

***Fraud Against the Public Purse by Health Care  
Professionals:  
The Difference of Location***

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This paper was prepared for the Law Commission of Canada. The views expressed are those of the author and do not necessarily reflect the views of the Commission.

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## **Executive Summary**

The historical and present-day debates over “what is a crime?” often congregate around the differential treatment of suite crime (crimes of the powerful) and street crime (crimes of the less powerful). This blatant inequality in the application of the law undermines law’s legitimacy and leads us to question whether there is one law for the rich and one law for the poor. The powerful have ways to ensure that their activities are not defined as crime, whether they be through influencing the definition of crime or the application of the law. This inequality often results in demands to include activities of the powerful in the definitions and applications of the criminal law juxtaposed with the call for the reduction in the use of criminal law. This paper explores the possibility that we could reduce the use of the criminal law against crimes of the less powerful by duplicating some of the attitudes and approaches that we presently have towards crimes of the powerful.

This paper studies crimes of the powerful by focussing on one aspect of health care fraud—inappropriate and fraudulent billing carried out by health care professionals (mostly physicians) who bill on a fee-for-service basis. It examines all administrative, self-regulating, and criminal and quasi-criminal actions against health care misconduct commenced between 1990 and 2003 across Canada, which were available in the public domain through court and Quicklaw databases, newspaper coverage, and court transcript services. It then focuses in greater detail on the 31 cases arising out of British Columbia and the 34 cases from Ontario, and explores the similarities and differences between the two provinces. Ten interviews were conducted in British Columbia to gain some insight into the billing process, and submissions to the Cory Review of the Medical Review Committee (MRC) in Ontario were reviewed for the same purpose.

There are provincial differences in the structures through which billing laws and regulations are enforced and their actual enforcement. In British Columbia, billings are managed by a tripartite Commission, including physicians. Although structural changes in 1998 resulted in the monitoring of billings being transferred from a physicians’ committee to a government programme, physicians are still very involved in the process. In Ontario the government agency (Ontario Health Insurance Plan: OHIP) which monitors billings is part of the Ministry of Health and Long-Term Care. It refers inappropriate billing cases to the MRC (a Committee of the College of Physicians and Surgeons of Ontario), but it may also refer cases to the police or (since 1996) recover money directly from the health care professional.

The billing process in British Columbia offers a number of informal avenues for health

care professionals to challenge any assessment done by the Billing Integrity Program (BIP). The British Columbia model is based on education, warnings, reconciliation, and assistance; if that does not work, the interest appears to be in recovery of money, not prosecution or punishment. This culture of non-criminalization appears to permeate the government, professional, and criminal justice systems in British Columbia when it comes to medicare fraud. The process in Ontario is far-less forgiving than the one in British Columbia. Professionals are responsible for accurate billing and are not provided with billing profiles so they can adjust their billing to avoid an audit based on comparative patterns of practice. In addition, a zero tolerance approach to fraud was introduced in Ontario, in 1997, along with the creation of a special police unit to investigate health care fraud. The MRC, which is presently under review by former Supreme Court of Canada Justice Peter Cory, has been criticized for not controlling OHIP fraud, but is also blamed by physicians who feel victimized for overly aggressive enforcement tactics.

Despite the differences in structures, the proportion of physicians subjected to administrative orders or recommendations and the amounts targeted for recovery are similar in the two provinces. The Audit Committee in British Columbia ordered 59 physicians (an average of 12 per year) to return \$4,078,112 (an average of \$69,120 per physician) to the plan between 1998 and 2003. In Ontario, between 1991-2002, the MRC recommended recovery from 548 physicians (an average of 49.8 physicians per year) of over \$36 million (an average of \$66,449 per physician). The Ontario system, which has 3.8 times as many doctors as British Columbia, recommended four times as many recoveries. Neither province reports actual recoveries.

There were 31 cases and 37 actions in British Columbia and 34 cases and 49 actions in Ontario in which a professional had his or her name in the public domain as a result of administrative, professional, or criminal or quasi-criminal actions commenced between 1990 and 2003. The professional SROs in Ontario took a greater proportion of disciplinary measures ( $22/34=65\%$ ) than the professional SROs in British Columbia ( $11/31=35\%$ ), and there was a greater proportion of criminal cases in Ontario ( $15/34=44\%$ ) than British Columbia ( $6/31=19\%$ ). In terms of multiple proceedings, five of the 31 cases in British Columbia (16%), as compared to 12 of the 34 cases (35%) resulted in both SRO and criminal or quasi-criminal action.

There were six criminal or quasi-criminal prosecutions and convictions in British Columbia between 1990 and 2003, compared to 15 prosecutions and 12 convictions in Ontario. Only three of the six prosecutions in British Columbia, and 14 of the 15 in Ontario were against physicians (4.7 times as many as in British Columbia). All but one of the accused were men, and all pleaded guilty.

Although there were only six prosecutions in British Columbia, there appeared to be a pattern of plea negotiations that resulted in facts before the court that were substantially less serious than the original allegations reported by the media. The penalties imposed appear quite lenient and the judges' comments were, with one exception, quite sympathetic to the plight of the convicted health care providers. Plea negotiations were also a major factor in Ontario, but overall the professionals did not seem to fare as well as their BC counterparts when it came to criminal sentencing.

Two of the three physicians who were convicted in British Columbia had received their medical training outside of Canada (India and Ireland), as had the physiotherapist (Yugoslavia, with upgrading in Canada). There was no indication where the two optometrists were trained; however, both have names that would indicate they might be members of a visible minority, and one had his picture in the paper that would confirm this. Country of training was available for 11 of the 12 convicted professionals in Ontario and only two of the 11 had received their training outside of Canada. Surnames of the professionals in Ontario did not indicate over-representation from any minority group.

In order to explore the proposition that there is one law for the rich and another for the poor, I compared my findings with other studies on the enforcement against welfare fraud. There are differences between people who are accused of welfare fraud and those who are accused of professional health care fraud (impoverished women and men as compared to privileged men) and how the public perceives each group (lazy, dependent, not deserving as compared to hardworking, underpaid and deserving). Complex rules work against the welfare recipient who is assumed to know the law, whereas complex rules can serve as an excuse for health care professionals who commit fraud. Welfare recipients are subjected to surveillance, whereas health care professionals are subjected to education—more so in British Columbia than Ontario. Administrative actions (e.g., removal of entitlement to social assistance) against welfare recipients have harsh consequences, and they have little power to resist. Once in the criminal justice system, welfare recipients may be found guilty on evidence which is probed very little, or not at all, by defence counsel. The costs of enforcement of the criminal law against welfare recipients are minimal compared to the prosecution of professionals who can afford to hire the best of lawyers to either test the prosecution's case to the fullest or negotiate a plea bargain to minimize the criminal law's impact. The high social and economic costs to the welfare recipient appear to be ignored whereas the high social and economic costs to the professional are recognized. The welfare recipients are much less powerful than the professionals when it comes



to influencing what the rules are and how they might be enforced.

In conclusion, I suggest that our more compassionate approach to white-collar criminals should be transferred to crimes of the less powerful so that we restrict the use of criminal law rather than feed the crime control industry's voracious appetite for more crime. Many occupations benefit from labelling individuals as criminals, and a critical examination of "problem definers" is crucial to reducing crime in our society. Other writers have suggested that a move to more heavily penalizing white-collar criminals will simply lead to further criminalization of the less powerful. In addition, the criminalization of conduct can do more harm than good, and the increased focus on the use of criminal law obscures the need to find non-criminal solutions to social harm (perhaps in societal structures that produce social harm). The solution is not, however to substitute administrative action for criminal action, as the former can result in harsher results than the latter.

It is difficult to conclude that the monitoring systems in British Columbia and Ontario catch more than a small fraction of health care fraud. When caught, white-collar criminals have numerous advantages over less powerful criminals. Wealthier offenders can more readily avoid detection, investigation, prosecution, conviction, and penalty. If the less powerful could do the same, we would have a drastic reduction in the behaviour that we define and enforce as crime. The study of white-collar crime in the "what is a crime?" debate exposes the class-biased criminal justice system and the crime control industry. We are warned that a harsher approach to white-collar crime will have the unintended consequences of fuelling the crime control industry against the less powerful. It may be time to seriously reconsider the inequality of the criminal law and restrain its use.

# PART ONE: Health Care Fraud: The Difference of Location<sup>1</sup>

In 1939, Sutherland coined the phrase “white-collar crime” to draw attention to crimes committed by the upper class and the fact that they were “not ordinarily included within the scope of criminology.”<sup>2</sup> Such crimes were less likely to be prosecuted in the criminal justice system than crimes by the lower-class. If such deviant acts were processed at all, it was often by administrative agencies. This difference of location in effect provided criminal immunity to white-collar criminals. Sutherland’s definition of crime was strongly rejected by Tappan, a lawyer-sociologist, who would have limited the term “crime” to criminal law prohibitions and “criminal” to those who had been found guilty by the courts.<sup>3</sup>

The debate over “what is (a) crime?” has a long history and continues today.<sup>4</sup> Greer and Hagan’s “crime pyramid” and Henry and Lanier’s “crime prism” are attempts to integrate the various definitions of crime. According to the crime pyramid, deviant acts that are more likely to attract the criminal label involve “(1) broad agreement about the wrongfulness of the acts, (2) a severe social response, and (3) an evaluation as being very harmful.”<sup>5</sup> Henry and Lanier point to a number of limitations of the crime pyramid, including the fact that crimes of the less powerful<sup>6</sup> “are far more likely to receive the full weight of the law than crimes of the powerful.”<sup>7</sup> Henry and Lanier develop a crime prism that differentiates between highly visible crimes (usually crimes of the less powerful, which they situate on the top of the prism) and relatively invisible crimes (usually crimes of the powerful often conducted in private and violating trust, which appear on the bottom of the prism). There are four dimensions to the prism. First, generally, there is the greatest social agreement at the top of the prism and the least amount of social agreement at the bottom. Second, behaviour in the upper part of the prism is more likely to attract a social

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<sup>1</sup> The word location is used throughout this paper to symbolize various differences—difference in socio-economic position, geographical location, professional status, and so on.

<sup>2</sup> Edwin H. Sutherland, *White Collar Crime: The Uncut Version* (with an Introduction by Gilbert Geis and Colin Goff) (New Haven and London, Yale University Press, 1983) at 7. His 1939 speech is reproduced in Edwin H. Sutherland, “White-Collar Criminality” (1940) 5(1) *American Sociological Review* 1.

<sup>3</sup> Paul W. Tappan, “Who Is the Criminal?” (1947) 12 *American Sociological Review* 96.

<sup>4</sup> See Stuart Henry and Mark M. Lanier (eds.), *What is Crime? Controversies over the Nature of Crime and What to Do about It* (Lanham, Maryland: Rowan & Littlefield Publishers Inc., 2001) and Law Commission of Canada (ed.), *What is a Crime?* (Vancouver: UBC Press, 2004).

<sup>5</sup> Scott Greer and John Hagan, “Crime as Disrepute” in Henry and Lanier (eds.). *What is Crime?* 207 at 213.

<sup>6</sup> Henry and Lanier use the term “powerless.” I prefer and will use the term “less powerful” to recognize the agency that such individuals exercise. None of us are without power; but power is not distributed equally.

<sup>7</sup> Stuart Henry and Mark M. Lanier, “The Prism of Crime: Towards an Integrated Definition of Crime” in Henry and Lanier (eds.). *What is Crime?* 227 at 228.

response than crimes towards the bottom. This differential response, in part, reflects the ability of the powerful to influence the definition and application of the laws. Third, crimes at the top of the prism generally result in more direct individual harm, whereas crimes at the bottom involve indirect social harm. Both can involve very serious harm, including death. Fourth, crimes at the top of the prism are targeted more at individuals, whereas crimes at the bottom are targeted at social categories (e.g., people who work in a high risk occupation).<sup>8</sup>

In reality, we use the criminal law to enforce some laws which lack social consensus and which cause little harm.<sup>9</sup> Sometimes the enforcement of our criminal law causes more harm than it prevents.<sup>10</sup> We also exclude from the criminal law activities that cause great harm.<sup>11</sup> When asking “what is a crime?” the social harm we do not define as crime is as important as that which we do. It appears that what is key to the nature of crime in both the crime pyramid and the crime prism is our response to unwanted behaviour. In defining crime, what social actors do in terms of enforcing the law is as important as the law itself.

The Law Commission of Canada took up the task of defining “what is a crime?” in a Discussion Paper released in 2003. It reviewed a number of earlier reports that called for the criminal law to be limited to controlling or responding to serious threats of harm when other means of control are not appropriate.<sup>12</sup> In a section on the “Realities of Criminal Law,” the Commission recognized that our reactions to crime are as important as our definitions of crime. Some crimes are dealt with privately; some are not dealt with at all. Some offenders are “over-policed,” others are “under-policed.” This blatant inequality led the Commission to ask, “Why do we treat some people as criminal and not others?”<sup>13</sup> It later asks, “Do our intervention strategies support notions of equality?”<sup>14</sup> In 2004, the Commission published a series of case studies on both the creation and enforcement of criminal laws in Canada. In their introduction to the

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<sup>8</sup> Henry and Lanier, “The Prism of Crime” at 227-232.

<sup>9</sup> For an exposé on how we waste criminal justice resources on activities that should not be criminalized because they do not cause serious harm to others, see Alan N. Young, *Justice Defiled: Perverts, Potheads, Serial Killers and Lawyers* (Toronto: Key Porter Books, 2003).

<sup>10</sup> While there is probably social consensus that car theft should be prevented, one can only wonder if the highly publicized car-bait programme used by the police in the Vancouver Lower Mainland (where bait cars are left in parking lots for the would-be thieves; and some are caught on tape wondering out loud whether they might be stealing the bait) might lead to a greater number of car-jackings, purse snatchings, park muggings, and home invasions. Increase in the latter crime is likely to increase fear of crime and fuel support for the crime control industry.

<sup>11</sup> Paddy Hillyard and Steve Tombs, “Beyond Criminology” in Paddy Hillyard, Christina Pantazis, Steve Tombs, and Dave Gordon (eds.), *Beyond Criminology: Taking Harm Seriously* (Blackpoint, Nova Scotia, Pluto Press, 2004) 10 at 12-14.

<sup>12</sup> Law Commission of Canada, *What is a Crime? Challenges and Alternatives* (Ottawa: Law Commission of Canada, Discussion Paper, 2003) at 15.

<sup>13</sup> Law Commission of Canada, 2003 at 20.

<sup>14</sup> Law Commission of Canada, 2003 at 39.

publication, Des Rosiers and Bittle call for “a more equitable and accountable process for defining crime and enforcing criminal law.”<sup>15</sup>

This paper on fraud by health care professionals is not about the creation of new laws, but the enforcement of laws that have been around for some time. Although historically there was some question as to whether fraudulent practices should be considered criminal,<sup>16</sup> today there seems to be a general consensus that fraud should be prohibited. At least there is no widespread support to decriminalize fraud, as there is, for example, with the offence of possession of marijuana.

Under section 380 of the *Criminal Code*, anyone “who, by deceit, falsehood or other fraudulent means . . . defrauds the public or any person . . . of any property, money or valuable security or any service” commits the offence of fraud.<sup>17</sup> Fraud is a crime that spans socio-economic classes. It ranges from welfare and unemployment fraud to health care fraud by doctors, legal aid fraud by lawyers, and corporate fraud by officers and directors of corporations. The crime of fraud allows us to examine how we deal with one crime that occurs in a variety of different social and economic spheres. Although there are many issues surrounding the elements of the offence of fraud,<sup>18</sup> the more contentious issues seem to be in how we enforce, or do not enforce, this law. What we do about a law is perhaps as important or more important than what the law says, and has a major impact on “what is a crime?”<sup>19</sup>

Crime definers can respond to fraud and other billing misconduct by health care professionals by a number of different means. If fraud is discovered, it can be ignored or tolerated. The government agency in charge of monitoring the payment of bills can react informally or formally. The police may or may not be called upon to investigate. The Crown may or may not prosecute under the *Criminal Code* or provincial legislation. The judge may or may not find fraud, and the social context may be a deciding factor.<sup>20</sup> The professional may be

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<sup>15</sup> Nathalie Des Rosiers and Steven Bittle, “Introduction” in Law Commission of Canada, 2004 vii at xxiii.

<sup>16</sup> Brenda L. Nightingale, *The Law of Fraud and Related Offences* (Toronto: Carswell, 1996) at 1-3 provides an example from 1703 where Holt, C.J. questioned, “Shall we indict one man for making a fool of another?”

<sup>17</sup> If the subject matter exceeds \$5000, it is an indictable offence punishable by a term of imprisonment not exceeding fourteen years. Prior to 2004, the maximum penalty was ten years. If the value of the subject matter does not exceed \$5000, the offence can be prosecuted by indictment (maximum term of imprisonment not to exceed two years) or by way of summary conviction.

<sup>18</sup> See Nightingale, *The Law of Fraud*; Law Reform Commission of Canada, *Theft and Fraud Offences* (Ottawa: Law Reform Commission of Canada, Working Paper 19, 1977); and Law Reform Commission of Canada, *Theft and Fraud Offences* (Ottawa: Law Reform Commission of Canada, Report 12, 1979).

<sup>19</sup> As the Law Reform Commission of Canada said about theft and fraud in 1977, “A law, it’s said, is what it does. Criminal law, for instance, isn’t merely what the *Criminal Code* says but also what is done by judges, prosecutors, defence counsel, police, prison officials and all who operate our criminal justice system. What all these do is law reform’s prime target;” Law Reform Commission, 1977 at 1.

<sup>20</sup> Consider McLachlin, J.’s discussion on how to determine the *actus reus* of “other fraudulent means” under section

brought before the self-regulating organization (SRO) for a disciplinary hearing. A study by Ericson and Doyle, on how insurance companies define and regulate fraudulent insurance claims, is particularly illustrative of how laws are differently enforced against the rich and the poor. The authors found that one insurance company, which catered to clients from a more desirable socio-economic background, serviced them by accommodating professional in-house adjusters. Another company, with clients from a lower socio-economic background, contracted ex-police officers as private investigators to reduce the amount they had to pay on insurance claims, and it more readily invoked the criminal justice system.<sup>21</sup> When people question whether there is one law for the rich and one law for the poor, it is generally a question about the application of the law—law in practice or law-in-action, not the definitions of crime. This is a paper about law-in-action.

## I. Research Methods

Part II of this paper reviews the literature on the range of health care fraud that exists and narrows the scope of the paper to a specific form of health care fraud and misconduct by professionals—that which occurs during fee-for-service billing. Most of these professionals are medical doctors because they have the greatest access, in the greatest number, to the fee-for-service billing system. This part then briefly examines historical concerns over fraud by health care professionals, attempts to measure the extent of health care fraud, and how the work of professionals is controlled.

Parts III and IV review the legislation governing health care billing, and how deviant billings are monitored and processed in British Columbia and Ontario. In order to piece these processes together, I canvassed the legislation, regulations, and publications by the government agencies that monitor fee-for-service billing. I also searched newspapers, and websites and bulletins/newsletters of the government agencies and the colleges of physicians and surgeons. The Ontario system is much more transparent, especially following the government of Ontario's appointment of the Honourable Peter Cory on April 30, 2004, to review and make recommendations regarding "the best-practice method to audit fee-for-service claims that: (a) is accountable to the people, physicians and government of Ontario and (b) rebuilds the

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380 of the *Criminal Code* in *R. v. Zlatic*, [1993] 2 S.C.R. 29 at para. 32: "Would the reasonable person stigmatize what was done as dishonest? Dishonesty is, of course, difficult to define with precision. . . . A use is 'wrongful' in this context if it constitutes conduct which reasonable decent persons would consider dishonest and unscrupulous."

<sup>21</sup> Richard Ericson and Aaron Doyle, "Criminalization in Private: The Case of Insurance Fraud" in Law Commission of Canada (ed.), *What is Crime? Defining Criminal Conduct in Contemporary Society* (Vancouver: UBC Press, 2004) 99

confidence of the medical profession in the audit process."<sup>22</sup> Public documents, including submissions to the Review, are posted on a public website, and I accessed them as part of my research.

Part V describes administrative, self-regulating, and criminal and quasi-criminal actions against health care misconduct commenced between 1990 and 2003 across Canada, which were available in the public domain through court and Quicklaw databases, newspaper coverage, and court transcript services. It then focuses in greater detail on cases arising out of British Columbia and Ontario and examines the similarities and differences between the two provinces. Cases were coded and entered into SPSS to assist in both quantitative and qualitative analysis (see Appendix A for the Coding Sheet).

There were some differences between the two provinces in terms of access to information. The College of Physicians and Surgeons of Ontario decisions are available through its website and Quicklaw. The College of Physicians and Surgeons of British Columbia takes the position that its decisions are covered by privacy legislation and it will not release them. The College simply refers inquiries to the short summaries of its actions that appear on its website. None of its full decisions are posted on its website or on Quicklaw. The only hint at the details of what these decisions contain is when a doctor appeals them to the courts or the facts make their way into another court decision, such as a divorce or bankruptcy case. The lack of transparency exhibited by the British Columbia College is becoming more the exception than the norm with professional SROs,<sup>23</sup> and one might question why a professional SRO, with disciplinary powers delegated to it by government, should lack such transparency.

