

# **A PROFESSION UNDER SIEGE?**

**Medical practice and ethics**

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<sup>1</sup> In fairness to Professor Becker, we would like to point out that he differs from the authors on many aspects of this report and some of the interpretations and conclusions reported here. The fact that we acknowledge the value of his comments should not be read to imply that he agrees with the conclusions or recommendations contained in this report.

## **EXECUTIVE SUMMARY**

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### **BACKGROUND**

During October and November 2000 the Ethics Institute of South Africa (EthicSA) conducted a survey in order to gauge various aspects of the business (as opposed to clinical) ethics of medical practice of a representative sample of medical practitioners in South Africa - general practitioners (GPs) as well as specialists. This Executive Summary highlights the main findings of the study.

### **THE COMMITMENT TO ETHICALLY SOUND PRACTICE**

**Most South African doctors believe that medical practitioners in this country are ethical in their professional conduct. They also believe that the medical profession sets higher standards of ethical conduct than other professions. The key findings in this regard are the following:**

- Most respondents agree that South African doctors are ethical in their professional conduct.
- The practice of medicine imposes a higher standard of moral integrity than other professions do.
- The medical profession is being singled out unfairly on ethical issues.

Our respondents similarly subscribe to the following beliefs:

- Many respondents are of the opinion that most members of the public believe that doctors are ethical in their professional conduct.
- When doctors are tempted to act unethically (for example, by over-servicing patients or issuing unwarranted medical certificates), they are adamant that they do this only to keep their patients happy.

## **ETHICS AND FINANCIAL INTERESTS**

**The changing nature of the medical profession and the new demands being placed on medical practitioners due to business-type considerations require new innovative approaches. South African doctors are increasingly faced with these new developments and are clearly divided over many of the implications!**

- South African doctors are clearly divided over the (changing) nature of the medical profession. There are comparable proportions of doctors who believe that a medical practice is merely another business and of those who believe that it is different from other occupations.
- This division leads to rather significant differences among the respondents about the acceptability of having financial interests in organisations to which they make referrals. However, there is also considerable agreement that doctors who have vested interests should declare them to their patients.
- There is a similar consensus among the sample that having such an interest does not or would not affect their clinical decisions.

## **BUT THERE IS ALSO CAUSE FOR CONCERN!**

**Despite their clear commitment to practising medicine in a morally responsible manner, there is strong evidence of widespread unethical practices within the medical community.**

- Nearly two out of every three respondents claim that they have observed incidents of misconduct by a colleague.
- Nearly two-thirds of respondents claim that doctors supplement their own income through the over-servicing of patients.
- Two out of every five respondents believe that doctors supplement their own income through arrangements with private hospitals or clinics.
- Half of the respondents state that doctors accept cash payments not declared for income tax purposes at least once a month.

- Nearly half of the respondents say that doctors increase charges to medical aids by over-servicing at least once a month.

## **WHAT ARE THE MAIN REASONS FOR THESE TRENDS?**

**The demands of being a good clinician *and* managing a profitable medical practice are not easily met. Our respondents report numerous sources of stress in a medical practice that contribute to (a growing?) incidence of unethical conduct. This is evident from the following:**

- Three-quarters of our respondents believe that the low medical aid scheme rates for consultations contribute to unethical behaviour among doctors.
- An overwhelming majority of our respondents claim that their patients are unable to pay them because their medical benefits are inadequate and that this occurs at least once a month.
- A large majority of the sample claim that inadequate remuneration is an important source of stress.
- An equally high proportion of doctors claim that government intervention in the profession is an important source of stress.
- Managed care is an important source of stress for many doctors.
- A significant proportion of doctors indicates that the fear of litigation is another important source of stress.

## **WHAT IS THE REMEDY?**

**In addition to pointing out the urgent need to address the very real material reasons or background conditions that induce stress and contribute to unethical conduct (such as inadequate remuneration, low medical aid rates and government intervention), responses to the survey also clearly point to a number of practical remedies for unethical business practices. These are: (a) education and training in ethics, (b) the design and implementation of codes of ethics or ethical guidelines, and (c)**

## **reviewing the role of the Health Professions Council of South Africa (HPCSA).**

Against the background sketched thus far, it should come as no surprise that almost all doctors are in favour of formal education and training in medical ethics during undergraduate medical training. A large majority of respondents hold the view that a strong background in ethics would have an influence on doctors' conduct. Another possible way to address some of the concerns expressed by our respondents is to have a formal code of ethics: three-quarters of the sample agree that such a code of ethics would be a useful guide for doctors.

Most doctors in South Africa are less than satisfied with the role of the HPCSA in the field of ethics.

- More than half of the doctors in the sample say that they do not have a copy of the "Ethical Rules" of the HPCSA. There is also some disagreement about whether the existing guidelines of the HPCSA are sufficiently clear about what constitutes ethical and unethical behaviour.
- Most of the members of the sample claim not to have received any documentation on ethics from the HPCSA over the past 12 months.
- Nearly two-thirds of the sample agrees that the HPCSA should be stricter in dealing with serious ethical transgressions, but even more are of the opinion that peers should judge disciplinary hearings of the HPCSA.

## **SUMMARY CONCLUSIONS**

Based on the survey results, our overwhelming impression is of a profession caught between its traditional commitment to ethically sound practices and the growing demands of financial survival. South African doctors very clearly recognise and subscribe to an ethos that observes the best interests of the patient. At the same time they are increasingly frustrated and constrained by unrealistic medical aid tariffs, government demands and the conflicting interests of various other role players (managed care, pharmaceutical companies and others).

## INTRODUCTION

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When the Ethics Institute of South Africa (EthicsSA) became fully operational in August 2000, it decided that its first major project would be a nationwide representative survey of the ethics of the business practices of South African medical practitioners (general practitioners and specialist doctors). This decision was consistent with the vision of EthicsSA to help build an ethical South Africa. Moreover, the focus of the survey on a complex set of ethical issues located specifically in the field of *medical* practice was informed by a commitment in this regard in the founding document of EthicsSA.

A review of existing research and scholarship did not produce any recent evidence of scientifically sound studies of the nature and extent of ethically compromised business practices among South African doctors. Evidence appeared to be anecdotal or, at best, limited in scope. However, given how widespread it has become, anecdotal evidence does have some cumulative force. There was, therefore, in EthicsSA's considered judgment, a clear need for a study that would produce reliable empirical data on the basis of which one could assert, with some confidence, what South African medical practitioners do, what they perceive to be happening in this field, and what they have good reason to believe to be going on. The most important rationale for the study was thus the need to identify and to find ways of addressing at least some of the main problem areas.

EthicsSA believes that the facts, as revealed by the survey, are - on the whole - self-explanatory. The survey identifies key and salient issues that live in the minds of medical practitioners. They signify areas of concern that require the attention of the main role players in health care, and they point to areas where steps should be taken to address unethical business practices.

It should be pointed out that EthicsSA has already initiated various actions that address some of the concerns expressed in the survey.

## **Outline of the report**

The report consists of five sections. In Section One we discuss the *research design*, and pay special attention to the sampling design, fieldwork methods and response rates. Section Two is devoted to a discussion of the *sample profile*, which will provide the reader with a more detailed picture of the characteristics of the survey respondents.

The main section of the report - Section Three - presents *the results*. The discussion in this section is organised around the following themes:

- Ethical values and beliefs: A commitment to sound practice
- Ethics and financial interests
- Evidence of unethical practices
- Reasons for trends in unethical practices
- Remedies: Education and training, codes, and the HPCSA.

Section Four is a summary of the *main conclusions*. The final section – Section Five – offers a number of *key recommendations*.

A copy of the survey questionnaire is attached as Appendix 2, while Appendix 3 contains a sample of the letter that accompanied the survey questionnaire.

## **SECTION 1**

### **RESEARCH DESIGN AND METHODOLOGY**

---

During October and November 2000, the Ethics Institute of South Africa (EthicSA) conducted a postal survey in order to gauge various aspects of the business (as opposed to clinical) ethics of medical practice among a representative sample of medical practitioners in South Africa - general practitioners (GPs) as well as specialists. The questionnaire used in the survey was developed over a period of six weeks, in consultation with various experts in the field of medical ethics and survey research. The final version of the questionnaire was piloted with a small number of practitioners.

The sample design involved drawing a 10% stratified random sample of 2 000 (out of the registered 23 363 general practitioners and specialists on the database of the South African Medical Association (SAMA) - members as well as non-members.<sup>2</sup> This database was defined as the sampling frame for the study. The 10% sample that was drawn was designed to be representative of the target population in three key aspects: gender (male/female), geographical location (metropolitan/rural) and type of practitioner (GP/specialist). Table 1 below shows how these three stratification variables were distributed in the sampling frame, the sample that was drawn and the realised sample.

Fieldwork commenced during the second week of October. The response rate of returned questionnaires was tracked systematically. This led to a first reminder being sent out during the third week of October, followed by a second reminder during the second week of November. Questionnaires were received as late as 21 December 2000. At the time of reporting, a total of 627 questionnaires had been returned. This constitutes a response rate of 31,9%, which is generally accepted as

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<sup>2</sup> At the time of writing this report, the HPCSA database is reported to consist of 29 788 names. The difference between these two databases can be accounted for by the fact that the HPCSA database also includes a large number of interns and registrars - categories deliberately excluded from our target population. Databases may also be updated in different ways.

a good response rate for postal surveys. Of the 627 questionnaires returned, 562 were completed, while the remainder (65) were returned as address unknown. The results reported here, therefore, represent the views of the 562 completed questionnaires. A comparison between the sample and the population proportions on the stratification variables clearly shows that the realised sample is sufficiently representative of the sample drawn<sup>3</sup>. The only exception to this is a slight overrepresentation of specialists.

Table 1: Comparison between population, sample designed and sample realised statistics

		<b>Population (n=23 363)</b>	<b>Sample (n=2 000)</b>	<b>Sample realised (n=562)</b>
<b>Gender</b>	Male	76%	76%	76%
	Female	24%	24%	24%
<b>Geography</b>	Metropolitan	71%	73%	69%
	Rural	29%	27%	31%
<b>Practitioner</b>	GP	72%	74%	64%
	Specialist	28%	26%	36%

<sup>3</sup> Much confusion and misunderstanding exist in everyday conversations about the criteria that define "representative samples". Cooper and Schindler (1998) point out: "Much folklore surrounds the question of what size sample is needed. One false belief is that a sample must be large or it is not representative... Samples of 1,000 or more have been branded as inadequate by many critics but seldom, if ever, by a statistician. Sample size is only one aspect of representativeness... The absolute size of a sample is much more important than its size compared with the population. *How large a sample should be is a function of the variation in the population parameters under study and the estimating precision needed by the researcher.* A sample of 400 may be appropriate sometimes, while more than 2,000 are required in other circumstances" (*Business Research Methods*, McGraw-Hill, p. 223). Both the sampling design used in this study (stratified sampling design), as well as the sample realisation (Table 1) AND the final size of more than 500 respondents are more than sufficient to guarantee claims to representativeness in this study. As far as precision is concerned, all results reported in this study can be assumed to be correct (at a confidence level of 95%) within a margin of error of 3-4%. This means that for any percentage reported, for example, that 61% of respondents reported having observed instances of medical misconduct by a colleague, the true value for responses to this question in the population lies somewhere between 57% and 65% and will obtain for 95 out of a 100 samples drawn from this target population.

## SECTION 2

### SAMPLE PROFILE

A total of 562 completed questionnaires were analysed for the purpose of this report. The basic demographic characteristics of the sample are presented in Figures 1 to 3 below. As indicated above, the gender distribution (Figure 1) is identical to the sampling frame and the sample drawn.<sup>4</sup>

Figure 1: Gender distribution

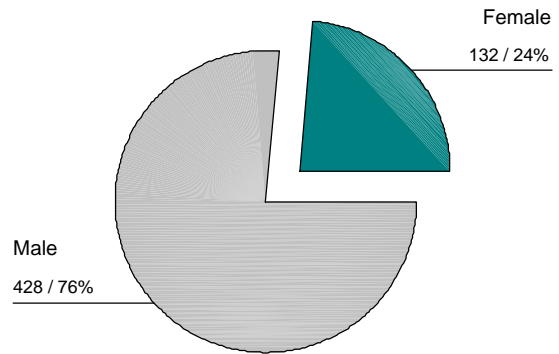
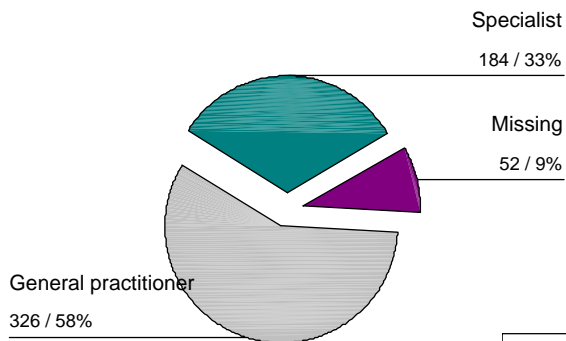
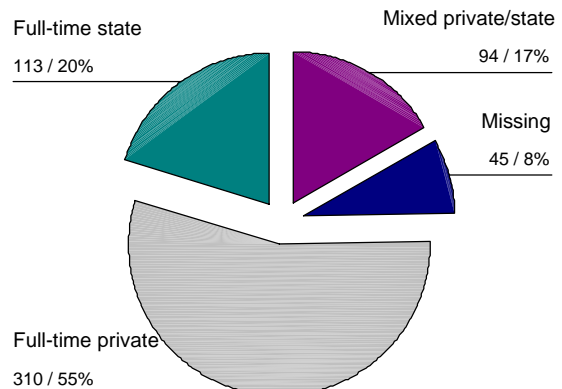


Figure 2: General practitioner/Specialist



The proportion of general practitioners to specialists in the sample (Figure 2 above) is consistent with the sampling frame. Figure 3 presents the distribution of type of practice.

Figure 3: Type of practice



<sup>4</sup> Where subtotals for responses to a particular items do not add up to the sample total, this is usually due to missing responses.

The age profile of the sample is summarised in Figure 4 below. The average age of respondents is 43.6 years. Interestingly, there is a significant difference in the age profiles of male (average age is 45.2) and female (average age is 38.6) doctors. In all likelihood this reflects the increased intake of female students in South African medical schools over the past decade in order to attain greater gender equality.

Nearly 9 out of 10 respondents (86.8%) graduated at a South African university. The breakdown per South African university is presented in Table 2 below, with a summary according to medium of instruction in Table 3 below, while Figure 5 below presents the distribution of the years when the basic medical degree was obtained.

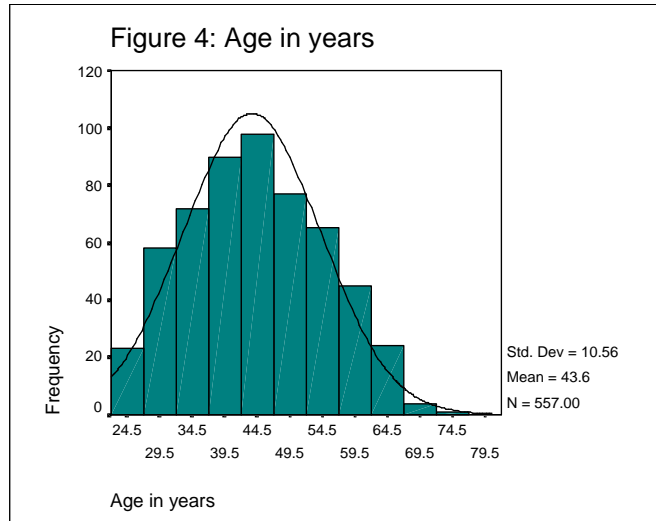


Table 2: University graduated from<sup>5</sup>

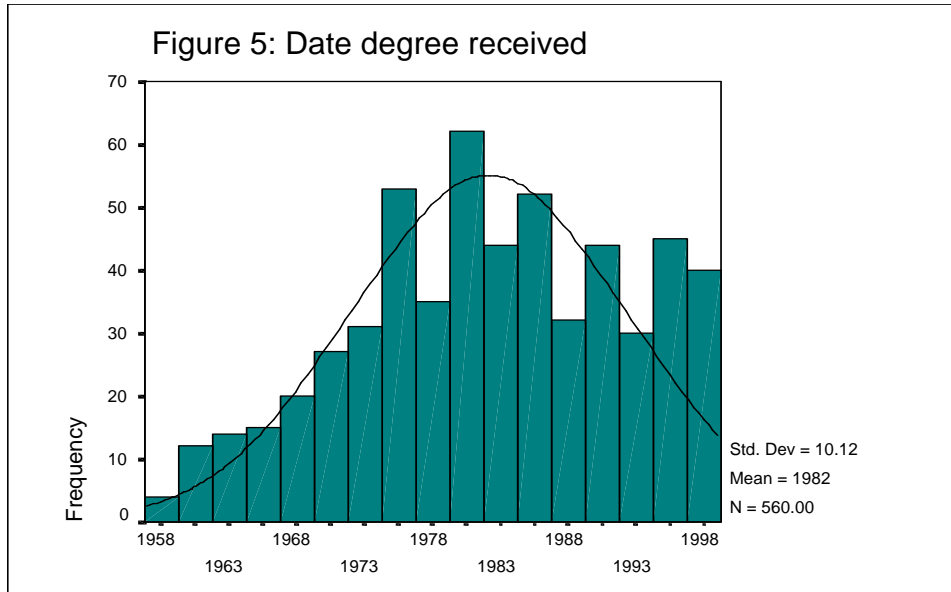
University graduated from		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	University of Cape Town	90	16.0	16.0	16.0
	University of the Free State	41	7.3	7.3	23.3
	Medunsa	23	4.1	4.1	27.4
	University of Natal	52	9.3	9.3	36.7
	University of Pretoria	126	22.4	22.4	59.1
	University of Stellenbosch	55	9.8	9.8	68.9
	University of the Witwatersrand	99	17.6	17.6	86.5
	University of Transkei	2	.4	.4	86.8
	Overseas university	74	13.2	13.2	100.0
<b>Total</b>	<b>562</b>	<b>100.0</b>	<b>100.0</b>		

<sup>5</sup> All frequency tables presented in this report have this format. The 'percent' column reports on the percentage of responses while including any missing values. The 'valid percent' columns presents the percentage of responses excluding any missing values or responses (not applicable here). The 'cumulative percent' column presents the accumulated percentage of responses for a particular response and all preceding responses. This column only makes sense when the variable is measured at an ordinal or interval level and can be ignored in most of the cases.

