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Impact of Unethical Medical Practices on Patients' Socio-Economic Challenges in Peshawar

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ABSTRACT

Objectives

This research aims to analyze patients' experiences in Peshawar regarding the impact of over-prescription, unnecessary surgeries and costly treatments on their overall well-being. It also seeks to investigate the underlying causes of the high prevalence of unethical medical practices among private physicians in the region. By examining these factors, the study intends to illuminate the adverse effects of such practices on patient health and financial security, while identifying systemic issues that contribute to unethical prescribing behaviors within the local healthcare landscape.

Methodology

This qualitative study employed various research methods to gather data from healthcare providers and patients, selected from diverse socio-economic backgrounds to ensure a wide range of perspectives. The data collection took place at Dabgari Garden Plazas in Peshawar, specifically targeting healthcare facilities such as Khattak Medical Centre, Khyber Medical Centre, Khusal Medical Centre, Ibrahimi Hospital, Akbar Medical Centre, Abaseen Hospital, Habib Medical Centre, and Auqaf Plaza. A total of 30 respondents, including doctors, patients, attendants, touts, pharmaceutical representatives, chemists, pharmacists, laboratory technicians, and X-ray technicians, were interviewed to provide comprehensive insights into the healthcare dynamics at these centers. In line with the qualitative nature of the research, in-depth interviews were conducted to explore nuanced perspectives and insights. Each interview lasted between 20 to 30 minutes, using unstructured questions to encourage open-ended responses, and the sessions were tape-recorded for further analysis. Some participants, such as X-ray and laboratory technicians and their supervisors, were interviewed using thematic questions to delve into their experiences with unethical medical practices. In addition, demographic information was collected to better understand the socio-economic conditions of patients affected by various illnesses, contributing to a deeper understanding of the healthcare environment in these medical centers. The study made an effort to maintain gender balance, with both male and female participants contributing to ensure representation from both genders. This diversity of participants provided comprehensive insights into the healthcare dynamics within the selected medical centers.

Results

The investigation into unethical medical practices in Peshawar's Dabgari Garden has revealed alarming findings. Overprescribing medications, driven by the pursuit of profit, is a rampant issue in the area, where some doctors prioritize financial gains over patient health. This practice, often facilitated by deceptive

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marketing from pharmaceutical companies, leads to prescription deception, where unnecessary or harmful drugs are recommended. Additionally, patients face exorbitantly high consultation fees, further burdening their financial well-being. Profit-driven surgeries have also surfaced as a critical issue, where procedures are suggested or conducted not based on medical necessity, but rather on the surgeon's financial incentives. These high-cost healthcare services have severe socio-economic implications, pushing lower-income patients deeper into financial distress. The influence of pharmaceutical companies on medical practice introduces significant ethical dilemmas, as doctors are swayed by financial incentives to prescribe certain medications. Moreover, referral frauds, where patients are referred to specific hospitals or specialists in exchange for kickbacks, highlight the darker side of healthcare in the region, further eroding patient trust and compromising the integrity of medical practice in Dabgari Garden.

Conclusion

The healthcare landscape in Peshawar faces significant challenges stemming from the knowledge gap between doctors and patients, which is exacerbated by poverty, limiting access to essential health information and services. This disparity has contributed to a troubling shift where doctor prescriptions increasingly prioritize pharmaceutical sales over genuine patient care, raising ethical concerns. This is compounded by the unquestioned authority of registered doctors from Pakistan Medical and Dental Colleges, who often operate with impunity in their prescription and surgical practices, undermining the integrity of the healthcare system.

Key words: Unethical, financial incentive, pharmaceutical companies, unjust cuts, referral fraud, health care.