The College of Physicians and Surgeons of Ontario has a database of its physicians accessible through its public website which includes their disciplinary history, year of birth, and year and place of graduation. Unfortunately, information about physicians who have resigned from the College is not retained on the public website. The British Columbia College of Physicians and Surgeons launched its database in January, 2005.<sup>24</sup> It includes disciplinary history (a brief summary only) since January 1998, year and place of graduation, but not year of birth.

Although court decisions are in the public domain, there were still problems gaining

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at 119-120.

<sup>22</sup> Terms of Reference, April 30, 2004; [www.petercory.org](http://www.petercory.org); accessed December 30, 2004.

<sup>23</sup> See Joan Brockman, "'Fortunate Enough to Obtain and Keep the Title of Profession:' Self-Regulating Organizations and the Enforcement of Professional Monopolies" (1998) 41(4) *Canadian Public Administration* 587 at 608-09.

<sup>24</sup> [www.cpsbc.ca/](http://www.cpsbc.ca/) accessed January 12, 2005.

access to transcripts. I was told that transcripts in Ontario are destroyed after six years, and that one cannot order a transcript without the name of the judge before whom the accused appeared or the name of the reporter. The date of appearance and the name of the accused are not sufficient. Court transcripts were much easier to order in British Columbia as the name of the accused (even when misspelt) was sufficient to order a transcript.

I conducted interviews with ten lawyers, doctors and administrators who worked in the health care system in British Columbia in order to better understand how the system worked (see Appendix B for the Interview Schedule and further explanation). I was greatly assisted in understanding the system in Ontario by a number of submissions to Justice Cory, whose review of the audit system in that province was ongoing as I conducted my research.

The conclusions, Part VI, identify a number of issues that arise out of the differences of location—professional fraud and welfare fraud, and health care fraud in British Columbia and Ontario. I then address the question of how the compassion, or perhaps the deference, that we show to white-collar criminals can be transferred to so-called “street” criminals.

## **PART TWO: Defining the Problem of Health Care Fraud**

### **I. The Range of Health Care Fraud**

Health care fraud can be perpetrated by individual patients (using someone else’s card or a fraudulent health card), hospitals, extended-care facilities, suppliers, laboratories, health care providers and fictitious companies. The victims can be a publicly funded system or private insurance and all those who are required to pay higher premiums or go without service because of lack of funds. Sparrow provides numerous examples of health care fraud in the United States and suggests that organized crime has turned from drugs to health care fraud because it is “safer and more lucrative, and the risk of being caught is smaller. Moreover, if they are unlucky enough to get caught, these criminals know the punishments for health care fraud are likely to be much less severe than those for drug dealing.”<sup>25</sup>

This paper deals with one aspect of health care fraud—over-billing and fraudulent billing carried out by health care professionals (mostly physicians) who bill on a fee-for-service basis.

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<sup>25</sup> Malcolm K. Sparrow, *License to Steal: How Fraud Bleeds America’s Health Care System* (Boulder, Colorado: Westview Press, 2000) at 19.

According to a number of academics, a fee-for-service health care system is criminogenic or crime facilitative in that it “subtly corrupts its own practitioners [and is] a major contributor to the disintegration of standards among physicians.”<sup>26</sup> It allows doctors to “increase income illegally with little risk of apprehension.”<sup>27</sup>

In 1991, Barer and Stoddart recommended a capitation system for Canada because the fee-for-service system encouraged the proliferation of visits and procedures, was inherently inequitable, and consumed an inordinate amount of time to negotiate.<sup>28</sup> Since that time there has been a decrease in the fee-for-service mode of payment, but it still is the dominant mode for paying physicians in Canada.<sup>29</sup>

The fee-for-service billing system is based on trust, and without serious monitoring it provides easy opportunities to engage in inappropriate or fraudulent billing. Health care professionals may bill for services when none were provided; they may charge for a more expensive procedure than one performed (known as up-coding), unnecessary or inappropriate services, or even unethical conduct. In addition to the financial cost of health care fraud, unnecessary diagnostic techniques and surgeries may cause serious harm or death to patients.<sup>30</sup>

The fact that there is some discretion in what might be billed following some services, so-called “aggressive billing” or “fudging and padding” might be tolerated or viewed more as business/money oriented behaviour than as fraud. Even the terminology (“up-coding,” “over-billing,” “inappropriate billing”) leaves the impression that this type of behaviour might not be considered “fraud.”

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<sup>26</sup> Paul Jesilow, Henry N. Pontell, and Gilbert Geis, *Prescription for Profit: How Doctors Defraud Medicaid* (Berkeley: University of California Press, 1993) at 8.

<sup>27</sup> Jesilow, Pontell, and Geis, *Prescription for Profit* at 3-5. This is not to say that other systems do not have problems.

<sup>28</sup> M. Barer and G. Stoddart, *Towards Integrated Medical Resource Policies for Canada* (Winnipeg: Manitoba Health, 1991) as cited in Dana Hanson (Chair) Ad Hoc Policy Working Group on the Physician Workforce, *Who Has Seen the Winds of Change? Towards Sustainable Canadian Physician Workforce* (Ottawa: Canadian Medical Association, July 2004) at 21. According to some critics, the capitation system which pays per beneficiary rather than per-service, simply “moves the risks of fraud and abuse downstream;” Timothy Stolfus Jost and Sharon L. Davies, “The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement” (1999) 51 *Alabama Law Review* 239 at 252-254.

<sup>29</sup> Hanson, *Who has Seen* at 22 cites a study that shows that the proportion of physicians who receive 90% or more of their professional income from fee-for-service billings declined from 66% to 57% between 1995 and 2003.

<sup>30</sup> Jesilow, Pontell, and Geis, *Prescription for Profit* at 19 refers to a study in the United States that found that 10% of operations were unwarranted. For some procedures the estimate of inappropriate surgery is 44%. Recently the Blue Cross and Blue Shield Association found that some physicians were willing to put patients at serious risk, citing the case of a California cardiologist who performed unnecessary open-heart surgeries; Vanessa Matlin, “Fraud Plagues U.S. Health Care” (14 July 2004) *Knight-Ridder Tribune*. In a recent case in Ontario, Dr. Wai-Ping was found to have exposed women to unnecessary and risky hysterectomies; *College of Physicians and Surgeons of Ontario v. Dr. Errol Sonny Wai-Ping* (11 March 2004). The lawyer, who filed a lawsuit on behalf of his former patients, alleges that financial gain may have been a motivating factor in these surgeries; Joseph Brean, “MD Pressured Women Into Unneeded Hysterectomies” (19 November 2003) *National Post* A5.



There are a number of violations included in this research that may fall outside the definition of fraud. First, a “patterns of practice” violation means a doctor has exceeded the billing practices of colleagues in his or her area of practice to the extent that it calls for explanation or correction. This may simply mean that the doctor is providing patients with exceptional care. However, it may also imply the provision of unnecessary or inappropriate services. “Inadequate records” may simply mean that the doctor is a sloppy business person; however, it may also mean that the doctor did not conduct the services billed for but there was insufficient evidence or time to develop this aspect of the case.

There also appears to be an element of “group think” in health care fraud, and techniques of neutralization allow health care professionals to engage in fraud without being overly concerned for the criminal nature of their behaviour. This is reinforced by the fact that physicians who are charged with misconduct may bring in other physicians to testify that the alleged misconduct is common practice in their field, and therefore justified. Jesilow, Pontell, and Geis suggest that the conditions that facilitate health care fraud include: “(1) the perpetrator’s ability to redefine the violation, both in private and to others, in benign terms; (2) the perpetrator’s feeling that insensitive external forces are interfering with his or her just deserts; (3) the availability of opportunities to violate the law easily; and (4) the perpetrator’s belief that the violations are unlikely to be discovered, or, if found out, are unlikely to result in serious penalties.”<sup>31</sup>

## II. Historical Concerns Over Fraud by Health Care Professionals

Unlike the United States,<sup>32</sup> there appeared to be little concern over health care fraud in Canada until recently.<sup>33</sup> However, Gordon Hatcher, a native of Canada and a resident of the United States, discussed the various cost control mechanisms in Saskatchewan, Ontario, and Quebec in the mid-1970s, in order to assist policy development in the United States.<sup>34</sup> As a result of his

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<sup>31</sup> Jesilow, Pontell, and Geis, *Prescription for Profit* at 186.

<sup>32</sup> See, for example, Jesilow, Pontell, and Geis, *Prescription for Profit*; and Sparrow, *Licence to Steal*.

<sup>33</sup> Between January 29, 1973 and February 23, 2004, there were 97,774 oral questions in the Question Period, Canada House of Commons and responses, and between January 22, 1973 and November 20, 1992, there were 17,531 written questions. Only one question, in 1982, asked about health care fraud. Jim Fulton asked Monique Begin about the President of the British Columbia Medical Association who was “grossly ripping off the medical system.” Search words used: “fraud and medicare or OHIP,” “health care fraud,” medical care fraud” “OHIP.” This lack of interest at the federal level may be because enforcement takes place at the provincial level.

<sup>34</sup> Gordon H. Hatcher, *Universal Health Care In Canada, 1947-1977* (Washington: U.S. Department of Health and

examination of utilization control in Saskatchewan, he concluded that “tight claims review by experienced clerical and administrative staff, aided by a good computer program and by checking with patients, is more effective than peer review in preventing the kinds of abuses prevalent under fee-for-service health insurance.”<sup>35</sup>

Problems in Ontario stemmed from the fact that the province decided to use private carriers so that physicians would be paid on a timely basis. Since these private agencies simply billed on a cost-plus basis there was no incentive or means to control overuse. Unlike other provinces that had used physician profile tools since the mid-1960s (to curb “overservicing by physicians . . . rather than excessive demands by patients”), Ontario did not introduce this investigative tool until 1974 following “public concern over runaway physicians’ incomes and government concern over escalating costs.” Following proposals to institute controls, the physicians persuaded the government to allow the College of Physicians and Surgeons to monitor billings through their Medical Review Committee that was allowed to exclude any government employees.<sup>36</sup>

Hatcher found that in its first three years of operation, the Quebec Health Insurance Board prosecuted 60 cases, resulting in over 30 convictions. He attributed this high monitoring to the fact that the Board dealt directly with such behaviour, rather than relying on peer review. These tight controls on claims also resulted in large sums being recovered because of inaccurate (as opposed to fraudulent) billing.<sup>37</sup>

In the mid-1980s, Wilson, Chappell and Lincoln found that “despite widespread public and government interest in medical fraud and overservicing in other industrial countries, little interest in this issue has been generated in Canada.”<sup>38</sup> Little seems to have changed in Canada until recently; however, the interest in other countries appears to have grown exponentially. For example, in 1993 the US Attorney General declared that health care fraud would be the Department of Justice’s second priority (violent crime was first), and announced several initiatives to “crack down” on it. Legislative changes in 1996 and 1997 were designed to assist anti-fraud initiatives.<sup>39</sup> The United States also subjects health care fraud to *qui tam* actions under the *False Claims Act*. This legislation allows whistleblowers (formally referred to as

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Human Service, 1981).

<sup>35</sup> Hatcher, *Universal Health Care* at 91.

<sup>36</sup> Hatcher, *Universal Health Care* at 114-116.

<sup>37</sup> Hatcher, *Universal Health Care* at 138. It is not entirely clear if these were criminal or quasi-criminal prosecutions or civil recovery actions, as Hatcher states that both criminal and civil actions could be taken.

<sup>38</sup> Paul R. Wilson, Duncan Chappell, and Robyn Lincoln, “Policing Physician Abuse in BC: An Analysis of Current Policies” (1986) 12 *Canadian Public Policy* 236 at 236.

<sup>39</sup> Sparrow, *License to Steal* at 56-79.

relators) to receive between 15-30% of the amount recovered, which in some cases can amount to millions of dollars.<sup>40</sup>

There were a number of cases in the mid-1990s that brought the issue of health care fraud to the public's attention in two Canadian provinces. In 1994, the British Columbia Medical Services Plan released the names of seven doctors who were required to repay between \$50,000 and \$750,000 to the Plan. While these doctors received some media attention, it was not until 1996 that the system encountered serious criticism after the provincial cabinet approved settlements that excused two doctors from repaying \$216,164 and \$400,000 to the Plan. The government was criticized for its "deferential coddling of the doctors."<sup>41</sup>

In 1996, a number of newspapers covered a story about Dr. Ara Artinian, a Toronto doctor, who was alleged to have over-billed OHIP by \$4.7 million for services that were never provided. It was reported that he left the country in 1994. It is unclear whether OHIP ever recovered the money;<sup>42</sup> however Dr. Artinian and his mother had moved \$5.5 million in liquid assets to the Bahamas. It was reported that the criminal charges were stayed because of delay. This was not Dr. Artinian's first encounter with over-billing. In an earlier discipline decision, the College of Physicians and Surgeons wrote, "By his dishonest and persistent billing to both OHIP and Workers Compensation, Dr. Artinian showed total disregard for the trust which is essential for the operation of publicly funded health care system."<sup>43</sup> In another case, in 1997 and 1998, various newspapers reported that National Medical Enterprises, a United States company, had defrauded OHIP of between \$25 and \$80 million in its dealings with Ontario patients who were sent to United States psychiatric hospitals for drug and alcohol abuse and eating disorders.<sup>44</sup>

Although changes to managing health care fraud occurred in both provinces following

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<sup>40</sup> Mary T. Scott received \$1.1 million (18%) of the amount recovered from a Grande Rapids hospital; No Author, "\$6 Million Settles Lawsuit; Hospital Denies any Wrongdoing Over a Whistleblower Case" (11 December 2003) *Detroit Free Press* np. When HealthSouth Corp., an operator of rehabilitation hospitals, agreed to pay \$325 million to settle numerous Medicare fraud charges in the United States, Devage (a patient at one of HealthSouth's facilities) received \$8.2 million; others complaints received a total of \$4.2 million under the *False Claims Act*; Patti Bond, "Hospital operator settles case HealthSouth ends probe by Medicare for \$325 million" (31 December 2004) *The Atlanta Journal-Constitution* F1. Dr. Steven J. Bander was paid \$56 million when the US government collected \$350 million from Gambro Healthcare. The company set up a shell company which allowed it to illegally collect almost \$500 per patient per month for kidney dialysis, above the entitled amount. Dr. Bander had tried unsuccessfully to stop the fraud before bringing an action. Peter Shinkle, "Doctor who exposed fraud at Gambro will get \$56 million" (26 March 2005) *Knight-Ridder Tribune* np. For further information on these actions see: "All About Qui Tam" [www.all-about-qui-tam.org/](http://www.all-about-qui-tam.org/) accessed March 26, 2005.

<sup>41</sup> Editorial, "Doctored Billing" (23 December 1996) *Vancouver Sun* A10.

<sup>42</sup> The MRC reported that in 1995/96 it recommended one recover in excess of \$3 million; it is not clear if this recommendation related to Artinian or whether the amount was ever recovered; Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 13.

<sup>43</sup> Estanislao Oziewicz, "Doctor Vanishes in Midst of Overbilling Case" (21 August 1996) *The Globe and Mail* A1, A6; Lisa Priest, "OHIP Paid MD Despite his History" (2 August 1996) *Toronto Star* A4.

<sup>44</sup> Canadian Press, "U.S. hospitals being sued" (6 May 1997) *The Windsor Star* at A10.

these incidents, it was Ontario that introduced harsher measures. In 1997, the Ontario Health Minister, Jim Wilson, stated in a news conference that his “government has zero tolerance for fraud. Every health-care dollar lost to fraud is a dollar stolen from a patient in need.”<sup>45</sup> The historical solution of dealing with fraud by increasing premiums or the money available for health care appeared to be coming to an end. Ericson and Doyle, who studied private property and casualty insurance, suggest that the “fraud problem” in the insurance industry became a more prominent issue when the cost of recovering amounts paid to fraud artists through increasing premiums became an issue.<sup>46</sup> This may have been the trigger with health care fraud in Canada, as a shortage of funds brings fraud to the attention of budget conscious governments. Jesilow, Pontell and Geis suggest that the focus on Medicaid fraud may also be a tactic to distract the public from another major issue, that is the under-funding and unavailability of health care for many individuals in the United States.<sup>47</sup> In Canada, Saul suggests that this fear-mongering focus on fraud is a government tactic to make privatization of health care more acceptable to the public.<sup>48</sup>

Recently, the untimely death of Dr. Anthony Hsu (an Ontario pediatrician who committed suicide following an order to reimburse OHIP for \$108,000) and the appointment of former Supreme Court Justice Peter Cory to conduct a review of Ontario’s medical audit system have brought the issue to the public’s attention in Canada. This time, it appears as though some public sympathy is with the Ontario doctors who have been complaining for some time that the Medical Review Committee is too aggressive and unfair in its approach to over-billing. Although the terms of reference for the Review stated that “The initiative shall be undertaken in a manner which does not affect or impede the ongoing statutory and operational duties and functions of the Medical Review Committee and the General Manager of the Ontario Health Insurance Plan,” on June 24, 2004, the Ontario legislature passed *The Transitional Physician Payment Review Act*, S.O. 2004, C.13. The law halts all audits conducted by the Medical Review Committee until after Justice Cory’s report.<sup>49</sup>

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<sup>45</sup> Jane Armstrong, “Wilson to slash health fraud Province hopes to save millions in crackdown” (24 September 1997) *Toronto Star* A3. Although this news report was more about users of OHIP services, the concern also applied to the providers of health care.

<sup>46</sup> Ericson and Doyle, “Criminalization in Private” at 106-107.

<sup>47</sup> Jesilow, Pontell and Geis, *Prescription for Profit* at 35-36.

<sup>48</sup> John Ralston Saul, “Health Care at the End of the Twentieth Century: Confusing Symptoms for Systems” in Margaret A. Somerville (ed.) *Do We Care: Reviewing Canada’s Commitment to Health* (Montreal: McGill-Queen’s University Press, 1999) 3 at 8.

<sup>49</sup> As of March 24, 2005, the report has not been released.

### III. How extensive is Health Care Fraud?

Guesstimates of health care fraud come largely from other countries. Jesilow, Pontell and Geis suggest that estimates of Medicaid fraud by physicians in the United States ranged from 10-25% of the total budget, which in 1989 was \$61 billion. They provide some extreme examples of fraud and associated offences such as the psychiatrist who billed Medicaid for 4800 hours a year (almost 24 per work day); and physicians who billed for services on the dead, and unnecessary eye operations which resulted in impaired vision. Others charged Medicaid for sexual liaisons, abortions on women who were not pregnant, and to extract 38 teeth from one person (when there are only 32 in a human mouth).<sup>50</sup>

Sparrow suggests that health care fraud in the United States was somewhere between 10-40% of the 1.3 trillion dollar costs in 2000.<sup>51</sup> He points out that evaluations of efforts to reduce health care fraud can be very misleading. One study showed that overpayments were reduced in 1997, 1998, and 1999 from 14% to 11% to 7.1%, respectively. However, the auditing procedures, which simply compared claims submitted with the documentation that the providers were later asked to submit for verification, did not include contact with patients. Providers simply had to lie twice in order to verify any phantom services.<sup>52</sup> The system, which is based on trust, is also set up for thieves: "Bill your lies correctly [and you] can rely on the payment systems to process [your] lies correctly, and pay them."<sup>53</sup> A more recent and more modest estimate comes from the Blue Cross and Blue Shield Association—\$85 billion was lost to health care fraud in the United States in 2003—a mere 5% of the \$1.7 trillion spent on health care in that year.<sup>54</sup>

In Canada, a number of newspaper articles cite the Inkster report, done in 1997 for the Ministry of Health in Ontario, as stating that there is up to \$60 million in fraud each year in the province of Ontario. However, the report merely states that as an example, "Provider Services' analysis of one billing code, intermediate medical examinations, indicates that the abuse of this code could be as high as \$60 million per year."<sup>55</sup> The Ontario government has estimated that

<sup>50</sup> Jesilow, Pontell, and Geis, *Prescription for Profit* at 12-13.

<sup>51</sup> Sparrow, *Licence to Steal* at 71.

<sup>52</sup> Sparrow, *Licence to Steal* at 90-93.

<sup>53</sup> Sparrow, *Licence to Steal* at 39. The trust the system depends on is illustrated by an Ontario physician who decided to test the system by billing for a heart-lung transplant conducted in the patient's home with local anaesthetic. He was amazed to see that his bill was paid by OHIP; "No Author, Prank billing by Ontario Doctor Proves OHIP easy to Defraud: No One Questioned bill for Transplant at Patient's Home " (24 January 1996) *The Ottawa Citizen* A2.

<sup>54</sup> Vanessa Maltin, "Fraud Plagues U.S. Health Care" (14 July 2004) *Knight-Ridder Tribune* n.p.