Table 3: Medium of instruction of university

**Medium of instruction of university**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>English-medium</b>	266	47.3	47.6	47.6
	<b>Afrikaans-medium</b>	222	39.5	39.7	87.3
	<b>Overseas university</b>	71	12.6	12.7	100.0
	<b>Total</b>	559	99.5	100.0	
<b>Missing</b>	<b>System</b>	3	.5		
<b>Total</b>		562	100.0		



We presented the distribution of gender in our sample earlier (Figure 1). For the overall sample the proportion of female to male doctors is 24:76. However, when this proportion is tracked over time, it is very interesting to witness the gradual increase in female doctors. Table 4 below presents the data on gender, grouped according to the year in which the individual received his or her degree. Of those who received their degree before 1975, a mere 12.1% are female. This proportion increases to where 42% of all doctors who graduated after 1990 are female.

Table 4: Gender distribution by degree date

Date received degree (4 groups) \* Gender Crosstabulation

			Gender		Total
			Male	Female	
Date received degree (4 groups)	Before 1975	Count	124	16	140
		Expected Count	107.0	33.0	140.0
		% within Date received degree (4 groups)	88.6%	11.4%	100.0%
		% within Gender	29.0%	12.1%	25.0%
	Between 1975 and 1982	Count	129	24	153
		Expected Count	116.9	36.1	153.0
		% within Date received degree (4 groups)	84.3%	15.7%	100.0%
		% within Gender	30.1%	18.2%	27.3%
	Between 1982 and 1990	Count	100	37	137
		Expected Count	104.7	32.3	137.0
		% within Date received degree (4 groups)	73.0%	27.0%	100.0%
		% within Gender	23.4%	28.0%	24.5%
	After 1990	Count	75	55	130
		Expected Count	99.4	30.6	130.0
		% within Date received degree (4 groups)	57.7%	42.3%	100.0%
		% within Gender	17.5%	41.7%	23.2%
Total	Count	428	132	560	
	Expected Count	428.0	132.0	560.0	
	% within Date received degree (4 groups)	76.4%	23.6%	100.0%	
	% within Gender	100.0%	100.0%	100.0%	

As Table 5 below shows, the majority of respondents practise in cities or metropolitan centres (69%), while the balance is located in towns and rural areas (31%). However, it should be pointed out that this distinction could be problematic. 'Metropolitan' was understood to refer to the *main* metropolitan centres only (Johannesburg/ Pretoria/ Durban/ Pietermaritzburg/ Cape Town/ Port Elizabeth/ East London/ Bloemfontein/ Kimberley).

Table 5: Geographical location of practice

**Metropolitan/town**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Metropolitan</b>	381	67.8	68.9	68.9
	<b>Town</b>	172	30.6	31.1	100.0
	<b>Total</b>	553	98.4	100.0	
<b>Missing</b>	<b>System</b>	9	1.6		
<b>Total</b>		562	100.0		

Tables 6 to 9 (below) present data on the extent to which the sample was exposed to a course in medical ethics as part of their undergraduate curriculum. The sample results are summarised in Table 6, whereas Table 7 presents the data grouped according to the medium of instruction of the university attended. The breakdown by degree date is summarised in Table 8 and the differences between the age groupings in Table 9.

Table 6: Course in medical ethics

**A course in medical ethics was part of the undergraduate curriculum**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Yes</b>	295	52.5	52.9	52.9
	<b>No</b>	205	36.5	36.7	89.6
	<b>Cannot remember</b>	58	10.3	10.4	100.0
	<b>Total</b>	558	99.3	100.0	
<b>Missing</b>	<b>System</b>	4	.7		
<b>Total</b>		562	100.0		

Table 7: Course in ethics by university

Crosstab

		Medium of instruction of university			Total	
		English-medium	Afrikaans-medium	Overseas university		
A course in medical ethics was part of the undergraduate curriculum	Yes	Count	113	145	35	293
		Expected Count	140.2	116.5	36.4	293.0
		% within A course in medical ethics was part of the undergraduate curriculum	38.6%	49.5%	11.9%	100.0%
		% within Medium of instruction of university	42.5%	65.6%	50.7%	52.7%
	No	Count	126	50	29	205
		Expected Count	98.1	81.5	25.4	205.0
		% within A course in medical ethics was part of the undergraduate curriculum	61.5%	24.4%	14.1%	100.0%
		% within Medium of instruction of university	47.4%	22.6%	42.0%	36.9%
	Cannot remember	Count	27	26	5	58
		Expected Count	27.7	23.1	7.2	58.0
		% within A course in medical ethics was part of the undergraduate curriculum	46.6%	44.8%	8.6%	100.0%
		% within Medium of instruction of university	10.2%	11.8%	7.2%	10.4%
Total		Count	266	221	69	556
		Expected Count	266.0	221.0	69.0	556.0
		% within A course in medical ethics was part of the undergraduate curriculum	47.8%	39.7%	12.4%	100.0%
		% within Medium of instruction of university	100.0%	100.0%	100.0%	100.0%

(Chi-square < 0.000; Cramer's V = 0.175)

As Tables 6 to 9 show, there are interesting patterns with regard to whether the respondents attended a course in ethics. In general, respondents who attended Afrikaans-medium universities (Table 7), who graduated more recently (Table 8) and who are younger than 38 (Table 9) are much more likely to have attended such a course. (Note: Given the correlation between age and degree graduated, the results in the latter two tables are, of course, to be expected.)

Table 8: Course in ethics by degree date

Crosstab

			Date received degree (4 groups)				Total
			Before 1975	Between 1975 and 1982	Between 1982 and 1990	After 1990	
A course in medical ethics was part of the undergraduate curriculum	Yes	Count	61	64	76	93	294
		Expected Count	72.8	80.2	72.3	68.6	294.0
		% within A course in medical ethics was part of the undergraduate curriculum	20.7%	21.8%	25.9%	31.6%	100.0%
		% within Date received degree (4 groups)	44.2%	42.1%	55.5%	71.5%	52.8%
	No	Count	62	72	44	27	205
		Expected Count	50.8	55.9	50.4	47.8	205.0
		% within A course in medical ethics was part of the undergraduate curriculum	30.2%	35.1%	21.5%	13.2%	100.0%
		% within Date received degree (4 groups)	44.9%	47.4%	32.1%	20.8%	36.8%
	Cannot remember	Count	15	16	17	10	58
		Expected Count	14.4	15.8	14.3	13.5	58.0
		% within A course in medical ethics was part of the undergraduate curriculum	25.9%	27.6%	29.3%	17.2%	100.0%
		% within Date received degree (4 groups)	10.9%	10.5%	12.4%	7.7%	10.4%
Total	Count	138	152	137	130	557	
	Expected Count	138.0	152.0	137.0	130.0	557.0	
	% within A course in medical ethics was part of the undergraduate curriculum	24.8%	27.3%	24.6%	23.3%	100.0%	
	% within Date received degree (4 groups)	100.0%	100.0%	100.0%	100.0%	100.0%	

(Chi-square  $p < 0.00^6$ ; Cramer's V = 0.171)

<sup>6</sup> The minimum threshold for statistical significance for findings presented in this report is  $p < 0.05$ . This means that if the survey were to be repeated 100 times, any finding reported as significant would be likely to occur by *chance* only five times. A chance occurrence would mean that a reported relationship was spurious. Stated differently, 95 times out of 100, a reported finding is likely to represent a real relationship or difference. Often - as in this specific case - the findings reported are much less likely ( $p < 0.0001$  for instance) to have occurred by chance.

Table 9: Course in ethics by age group

Crosstab

			Age groups (3)			Total
			38 and younger	Between 39 and 48	49 and older	
A course in medical ethics was part of the undergraduate curriculum	Yes	Count	128	90	75	293
		Expected Count	99.6	102.8	90.6	293.0
		% within A course in medical ethics was part of the undergraduate curriculum	43.7%	30.7%	25.6%	100.0%
		% within Age groups (3)	67.7%	46.2%	43.6%	52.7%
	No	Count	44	80	81	205
		Expected Count	69.7	71.9	63.4	205.0
		% within A course in medical ethics was part of the undergraduate curriculum	21.5%	39.0%	39.5%	100.0%
		% within Age groups (3)	23.3%	41.0%	47.1%	36.9%
	Cannot remember	Count	17	25	16	58
		Expected Count	19.7	20.3	17.9	58.0
		% within A course in medical ethics was part of the undergraduate curriculum	29.3%	43.1%	27.6%	100.0%
		% within Age groups (3)	9.0%	12.8%	9.3%	10.4%
Total		Count	189	195	172	556
		Expected Count	189.0	195.0	172.0	556.0
		% within A course in medical ethics was part of the undergraduate curriculum	34.0%	35.1%	30.9%	100.0%
		% within Age groups (3)	100.0%	100.0%	100.0%	100.0%

Summary points

The data on the sample profile presented in this section reveal the following interesting patterns and trends:

- The gender distribution (76: 24/ male: female) is representative of the national picture, but masks the trend towards greater representation by female doctors in more recent years.
- The average age of respondents in the sample is 44 years, with significant differences between male doctors (45 years) and female doctors (39 years).
- The majority (87%) of respondents graduated at a South African university.

- More than two-thirds of our respondents practise medicine in cities or metropolitan areas. However, as pointed out, the distinction between metropolitan and rural could be problematic.
- Interestingly, slightly more than half (53%) of the respondents had taken a course in medical ethics as part of their undergraduate studies, and only slightly more than a third (37%) indicated that they had not taken such a course. Further analyses revealed that younger respondents who attended Afrikaans-medium universities were more likely to have been exposed to such a course.

This concludes our profile of the respondents. As we argued in Section One, given the fact that there is sufficient evidence that our sample represents the general population of South African medical practitioners, it is fair to conclude that these demographic characteristics are also applicable to the total population.

## **SECTION 3**

### **RESULTS: DISCUSSION AND INTERPRETATION**

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In this section, the main body of the report, we discuss and interpret the results of the study according to a number of main themes or headings:

- Ethical values and beliefs: A commitment to sound practice
- Ethics and financial interests
- Evidence of unethical practices
- Reasons for trends in unethical practices
- Remedies: Education and training, codes, and the HPCSA.

#### **Section 3.1:      Ethical values and beliefs: A commitment to sound practice**

In this section we discuss a number of issues concerning the ethical conceptions and beliefs of the sample. In order to make sense of respondents' attitudes and opinions on ethical matters in their daily work environment, it is essential to understand, first, what they believe about the nature of ethics and the medical profession, the professional conduct of their colleagues, and the existence of agreement or not on matters of an ethical nature.

### **Is ethics a matter of personal taste?**

Traditionally, within the field of moral philosophy it is possible to distinguish between people who believe that ethics is inherently a matter of taste - and therefore predominantly subjective and situation-specific - and those who believe that it involves more than mere personal preference, with ethical judgments being based on more "objective" factors. The more "objectivist" standpoints typically relate moral judgments to religion, the law, tradition, reason, or other commonly accepted sources of moral authority.

In response to the question whether ethical conduct is a matter of personal opinion, the majority of respondents (more than 60%) disagreed. About 30% either agreed or strongly agreed with this sentiment, with the remainder (10%) undecided (see Table 10 below).

Further analyses did not reveal any subgroup differences (for example, between gender or age categories). This is thus clearly a rather widely held position.

#### **BOX 1: Conceptions of ethics**

59-year old male doctor from Cape Town: "Ethical awareness is built up over many years from the environment, home, school, religion, standards of society, university, peers. It is too much to hope that a series of ethics lectures will suddenly change a person. We live in an environment that is worldwide largely based on situational relative standards and ethics. Until people grow up in an environment of absolute ethical standards a course of lectures will not have such an impact. A deficiency in ethical standards is found among doctors but it is also found in the full-time and private practice business environments as well as being seen in patients' behaviour."

61-year old male doctor from Cape Town: "Ethical behaviour cannot be taught through textbooks or via the web. It is something one grows up with and then learns more about from role models when you are a young doctor."

36-year old male doctor from a rural town in the Free State: "Ethical conduct in practice is a natural follow-on of sound values learned as a child in the home. The opposite is equally true!"

In their comments on the questionnaire, a number of respondents addressed this issue (see Box 1 above). Again, it is evident from these comments that most believe that ethics is something one acquires through socialisation (church, school, or family) or something related to human nature.

Table 10: Conception of ethical conduct

What constitutes ethical conduct is a matter of personal opinion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	25	4.4	4.5	4.5
	Agree	137	24.4	24.5	29.0
	Neutral	58	10.3	10.4	39.4
	Disagree	266	47.3	47.6	86.9
	Strongly disagree	73	13.0	13.1	100.0
	Total	559	99.5	100.0	
Missing	System	3	.5		
Total		562	100.0		

**Do most doctors act ethically?**

Nearly three-quarters of our respondents hold the opinion that the vast majority of South African doctors are ethical in their professional conduct (Table 11 below). It is important to emphasise this particular result, given the range of "unethical" practices discussed later in this report.

Table 11: Professional conduct of doctors

The vast majority of doctors are ethical in their professional conduct

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongle agree	138	24.6	25.1	25.1
	Agree	262	46.6	47.6	72.7
	Neutral	91	16.2	16.5	89.3
	Disagree	55	9.8	10.0	99.3
	Strongly disagree	4	.7	.7	100.0
	Total	550	97.9	100.0	
Missing	System	12	2.1		
Total		562	100.0		

Further multivariate analyses (see more detailed data in Appendix 1: Figure 1) revealed some interesting subgroup differences. The most significant predictor was whether respondents indicated (in response to question 29) that they had observed incidences of misconduct compared with those who did not. Only 69% of those who had observed such incidences of misconduct (compared with 81% of those who did not) agreed with this statement.

The qualitative comments presented in Box 2 (below) provide evidence in support of the views expressed here and are consistent with the optimistic and idealistic picture presented by common wisdom in society, for example, that doctors are in fact fundamentally ethical in their conduct (and are bound by the Hippocratic Oath or tradition).

**BOX 2: Higher ethical standards for doctors**

59-year old female doctor from Johannesburg: "A doctor should have high ethical standards that can accommodate all cultures and beliefs."

45-year old male doctor from Pretoria: "Doctors are still practising very high standards. You would have to be blind to practise unethically."

25-year old female doctor from a town in the KZN midlands: "As a young doctor, fresh from medical school who has not yet been tempted by financial benefits that seem to be more common in private practice, it might be easier for me to say this, but I believe that all doctors have an ethical and moral responsibility towards their patients that should always come before any financial gain."

**Is there agreement about the meaning of "unethical behaviour"?**

Responses to questions about specific instances of unethical behaviour of medical practitioners do of course presuppose agreement among the respondents as to what is ethical or unethical. In response to the question whether they believe that there is agreement within the medical community about what constitutes "unethical behaviour", nearly half of the respondents (46%) stated that they do not think that there is consensus on this matter. Another quarter remained undecided, while 30% believed that there is agreement on this matter (see Table 12 below). This pattern

of responses does indeed point to a considerable degree of uncertainty and difference. It suggests that there is no obvious consensus within the community about the meaning of "unethical" (and its converse "ethical"). Not surprisingly, a few of the comments made by respondents are consistent with the observed uncertainty. A 56-year old male doctor from Chatsworth asks: "Is medical ethics synonymous with moral values, spiritual values, or of a different value system guided by occupation or vocation?", and a 43-year old male doctor from Durban suggests: "There is an urgent need for firm ethical guidance."

Table 12: What constitutes unethical behaviour

**There is widespread disagreement among doctors about what constitutes unethical behaviour**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Strongly agree</b>	33	5.9	5.9	5.9
	<b>Agree</b>	228	40.6	40.9	46.8
	<b>Neutral</b>	136	24.2	24.4	71.1
	<b>Disagree</b>	146	26.0	26.2	97.3
	<b>Strongly disagree</b>	15	2.7	2.7	100.0
	<b>Total</b>	558	99.3	100.0	
<b>Missing</b>	<b>System</b>	4	.7		
<b>Total</b>		562	100.0		

**Should there be higher moral standards for the medical profession?**

Should the medical profession adhere to higher standards of professional conduct than other professions because of its focus on issues of human life and health? Most South African doctors certainly do believe that their profession requires a higher standard of moral integrity. Nine out of ten doctors agreed or strongly agreed with this sentiment (Table 13 below). Further analyses also showed that this belief is widely shared, and no significant differences emerged within subgroups.

Table 13: Medicine and standard of moral integrity

**The practice of medicine imposes a higher standard of moral integrity than other professions**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	299	53.2	53.5	53.5
	Agree	207	36.8	37.0	90.5
	Neutral	26	4.6	4.7	95.2
	Disagree	26	4.6	4.7	99.8
	Strongly disagree	1	.2	.2	100.0
	Total	559	99.5	100.0	
Missing	System	3	.5		
Total		562	100.0		

Qualitative comments made by some respondents reinforce the view that doctors do view their profession as a "calling" that demands more commitment and integrity than many other professions (Box 3).

<p><b><u>BOX 3: Integrity in medical practice</u></b></p> <p>40-year old male doctor from Cape Town: "Primarily medicine is a 'calling'... A great profession, but not a good space right now with respect to ethics and medical ethics."</p> <p>43-year old male doctor from Durban: "Healthcare is a most intimate profession and therefore demands the most emotion from one's career. Hence it calls for the highest standards of integrity. That explains why it has been unfairly [<i>sic</i>] singled out."</p>
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### **General perceptions of the medical profession**

Recent reporting in the South African media that focused on incidences of ethical misconduct within the medical profession has led to renewed interest and concern over the standards of professional ethics in the profession<sup>7</sup>. Given similar concern in other professions and regular reports of misconduct and corruption within government departments and other public offices, these reports have also raised the question whether the medical profession is not being unfairly singled out for attention.

Two questions in our survey addressed these issues. Firstly, respondents were asked to indicate what their views are on the general public's attitudes towards the professional conduct of medical practitioners. Secondly, they were asked whether they believe that the medical profession is being unfairly singled out amidst wider concerns about ethical misconduct in other spheres of society.

As far as the first issue is concerned, namely, whether the general public thinks doctors are unethical in their everyday professional conduct, opinion is pretty much divided across the sample. Thirty percent agreed or strongly agreed with the statement, another 28% was undecided and the remaining 45% disagreed with the statement (Table 14 below). More detailed analyses revealed interesting differences within subgroups in the sample. The most significant differences of opinion were observed between those respondents who had observed misconduct among their colleagues and those who had not. Not surprisingly, more of the former group (33%) agreed with this statement compared with the latter group (18%) (see Chaid data in Appendix 1: Figure 2).

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<sup>7</sup> An example of such reporting is Claire Bisseker's article, Will these physicians be able to heal themselves?, in *Financial Mail*, 21 April 2000, pp. 42-43.

