



MUCH ADO ABOUT ETHICS AT UCT CLINIC

The CEO of the newly purchased and renamed University of Cape Town Academic Private Hospital, Riel du Toit, and a representative of the 44 UCT academics who hold a 12% share in it, Dr Gaby Walthers, have strongly defended their ethical position.

This follows mutterings in academic circles and confirmation from the chairman of the Medical and Dental Professions Board (MDPB), Professor Len Becker, that the academics had yet to apply to have their shareholding vetted, as required by the ethical guidelines.

Admitting this, Walthers emphasised that their contract stipulated that unless the MDPB approved their application, their shareholdings were null and void.

'The guy that we delegated (to make the application) just hasn't got around to it in the two months since we signed the agreement,' she explained.

She and Du Toit said that without the shareholding, the deal with former owners, German consortium Rhone Klinikum, would have fallen through and the sophisticated equipment they left behind would have been sold off and the enterprise liquidated.

A vital service that benefited public and private patients in terms of staff and equipment-sharing, cost savings and created vital training opportunities in elective surgery and other areas, would have been lost.

The hospital is part of the Groote Schuur Hospital complex and the new company has renegotiated a rental agreement with the Western Cape Provincial Administration, which owns the building.

Du Toit purchased the equipment in February last year at a very favourable price from the German health consortium that developed and equipped the 112-bed facility.

The Germans cited global company rationalisation and the strengthening rand as reasons for their pull-out, leaving behind a sophisticated infrastructure.

Said Walthers: 'Basically Du Toit would not have bought from Rhone Klinikum if the doctors hadn't shown some support - he thought support was also shown by financial involvement'.

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Walthers cited the UCT Academic Private Hospital loaning their new heart-lung machine to the cash-strapped Groote Schuur Hospital (whose own machine was 'broken') as evidence of how vital the arrangement was.

'We want Groote Schuur Hospital to remain an academic institution, to do our research there and to give young registrars and consultants a good reason for sticking around and not leaving for overseas,' she added. She said this, and not any financial incentive, was the motivation behind the investment by her group.

A medical superintendent of a secondary public sector hospital in Cape Town, who declined to be named, labelled the business set-up 'limited private practice in a different guise,' and said it was ethically inappropriate. 'I would distinguish between ethical conduct and the letter of the law. If you're discussing ethics, surely the primary obligation is to serve the poor?'

He said universities were inappropriately delivering a cadre of people more qualified to work in overseas environments. Academic medicine in South Africa needed to re-orientate itself towards primary and secondary care.

'We need to create an environment where if these guys are unhappy they adjust, not promote the continuation of the privileged status quo,' he added.

Du Toit said the academics investment came to R2.3 million and that they held between one and three shares each, representing a 0.1 % minimum stake each.

He added: 'Any guy who puts a R19 000 per share into this hospital thinking he'll get return on investment is crazy. This is not an investment nor will it ever be. You're either in this for the passion because it gives you the opportunity for private medicine or teaching or you need your head read.'

He said that at current projections, the shares would yield each investor 'at most R500' after three years.

Becker said the official rule on perverse incentives was quite specific - 'unless the shareholding of that company is listed on the JSE, doctors must apply to the MDPB to have their shareholding vetted'.

He was unaware of any such application having been made.

Du Toit and Walthers said they would immediately ensure the situation was rectified.

They said the guidelines did allow for some time for an application to be made, adding that in all other respects, the academics were 'extremely careful' in taking advice from appropriately placed local experts to ensure ethical rules were followed. This included prominently displaying signs in their consulting rooms declaring their



shareholding and verbally informing any patients whom they were referring to the private hospital of their financial interest in it.

Becker cited the MDPB recently turning down an application by specialists who owned a theatre facility and who wanted to offer shares to private practitioners.

He said the board had also recently dealt with a highly irregular case where academics obtained medicines from a hospital at cost and sold them to patients at inflated prices, citing this as evidence that 'academics are also prone'.

'For me the important issue is that the trust between a patient and doctor should not be disturbed by financial considerations,' he said.

Becker said the HPCSA met early in June and declared itself in favour of setting up a special committee to consider matters of ownership and shareholdings and consider applications from across all health professions.

This suggestion came from a workshop on undesirable business practices in the health industry held near Pretoria in May this year.

It would probably become a reality by October this year when the council met again.

Becker said that in the meantime doctors should continue to submit applications concerning shareholding ventures to the MDPB for approval.

A top Gauteng academic and Health Professions Council member, who declined to be named, said he could see no exceptions applying to what, 'on the face of it, seems to be a blatant flouting' of the rules around perverse incentives. 'If they had shares in a hospital in another province for example, then the temptation to refer patients to it would not be nearly as great as if they are right there on site or in the same town,' he stressed.

Du Toit responded that in terms of the official Remuneration for Work

Outside the Public Service (RWOPS), 'these guys may not use any other hospital'.

'Theoretically if I don't have an interest, I use the best hospital for a particular case. These guys don't have that option - in terms of RWOPS they may not use private hospitals other than this one, so they're stuck'.

He said that in theory, public service doctors were allowed 16 hours per week to work RWOPS. In terms of consultation time, work-ups and postoperative monitoring, such as that required in an ICU, 'the busiest guy in this hospital manages about 15 procedures a month'.

The New York Times front page test applied, meaning that a doctor should be so confident of the ethics of his or her shareholding that this could be published on the front page of a major local newspaper without causing them any discomfort.

Du Toit said a cardiothoracic surgeon in private practice could turn over R2 million per month, 'but my guys are academics, there's no ways any of them can operate enough to make a financial difference to the hospital. Together they can do a little bit'.

His experience in the hospital industry had taught him that five successful private specialists could create 50 - 60% of turnover in a private hospital. 'But here with them only doing 16 hours, I'd need 50 guys!' At 16 hours per week in the public sector versus 56 hours per week in the private sector, his doctors were working at 28% of capacity 'so even if they wanted to make a financial incentive difference, they couldn't'.

Du Toit said that never in his experience had he 'seen a guy overuse a hospital because he has shares - I've often seen them overuse because they

get money out of the procedure, but that's a different story'.

He said the same ethical rules on unnecessary procedures applied everywhere and were not applicable in the perverse incentives discussion.

Groote Schuur Hospital doctors were 'desperate to get training material or a place for training. In Groote Schuur you see mainly traumatised people. No electives are done there anymore and that leaves a huge gap in training of registrars and consultants.'

Du Toit said that from an asset value perspective the private hospital was a good buy, but from a business perspective it was 'far from a bargain', and was currently running at a R30 million loss.

Of his investors, he said the hospital was 'unlikely' to make more than R1.5 million (pre-tax) next year. 'If they're lucky they'll get a cash dividend in the third year, with a best case scenario of R500 each, but it's highly unlikely they'll get any dividend for about six years.'

Walters said skills retention was one of the uppermost factors in the investment decision by her and her colleagues.

'It's very difficult for the upcoming good guys because there's hardly any career path in the public sector,' she said.

She said the MDPB application was currently 'the only missing link we're aware of - I'm sending the guy we delegated to it an e-mail right now'.

Elsabe Klink, until recently SAMA's internal legal advisor, said that the entire issue 'hinges on transparency'. The *New York Times* front page test applied, meaning that a doctor should be so confident of the ethics of his or her shareholding that this could be published on the front page of a major local newspaper without causing them any discomfort.

Chris Bateman