<sup>55</sup> Norman D. Inskster, *Fraud and Abuse in the Ontario's Health Care System: A Preliminary Review* (Prepared by KPMG Investigation and Security Inc., September 10, 1997) at 9. Obtained from the Ministry of Health and Long-Term Care March 5, 2004 through Freedom of Information request.

health care fraud runs between \$60 and \$300 million a year.<sup>56</sup> One estimate is as high as \$650 million per year<sup>57</sup> and another suggests it could be up to \$1 billion.<sup>58</sup> Saul suggests that there are probably no more cheating doctors than there are cheating patients and CEOs—between .5% and 5%.<sup>59</sup> This would amount to between 186 and 1860 doctors in Ontario and between 49 and 490 in British Columbia.

One measure of fraud surveillance or enforcement (or lack thereof) might be the number of physicians who employ the services of the Canadian Medical Protective Association (“a mutual defence organization for physicians who practice in Canada”). Between 1999 and 2003, only .4 to .7% of its 65,000 members used CMPA’s legal services to deal with billing matters. In the years 1999 through to 2003 it reported the following number of billing matters: 229, 275, 254, 452, and 279. The spike to 452 billing matters in 2002 was attributed to the increased activity in Alberta and Quebec.<sup>60</sup>

## IV. The Social Control of Work

Eliot Freidson elaborates on three ideal types for how professional work is controlled: 1) professionalism (control by the occupation); 2) managerialism (control through bureaucracy); and 3) the free labour market (control through consumerism or commercialism).<sup>61</sup> He believes that the monitoring of service delivery and fraud is moving from professional control to bureaucratic control, and there is increasing pressure for labour market control (through privatization). Saul reminds us that although managerialism is often associated with government bureaucracy, “the private sector is also managerially-driven and suffers to an equal if not greater extent from the negative consequences of corporatism.”<sup>62</sup> In practice, Freidson believes there

<sup>56</sup> Canadian Press, “Doctors who falsely billed Ontario ordered to pay back \$16 million” (23 January 2001) CP Wire.

<sup>57</sup> Matt Borsellino, “Controversy clouds MRC auditing process” (7 August 2001) 37 (27) *Medical Post* 50 at 51.

<sup>58</sup> Tom Blackwell, “Ontario to crack down on health fraud” (24 September 1997) *Kingston Whig* at 12.

<sup>59</sup> Saul, “Health Care” at 6. Like most estimates, there is no evidence to back this claim.

<sup>60</sup> Canadian Medical Protective Association, *2004 Review of the Medical Audit Practice in Ontario: Canadian Medical Protective Association Submission to the Honourable Justice Peter Cory* (August 3, 2004) at 3.

<sup>61</sup> Eliot Freidson, *Professionalism: The Third Logic* (Chicago: University of Chicago Press, 2001) at 179.

<sup>62</sup> Saul, “Health Care” at 15. According to Freidson, managerial control can occur in the public and private sphere (at 4). Saul suggests that the more efficient a system becomes the more ineffective it will be (at 10). The growth of management over the last 100 years was a “natural and necessary parasite of growing specialization among those who actually do something” (at 11) and that the resulting corporatism or corporatist technocracy has pushed the public interest out of a system now obsessed with self-interest (at 12-17). Similarly, Germov suggests that the goals of efficiency are not neutral, rather they deflect attention away from “issues of equity, participation, minority rights and social justice.” Later he suggests that “managerialism and its associated commercialism and consumerism may undermine the access, equity, and universalism of Medicare itself;” John Germov, “Medi-Fraud, Managerialism and the Decline of Medical Autonomy: Deprofessionalization and Proletarianisation Reconsidered” (1995) 31(3) *Australian and New Zealand Journal of Statistics* 51 at 60 and 63. The privatization/competition debate is beyond the scope of

should be a policy-driven mix of the three logics, but he also believes that managerialism and consumerism have invaded the medical profession.<sup>63</sup> He appears to favour the professions regaining their control over medical services through better self-regulation and enforcement of ethical codes to regain the public's trust of the professions.<sup>64</sup>

One of the defining characteristics of a profession is that it is self-regulating.<sup>65</sup> The professions argue that they are in a better position to monitor their colleagues behaviour because they have the expertise to do so. They can funnel in unethical and inappropriate behaviour that would not easily be subjected to government control. Critics of the professions say that professional SROs are too easy on their members and in effect funnel out deviant professionals by not imposing any, or any significant, penalties for professional misconduct. SROs are also criticized for funnelling professional misconduct away from the criminal justice system.<sup>66</sup> In addition, harsh treatment by SROs against selected "scapegoats" in their communities may result in unfairness to some of the more marginal professionals.<sup>67</sup>

There are other systems that control professional work—the criminal justice system and the common law tort system.<sup>68</sup> For example, health care professionals can face criminal charges for fraudulent billing and civil law suits for unnecessary surgery. In the United States, the civil law system is also used to impose harsh financial penalties on health care fraud without the protections of the criminal justice system.<sup>69</sup> These various systems raise the question of which is

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this paper. For a recent discussion of how competition can be introduced into health care delivery without privatization see Michael J. L. Kirby and Wilbert Keon, "Why Competition is Essential in the Delivery of Publicly Funded Health Care Services" *Policy Matters* 5, No. 8 (Montreal: Institute for Research on Public Policy, September, 2004). Also see *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, November, 2002); and Darren Puscas, *Waiting in the Wings! How for-profit Health Corporations are Planning to Cash in on the Privatization of Medicare in Canada* (Ottawa: Polaris Institute, September, 2002).

<sup>63</sup> This view is shared by David Garland, *The Culture of Control: Crime and Social Order in Contemporary Society* (University of Chicago Press, 2001) at 151 who suggests that decision-making power has moved from practitioners to accountants and managers. It should be remembered, however, that this movement is less invasive in Canada where the professions have much stronger self-regulating powers. For a discussion of how the professional autonomy of doctors and nurses in Ontario has been eroded in favour of managerial control see Barbara Beardwood, "The Loosening of Professional Boundaries and Restructuring: The Implications for Nursing and Medicine in Ontario, Canada" (1999) 21(3) *Law and Policy Quarterly* 315.

<sup>64</sup> Freidson, *Professionalism* at 216.

<sup>65</sup> Self-regulation is one of the characteristics that I and others use to define a professions. Others disagree. I discuss this further in Joan Brockman, *Crimes and Misconduct in the Professions* (manuscript in preparation).

<sup>66</sup> The funnel analogy is used in Joan Brockman and Colin McEwen, "Self-Regulation in the Legal Profession: Funnel In, Funnel Out or Funnel Away" (1990) 5 *Canadian Journal of Law and Society* 1; and Joan Brockman, "An Update on Self-Regulation in the Legal Profession (1989-2000): Funnel In and Funnel Out" (2004) 19(1) *Canadian Journal of Law and Society* 55.

<sup>67</sup> Ann Daniel, *Scapegoats for a Profession: Uncovering Procedural Injustice* (Australia: Harwood Academic Publishers, 1998).

<sup>68</sup> One could argue that the criminal justice system is part of the bureaucratic-managerial system and that the civil law system is part of the free labour market, and therefore neither of these are in addition to Freidson's three ideal types.

<sup>69</sup> Jost and Davies, "The Empire Strikes Back" at 247 discuss the federal civil *False Claims Act* which allows for treble

the best way to control the billing practices of health care professionals and under what circumstances is each system appropriate? When is it appropriate to use more than one system? Is there a particular policy-driven mix that should prevail?<sup>70</sup>

One of the issues raised by Sutherland's challenge to criminology which is echoed by the Law Commission of Canada and Henry and Lanier's "crime prism" is the role of equality in the application of the criminal law. Does the application of criminal law to street criminals and white-collar criminals result in inequality based on socio-economic status? Does the existence of self-regulating professions and other administrative alternatives for dealing with white-collar crime allow professional criminals to be funnelled away from the criminal justice system? If white-collar criminals are treated more leniently, can we apply that leniency to street criminals to even the playing field? Can the lessons we learn from the application of the criminal law to white-collar crime be used to decrease its application in other areas of enforcement? I will return to some of these questions at the end of this paper.

## **Part III. The Monitoring and Investigation of Medicare Billings in British Columbia**

### **I. How Physicians are Paid in British Columbia**

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damages and civil penalties of \$5,000-\$10,000 per claim. This can result in multi-million dollar penalties. Such punitive/criminal sanctions in our civil law system in Canada would likely be unconstitutional.

<sup>70</sup> Some of the issues of multiple proceedings are discussed in Caroline Murdoch and Joan Brockman, "Who's On First? Disciplinary Proceedings by Self-Regulating Professions and other Agencies for 'Criminal' Behaviour" (2001) 64(1) *Saskatchewan Law Review* 29.



The publicly funded British Columbia Medical Services Plan (MSP) was established in 1965 to pay for medical and health care services of British Columbia residents.<sup>71</sup> The funds are managed by the Medical Services Commission (MSC) “on behalf of the Government of British Columbia in accordance with the *Medicare Protection Act*<sup>72</sup> and Regulations.” The MSC has tri-representation—three from Government, three from the British Columbia Medical Association (BCMA),<sup>73</sup> and three public members who are suppose to represent the beneficiaries of the MSP. All members are appointed by the Lieutenant Governor in Council. The public members are jointly nominated by the BCMA and the Government.<sup>74</sup> Although members of the MSC are not listed on the MSP website, they can be found at another government website.<sup>75</sup> The MSC is in many respects a political entity in which the BCMA has a vested interest.<sup>76</sup>

The majority of physicians in British Columbia (80%) are self-employed and are paid on a fee-for-service basis.<sup>77</sup> The MSC Fee Payment Schedule is established under section 26 of the *Medicare Protection Act*, through an agreement between the MSC and the BCMA.<sup>78</sup> The fees for listed benefits are established through the BCMA’s Tariff Committee that consults with Section representatives.<sup>79</sup> Services that are not listed cannot be billed for under other listings.<sup>80</sup> Under section 1 of the *Medicare Protection Act* “benefits” are defined as “medically required services rendered by a medical practitioner” or “required services prescribed as benefits,” unless the MSC determines that they are not benefits. The MSP contains a number of schedules, guidelines, protocols, newsletters, and even an MSP Tutor (online testing of knowledge about

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<sup>71</sup> Medical Services Plan, “Legislation and Governance of the Medical Services Plan” [www.hlth.gov.bc.ca/msp/legislation/index.html](http://www.hlth.gov.bc.ca/msp/legislation/index.html); accessed September 12, 2003.

<sup>72</sup> R.S.B.C. 1996, Chapter 286.

<sup>73</sup> The mission of the BCMA is “to promote a social, economic, and political climate in which members can provide the citizens of British Columbia with the highest standard of health care while achieving maximum professional satisfaction and fair economic reward;” [www.bcma.org/public/about\\_bcma/](http://www.bcma.org/public/about_bcma/); accessed September 4, 2004.

<sup>74</sup> Medical Services Plan, Medical Services Commission (MSC); [www.hlth.gov.bc.ca/msp/legislation/msc.html](http://www.hlth.gov.bc.ca/msp/legislation/msc.html); accessed September 12, 2003; Section 3, *Medicare Protection Act*.

<sup>75</sup> Board Resourcing and Development Office, Medical Services Commission [www.fin.gov.bc.ca/abc/boardpages/msc.html](http://www.fin.gov.bc.ca/abc/boardpages/msc.html). As of January 14, 2004, the MSC provides a link to the Board Resourcing and Development Office.

<sup>76</sup> This is illustrated by comments from the Chair of the BCMA’s Public Affairs Committee when, in 1993, Dr. Henderson, a physician and career public servant, was fired as the chair of the MSC (which he was in charge of since 1988), and Gillian Wallace, a lawyer and career public servant, was appointed as Chair. The Chair of the BCMA described it as “perhaps the most contentious health issue recently;” R. N. Young, MD, Chair, Public Affairs Committee, “Health Issues in the Fall Session” (1993) 35(1) *BC Medical Journal* 16 at 16.

<sup>77</sup> BC Medical Association, Policy Backgrounder, “How Physicians in BC are Compensated” (February, 2002); [www.bcma.org/public/news\\_publications/publications/policy\\_backgrounders/physicianscompensated.asp](http://www.bcma.org/public/news_publications/publications/policy_backgrounders/physicianscompensated.asp); accessed September 12, 2003.

<sup>78</sup> The agreements are found at Medical Services Commission, “Agreements with the British Columbia Medical Association (BCMA)” [www.healthservices.gov.bc.ca/msp/legislation/mscagree.html](http://www.healthservices.gov.bc.ca/msp/legislation/mscagree.html); accessed September 12, 2003.

<sup>79</sup> The British Columbia Medical Association, *Annual Report, 2001-2002* at 2 lists 11 sections such as Dermatology, Laboratory Medicine, Plastic Surgery, and so on.

<sup>80</sup> [www.bcma.org/public/news\\_publications/publications/fee\\_guide.htm](http://www.bcma.org/public/news_publications/publications/fee_guide.htm); accessed September 12, 2003.

billing claims) to assist practitioners in their billing claims to MSP.<sup>81</sup>

In 2002-2003, British Columbia spent \$10.4 billion on health care (42% of its budget); 70% of the health care budget (\$7.3 billion) was spent on nurses, physicians and employees (\$2.4 billion on physicians). The approximate 8,000 physicians' annual average billing rate was \$301,816.<sup>82</sup>

## II. Disagreements between Physicians and MSP

Physicians who disagree with how the MSP staff pay their claims can resubmit the claim for a reassessment. If they are still in disagreement, they may contact the Claims Billing Support Unit of MSP, and the MSP adjudication staff will respond to the claim.<sup>83</sup>

Further disagreements between physicians and the MSP on the fee assessment for complex or novel procedures may be resolved by the Reference Committee, which is composed of BCMA representatives only.<sup>84</sup> These reviews are based on written submissions by the parties which contain, for example, pathology reports, consultation reports, correspondence, and so on. The Committee makes recommendations to MPS; however, they are not always followed.<sup>85</sup> Annual Reports from 1996-97 to 2001-02 indicate that the Committee's work has decreased over the years (from 90 adjudications in 1996-97 to 34 in 2001-02), and that an increasing number of cases referred to the Committee are being resolved before they get to a review. The decrease in work is attributed to the revised Guide to Fees.<sup>86</sup>

## III. How Physicians' Bills are Monitored in British Columbia

Section 5(1)(r) of the *Medicare Protection Act* allows for the MSC to conduct inspections and audits through committees prescribed by regulations. In British Columbia, physicians play a

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<sup>81</sup> Medical Services Plan, "MSP for Medical and Health Care Practitioners" [www.hlth.gov.bc.ca/msp/infoprac/index.html](http://www.hlth.gov.bc.ca/msp/infoprac/index.html) accessed September 13, 2003; and "Billing Procedures for Physicians" [www.hlth.gov.bc.ca/msp/infoprac/physbilling/index.html](http://www.hlth.gov.bc.ca/msp/infoprac/physbilling/index.html); accessed September 13, 2003.

<sup>82</sup> Information Brochure on BC Health Care; [www.healthservices.gov.bc.ca/bchealthcare/video.html](http://www.healthservices.gov.bc.ca/bchealthcare/video.html); accessed January 11, 2004.

<sup>83</sup> "Disagree with how MSP has Paid Your Claim?" (2000) 24(2) *Physician's Newsletter* at 3.

<sup>84</sup> Medical Services Plan, "Committees under the Medical Services Commission (MSC)" [www.healthservices.gov.bc.ca/msp/legislation/msccomm.html](http://www.healthservices.gov.bc.ca/msp/legislation/msccomm.html); accessed September 13, 2003.

<sup>85</sup> In 1996-1997, MSP paid only two-thirds of the Committee's recommended fees for these cases; British Columbia Medical Association, *Annual Report, 1996-97* at 49.

<sup>86</sup> British Columbia Medical Association, *Annual Report, 1997-98* at 50.

crucial role not only in setting the fees for their services, but also for ensuring that physicians abide by the billing rules.<sup>87</sup> Although the MSC has the power to inspect and audit physicians' claims for payment and their patterns of billing practices (section 36), "Medical records may only be requested or inspected . . . by an inspector who is a medical practitioner" (section 36(3)). Inspectors may enter any premise other than a dwelling house<sup>88</sup> for the purpose of an audit, and upon request a person must "produce and permit inspection" of all records and "answer all questions of the inspector respecting the records." It is an offence under section 46(4) to obstruct an inspector who is performing his or her duties under the legislation. The inspector must report the results of the audit to the chair of the MSC under section 36(11). Although the MSC has medical physicians on staff, it also employs physicians on contract to assist with their inspections.

The Commission is required to advise the appropriate licensing body of any order that it makes for repayment (section 37(4)). Subsections 5(5) and (6) allow the Commission to share information with other public bodies for the purpose of administering the *Act*. Under B.C. Reg. 182/97 (including amendments up to B.C. Reg. 223/2002), information sharing arrangements may be made with a number of different agencies dealing with income assistance, insurance, workers compensation and income tax.

The MSC is assisted in its work through its own Billing Integrity Program (BIP) and by the Patterns of Practice Committee (POPC) and the Audit and Inspection Committee (AIC).<sup>89</sup>

## **A. Billings Integrity Program (BIP) of the Medical Services Plan**

The BIP was introduced by MSP in 1997. In some respects, it usurped the function of the POPC, and provided MSP with a method to conduct audits without the approval of the POPC.<sup>90</sup> BIP provides auditing services to the MSC, so that the MSC can "manage expenditures for medical and health care on behalf of MSP beneficiaries." In cooperation with the health

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<sup>87</sup> Physicians' role in monitoring billing practices has lessened other time. For example, at one time (prior to 1993) the Chair of the Medical Services Commission was a physician. Now section 3(4) of the *Act* requires that the Chair be one of the government representatives.

<sup>88</sup> Under section 37(6), they may enter a dwelling house with permission or a warrant obtained from a justice under section 37(7).

<sup>89</sup> Other committees include the Advisory Committee on Diagnostic Facilities, the Guidelines and Protocols Advisory Committee, the Reference Committee, and the Joint Utilization Committee that have less direct relevance to monitoring billing practices. Medical Services Plan, "Committees under the Medical Services Commission (MSC)" [www.healthservices.gov.bc.ca/msp/legislation/msccomm.html](http://www.healthservices.gov.bc.ca/msp/legislation/msccomm.html); accessed September 13, 2003.

<sup>90</sup> British Columbia Medical Association, *Annual Report, 1997-98* at 47; British Columbia Medical Association, *Annual Report, 1999-2000* at 57.

professions, “BIP monitors and investigates billing patterns and practices of medical and health care practitioners to detect and deter inappropriate and incorrect billing of MSP claims.” Its staff includes “medical consultants, research analysts and a team of auditors [who] work closely with the Ministry of Attorney General, ICBC [Insurance Corporation of British Columbia], WCB [Workers Compensation Board] and the Royal Canadian Mounted Police.”<sup>91</sup>

BIP uses two methods to monitor fee-for-service billings. Every year it sends out over 75,000 questionnaires to patients asking them whether they received the services that were billed to MSP (Service Verification Audits). It also produces an annual profile report on each practitioner (Practitioner Profiles) and compares it to the practitioners’ peer groups “based on registered specialties, and group averages (standard deviations, medians) are calculated based on the peer group. Each practitioner within an individual peer group is then compared against the group average statistics.”<sup>92</sup> Investigators “normally” look for “overservicing—rendering more services than are clinically required [and] misbilling—substitution of fee items, usually a higher priced item, not consistent with the actual service rendered.”<sup>93</sup> Once focussed on a particular physician, the BIP may use more specific Service Verification Audit surveys and other statistical profiling tools.<sup>94</sup> BIP also receives complaints from the public and other professionals or their licensing bodies.

The MSC may order a physician to return an amount to the MSP, if after giving the physician an opportunity to be heard, it determines that an amount should not have been paid, because of

- (a) an unjustifiable departure from the patterns of practice or billing of practitioners in the practitioner’s category,
- (b) a claim for payment in respect of a benefit that was not rendered, or
- (c) a misrepresentation about the nature or extent of benefits rendered (*Medicare Protection Act*, section 37(1)).

MSC may pursue restitution if payments were made as a result of “error; unjustified departure in patterns of practice or billing; misrepresentation of the nature of the service; service not

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<sup>91</sup> Medical Services Plan, “Billing Integrity Program” [www.healthservices.gov.bc.ca/msp/infoprac/bip.html](http://www.healthservices.gov.bc.ca/msp/infoprac/bip.html); accessed August 26, 2003.

<sup>92</sup> Medical Services Plan, “Billing Integrity Program.”

<sup>93</sup> Medical Services Plan, “Billing Integrity Program.”

