TOP DOCTORS WANT TOUGHER PERVERSITY PENALTIES

Leading lights in South Africa's medical fraternity are perturbed at the 'mild' sentences meted out to doctors in two high-profile kickback hearings after plea bargaining recently ended protracted legal battles.

Boyce Mkhize, HPCSA Registrar, Len Becker, chairperson of the MDPB' and Jan van der Merwe, perverse incentives policy architect at an open workshop on perversity last year.

Among those prepared to speak out are Dr Kgosi Letlape, the current chairman of the South African Medical Association, Professor YK Seedat, a past SAMA president, and Professor Jan van der Merwe, the architect of the Health Professions Council policy on perverse incentives.

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Letlape wants a 'table of offences' with minimum punishments drawn up and a switch to criminal instead of HPCSA investigations for serious cases.

The first hearing involved Lancet Laboratories and was prompted by reports in the *Star* newspaper in May 2000 claiming 'hundreds' of doctors were being paid to order millions of rands' worth of unnecessary medical tests from pathology laboratories.

An independent investigator was hired by the HPCSA to check *(a)* the veracity of the *Star* reports; *(b)* whether Lancet was continuing to pay perverse incentives or had begun a different perverse incentive scheme (no *prima facie* evidence emerged); and *(c)* whether Lancet's corporate structure complied with medical ethical rules. (A 6-month HPCSA moratorium expires at the beginning of April this year.)

A preliminary Medical and Dental Professions Board (MDPB) enquiry finally ruled that a full disciplinary hearing was justified but resolved that Lancet should be offered the alternative of paying admission of guilt fines.

The outcome was that 13 unnamed pathologist partners each paid the Health Professions Council admission of guilt fines of R10 000 per count after withdrawing a High Court application (for which they had to pay costs).

HPCSA communications officer, Phephela Makgoke, was unable to supply the total, but reliable legal sources said it came to 'around R300 000'.

Makgoke said 29 referring doctors were 'still under investigation' for receiving kickbacks from the pathologists and that the entire matter was *sub judice*.

He concluded: 'We are therefore not at liberty to disclose the names of the Lancet Laboratory partners or the referring doctors.'

The second 'settlement' involves four radiologists from Illes and Partners who also challenged their HPCSA professional conduct hearing in the courts, fighting and losing time-consuming technical legal challenges. (They were also ordered to pay the High Court costs.)

Charges of interfering with witnesses and fraud were omitted from the final settlement by mutual consent, even though much evidence emerged during the official hearing.

In their deal with the HPCSA, three of the radiology partners finally admitted to over-billing and creating perverse incentives after consistently protesting their innocence. They were effectively suspended from their practices for between 3 and 18 months and fined between R50 000 and R150 000 each.

The fourth partner received a suspended suspension and a R50 000 fine.

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The *SAMJ* learnt that members of the MDPB professional conduct committee regarded the omitted charges as serious, but found themselves legally constrained.

The MDPB committee *does* have the power to decide whether or not the plea is acceptable and the penalty suitable under the circumstances — and can reject the HPCSA proposal and make up its own mind. However, it cannot make findings on charges that have been plea-bargained away with the *pro forma* complainant.

The MDPB committee was thus faced with a *de facto fait accompli* in respect to these charges.

Seedat was a member of the MDPB fraud preliminary hearing committee that recommended the professional conduct enquiry of the radiologists.

Seedat says plea bargains should only be allowed for doctors 'who are contrite and don't use all the financial resources at their disposal to fight the HPCSA and then, when they find themselves on a losing wicket, go into plea bargaining (as a last resort)'.

He officially noted his objection because he believes a crucial principle was violated.

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'They need to show remorse — we have to set an example to the whole medical profession in this country as to how to behave — I think they got off lightly,' he added.

One specific objection is to a 'lack of transparency' in the deal that finalised the 4-year Lancet Laboratories kickbacks case. Seedat revealed that the Lancet Laboratory doctors had offered to pay their fines and those of the referring doctors with a single cheque.

However the MDPB preliminary hearing committee rejected this, both on principle and on practical grounds. Van der Merwe described this attempt and mindset as 'a disgrace'.

Seedat said that by the end of February this year, neither case had yet come before the MDPB for final approval.

On plea bargaining, Van der Merwe said: 'It's one thing to allow a doctor who forgot to pay his registration fees to pay a fine and be put back on the register but this kind of thing is quite another. We should not allow real crooks soft options.'

Van der Merwe, a former vice-president of the SA Medical and Dental Council (the HPCSA forerunner) and currently the medical advisor to the Council for Medical Schemes, said he was 'extremely disappointed with what is happening'.

'I have the perception that us "gryskoppe" of the medical profession, including those currently in leadership positions, are finding it quite difficult to discharge our responsibility to our colleagues on one hand and serve, in the first and last instance, the public and patients' interests.'

'We're simply too soft (on offending doctors) and willing to allow things to evolve that will be to the detriment of the industry,' he added.

The outcome of both cases and the use of plea bargaining as a tool were strongly defended by HPCSA's outside investigation co-ordinator and attorney, Mr Tebogo Malatji. He said the Professional Conduct Committee's job was to hear and adjudicate on the evidence placed before them.