Table 14: Attitudes of general public towards doctors

The general public thinks doctors are unethical in their everyday professional conduct

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	19	3.4	3.4	3.4
	Agree	133	23.7	23.9	27.3
	Neutral	156	27.8	28.0	55.3
	Disagree	220	39.1	39.5	94.8
	Strongly disagree	29	5.2	5.2	100.0
	Total	557	99.1	100.0	
Missing	System	5	.9		
Total		562	100.0		

As far as the (second) issue of unfair attention is concerned, a large majority (70%) of respondents indicated that they believe that the medical profession is receiving more negative "publicity" than is warranted (Table 15 below). These sentiments were also echoed in the qualitative comments made by a number of respondents (Box 4).

**BOX 4: Media representation of doctors**

47-year old male doctor from Cape Town: "Medical events are over-sensationalised by the press and TV to satisfy readers and viewers. However, the medical profession needs to be less self-righteous and more realistic about its role in society."

50-year old female doctor from Gauteng: "Doctors are portrayed by the press as bloodsuckers and profiteers. The lay press demands that the best service is given for minimal fees because of the Hippocratic Oath!! No such demands are made on any other profession!"

48-year old male doctor from Pretoria: "I find these days that doctors are scapegoats for all that goes wrong in the health service, for example [high] cost."

Table 15: Are doctors being singled out?

Compared with other professions and occupations, doctors are unfairly singled out for being unethical

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	154	27.4	27.6	27.6
	Agree	238	42.3	42.7	70.4
	Neutral	78	13.9	14.0	84.4
	Disagree	83	14.8	14.9	99.3
	Strongly disagree	4	.7	.7	100.0
	Total	557	99.1	100.0	
Missing	System	5	.9		
Total		562	100.0		

In conclusion, the following salient points emerged in this section:

- Most doctors hold the view that ethics is more than a matter of mere opinion or taste.
- Although there are interesting subgroup differences, it is clear that most South African doctors believe that their colleagues act in a morally responsible manner.
- At the same time, there is evidence to suggest there is insufficient clarity on what constitutes “ethical” or “unethical” practice to lead to consensus on the issue. This might - as we will show later - be due to the fact that many of our respondents indicated that the existing rules provided by the HPCSA are not clear.
- There is considerable agreement, however, that the medical profession imposes higher standards of moral integrity on its members when compared with most other professions.
- Doctors are divided about whether the general public holds negative views on the profession, but a majority agrees that the profession has recently been unfairly singled out in negative media reporting.

It would probably be fair to conclude that the overriding impression one gains from this set of responses is of a community that (1) is still firmly committed to upholding the high moral standards traditionally associated with the medical profession; but which also (2) recognises that there are increasingly high expectations and scrutiny from the public that require continuous attention to ethical issues. The latter trend should not be viewed in isolation from the current climate of debates about ethics in other sectors of South African society and government that have raised the general ethical awareness of the public and the media.

**Section 3.2      Ethics and financial interests**

In this section we focus on a set of issues that increasingly have become part of public debates - the relationship between medical practice and financial interests. This raised awareness is perhaps due, at least in part, to the fact that this relationship is inherently problematic and that no clear guidelines or conventions have been established to guide medical practitioners.

**Is the medical profession fundamentally different from other professions AND do doctors deserve greater financial rewards?**

In order to establish the broader context within which doctors would interpret what is acceptable or not regarding financial interests, we decided to ask two more general questions first, that is, whether they agreed with the following statements:

- (1) Doctors deserve financial rewards greater than individuals in most other occupations, and
- (2) Being a doctor in private practice is no different from any other business selling a service.

Tables 16 and 17 (below) present the frequencies of the responses to each statement, whereas Table 18 (below) presents the crosstabulation on these statements. (One would expect to find a strong correlation between the respondents' responses to these two related questions.)

Table 16: Doctors deserve greater financial rewards

**Doctors deserve financial rewards greater than individuals in most other occupations**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	91	16.2	16.4	16.4
	Agree	162	28.8	29.1	45.5
	Neutral	138	24.6	24.8	70.3
	Disagree	129	23.0	23.2	93.5
	Strongly disagree	36	6.4	6.5	100.0
	Total	556	98.9	100.0	
Missing	System	6	1.1		
Total		562	100.0		

Table 17: Medical practice comparable to any other business

Being a doctor in private practice is no different from any other business selling a service

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	68	12.1	12.2	12.2
	Agree	133	23.7	23.9	36.1
	Neutral	58	10.3	10.4	46.5
	Disagree	185	32.9	33.2	79.7
	Strongly disagree	113	20.1	20.3	100.0
	Total	557	99.1	100.0	
Missing	System	5	.9		
Total		562	100.0		

Interestingly - and perhaps somewhat surprisingly in view of the Hippocratic tradition - the responses to the two separate statements do not reveal a strong view about the uniqueness or distinctiveness of the medical profession. Although 46% of respondents agreed that doctors deserve greater financial rewards compared with other occupations, a significant 25% were neutral on the matter, and nearly 30% disagreed with this view (Table 16 above). Similarly (see Table 17 above), more than a third (36%) of respondents indicated that they agree or strongly agree with the view that being a doctor in private practice is no different from any other business selling a service. A plurality of 46% of respondents recorded their disagreement with this view, while the remaining 10% are undecided.

Further multivariate analyses revealed a few subgroup differences.

- Significantly more male doctors (48%) than female doctors (36%) indicated that they agree with the view that doctors deserve greater financial rewards.
- Significantly more doctors who received their degrees at South African universities (38%), compared with those who studied overseas (26%), agreed with the statement that being a doctor in private practice is no different from any other business selling a service.

No other significant differences were recorded on either of these items.

Table 18 below summarises the crosstabulation of responses to both questions. The most salient point to emerge from this table is the following: One would have expected that respondents who believe that a medical practitioner is (fundamentally?) different from an individual who sells his or her services, would be also be more likely to believe that doctors deserve financial rewards greater than most other occupations. In terms of the table, one would have expected that those who DISAGREE with the statement presented in the columns (Being a doctor in private practice is no different from any other business selling a service) would also tend to AGREE with the statement in the rows (Doctors deserve financial rewards greater than individuals in most other occupations). The results, however, do not show a consistent pattern along these lines. In fact, the results show equal numbers in all the cells of the crosstabulation. Stated differently, it does not seem as if these two beliefs (about the fundamental "uniqueness" of the medical profession and the issues of greater financial rewards) are related in the minds of our respondents.

As far as our respondents are concerned, this means that whether they view the medical profession as being fundamentally different from other professions or not (and our sample is clearly divided on this matter) does not have clear implications for their beliefs about remuneration for their services. This appears contrary to a common viewpoint that would argue that the remuneration or reward system is likely to be linked to the perceived uniqueness (and importance) of the medical profession!

Table 18: Relationship between perceptions about financial rewards and perceptions about clinical practice as similar to other businesses

Doctors deserve financial rewards greater than individuals in most other occupations \* Being a doctor in private practice is no different from any other business selling a service Crosstabulation

			Being a doctor in private practice is no different from any other business selling a service			Total
			Agree	Neutral	Disagree	
Doctors deserve financial rewards greater than individuals in most other occupations	Agree	Count	108	17	128	253
		Expected Count	91.3	26.0	135.6	253.0
		% within Doctors deserve financial rewards greater than individuals in most other occupations	42.7%	6.7%	50.6%	100.0%
		% within Being a doctor in private practice is no different from any other business selling a service	54.0%	29.8%	43.1%	45.7%
	Neutral	Count	42	21	75	138
		Expected Count	49.8	14.2	74.0	138.0
		% within Doctors deserve financial rewards greater than individuals in most other occupations	30.4%	15.2%	54.3%	100.0%
		% within Being a doctor in private practice is no different from any other business selling a service	21.0%	36.8%	25.3%	24.9%
	Disagree	Count	50	19	94	163
		Expected Count	58.8	16.8	87.4	163.0
		% within Doctors deserve financial rewards greater than individuals in most other occupations	30.7%	11.7%	57.7%	100.0%
		% within Being a doctor in private practice is no different from any other business selling a service	25.0%	33.3%	31.6%	29.4%
Total	Count	200	57	297	554	
	Expected Count	200.0	57.0	297.0	554.0	
	% within Doctors deserve financial rewards greater than individuals in most other occupations	36.1%	10.3%	53.6%	100.0%	
	% within Being a doctor in private practice is no different from any other business selling a service	100.0%	100.0%	100.0%	100.0%	

In similar vein, we asked respondents to indicate their degree of agreement with the following statement: Being a good clinician and running a profitable medical practice is an uneasy alliance. The responses are summarised in Table 19 below.

Table 19: Good clinician and running a profitable medical practice

**Being a good clinician and running a profitable medical practice is an uneasy alliance**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	77	13.7	13.9	13.9
	Agree	173	30.8	31.2	45.0
	Neutral	80	14.2	14.4	59.5
	Disagree	160	28.5	28.8	88.3
	Strongly disagree	65	11.6	11.7	100.0
	Total	555	98.8	100.0	
Missing	System	7	1.2		
Total		562	100.0		

Given the division of responses to the previous questions, it was perhaps to be expected that our respondents would not exhibit a clear consensus on this matter either. Although nearly half (45%) indicated their agreement with the statement, an equally substantial 40% disagreed, while 14% remained undecided. An example of a response of the former kind is included in Box 5.

**BOX 5: Clinical obligations and profit**

44-year old male doctor from Johannesburg: "The medical profession has been put under enormous pressure because of the interference of so many other agencies - health management, government, private hospitals, the pharmaceutical industry have the prime objective of making a quick profit. Doctors' decisions are no longer based on clinical judgement, but on satisfying the demands of other agencies. Even doctors who have an ethical fiduciary relationship with their patients are forced to make compromises in their treatments on a regular basis."

In summary: We have shown three sets of results related to the question of how doctors view their practice: Do they believe that a medical practice is fundamentally different from other business practices? Do they believe that doctors deserve greater financial rewards than individuals in other occupations? Do they believe that it is easy to align the concerns of a clinician with running a profitable medical practice? The responses to these questions reveal a consistent pattern: South African doctors are clearly divided on the (changing) nature of the medical profession. There are comparable proportions who believe that a medical practice is merely another

business and those who believe that it is different from other occupations. This might not indicate strong disagreement within the medical community, but may rather signify that there are fundamental changes within the medical profession - its increasing commercialisation or "corporatisation".

**Doctors, financial interests and clinical decision making**

One of the implications of these developments, of course, is that it raises a host of questions about the financial interests of medical practitioners and whether such interests are fundamentally in conflict with the ethos of a clinician. Three related statements were put to our respondents:

- It is acceptable for doctors to have a financial interest in an organisation to which they make referrals (Table 20 below).
- Doctors should disclose to their patients if they have a financial interest in an organisation to which they make referrals (Table 21 below).
- Having a financial interest in an organisation to which I refer patients would not influence my clinical decisions in any way (Table 22 below).

Table 20: Interest in organisation to which referrals are made

**It is acceptable for doctors to have a financial interest in an organisation to which they make referrals**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	29	5.2	5.2	5.2
	Agree	198	35.2	35.5	40.7
	Neutral	137	24.4	24.6	65.2
	Disagree	129	23.0	23.1	88.4
	Strongly disagree	65	11.6	11.6	100.0
	Total	558	99.3	100.0	
Missing	System	4	.7		
<b>Total</b>		562	100.0		

Table 21: Doctors should disclose financial interests

**Doctors should disclose to their patients if they have a financial interest in an organisation to which they refer patients**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	145	25.8	26.0	26.0
	Agree	197	35.1	35.4	61.4
	Neutral	110	19.6	19.7	81.1
	Disagree	85	15.1	15.3	96.4
	Strongly disagree	20	3.6	3.6	100.0
	Total	557	99.1	100.0	
Missing	System	5	.9		
Total		562	100.0		

Table 22: Financial interest would affect clinical decisions

**Having a financial interest in an organisation to which I refer patients would not influence my clinical decisions in any way**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	148	26.3	26.6	26.6
	Agree	175	31.1	31.5	58.1
	Neutral	86	15.3	15.5	73.6
	Disagree	121	21.5	21.8	95.3
	Strongly disagree	26	4.6	4.7	100.0
	Total	556	98.9	100.0	
Missing	System	6	1.1		
Total		562	100.0		

The salient points that emerge from these results are as follows:

- Clearly, the sample is divided on whether it is *acceptable* for doctors to have a financial interest in organisations to which they make referrals (41% agreed, 35% disagreed, with 25% undecided). Further analyses did not reveal any significant subgroup differences. The only exception relates to differences between GPs and specialists. A slightly larger proportion of specialists (44%) compared to GPs (39%) agreed with the statement.

- There is much more agreement that where doctors have such interests these should be *declared* or *disclosed* to their patients (61%). It is perhaps more surprising that nearly 20% of our respondents disagreed with this statement! These views are widely shared by respondents; no subgroup differences were recorded.
- There is a similar consensus (58%) among our sample that having such an interest would not affect their *clinical decisions*. However, it is also noteworthy that a significant quarter of the sample indicated their disagreement with this sentiment. There are interesting differences within subgroups in the sample that are revealed in the Chaid data of Appendix 1: Figure 3. The most salient of these are the following:
  - The fact that the type of employment (whether the respondent is in full-time private practice, full-time state employment, or mixed private/state employment) emerged as the most significant predictor of differences on this item. Significantly more doctors in private practice (68%) than in state employment or in mixed type employments (45%) said that having such an interest would not affect their clinical decisions.
  - A further division within the first group (full-time private practice) emerged: A significant difference exists between those private practitioners who indicated that they had observed some form of misconduct amongst their colleagues compared with those who had not. Sixty percent of those who had observed such instances of misconduct, compared with 78% of those who had not, said that they believe that having a financial interest would not affect their clinical decisions. Clearly the former group is somewhat more sceptical about this link.

In summary: South African doctors clearly disagree about whether having a financial interest in an organisation to which they refer patients is acceptable. Not surprisingly, when asked whether such interests (where they exist) should be declared, the majority selected the "morally appropriate" option! Similarly, most respondents indicated - perhaps more out of an idealistic expectation than actual

experience - that having such interests would not affect their clinical decisions. There are interesting and significant differences within the medical community on this matter, which are related to the type of practice as well as previous experiences regarding instances of misconduct.

In the final analysis, it is clear that the changing nature of the medical profession, and the new demands that are being placed on medical practitioners because of business related considerations, require new innovative approaches. South African doctors are increasingly facing such new developments and are clearly divided about many of their implications!

### **Section 3.3      Evidence of unethical practices**

It was one of the main goals of this survey to establish the nature and extent of unethical conduct within the medical profession as it pertains to issues of professional ethics. It is worth repeating that the focus was on ethical issues which result from the practice of medicine as a "business" and the peculiar ethical problems and dilemmas that medical practitioners have to face in their interactions with other actors such as pharmaceutical companies, hospitals and clinics, medical aid firms, and so on. The survey explicitly did not focus on the ethics of the doctor-patient relationship or clinical ethics.

#### **A methodological note on ethics research**

Empirical studies, and surveys in particular, on ethics are notoriously difficult. They fall within the general category of sensitive research<sup>8</sup>. It is considered sensitive research for a number of reasons, but primarily because of the degree of "reactivity" involved. "Reactivity" refers to the phenomenon in social research where research subjects and participants react and respond in various ways because they are aware

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<sup>8</sup> For a comprehensive discussion of the problems peculiar to sensitive research, see R. Raymond M. Lee's book *Doing research on sensitive topics* (London: Sage, 1993). Another good text on the same topic is that by C.M. Renzetti e.a. (Eds) *Researching sensitive topics* (London: Sage, 1993).

that they are being investigated (except in cases of covert research), which in turn can affect the overall validity and reliability of social science data<sup>9</sup>.

Some of these responses involve lying, deception, social desirability responses (trying to please the investigator), acquiescence response sets (agreeing with everything being asked), and so on. Reactivity is a general feature of much social research but is more pronounced in research on sensitive topics. Any study that addresses matters of morality (such as this survey), private actions and behaviours (for example, sexuality), or potentially threatening issues (for example, information on income or crime related behaviours) is generally considered "sensitive research". In studies of this nature the "reactivity" is often even more pronounced. This clearly requires greater awareness and methodological sensitivity on the part of the researcher.

We faced such problems when formulating the items in the questionnaire that refer to matters of unethical behaviour. The first problem we faced was that no respondent would intentionally incriminate himself or herself when required to answer affirmatively about an unethical action. *This led us to formulate questions (such as Questions 34 to 38) in the third person.* Rather than asking the question: "Has a pharmaceutical company offered you a discount for purchasing a certain volume of medicine?" we rephrased it to read: "How often - in your estimate - does it happen to a doctor that a pharmaceutical company offers him or her a discount?".

The only exceptions were in the formulation of Question 29 (Have you ever observed medical misconduct by a colleague?) and Question 30 (Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?). We believed that these questions (a) needed to be asked in the first person and (b) would not be perceived to be threatening in any way to our respondents.

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<sup>9</sup> See J. Mouton's *Understanding social research* (Pretoria: Van Schaik, 1996) for a general discussion of the problem of reactivity.

During pre-testing of the pilot questionnaire, we specifically asked our respondents to comment on these issues. The feedback did not warrant any changes to any of these questions.

Some of the more critical comments made about this survey, after its initial results had been released on 30 November 2000, concerned the veracity of the responses to the questions in this section. Typically, questions were asked about whether one can place much weight on the answers to questions that require respondents to report on "observed misconduct" (Question 29) and "estimated frequency of unethical practices" (Question 35). Criticisms were levelled against the fact that responses to these items "merely" reflect subjects' opinions or estimates, or the experiences of respondents which are not "verifiable" or "substantiated", and so on. Our response to this criticism is twofold. Firstly, all surveys are based on self-reporting by respondents and in that sense are invariably "subjective". This does not necessarily make them unreliable or unbelievable, but means that we have to be conscious of the limitations of such data in general. Our survey is no different from any other survey in this respect. Secondly, survey analysts always emphasise - for obvious reasons - that the results of surveys should be analysed and interpreted not by looking at individual responses to individual items, but rather by focussing on *patterns* and *trends* in the data. If one *consistently* gets a set of responses that are *mutually reinforcing*, or if patterns in one part of the data set are *replicated* by patterns elsewhere in the set, then one has reason to believe that the data have an acceptable level of reliability and credibility.

We believe that the results that have been presented thus far, and particularly the trends and patterns that emerge from our discussion of the findings in this section, meet this criterion. We have seen no evidence in the data (or in the hundreds of qualitative comments made by respondents) that would suggest that the respondents wilfully misrepresented matters or deliberately tried to mislead us. On the contrary, we would argue that the anonymity of the survey, the positive remarks made in the qualitative open-ended comments, and the relatively high response rate, are all indicators that the majority of respondents gave reliable and honest responses.

## **Misconduct "observed" and 'whistle-blowing'**

After this methodological "detour" we now turn to the findings of this section. We begin our discussion with the two questions that were aimed at establishing the extent of "observed medical misconduct" (Table 23 below) and whether respondents believed that reporting such cases of misconduct would have negative consequences for themselves (Table 24 below). The qualitative comments that relate to the first set of responses are included in Box 6 below.