<sup>94</sup> Canadian Medical Protective Association, *2004 Review of the Medical Audit Practice in Ontario: Canadian Medical Protective Association Submission to the Honourable Justice Peter Cory* (August 3, 2004), TabB2 “British Columbia” at 2-3.

rendered; or service no an MSP benefit”<sup>95</sup>

## B. Patterns of Practice Committee (POPC)

The POPC, a joint Committee of the BCMA and MSP, provided peer review for physicians’ billings in British Columbia between the 1970s and 1998. Its composition and mandate changed in 1998 after MSP established its BIP.<sup>96</sup> Lay representatives were then excluded from the POPC, and its main focus became “to provide education that will encourage appropriate patterns of practice and billing in adherence to the requirements of the payment schedule/guide to fees.”<sup>97</sup> To this end, the POPC communicates “to physicians whose practices are ‘statistical outliers’ the need to review the preamble to the Guide to Fees to ensure that the services provided were medically necessary and that the service billed met the criteria laid out in the Guide to Fees. It also will point out that adequate documentation must be present on the chart to justify the billings.”<sup>98</sup> The POPC provides every physician in British Columbia with “mini-profiles” so they can see their billings relative to other physicians in similar situations. Physicians are advised that “patterns of billings, which are statistical outliers, may subject a physician to an audit by the Billing Integrity Program (BIP) of the Medical Services Plan under the legislative authority of the *Medicare Protection Act*.”<sup>99</sup> The POPC “also provides advice to MSP regarding inappropriate billing and scrutinizes MSP’s process of detecting and deterring inappropriate billing.”<sup>100</sup>

## C. Audit and Inspection Committee

The BIP gets authorization from the Audit and Inspection Committee (AIC) to conduct audits, if the AIC is “convinced there is a reasonable case.”<sup>101</sup>

The Audit and Inspection Committee is a panel composed of representatives of

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<sup>95</sup> Canadian Medical Protective Association, *2004 Review of the Medical Audit Practice in Ontario: Canadian Medical Protective Association Submission to the Honourable Justice Peter Cory* (August 3, 2004), TabB2 “British Columbia” at 4.

<sup>96</sup> This further reduced the physicians’ role in monitoring their colleagues’ billings. This change can be seen as a shift from professional to a government managerial system of control, although physicians are hired by BIP to conduct investigations.

<sup>97</sup> British Columbia Medical Association, *Annual Report, 1998-99* at 50.

<sup>98</sup> British Columbia Medical Association, *Annual Report, 1999-2000* at 57.

<sup>99</sup> British Columbia Medical Association, *Annual Report, 2001-02* at 50; British Columbia Medical Association, *Annual Report, 2000-01* at 52. This education provided by POPC could also allow delinquent physicians to more readily avoid detection by BIP.

<sup>100</sup> Medical Services Plan, “Committees under the Medical Services Commission (MSC)” [www.healthservices.gov.bc.ca/msp/legislation/msccomm.html](http://www.healthservices.gov.bc.ca/msp/legislation/msccomm.html); accessed September 13, 2003.

<sup>101</sup> No author, “I’m Worried I might Get Audited “ (1998) 2(1) *Protocols & Guidelines–Update* at 5.

the British Columbia Medical Association (BCMA), the College of Physicians and Surgeons of B.C., the public and MSP. The panel approves audits of physicians' services and billing practices, reviews all audit reports and makes recommendations to the MSC with regard to whether recovery of funds should be pursued.<sup>102</sup>

An on-site investigation may take place if BIP discovers "unexplained variation." Such investigations are done by an accountant who examines the business practices of the practitioner and a physician peer who reviews patients' charts. The audit looks for whether a claimed service was: "actually rendered, a benefit of MSP, billed correctly, medically necessary, properly documented, rendered by the practitioner making the claim, and performed in such a way that there are no quality of care concerns."<sup>103</sup>

An Alternative Dispute Resolution Process (ADR) exists to allow practitioners to negotiate, either with or without a mediator, a settlement with MSP (BIP). According to the MSP website, "a cooperative rather than adversarial process can be used to reach a fair and appropriate settlement with less financial, psychological and procedural stress."<sup>104</sup>

Where settlement does not occur, an audit report is submitted to the MSC, and "if there are reasons to consider recovering funds that may have been paid inappropriately, the practitioner is given the opportunity to have a hearing before an Audit Hearing Panel prior to any order for recovery being made."<sup>105</sup>

The Audit Hearing Panel includes representatives of the government, the profession and the public. It is a quasi-judicial body that has authority to make an order for recovery. Orders for recovery are filed with the B.C. Supreme Court. The hearing affords the practitioner a fair process, adhering to the rules of natural justice.<sup>106</sup>

Although there is little information about the BIP's activities, in 2001-2002 it had 140 active files.<sup>107</sup> The MSP's *Physician's Newsletter* contains an Audit Update and Inspection Committee Update that summarize recoveries from physicians. In 1998, the Committee reported that since its first meeting in 1994, it had dealt with 58 referrals and completed 41 audits. In five of the audits, the billings were justified and the remainder were referred to the MSC for further

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<sup>102</sup> Medical Services Plan, "Committees under the Medical Services Commission (MSC)" [www.healthservices.gov.bc.ca/msp/legislation/msccomm.html](http://www.healthservices.gov.bc.ca/msp/legislation/msccomm.html); accessed September 13, 2003.

<sup>103</sup> Medical Services Plan, "Billing Integrity Program."

<sup>104</sup> Medical Services Plan, "Billing Integrity Program." Also see *MSP Bulletin* (January 7, 2000) at 2.

<sup>105</sup> Medical Services Plan, "Billing Integrity Program."

<sup>106</sup> Medical Services Plan, "Billing Integrity Program."

<sup>107</sup> British Columbia Medical Association, *Annual Report, 2001-02* at 50.

action. The majority of the referrals to the AIC involved “questions arising from aberrations found in statistical comparisons of physicians’ frequencies of billing various services related to their peers, and/or questions arising from patient service verification audits regarding the accuracy of physician billings.”<sup>108</sup> A newspaper report in 1997 stated that “since 1994, the commission has found 40 physicians who overbilled by a total of about \$5 million.”<sup>109</sup> This would amount to approximately 13 physicians a year and an average of \$125,000 per physician over the three years.

In 1998, the MSP began to publish brief summaries of cases in its *Physicians’ Newsletter*. Between the Winter Issues of 1998 and 2003, the Audit Committee ordered 59 physicians (an average of 12 per year) to return \$4,078,112 (an average of \$69,120 per physician) to the plan. Only five of the cases were for amounts below \$10,000, and 12 were for amounts over \$100,000.<sup>110</sup> All but eleven of the physicians were General Practitioners, and only five of the 59 physicians are named in the publication.<sup>111</sup> Although it is sometimes difficult to decipher the exact issues in each case from the cryptic summaries, it appears as though unnecessary services (N=29), upcoding (N=28), exceeding patterns of practice guidelines (N=26), and inadequate records (N=25) were the most frequent problems. In five cases, the physicians were found to have billed for services that did not occur. The MSP also uses its newsletter to tell physicians about the types of billing errors it encounters and how physicians can ensure that their billings comply with the requirements.

## D. Medical and Health Care Services Appeal Board

The Medical and Health Care Services Appeal Board (MHCSAB), which was created under the *Medicare Protection Act* in the mid-1990s, was abolished as of January 31, 2004.<sup>112</sup> Up until that time, appeals of decisions made by the MSC under the *Medicare Protection Act* could be appealed to the MHCSAB which was chaired by a member of the Law Society of British Columbia and had at least two other members. It heard appeals from “medical practitioners, diagnostic facilities and beneficiaries of the Medical Services Plan regarding a contested

<sup>108</sup> “Audit and Inspection Committee Activities” (Winter, 1998) *Physician’s Newsletter* 6.

<sup>109</sup> Wendy McLellan, “Doctor Overbills Plan by \$500,000” (10 June 1997) *Province A2*.

<sup>110</sup> Effective July 3, 2002, the MSC was required to add a 5% surcharge and interest, from the last day of the audit period, on any amount that it orders health practitioners to repay or any amount it negotiates for repayment in a consent order; *Medicare Protection Act*, section 37(1.1) and *Medical and Health Care Services Regulations*, B.C. Reg. 426/97, section 48. These amounts are included in the figures.

<sup>111</sup> Data analyzed from *Physician’s Newsletter*. Some were obtained from BIP; the more recent ones are available at [www.healthservices.gov.bc.ca/msp/infoprac/physnews/index.html](http://www.healthservices.gov.bc.ca/msp/infoprac/physnews/index.html), accessed January 11, 2004.

<sup>112</sup> S.B.C., 2003-96-47 effective January 31, 2004 (B.C. Reg. 28/2004).

decision of the Medical Services Commission.”<sup>113</sup>

## IV. Criminal Prosecution

According to an MSP Bulletin, “where criminal conduct is suspected, the case will be forwarded to the Royal Canadian Mounted Police.”<sup>114</sup> However, the MSP tries to avoid labelling billing behaviour as fraudulent. It would prefer to reach an agreement with the physician about the amount that should be paid back.<sup>115</sup> A ministry official in 1999 stated that only 15-20 physicians are guilty of inappropriate billing each year. “It’s a relatively small number, but there’s probably a little bit of fudging or padding, which occurs in every practice, while fraudulent billing is in fact very rare.”<sup>116</sup> Some interviewees agreed that padding occurs, and that it is unacceptable. It is a serious problem, “but most doctors are not fraudulent.” One interviewee explained that some doctors “are antagonists towards government. They feel they are entitled to bill more than they are allowed to. It’s a relationship issue; their perception at the micro level is that they did so much work they’re entitled to more. A small percentage would bill fraudulently. Others would use greyness to justify their billing—rarely intentionally. In fairness to doctors, some believe what they’re doing is ok.”<sup>117</sup> Some doctors maximize their revenue by “aggressive billing” or taking advantage of “good practice management.” Others are poor managers and “lots of services go un-billed.”

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<sup>113</sup> [www.fin.gov.bc.ca/abc/boardpages/mhcsappeal.html](http://www.fin.gov.bc.ca/abc/boardpages/mhcsappeal.html) accessed September 12, 2003 and now deleted. It’s unlikely the Board was used for these sorts of appeals as a summary of its function in February 5, 2002, stated that it “hears appeals from non-residents denied coverage” and that the Board was “ineffective in dealing with appeals in a timely way.” The Board had received 30 appeals since 1996, eleven had been abandoned, and in 2002 it was still dealing with twelve of them; British Columbia, Core Services Review (Phase 1), *Restructuring Administrative Justice Agencies* (February 5, 2002) at 45.

<sup>114</sup> *MSP Bulletin* (January 7, 2000) at 2. Through 126 detachments and 5,000 police officers, the RCMP provide provincial, federal and municipal policing to all but 12 municipalities in British Columbia; [http://www.rcmp\\_grc.gc.ca/bc/about\\_ediv/index\\_e.htm](http://www.rcmp_grc.gc.ca/bc/about_ediv/index_e.htm); accessed March 25, 2005.

<sup>115</sup> Matt Borsellino, “Controversy Clouds MRC Auditing Process” (2001) 37(27) *Medical Post* 50 at 51.

<sup>116</sup> Pamela Fayerman, Ministry To Caution Doctors About Double-Billing Fraud” (15 September 1999) *Vancouver Sun* B8.

<sup>117</sup> Of course, such a belief does not negate fraud. As Madame Justice McLachlin said in *R. v. Théroux*, [1993] 2 S.C.R. 5 at para 22 “just as the pathological killer would not be acquitted on the mere ground that he failed to see his act as morally reprehensible, so the defrauder will not be acquitted because he believed that what he was doing was honest.”



## V. Discipline by the College of Physicians and Surgeons of British Columbia

The College of Physicians and Surgeons of British Columbia, the self-regulating body of physicians in British Columbia, is established and functions under the *Medical Practitioners Act* and the *Health Professions Act*. The College is governed by a Council of ten physicians elected from medical electoral districts and five public members appointed by government (sections 6 and 8, *Medical Practitioners Act*). The Council may delegate matters to an Executive Committee, composed of four physicians and two public members (section 27), and three members constitute a quorum (section 29).

The Council, by definition under the *Act*, includes a committee appointed by the Council “for the purpose of investigating a complaint.” Council or the Executive Committee may initiate an inquiry into a member’s behaviour and appoint an Inquiry Committee composed of three or more members or former members of the Council—at least one must be a public member (section 53). The College website states that the Inquiry “is held at the College before a Committee of four people made up of two physicians, a public representative and a senior lawyer.” This Inquiry Committee is the hearing panel.

The Council may also appoint inspectors to “investigate, inquire into, inspect, observe or examine” records and practices to assist such an inquiry (section 54 and 55). If the Inquiry Committee finds that the member is guilty of infamous or unprofessional conduct (and other forms of misconduct), it must report back to Council, and Council may impose one of a series of penalties ranging from probation, a reprimand or suspension, to eraser from the register (section 60(3)). The Council may order the member to pay costs (section 61), and also has the additional power to erase a member’s name from the register if the person is convicted of an indictable offence in British Columbia or elsewhere (section 50(1)).

Members are obliged to report any other members who they believe are “suffering from a physical or mental ailment, emotional disturbance or addiction to alcohol or drugs that . . . might constitute a danger to the public or be contrary to the public interest” or has engaged in sexual misconduct (section 63 and 65). There is no obligation to report medicare fraud.

Amendments to the *Health Professions Act*, effective December 12, 2003 allow the Minister, at the College’s expense, to appoint a person to inquire into any aspect of the

College's administration if the minister "considers it necessary in the public interest" (section 18.1). Following the inquiry, the Lieutenant Governor in Council may issue a directive to the College (section 18.2).

Between 1990 and 1997, the College dealt summarily with seven cases of improper billing and seven additional cases involving both improper billing and inadequate records. After that, it reported no improper billing cases, but in 2002 it reported one case of financial/fraud (dealt with summarily) and two cases of financial/fraud (in which charges were laid under the *Medical Practitioners Act*). In 2003, it reported two "financial" cases and one "record keeping" case dealt with informally, and in 2004 it reported one "record keeping" case dealt with informally.<sup>118</sup>

In practice, BIP reports to the professional colleges (SROs) that they are investigating a health care practitioner for improper billing practices, and for the most part the colleges do nothing with these reports unless there has been a criminal conviction. Interviewees suggested that the reports do not provide adequate evidence to proceed against the practitioner.

If a case involves both standard of care and billing issues, the College of Physicians and Surgeons will deal with the standard of care aspect and refer the billing issue to MSC. Their rationale is that MSC has better powers and more resources to deal with fraud. For example, MSC can order the physician to repay the overpayment; the College does not have this power.

## **PART FOUR: The Monitoring and Investigation Process in Ontario**<sup>119</sup>

### **I. How Physicians are Paid in Ontario**

The Ontario Health Insurance Plan (OHIP), which was introduced in Ontario in 1972, is administered through the Ministry of Health and Long-Term Care (MOHLTC) (called the Ministry of Health between 1971 and 1999).<sup>120</sup> OHIP pays for essential or insured services provided by

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<sup>118</sup> These numbers are from the College's Annual Reports. The reports from 1994-2004 are found on the College's website: [www.cpsbc.ca/cps/physician\\_resources/publications/annual\\_reports](http://www.cpsbc.ca/cps/physician_resources/publications/annual_reports); accessed December 31, 2004.

<sup>119</sup> As indicated in the introduction, the Ontario legislature passed *The Transitional Physician Payment Review Act*, S.O. 2004, C.13, on June 24, 2004 which halted all audits conducted by the Medical Review Committee until after Justice Cory's review and report. This section discusses the audit process as it existed prior to June 24, 2004.

<sup>120</sup> Ministry of Health and Long-Term Care, "About Ministry of Health and Long-Term Care" [www.health.gov.on.ca/english/public/ministry/about.html](http://www.health.gov.on.ca/english/public/ministry/about.html); accessed September 16, 2003.

physicians and some services provided by dental surgeons and physiotherapists. It also provides partial payment for services by podiatrists, chiropractors and osteopaths, and limited optometry services.<sup>121</sup> Physicians are paid for “insured services” according to a Schedule of Benefits for Physician Services under the *Health Insurance Act*, R.S.O. 1990, Chapter H.6. The schedule of fees is established by negotiations between the Ontario Medical Association (OMA) and MOHLTC.<sup>122</sup> In 2001-2002, approximately 23,000 physicians submitted 130 million claims to OHIP for \$4.5 billion.<sup>123</sup>

Under section 4 of the *Health Insurance Act*, a General Manager for OHIP is appointed by the Lieutenant Governor in Council to administer the legislation. The General Manager has the power, under section 4(2)(c) “to make payments by the Plan for insured services, including the determination of eligibility and amounts.” Under section 18(2), the General Manager may refuse to pay for a service or pay a reduced amount, if the General Manager is “of the opinion that all or part of the insured service was not in fact rendered,” the service claimed was “deliberately or inadvertently” misrepresented or “the service was not provided in accordance with accepted professional standards and practice.” The General Manager may also refuse to pay for services or pay a reduced amount that the General Manager “is of the opinion, after consulting with a physician, that all or part of the service was not medically necessary” or “not therapeutically necessary.” Under section 18(5), the General Manager may require reimbursement to the Plan for an amount paid for a service described in subsection 18(2). This “direct recovery” process, which allows the General Manager to pay all, part or none of a bill, was instituted in 1996.

## II. How Physicians’ Bills are Monitored in Ontario

### A. OHIP Monitoring

Staff in the OHIP offices (in the MOHLTC) monitor incoming claims for “duplicate claims, parallel procedures, frequent repeat visits or major assessments, recurrent billing for highly priced services, habitual laboratory tests, and office visits billed regularly and concurrently with minor

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<sup>121</sup> Ministry of Health and Long-Term Care, “Health Services: What’s Covered by OHIP” [www.health.gov.on.ca/english/public/pub/ohip/services.html](http://www.health.gov.on.ca/english/public/pub/ohip/services.html); accessed September 16, 2003.

<sup>122</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 1.

<sup>123</sup> Ministry of Health and Long-Term Care, “Health Update: Reviewing OHIP Claims: Ensuring Accountability for Ontario’s Healthcare System” [www.health.gov.on.ca/english/public/updates/archives/hu\\_03/hu\\_ohip.html](http://www.health.gov.on.ca/english/public/updates/archives/hu_03/hu_ohip.html); accessed September 16, 2003.

diagnostic tests.”<sup>124</sup> Some of this monitoring is done before payment,<sup>125</sup> some after. OHIP staff are provided with reports that they examine in greater detail, looking at patterns of billing that may uncover “unnecessary or frequent repeat visits; undue use of or billing for expensive services; or high volumes of services, that may not be medically necessary or performed in accordance with appropriate standards.”<sup>126</sup>

One contentious issue with such monitoring is that OHIP does not disclose to practitioners the computer programmes or statistical models that it uses to determine if a practitioner’s billings deviate from statistical norms. The OMA argues that if physicians knew what the acceptable norms were, they could bill more appropriately.<sup>127</sup> This is unlike the situation in British Columbia where the SRO’s POPC provides doctors with their billing profiles so they can adjust their billings to avoid an audit by the BIP based on patterns of billing. A recent detailed description of what OHIP looks for in computer-generated analysis<sup>128</sup> does not provide Ontario doctors with a preview of their billing practices relative to their peers as is provided in British Columbia. Physicians in Ontario were automatically provided with a summary billing profile prior to the mid-1990s that allowed them to compare their billings with their peers; however, they now have to pay for such information and it is “provided in a format that is cumbersome and difficult to interpret.”<sup>129</sup>

The MOHLTC’s Processing Office takes the position that “physicians and practitioners are solely accountable for the propriety and accuracy of their claims to OHIP.”<sup>130</sup> If OHIP staff is concerned about questionable billing practices, the General Manager has four options: 1) send letters pointing out the unusual billing pattern; 2) recover the funds under section 18(5) of the *Act* (without a review referral); 3) refer the matter to the Medical Review Committee (MRC) or

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<sup>124</sup> “Medical Review Committee: A Peer Review of Physician Billings” (September/October 2002) *Members’ Dialogue* [www.cpso.on.ca/publications/dialogue/0902/mrc.htm](http://www.cpso.on.ca/publications/dialogue/0902/mrc.htm); accessed September 18, 2003.

<sup>125</sup> The computer rejects about \$10 million in claims each month; MHOTC

<sup>126</sup> “Medical Review Committee: A Peer Review of Physician Billings.”

<sup>127</sup> Ontario Medical Association, “OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process” (July/August, 2004) *Ontario Medical Review* 24 (I have used page numbers 1-12 from a printed online version). When this issue was raised before the Health Services Review and Appeal Board, it stated that it did not have jurisdiction to review OHIP’s decision to refer a matter to the MRC, but rather that was an issue for the courts as it was limited to reviewing MRC decisions; *Carstoniu v. The General Manager, Ontario Health Insurance Plan* (Health Services Review and Appeal Board; August 13, 2004; 03-HIA-0050) at 25.

<sup>128</sup> Garry Salisbury and Larry Patrick (Co-Chairs) “Post-Payment Review and Auditing of OHIP Claims—Part B The Claims Review Process” (September, 2003) *Ontario Medical Review* online: [www.oma.org/pcomm/omr/sep/03bulletin.htm](http://www.oma.org/pcomm/omr/sep/03bulletin.htm); accessed August 29, 2004.

<sup>129</sup> College of Physicians and Surgeons of Ontario, “Submissions to The Hon. Peter Cory, Reviewer of Ontario’s Medical Audit System” (13 July 2004) at 11.

<sup>130</sup> MOHLTC, Processing Office, “Medical and Practitioner Review Committee Activity” Bulletin No 4383 (April 1, 2002) at 1.

other appropriate review committee,<sup>131</sup> under section 39.1 of the *Health Insurance Act*; 4) if fraud is suspected, refer the case to the Ontario Provincial Police (OPP).<sup>132</sup> The physician may appeal to the MRC to dispute a payment or lack of payment by OHIP (section 18.1).