Introduction

Unethical medical practices involve actions that deviate from ethical standards, compromising patient well-being. This encompasses over-prescription of medications, subjecting patients to unnecessary diagnostic tests and X-rays, prescribing inappropriate medications, high consultation fees, prioritizing pharmaceutical sales over patient care, prescribing substandard medications and performing unnecessary surgeries. Pakistan's healthcare system is quite vulnerable to unethical drug prescription practices. unethical drug prescribing and promotion practices in Pakistan pose significant risks to the healthcare system, with both pharmaceutical companies and prescribers contributing to the problem through inducements and incentives (Khan et al., 2016) 1. Prescribers in the nation often engage in illogical prescription. Numerous studies conducted across the nation have documented the problem of irrational prescribing by the majority of prescribers (Khan et al., 2016) 2.

The world's highest average number of prescribed medications per patient was found in Pakistan (4.4) (Home, 2024) 3. Although reports of overprescribing antibiotics have been made, over 70% of patients received prescriptions for them. Antimicrobial medications in particular were found to be inappropriate in a large proportion of cases in Pakistan. Only 20% of patients received the appropriate prescription for the 60% of patients who were given antimicrobials. Even for common disorders like psychiatric and paediatric conditions, a large proportion of certified medical professionals often prescribe incorrectly. In 25% of these

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situations, the therapy did not correspond to the diagnosis. In addition to prescribing excessive amounts of needless drugs, many doctors also add new, pricy first-line treatments. While concurrently using supplements like minerals and multivitamins, resulting in polypharmacy complications. This is because doctors are heavily motivated by the lucrative financial incentives of pharmaceutical firms rather than by clinical results, which leads to a lack of ethical procedures in prescribing. Over the past few years, there has been a noticeable increase in this unethical conduct, which is still a problem in Pakistan. The most commonly misused medications are antibiotics, anti-cancer, hormones, opioids, and psychotropic. (Aslam et al., 2020) 4. In terms of injectable medication use, Pakistan has the highest rate in the world, more over 60% of patients were prescribed medication, and 90% of those prescriptions were thought to be unnecessary (Babar & Jamshed, 2008) 5. Doctors prescribe as many medicinal medications as possible in order to maximize their financial gain from pharmaceutical corporations, which drives up the cost of patient treatment (Asif, 2012) 6. Regulatory agencies, pharmaceutical firms, and prescribers who act unethically are the main sources of irrational medicine use in underdeveloped nations such as Pakistan (Hussain et al., 2011) 7. Prescribers and other medical professionals might be a challenge to pharmacists when it comes to providing direct patient care since they experience insecurity and discomfort due to interruption in their work (Azhar et al., 2010) 8. Thus, the space is left open for the prescribers to use their power and freely recommend any drug they think is appropriate for the patient. In this scenario, prescribers hold a dominant role inside the healthcare system (Khan et al., 2016) 1.

In Pakistan, there are reportedly more than 600,000 unofficial healthcare providers working in tiny clinics (Noor et al., 2022) 9. In environments where the private sector provides the majority of healthcare and there is no regulatory oversight, incentive-linked prescription, or ILP, is more likely to occur. ILP is a major concern in Pakistan, a nation where the private healthcare sector provides more than 75% of all healthcare services (Khalid et al., 2021) 10. Physicians who participate in incentive-linked prescription (ILP) may prescribe patients more expensive alternatives or needless treatments, increasing the financial burden on patients in countries like Pakistan where over 50% of healthcare costs are paid for out of pocket (Wazana, 2000) 11. As a result, if patients are prescribed expensive or needless medications, their health and well-being may suffer. Patients are reluctant to challenge physician advice and prescriptions because they are frequently unaware of this wrongdoing. Patients' poverty and lack of knowledge about medicine and the health care industry also contribute to this power disparity between them and doctors, making them more reliant on doctors when they are sick (Arsani et al., 2020) 12.

