Issue of fraud raised as MD self-referral comes under spotlight in Ontario

Lynne Cohen

In Brief • En bref

Physician self-referral, fraud and conflict of interest are causing increasing concern in Ontario, where 100 physicians are now being investigated for such activities. These and related offences recently have been pushed to the top of the agenda of the provincial college, which recently asked physicians to vote on what kind of self-referral regulations they prefer.

L'autorecommandation par les médecins, la fraude et les conflits d'intérêts préoccupent de plus en plus en Ontario, où 100 médecins font maintenant l'objet d'enquêtes sur de telles activités. Ces infractions et d'autres délits connexes ont été placés récemment à l'avant-plan des activités du collège provincial, qui a demandé à des médecins de se prononcer sur le type de réglementation de l'autorecommandation qu'ils préfèrent.

Physician self-referral, fraud and conflict of interest are causing increasing concern in Ontario, where a record 100 physicians are currently being investigated for such activities. These and related offences recently have been pushed to the top of the agenda of the College of Physicians and Surgeons of Ontario (CPSO).

Public concern is growing because of the number of media reports about fraud and other illegal activities involving doctors, Jim Maclean, the CPSO's director of public affairs and communications, said in a February report to the college's council. The seven-page document, written to "sensitize" the council, discussed a host of legal issues: physician self-referral, criminal conspiracy, incompetence, deliberate and inadvertent abuse of trust, waste and theft.

Council took immediate action on the most ill-defined of the matters, self-referral, and established a special committee to draft policy recommendations for a council meeting to be held this month. These recommendations will eventually be the basis for a provincial regulation under the Regulated Health Professions Act (RHPA), the December 1993 statute that established current CPSO authority and under which more than 20 health professions in Ontario are governed. In response to criminal and unethical practices outlined in the report, council directed its public-complaints office to continue its 100 investigations.

Conflict of interest — real or perceived — is the legal thread running through many of the activities being reviewed by the CPSO, including self-referral and fraud. A conflict of interest occurs when fiduciaries — a type of trustee who by law must act with the ultimate degree of fidelity — are in a position to benefit financially from the services they provide to a beneficiary. Under the RHPA, the doctor is a fiduciary, the patient a beneficiary.

Conflict of interest is a complicated concept that takes up three pages within the RHPA regulations. In practice, conflict of interest is virtually impossible to avoid at all times. Using self-referral as an example, CPSO deputy registrar Dr. John Carlisle said that "you can take it to the point where it could be said that a doctor ought not to own a stethoscope, because he or she can make money with the stethoscope. What about surgeons who see patients on referral, and then determine that an operation is needed?" Issues like these, he told *CMAJ*, are also being studied by the committee.

Maclean's report briefly outlines the most serious cases under investigation by the complaints office. Evidence suggests that some physicians are making fraudulent self-referrals "outside the bounds of medical necessity"; others, who are referring patients to particular clinics, "are receiving excessive fees for providing patient information." Some doctors are receiving kickbacks in the form of "cash payments, advantageous rental arrangements and office improvements and equipment" in return for referrals to medical laboratories.

Other cases are directly linked to the generous benefits available under Bill 164, Ontario's no-fault auto in-

Lynne Cohen, a lawyer, is a freelance writer living in Nepean, Ont.

surance scheme. Enacted by the former New Democrat government in January 1994, the entitlement-rich statute has forced insurance companies to provide up to $1 million in rehabilitation payments for every person injured in a car accident. "[I]t is likely that millions of dollars are being paid fraudulently to alleged accident 'victims' and to clinics which excessively treat patients who are not injured or whose injuries are exaggerated," Maclean's report noted. In some clinics, patient well-being is ignored, as health services are "continued only until the insurance resources are exhausted, simply to benefit the owners of the clinics. This type of activity suggests criminal conspiracy."

Ed Singleton, director of public complaints and investigations at the CPSO, declined comment on who reported any of the 100 doctors to the college, but he said "there were a number of members of the public charged by the police under the auto insurance [scheme]. It is as a result of those charges that we are looking at particular doctors."

He would not comment on the possible outcome of the cases, some of which began in 1994. "We are [still] dealing only with allegations. None of the cases has gone to the Discipline Committee. I can't say if I anticipate any of them going [to discipline]." Singleton does promise, however, that findings of fraud could "absolutely" end in the revocation of medical licenses.

Maclean noted that the CPSO is only one of many official agencies concerned about increasing fraud and abuse of the entitlements system. The Unemployment Insurance Commission, Canada Pension Plan (CPP), Workers' Compensation Board and various social-service agencies and insurance companies "have expressed an interest in joining together to discover ways to root out the problem," his report said.

Yet no one seems to know its scope. "What percentage of our clients jump out of their wheelchair after they leave our office?" comments Dr. Alex Romaniuk, senior medical adviser to the CPP. "Your guess is as good as mine." He adds that he hopes and believes the number is small.

In some cases, the doctor is duped. "Though most conditions we deal with involve tests," said Romaniuk, who is also a part-time general practitioner, "these safeguards offer only some protection for the system. If the patient really appears genuine, what can you do?" The CPP has programs to try and catch cheaters, he added.