## B. Medical Review Committee

The MRC is established under section 5 of the *Health Insurance Act* as a committee administered by the College of Physicians and Surgeons of Ontario to review physicians bills when requested by the General Manager of OHIP (under section 39.1) or when requested by physicians (under section 18.1).<sup>133</sup> Under the *Act* and Regulations, the Committee consists of 18 physicians nominated by the College of Physicians and Surgeons of Ontario and 6 public members, all appointed by the Minister. The MRC operates under what appears to be a confidential contract between the MHLTC and the CPSO.<sup>134</sup>

In 2002, the Chair of the MRC explained how the Committee worked: “The Medical Review Committee gives those physicians, whose billing patterns catch the attention of OHIP, an opportunity to explain how they bill. If they can show that they are providing the services they say they are, great. If not, then the money has to go back in the pot.”<sup>135</sup> More formally stated, the MRC “conducts an on-site audit, inspects the records of the services, interviews the physician who provided the service, determines whether the accounts were properly rendered in accordance with the statutory questions and if any repayment or increased payment to the referred physician is to be ordered.”<sup>136</sup> The medical auditor’s Completed Inspection Report (CIR) is provided to the physician. Following receipt of the CIR, the MRC may conduct its own interviews and it will then make a binding direction to the General Manager of OHIP to pay the claims or require recovery of the money already paid.<sup>137</sup> The MRC review does not require a

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<sup>131</sup> There are five peer review committees: medical, chiropody, chiropractic, dentistry and optometry; however, the MRC receives most of the work.

<sup>132</sup> MOHLTC, Processing Office, “Medical and Practitioner Review Committee Activity” Bulletin No 4383 (April 1, 2002) at 1.

<sup>133</sup> The MRC was first created in 1971; Ontario Medical Association, “OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process” (July/August, 2004) *Ontario Medical Review* (online: [www.petercory.org](http://www.petercory.org)).

<sup>134</sup> The OMA has requested, but never received, the contract; Ontario Medical Association, “OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process” (July/August, 2004) *Ontario Medical Review* (online: [www.petercory.org](http://www.petercory.org)).

<sup>135</sup> “Medical Review Committee: A Peer Review of Physician Billings” (September/October 2002) *Members’ Dialogue* [www.cpso.on.ca/publications/dialogue/0902/mrc.htm](http://www.cpso.on.ca/publications/dialogue/0902/mrc.htm); accessed September 18, 2003.

<sup>136</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 2.

<sup>137</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 3.

formal hearing; however, “the doctrine of deliberative secrecy applies to documents generated by members of the MRC during the decision-making process” (but not information gathered in support of its decision); and written reasons are required.<sup>138</sup>

Following a review, the MRC may direct the General Manager to increase the amount paid or to require the physician to repay all or part of any payment (section 38.1(5)). A direction of repayment may be made:

1. If the applicable committee has reasonable grounds to believe that all or part of the insured services were not rendered.
2. If the applicable committee has reasonable grounds to believe that all or part of the services,
  - i. were not medically necessary, if they were provided by a physician, or
  - ii. were not therapeutically necessary, if they were provided by a practitioner.
3. If the applicable committee has reasonable grounds to believe that the nature of the services is misrepresented, whether deliberately or inadvertently.
4. If the applicable committee has reasonable grounds to believe that all or part of the services were not provided in accordance with accepted professional standards and practice.
5. In such other circumstances as may be prescribed (section 39.1(6)).<sup>139</sup>

In 1996, a number of amendments to the *Act* expedited the process. In addition to direct recoveries (section 18), section 5(3.1), allowed the MRC to “sit in several divisions simultaneously, if a quorum of the Committee is present in each division.” A quorum is three members of the MRC, one of whom cannot be a physician. However, section 5(3) states that “one member who is a physician constitutes a quorum for the purposes of a review requested” under certain circumstances. Section 18.1(2) of the *Act* and 38.1(1) of the Regulations allow for a review by one member if the amount in dispute is under \$100,000 or if the General Manager consents.

Further amendments in 1996 required that the referred physician pay interest<sup>140</sup> and

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<sup>138</sup> *Carstoniu v. The General Manager, Ontario Health Insurance Plan* (Health Services Review and Appeal Board; August 13, 2004; 03-HIA-0050) at 19-23.

<sup>139</sup> If the MRC discovers quality of care issues, it will refer them to the College’s Registrar which may take action; College of Physicians and Surgeons of Ontario, “Submissions to The Hon. Peter Cory, Reviewer of Ontario’s Medical Audit System” (13 July 2004) at 4.

<sup>140</sup> The interest, in a prescribed amount, is payable from the date determined in a prescribed manner (section 18.1(14)).

some of the costs of the MRC review, which were previously paid by the Ministry. This led to many physicians opting to discuss settlement to avoid paying interest and the costs of hearings.<sup>141</sup> Following the amendments, the MRC offered physicians three options: a) settlement; b) expedited review; or c) regular or full review.<sup>142</sup> Given the increasing number of settlements, the MRC had the inspection report reviewed by a medical and public member of the MRC who make recommendations to the General Manager. The expedited review process involved no formal inspection, but an interview with one medical member of the MRC. This mechanism is seen as appropriate by the MRC for “straightforward cases involving only one or a very small number of fee schedule codes where the issues are straightforward and uncomplicated.”<sup>143</sup> According to the MRC, the requirement that doctors pay the costs of a full review resulted in a dramatic drop of these reviews.<sup>144</sup> The reduction in the number of hearings and interviews has challenged the continuing expertise of the MRC, and so the MRC has increased its meetings and workshops to educate its members.

Table 1 shows that the number of regular and expedited reviews increased between 1998-2002; however, the MRC still only completed less than a 100 cases per year. This is in line with its contract with OHIP, but amounts to less than .5% of all physicians who bill OHIP.

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<sup>141</sup> There were some changes retroactive to April 1, 2003, in the amount of costs that the physician must pay; however, costs are still a contentious issue in Ontario; College of Physicians and Surgeons of Ontario, “Submissions to The Hon. Peter Cory, Reviewer of Ontario’s Medical Audit System” (13 July 2004) at 10 (online: [www.petercory.org](http://www.petercory.org)).

<sup>142</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 3.

<sup>143</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 4.

<sup>144</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 5.

**Table 1**  
**Number of Regular and Expedited Reviews by the MRC in Ontario, 1998-2002**

Year	Regular	Expedited	Total
1998-1999	46	6	52
1999-2000	46	18	64
2000-2001	55	19	74
2001-2002	69	29	98
<b>Total</b>	216	72	288

Table 2 shows that the MRC recommended that OHIP recover over \$36 million from 548 physicians between 1991 and 2002—an average of \$3.3 million per year from an average of 49.8 physicians a year. The average amount recommended for recovery per physician was in excess of \$66,449 and the average per physician ranged from \$45,000 to \$196,000 in any given year. The largest recommended recovery from one physician was \$3 million in 1995-96.<sup>145</sup> The amount recommended in 2001-02, \$5.634 million, represented only .13% of the \$4.5 billion paid out. According to the Co-Chairs of the MRC, “Clearly, Ontario physicians have an admirable record of accuracy in submitting their accounts.”<sup>146</sup>

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<sup>145</sup> Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report, April 1, 2000-March 31, 2001* at 13.

<sup>146</sup> Drs. Barry Giblon and Rachel Edney, Co-Chairs of the MRC, Respond to “Dear Editor: Re: Medical Review Committee: A Peer Review of Physicians Billings—Sept/Oct 2002” (2003) *Members’ Dialogue* 7 at 9.



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Table 2<sup>147</sup>

**Number of Cases and Amounts Recommended for Recovery by MRC, 1991-2002**

<b>Year</b>	<b>Cases</b>	<b>Rx Recovery</b>	<b>Rx Recovery/case</b>
<b>1991-1992</b>	35	2,062,000	58,914
<b>1992-1993</b>	30	1,551,000	51,700
<b>1993-1994</b>	28	1,306,000	46,643
<b>1994-1995</b>	22	4,303,000	195,591
<b>1995-1996</b>	36	5,604,000	155,667
<b>1996-1997</b>	19	1,733,000	91,211
<b>1997-1998</b>	44	2,240,000	50,909
<b>1998-1999</b>	81	4,888,000	60,346
<b>1999-2000</b>	81	3,635,000	44,877
<b>2000-2001</b>	74	3,458,000	46,730
<b>2001-2002</b>	98	5,634,000	57,490
<b>Total</b>	548	36,414,000	66,449

### **C. OHIP Payment Review Program (OPRP)**

The OHIP Payment Review Program (OPRP) was introduced in January 2003, as a result of a joint review of the MRC by the MOHLTC and the Ontario Medical Association (OMA). The Joint Committee recommended that the auditing of physicians' claims remain with the MRC, but that "a physician should be given the opportunity to attempt to reach an agreement with the ministry prior to a referral to the MRC." The OPRP is optional, and physicians can always ask that their cases move directly to the MRC. A MOHLTC Bulletin points out some of the advantages of OPRP to a physician: "faster resolution of claim submission issues; fewer people involved; no additional charge for the cost of the review; interest starts after an agreement is reached, not at

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<sup>147</sup> Numbers taken from the Medical Review Committee of the College of Physicians and Surgeons of Ontario, *Annual Report* (April 1, 2001 to March 31, 2002) at 5. I was unable to access the MRC web site for an update on these

the end of the service period under review; and no publication of review information.<sup>148</sup>

## D. Education and Prevention Committee (EPC)

The Education and Prevention Committee, a joint effort by the MOHLTC and the OMA, was introduced in January of 2003, because of physicians' concerns with the MRC.<sup>149</sup> Its "objective is to provide physicians with information about how to submit claims correctly," thereby reducing "the need to recover payments for inappropriately submitted claims."<sup>150</sup> The EPC, which includes at least four members from the OMA and the MOHLTC, will make recommendations in areas including:

1. Principles on which to base further development of educational communication policy and billing matters.
2. Future steps to improve physician education in order to ensure appropriate claims to the Ontario Health Insurance Plan and thereby avoid misinterpretations based on the Schedule of Benefits.
3. Ensuring consistency and compliance of the educational policy with existing professional standards, and with the CPSO and ministry's policies pertaining to claims submissions.
4. Communication to physicians about the MOHLTC monitoring and control processes and activities.
5. Additional communication programs to improve physician awareness and understanding of claims issues.<sup>151</sup>

## E. Dissatisfaction with the MRC

In early 2003,<sup>152</sup> 400 physicians signed a letter complaining that the MRC process presumed that physicians were guilty until they proved themselves innocent, and that the requirement that physicians pay for the cost of audits was a denial of natural justice. They questioned the "peer" aspect of the review, since all but two of the members are appointed and paid by the MOHLTC and the "College rents the space occupied by the MRC to the MOHLTC. Thus, there is an

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statistics on October 16, 2004 because it is now only accessible with a password.

<sup>148</sup> MOHLTC, "OHIP Payment Review Program" (January 16, 2003) Bulletin Number 4396.

<sup>149</sup> "New initiatives aim to improve billing processes and reduce risk of MRC referral"

[www.oma.org/pcomm/omr/dec/02agreement.htm](http://www.oma.org/pcomm/omr/dec/02agreement.htm) (accessed September 20, 2003).

<sup>150</sup> Ministry of Health and Long-Term Care, "Health Update: Reviewing OHIP Claims: Ensuring Accountability for Ontario's Healthcare System" [www.health.gov.on.ca/english/public/updates/archives/hu\\_03/hu\\_ohip.html](http://www.health.gov.on.ca/english/public/updates/archives/hu_03/hu_ohip.html); accessed September 16, 2003.

<sup>151</sup> "OMA\_MOHLTC Agreement Update" [www.oma.org/pcomm/omr/may/02agreement.htm](http://www.oma.org/pcomm/omr/may/02agreement.htm); accessed September 20, 2003.

<sup>152</sup> Dissatisfaction by physicians did not commence in 2003, rather it has a fairly long history. Some of this can be seen in the *Ontario Medical Review*, a publication by the OMA in which agreements between the OMA and MOHLTC are discussed.

apparent financial conflict of interest.”<sup>153</sup> According to the letter, the MRC process has resulted in physicians suffering “financial hardship and permanent psychological after-effects. Bankruptcy, emigration, withdrawal from practice and marital breakdown are not uncommon.” The authors call for “a new independent tribunal, separate from the MOHLTC.”<sup>154</sup>

In response to the letter, the Co-Chairs of the MRC clarified that much of what they do is enforce the rules, not create them. In addition, there is ample opportunity to avoid paying costs by resolving the issues prior to a full review. Furthermore, a fee-for-service system will not exist without an audit, and that the MRC system is much better than the one in the United States with “rewards for informants, fines for incorrect billing, and triple recovery.” If the audit is not done by the physicians’ SRO, it will be done by the government or the police. The Co-Chairs explained that they exist under “the auspices of an agreement between the OMA and MOHLTC,” and a recent one year audit by these organizations concluded that the MRC’s role in the audit process “should be continued and improved.”<sup>155</sup>

The MRC, however, faced continuing criticism, including a home page for “MRC Victims.”<sup>156</sup> The Ontario Physicians’ Alliance also went on the attack, referring to the “grotesque harassment” of doctors by the MRC, a “kangaroo court,” and calling for an “independent tribunal with the usual legal safeguards for those accused.”<sup>157</sup> Some newspaper reports implicated the MRC in the suicide death of Dr. Anthony Hsu in April, 2003. Dr. Hsu had been ordered to repay \$108,000 because of inaccurate billing to OHIP.<sup>158</sup>

On May 23, 2003, the President of the College of Physicians and Surgeons requested the Minister to conduct an external and independent review of the entire audit process, including the criteria used by OHIP in referring cases to the MRC, the composition of the MRC, the criteria MRC use to decide to perform an audit, the cost recovery provisions and so on. On April 30, 2004, the Ontario government appointed the Honourable Peter Cory to review the MRC’s practices and to make recommendations regarding the audit system.<sup>159</sup>

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<sup>153</sup> Some doctors also seemed concerned that the MRC was too connected to the CPSO. One of the recommendations of a joint OMA-MHLTC Committee on the MRC was that the MRC function remain with the CPSO, but that the MRC make it clear to physicians that it is separate from other CPSO functions.

<sup>154</sup> “Dear Editor: Re: Medical Review Committee: A Peer Review of Physicians Billings–Sept/Oct 2002” (2003) *Members’ Dialogue* 6 at 6-7.

<sup>155</sup> Drs. Barry Giblon and Rachel Edney, Co-Chairs of the MRC, Respond to “Dear Editor: Re: Medical Review Committee: A Peer Review of Physicians Billings–Sept/Oct 2002” (2003) *Members’ Dialogue* 7 at 10.

<sup>156</sup> “MRC Victims Home Page” [www3.sympatico.ca/dindar/mrc/mrc.htm](http://www3.sympatico.ca/dindar/mrc/mrc.htm); accessed September 19, 2003.

<sup>157</sup> “01/03/2003 Entry: “how bad it is” [www.opaonline.org/gmatter/archives/00000012.html](http://www.opaonline.org/gmatter/archives/00000012.html); accessed September 19, 2003.

<sup>158</sup> Peter Downs, “No moratorium on doctor audits” (17 May 2003) *The Review* (Niagara Falls) A1; Allan Benner, “They know it is a faulty system” (16 May 2003) *Tribune* (Welland) A1.

<sup>159</sup> Terms of Reference, April 30, 2004; [www.petercory.org](http://www.petercory.org); accessed December 30, 2004.

In preparation for their submissions to Justice Cory's Review, the OMA surveyed its 25,000 members and found that there was much dissatisfaction with the review process. Physicians wanted the process to be more transparent, shorter, less arbitrary, and more reasonable in terms of its record-keeping demands, and they wanted a more comprehensible Schedule of Benefits. Physicians were concerned with the way the audit process targeted certain fee codes and specialities and thought the dollar recovery amounts were too high. They also thought the onus of proving billing errors should be on the MHLTC and that no amounts should be payable until all appeals were exhausted. There was also a concern that doctors were leaving Ontario or not coming to Ontario because of the auditing practices. The OMA concluded that a "best practices" audit system would be "fair, open and transparent in administration and adjudication, independent, objective, competent, reasonable, and timely." In addition, there should be no recovery from a physician who is practising "in accordance with prevailing standards of care."<sup>160</sup> The OMA believes that the audit process should focus on education and prevention, and that physicians should be given six months to alter their billing behaviour if the Ministry is not satisfied with the physicians' explanations of their billing behaviour. According to the OMA, physicians should have knowledge of the statistical norms expected of them so they can bill accordingly.<sup>161</sup>

In its submissions to the Cory Review, the OMA suggested that direct recoveries by the General Manager should be abolished as there is no hearing or procedural protection for the physicians.<sup>162</sup> Both the College and the OMA recommended that the expedited review before one panel member be abolished. The notion of peer assessment was key to the OMA's submissions.

In their submissions to Justice Cory's Review, the Coalition of Family Physicians of Ontario described the audit system as "inquisitorial" and "abhorrent to our common law traditions of fairness and justice." It resulted in physicians being "demoralized, dejected and insulted" by their experiences with it.<sup>163</sup>

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<sup>160</sup> The OMA was of the view that given the record-keeping requirements, the current system "would mandate a recovery from virtually any Ontario physician reviewed by it;" Ontario Medical Association, "OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process" (July/August, 2004) *Ontario Medical Review* (online).

<sup>161</sup> Ontario Medical Association, "OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process" (July/August, 2004) *Ontario Medical Review* (online). The OMA actually uses the word "appropriately" not "accordingly" but there is a fine line between the two. The reference to the purpose of the audit process as "education and prevention" is repeated in the OMA's submission at pages 3, 7 and 9.

<sup>162</sup> Ontario Medical Association, "OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process" (July/August, 2004) *Ontario Medical Review* at 4.

<sup>163</sup> Coalition of Family Physicians, "Enshrining Confidence: COFP's Submission to Justice Peter Cory" at 2-3.

## F. Appeals to the Health Services Appeal and Review Board

Physicians who are dissatisfied with decisions of the MRC can appeal to the Health Services Appeal and Review Board.<sup>164</sup> Between 1994 and 2004, the Board opened 70 files. Most cases were either settled or the appeals were withdrawn; only seven proceeded to a determination by the Board. Of those seven, six were heard and decided in 2003-2004.<sup>165</sup> The seven cases are included in the analysis of cases in the public domain under Part V.

## III. The College of Physicians and Surgeons of Ontario

The College of Physicians and Surgeons of Ontario (CPSO), the self-regulating body of doctors in Ontario, is established under the *Medicine Act*, S.O. 1991, Chapter 30. The College is governed by a Council of 15-16 doctor members, 13-15 public members appointed by the government, and three faculty members from faculties of medicine in Ontario (section 6). The Council may delegate matters to an Executive Committee, composed of four doctors and two public members (section 27), and three members constitute a quorum (section 29).

In addition to its role in the MRC, the College also has disciplinary powers over its members who engage in professional misconduct.<sup>166</sup> Professional misconduct includes fee-splitting, falsifying medical records, signing or issuing a misleading or false document, charging for services not performed, charging excessive fees, failure to itemize professional services when requested, contravening a federal or provincial law that is relevant to the physician's suitability to practise medicine, and any act or omission that is "disgraceful, dishonourable or unprofessional."<sup>167</sup> The College's practice is to take disciplinary action against doctors after they are convicted of OHIP fraud.<sup>168</sup>

## IV. Ontario Provincial Police Investigate Fraud by Doctors

If OHIP staff suspect fraud, they can refer the matter to the Ontario Provincial Police (OPP). The

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<sup>164</sup> *Health Insurance Act*, R.S.O. 1990, C. H-6, section 20(1).

<sup>165</sup> Letter from Beverly A. Harris, Chair, Health Services Appeal and Review Board to The Honourable Peter Cory, dated September 27, 2004 (online: [www.petercory.org](http://www.petercory.org)).

<sup>166</sup> Section 51, Schedule 2, *Health Professions Procedural Code*.

<sup>167</sup> Ontario Regulation 856/93 as amended by Ontario Regulation 53/95 under the *Medicine Act*, 1991.

OPP's Health Fraud Investigation Unit, which was created in April, 1998, doubled in size from nine to 20 in the first year. From 1998-2000, 500 cases were referred to the Unit, including 60 cases of alleged fraudulent billing by health care professionals. In 2000, the Unit was "pursuing 10 cases of alleged fraud by physicians and pharmacists in the courts; the fraud involve[d] an average of about \$800,000 per case." The Unit also has proceeds of crime investigators who will pursue property bought by doctor's "ill-gotten gains."<sup>169</sup> By 2001, the OPP had 28 members in its OHIP fraud squad, and 13 of them were assigned to investigating physicians' billings.<sup>170</sup> It was also reported that since inception, 25 charges were laid—15 were before the courts, one was stayed and nine physicians were convicted.<sup>171</sup> By 2002, 18 physicians had been convicted.<sup>172</sup>

## **PART FIVE: Cases of Fraudulent and Inappropriate Billing**

This section provides an overview of the cases of fraudulent and inappropriate billing that were found in the public domain in Canada, and then focuses in greater detail on the cases from British Columbia and Ontario.