Table 23: Observed medical misconduct by a colleague

Have you ever observed medical misconduct by a colleague?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	343	61.0	61.4	61.4
	No	199	35.4	35.6	97.0
	Don't know	17	3.0	3.0	100.0
	Total	559	99.5	100.0	
Missing	System	3	.5		
Total		562	100.0		

### **BOX 6: Observed medical misconduct**

54-year old male doctor from Durban: "I've never seen or directly heard of any such things."

31-year old male doctor from Pretoria: "I am in the unique position to view the profession from the pharmaceutical multinational perspective. I have witnessed extremely unethical behaviour in the guise of IPA formulary development. I am disgusted in the behaviour of individuals."

53-year old male doctor from Germiston: "Most doctors, like humans in all walks of life, have their price."

28-year old male doctor from Pretoria: "As a GP I cannot comment for specialists. I have seen doctors/institutions being unethical in my short career."

36-year old female doctor from northern KZN: "On a weekly basis we hear of gross stories of professional misconduct and unethical practice by means of ruthless, unscrupulous colleagues. This makes me very angry, as these practices tend to draw the larger patient pool due to their corrupt practices. Patients today are not only concerned about medical care, but [also] the best 'deal' they can get from a doctor. So, if a doctor is corrupt, receives kickbacks, over-services patients, etc., he tends to draw more patients who are as corrupt as he is. However, we just have to sit back and watch all these unethical practices without reporting them as we don't have concrete proof and fear negative reactions should we spill the beans on a corrupt colleague. Some of us do an honest day's work, i.e. seeing patients who are really ill and not just merely boosting numbers because of unsavoury practices and medical aid fraud."

Table 24: Negative consequences of reporting unethical conduct

**Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Yes</b>	285	50.7	51.1	51.1
	<b>No</b>	170	30.2	30.5	81.5
	<b>Don't know</b>	103	18.3	18.5	100.0
	<b>Total</b>	558	99.3	100.0	
<b>Missing</b>	<b>System</b>	4	.7		
<b>Total</b>		562	100.0		

Discussion

Detailed analysis of the results presented in Table 23 (above) shows that the reported 61% of doctors who indicated that they had observed medical misconduct by a colleague applies to all subgroups within the sample. No significant subgroup differences were recorded<sup>10</sup>.

The results in Table 24 (above) are interesting in terms of what they say, but perhaps even more so in terms of what they do not reveal. Half of the respondents believe (rightly or wrongly) that there would be negative consequences for themselves if they were to report instances of misconduct. Nearly a third disagrees and 19% said that they do not know. The logical question that follows is why do such a large percentage of the sample believe that they would be faced with negative consequences? By whom? And for what reasons? These questions need to be asked in future studies, because the results suggest *that the existing professional climate is not amenable to or supportive of "coming clean"*. If our respondents are correct in their belief or assumption that there might be such negative implications (of what kind?), it does not augur well for future discussions about transparency and

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<sup>10</sup> Some of the more critical comments made about the survey specifically singled out this result. In a press statement, the HPCSA asserts that "the report merely reflects unsubstantiated claims without any supporting evidence". Some commentators asked how doctors, especially those who work in single-person private practice, could claim that they had observed instances of medical misconduct by a colleague. No doubt these are worthwhile questions, and perhaps require further investigation in the future. However, in defence of this result, it should be pointed out that there is no obvious reason why doctors would want to exaggerate or lie about this. On the contrary, one could argue that doctors would want to present as favourable a picture of the profession as possible, and might therefore rather be tempted to downplay such instances. Either way, we would suggest that it is the size of the proportion of affirmative instances (more than half of the respondents) rather than the actual percentage point that is significant!

ethically acceptable conduct. Finally, we asked whether there was a relationship between the responses to these two questions. The results are presented in Table 25 below.

Table 25: Crosstabulating observed misconduct with the likelihood of negative consequences for oneself if one reports

**Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically? \* Have you ever observed medical misconduct by a colleague?**  
Crosstabulation

			Have you ever observed medical misconduct by a colleague?			Total
			Yes	No	Don't know	
Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?	Yes	Count	212	59	10	281
		Expected Count	172.1	100.3	8.7	281.0
		% within Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?	75.4%	21.0%	3.6%	100.0%
	No	Count	71	97	2	170
		Expected Count	104.1	60.7	5.2	170.0
		% within Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?	41.8%	57.1%	1.2%	100.0%
	Don't know	Count	55	41	5	101
		Expected Count	61.8	36.0	3.1	101.0
		% within Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?	54.5%	40.6%	5.0%	100.0%
Total		Count	338	197	17	552
		Expected Count	338.0	197.0	17.0	552.0
		% within Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?	61.2%	35.7%	3.1%	100.0%

The results presented in Table 25 (above) reveal a moderately strong relationship between the responses to the two questions (Cramer's  $V = 0.240$ ) that is highly significant ( $p < 0.0001$ ). Closer inspection shows why this is the case. There is a clear association between whether a respondent answered affirmatively to Question 28 (Whether you observed medical misconduct) and whether a respondent anticipated negative consequences for himself or herself (Question 29). If one bears in mind that 51% of the total sample indicated that they anticipated negative consequences for themselves should they report a colleague who acts unethically (Table 23 above), it is quite noteworthy *that this proportion increases to 75% when we confine ourselves to those who said that they had observed medical misconduct* (in response to Question 28). So, obviously, those who had observed instances of medical misconduct were of the opinion that negative consequences might ensue. It could be that they had thought about it more, or might even have seen examples of this. This set of results fits in with the general pattern of responses thus far and provides further support for the overall veracity of the findings. In the remainder of this section we present and discuss the results as they pertain to specific examples of ethical dilemmas or unethical practices as reported by the sample.

### **Cases where doctors supplement their income through inappropriate practices**

The first set of statements (Question 34) all refer to various sources used by doctors to supplement their income in ways that may be regarded as inappropriate or unethical. Table 26 (below) summarises the results with regard to the five sources of questionable additional income listed in the questionnaire:

- Over-servicing of patients
- The use of multinational pharmaceutical companies
- The use of generic (local) pharmaceutical companies
- The use of specialists

- The use of private hospitals or clinics.

Table 26: Doctors supplementing their income

			Observed misconduct		Employment			Total
			Yes	No	Full-time private practice	Full-time state employment	Mixed private/state	
Doctors supplementing their own income through over-servicing of patients	Yes	Count	245	94	202	60	57	319
		Col%	72.7%	49.5%	65.8%	56.6%	64.0%	63.5%
	No	Count	30	40	48	9	11	68
		Col%	8.9%	21.1%	15.6%	8.5%	12.4%	13.5%
	Don't know	Count	62	56	57	37	21	115
		Col%	18.4%	29.5%	18.6%	34.9%	23.6%	22.9%
Doctors supplementing their own income through multi-national pharmaceutical companies	Yes	Count	110	31	83	18	26	127
		Col%	33.5%	16.1%	27.4%	17.3%	29.2%	25.6%
	No	Count	52	38	61	15	13	89
		Col%	15.9%	19.8%	20.1%	14.4%	14.6%	17.9%
	Don't know	Count	166	123	159	71	50	280
		Col%	50.6%	64.1%	52.5%	68.3%	56.2%	56.5%
Doctors supplementing their own income through generic (local) pharmaceutical companies	Yes	Count	97	45	88	18	23	129
		Col%	29.6%	23.6%	29.3%	17.1%	25.6%	26.1%
	No	Count	55	34	56	14	17	87
		Col%	16.8%	17.8%	18.7%	13.3%	18.9%	17.6%
	Don't know	Count	176	112	156	73	50	279
		Col%	53.7%	58.6%	52.0%	69.5%	55.6%	56.4%
Doctors supplementing their own income through specialists	Yes	Count	64	18	37	27	12	76
		Col%	19.4%	9.4%	12.2%	25.7%	13.5%	15.3%
	No	Count	108	73	122	22	31	175
		Col%	32.7%	38.0%	40.1%	21.0%	34.8%	35.1%
	Don't know	Count	158	101	145	56	46	247
		Col%	47.9%	52.6%	47.7%	53.3%	51.7%	49.6%
Doctors supplementing their own income through private hospitals/clinics	Yes	Count	154	55	109	49	34	192
		Col%	46.7%	28.5%	36.0%	46.2%	37.8%	38.5%
	No	Count	56	50	82	10	14	106
		Col%	17.0%	25.9%	27.1%	9.4%	15.6%	21.2%
	Don't know	Count	120	88	112	47	42	201
		Col%	36.4%	45.6%	37.0%	44.3%	46.7%	40.3%
Total	Count	330	193	303	106	90	499	
	Row%	63.1%	36.9%	60.7%	21.2%	18.0%	100.0%	

We have used two grouping variables (Whether the respondent had observed cases of misconduct or not, AND Type of practice). This decision was based on the fact that the CHAID-analyses showed that these two variables generated some significant subgroup differences within the responses to Question 34.

The salient points to emerge from this table are as follows:

- Nearly two-thirds (64%) of respondents estimated that doctors supplement their income through over-servicing patients. Another 14% responded in the negative, whereas a sizeable 23% indicated that they did not know. As one might expect, of those who had previously indicated that they had observed cases of misconduct, nearly three-quarters (73%) indicated their concurrence with this estimate. Differences in type of practice do not appear to be associated with differences in responses to the first questions.
- Looking at the remainder of the items in Question 34, the most noticeable feature is the very substantive percentages of "don't know" responses. They vary between 40% and 57%. This indicates how difficult it would be to estimate the frequency of occurrences where observations were not first-hand. It also, incidentally, suggests that our respondents were on the whole quite honest in their responses! In all four of these items, the percentage of affirmative responses varies between 15% (Doctors estimated to supplement their income through using specialists) and 39% (Use of private hospitals and clinics to supplement income).
- In most cases, the estimates for the proportions of affirmative responses correlate with whether the respondent claimed to have had observed instances of misconduct. In a few cases, type of practice is seen to correlate weakly with such estimates. In these cases, higher estimates are generally given by respondents who are in private practice. The only exception to this pattern is the use of specialists, where higher percentages of those in state employment or mixed private/state employment indicated that they believe doctors use this as a source of additional income.

Some of the qualitative comments relating to these issues are presented in Box 7 below. In summary, then, it is clear that doctors do believe or estimate that their colleagues supplement their income through various means. The most obvious source is *over-servicing* patients. Although there is some evidence that the other sources or means listed are also used by doctors, there is no conclusive or strong evidence to suggest that these are pervasive practices.

### **BOX 7: Doctors supplementing their income**

40-year old female doctor from Wonderboom: "Ek dink dat die GPs die 'gatekeeper' moet wees. Ongelukkig verwys pasiënte hulle self onnodig na spesialiste wat kostes opjaag. Pasiënte loop onnodig rond tussen dokters, wat ook kostes opjaag."

31-year old female doctor from Cape Town: "Specialists certainly sometimes 'overpay' for assisting trying to win future referrals - its all quite interesting to watch!"

41-year old male doctor from Boksburg: "The alternates of over-servicing or receiving 'unethical payments' or, alternately, leaving the country are very attractive."

53-year old male doctor from Potchefstroom: "Sekere klinieke moedig dokters aan om meer prosedures te doen om sodoende hulle eie kliniek en dokters se sakke te vul... Bogenoemde dokters doen ook procedures, bv. gastroskopie, waarvoor hulle nie gekwalifiseer is nie. Waarom word dit nie gemonitor nie?"

41-year old male doctor from Cape Town: "Specialised investigations are often done to 'prove' to the patient that nothing is wrong requiring surgical correction. Despite clinical assessment, 'scans' etc. are the 'gold standard' for the patient."

### **Frequency of other unethical practices**

In this section we discuss the results regarding the prevalence of a number of other unethical practices. Respondents were asked (again by estimating the frequency) how often they believe certain instances of unethical practices occurred. We wish to point out that although these estimates are based on the particular experience and frame of reference (also a matter of interpretation) of each respondent, we would contend that it is the *overall pattern of responses* which emerges from this question that is worth discussing, rather than individual percentages of responses. Table 27 (below) summarises the responses to this question using 'type of employment' as a grouping variable. Again, Chaid-analyses identified this as the most significant predictor of differences within the sample with regard to these items.

Table 27: Awareness of unethical practices

			Employment			Total	
			Full-time private practice	Full-time state employment	Mixed private/state		
A pharmaceutical company offers a doctor a discount for purchasing a certain volume of medicine	Daily	Count	46	12	13	71	
		Col%	16.3%	14.1%	15.7%	15.7%	
	Weekly	Count	67	12	14	93	
		Col%	23.7%	14.1%	16.9%	20.6%	
	Monthly	Count	94	38	29	161	
		Col%	33.2%	44.7%	34.9%	35.7%	
	Once/twice a year	Count	33	14	8	55	
		Col%	11.7%	16.5%	9.6%	12.2%	
	Never	Count	43	9	19	71	
		Col%	15.2%	10.6%	22.9%	15.7%	
	A pharmaceutical company invites a doctor to a lavish promotion in an exotic place	Daily	Count	5	4	3	12
			Col%	1.7%	4.8%	3.5%	2.6%
Weekly		Count	12	2	3	17	
		Col%	4.1%	2.4%	3.5%	3.7%	
Monthly		Count	38	20	9	67	
		Col%	12.9%	24.1%	10.6%	14.5%	
Once/twice a year		Count	173	52	40	265	
		Col%	58.8%	62.7%	47.1%	57.4%	
Never		Count	66	5	30	101	
		Col%	22.4%	6.0%	35.3%	21.9%	
A private hospital/clinic offers a doctor money for ordering additional tests for patients after admission		Daily	Count	4	5	3	12
			Col%	1.5%	6.5%	3.9%	2.8%
	Weekly	Count	6	3		9	
		Col%	2.2%	3.9%		2.1%	
	Monthly	Count	16	15	5	36	
		Col%	5.9%	19.5%	6.6%	8.5%	
	Once/twice a year	Count	27	22	2	51	
		Col%	9.9%	28.6%	2.6%	12.0%	
	Never	Count	220	32	66	318	
		Col%	80.6%	41.6%	86.8%	74.6%	
	A specialist or specialist group offers a doctor money for referrals	Daily	Count	3	4	2	9
			Col%	1.1%	5.3%	2.6%	2.1%
Weekly		Count	4	5	1	10	
		Col%	1.4%	6.6%	1.3%	2.3%	
Monthly		Count	14	12	4	30	
		Col%	5.0%	15.8%	5.2%	6.9%	
Once/twice a year		Count	28	20	8	56	
		Col%	10.0%	26.3%	10.4%	13.0%	
Never		Count	230	35	62	327	
		Col%	82.4%	46.1%	80.5%	75.7%	
Total		Count		279	76	77	432
		Row%		64.6%	17.6%	17.8%	100.0%

Table 27(Continued): Awareness of unethical practices

			Employment			Total	
			Full-time private practice	Full-time state employment	Mixed private/state		
A doctor accepts cash payments not declared for income tax purposes	Daily	Count	46	24	14	84	
		Col%	16.3%	28.9%	17.3%	18.8%	
	Weekly	Count	28	13	3	44	
		Col%	9.9%	15.7%	3.7%	9.9%	
	Monthly	Count	48	19	22	89	
		Col%	17.0%	22.9%	27.2%	20.0%	
	Once/twice a year	Count	50	9	9	68	
		Col%	17.7%	10.8%	11.1%	15.2%	
	Never	Count	110	18	33	161	
		Col%	39.0%	21.7%	40.7%	36.1%	
	A doctor increases charges to medical aid/insurance by over-servicing	Daily	Count	27	20	14	61
			Col%	9.5%	24.1%	17.3%	13.6%
Weekly		Count	40	18	6	64	
		Col%	14.1%	21.7%	7.4%	14.3%	
Monthly		Count	41	15	11	67	
		Col%	14.4%	18.1%	13.6%	15.0%	
Once/twice a year		Count	44	18	13	75	
		Col%	15.5%	21.7%	16.0%	16.7%	
Never		Count	132	12	37	181	
		Col%	46.5%	14.5%	45.7%	40.4%	
A medical service or goods provider offers a doctor payment towards household expenses or office equipment		Daily	Count	4	4		8
			Col%	1.4%	5.2%		1.8%
	Weekly	Count	9	4		13	
		Col%	3.2%	5.2%		3.0%	
	Monthly	Count	17	13	8	38	
		Col%	6.0%	16.9%	10.4%	8.7%	
	Once/twice a year	Count	46	29	10	85	
		Col%	16.2%	37.7%	13.0%	19.4%	
	Never	Count	208	27	59	294	
		Col%	73.2%	35.1%	76.6%	67.1%	
	Total	Count		284	77	77	438
		Row%		64.8%	17.6%	17.6%	100.0%

**Pharmaceutical companies and unethical practices**

As far as the role of pharmaceutical companies is concerned, the respondents were asked (1) how often pharmaceutical companies offer doctors discounts for

purchasing certain volumes of medicines, and (2) how often they believe pharmaceutical companies invite doctors to lavish promotions.

As for the former, 36% of our sample estimated that this happens either daily or weekly. Conversely, only 15% thought that it never happens! Regarding the second issue, one would not expect invitations to "lavish promotions" to occur so frequently. It is still surprising, though, that 78% of respondents estimated that this happens at least once a year. The qualitative comments in Box 8 (below) again give an indication of the kinds of issues raised by respondents.

**BOX 8: Pharmaceutical companies and unethical practices**

69-year old male doctor from Newcastle: "Doctors in this area are prescribing drugs according to a formulary devised by NAIPA and get a kickback according to the value of their prescriptions. Mostly specialists are given overseas trips to congresses, also local congresses. Golf tournament sponsorships. Samples given liberally as incentives; also presents, and private lunches to certain doctors, mainly whites."

32-year old male doctor from Durban: "Why is it that every single drug company taunts doctors with bobbles/getaways/golf weekends/holidays etc.? Drop the drug prices. Patients get a better deal and doctors wouldn't complain about exhausted medical aids."

47-year old male doctor from Durban: "I do know that pharmaceutical companies pander to the whims and fancies of the private sector. Overseas trips and other perks seem to be the norm."

53-year old male doctor from Cape Town: "In my discipline an ethical question that concerns me is that of sponsorship to medical conferences, etc. by pharmaceutical and other major suppliers."

**Unnecessary tests and referrals**

When asked whether they believe that private hospitals or clinics regularly offer doctors money for ordering additional tests or procedures for patients after admission, an overwhelming majority of 75% of the sample said that they thought that this never happens. It is worth pointing out, however, that there are large and significant differences associated with practitioners in different kinds of employment, with a higher percentage (58%) of those respondents in some form of state employment estimating that this happens at least once a year.