The majority of doctors are thought to have terrible, unreadable handwriting. Regardless of their specialty, area of practice, or nation of birth, doctors appear to be writing in legible fonts (“Doctor’s Handwriting: A Review,” n.d.) 13. The general public's perception of unreadable doctor prescriptions is that there can be a sinister relationship between the prescribing physician and the pharmacy. In order to prevent others from reading the prescription, the doctors deliver it in code words (Jain & Rastogi, 2009; Dunea, 1999) 14. It is disclosed that poor prescribing procedures may result in medication toxicity, financial losses, patient mistrust, illness worsening or extension, and therapeutic failure (Abbas et al., 2021) 15.

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Polypharmacy, the inappropriate use of antibiotics, analgesics, multiple vitamins, and injections, the prescription of unnecessary medications, the disregard for drug-drug interactions, and incomplete or poorly legible prescriptions are among the common prescribing errors that have been documented from Pakistan (Masnoon et al., 2017) 16.

Numerous individuals said that pharmacies were frequently found inside or near private clinics. It allows physicians to make additional money by charging more for their prescription drugs. Additionally, some patients mentioned how doctors communicate with pharmacists regarding commissions using sign language when their patients visit partner pharmacies to purchase prescriptions. In order to receive a commission from pharmacies for each customer they refer, doctors mark specific prescriptions. To receive their cut of the profits from the sales of particular goods, they do this action. Patients have observed that doctors occasionally write prescriptions that are difficult to read. This is something that doctors purposefully do to make it difficult for pharmacists who aren't their partners to understand the prescriptions (Noor et al., 2023) 17.

In clinical decision making, doctors may order more laboratory tests than necessary. There are a number of reasons for this, including doctors' anxiety about their legal responsibilities at this stage of the process, the sheer volume of patients they see, the lack of time they have to spend with patients, and the difficulty of making decisions (Henry et al., 2020) 18. Approximately 7.5% to 30% of laboratory tests are considered redundant or superfluous, according to reports (Yang et al., 2020) 19. Clinicians who order unnecessary and supplementary tests result in a marked increase in the expenditures and workload associated with health expenses (Wang et al., 2020) 20.

The World Health Organization suggested in 1985 that the optimal range for cesarean sections (CS) should be between 10% and 15% ("APPROPRIATE TECHNOLOGY FOR BIRTH," 1985) 21. These days, needless cesarean sections are frequently performed. Numerous factors, including absolute, relative, and no indication, are taken into consideration. Giving birth vaginally is a normal, healthy process. On occasion, nevertheless, a caesarean section (CS) could be necessary to safeguard the health of both the mother and the fetus. Insufficient use of CS in these situations raises the risk of mother and newborn death as well as morbidity. But overusing CS, or using it without a medical reason, has not proven to be beneficial and could potentially be dangerous and a waste of time and money. According to the study's findings, 48.2% of the women had definite indications of a cesarean section, 23.3% had relative indications, and 28.4% had the procedure performed without any indications (Azra et al., 2023) 22.

Methodology

The study employs qualitative methods, specifically using In-Depth Interviews (IDIs) with unstructured questions to elicit open-ended responses from various stakeholders, including doctors, patients, attendants, touts, pharmaceutical representatives, chemists, and pharmacists. Thematic questions were also used for laboratory and X-ray technicians to explore their experiences with unethical medical practices. The research focuses on Dabgari Garden, a district in Peshawar, Khyber Pakhtunkhwa, known for its high patient influx and concentration of consultant and specialist doctors, making it a significant location for examining these practices.

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The participants in the study were carefully selected based on various demographic factors such as patient's age, gender, locality, socio-economic status, occupation, monthly income, and the type of illness they were dealing with, whether chronic or severe. These factors were essential to ensure a comprehensive understanding of how these variables influence healthcare needs and experiences. Additionally, family structure and education levels were considered, as they are crucial in shaping patients' healthcare access. For doctors, selection criteria included their specialization, practice setting, and years of experience, ensuring that a diverse range of medical expertise was represented in the study. Medical representatives and managers were chosen based on the length of their employment, area of working, business relationship with doctors and whether they worked for national or multinational pharmaceutical companies or local franchises. This distinction allowed the study to capture different perspectives within the pharmaceutical industry. Moreover, relevant professionals such as nearby chemists, doctor attendants, touts, pharmacists, and x-ray and laboratory technicians were purposefully included. Their roles in healthcare delivery make them significant stakeholders in the broader medical ecosystem. Demographic factors were highlighted in tables 3, 4, and 5, underscoring their strong association with health literacy and the overall impact on patient care. The focus on these variables is crucial as they have a well-established connection with both illness patterns and the knowledge patients possess about managing their health.