### **I. Cases of Health Care Fraud and Inappropriate Billing In Canada**

#### **A. Parameters of Data Collection**

As stated in the introduction, this study is about health care professionals abusing or defrauding the public health's fee-for-service system. Included are cases from all the provinces and territories in the public domain (newspapers, court decisions, professional publications, websites, and decisions accessible by request), in which the health professional's name was mentioned at least once and one or more of the following occurred: 1) administrative investigation or action by a government branch or agency; 2) a professional SRO investigation

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<sup>168</sup> See cases discussed under Part V.

<sup>169</sup> Barbara Sibbald, "MDs Get Jail Terms, Fines as New Police Squad Targets Health Fraud" (2000) 163(5) *Canadian Medical Association Journal* 591.

<sup>170</sup> Editorial, "Policing physician fraud" (26 April 2001) *The Ottawa Citizen* A17.

<sup>171</sup> Editorial, "Policing physician fraud" (26 April 2001) *The Ottawa Citizen* A17. Not all of these cases would necessarily be OHIP fraud.

<sup>172</sup> Ellie Teshler, "Stepped-up OHIP audit taints doctors" (7 March 2002) *The Toronto Star* A31.

or action (usually a College of Physicians and Surgeons); or 3) a criminal or quasi-criminal charge. Cases where the allegations were not upheld by a tribunal or court are also included, but there were very few of these.<sup>173</sup> In some cases, there is little information in the public domain—for example, only the professional's name and the amount he or she was required to return to the health care system. Statistics of recovery from unnamed health professionals were discussed earlier in this paper.

These parameters exclude some spectacular cases of fraud. For example, Stephen Chung impersonated a family practitioner for 15 years in Hamilton Ontario, defrauding OHIP of \$4.4 million throughout his career. He was given a conditional sentence because the judge accepted the argument that he was motivated by his passion to be a doctor and to help people, as opposed to greed.<sup>174</sup> Chung was excluded because he was not recognized as a legitimate health professional in a system where the College of Physicians and Surgeons holds a monopoly on specified services. There are also a number of cases of unnecessary surgery, unnecessary prescribing of drugs, and “sex as therapy,” in which the financial fraud side of the case was never developed (or at least not in the public domain). Cases of defrauding patients (e.g., charging up to \$30,000 for ineffective cancer treatment), hospitals, workers' compensation (without a medicare/OHIP angle), other private insurance companies/financial institutions, or drug plans were also excluded. I have also excluded two psychologists and two doctors who were investigated by the British Columbia MSC after nurses complained that they were overcharging at the pretrial centre in Vancouver. There were conflicting reports in the media on the results, except for the fact that the MSC did not proceed with recovery of the money paid. Excluded at this time are 12 doctors from a Mississauga, Ontario walk-in clinic who were charged with fraud over \$5,000 and conspiracy to commit fraud over \$5,000 in regard to allegations that they (doctors and the clinic) defrauded the Ontario Health Insurance Plan of about \$2 million during the 12 months of 1997. Charges were laid in 2000, and after a preliminary hearing involving three of them they were committed to stand trial on December 19, 2003. As of April 23, 2005, the case is still before the court.

The time frame used is 1990-2003. Cases that were commenced prior to 2003 are followed into 2004 and 2005 for results. Decisions by the Medical Review Committee in Ontario, although a committee of the College, are treated as administrative decisions, not as SRO decisions. The College of Physicians and Surgeons of Ontario has its own disciplinary system,

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<sup>173</sup> It is not clear whether this is because few are dismissed or because those that are dismissed are usually not in the public domain.

<sup>174</sup> Editorial, (14 August 2002) *Ottawa Citizen* A14.

and the MRC is considered somewhat independent of the College and is funded by the Ontario government as an agency of the government.

## B. The Cases

The above search and culling of decisions resulted in 87 cases: 36% from British Columbia, 39% from Ontario, 17% from Saskatchewan, 5% from Newfoundland/Labrador and 3% from Quebec (Table 3). Given that I was accessing English newspaper sources, I am fairly certain that the number of cases I found in Quebec is fewer than those in the public domain. I also put most of my efforts into finding cases in British Columbia and Ontario, so there may be cases in other provinces that were in the public domain but were not discovered. In Saskatchewan, the lawyer for the College of Physicians and Surgeons confirmed that the College had dealt with only three doctors on this issue.

**Table 3**  
**Cases of Health Care Fraud/Inappropriate Billing**  
**by Province, 1990-2003**

	<b>Number of Cases</b>	<b>Percentage</b>
<b>British Columbia</b>	31	36%
<b>Saskatchewan</b>	15	17%
<b>Ontario</b>	34	39%
<b>Quebec</b>	3	3%
<b>Newfoundland/Labrador</b>	4	5%
<b>Total</b>	87	100%

The 87 cases resulted in at least 113 actions. Table 4 shows the types of actions in each province. For example, 16% of the actions in British Columbia were criminal or quasi-criminal, compared to 31% of the actions in Ontario. Most of the cases in Saskatchewan (81%) were administrative.



**Table 4**  
**Types and Numbers of Actions Against Health Care Professionals**  
**by Province, 1990-2003**

	<b>Administrative</b>	<b>SRO</b>	<b>Criminal/quasi</b>	<b>Total</b>
<b>British Columbia</b>	20 (54%)	11 (30%)	6 (16%)	37 (100%)
<b>Saskatchewan</b>	13 (81%)	3 (19%)	0 (0%)	16 (100%)
<b>Ontario</b>	12 (24%)	22 (45%)	15 (31%)	49 (100%)
<b>Quebec</b>	3 (50%)	1 (17%)	2 (33%)	6 (100%)
<b>Nfld/Labrador</b>	4 (80%)	0 (0%)	1 (20%)	5 (100%)

## 1. Profession and Speciality

Most (93%) of the cases involved physicians. This is to be expected because physicians bill on a fee-for-service basis in much greater numbers than other health care professionals. There were also two physiotherapists, two chiropractors, one dentist, and one optometrist. Some studies suggest that psychiatrists are more likely to be delinquent than other specialities. Of the 81 physicians, 16% were psychiatrists. A rough indication of their proportion in the profession comes from a search of the College of Physicians and Surgeons of Ontario database for specialists. It indicates that 2,677 of the 37,214 physicians (7%) specialize in psychiatry.<sup>175</sup> In this study, an additional 6% of the delinquent physicians practised psychotherapy, and 57% were general practitioners or family doctors. In the United States, "psychiatrists represent about 8% of all physicians but about 20% of all doctors suspended from Medicaid for fraudulent practices."<sup>176</sup>

## 2. Gender

As with most crimes, men appear in the health care fraud/misbehaviour statistics in greater proportion than women. Only 7% of the 87 cases involved women, and 7% of the 81 cases of

<sup>175</sup> Search conducted on September 26, 2004. Not all of these physicians would work on a fee-for-service basis, but it does give some indication of the percentage of psychiatrists in Ontario today.

<sup>176</sup> Stephen M. Rosoff, Henry N. Pontell and Robert H. Tillman, *Looting America: Greed, Corruption, Villains and Victims* (New Jersey: Pearson Education Inc., 2003) at 364.

physicians were women. In 2001, 33% of the 65,525 physicians in Canada were women.<sup>177</sup> A search of the College of Physicians and Surgeons of Ontario database for active physicians, including specialists, indicates that 11,636 or 31% of the 37,214 physicians in the database are female.<sup>178</sup>

### 3. Age and Experience

For those health care professionals whose age and the year the behaviour commenced were available (N=38), their ages ranged from 29 to 74, and the median age at the commencement of the misconduct was 44 and the mean was 45.3. The average age of physicians in Canada was 47.1 in 1998 and 47.7 in 2002.<sup>179</sup> The median number of years between graduation and when fraudulent or inappropriate billing started (N=42) was 16.5 years after their graduation from professional degree and the number of years ranged from one to 45.

## II. Cases of Fraudulent and Inappropriate in British Columbia and Ontario

This section focuses in greater detail on the 31 cases and 37 actions in British Columbia and the 34 cases and 49 actions in Ontario. Table 5 shows how many of the cases resulted in a particular action. It should be remembered that this analysis is confined to cases in which the health care professionals name made it into the public domain. The most accurate of the three is probably the criminal/quasi-criminal prosecution. Only 19% of the 31 cases in British Columbia, compared to 44% of the 34 cases in Ontario, resulted in criminal or quasi-criminal charges. This difference corresponds with the media coverage and the interviews I conducted, which confirmed that British Columbia appears reluctant to prosecute these offenders and Ontario has taken a “get tough” approach to them.

Only 35% of the cases in British Columbia resulted in action by the professional SRO compared to 65% in Ontario. This too is consistent with media coverage and interview data: the

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<sup>177</sup> Statistics Canada, *Occupation 2001 National Occupational Classification, Canada, Total Labour Force* (Catalogue number 97F0012XCB01017).

<sup>178</sup> Search conducted on September 26, 2004. Not all of these physicians would work on a fee-for-service basis, but it does give some indication of the percentage of women doctors today. The British Columbia College of Physicians and Surgeons' database that contained 9799 doctors on January 25, 2005, cannot be searched by gender.

<sup>179</sup> Canadian Institute of Health Information, “Average Age of Physicians by Physician Type and Province/Territory, Canada, 1998 and 2002;” [secure.cihi.ca/cihiweb/en/AR14\\_2002\\_tab2\\_e](http://secure.cihi.ca/cihiweb/en/AR14_2002_tab2_e); accessed October 2, 2004.

British Columbia College of Physicians and Surgeons<sup>180</sup> leaves these matters to the Medical Services Commission because they are better equipped with the tools to recover inappropriately paid sums. The BC College does not look at these cases unless it involves a quality of care issue or the doctor is convicted of a criminal offence. The Ontario College deals with fraudulent or inappropriate behaviour, even if it is not subject to criminal proceedings. However, if there are criminal proceedings it usually waits for the outcome of these proceedings.

In terms of multiple proceedings, five of the 31 cases in British Columbia (16%), as compared to 12 of the 34 cases (35%) resulted in both SRO and criminal or quasi-criminal action.

The most inaccurate data are on administrative actions. The British Columbia MSC has had more of their administrative actions published in the news media and through their own news releases; OHIP publishes amounts recovered, but seldom the names of the health care professionals.<sup>181</sup>

**Table 5**  
**Actions Taken in the British Columbia and Ontario**  
**Cases of Health Care Fraud and Inappropriate Billing**

	<b>Administrative</b>	<b>SRO</b>	<b>Criminal/quasi</b>
<b>British Columbia</b>	20/31 (65%)	11/31 (35%)	6/31 (19%)
<b>Ontario</b>	12/34 (35%)	22/34 (65%)	15/34 (44%)

## **A. Triggers to Investigation**

Although this variable had a slightly larger number of missing cases than cases with data, where data were available, the most frequent trigger for an investigation in British Columbia was a patterns of practice audit (67%); the most frequent triggers in Ontario were a patterns of practice audit (33%) and patient complaints (33%). A patterns of practice audit involves targeting doctors for an investigation based on the fact that their billings were out of line with their colleagues in similar circumstances. A couple of cases were also discovered through complaints from co-workers or employees.

<sup>180</sup> Nine of the eleven SRO proceedings in British Columbia were by the College of Physicians and Surgeons.

<sup>181</sup> In January, 2005, I was able to add seven administrative cases to the database which had been posted on the Cory Review website.

## B. Forms of Misconduct/Fraud

Table 6 shows the types of behaviour that the administrative agency or SRO examined. The most frequent type of behaviour was a health care provider billing for services that were not provided (24% of the behaviour investigated in British Columbia and 38% of the behaviour in Ontario).

**Table 6**  
**Types of Behaviour dealt with by Administrative Agency or SRO**  
**in British Columbia and Ontario**

Type of Behaviour	British Columbia	Ontario
<b>Service not provided</b>	10 (24%)	17 (38%)
<b>Up-coding</b>	8 (19%)	12 (27%)
<b>Overservicing/unnecessary</b>	8 (19%)	4 (9%)
<b>False diagnosis</b>	3 (7%)	4 (9%)
<b>Inadequate records</b>	8 (19%)	7 (16%)
<b>Patterns of practice</b>	5 (12%)	1 (2%)
<b>Total</b>	42 (100%)	45 (101%)

### 1. Billing for Services Not Provided

An example of a case where services were not provided is that of Dr. Michael Bogart who was ordered to pay back close to \$1 million for fraud between 1990-1996. He billed for services conducted in his Toronto office while he was holidaying in Europe, Australia and various other places. Bogart would regularly bill for seeing patients on Thursday and Friday, when he never saw patients on these days. Another example is Dr. Mario Halenar who apparently charged the MSP in British Columbia for treating a 78 year old woman for problems surrounding child birth and menopause.<sup>182</sup>

When interviewees were asked a general question about whether billing for services that

did not occur was fraud, some suggested that such billings may be the result of clerical errors or carelessness and could be explained away. Although recognizing it as fraud, one respondent stated that since the standard of proof is high, it may be hard to prove. One respondent indicated it was fraud, without any provisos. All respondents thought it would be fraudulent for doctors to bill for sexual encounters with their patients. One commented, “the college would be all over them. Most of that stuff is extra curricula—not billed for.”

## 2. Up-coding

The next most frequent activity was up-coding—simply charging for more than was performed (19% of the activities in British Columbia and 27% of the activities in Ontario). For example, Dr. Michael Ing, a British Columbia optometrist, billed for extensive eye examinations when conducting only brief examinations. Some doctors bill for a complete physical examination when they do only a brief one.

When interviewees were asked a general question about whether billing for more than was actually performed was fraud, some suggested that it may be difficult to prove intention and there are grey areas or sliding scale issues that are a matter of interpretation and in some cases the physician’s own judgement comes into play. Another respondent indicated it was fraud, without any provisos. In response to whether it was fraud to bill for individual psychiatric therapy while conducting group sessions, some stated it depended on whether it was done knowingly. One thought it was deceptive and inappropriate but was not sure it would meet a judge’s standard of fraud.

## 3. Over-servicing/Unnecessary Services

There were eight instances in British Columbia and four in Ontario of overservicing or unnecessary services. For example, Dr. Ara Artinian who administered anabolic steroids to his patients, was found to have billed for medically unnecessary services.<sup>182</sup> There were a number of cases that I found (not included in this analysis) where physicians performed unnecessary services but the billing aspect of the case was not discussed.

When interviewees were asked a general question about whether billing for medically unnecessary service or over-servicing was fraud, some said it is very difficult to determine this or to see it as a criminal issue. In some cases, it is just poor judgement on the part of the

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<sup>182</sup> Rick Ouston, “Controversial Doctor Faces Possible Loss of Privileges” (24 November 1998) *Vancouver Sun* A3.

<sup>183</sup> *College of Physicians and Surgeons of Ontario v. Artinian*, [1992] O.C.P.S.D. No. 11 at para 34.

physician and they should repay the MSP. Some physicians are just pushing the envelope in terms of giving their patients maximum care. Another respondent indicated it was fraud, without any provisos.

#### 4. False Diagnosis

To some extent, many of the billings for services not rendered could be considered a false diagnosis; however, this item was coded only when the false diagnosis was an issue in the proceedings. As such, false diagnoses (three instances in British Columbia and four in Ontario) can create serious problems. In addition to being a fraud on the public purse, it creates a medical record that may have negative consequences for the unsuspecting patient. For example, Dr. Alexander Victor Scott billed OHIP for “29 treatments for alcoholism, two treatments for a brain tumour, and five treatments for anxiety, hysteria and nervous exhaustion [on one patient]—none of which were ever requested or received.”<sup>184</sup> After much effort, the patient managed to obtain an order from the Information and Privacy Commissioner ordering the Ministry to remove the false medical records from his file.<sup>185</sup> In another case, Dr. Ara Artinian was found by the College to have billed for sexual and psychological problems and assessments that his patients never had or discussed with him. He also billed for diagnosis such as asthma, dermatitis, vertigo, and low back pain—services which his patients denied receiving.<sup>186</sup>

When interviewees were asked a general question about whether stating a false diagnosis in order to bill for something that was done, but not covered, all stated that this was fraud; however, one had never seen such an event and added that physicians would simply get advanced approval to do such a thing.

#### 5. Patterns of Practice

Some legislation allows for recovery from doctors who exceed the patterns of practice in their cohort of doctors by a specified amount (five cases in British Columbia, one in Ontario). For example, Dr. Simon Wing Yip was found to have seen each of his patients an average of eight times a year when the average doctor saw patients only four times a year. Dr. Yip was seeing patients at twice the normal rate, and his visits per patient were more than two standard

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<sup>184</sup> Louise Elliott. “Ontario Needs Standards for Faulty Medical Files: Privacy commissioner” (21 March 2001) Canadian Press Newswire.

<sup>185</sup> *Order PO-1881-1 (Institution: Ministry of Health and Long-Term Care)*, [2001] O.I.P.C. No. 55.

<sup>186</sup> *College of Physicians and Surgeons of Ontario v. Artinian*, [1992] O.C.P.S.D. No. 11 at para 34.

deviations from the average. On appeal, the British Columbia Supreme Court indicated that when the audit committee found “an unjustifiable departure from the patterns of practice of practitioners in the practitioner’s class” there was no finding of wrongdoing. “Doctors can choose to give exceptional care to their patients and the purpose of clause (a) is simply to place a limit on the amount that the Medical Services Plan is obliged to pay.”<sup>187</sup> Sometimes a pattern of practice audit will lead to the discovery of up-coding or billing for services that were not rendered.

### **C. Amount in Issue**

Where the information was available, the median amount in issue in British Columbia (N=19) was \$216,164, and the median amount in Ontario (N=22) was \$104,000. The mean (average) amounts were \$297,558 in British Columbia and \$421,844 in Ontario. Although British Columbia had five cases over \$500,000, compared to Ontario’s four, Ontario had three cases of over \$900,000 and British Columbia had none.

### **D. Administrative Proceedings**

As shown in Table 5, information in the public domain indicated that administrative proceedings were conducted in 65% of the 31 British Columbia cases and in 35% of the 34 Ontario cases. This probably reflects the fact the administrative process in Ontario is more secretive than the process in British Columbia. Given Ontario’s position of zero tolerance, it is very likely that administrative actions were taken in close to 100% of the Ontario cases. There was insufficient data to do any further quantitative analysis of these cases.

### **E. SRO Proceedings**

SRO proceedings were conducted in 35% of the British Columbia cases (N=11; nine by the College of Physicians and Surgeons) and 65% of the Ontario cases (N=22; all by the College of Physicians and Surgeons). Only two of the nine cases in British Columbia (22%) were by the College of Physicians and Surgeons in 2000 or later, compared to 15 of the 22 cases in Ontario (68%). The two later cases in British Columbia also involved criminal or quasi-criminal convictions. As was explained to me by the College of Physicians and Surgeons in British

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<sup>187</sup> *Yip v. Audit Committee, Medical Services Commission* (unreported) January 26, 1993, B.C. Supreme Court, Vancouver Registry, No. A924879 at 13-14.

Columbia, the College usually leaves medicare fraud to the MSC and only examines the case if there is an issue of quality of service or if a criminal or quasi-criminal conviction leads to some question about the physician's ability to deliver quality service.

The College of Physicians and Surgeons in British Columbia disciplined five doctors between 1990 and 1997 (when the government introducing BIP which took over the monitoring of medicare fraud). I could find no evidence in the public domain that these physicians were prosecuted in the criminal justice system. These five cases were examined to determine whether any conclusions could be drawn on the question of whether the SRO was funnelling in behaviour that was not suitable for the criminal justice system or whether the SRO was funnelling behaviour away from the criminal justice system. Dr. C.<sup>188</sup> made 32 "improper claims . . . for fees with respect to patients who had not received the service claimed. In the majority of cases he billed the Plan for office attendances when he had not seen the patients. In some cases he billed for office attendances when he had only spoken to the patients by telephone." He promised to stop doing this after being confronted by his staff. Thirteen of the 32 claims took place after his staff confronted him. According to newspaper reports, Dr. L. billed MSP for sexual encounters with one of his patients, but did not record all of her visits on her chart. The issue of billing disappeared in the physician's appeal to the British Columbia Supreme Court and Court of Appeal on the findings by the College of infamous and unprofessional conduct regarding the sexual encounters. Dr. H. was found guilty by the College of entering into financial relationships with his patients when they were incapacitated by the drugs he was prescribing to them. He also billed MSP for services that could not have been rendered, for example, removing tonsils from a person who had them removed 25 years earlier. Dr. T. billed the MSP for "approximately 150 instances where she had either performed no service or a service for which she was not entitled to bill the Plan." Dr. F. billed MSP for services to family members which violated the physicians' code of ethics, and he was required to repay the amounts. With the exception of the last case, it is difficult to see why these cases could not have been prosecuted in criminal or quasi-criminal proceedings. Once the College withdrew from enforcement of billing behaviour in 1998, the criminal justice system did not pick up the slack.