To fight widespread fraud in Ontario, the CPSO council authorized the college to canvas federal and provincial government departments in search of a department that could "lead and coordinate" strategies. "There may be legislation required to allow exchange of information between, for example, the college and police, which is why we need a government ministry to take the lead," Maclean explained.

On the controversial matter of physician self-referral, Carlisle feels the college's regulation committee has a difficult mandate; as well as dealing with immediate problems, the committee must address complex philosophical questions. "Defining [the concept] could take years," he lamented, speculating that the committee may therefore delay its broad analysis and focus on what is "actually troubling the public today, and try to do something fairly quickly."

The CPSO currently requires disclosure of ownership interest: "It is a conflict of interest for a member to order a diagnostic or therapeutic service to be performed by a facility in which the member or a member of his or her family has a proprietary interest unless the fact of the proprietary interest is disclosed to the patient and to the College before the service is performed."

This, says Carlisle, is inadequate, "and is in fact viewed by some as a relaxation of the previous position, a licence to do things that society wouldn't approve of." Before 1993, doctors were barred from making referrals to any facility in which they or members of their family had a financial interest. Carlisle, a lawyer as well as a physician, explained that some believe disclosure alone is not restrictive enough to ensure that a doctor makes only appropriate referrals.

"There is no grey area from an ethical point of view. It is simply wrong to self-refer for personal gain, or any personal motive at all. The only appropriate reason to self-refer is in the best interest of the patient. This is crystal clear."

— Dr. Douglas Sawyer, chair, CMA Committee on Ethics

In theory, self-referral is not complicated. "The ethics are unequivocal," says Dr. Douglas Sawyer, chair of the CMA's Committee on Ethics. "There is no grey area from an ethical point of view — it is simply wrong to self-refer for personal gain or any personal motive at all. The only appropriate reason to self-refer is in the best interest of the patient. This is crystal clear."

Carlisle believes the fiduciary relationship, based solely on patient trust, is fundamental, "but it is not just a matter of prohibiting all doctors from owning clinics to which they may refer patients. Such a solu-

tion is deceptively simple, though it is the approach many hope the committee will adopt."

Does the answer to this problem lie in prohibiting all self-referral to doctor-owned clinics? Sawyer thinks this would not be in the best interests of patients. However, he does favour location-based prohibitions. "In a major city there is probably no reason for a doctor to have a pharmacy in his clinic, so most provincial colleges should prohibit that. But in smaller centres, it may be necessary for a doctor to have, for example, certain pharmaceuticals so they are available to the patients."

To Carlisle, summarily ending self-referral to physician-owned facilities, even in urban areas, could lead to other serious problems. "Experience [in other countries] has shown that, after a period of time, what you have is a number of wealthy lawyers and a number of Grand Cayman Island corporations, and no doctors who appear to own any interest in [any medical] facilities. Have you changed the situation? Not really. You have just changed the form of things."

Among the possibilities for a self-referral policy is the introduction of licensing programs similar to those found in the 1988 Independent Health Facilities Act (IHFA), which has been successful in reassuring the public while at the same time allowing practitioners to operate their own clinics and equipment freely. Under the IHFA, doctors who own certain diagnostic and therapeutic facilities, including radiology clinics, are invited to write their own standards and practice parameters. These are circulated to every interested physician in the province for comment, and even externally validated in other countries, before being passed by the CPSO's council. "The IHFA is providing a pretty good quality-management technique for certain groups," said Carlisle.

Also possible is a regulation similar to the one suggested by Dr. David Etlin, a Toronto general internist who contributed to Maclean's report. He favours disclosure, as the current rule requires, but also wants doctors to self-refer only to facilities in which they have a clinical role. "The problem I have," said Etlin, "is with the doctor who actually has a financial interest in a clinic where he or she refers patients, but who will ultimately not be providing the service."

Ontario's 20 000-plus doctors are having their chance to be heard on the issue. A mail-in ballot, included in the March issue of the CPSO's *Members' Dialogue*, asked doctors to cast a vote on the kind of self-referral regulation they prefer: an outright ban, or a policy requiring disclosure coupled with quality assurance and outcomes evaluations. Maclean said the responses will be summarized and presented to council in June.

A self-referral policy acceptable to everyone is probably impossible to develop. The American Medical Association's House of Delegates failed in the task, reversing a policy it adopted in December 1991 within 6 months; that policy had been indirectly endorsed by major medical groups such as the American College of Physicians and the American College of Surgeons. Dr. Arnold Relman, former editor of the *New England Journal of Medicine*, described that exasperating experience in a November 1992 editorial in which he analysed self-referral and concluded that the AMA's pre-1980 policy — which was very similar to the one Etlin likes — is still the most suitable.

According to Carlisle, the policy Ontario physicians consider most suitable won't be written into the regulations any time soon. Recommendations will be received by council in June; if they are endorsed, they will be sent to the Ministry of Health for review and rewriting into regulatory language, a process that may take years. "There is no reasonable or likely possibility of completing the regulatory process in the foreseeable future," said Carlisle. "It will take a minimum of a year, possibly 2." ■