A total of 30 respondents were purposively selected for In-Depth Interviews (IDIs) and thematic questions from Dabgari Garden plazas. The sample was divided equally among three key groups: 10 patients, 10 healthcare professionals, and 10 individuals from the pharmaceutical industry. In addition to these interviews, thematic questions were conducted with two X-ray technicians and two laboratory technicians. This structured approach allowed for a comprehensive exploration of the perspectives across various stakeholders in the healthcare sector, as detailed in Table 2.

The study also included interviews with pharmaceutical companies and their field workers who maintain direct liaison with doctors to facilitate sales. These companies, which typically engage in a system where field workers interact with doctors to promote products, play a significant role in driving pharmaceutical sales. The interviews also covered pharmaceutical companies that refrain from offering monetary incentives to doctors in exchange for sales. By including both types of companies, the study provides a broader understanding of the various sales strategies used within the pharmaceutical industry.

In addition to male interview, female respondents were also interviewed to gather diverse perspectives. Among the 30 participants, 4 were females: 1 was a gynecologist, and the other 3 were directly connected to patients—2 were mothers of patients, and 1 was a female cardiac patient. Their input provided valuable insights from both professional and personal experiences related to healthcare.

In the study, three interviews had to be excluded due to issues with the respondents. One professor, who was the head of a ward, became upset after just 6-7 minutes into the interview and chose not to continue. Another respondent, a tout, grew confused after completing the session and insisted that his data not be included in the study. Similarly, a laboratory technician also refused permission to include his interview in the final analysis. These incidents led to the omission of their data from the research.

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The interviews for the study were recorded using a digital voice recorder. Throughout the research process, ethical standards were strictly followed, including obtaining informed consent from participants. Measures were also taken to ensure the confidentiality and anonymity of the respondents, protecting their privacy and personal information.

In this qualitative research, data analysis followed a structured process, starting with the transcription of interviews conducted in Pashto and Urdu. The transcripts were then translated into English. Researchers carefully reviewed each transcript multiple times, coding different sections to identify recurring themes. To ensure accuracy, the codes and themes were thoroughly discussed among the researchers, ensuring inter-coder reliability and validity in interpreting the data. This step-by-step process helped extract meaningful insights from the collected information.

Results

The result of the study reveals that patients, particularly those seeking treatment at Dabgari Garden and private medical centers or clinics, face numerous challenges. A significant issue is their lack of awareness about medical procedures, which gives healthcare professionals an upper hand to exploit them in various ways. The healthcare services at Dabgari Garden, in particular, appear to be profit-driven, often extracting money from patients without regard for their financial situations. This exploitation is exacerbated by the fact that many patients are already struggling with multiple issues, including economic hardships, poor health, limited access to education, societal discrimination, and political instability. A large proportion of these individuals live below the poverty line, which further worsens their circumstances and limits their ability to seek fair and effective medical care.