A similar pattern emerged with regard to the question whether specialists offer doctors money for referrals. Overall, a large majority said that they did not believe this to be the case. Again, however, a higher percentage (54%) of respondents in some form of state employment estimated that this happens at least once a year.

### **Unethical practices related to income tax avoidance**

Nearly two-thirds (64%) of the total sample estimated that doctors accept cash payments that they do not declare for income tax purposes at least once a year. Again, the differences between those in different types of practice are noteworthy, with nearly 80% of respondents in state employment estimating that tax avoidance occurs at least once a year.

### **Doctors and over-servicing**

Earlier we observed that a substantial proportion (64%) of the sample indicated that they believe doctors use over-servicing of patients to supplement their income. In response to the question how often they estimate this happens, the responses are consistent, with 60% indicating they estimate this to happen at least once a year. The differences between respondents according to type of employment again follows the same pattern as above, with 85% of doctors in state employment indicating that they believe this to happen at least once a year.

### **Payments offered by a medical service or goods provider for expenses**

One-third of the respondents said that they believe medical service or goods providers offer doctors payments towards expenses at least once a year. Repeating the pattern that has established itself by now, a much larger proportion of doctors in state employment (nearly two-thirds) indicated that they believed that this happens at least once a year.

### **Unwarranted issuing of medical certificates**

The question of medical practitioners issuing - without sufficient justification - medical certificates has recently come under the spotlight again. We asked our sample how important or unimportant three considerations are when doctors indulge in such practices: the satisfaction of the patient, financial benefit, or convenience (the quickest option in a busy practice). The findings are summarised in Tables 28 - 30 below.

Table 28: Issuing medical certificates to satisfy the patient

#### **Unwarranted medical certificates - to satisfy the patient**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Not important at all</b>	97	17.3	17.9	17.9
	<b>Unimportant</b>	118	21.0	21.7	39.6
	<b>Important</b>	251	44.7	46.2	85.8
	<b>Very important</b>	77	13.7	14.2	100.0
	<b>Total</b>	543	96.6	100.0	
<b>Missing</b>	<b>System</b>	19	3.4		
<b>Total</b>		562	100.0		

Table 29: Issuing medical certificates to benefit financially

#### **Unwarranted medical certificates - to benefit financially**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Not important at all</b>	258	45.9	47.7	47.7
	<b>Unimportant</b>	181	32.2	33.5	81.1
	<b>Important</b>	72	12.8	13.3	94.5
	<b>Very important</b>	30	5.3	5.5	100.0
	<b>Total</b>	541	96.3	100.0	
<b>Missing</b>	<b>System</b>	21	3.7		
<b>Total</b>		562	100.0		

Table 30: Issuing medical certificates because it is the quickest option in a busy practice

**Unwarranted medical certificates - the quickest option in a busy practice**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not important at all	169	30.1	31.6	31.6
	Unimportant	192	34.2	35.9	67.5
	Important	146	26.0	27.3	94.8
	Very important	28	5.0	5.2	100.0
	Total	535	95.2	100.0	
Missing	System	27	4.8		
Total		562	100.0		

**BOX 9: Unwarranted issuing of medical certificates**

33-year old male doctor from Cape Town: "Sick certificates' is a community-wide problem, affecting more than just the medical profession in terms of employment/economic factors, etc. Therefore, doctors should NOT add to this by supplying unwarranted certificates."

40-year old male doctor from Roodepoort: "Employers should learn to make clear and practical guidelines on absenteeism. They tend to make doctors make decisions for them when it comes to medical certificates, especially when dealing with low income/black employees. No compassionate leave. Doctors then have to improvise."

47-year old male doctor from Kirkwood: "I know certain doctors benefit from sick certificates and pharmaceutical companies, etc. There is also lots of other unethical conduct by doctors but the Council [HPCSA] close their eyes. So why bother."

27-year old male doctor from a small town in Mpumalanga: "Big problem in the area of fraudulent sick letters."

48-year old male doctor from Butterworth: "The labour laws are forcing workers to seek the only available option to get away from work and attend to pressing matters in their lives. This has put the general practitioner on the edge of a dilemma – helping the patient and boosting the practice, on the one hand, and sticking to the dictates of ethics, on the other hand."

61-year old male doctor from Pietermaritzburg: "Here in Pietermaritzburg, there is collusion between some doctors and undertakers in issuing death certificates, especially in rural patients and people of low income. I am aware of doctors issuing death certificates without any knowledge of the deceased. When I reported this to the local forensic laboratory, I was advised to write a letter to our local newspaper!"

### Discussion:

- A significant majority of our respondents (60%) indicated that they believe that keeping the patient satisfied is a sufficiently important consideration when issuing medical certificates - even if it is not warranted. The fact that 40% regard even this consideration as unimportant is noteworthy.
- Large majorities of the sample do not regard financial benefit (81%) or convenience (68%) as sufficiently important to justify these practices.

So, although there is evidence of unwarranted medical certificates being issued (see also the comments in Box 9 above), the general sentiment among South African doctors is that unwarranted issuing of medical certificates is not acceptable. The only exception might be to keep patients happy and even here there is a significant difference of opinion.

It is perhaps appropriate to conclude this section with a quote from a 45-year old male doctor from East London: "The ethics of medical aids and private hospitals are questionable. Both show exorbitant profits... Hospitals charge for drugs and disposables not used. The medical aids never seem to query these accounts... As a medical practitioner I try to give my patients the best care at the least cost to them, but the medical aids and hospitals run as businesses, with profits as the bottom line, at the expense of the patient."

The sentiment expressed here might be typical of the views of many of our respondents who struggle to reconcile the demands of running a practice along business lines, while dealing with rising costs and expenses, with the traditional commitment to and belief in providing quality care to patients. Again, without putting too much weight on any specific or single response discussed here, it is worth noting how many doctors believe that many of the unethical practices listed here occur quite frequently. In the final section, we turn our attention to a discussion of the possible reasons for this state of affairs.

### **Section 3.4**      **Reasons for the trends in unethical practices**

A number of reasons or causes for the possible occurrence (and increase?) in instances of unethical practice have been proposed. The respondents were asked to rate how serious or relevant four categories of factors are as sources of stress in their work environment. These were:

- Factors related to inadequate remuneration, including low medical aid rates
- Government intervention
- Managed care
- Fear of litigation

We discuss the responses to each category separately below.

#### **Low remuneration as a source of stress and low medical aid scheme rates as a factor contributing to unethical behaviour**

Three related questions on remuneration and medical aid rates were posed:

- How significant is inadequate remuneration as a source of stress? (Table 31 below)
- How often would they estimate that patients are unable to pay their fees because their medical benefits are inadequate? (Table 32 below)
- To what extent do they agree or disagree that low medical aid scheme rates for consultations contribute to unethical behaviour among doctors? (Table 33 below)

Table 31: Low remuneration as a source of stress

**Inadequate remuneration as a source of stress?**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Not important at all</b>	8	1.4	1.4	1.4
	<b>Unimportant</b>	38	6.8	6.9	8.3
	<b>Important</b>	211	37.5	38.1	46.4
	<b>Very important</b>	297	52.8	53.6	100.0
	<b>Total</b>	554	98.6	100.0	
<b>Missing</b>	<b>System</b>	8	1.4		
<b>Total</b>		562	100.0		

The results in Table 31 above show that there is unequivocal agreement among South African doctors (92%) that inadequate remuneration is an important source of stress. Further analyses revealed no significant subgroup differences, which indicates that this is a widely held opinion. When asked to add qualitative comments to the questionnaire, large numbers of respondents commented on the matter of inadequate remuneration (see Box 10 below).

**BOX 10: Low remuneration as a source of stress**

41-year old male doctor from Bellville: "It will be very easy to conduct an ethically sound practise if adequate remuneration existed. General surgeons in private practice on average get paid R169 per hour. Running costs of practice = R223 per hour. Only way they can make ends meet is having more patients and longer hours."

44-year old male doctor from Pietermaritzburg: "Our primary objective is to supply a service, NOT make a profit. However, for that service, we should expect REALISTIC, ADEQUATE financial reimbursement... Doctors deserve similar 'hourly' remuneration as other professionals... I feel that 95% of doctors try to run an ethical practice, giving good service and care. They are under pressure from low incomes and... an inability to [pursue] a non-payer on 'ethical grounds'. As this has been perceived as wealthy 'doctor bashing' by newspapers and funders, it is always news! Every year at the time of fee negotiations there are reports of 'medical fraud' in the papers."

26-year old female doctor from Randburg: "Medicine is one of the few professions where the cost per consultation has decreased relative to inflation over the past 20 years."

36-year old male doctor from Kempton Park: "Private practitioners should be reimbursed at least R160 per consultation... Corruption is the most important issue that needs to be overcome... Ethical, clean practitioners are the scapegoat in this huge industry."

Arguably, the most contentious issue associated with perceptions of inadequate remuneration within the medical community is the matter of *medical aid rates*. In response to the question whether they find that their patients are unable to pay their fees because of inadequate medical aid coverage, *half of the sample indicated that this happens every day* (Table 32 below). Nearly every respondent indicated that this happens at least once a year.

Table 32: Medical benefits are inadequate<sup>11</sup>

**Patients are unable to pay their fees because their medical benefits are inadequate**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Daily	269	47.9	50.9	50.9
	Weekly	151	26.9	28.6	79.5
	Monthly	79	14.1	15.0	94.5
	Once/twice a year	28	5.0	5.3	99.8
	Never	1	.2	.2	100.0
	Total	528	94.0	100.0	
Missing	System	34	6.0		
Total		562	100.0		

Qualitative comments provide extensive evidence that inadequate medical benefits are a serious bone of contention (Box 11 below)! In addition, they give some insight into how medical aid fraud is understood by medical practitioners. (See also Box 12 below.)

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<sup>11</sup> The results in this table refer to the total sample, whether doctors are in private practice, state employment or mixed private/state employment. Given that it is not clear what meaning respondents who are in full-time state employment would give to this question, a follow-up analysis was done focusing on the respondents who are either in full-time private practice or in mixed private/state employment. The overall pattern remains unchanged, with 95% indicating that their patients are unable to pay their fees on a monthly or more regular basis.

A rational explanation needs to be sought for the puzzling fact why so many doctors in full-time state or public employment would indicate that their patients are unable to pay their fees. Summarily dismissing these data as meaningless or unreliable would be unwise. There are several possible explanations. First, they may be doing locums without approval from their public employer. Second, this may be a way of giving vent to their frustrations about low pay and slow promotions.

**BOX 11: Inadequate medical benefits**

48-year old male doctor from Benoni: "Patients' money is managed by medical aids, but there is no managed health care. Patients and medical aids underestimate the value of a consultation and a good clinical examination."

48-year old male doctor from Benoni: "There are doctors in the townships who offer their patients groceries on their medical aid benefits. They own the shop next door to their practice. A mother got her child riding lessons by taking scripts to their pharmacy. You should provide incentives to medical aid users to expose other patients who abuse their medical aids. Also, incentives to doctors to expose all these fraudulent claims."

40-year old male doctor from Durban: "The result is an unwillingness to pay the bill (of course after the service received). This causes a strong incentive to shift costs to the medical aid."

30-year old male doctor from Tembisa: "Certain doctors are known for using medical aids inappropriately by selling things which are not for medical reasons, and charging medical aid."

36-year old male doctor from Durban: "Medical aids shift blame onto doctors - a common trick is to tell patients to ask the doctor to motivate for extra hospitalisation on a Friday, for example, which I do, and then to come back Monday and say not authorised! So the patient is told the doctor did not motivate, or did not motivate enough. Medical aid regularly refuses specialist neurosurgeons, while having no due regard for the patient's problem. This leaves me in a dilemma about how to help a patient!"

In the third and final question on this topic, we asked whether the respondents believe that low medical aid scheme rates contribute to unethical behaviour. As Table 33 (below) shows, nearly *three-quarters* of the sample agreed that this is the case. Interestingly, the Chaid analysis (see Appendix 1: Figure 4) reveals that two factors are related to the responses to this statement. The first factor is the type of employment. A significantly lower proportion of those in state employment (58%) compared with those in private practice (83%) and those in mixed types of employment (74%) indicated their agreement with this statement. This is to be expected given that state employed practitioners on the whole have less of a concern with medical aid scheme rates. Secondly, within the subgroup of private practitioners, the sample splits further according to when they received their degrees. Eighty six percent of those who received their degrees before 1982 and 88% of those who received their degrees before 1990 agreed with the statement, compared with 67% of those who received their degrees after 1990.

There are extensive qualitative comments on the structural problems in the medical aid industry, and on the link between low medical aid rates and unethical behaviour. A selection of these comments is presented in Box 12 below.

Table 33: Low medical aid scheme rates contribute to unethical behaviour

**Low medical aid scheme rates for consultations contribute to unethical behaviour among doctors**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Strongly agree</b>	212	37.7	38.3	38.3
	<b>Agree</b>	197	35.1	35.6	74.0
	<b>Neutral</b>	74	13.2	13.4	87.3
	<b>Disagree</b>	54	9.6	9.8	97.1
	<b>Strongly disagree</b>	16	2.8	2.9	100.0
	<b>Total</b>	553	98.4	100.0	
<b>Missing</b>	<b>System</b>	9	1.6		
<b>Total</b>		562	100.0		

### **BOX 12: Low medical aid scheme rates**

Male doctor from Pretoria: "(1) Not worth being a doctor because of low income, litigation fears, overwork, overstress. Expensive medical training. (2) Total costs are always blamed on doctors but not on hospitalisation, rising medical products and especially medicines. (3) Can almost never give the best medicine because of costs. (4) Patients bypass GPs and go to specialists and that costs a lot because of the nature of their work. (5) Very, very important - can't claim for telephone costs, syringes, needles, gloves, paperwork, printing matter, faxes, etc., all of which must come out of meager consultation fee dictated by medical aids. Importantly, a lot of above mentioned can be claimed by dentists."

31-year old male doctor from Cape Town: "The whole medical aid system seems to encourage fraud and mismanagement at every level."

64-year old male doctor from Cape Town: "I think a better consultation fee (like double the present) will avoid many of the ethical ills. It will probably also be cost-effective in the long run."

52-year old male from Durban: "The medical aid remuneration to GPs is totally inadequate. Patients are unhappy about paying a 'contracted-out' fee to a GP. However, they will willingly pay a specialist cash up front for a consultation despite the specialist being 'contracted out'. Many specialists - particularly paediatricians, dermatologists, ENT physicians - behave like glorified GPs. They push up the cost of care by seeing patients off the street, i.e. without referral from a GP."

46-year old male doctor from Johannesburg: "(1) The very low consultation fee is the prime reason for any misconduct that occurs. (2) The medical aids make it very difficult for doctors to (a) access patient benefits, (b) receive payment..."

45-year old male doctor from Tzaneen: "Poor remuneration, especially for state doctors, is frustrating and may lead to unethical conduct by necessity."

44-year old male doctor from Cape Town: "As a busy specialist with 12 years of private practice experience, I can state unequivocally that it is impossible to make a decent living in my specialty by practising ethical, honest medicine. The remuneration is inadequate. You will never obtain ethical medicine in this country so long as an hour's consultation is R168,20!"

28-year old male doctor from Pretoria: "As a GP I cannot comment for specialists. I have seen doctors/institutions being unethical in my short career. I must add that in 90% of cases they resorted to this as a financial outcome. If you take into consideration the huge expenses involved in running a practice successfully and the ridiculous consultation fees that a GP can ask, no wonder they resort to misconduct. Those that do not resort to these practices normally work themselves to death until they burn out or end up in court. I don't want to be unethical and I am leaving medicine as a whole. There is no financial future for a GP in South Africa."

52-year old male doctor from a rural town in the Eastern Cape: "Because of the inadequate payment for professional services doctors are always tempted to supplement income by being unethical. This is disastrous and they only get away with it because everyone else in this country seems to survive by being dishonest. Dishonesty in South Africa is the major problem..."

**Other sources of stress for medical practitioners**

In the remainder of this section we discuss three other sources of stress: too much government intervention, the effect of managed care, and fear of possible litigation. Although it is clear from the results that none of these sources were considered as important as inadequate remuneration, we still found substantial proportions of the sample indicating that these are important sources of stress for doctors. The results are summarised in Tables 34 to 36 below. Box 13 (extended) below contains a wide range of comments pertaining to sources of stress within the profession, including government intervention and managed care.

Table 34: Government intervention as a source of stress

**Government intervention in the profession as a source of stress?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not important at all	13	2.3	2.4	2.4
	Unimportant	62	11.0	11.3	13.6
	Important	252	44.8	45.7	59.3
	Very important	224	39.9	40.7	100.0
	Total	551	98.0	100.0	
Missing	System	11	2.0		
Total		562	100.0		

**BOX 13: Government intervention as a source of stress**

26-year old male doctor from Pretoria: "Government intervention and regulation create an increasing socialistic and hostile medical environment."

52-year old female doctor from Johannesburg: "Government interference and threats of interference from the government are very stressful. Antagonism towards white doctors on racial grounds causes feelings of marginalisation and hostility instead of a spirit of co-operation and enthusiasm to tackle poverty and AIDS."

49-year old male doctor from Alberton: "Doctors must be doctors. The government and the ... Department of Health must stop interfering with doctors' affairs. Let doctors build the best possible system for our people."

### **BOX 13 (Continued)**

#### **Public or state employment**

51-year old male doctor from Johannesburg: "A large proportion of employed doctors (government or NGO) do private work during the hours paid by their employer. This is corrupt and patients get a poor deal."

34-year old male doctor at a rural hospital in KZN: "For a government-service doctor financial issues impacting upon ethics are really only evident in the area of limited private practice where time allocated between state and private services is market driven and not driven by medical need."

58-year old male doctor from Johannesburg: "Government institutions are understaffed and underpaid compared to private practice, which is very lucrative."

60-year old male doctor at a rural mission: "GPs doing sessions in public hospitals at times charge the patient in their clinics but refer these patients to meet them on their session days where they use public facilities to treat their patients. At times, some GPs also 'steal' drugs and other small equipment from government hospitals for use in their clinics."

38-year old male doctor from Port Elizabeth: "In the public sector: resources are the main problem, causing a number of ethical problems. We have taken decisions (negative) about patient treatment for financial reasons."

42-year old female doctor from Pidsbury: "Overwork and under-supervision of junior doctors in government hospitals."

49-year old male doctor from Johannesburg: "The introduction of limited private practice has been a disaster for the state sector, resulting in the general decline in services and standards in the academic teaching hospitals. Tertiary care has been bled in order to expand primary health-care services. However, unless zoning is introduced, patients will continue to flood the tertiary services. This will inevitably result in the collapse of the latter unless larger budgets are allocated and posts are unfrozen or newly created. The above would explain the general decline in the ethical standards we are currently witnessing."