Malatji said finalising the Illes enquiry cost the HPCSA R2.9 million.

Allowing the matter to 'drag on' would have incurred further costs and, in his experience, the eventual outcome would have been what the doctors pleaded to and were sentenced for anyway.

The official record of the Illes case ran to 'tens of thousands of pages' and a 'non-plea-bargain' verdict plus a sentence would have required lengthy ratification by the 25-member MDPB.

This would have 'probably meant a 5-day hearing' with all parties represented, plus each (paid) member poring over the voluminous record in advance.

Following the professional conduct enquiry's final approval of this board ratification, the respondents were entitled to take the outcome on appeal to the High Court. This could have taken 'another 4 or 5 days' of further costly hearings and legal preparation.

The HPCSA had chosen a pragmatic route 'rather than enrich the lawyers involved at great cost to the council's coffers'.

He said the 'likely outcome' was always of paramount importance in choosing which route to take.

Malatji, a seasoned medical litigator, said his experience was that judges were more lenient towards individual petitioners than 'those wielding power' (the HPCSA).

He revealed that two of the accused radiologists, Jeffrey Swartzberg and Leon le Roux, had approached the HPCSA 'wanting to resolve the matter'.

HPCSA Registrar, Boyce Mkhize, had said he would deal only with all four respondents and asked them all to make submissions about pleas and effective penalties.

'We're simply too soft (on offending doctors) and willing to allow things to evolve that will be to the detriment of the industry,' he added.

The outcome of the ensuing negotiations ended in the effective suspensions and fines for the radiologists — who had pitched for suspended suspensions.

As for the lack of transparency in the Lancet case, Malatji said the naming of the doctors concerned fell under a confidentiality clause of the Health Professions Act.

Malatji's final report was given to Mkhize and the chairman of the MDPB, Professor Len Becker, before being handed to Lancet for their comments.

Malatji said legal opinion was that the doctors' names could be published only

if they entered pleas before a full disciplinary enquiry.

'You can draw the analogy of a traffic offence. There is a *prima facie* case of exceeding the speed limit and you can either pay an admission-of-guilt-fine or fight it in court. If you pay the fine, you don't appear in court and thus your name is not a matter of public record, nor can it be treated as a previous conviction.'

He said both disciplinary matters were 'not dealt with in any kind of unique or special way — this all falls well within the current professional conduct regulatory environment'.

This meant that the Exco of the MDPB was empowered to authorise the registrar to enter into plea bargain negotiations with respondent doctors.

A veteran medical insider said that while plea bargaining was 'admirable' as a tool for resolving matters, 'the fundamental fact remains that guilt has been established by admission and a penalty being imposed'.

'Surely the logical consequence of this is recorded on their files in case similar charges are brought against them in future, just like others found guilty in professional conduct enquiries?'

Letlape said such matters should be probed by the police or the Scorpions, so that punitive measures could be appropriate to the crime.

'When professional activity turns criminal, it's easier for the health professions to act appropriately if people are tried as fraudsters. At least then they can even face jail terms that the HPCSA simply can't impose. It becomes an entirely different ball game.'

Chris Bateman

The South African Medical Journal

100 years ago:

As a consequence of the parlous condition of things medical in South Africa, we are now witnessing a phenomenon which is entirely novel, in the considerable numbers of departures from the country of medical men some of whom have been here for some years. None but those who like ourselves come into contact with the whole body of the profession and get behind the scenes which a somewhat exaggerated self-respect hides from most people, know to what an extent this phenomenon is justified. It is not the difficulty of getting the initial 'bread-and-butter' that is the trouble, but the hopelessness, for the great majority, of ever getting beyond the bread-and-butter. The average income may be quite sufficient for the bachelor of twenty-five, but it is when he blossoms out into a family man of forty-five that the South African practitioner bewails alike the lack of progressiveness as compared with British practice and the enormously enhanced expenses. And when the realisation comes it is often too late to commence afresh, unless one is fortunate enough to drop into the Public Service, which the wise men do whilst young, and the unwise ones regret not having done, when it is too late.

50 years ago: The problems of old age

The health and welfare of the elderly is a subject which looms large in modern life. With the continuous fall of the death rate the people over 60 years old constitute a proportion of the population that grows greater year by year. In periods when the falling death rate is accompanied by a decline in the birth rate, as has been the case during recent times, this 'aging' of the population is still more marked.

If people over 60 cease from work the economic effect of the change in the age-constitution of the population is very great. Production is limited to the younger age groups, and the consumer needs of the growing mass of the elderly or aged, with those of children and young persons, become a growing charge on the producer age groups. The policy of 'retiring' healthy and capable people merely because they have reached a prescribed age is clearly one of promoting scarcity rather than plenty. Many people at 60 are at the peak, or very little below the peak, of their capacity; what they may have lost in certain phases of vitality is often compensated for by experience and judgment; and although their future years may be years of decline the productive capacity of these years may add up to a very substantial total...

The control of the aging process and the maintenance of the health of the aged is a subject that is assuming greater prominence in medicine, and promises valuable results.