Private Clinics Exploitation and Overprescription in Peshawar

The findings of this study highlight the pervasive exploitation faced by patients in private clinics, driven by the materialistic approach of many doctors. A significant concern reported by patients is the issue of overprescription, which has become alarmingly common in Peshawar. This phenomenon is fueled by a combination of financial incentives, patient expectations, and systemic flaws within the healthcare system. Physicians, often influenced by pharmaceutical companies, are incentivized to prioritize profit over patient well-being. Overprescription arises when doctors, instead of pharmacists, prescribe medications without proper consultation. Globally, pharmacists are responsible for prescriptions to ensure unbiased healthcare. In Peshawar, however, doctors monopolize prescriptions, often favoring specific pharmaceutical companies. This practice creates conflicts of interest, compromising patient welfare with higher costs, limited drug options, and biased medical advice. Simultaneously, patient behavior contributes to the issue, as many individuals demand medications without understanding their proper use or necessity. The interplay of these factors creates a cycle of exploitation that undermines patient trust and compromises the quality of healthcare in the region. In this regard one of the medical representative stated in an interview in peshawar;

"...physicians may prescribe drugs even when a patient doesn't require them, particularly PPIs, multivitamins, and vitamin D3."

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Category	Subcategories/Details	Count	Description
Pharmaceutical Representatives	A. Multi-national	1	Representatives promoting medicines for global companies.
	B. National	2	Representatives promoting medicines for local companies.
Pharmaceutical Management	A. Multi-national	1	Managers overseeing operations for global pharmaceutical companies.
	B. National	1	Managers overseeing operations for local pharmaceutical companies.
Doctors	A. Head of Department	1	Senior medical professionals leading their respective departments.
	B. Consultant	1	Specialists providing expert medical opinions and treatments.
	C. TMO's	1	Trainee Medical Officers undergoing clinical training.
	D. General Practitioners (GPs)	1	Doctors providing general healthcare services.
Doctor's Attendants	-	1	Individuals assisting doctors during patient care or procedures.
Touts	-	1	Unauthorized individuals soliciting services or facilitating appointments.

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Patients	A. Male	3	Male individuals receiving medical treatment.
	B. Female	3	Female individuals receiving medical treatment.
Patient's Attendants	A. Male	1	Male helpers or relatives assisting patients.
	B. Female	1	Female helpers or relatives assisting patients.
Pharmacists	-	2	Licensed professionals dispensing medicines and offering drug-related advice.
Chemists/Vendors	-	2	Sellers of medicinal drugs and related supplies.
Promoter Representatives	-	2	Representatives promoting specific healthcare products or services.
Promoter Owners	-	2	Business owners managing promotional activities for healthcare products.
Laboratory Technicians	-	2	Professionals conducting lab tests and preparing diagnostic reports.
Imaging Technicians	-	1	Professionals operating imaging equipment like X-rays and ultrasound machines.

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Statistical analysis (minimum, maximum, mean, and range values where applicable) of the samples:

Category	Experience (Years)	Ages (Years)	Qualifications	Additional Info	Statistical Analysis
Pharmaceutical Representatives	2 to 15	22 to 45	B.A to MPhil		Mean Experience: 8.5 years; Mean Age: 33.5 years
Pharmaceutical Management	4 to 37	25 to 57	B.A to MPhil		Mean Experience: 20.5 years; Mean Age: 41 years
Doctors	3 to 34	27 to 59	MBBS to Foreign Higher Studies		Mean Experience: 18.5 years; Mean Age: 43 years
Doctor's Attendants	10	32	10 grades		Single value, no range for experience or age
Touts	13	43	8 grades		Single value, no range for experience or age
Patients	Varies	16 to 74	10 to Master	Various diseases (Cardio, Skin, Gyne, etc.)	Age Range: 58 years; Income Range: 188,000 PKR (12,000 to 200,000 PKR); Diverse qualifications
Patient's	Varies	28 to	6 to		Age

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Attendants		61	University Graduate		Range: 33 years
Pharmacist	5 to 24	28 to 54	D Pharmacy to PhD		Mean Experience: 14.5 years; Mean Age: 41 years
Chemist/Vendor	22	52	Not specified		Single value, no range for experience or age
Promoter Representatives	4 to 33	26 to 57	Not specified		Mean Experience: 18.5 years; Mean Age: 41.5 years
Promoter Owners	4 to 24	28 to 55	D Pharmacy and B.A		Mean Experience: 14 years; Mean Age: 41.5 years
Laboratory Technician	11 to 23	33 to 46	Lab Diploma and MLT		Mean Experience: 17 years; Mean Age: 39.5 years
Imaging Technician	21	48	BS Radiology		Single value, no range for experience or age