29-year old female doctor from Johannesburg: "Working in a very busy three-level hospital, we see ethical malpractice daily, not only by doctors but by nurses and allied medical staff too. Many doctors who work in government hospitals try very hard to do the 'right thing' for their patients under extremely harrowing and frustrating circumstances, for example, lack of personnel and resources. Sometimes there are colleagues who, by simply being lazy and/or incompetent, commit grossly irresponsible acts. These people are hardly ever reprimanded and seldom is disciplinary action taken. If you report a colleague, you are told that this will count against you!"

**BOX 13 (Continued)**

**"Outside" forces compromising, or interfering with, the independence of medical practice**

54-year old male doctor from Cape Town: "The noble profession of medicine is being decimated by government, big business, health insurance companies and certain unscrupulous doctors and businessmen. The profession is losing its independence. There is low morale and the poor economy is impacting very negatively on the profession. With an unacceptable high level of crime and violence, many doctors are emigrating, and discouraging students from studying medicine. The high rates of HIV/AIDS adds to the problem."

42-year old male doctor from a rural town: "The majority of doctors are ethical in their conduct, regardless of all the stress - both in their providing sound medical care to their patients and from outside intervention, i.e. government, medical aids, managed health care, etc."

44-year old male doctor from Johannesburg: "The medical profession has been put under enormous pressure because of the interference of so many other agencies. Health management, government, private hospitals, and the pharmaceutical industry have the prime objective of making a quick profit. Doctors' decisions are no longer based on clinical judgement, but on satisfying the demands of other agencies. Even doctors who have an ethical fiduciary relationship with their patients are forced to make compromises in their treatments on a regular basis."

51-year old male doctor from Port Elizabeth: "With interference of government and medical aids, doctors find survival more and more difficult, and this can only add to more unethical behaviour in the future. Maybe a doctor is not allowed just to make an honest, decent living. Compare the financial positions of doctors today and in the past to that of other professions. If a person can earn a decent living, he won't need to think up all sorts of schemes, so if there are unethical doctors maybe one should find out why?"

Table 35: Managed care as a source of stress

**Managed care as a source of stress?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not important at all	15	2.7	2.8	2.8
	Unimportant	77	13.7	14.3	17.1
	Important	267	47.5	49.6	66.7
	Very important	179	31.9	33.3	100.0
	Total	538	95.7	100.0	
Missing	System	24	4.3		
Total		562	100.0		

Table 36: Fear of litigation as a source of stress

**Fear of litigation as a source of stress?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not important at all	30	5.3	5.4	5.4
	Unimportant	97	17.3	17.6	23.0
	Important	249	44.3	45.2	68.2
	Very important	175	31.1	31.8	100.0
	Total	551	98.0	100.0	
Missing	System	11	2.0		
Total		562	100.0		

The salient point emerging from these results is the following: Majorities of respondents indicated that government intervention (86%), managed care (83%) and fear of litigation (77%) are either very important or important sources of stress. Chaid-analyses do indicate some subgroup differences, but none of these had any affect on the overall trends reported.

Some of these responses are puzzling.

- Why exactly do doctors fear litigation? (Are there more successful criminal or medical malpractice actions than we realise? Are patients beginning to assert their rights?)

- What is meant by government interference? (Devaluing tertiary care as a consequence of directing more resources to primary care? Inadequate remuneration for doctors in public service? Reducing financial support for public hospitals and public health care in general?) (See Box 13, extended.)

In conclusion: It is very clear that a number of factors (inadequate remuneration, too much government intervention, the implications of managed care, and the constant fear of litigation) are regarded by South African doctors as very real and important sources of stress in their working environment. We also saw that an overwhelming majority of respondents had indicated that inadequate remuneration is often a strong contributing factor in instances of unethical practice. It is not too farfetched to conclude from our results that the other sources of stress might also be regarded as factors contributing to unethical practices. We believe that these results have far-reaching implications for possible interventions and "remedial" actions. We will return to this topic in the final section (see Section 5: Key recommendations).

### **Section 3.5      Remedies: Education and training, codes, and the HCPSA**

The final section of this report in which we discuss the empirical findings of the survey, addresses the issue of possible solutions to the problems raised in the study. We have seen, particularly in the previous two sections, that the prevalence of unethical practices within the medical profession is a matter of considerable concern. We have also seen that doctors are in agreement about the main sources of stress that contribute to this state of affairs. The survey contained a number of items that attempted to gauge what doctors considered possible remedies to the problems raised thus far. It is possible to arrange these items into three generic categories:

- Issues related to training and education in medical ethics
- The value of codes of ethics, or ethical guidelines
- The role that the HPCSA could play and aspects of its functioning.

**Training and background in medical ethics**

In our discussion of the sample profile in Section Two, we presented results for the proportion of our sample (53%) that had attended some course in medical ethics during undergraduate medical training. In three additional questions we asked respondents to what extent they agreed that medical ethics should form part of every undergraduate medical curriculum (Table 37 below), whether the ethics component of Continuing Professional Development (CPD) should carry more weight (Table 38 below), and also whether they believed that a strong background in ethics would assist in guiding doctors' conduct (Table 39 below). We again include the relevant qualitative comments in boxes.

Table 37: Desirability of medical ethics in the undergraduate curriculum

**Medical ethics should form part of every undergraduate medical curriculum**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	391	69.6	69.6	69.6
	Agree	156	27.8	27.8	97.3
	Neutral	14	2.5	2.5	99.8
	Disagree	1	.2	.2	100.0
	Total	562	100.0	100.0	

**BOX 14: Medical ethics in the undergraduate medical curriculum**

49-year old doctor from a rural town in the Eastern Cape: "Courses on ethics will surely help."

42-year old female doctor from Pretoria: "Ethics should be included for undergraduates, but it remains theoretical until you are confronted with problems in practice. Therefore, later exposure is much more important."

54-year old female doctor from Pretoria: "The teaching of ethics should start in childhood - pre-school. Only then may it be possible to build an ethical SA."

31-year old female doctor from Pretoria: "I think ethical training at varsity should be more interactive and not only lecture-type of training. By interactive discussions on various topics students would definitely learn more than by formal lectures - or at least remember better and make it more of their own thinking. By the time students leave varsity they should have strong ethical standards."

Table 38: Ethics component of CPD credits

The ethics component of CPD credits should carry more weight

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	72	12.8	12.8	12.8
	Agree	125	22.2	22.2	35.1
	Neutral	183	32.6	32.6	67.6
	Disagree	122	21.7	21.7	89.3
	Strongly disagree	60	10.7	10.7	100.0
	Total	562	100.0	100.0	

Table 39: Desirability of a strong background in ethics

A strong background in ethics would assist in guiding doctors' conduct

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	166	29.5	29.5	29.5
	Agree	255	45.4	45.4	74.9
	Neutral	77	13.7	13.7	88.6
	Disagree	55	9.8	9.8	98.4
	Strongly disagree	9	1.6	1.6	100.0
	Total	562	100.0	100.0	

**BOX 15: Ethics and CPD credits**

41-year old male doctor from Worcester: "Specialists and [?] groups should have separate workshops on this issue, for example orthopaedic specialists. One day/evening every six months for a certain area. A choice of four dates to accommodate everyone. Spread CPD points... over a five-year period (ten meetings)."

57-year old male doctor from Springs: "CPD points is a money making issue at academic hospitals."

61-year old male doctor from Pretoria: "For 28 years as a doctor I have enjoyed keeping abreast with newer medical practices and research - through journals, symposia, radio talks, etc., but now that I am 'forced' to do the same by acquiring 'CPD' credit points, my joy and pleasure have been soured. I feel I am being punished for being a member of this noble profession. No other profession is required to do this. Moreover, the so-called traditional healers can acquire their profession in 3-6 months and practise for life without suffering this indignity. I resent being subjected to this schoolboy monitoring for the life of my professional career. Why, oh why, can't ordinary market forces be relied upon to choose between a good and a bad doctor?"

### **BOX 15: Ethics and CPD credits (Continued)**

49-year old male doctor from Port Shepstone: "I am not sure that morality can be increased through CPD programmes. Much depends upon home influence and religious upbringing and early schooling influences. Unfortunately ethical behaviour is not rewarded."

43-year old male doctor from Durban: "I find the high cost of CPD courses, especially courses involving ethics, unacceptable."

30-year old female doctor from Cape Town: "I would be interested to know what difference the compulsory CPD does to general private practice because, quite frankly, some colleagues may as well be running supermarkets the way they seem out of touch with medicine."

25-year old female doctor from Durban: "Important to have regular updates, but for updates a fee is usually required. How ironical!"

43-year old male doctor from Greytown: "The wide structure of CPD points and the issuing of these must be revised. You can teach ethics till you are blue in the face. Some doctors will abide by the rules and some won't, irrespective of what."

### Discussion

The following trends emerged from the responses to and comments on the questions about training and a background in ethics:

- There is overwhelming support (97%) for the idea that medical ethics should form part of every undergraduate medical curriculum. This view is held across the board with no significant subgroup differences.
- Doctors are clearly divided on whether the ethics component of CPD should carry more weight: equal percentages (for all practical purposes) of respondents indicated their agreement and disagreement with this statement. Chaid analyses did, however, reveal interesting subgroup differences (see Appendix 1: Figure 5). The most significant predictor of such differences is the university where the respondent graduated. Equal percentages of those who had received their degrees at English-medium and overseas universities (40% and 45% respectively) agreed that the ethics component should carry more weight. In comparison, only 26% of the respondents who had graduated at an Afrikaans-medium university supported this sentiment. Within the first subgroup (those who received their degree from an English-medium university), a further distinction between general practitioners and specialists emerges. GPs tend to be

more positive (45%) about the statement than their specialist colleagues (31%). Possible reasons for the lack of enthusiasm for ethics CPD credits (in contrast to far more positive opinions about ethics education, codes, etc.) may relate to aspects of the CPD system in general, for example, its compulsory or imposed nature, the cost or payment involved, sacrifice of time, practical difficulties, and so on.

- As far as a strong background in ethics is concerned, three-quarters of the sample indicated that they agree or strongly agree that this would assist in guiding doctors' conduct. No significant subgroup differences were recorded for this item.

On the whole, then, one can conclude that there is widespread support among South African doctors for general training and education in medical ethics. They clearly believe that a strong background (and presumably training) would be useful to doctors when confronted with ethical decisions and choices. They are less convinced that the ethics components of CPD should carry more weight (the sample is virtually evenly divided on this issue), with some interesting differences emerging within the sample. There is some evidence, though (based on the qualitative comments), that the more sceptical attitudes about this issue are part of a general scepticism about CPD as a whole.

### **The value of codes of ethics**

In addition to education and training courses in medical ethics, most regulatory and professional overseeing bodies produce codes of ethics, or ethical guidelines, to inform the professional conduct of their members. Although there are clearly differences of opinion in the literature on the value and practical effect of such codes of ethics, or ethical guidelines, we decided that it was still important to ascertain to what extent our respondents would agree that a formalised code of ethics would assist in guiding doctors' conduct. The results in Table 40 (below) are quite unequivocal, with three-quarters indicating their agreement with this view. Further analyses did not reveal any substantive subgroup differences, suggesting that this is a reasonably widely held opinion.

Table 40: Value of a formalised code of ethics

**A formalised code of ethics would assist in guiding doctors' conduct**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	124	22.1	22.1	22.1
	Agree	304	54.1	54.3	76.4
	Neutral	85	15.1	15.2	91.6
	Disagree	36	6.4	6.4	98.0
	Strongly disagree	11	2.0	2.0	100.0
	Total	560	99.6	100.0	
Missing	System	2	.4		
Total		562	100.0		

**The role the HPCSA could play and aspects of its functioning**

As the main professional and regulatory body of health practitioners in South Africa, the HPCSA has a major role to fulfil in ethical matters. We therefore decided to ask a number of questions about the role and functioning of the HPCSA which were aimed at gauging knowledge and awareness of the work of the body, perceptions about the functionality of the ethics guidelines provided by the HPCSA, as well as views about the HPCSA's handling of ethical transgressions within the medical profession. The summary results for these five items are presented in Tables 41 to 45 below.

Table 41: Do you have a copy of the Rules of the HPCSA in your practice?

**Do you have a copy of the Rules made by the HPCSA?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	153	27.2	27.3	27.3
	No	347	61.7	62.0	89.3
	Don't know	60	10.7	10.7	100.0
	Total	560	99.6	100.0	
Missing	System	2	.4		
Total		562	100.0		

**BOX 16: Copy of Rules of HPCSA kept in practice**

62-year old male doctor from Johannesburg: "I do not have copy of the rules laid down by HPCSA. I have only known some of its contents."

53-year old male doctor from Umtata: "I am surprised that there is [a set of] HPCSA ethics guidelines since I have never heard of it nor do I have one. Are they normally distributed to all practising doctors?"

54-year old female doctor from Cape Town: "I was aware that the HPCSA had laid down ethical guidelines, [but I] have never received nor been offered a copy."

Table 42: Have you received any documentation on ethics from the HPCSA recently?

**Have you received any documentation on ethics from the HPCSA in the last 12 months?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	145	25.8	25.8	25.8
	No	331	58.9	59.0	84.8
	Don't know	85	15.1	15.2	100.0
	Total	561	99.8	100.0	
Missing	System	1	.2		
Total		562	100.0		

Table 43: Clarity of the ethical guidelines of the HPCSA

**The ethics guidelines of the HPCSA are sufficiently clear about what constitutes ethical and unethical behaviour**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	18	3.2	3.4	3.4
	Agree	162	28.8	30.6	34.0
	Neutral	245	43.6	46.2	80.2
	Disagree	86	15.3	16.2	96.4
	Strongly disagree	19	3.4	3.6	100.0
	Total	530	94.3	100.0	
Missing	System	32	5.7		
Total		562	100.0		

Table 44: Should the HPCSA be stricter in dealing with ethical issues?

The HPCSA should be stricter in dealing with serious ethics transgressions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	101	18.0	18.5	18.5
	Agree	243	43.2	44.6	63.1
	Neutral	163	29.0	29.9	93.0
	Disagree	33	5.9	6.1	99.1
	Strongly disagree	5	.9	.9	100.0
	Total	545	97.0	100.0	
Missing	System	17	3.0		
Total		562	100.0		

**BOX 17: Stricter control by the HPCSA**

58-year old male doctor from Johannesburg: "The HPCSA has, it seems, a major dilemma in juggling 'ethical standards' against a changing world of technology and how one does 'business'. It seems to be groping behind, rather than leading, the profession(s) from the front. Clearly, therefore, it and the health professions need help and guidance."

40-year old male doctor from Durbanville: "Very poor ethical control of the HPCSA on ground level compared with British Medical Council and Belgium system."

57-year old male doctor from KZN: "I also feel the HPCSA needs to be more active in following up complaints. From personal experience I have been left in the dark about certain complaints and no action has ever been taken by the Council."

34-year old female doctor from Johannesburg: "Most of the bad and unethical practices happen because doctors can get away with them. I have heard of dreadful cases of misconduct where the HPCSA has NOT acted against the doctor [on grounds of] racism or inadequate evidence when, really, the doctor concerned should have been struck off. Severe action needs to be taken against anyone transgressing standards. I am horrified by the stories one hears of the abuses taking place - if they are common knowledge why aren't these doctors caught!"

Table 45: Should peers judge disciplinary hearings of the HPCSA?

**Peers should judge disciplinary hearings of the HPCSA**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>Strongly agree</b>	141	25.1	25.5	25.5
	<b>Agree</b>	293	52.1	53.0	78.5
	<b>Neutral</b>	95	16.9	17.2	95.7
	<b>Disagree</b>	15	2.7	2.7	98.4
	<b>Strongly disagree</b>	9	1.6	1.6	100.0
	<b>Total</b>	553	98.4	100.0	
<b>Missing</b>	<b>System</b>	9	1.6		
<b>Total</b>		562	100.0		

Discussion:

- Nearly two-thirds of respondents (62%) indicated that they do not possess a copy of the Rules of the HPCSA in their practice, and 59% said that they had not received any documentation dealing with ethical matters from the Council over the past twelve months. Even allowing for some degree of exaggeration in these responses - which might be a result of some negative opinions about the HPCSA (as is evident from the qualitative comments) - these percentages are surely a cause for concern to the HPCSA.
- Another cause for concern is the fact that a sizeable proportion of the sample indicated that they believe that the existing guidelines are unclear (20%). The results in Table 43 (above) are - on the face of it - confusing. A sizeable proportion of respondents who answered this question had also previously indicated that they did not have a copy of the ethical guidelines (Rules) of the HPCSA in their practice. This could mean, of course, that they do have a copy available somewhere else. However, to get a clearer picture of the respondents' views on this matter, we crosstabulated the responses to this question with the question whether they have a copy of the guidelines in their practice. Confining oneself to the group (27%) who had a copy of the guidelines in their practice, it is interesting to note that 54% of them indicated that the guidelines are sufficiently clear. A further 22% were neutral on the

matter, and the remaining 24% indicated that they believe the guidelines were not sufficiently clear.

- There is no question about what the majority of South African doctors think about how the HPCSA should operate. Large majorities believe that the Council should be stricter in dealing with serious ethical transgressions (63%), while 79% think that peers should judge disciplinary hearings of the Council.

In conclusion: Both the structured and qualitative responses to the questions in this section indicate convincingly that the HPCSA<sup>12</sup> has some way to go in order to improve its service to the medical community and public. Levels of awareness of its ethical documentation are low; too high a proportion of those who possess (and presumably have read) the Rules believe they are unclear and there are widely held views on how the Council can improve its operations.

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<sup>12</sup> In December 2000, the HPCSA released a lengthy two-page press statement that dealt with our preliminary results, published as *EthicSA Technical Report 01*, on 30 November 2000.

The HPCSA's main objections are methodological. They claim that "the sample used by the Ethics Institute is severely limited to form the basis for the resultant findings and conclusions which are being reached", and "the report merely reflects unsubstantiated claims without any supporting evidence." We address such methodological criticism in Section 3.3 (Evidence of unethical practices) above.

The HPCSA also states that claims of unethical practices do not provide specifics and therefore fail to assist the HPCSA in dealing with alleged cases of over-servicing and overcharging. We wish to point out that the logic of a survey of this kind comprises ascertaining reliable *general* facts and trends, as opposed to specific facts about individual actions. Stated differently: the aims and objectives of surveys are to provide a broad-based overview and perspective on the opinions and attitudes of certain constituencies in society. Surveys are like barometers that allow one to gauge the pulse of shifts in opinions, conceptions and attitudes. Councils, such as the HPCSA, on the other hand, operate much more like commissions and other oversight bodies and are therefore interested in specific events and possible transgressions. For this reason, they will require different kinds of evidence - not necessarily the kind that surveys provide - when required to act.