Five cases in Ontario resulted in a resignation or licence revocation by the College. Ten professionals were suspended from three to eighteen months (a mean of 7.5 months and a median of 5.5 months); however six of these had their suspensions reduced to 1-12 months if

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<sup>188</sup> I have used initials here because these doctors were not charged or convicted with a criminal offence, but I have assessed the facts as they appear in the College proceedings. Had these cases gone through the criminal justice system, the doctors may have been acquitted.



they fulfilled certain conditions. Seven professionals were fined from \$3,000-\$10,000 (a median of \$5,000). Three were required to take remedial courses; two were subjected to inspections or oversight; and all 15 were reprimanded and ordered to pay costs ranging from \$1,000-15,000 (mean \$4,600; median \$2,500). Only three decisions were appealed; results were against the professional in two cases and one was split as to which party was successful.

There were nine cases in Ontario where the College of Physicians and Surgeons disciplined doctors for inappropriate billing, but it appears as though no criminal charges were laid. In three cases the College found various violations of practice standards, but that there was insufficient evidence to establish that the physicians billed OHIP for services that were not performed or that the bills were false or misleading. In another case the physician had billed same day visits on different days, but had not billed for services he did not perform. In the remaining cases, the inappropriate billings seemed to be of less concern as the physicians were involved in other matters such as sexual abuse or sexual relations with patients, violating professional boundaries, and inappropriate prescription of drugs. In some cases the witnesses would probably not have stood up to cross-examination in the criminal justice system. In these cases, the SRO was probably funnelling in inappropriate billing behaviour that would not have been dealt with elsewhere. Unlike the College in British Columbia prior to 1997, the Ontario College of Physicians and Surgeons does not appear to be funnelling misconduct away from the criminal justice system.

## F. Criminal and Quasi-Criminal Proceedings

In their efforts to reconcile two versions of law—"law as a fair and impartial arbiter of social conflicts; and law as one of the sites in society that reproduces gender, race and class inequalities,"<sup>189</sup> Comack and Balfour examine how social-structural conditions (for example, neo-liberalism<sup>190</sup> and neo-conservatism) channel lawyers' actions as they transform individuals charged with interpersonal violent offences into criminals. According to the authors, law is a "contested terrain on which various discourses operate to produce and reproduce certain claims to 'truth.'"<sup>191</sup> Lawyers develop their own characterizations of what they consider "normal crime"<sup>192</sup>

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<sup>189</sup> Comack and Balfour, *The Power to Criminalize* at 10.

<sup>190</sup> For example, neo-liberalism, which shifts the government's focus from social welfare and collective values to the privatization of responsibility, has an impact on lawyers' case-building strategies; Comack and Balfour at 41-42; also see Wendy Lerner, "Neo-Liberalism: Policy, Ideology, Governmentality" (2000) 63 *Studies in Political Economy* 5.

<sup>191</sup> Comack and Balfour, *The Power to Criminalize* at 31. David Sudnow, "Normal Crime: Sociological Aspects of the Penal Code" in E. Rubington and M. Weinberg (eds.), *Deviance the Interactionist Perspective* (London: Macmillan, 1968).

which influence their case-building strategies. If offenders and their behaviour do not fit these images or scripts of normal crime, lawyers will use the psy professions' discourse to explain the offenders' behaviour.

The only professional that Comack and Balfour discuss is a middle-aged chiropractor who was charged with sexual assault and fraudulent billings. Defence counsel managed to have some charges dismissed because of lack of Crown disclosure; other charges were delayed because the accused suffered from a depressive disorder to the extent that he was unable to instruct counsel. Eventually, at the sentencing hearing, defence counsel relied on letters of community support and the devastating psychological and financial impact the case had had on the accused and his family. How one is psychologized in the criminal justice system may depend on one's class. The sociopath is "uncaring, self-centred, irresponsible and manipulative;" however, for the professional "blameworthiness is ostensibly mitigated by the clinical depression brought on by the criminal proceedings."<sup>193</sup> Based on Mandel's analysis of sentencing law in Canada, Comack and Balfour suggest that given the chiropractor's conformity to the capitalist system as a social being, he requires and deserves lesser punishment.<sup>194</sup>

Another factor that may be operating in how professionals are treated in the criminal and other justice systems is what Daniel calls scapegoating. Although professions are often accused of "looking after their own," and they may actually do this, sometimes deviant members are "denounced, pilloried, and driven out" as a means of maintaining the integrity of the profession.<sup>195</sup>

In examining the prosecution of health care fraud I have looked at how the lawyers and judges have characterized offenders and how the psy professions have been used to either assist (excuse) or vilify the accused. Three of the six prosecutions in British Columbia were against physicians (there were also charges against two physiotherapists and one optometrist). Fourteen of the 15 prosecutions in Ontario were against physicians.

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<sup>192</sup> Comack and Balfour, *The Power to Criminalize* borrow this concept from David Sudnow, "Normal Crime: Sociological Aspects of the Penal Code" (1965) 12 *Social Problems* 255. The man who kills his mother and the violent woman are examples of offenders who do not fit normal crime scripts; Comack and Balfour at 59-61, 137, and 144.

<sup>193</sup> Comack and Balfour, *The Power to Criminalize* at 144.

<sup>194</sup> Comack and Balfour, *The Power to Criminalize* at 143 referring to Michael Mandel, "Democracy, Class and Canadian Sentencing Law" in E. Comack and S. Brickey (eds.), *The Social Basis of Law: Critical Readings in the Sociology of Law* (Halifax: Fernwood, 1991).

<sup>195</sup> Daniel, *Scapegoats* at 1-3. Although one usually thinks of marginal professionals suffering the effects of scapegoating, Daniel purposely focussed on "practitioners of distinction" in her study.

## 1. British Columbia

Dr. Richmond James Lee, who worked in Trail, British Columbia as a general practitioner and anaesthetist, was charged with fraud under section 380(1) of the *Criminal Code* and with knowingly making false documents under section 367(1). In 1985, he began billing MSP for more units of time than he actually worked and for services on people who were not his patients. Over four years he increased his billings by 40%, and defrauded the Medicare system of \$261,687. At his sentencing hearing in 1992 following a guilty plea, the trial judge described the fraud as a gross violation of trust, but “as completely without sophistication.”<sup>196</sup>

A psychiatrist testified that Lee had significant stress in his life (marriage and work problems and a rebellious son) and that his emotional deficiencies led to “passive aggressive behaviour, i.e., the false billings.” The psychiatrist compared him to the “middle age shoplifters who have no apparent need or motive for their crime.”<sup>197</sup> The judge pointed out that Lee would not benefit from his crime as the MSP was withholding 50% of his billings until the amount was repaid. According to the judge, personal deterrence was not an issue because the MSP “will watch him like a hawk for evermore.”<sup>198</sup> Rehabilitation was not an issue because Lee had suffered humiliation and reprobation from his colleagues and the community. The judge stated that this type of fraud was “very rare in the medical community” and that no one would commit this crime if they were aware of the punishment Lee had “already suffered, let alone the further punishment he is facing.” The judge was also confident that the lenient sentence he was about to impose would not send a message to fraud artists outside the medical community: “Financial corporations and trust fund defalcations, as well as both welfare and unemployment insurance frauds are a [sic] the frequent subject of much publicity, and would-be perpetrators of those misdeeds should be guided by the consistent sentences meted out in those generic varieties of offences.”<sup>199</sup>

Although the Crown objected, the trial judge decided that it was appropriate to consider the impact on the community of Trail, which found it hard to attract specialists. Surgical specialists wrote letters exhorting the judge not to deprive the community of Lee’s services. The trial judge concluded that the sentence he imposed would bring the community into continuous awareness that Lee was being punished. He added, “It will be clear to all that white collar crimes

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<sup>196</sup> *R. v. Lee* (unreported) January 27, 1992, B.C. Provincial Court, Rossland, British Columbia, No. 11480 at 1.

<sup>197</sup> *Lee* at 2-3.

<sup>198</sup> *Lee* at 3.

<sup>199</sup> *Lee* at 3-4.

are treated seriously, and its effects and results will be before the public for all to see.”<sup>200</sup> Lee was sentenced to 90 days in jail (to be served on weekends), probation, and 500 hours of community service.

An editorial in the *Vancouver Province* questioned whether the lenient sentence, which may have served the community of Trail by allowing Lee to work during the week, served the broader community. It added, “What about the father who commits a robbery? Should he be given a weekend sentence so he could keep his job and feed his family? . . . White collar crime is increasing in this country. Yet the perpetrators are often given treatment that would not be available to blue collar criminals.”<sup>201</sup>

Following his conviction, the College of Physicians and Surgeons found that Lee “had brought disgrace to the medical profession” and erased his name from the medical register.<sup>202</sup> The Registrar was quoted as saying that Lee could apply to have his name returned to the register, but he was wasting his time if he applied within a year.<sup>203</sup> Lee relocated to Bishop’s Falls, Newfoundland<sup>204</sup> and died on April 8, 2004 at the age of 67.<sup>205</sup>

Dr. Pradeep Kurma Verma, a general practitioner who worked with drug addicts in Vancouver, was initially charged with 13 counts under the *Narcotic Control Regulations* for improperly prescribing codeine and eight charges of fraud under section 380(b)(ii) of the *Criminal Code* (fraud under \$5000, a summary conviction offence) for submitting eight bills for \$23.50 each, for services that were not rendered.<sup>206</sup> This case started as a drug investigation. Two undercover police officers posed as recovering drug addicts and Verma gave them prescriptions for codeine without proper inquiry. In addition to billing for these visits, Verma billed an additional eight visits that had not occurred. The accused pleaded guilty to an amended information which contained only one count related to codeine and one fraud count for \$188.00. Defence counsel outlined the “incredible” personal and work stress that Verma was under, his depression, and hospitalization in a psychiatric ward following disciplinary action by the College (and around the time the fraud charges were laid).<sup>207</sup> Although the judge expressed some misgivings about the leniency of the sentence proposed by the Crown and defence counsel for

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<sup>200</sup> Lee at 6.

<sup>201</sup> Editorial. (30 January 1992) *Vancouver Province* A40.

<sup>202</sup> College of Physicians and Surgeons of British Columbia, *1993 Annual Report* (Vancouver: College of Physicians and Surgeons, 1993) at 16.

<sup>203</sup> Gordon Clark, “Trail Laments Losing Banned Doctor” (1 April 1992) *Vancouver Province* A4.

<sup>204</sup> The CPSBC recorded this new address as of 1996, but it is not clear when he moved.

<sup>205</sup> “Obituary: Remembering Richmond James Lee” [www.hoskinsfuneralhomes.com](http://www.hoskinsfuneralhomes.com); accessed March 27, 2005.

<sup>206</sup> Information Number 64501, dated May 27, 1993.

<sup>207</sup> *R. v. Verma* (unreported) May 6, 1994, B.C. Provincial Court, Vancouver, British Columbia, No. 64501C at 8-10.

the fraud against Medicare, he followed their recommendation and imposed a \$500 fine on each of the two counts.<sup>208</sup>

A Committee of the College of Physicians and Surgeons considered Verma's convictions and also found that he had created a false medical chart for another patient and issued prescriptions under her name (for her husband) when she was not his patient. In addition, he fraudulently billed the Medical Plan for \$164 for these phantom visits. The Committee found that after his activities came to light, Verma threatened the husband with physical harm, and the husband, in response, wrote a false statement to cover-up Verma's fraud. The College Council erased Verma's name from the register, and his appeal to the British Columbia Supreme Court was dismissed.<sup>209</sup> Verma moved to Waterloo, Ontario and practised medicine until his licence was suspended in 1996 following charges of sexual assault on patients and trafficking in narcotics. He was convicted of sexual assault in 1998, and his licence was revoked in 2001 by the College in Ontario.<sup>210</sup>

Dr. Paul Gerard Devlin, a psychiatrist<sup>211</sup> in Surrey, British Columbia, pleaded guilty to a lesser included offence under section 46(2) of the *Medicare Protection Act* (knowingly obtaining a benefit he was not entitled to—\$93,000) and the Crown did not proceed with the charge of fraud under the *Criminal Code*. For five years (1993-1997), Devlin wrote letters to the MSP falsely indicating he had sufficient private medical income that entitled him to a larger fee. The Crown recommended a \$100 fine, adding that Devlin would have to repay the amount he was not entitled to and was to be de-rolled for two months. The judge followed defence counsel's recommendation of a discharge, giving Devlin a six month conditional discharge.

The judge had asked for some precedents in terms of previous sentencing decisions from other courts which the defence and Crown seemed reluctant to provide, claiming that there were no equivalent decisions under section 64. Defence counsel stated: "there are a couple of *Criminal Code* convictions for fraud, very egregious cases, but none in these circumstances." The judge asked for similar cases of billing that relied on trust, suggesting perhaps the Legal Aid system. Defence counsel suggested that a search would show "numerous cases" in which

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<sup>208</sup> *R. v. Verma* (unreported) May 9, 1994, B.C. Provincial Court, Vancouver, No. 64501C at 1.

<sup>209</sup> *Verma v. College of Physicians and Surgeons of British Columbia*, [1994] B.C.J. No. 2701.

<sup>210</sup> *College of Physicians and Surgeons v. Verma*, [2001] O.C.P.S.D. No. 27. The delay by the College was criticized in the news media; see Robert Cribb, "Doctor Loses Licence a Second Time: Earlier Convicted of Fraud in B.C. Sex Charges Lead to End of Practice" (7 June 2003) *Toronto Star* A4; Editorial. (10 June 2003) *Toronto Star* A22.

<sup>211</sup> Throughout the relevant time, Devlin, who was trained as a psychiatrist in Ireland, was on the British Columbia College's Temporary Register because of his inability to pass the required examinations; *Devlin v. The College of Physicians and Surgeons*, [2000] B.C.J. No 1730 (B.C.S.C.); appeal by Devlin dismissed [2002] B.C.J. No 1612 (B.C.C.A.).

discharges were granted. The Crown made a passing reference to the fact that defence counsel (apparently known as “Mr. Fraud” for the numerous fraud cases he had defended) had dealt with some welfare fraud cases in the past, but this avenue for precedents was never pursued.

After a one week adjournment, counsel returned with one unreported decision in which an employee of Canada Trust was given a conditional discharge for embezzling \$130,000 from the account of a deceased. Ultimately, the accused doctor was given a six month conditional discharge. This case was concluded in 2001, and no reference was made to the *Lee* or *Verma* cases (both unreported) or any of the Ontario cases.<sup>212</sup> There is an argument that fraud cases under the *Criminal Code* may not be relevant for sentencing for a quasi-criminal provincial conviction. Devlin accepted a two-month de-enrollment from MSP (no payment for his services for two months) and was reprimanded by the College of Physicians and Surgeons. As of March 25, 2005, he is listed as the Medical Director of Psychiatry at Surrey Memorial Hospital.<sup>213</sup>

Mr. Milorad Stokic, a physiotherapist, was charged with 18 counts of fraud under section 380 of the *Criminal Code* and charges of dealing in forged documents. He pleaded guilty to four counts of fraud against MSP, the Insurance Corporation of British Columbia and Canada Life Corporation, and one charge of dealing in forged documents. Over a five year period, Stokic fraudulently obtained \$35,000 from MSP and \$45,000 from ICBC. With regard to MSP, he created false patient charts and billed for services that he did not deliver. He also created phantom patients and clinical records for real people who were not his patients. At his sentencing hearing in October of 1998, the trial judge heard Victim Impact Statements from ICBC and MSP. MSP stated that given the volume of claims they had to process, the system relied on trusting practitioners to bill honestly. Stokic filed a number of letters attesting to his good character that had what the judge called “a double-edged sword” as he “was able to conceal his criminal side so well that even those closest to him saw nothing untoward.” Given Stokic’s ability to deceive over a long period “reflects a man of some cunning.” Although he had a “solid reputation” in the community, the judge noted that he lived in a large, paid-in-full house while he was behind in child support payments to his former wife who had terminal cancer.<sup>214</sup>

In February of 1999, he was sentenced to 22 months imprisonment to be followed by two years probation. Stokic’s sentence appeal was dismissed, but the Court of Appeal deleted the part of the warrant of committal that stated the sentence was “to be served in an institutional

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<sup>212</sup> *R. v. Devlin*, (unreported) May 9 and May 15, 2001, B.C. Provincial Court, Port Coquitlam, British Columbia, No. 61170-01.

<sup>213</sup> College of Physicians and Surgeons, Physicians Directory; [www.cpsbc.ca/](http://www.cpsbc.ca/) accessed January 30, 2005.

<sup>214</sup> *Stokic* at para. 36-37.

setting,” in order to leave this issue to correctional authorities.<sup>215</sup> The College of Physiotherapists cancelled his licence.<sup>216</sup> In a separate action by ICBC, it was reported that Stokic agreed to repay ICBC \$340,000 for exaggerated billing and for billing for services he did not perform.<sup>217</sup>

In November of 2001, Mr. Chi Chiu Chen, a physiotherapist, pleaded guilty to one count of defrauding the Insurance Corporation of British Columbia of \$3,250.20 and one count of defrauding MPS of \$32.50. The Crown proceeded by indictment and asked for a jail term of 18 months to act as a deterrent, but was not opposed to a conditional sentence with house arrest or curfew. Defence counsel argued that Chen had made “a very foolish error in judgment . . . and was remorseful.” He would have a criminal record for fraud, face professional disciplinary proceedings and a costly civil action by ICBC. The judge sentenced Chen to a \$1,000 fine on the MSP count and six months conditional sentence with a curfew on the ICBC charge. He was also ordered to pay back the amounts set out in the indictment. Given that Mr. Chen’s financial circumstances would be “taxed considerably with everything going on in his life . . . arising from this matter” he was given until July, 2002 to pay the fine.<sup>218</sup> It was reported in the newspapers that ICBC sued Chen to recover \$430,000 for submitting false claims to MSP which then billed ICBC.<sup>219</sup>

Dr. Michael Ing, an optometrist, pleaded guilty to defrauding MSP of \$227,247 over a five year period. Ing billed for services he did not perform, for unnecessary tests, and for extensive testings when only brief examinations were conducted. Prior to his criminal sentencing, the Board of Examiners in Optometry fined him \$3,000, ordered him to pay \$110,000 in costs, and suspended him for 20 months (which was reduced to 2 months when he convinced the Board that his knowledge and record keeping were satisfactory).<sup>220</sup> He had also made full restitution to MSP, but still owed the Board \$59,000 in costs which he was paying at \$2,000 per month. A pre-sentence report characterized Ing as a workaholic who supported his wife, children, mother, and brother, but the judge interpreted the report as saying that Ing “came to remorse late” and lacked

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<sup>215</sup> *R. v. Stokic*, [1999] B.C. J. No. 1312.

<sup>216</sup> College of Physical Therapists of British Columbia, “Discipline Panel Decision” (Winter 2000) *Update* [www.cptbc.org/newsletter.htm](http://www.cptbc.org/newsletter.htm).

<sup>217</sup> Clare Ogilvie, “Swindler to Pay” (31 December 1999) *Vancouver Province* A34; David Hogben, “Physiotherapist to pay ICBC \$340,000” (30 December 1999) *Vancouver Sun* B4. This case illustrates the problems of relying on newspaper reports for information. It was reported that Stokic “was jailed for defrauding ICBC of more than \$300,000” when in fact the criminal charge was for defrauding ICBC of \$45,000; Adrienne Tanner, “Physiotherapist admits \$430,000 fraud on ICBC” (9 November 2001) at C4 (this article was about Chen, but then also made reference to Stokic).

<sup>218</sup> *R. v. Chen*, (unreported) November 5 and 20, 2001, Provincial Court of British Columbia, Vancouver, British Columbia, No. 115882-1.

<sup>219</sup> Tanner at C4.

<sup>220</sup> BC Board of Examiners in Optometry, “Discipline Hearing of Dr. Michael Ing” (February, 2001) *The Examiner* 1; *R.*

“depth of insight” into his behaviour. The judge took into account the fact that Ing had been “punished in two other forums.” In addition to the sanctioning by the Board, MSP banned him from billing for five years. She writes, “it has been noted in many other cases that, particularly in the case of professionals or individuals who are known to their community, that such punishment by way of publication or other fines and consequences are factors to be taken into account in sentencing.”<sup>221</sup> Ing was given a two year less a day conditional sentence, six months house arrest (except for working hours and community service), ordered to perform 72 eye examinations as part of a community service order, and 18 months probation following the conditional sentence.

Plea negotiations figured prominently in all six prosecutions. In some cases the facts before the sentencing judge were substantially less serious than what the media reported as the original allegations. In two cases, the amounts reported as recovered during civil proceedings were substantially higher than the amounts that were the subject of the criminal charges. With one exception (Stokic) the professionals appeared to benefit from their social and economic location, some with the help of the psy professions.

Two of the three physicians who were convicted in British Columbia had received their medical training outside of Canada (India and Ireland), as had the physiotherapist (Yugoslavia, with upgrading in Canada). There was no indication where the two optometrists were trained; however, both have names that would indicate they may be members of a visible minority, and one had his picture in a newspaper which would confirm this. It is difficult to determine whether this indicates scapegoating in action or not.