In Peshawar, over prescription and unnecessary medication are particularly pronounced among Trainee Medical Officers (TMOs) and senior general practitioners. On the other hand consultant and wards HODs are bussy to take advantage from pharmaceutical companies such as family foreign Trips, children education fees, utility bills, cars, banglow, international CMEs on exchange of targeted medicine sales. In such situations, patients may receive medications that are not necessarily the best option for their condition, solely because it benefits the prescribing doctor financially. This not only undermines the trust patients have in their healthcare providers but also puts their health at risk. In many cases doctor only look for financial benefits instead of patient's disease. It is estimated that around seventy percent doctor of Peshawar are now involved in this practice, driven largely by incentives from pharmaceutical companies.

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Impact of Rising Healthcare Costs on Patient Well-Being

Charging higher fees became a norm and a status symbol among many physicians. In the competitive healthcare market, fee structures served as indicators of the quality and exclusivity of the services provided. Patients often perceived higher charges as a reflection of superior care and expertise, which, in turn, drove demand for services priced at a premium. It's quoted by one participant;

"...if a doctor accepts less money, people tend to stop seeing him because they begin to suspect that he may not be a qualified physician."

The data collected from 13.3% of doctors in Dabgari Garden, Peshawar, highlights significant concerns regarding the high fees charged by certain doctors. 26.6% of participants (patients and their attendants) reported instances where physicians appeared to exploit their position of authority by prioritizing financial gain over patient welfare. Respondents shared experiences of being advised to undergo unnecessary treatments or frequent follow-up appointments, which increased their healthcare costs. Additionally, the lack of accessible alternative care options often left patients with no choice but to accept these exorbitant fees. As one of the participant reflects;

"The only medical professional who specializes in treating congenital cardiac problems, like myself, is doctor (x), who charges patients 3000 rupees for a consultation..."

Globally, the costs associated with running a private clinic are substantial, encompassing not only the operational expenses but also the considerable investment made by doctors in their education and professional development. One private clinical doctor mentioned that;

"...state, not individual physicians, ought to be in charge of offering free medical care to all of its citizens."

13.33% of respondents highlighted the high costs doctors face in earning medical degrees, which can reach up to 20 million rupees. This financial burden, combined with rising inflation, justifies higher consultation fees to sustain private practices In this regard one participant express;

"The country's inflation rates indicate that doctor fees are reasonable...".

On the other hands, Many patients, especially those from low-income backgrounds, find it difficult to afford the high consultation fees of qualified doctors. As a result, they turn to quack centers for medical advice and treatment. This is concerning because quacks often lack proper medical training and can provide incorrect diagnoses and treatments, leading to serious health risks. Furthermore, the impact of high healthcare costs on the local population was devastating. Among the sample, 26.66% of patients reported that many people in Peshawar were so incredibly poor that they struggled to care for themselves properly. Basic medical necessities, such as urine bags, were beyond their financial reach, forcing them to endure severe discomfort and health risks. This burden was further worsened by rampant corruption within the healthcare system. Instances were observed where healthcare providers prescribed urine bags from specific companies, not because they were the best option for patients, but because the providers profited from the sales. Such unethical practices deepened the suffering of the poor, who were already unable to afford adequate care, highlighting a critical failure in the equitable delivery of healthcare services. One of the participant shared;

"...I observed several individuals with various illnesses who came with shopping

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bags rather than pee bags. Since they are unable to afford the company's urinal bags..."