Importantly, this survey presents much information that may be labelled as "perceptions" of doctors. It would be a mistake to contrast perceptions with so-called "facts" in an attempt to devalue or dismiss them. Perceptions are facts of a particular kind, and often they may be more important than disinterested facts. The real question is what to do about such perceptions, especially if they are pervasive and reflect important social realities.

It is worth pointing out that our survey clearly shows that doctors believe that the HPCSA is the appropriate disciplinary body, and urge it to take the lead in ethical matters – all this despite all sorts of reservations or perceptions about the HPCSA's lack of effectiveness. Significantly, doctors want the profession itself, in the form of peers, to be the judges in matters of ethical and legal transgressions.

## **SECTION 4**

### **MAIN CONCLUSIONS**

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#### **Ethical values and beliefs**

The overriding impression one gains from this set of responses is of a community that (1) is still firmly committed to upholding the high moral standards traditionally associated with the medical profession, but that also (2) recognises that there are increasingly high expectations and scrutiny from the public that require continuous attention to issues of ethics. The latter trend is surely not unrelated to the fact that debates about ethics in other sectors of South African society and government have raised the levels of ethical awareness of the public and the media.

#### **Ethics and financial interests**

South African doctors clearly disagree about whether having a financial interest in an organisation to which they refer patients is acceptable or not. Not surprisingly, when asked whether such interests (where they exist) should be declared, the majority selected the "morally appropriate" option! Similarly, most respondents indicated - perhaps more out of an idealistic expectation than actual experience - that having such interests would not affect their clinical decisions. There are interesting and significant differences related to the type of practice as well as previous experiences regarding instances of misconduct.

In the final analysis, it is clear that the changing nature of the medical profession and the new demands being placed on medical practitioners due to business related considerations require new innovative approaches. South African doctors are increasingly being faced with new developments and are clearly divided about many of their implications!

## **Evidence of unethical practices**

Almost two out of every three doctors indicated that they had observed instances of medical misconduct by a colleague, while the majority of respondents indicated that they believe they would suffer negative consequences if they were to report such a colleague. There is a notable correlation between respondents who observed incidences of misconduct by a colleague and those who anticipated negative consequences for themselves if they were to report such an event.

These results suggest that the current climate within the profession is not amenable to or supportive of “coming clean”. If our respondents are correct in this regard, it does not augur well for future discussions about transparency and ethically acceptable conduct within the profession.

Doctors were asked whether they believed that colleagues use the following five sources to supplement their income: over-servicing patients, multinational pharmaceutical companies, generic (local) pharmaceutical companies, referrals to specialists, and private hospitals or clinics. Most notably, very substantive percentages of responses are “don’t know”. However, nearly two-thirds of all respondents estimated that doctors do in fact supplement their income through over-servicing patients. In addition, in most cases the estimates for the proportions of affirmative responses correlate with whether the respondent had indicated that he or she had observed instances of misconduct by a colleague.

We inquired about the prevalence of a number of other practices that might be regarded as unethical, such as the conduct of pharmaceutical companies, the occurrence of unnecessary tests and referrals, non-declaration of cash receipts for income tax purposes, and payments offered by a medical service or goods provider for expenses. Here are some of the most salient findings: 58% of respondents in some form of state employment estimated that private hospitals or clinics offer doctors money for ordering additional tests or procedures for patients after admission at least once a year; 64% of the total sample estimated that doctors accept cash payments which they do not declare for income tax purposes at least

once a year (80% of the respondents in state employment estimated such tax avoidance occurs at least once a year); and one-third of respondents said that they believed that a medical service or goods provider offers doctors payments towards expenses at least once a year (with, again, a much larger proportion – two-thirds - of doctors in state employment believing this to be the case).

### **Reasons for trends in unethical practices**

It is abundantly clear that a number of factors (inadequate remuneration, too much government intervention, the implications of managed care, and the constant fear of litigation) are regarded by South African doctors as very real and important sources of stress in their working environment. We also saw that a substantial majority of our respondents indicated that inadequate remuneration is, in many instances, a strong contributing factor to unethical practices. It is not too farfetched to conclude from our results and qualitative comments by doctors that the other sources of stress might also be regarded as factors contributing towards incidences of unethical practices.

### **Remedies: Education and training, codes, and the HPCSA**

Our survey contained a number of items that suggested possible remedies to the problems raised by the survey. The findings show that there is widespread support among South African doctors for general training and education in medical ethics. Many clearly believe that a strong background (and presumably training) in ethics would be useful to doctors when confronted with ethical decisions and choices. They are less convinced that the ethics components of CPD should carry more weight (the sample is quite divided on this issue), with some interesting differences emerging within the sample. There is some evidence, though (based on the qualitative comments), that the more sceptical attitudes towards this issue are part of a more general scepticism about CPD as a whole.

Our overwhelming impression, then, is of a profession caught between its traditional commitment to ethically sound practice and the growing demands of financial

survival. South African doctors very clearly recognise and subscribe to an ethos that observes the best interests of the patient. At the same time, they are increasingly frustrated and constrained by unrealistic medical aid tariffs, government demands, and the conflicting interests of various other role players (managed care, pharmaceutical companies, and so on). It is perhaps not inappropriate to talk of a profession under siege!

## SECTION 5

### KEY RECOMMENDATIONS

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In this final section of the report we list - and briefly discuss - recommendations that are, to a greater or lesser extent, based on the main trends in our findings.

We have organised the recommendations into three broad themes or categories:

- Background conditions
- Educational and curricular issues
- The role of the HPCSA

#### **Background conditions**

There are large-scale or background systemic factors (hereafter simply referred to as "background conditions") that play a major role in inducing stress and influencing unethical business practices among doctors. We wish to identify three such factors that are interrelated:

- The method of health-care *resource allocation* or the system of health-care *provision* (South Africa's particular public/private mix)
- The system of health-care *funding* (public/private, medical aids/insurance, and managed care)
- The nature or structure of the *relationships* between doctors (and other health-care providers) and other crucial role players in the health sector (the government, public as well as private hospitals/clinics, the pharmaceutical industry, medical aid/insurance, managed care organisations, medical goods providers, and so on).

Responses from the vast majority of doctors in this study provide strong grounds for making quite specific recommendations regarding more clearly defined and manageable educational and curricular issues, as well as the role of the HPCSA (see below). In contrast, however, we cannot similarly ground specific, practical recommendations in respect of these background conditions.<sup>13</sup> In the most general way, however, we **recommend** *that the major role players in the health sector address these issues in a systematic, ongoing and comprehensive way.* A possible beginning could be to create forums, or to utilise and expand existing ones, where transformational issues as well as “structural” barriers to ethical practice in the health-care system could be discussed with a view to constructive action. This lack of specificity does not mean that we do not hold strong views about what ought to be done about these background conditions. It only means that making recommendations in this regard would require the support of extensive moral, political and economic argument.

When we discuss the very important oversight role of the HPCSA in the practice of medicine in South Africa (see below), we **recommend** *that the HPCSA take the lead in this regard.* Moreover, we **recommend** *that the government support the HPCSA in this crucial function.*

These background conditions influence and shape doctors’ feelings, motivations and actions, and doctors are clearly deeply concerned about them. Basically, these conditions involve fundamental debates about the kind of society we find worthwhile, the importance it attaches to health, and its provision of health care. If it is any consolation, these are questions of great magnitude that must be addressed by any society trying to build a just health-care system.

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<sup>13</sup> One of the authors, together with a colleague who also collaborated on this survey, addressed just one part of this nexus of background conditions, namely, the allocation of highly specialised health-care resources to children in South Africa, given ethical considerations and children’s constitutional health-care rights. See W.A. Landman and L.D. Henley, [1] Tensions in setting health-care priorities for South Africa’s children, *Journal of Medical Ethics*, 24, 268-273, 1998; [2] Equitable rationing of highly specialised health care services for children: A perspective from South Africa, *Journal of Medical Ethics*, 25, 224-229, 1999; [3] Rationing and children’s constitutional health-care rights, *South African Journal of Philosophy*, 19(1), 41-50, 2000; [4] Implementing children’s constitutional health-care rights fairly, *South African Medical Journal*, 90, 601-604, 2000.

Doctors earn their living within a nexus of such background conditions, together with their more immediate working conditions. Even though these conditions may be unreasonable or unfair, frustrating or inefficient, they fail to justify unethical practices. No human society is perfectly just or equitable. To a greater or lesser extent, therefore, everyone has to negotiate living and working conditions that may affect their ability to act morally. In times of war, for example, stress factors may be extreme, while in wealthy and stable societies these may be negligible.

There are reasons independent of the business practices and ethics of doctors for addressing these background conditions. The character and justice of a health-care system also exert an influence on the ethics of all the other role players and, crucially, the health and general well-being of citizens or patients. A complex set of factors (political, policy, economic, historical, cultural, and so on) has driven us towards a health-care system with a specific mix of public and private components. As a society we should explicitly address these background conditions. The authors are persuaded that a public health-care system (with public *financing*, and private as well as public *provision*) would be ethically preferable to the alternatives. However, this does not seem to be feasible in South Africa under the current prevailing economic and infrastructural conditions. Nevertheless, crucial moral and policy questions should be addressed. For example:

- Should we accept rationing or resource allocation that is often *ad hoc*, or made by default, with resulting inequities and frustrations?
- How committed are we, as a society, to the public component of health-care provision in general?
- More specifically, do we have the political will to address the deterioration of support for public hospitals?
- Do we really need so many medical aid institutions (Switzerland, for example, only has three) with all the attendant costly administrative duplication and proliferation of complex rules?
- How could the remuneration of doctors (especially GPs) by medical aid/insurance be made more equitable? In particular, would reducing large-scale unethical appropriation of funds (through “kickbacks” in

certain sectors of health-care delivery, or large-scale medical aid fraud, for example) make more equitable compensation for services rendered by doctors possible?

- How should medical aid/insurance companies and pharmaceutical companies negotiate with one another to keep costs down without sacrificing quality of care?
- Are we prepared to go down the (for profit) managed care route, like the one traversed in parts of the USA in the 1990s, where clinical decisions are increasingly dictated by profit margins and burdensome administrative oversight?

### **Educational and curricular issues**

We recommend that various practical steps should be taken in respect of ethics (medical ethics, bioethics) education and training, by both medical schools and the HPCSA. (The latter will be dealt with under the next heading.)

We **recommend** that *medical schools* take *ethics education* (clinical *as well as* business ethics) for undergraduate *and* postgraduate medical students very seriously. This means introducing ethics courses where there are none, reviewing existing courses, and learning from others who can make a contribution to curriculum design and teaching. Almost all the doctors in this study underlined the need for undergraduate ethics teaching. In addition, we would argue that such teaching is equally imperative on the postgraduate level, where young doctors care for patients and face real ethical dilemmas. At this level it may be easier to integrate clinical and ethics education.

We **recommend** that ethics courses be explicitly designed with the *objective of teaching students how to reason morally and how to think critically about what to do*, and not of teaching them what to do. Other possible objectives of such courses would be to identify the moral dimensions of medical practice, and to understand and embrace the professional responsibilities of doctors.

We further **recommend** that special attention be devoted to the *method of teaching ethics* in medical schools. Such teaching should preferably be ongoing and stretch, in some form or another, over all the years of medical training. Ethics education should be included in the medical curriculum in ways that suit the exigencies of local curricula. Integration of ethics teaching with clinical teaching could be done in several ways, for example:

- Small-group discussions, led jointly by ethics and clinical faculty members
- Case-based discussions in clinical years
- Building an ethics component into ward rounds.

We strongly **recommend** that ethics courses be *examined* courses. A course that is not examined may not be taken seriously by a significant percentage of students. In addition, we **recommend** that passing an ethics course be made a *necessary condition* for passing a particular year. Ethics education may also be implemented as a part of larger multidisciplinary courses in the medical curriculum. We do not, however, recommend that this option be followed as we believe it could result in minimising the role and importance of ethics. Put differently: we **recommend** that *ethics be offered as a separate required course and not as a non-essential part of an existing required course.*

We appreciate that ethics education already has had a long history at some medical schools. Other medical schools can benefit from their experience and expertise. We **recommend** that a national workshop of medical schools be held to exchange ideas and plan the way forward. Such a workshop should focus on all aspects of ethics education in medical schools, for example, course content, teaching methods, the necessary qualifications for instructors, as well as how best to utilise existing resources, how to integrate ethics teaching with clinical teaching, and, in general, how to make ethics courses a respected component of medical training. Moreover, medical schools should consider the advantages of greater uniformity in their ethics education. Thus, one objective of a national workshop of medical schools could be

to develop a consensus statement on a *core curriculum* in medical ethics for South African medical schools.

### **The role of the HPCSA**

The role of the HPCSA is crucial for the well-being of the medical profession in South Africa. In respect of ethics issues, we urge the HPCSA to take the following steps.<sup>14</sup>

Firstly, we **recommend** that South African doctors be provided with a set of *ethical guidelines* that spells out the crucial areas of ethical controversy in the profession and gives broad guidance. (We have in mind two kinds of guidelines here: broad principles and issue-specific guidelines.) Such guidelines should be thoroughly tested in respect of clarity and content with the target audience, namely doctors, before they are adopted. The HPCSA has already taken a step in this regard – in October 2000 - by concluding a contract with EthicSA to review all its ethics-related documents and to formulate draft ethical guidelines.

Secondly, while we accept that such a new programme will be under ongoing review, we **recommend** that the HPCSA thoroughly reconsider aspects of the *ethics component of CPD*. Currently, this component consists of ten out of a total of 250 points in a five-year CPD cycle. The HPCSA oversees the entire system, and delegates its authority in this regard to 14 CPD accreditors (medical faculties, SAMA, and the like). These accreditors are authorised to appoint accredited providers of CPD courses to doctors. The accreditation process was apparently introduced without explicit and adequate substantive and procedural standards being in place, which has led to all kinds of uncertainties.

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<sup>14</sup> In feedback on a draft version of this report, Professor Len Becker of the HPCSA pointed out that the HPCSA has already taken the following steps:

1. In June 2000 the Professional Board instructed a legal firm to investigate and if indicated prosecute doctors for these so-called "kickbacks". It may well be that their findings will form the basis for future policy by the Board and Council.
2. At the same time the Board appointed a dedicated Committee of Preliminary Enquiry in order to expedite this process.
3. In October 2000 The Health Professions Council adopted a set of Guidelines on Perverse Incentives, which deals comprehensively with this problem.
4. In December 2000 the Executive Committee of the Board agreed to amend the regulations pertaining to multidisciplinary practices in an attempt to contain unethical practice.

Ethics will be given a bad name if ethics CPD resources are inadequate. Several steps can be taken to help shield ethics from the general negative sentiment towards, and objections to, the CPD system. We therefore **recommend** that the HPCSA, in conjunction with SAMA, as well as experts in medical faculties and ethics experts, *thoroughly review the following aspects of the ethics component of CPD:*

- Substantive and procedural standards
- Course or programme content
- Accreditation criteria
- More uniform criteria for points or credit allocation
- Evaluation of programmes
- Accessibility
- Cost

With regard specifically to accreditation criteria, we **recommend** that the HPCSA *investigate the nature of the CPD/pharmaceutical industry relationship*. Is it desirable that ethics education or development be so closely linked, via the accreditation process, to industry-sponsored events organised primarily for the promotion or marketing of products?

Thirdly, we **recommend** that the HPCSA intensify its role in *disciplinary action and oversight*. At present, the media calls the shots, with adverse publicity (whether justified or not) about disciplinary matters. In view of doctors' anticipation of negative consequences for themselves should they report unethical conduct by a colleague, we **recommend** that the HPCSA *review its protocol on reporting (alleged) medical misconduct*. The HPCSA should be proactive in informing the public about its disciplinary activities in this regard. Moreover, we **recommend that the HPCSA initiate an investigation into "structural" issues in health care that lead to unethical practices** ("perverse incentives", "kickbacks", medical aid fraud, and the like).

This would mean taking a thorough look at how role players (doctors, medical aid/insurance companies, pharmaceutical companies, suppliers of goods and services, and so on) interact in the medical market place.<sup>15</sup> *There should be no illusions about the enormity and difficulty of this task, given the extensive and lucrative vested interests at stake.* Some doctors evidently believe that should they report unethical practices it could jeopardise their livelihood or lead them to be ostracised. This kind of attitude needs to be reversed into a *culture of open reporting of unethical practices.*

Fourthly, a puzzling aspect of the survey is the large number of doctors citing fear of *litigation* as a major source of stress. It is puzzling because patients in South Africa passively take all kinds of treatment from doctors and there are few reports of successful criminal or civil actions against doctors. Moreover, who is sued in the public sector where most medicine is practised? Still, the fear seems to be there. In order to avoid going down the road travelled by our American colleagues, namely, that of a litigation culture and its resultant practice of “defensive medicine”, we **recommend** *that the HPCSA, in conjunction with SAMA and experts in medico-legal matters, examine the relationship between ethics and the law.* The HPCSA needs to be instrumental in conveying the message that practising according to the appropriate “standard of care”, setting the patient’s well-being as the primary goal, should greatly assist in deflecting fear of litigation. This could be done as part of an ongoing information drive, aimed at doctors, about the moral *and* legal responsibilities of doctors.

Lastly, we **recommend** that the HPCSA *establish a dedicated function for matters of an ethical nature.* Ethical “Rulings” that appear in the HPCSA’s publication *Meddent News* (for example, on confidentiality issues) need systematic ethical argument since they affect important interests of people in very significant ways.

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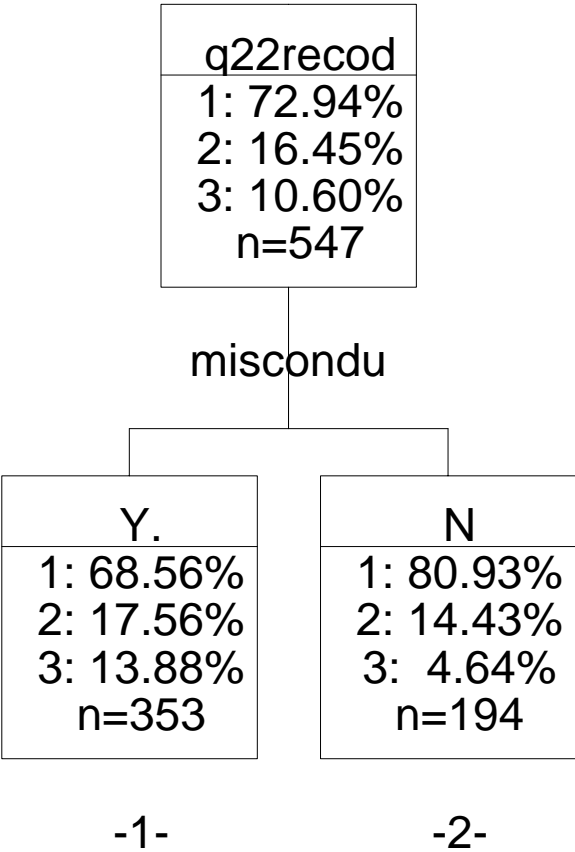
<sup>15</sup> *The Star* of 5 February 2001 reports that the HPCSA in fact made an announcement in line with this recommendation. The HPCSA has established a preliminary committee of inquiry to investigate medical kickbacks. We applaud this initiative.

