from its sacerdotal origins in Egyptian, Mesopotamian and Greek civilisations, but some things do not change. Doctors are human and like everyone else, faced with the undeniable necessity of having to make a living. The public too, is human and naturally more inclined to reward the doctor's devotion with gratitude and affection than with cold cash.

To prevent problems, and because claims of overcharging (insiders say undercharging as well) have on occasion arisen, the SMA has found it necessary to issue fee guidelines. Now into the third revision in ten years, these guidelines had been formulated in good faith without the benefit of hard data. They were essentially based on "feel" - professional feel at that, since there was no consumer input. Hence, the SMA recently decided on a survey to "verify the empirical figures that have been used in setting the guideline of fees for GPs". The report, just out, (see page) reveals a wealth of information such as practice costs, consultation fees, and GPs' earnings. On average, GPs work 48-hour weeks, see 45 patients a day, charge $19 for consultation (without medication) and earn $10,000 a month. By and large, older GPs earn more than younger ones - who actually work longer hours and see more patients, but charge less. Rentals and overheads have gone up, hitting latecomers to the scene and so on. These findings, while interesting, do not surprise. However, one small but candid observation in the report - that a range of fees should be in place as "older doctors may well charge the higher end to cover for the drop in number of patients seen" - deserves comment.

Doctors indeed have the ability to control their earnings to some extent, either by increasing their fees for individual services or by performing more of those services, or both. They can do this because they largely determine what services are needed and then proceed to supply those services and get paid for it. Now, there is nothing wrong with the power to act as patient-advocate, which is necessary for the doctor-patient relationship to work and which comes with patient consent. The problem is, with subtle redirection, this same power could be aimed instead at maintaining the doctor's own target income rather than the patient's best interest.

The medical profession should not lightly dismiss this observation. The question is not so much about lack of trust as about the potential for misuse of power. Denying that the possibility exists will only add to the impression that doctors prefer to practice their trade in a black box, shielded from informed scrutiny.

Seen in this light, the significance of the SMA survey lies in the fact that it is a step towards lifting the shroud that so often surrounds discussion of such a sensitive subject. In doing so, the SMA has done the profession a service. At least the public can now be assured that the earnings of their typical neighbourhood GP are not as astronomical as some have supposed. Moreover, health policy analysts looking at the figures, which are not unreasonable by any standards, would be inclined to conclude that the amount of overservicing taking place in general practice is small potatoes compared to hospital utilisation and use of expensive medical technology in specialist practice. This is not the same as saying that overservicing is not happening in primary health

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care or that we should be less concerned with it; the point is, to prove in any scientifically compelling way that it exists is not only extremely difficult, but may also introduce unacceptable intrusiveness into the doctor-patient relationship - would it be worth the effort? Far better that the profession is left to self-regulate, and that this is seen to be done in an honest and open manner.

On matters of professional ethics and conduct, it is important to remember that "perception is reality". Society will always apply double-standards to the priestly profession of healing (why aren't doctors - and priests - entitled to aspire to target income levels just like other wage-earners?). Thus, while the public needs to be educated, the onus is on doctors to make doubly sure they do not invite contempt by their greed. Even Hippocrates himself realised that as in all things mercenary (the twentieth century term is "fee-for-service") there is no such thing as pure altruism. But he must also have known the potential for pecuniary self-interest and abuse of sacred trust - or why else did he insist upon doctors committing on oath to serve their patients' interests above their own?

New medical realities are undoubtedly exerting new pressures on the medical profession to maintain the highest ethical standards. But in the final analysis, no set of external guidelines or forms of oath - or even penalties - can ensure ethical conduct. Integrity springs from within. The doctor's attitude towards fees is still best expressed by the eminent surgeon Guy de Chauliac who lived in the fourteenth century: *"Let (the physician) be... not covetous nor an extortionist of money; but rather let his reward be according to his work, to the means of the patient, to the quality of the issue, and to his own dignity"* [6].

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