Moreover, The majority of patients in Peshawar, primarily laborers and those below the poverty line, face significant barriers to medical care due to exorbitant doctor fees. The high consultation costs in Dabgari Garden worsen their financial struggles, limiting access to timely and adequate treatment. Even, In Peshawar, severe poverty prevents many from affording full prescriptions, forcing patients with multiple health issues to buy only essential medications for temporary relief. A black market for low-cost sample medicines exists in the city center, further reflecting the impact of unethical practices and acute poverty. This financial strain perpetuates a cycle of illness and poverty. In this regard one patient express his views as;

"The ability of poor patients to pay for all excellent and top-tier consultants is absent."

Unjust Cuts and Referral Frauds in Profit-Driven Healthcare

The World Health Organization (WHO) has released new data showing an increase in the number of cesarean section births (21%) worldwide. The analysis projects that this percentage will rise over the next ten years, with nearly a third (29%) of all newborns expected to be delivered by caesarean section by 2030 (Azra et al., 2023)22 reference. Peshawar, KP, of Pakistan is not lagging behind in this marathon. In Peshawar and its peripheries, the issue of unnecessary medical procedures, particularly in gynecology, stemmed from a combination of economic incentives, systemic inadequacies, and patient vulnerability. The study revealed that 10% of doctor's community admitted many unnecessary surgeries were performed in gynecology, often motivated by financial gain. Some doctors exploited patients by recommending surgeries that were not medically necessary. Many gynecologists insisted patients visit their private clinics, creating financial dependency. They often preferred C-sections over natural deliveries because they were quicker and more profitable, despite higher risks and longer recovery times for patients. Natural deliveries took several hours and yielded modest fees, while C-sections were more lucrative and efficient. Additionally, many gynecological patients were illiterate and unaware of their medical options, which allowed some doctors to exploit their lack of knowledge to perform unnecessary procedures.In this context one of the female reflects;

"We brought our patient to gynecologist (x), who informed us that the lives of both the patient and her child were in danger. Consequently, she asked for admission in her clinic, where she wanted to perform a C-section to save both the mother and child. She mentioned that she would only charge Rs 55k for the procedure. The next day, we visited government hospitals for further check-ups, including tests and ultrasounds, all of which showed normal results. The doctors on duty assured us that there was no danger to the mother or child, advising us to wait for a normal delivery in the government hospital, where the delivery subsequently took place."

Over and above, the misuse of Sehat Insaf Cards became a significant issue. Study revealed that 43.33 percent of respondents reported numerous incidents of unnecessary surgeries, particularly for patients with renal stones and appendix disorders, involving private hospitals and healthcare centers. They stated that doctors in these facilities often performed procedures for extremely small kidney

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stones that could have been effectively treated with medication. Same surgeries were also conducted for hemorrhoids and other minor and major conditions.
Surgeons, in particular, had a tendency to recommend surgeries even when they might not have been the best option. In situations where palliative care, which focused on relieving symptoms and improving the quality of life, was more appropriate than surgery, surgeries were still conducted for financial gains. The study revealed that some doctors in our region had operated on regular patients just to make money. There were instances where a doctor had directly suggested surgery instead of prescribing medication, aiming to earn more from the patients. Some surgeons were not even true experts in their field. They had conducted operations on patients primarily to keep their clinics running and to earn money, rather than out of genuine concern for the patients' health. Another contributing factor was the high demand for medical services coupled with a shortage of highly trained specialists. In such an environment, it had been easier for surgeons with questionable qualifications to find work and build a patient base, often by exaggerating their skills and experience.
It was found during the study that, pharmacies were frequently inside or near private clinics. 46.66 percent of individuals reported that this allowed physicians to make additional money by charging more for their prescribed drugs. Additionally, 43.33 percent of respondents mentioned that doctors communicated with pharmacists regarding commissions using sign language when their patients visited partner pharmacies to purchase prescriptions. Doctors marked specific prescriptions to receive a commission from pharmacies for each customer they referred. They took this action to receive their share of the profits from the sales of particular goods. Patients observed that doctors occasionally wrote prescriptions that were difficult to read.
In clinical decision making, doctors may order more laboratory tests than necessary. There are a number of reasons for this, including doctors' anxiety about their legal responsibilities at this stage of the process, the sheer volume of patients they see, the lack of time they have to spend with patients, and the difficulty of making decisions (Henry et al., 2020).(18 reference.). Moreover, it was observed that a network of doctors, pharmacies, labs, and x-ray centers often referred patients to each other to maximize their profits. When patients visited a doctor, they were often advised to have tests done at a particular lab or x-ray center. Doctors also recommended purchasing medicine from specific pharmacies. The collaboration between these parties was so close that doctors refused to accept x-rays from other imaging centers, medications from other pharmacies, or lab test results from other labs. The lab or x-ray center and pharmacy, in turn, sent new patients to the doctor and also gave the doctor a share of their earnings. This reciprocal arrangement ensured that each entity benefited financially, creating a closed-loop system where the flow of patients generated continuous revenue for everyone involved. The cause of this practice was rooted in the desire to increase earnings through mutual referrals, leveraging the interconnectedness of healthcare services to maintain a steady stream of customers for each participant in the network. Facility owners in Peshawar reflects that;
"Majority of doctors take commissions from us. If I talk in percentage terms, the practice of taking commissions exists among 90 percent of doctors. For laboratory tests, we give them 70-80 percent of the money we receive from patients. Similarly, for CT scans, MRIs, and X-rays, doctors write the amount on