**APPENDICES**

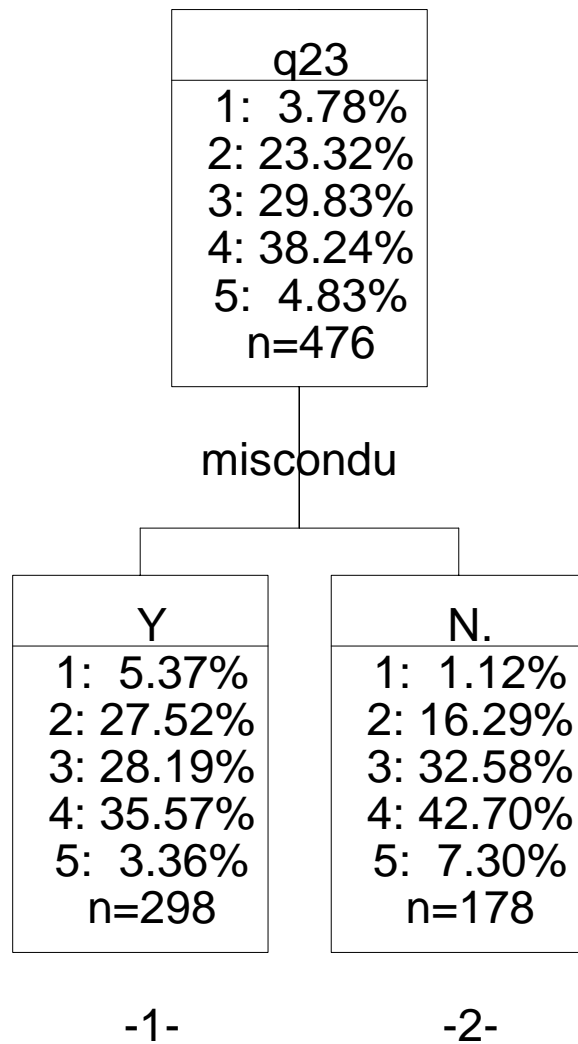
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**APPENDIX 1: CHAID FIGURES**

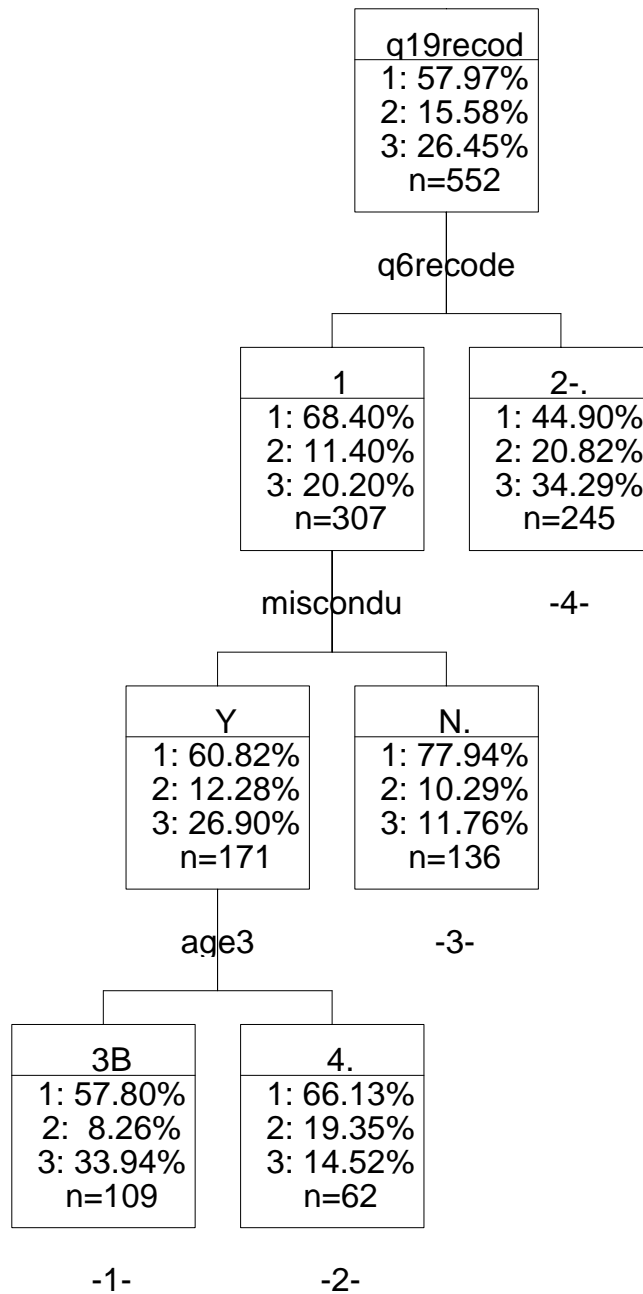
**Figure 1: Chaid analysis of question 22 (The vast majority of doctors are ethical in their professional conduct)**



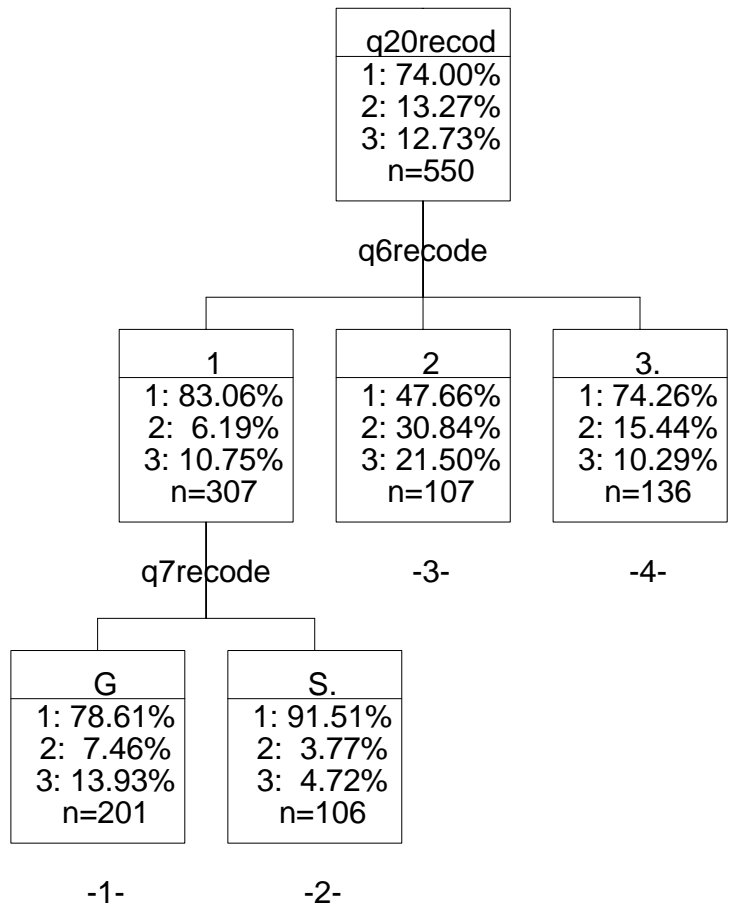
**Figure 2: Chaid analysis of question 23 (The general public thinks doctors are unethical in their everyday professional conduct)**



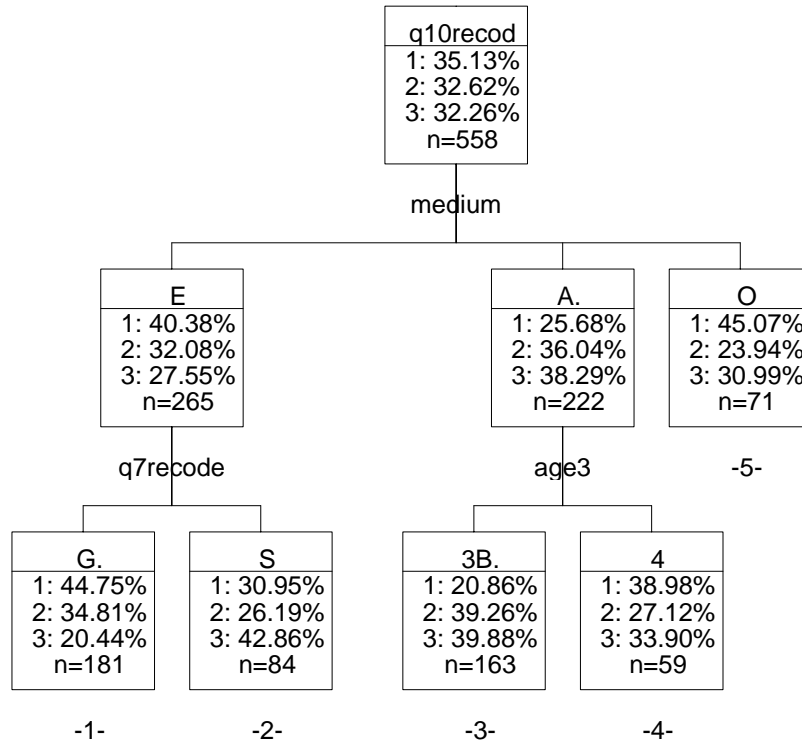
**Figure 3: Chaid analysis of question 19 (Having a financial interest in an organisation to which I refer patients would not influence my clinical decisions in any way)**



**Figure 4: Chaid analysis of question 20 (Low medical aid scheme rates for consultations contribute to unethical behaviour among doctors)**



**Figure 5: Chaid analysis of question 10 (The ethics component of CPD credits should carry more weight)**





**APPENDIX 2: QUESTIONNAIRE**

**Ethics Institute of South Africa**  
Building an ethical South Africa

**ETHICS SURVEY OF SOUTH AFRICAN MEDICAL DOCTORS**

1. I practise medicine in \_\_\_\_\_(please specify the town or city).
2. I received my basic medical degree in 19 \_\_\_\_\_.
3. I received my basic medical degree at the University of \_\_\_\_\_.
4. I am \_\_\_\_\_ years old.

5. I am a

Male	1
Female	2

6. My employment is

Full-time private practice	1
Full-time state employment	2
Mixed private/state employment	3
Other (please specify)	4

7. I am a

General practitioner	1
Specialist	2
Other (please specify)	3

8. A course in medical ethics was part of my required undergraduate medical curriculum.

Yes	1
No	2
Cannot remember	3

ATTITUDES TOWARDS TRAINING IN ETHICS

**Please indicate whether you agree or disagree with the statements below.**  
**1 = Strongly agree, 2 = Agree, 3 = Neutral, 4 = Disagree, 5 = Strongly disagree**

	SA	A	N	D	SD
9. Medical ethics should form part of every undergraduate medical curriculum.	1	2	3	4	5
10. The ethics component of Continuing Professional Development (CPD) credits should carry more weight (presently, 10 points out of 250 in a 5-year cycle).	1	2	3	4	5
11. A strong background in ethics would assist in guiding doctors' conduct.	1	2	3	4	5
12. A formalised code of ethics would assist in guiding doctors' conduct.	1	2	3	4	5

## ETHICS AND ECONOMIC REALITIES

		SA	A	N	D	SD
13.	Everything considered, I am satisfied with my choice of career.	1	2	3	4	5
14.	Doctors should disclose to their patients if they have a financial interest in an organisation to which they refer patients.	1	2	3	4	5
15.	Being a doctor in private practice is no different from any other business selling a service.	1	2	3	4	5
16.	It is acceptable for doctors to have a financial interest in an organisation to which they make referrals.	1	2	3	4	5
17.	Doctors deserve financial rewards greater than individuals in most other occupations.	1	2	3	4	5
18.	Being a good clinician and running a profitable medical practice is an uneasy alliance.	1	2	3	4	5
19.	Having a financial interest in an organisation to which I refer patients would not influence my clinical decisions in any way.	1	2	3	4	5
20.	Low medical aid scheme rates for consultations contribute to unethical behaviour among doctors.	1	2	3	4	5

## PERCEPTIONS OF ETHICAL CONDUCT

		SA	A	N	D	SD
21.	The practice of medicine imposes a higher standard of moral integrity than other professions.	1	2	3	4	5
22.	The vast majority of doctors (more than 80%) are ethical in their professional conduct.	1	2	3	4	5
23.	The general public thinks doctors are unethical in their everyday professional conduct.	1	2	3	4	5
24.	There is widespread disagreement among doctors about what constitutes unethical behaviour.	1	2	3	4	5
25.	What constitutes ethical conduct is a matter of personal opinion.	1	2	3	4	5
26.	Compared with other professions and occupations, doctors are unfairly singled out for being unethical.	1	2	3	4	5

## ETHICAL AND LEGAL REGULATIONS

		Yes	No	Don't know
27.	Do you have a copy in your practice of the Rules made by the Health Professions Council of South Africa (HPCSA) specifying the acts in terms of which disciplinary action may be taken against doctors?	1	2	3
28.	Have you received any documentation on ethics from the HPCSA in the last 12 months?	1	2	3
29.	Have you ever observed medical misconduct by a colleague?	1	2	3
30.	Do you anticipate any negative consequences for yourself should you report a colleague who acts unethically?	1	2	3

Please indicate whether you agree or disagree with the statements below.

1 = Strongly agree, 2 = Agree, 3 = Neutral, 4 = Disagree, 5 = Strongly disagree

	SA	A	N	D	SD
31. The ethics guidelines of the HPCSA are sufficiently clear about what constitutes ethical and unethical behaviour.	1	2	3	4	5
32. The HPCSA should be stricter in dealing with serious ethics transgressions.	1	2	3	4	5
33. Peers should judge disciplinary hearings of the HPCSA.	1	2	3	4	5

#### SPECIFIC ETHICAL DILEMMAS

34. In your experience, doctors who supplement their income use the following sources:	Yes	No	Don't know
Over-servicing patients	1	2	3
Multinational pharmaceutical companies	1	2	3
Generic (local) pharmaceutical companies	1	2	3
Specialists	1	2	3
Private hospitals/clinics	1	2	3

35. In your estimate, how often do the following happen to a doctor?	Daily	Weekly	Monthly	Once/Twice a Year	Never
Patients are unable to pay their fees because their medical benefits are inadequate.	1	2	3	4	5
If a patient has inadequate medical benefits, the doctor shifts costs (for example, by charging for an additional or a longer consultation).	1	2	3	4	5
A pharmaceutical company offers him/her a discount for purchasing a certain volume of medicine.	1	2	3	4	5
A private hospital/clinic offers him/her cash or a cheque for ordering additional tests or procedures for patients after admission.	1	2	3	4	5
A specialist or specialist group offers him/her cash or a cheque for referrals.	1	2	3	4	5
He/she accepts cash payments not declared for income tax purposes.	1	2	3	4	5
He/she increases charges to medical aid/insurance by over-servicing.	1	2	3	4	5
A medical service or goods provider offers him/her payment towards household expenses or office equipment.	1	2	3	4	5
A pharmaceutical company invites him/her to a lavish promotion in an exotic place.	1	2	3	4	5

**Please indicate on the scale below how important you judge each of the following:**

	Not Important at all	Unimportant	Important	Very Important
36. Based on your own experience, how important is each of the following sources of stress?				
Inadequate remuneration	1	2	3	4
Government intervention in the profession	1	2	3	4
Managed care	1	2	3	4
Fear of litigation	1	2	3	4
Other (please specify)	1	2	3	4
37. Doctors, for different reasons, sometimes agree to conduct tests or procedures that are medically unnecessary. How important do you rate each of the following reasons?	Not Important at all	Unimportant	Important	Very Important
To satisfy the patient	1	2	3	4
They fear litigation should they miss an important diagnosis	1	2	3	4
To benefit financially	1	2	3	4
It's the quickest option in a busy practice	1	2	3	4
Other (please specify)	1	2	3	4
38. Doctors, for different reasons, sometimes issue medical certificates that are medically unwarranted. How important do you rate each of the following reasons?	Not Important at all	Unimportant	Important	Very Important
To satisfy the patient	1	2	3	4
To benefit financially	1	2	3	4
It's the quickest option in a busy practice	1	2	3	4
Other (please specify)	1	2	3	4

ADDITIONAL COMMENTS

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**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.  
PLEASE RETURN IN THE ENCLOSED ENVELOPE BEFORE 26 OCTOBER 2000.**

### **APPENDIX 3: COPY OF ACCOMPANYING LETTER**

*ON LETTERHEAD*

6 October 2000

X  
X  
X  
X

Dear Dr XXX

Media attention has recently focused on the ethical conduct of doctors. Much of the reporting has been unflattering – fraud, kickbacks and occasionally high profile malpractice. Since these accusations strike at the heart of the profession, doctors not surprisingly feel aggrieved and unfairly persecuted; the more so since corruption seems rife in many other areas of South African society.

The Ethics Institute of South Africa is an independent body established to facilitate building an ethical South Africa - through education, research, consultation, and public-policy development. Whilst we initially focus on ethical issues in health care, in the future we intend opening different areas of business and public life in general to informed debate.

In this survey we focus on issues of professional integrity, particularly in respect of potentially questionable financial arrangements. We want to know more about the pressures doctors face, how they respond and, importantly, how things might be different. Our aim is to establish a baseline of facts and perceptions for future debate and action. In December 2000, findings will be published on our web site, or you can obtain a copy directly from the Institute.

Enclosed you will find a questionnaire that addresses a range of ethical issues - concerning codes, conduct, education and practice - that affect the profession and its future direction. Your responses will help us gain a sense of doctors' views of their profession. The survey sample was randomly drawn from the South African Medical Association's database of all South African doctors (SAMA members and non-members).

Because of your busy schedule, the questionnaire is short and most responses simply require a circle. However, the most useful and relevant information gleaned from surveys often comes from respondents' reports of personal experiences. Please add any comments, particularly concerning issues not adequately covered, in the blank space at the end of the questionnaire. You might want to include actual examples from your practice.

Remember your responses are completely anonymous, so please answer as freely and honestly as possible. Any question you would prefer not to answer, you are obviously welcome to ignore. Unfortunately, cost considerations make a multilingual mailing impossible.

Please return your completed questionnaire in the enclosed envelope as soon as possible but no later than 26 October 2000. Thank you for your time, patience and cooperation.

With thanks

**Willem A Landman**, BProc (SA), MA (Oxon), DPhil (Stell)  
CEO, Ethics Institute of South Africa  
Extraordinary Professor of Philosophy, University of Stellenbosch