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a note for patients. We only take a fixed amount of money and give the rest to the doctor..."

Another troubling practice involved transporting patients to designated facilities in Peshawar particularly in dabgari garden. Doctors' assistants and touts, often employed by private centers, participated in this process. These centers hired touts to deceive patients into choosing their facilities. In some cases, the touts even impersonated doctors. This practice particularly affected patients from Afghanistan and remote areas of KP, exploiting their lack of familiarity with the medical system for financial gain.

Conclusion

This research sheds critical light on the deep-rooted structural and ethical challenges that pervade the healthcare system in Peshawar. The findings underscore a troubling disconnect between medical practitioners and patients, largely shaped by poverty, educational disparities, and a lack of regulatory accountability. A central theme emerging from this study is the commodification of healthcare, where the focus has shifted from patient-centered care to profit-driven practices. This transformation has created a system where trust, transparency, and professional ethics are increasingly compromised.

The widespread exploitation in private clinics—manifested through overprescription, unnecessary procedures, and inflated consultation fees—reveals a system tailored more to financial incentives than to public health needs. Doctors, often operating unchecked due to their credentialed authority, engage in practices that reflect a broader culture of commercialization within medicine. Pharmaceutical influence over prescriptions, along with the sidelining of pharmacists from their rightful role in medication management, further amplifies this concern. Patients, many of whom lack adequate health literacy, are left vulnerable to manipulative practices and biased treatment options.

Moreover, the rising costs of healthcare have added another layer of inequity, transforming essential services into luxury commodities. The trend of associating higher fees with superior care has not only reinforced class divisions in access to healthcare but has also validated the commodification of medical expertise. This status-driven pricing model alienates low-income patients and places undue financial strain on already marginalized populations.

Of particular concern is the practice of unnecessary surgical procedures, especially within the field of gynecology. The study confirms that economic incentives often outweigh medical necessity, as seen in the preference for cesarean sections over natural births. Such practices not only endanger the physical and emotional well-being of women but also expose the systemic gaps in patient education and medical oversight.

In sum, the healthcare system in Peshawar, as reflected in this study, is entangled in a complex web of financial motivations, ethical ambiguities, and regulatory failures. Addressing these issues requires urgent policy interventions, enhanced regulatory mechanisms, and a renewed commitment to medical ethics. Strengthening health literacy among patients, empowering pharmacists, and fostering transparency in doctor-patient interactions are essential steps toward rebuilding trust and reorienting healthcare around the well-being of the people it is meant to serve. Without such reforms, the system risks further deterioration, deepening health inequalities and eroding public confidence in medical institutions.

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