## 2. Ontario

Of the 15 professionals charged in Ontario (14 physicians and one chiropractor), charges were stayed against two, and one was found guilty of defrauding Workers Compensation, but not guilty of OHIP fraud. Of the 12 who were convicted, nine were heard in provincial court and three in superior court. All 12 pleaded guilty. The convictions were all under the *Criminal Code*, except for one. Dr. Sarah Paikin, a Hamilton physician, was initially charged with fraud under the *Criminal Code*, but these charges were withdrawn when she pleaded guilty to an offence under section 44 of the *Health Insurance Act*. She had billed OHIP for \$10,628.76 for psychotherapy services that she was not entitled to bill under the Schedule of Benefits. She was required to

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v. Ing, [2001] B.C.J. No. 2855 (BC Provincial Court) at 13.

<sup>221</sup> Ing at para. 21.



repay the plan and was fined \$5,000, the maximum fine under the legislation. She was also required to pay a surcharge of \$1,250.<sup>222</sup> The College of Physicians and Surgeons then, recognizing “that this was a case of failing to exercise due diligence, and not a case involving fraudulent intent,” reprimanded her and ordered her to pay a fine of \$3,000 to the Minister of Finance and \$2,500 to the College for costs.<sup>223</sup>

Three of the 12 professionals served time in jail or prison. In 1991, Dr. Louis Stephen O’Connell, a family physician, pleaded guilty to defrauding OHIP of \$100,000. Apparently his behaviour was discovered because some days he billed for more hours than there were in a day.<sup>224</sup> O’Connell was sentenced to reimburse OHIP, spend 89 days in jail (to be served on weekends), complete 250 hours of community service, and serve two years probation. The College reprimanded him and ordered him to pay a fine of \$5,000 to the Minister of Finance. He was also suspended for 180 days, but 120 would be remitted if he paid the fine and costs of \$5,000 within 30 days and performed 45 hours of community service at an AIDS hospice.<sup>225</sup>

Dr. Alexander Victor Scott, a general practitioner in the Kingston area who made house-calls to shut-ins and the elderly, pleaded guilty to defrauding OHIP of \$586,924.59 between 1992 and 1999. Although there was a Order of Forfeiture for some of his retirement savings because they were obtained as part of an enterprise crime offence, “charges of money laundering and profiting from the proceeds of crime were dropped as part of Scott’s plea bargain.”<sup>226</sup> Scott had billed for fictitious appointments with some patients and fabricated procedures on patients he did see. For example, Scott would give a patient a flu shot and bill for a psychotherapy session (also see the earlier discussion under False Diagnosis). Despite the fact that Scott indicated that he had neglected his financial affairs because of his addiction to prescription drugs, following his rehabilitation programme in 1995 he continued fraudulent billing because of his debt load. On May 8, 2000, the judge followed a joint submission by Crown and defence counsel and sentenced Scott to 30 months in prison.<sup>227</sup> He was released on supervised parole on March 8, 2001.<sup>228</sup> On March 27, 2002, the College reprimanded Scott, revoked his

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<sup>222</sup> *R. v. Paikin*, (unreported) January 16, 2001, Ontario Court of Justice, Toronto (Metro North).

<sup>223</sup> *College of Physicians and Surgeons of Ontario v. Paikin*, [2003] O.C.P.S.D. No. 36.

<sup>224</sup> Sean Upton, MD Jailed for Bilking Health Plan” (1 September 1991) *Ottawa Citizen* A6.

<sup>225</sup> *College of Physicians and Surgeons of Ontario v. O’Connell*, [1994] O.C.P.S.D. No. 5. The transcripts from the criminal trial were no longer available, as the provincial division of the court retains them for only six years; email Tricia Doran, Client Service Representative, Court Support Office, Ottawa to Joan Brockman, March 12, 2004.

<sup>226</sup> Annette Phillips, “MD Gets Ban for Life in \$592K Fraud Case: College Hands Alex Scott Harshes Punishment Ever for Bilking Health System” (3 April 2002) *Kingston Whig-Standard* 1. Also see *R. v. Scott* (unreported) May 8, 2000, Ontario Court of Justice, Kingston, Ontario at 8.

<sup>227</sup> *R. v. Scott* (unreported) May 8, 2000, Ontario Court of Justice, Kingston, Ontario.

<sup>228</sup> Annette Phillips, “Island Doctor May Lose Licence” Disciplinary Committee Hears from Dr. Alex Scott” (31 August

Certificate of Registration, and ordered him to pay \$2,500 in costs.<sup>229</sup>

On September 11, 2000, Dr. Michael Charles Bogart pleaded guilty to defrauding OHIP of \$923,780.53 over a period of seven years (see earlier discussion under Billing for Services not Provided). Although of the view that such a crime warranted a five year penitentiary sentence, the trial judge considered “the accused’s background, his present status, his remorse, his continued service to his patients and his guilty plea” and sentenced him to two years less a day to be served in the community, three years probation, and restitution.<sup>230</sup> On appeal by the Crown, the Ontario Court of Appeal found that the sentence was “demonstrably unfit.” While ordinarily such a crime would call for a four-year penitentiary term, given the mitigating circumstances the court imposed an 18 month sentence in jail.<sup>231</sup> An application for leave to appeal to the Supreme Court of Canada was denied.<sup>232</sup> Following his conviction, the College of Physicians and Surgeons rejected Bogart’s argument that the commission of fraud was irrelevant to his suitability to practise medicine, as “trust and integrity are fundamental to the agreement between the physician and OHIP in a fee-for-service arrangement and are fundamental in the relationship between physicians and patients.” The College reprimanded Bogart, suspended him for 18 months (six months to be suspended if Bogart met a number of conditions), imposed terms on his Certificate of Registration, and ordered him to pay costs of \$15,000.<sup>233</sup> As of April 25, 2005, Bogart does not appear on the College’s registrar.

Three of the 12 professionals served conditional sentences of imprisonment (this means the sentence of imprisonment was served in the community). Dr. Donald MacDiarmid, a general practitioner in Ajax, Ontario, pleaded guilty to defrauding OHIP of \$155,675 under section 380(1)(a) of the *Criminal Code* and was sentenced to an 18 month conditional sentence, two years probation, a fine of \$100,000 and 150 hours of community service. On appeal, the fine was deleted as sentencing an accused to imprisonment and both probation and a fine was found to be illegal.<sup>234</sup> The College suspended MacDiarmid for five months, required him to undergo intensive psychotherapy, ordered him to pay \$1,000 in costs, and prohibited him from submitting accounts to OHIP for a period of three years following his suspension. On appeal, the Ontario Superior Court of Justice decided that the College had the power to prohibit MacDiarmid from

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2001) *Kingston Whig-Standard* 1.

<sup>229</sup> *College of Physicians and Surgeons of Ontario v. Scott*, [2002] O.C.P.S.D. No. 4.

<sup>230</sup> *R. v. Bogart*, [2001] O.J. No. 2323 at paras. 16-18. The conditional sentence included 100 hours of community service.

<sup>231</sup> *R. v. Bogart* (2002), 167 C.C.C. (3d) 390 at paras. 41-42.

<sup>232</sup> *R. v. Bogart*, [2002] S.C.C.A. No. 398.

<sup>233</sup> *College of Physicians and Surgeons of Ontario v. Bogart*, [2001] O.C.O.S.D. No. 9 at paras. 5 and 26.

<sup>234</sup> *R. v. MacDiarmid*, [2001] O.J. No. 243 (Ontario Court of Appeal).

submitting accounts to OHIP and that its decision was reasonable.<sup>235</sup>

In 2001, Dr. Miles Moore pleaded guilty of defrauding OHIP of \$75,000 under section 380(1)(a) of the *Criminal Code*. He was sentenced to a 15 month conditional sentence with a curfew from 9:00 p.m. until 6:00 a.m., followed by three years of probation, and he was ordered to pay \$75,000 in restitution.<sup>236</sup> The College reprimanded him, suspended him for 12 months, and ordered that he pay a fine of \$5,000 and costs of \$2,500. Six months of the suspension would be suspended provided he paid the fine and costs within six months of the date of suspension.<sup>237</sup> Moore met the conditions to reduce his suspension to six months, but appealed the College's decision arguing that the Committee had not adequately considered the principle of proportionality and had overemphasized the concept of general deterrence in its decision in that it quoted the following from a previous decision: "The Committee hopes that the penalty imposed by this committee will serve as an appropriate general deterrent and convey the message that health care fraud is a serious and escalating problem, which will not be tolerated by the medical profession in Ontario." It then added, "the Committee is concerned that this message may not be getting out to the members of the College, as the incidence of health care fraud continues to be significant."<sup>238</sup> The Ontario Superior Court of Justice dismissed Moore's appeal finding that the Committee's decision was "a measured response to what appears to be a continuing and an escalating problem in the medical profession."<sup>239</sup>

Dr. Gustavo Tolentino pleaded guilty to defrauding OHIP of \$58,120.40 under section 380(1)(a) of the *Criminal Code* on October 25, 1999. He was sentenced to a 12 month conditional sentence and ordered to pay restitution.<sup>240</sup> On February 28, 2002, the College, after "seriously considering revocation as an appropriate penalty" recognizing that "the scale of fraud in this case is in the lower range when compared to other cases," reprimanded Tolentino and suspended him for four months.<sup>241</sup>

Of the remaining six professionals convicted of an offence, two were fined \$5,000 each, three were placed on probation, and one was given a discharge.

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<sup>235</sup> *MacDiarmid v. College of Physicians and Surgeons*, [2003] O.J. No. 277.

<sup>236</sup> Since I did not have the judge's or the reporter's name in this case, the court staff were unable to trace the reporter so that I could obtain transcripts for this case. However, as of April 25, 2005, it appears as though I may be able to trace the reporter.

<sup>237</sup> *College of Physicians and Surgeons of Ontario v. Moore*, [2002] O.C.P.S.D. No. 5.

<sup>238</sup> *Moore*, 2002 at paras. 9-10; *Moore v. College of Physicians and Surgeons*, [2003] O.J. No. 5200 (Ontario Superior Court of Justice) at paras. 4-5.

<sup>239</sup> *Moore*, 2003 at 12.

<sup>240</sup> Since I did not have the judge's or the reporter's name in this case, the court staff were unable to trace the reporter so that I could obtain transcripts for this case. However, as of April 25, 2005, it appears as though I may be able to trace the reporter.

Country of training was available for 11 of the 12 convicted professionals, and only two of the 11 had received their training outside of Canada. Surnames of the professionals do not indicate over-representation from any minority group such that they may have been targeted for scapegoating.

## **PART SIX: Summary and Conclusions**

### **I. The Difference of Location: The Monitoring Process In British Columbia and Ontario**

In British Columbia, the MSP is managed by the MSC—comprised of one third BCMA appointees (i.e., physicians), one third government, and one third public (jointly nominated by the BCMA and the government). In 1998, structural changes occurred in the monitoring of medicare bills when the government created BIP to scrutinize inappropriate billing. At the same time, the professional SRO (College of Physicians and Surgeons) withdrew from monitoring medicare fraud by physicians and limits itself (through its POPC) to educating or warning doctors whose billings patterns exceed their colleagues' patterns. The SRO may still discipline a doctor who is criminally convicted of medicare fraud; however, criminal and quasi-criminal prosecutions are very rare in British Columbia. In Ontario the government agency OHIP (part the Ministry of Health and Long-Term Care) monitors claims and refers inappropriate billing cases to the MRC (a Committee of the College of Physicians and Surgeons of Ontario), but it may also refer cases to the police or (since 1996) recover money directly from the health care professional.

The billing process in British Columbia offers a number of informal avenues for health care professionals to challenge any assessment done by BIP. Practitioners who are unhappy with a decision by MSP staff can first resubmit their bill for reassessment and then take their complaint to the MSP's Claims Billing Support Unit for another assessment by adjudication staff. The complaint may be resolved through an Alternative Dispute Resolution Process. Where settlement does not occur, an Audit Hearing Panel will hear from the practitioner before any recovery order is made. The British Columbia model is also based on education, warnings, reconciliation, and assistance; if that does not work, the interest appears to be in recovery of money, not prosecution or punishment. This culture of non-criminalization appears to permeate the government, professional, and criminal justice systems in British Columbia when it comes to

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<sup>241</sup> *College of Physicians and Surgeons v. Tolentino*, [2002] O.C.P.S.D. no. 2 at paras. 10 and 13.

health care abuse and fraud.

The process in Ontario is far-less forgiving than the one in British Columbia. Professionals are responsible for accurate billing and are not provided with billing profiles so they can adjust their billing to avoid an audit based on comparative patterns of practice. In addition, a zero tolerance approach to fraud was introduced in Ontario, in 1997, along with the creation of a special police unit to investigate health care fraud. However, in January 2003, a more informal settlement process was introduced (the OPRP) as was an Education and Prevention Committee, following an outcry by physicians that they were the victims of enforcement actions. The MRC's enforcement activities were put on hold until after the Cory Review is completed and considered.

Although there was a move from professional oversight of billings to a government managerial model with the introduction of BIP in British Columbia, physicians still permeate the entire process from the MSC to BIP investigations and audit decision-making. The appearance is one of government bureaucratic control and responsibility; however, physicians are incorporated into all aspects of decision-making. In Ontario, the physicians are overseen by a government bureaucracy (OHIP); however, the professional SRO (through the MRC) maintains decision-making powers over billing disputes. As a consequence, the SRO takes the heat when physicians violate public trust by fraudulent billing. The government agency (OHIP) and the newly created police unit have taken an active role in bringing health care fraud into the criminal justice system. The SRO has little choice but to discipline physicians who are criminally convicted for OHIP fraud.

Physicians in British Columbia do not appear to suffer greater enforcement because their SRO lost its power over billing misconduct to the government-run BIP. It could be argued that there would be greater capacity (and perhaps pressure) for enforcement had the enforcement powers been left with the SRO (the "funnel in" justification for self-regulation). Although physicians are now employed by BIP to conduct much of the work that would have been conducted by physicians through the SRO had it stayed in the business of monitoring billing practices, when fraudulent cases are exposed in the media today the pressure is on the government agency and less so on the SRO. In Ontario, the College of Physicians and Surgeons seems to gather criticism through its MRC for not controlling fraud, but is also blamed by physicians for overly aggressive enforcement of the billing rules.

## II. The Difference of Location: Enforcement In British Columbia and Ontario

Despite the differences in structures, the recoveries ordered by government agencies are comparable. The Audit Committee in British Columbia, which is composed of representatives from government, physicians, and the public, ordered 59 physicians (an average of 12 per year) to return \$4,078,112 (an average of \$69,120 per physician) to the plan between 1998 and 2003. In Ontario, between 1991-2002, the MRC, a committee of the College of Physicians and Surgeons consisting of 18 physicians and six public members, recommended recovery from 548 physicians (an average of 49.8 physicians per year) of over \$36 million (an average of \$66,449 per physician). The Ontario system, which has 3.8 times as many doctors as British Columbia, recommended four times as many recoveries.<sup>242</sup> Both the proportion of physicians subjected to administrative orders or recommendations and the amounts targeted for recovery are similar in the two provinces. Some of these figures are artificially controlled by the fact that the number of audits that are conducted per year are limited in each province.

Between 1990 and 1997, the College of Physicians and Surgeons of British Columbia dealt summarily with seven cases of improper billing and seven additional cases involving both improper billing and inadequate records. After the introduction of BIP, the College reported no improper billing cases, but dealt with three cases of financial fraud, two of which were charges under the *Medical Practitioners Act*. The College takes the position that improper or fraudulent billing is best handled by BIP, and it only takes action if there is a question about the quality of service or if the physician is convicted of a criminal or quasi-criminal offence. The CPSO does not publish annual statistical data on its work.

There were 31 cases and 37 actions in British Columbia and 34 cases and 49 actions in Ontario in which a professional had his or her name in the public domain as a result of administrative, professional, or criminal or quasi-criminal actions commenced between 1990 and 2003. The professional SROs in Ontario took a greater proportion of disciplinary measures ( $22/34=65\%$ ) than the professional SROs in British Columbia ( $11/31=35\%$ ), and there was a greater proportion of criminal cases in Ontario ( $15/34=44\%$ ) than British Columbia ( $6/31=19\%$ ). In terms of multiple proceedings, five of the 31 cases in British Columbia (16%), as compared to

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<sup>242</sup> This ratio is based on the 37,214 doctors in the Ontario database on September 26, 2004 and the 9799 doctors in the British Columbia database on January 25, 2005.

12 of the 34 cases (35%) resulted in both SRO and criminal or quasi-criminal action.

There were six criminal or quasi-criminal prosecutions and convictions in British Columbia between 1990 and 2003, compared to 15 prosecutions and 12 convictions in Ontario. Only three of the six prosecutions in British Columbia, and 14 of the 15 in Ontario were against physicians (4.7 times as many as in British Columbia). All but one of the accused were men, and all pleaded guilty.

Although there were only six prosecutions in British Columbia, there appeared to be a pattern of plea negotiations that resulted in facts before the court that were substantially less serious than what the media reported as the original allegations. In two cases, the amounts that were repaid during civil proceedings were substantially higher than the amounts that were the subject of the criminal charges. The penalties imposed appear very lenient and the judges comments were, with one exception, quite sympathetic to the plight of the convicted health care providers. Plea negotiations were also a major factor in Ontario, but overall the professionals did not seem to fare as well as their BC counterparts when it came to criminal sentencing.

Two of the three physicians who were convicted in British Columbia had received their medical training outside of Canada (India and Ireland), as had the physiotherapist (Yugoslavia, with upgrading in Canada). There was no indication where the two optometrists were trained; however, both have names that would indicate they may be members of a visible minority, and one had his picture in the paper which would confirm this. Country of training was available for 11 of the 12 convicted professionals in Ontario and only two of the 11 had received their training outside of Canada. Surnames of the professionals in Ontario do not indicate over-representation from any minority group. It is difficult to determine whether this indicates scapegoating in action or not.

### **III. The Difference of Location: Professional Health care Fraud and Welfare Fraud**

In 1996, an editorial in the *Vancouver Sun* opined “the contrast between government’s deferential coddling of the doctors, and their handling of suspected welfare abuse is striking” and is “almost enough to make one believe there’s one law for the rich and another for the poor.”<sup>243</sup>

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<sup>243</sup> Editorial. “Doctored Billing: With little Check on the Payment claims MDs put in, the Possibility of Overpayments Runs Feverishly High” (23 December 1996) *Vancouver Sun* A10. The reference to one law for the rich and another for the poor was also made in reference to the sentencing of Dr. Bogart; Editorial. “Doctor’s Fraud Merited Jail Time” (19 June 2001) *Kingston Whig- Standard* 6; Editorial, “Uneven Scales of Justice” (18 June 2001) *The Ottawa Citizen* A12.

Intuitively one might think that health care fraud carries more moral turpitude than welfare fraud. However, it appears as just the opposite. The difference of social location of the offenders is so overwhelming that the nature of the offender seems to characterize the offence.<sup>244</sup> This difference between offenders who commit the same legally defined crime confirms Sutherland's need for a social, rather than simply a legal, definition of crime. A reviewer of an earlier version of this paper illustrates this social definition of crime in questions about treating welfare fraud and white-collar crime equally:

Equality of what? Fraud? Punitiveness? Poverty? Culpability? Would the same treatment be appropriate in the alternative? Welfare recipient's ability to re-pay monies is exceptionally limited. Do we have to treat differently in order to treat equally in this situation? Don't we have to recognize that welfare recipients and physicians are not in the same socio-economic location? . . . Is this simply a distinction about how a similar crime is conceived of and treated based on which side of the dependency ratio it falls on? One is a part of business in a capitalist system the other is a socio-economic support to those not involved in capitalist enterprises.

Table 7 provides a brief overview of the impressions I have of the differences between welfare fraud<sup>245</sup> and fraud by health care professionals. There is definitely a difference in terms of who these people are (impoverished women and men as compared to privileged men) and how the public perceives them (lazy, dependent, "never deserving" as compared to hardworking, underpaid and deserving). In terms of the law, complex rules work against welfare recipients who are assumed to know the law, whereas complex rules can serve as an excuse for health care professionals who commit fraud. Despite the individual responsibility that goes with the neo-liberal approach to welfare fraud, physicians to some extent still get to blame the system.

When it comes to law in practice, welfare recipients are subjected to surveillance, whereas health care professionals are subjected to education—more so in British Columbia than Ontario, but recently Ontario has introduced billing educational programmes for physicians. Administrative actions (e.g., removal of entitlement to social assistance) against welfare recipients have harsh consequences, and they have little power to resist. A reviewer of an earlier version of this paper suggested that given the informal and punitive nature of administrative actions taken against welfare recipients, the criminal law standard may be the way to re-

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<sup>244</sup> Dorothy E. Chunn and Shelley A.M. Gavigan, "Welfare Law, Welfare Fraud, and the Moral Regulation of the 'Never Deserving' Poor" (2004) 13(2) *Social Legal Studies* 219 suggest that the social images of welfare fraud have been transformed to welfare as fraud.

<sup>245</sup> Information about how we treat welfare fraud comes from Dianne L. Martin, "Passing the Buck: Prosecution of Welfare Fraud; Preservation of Stereotypes" (1992) 12 *Windsor Yearbook Access to Justice* 52 (which is somewhat dated, but it is unclear how much has changed); Chunn and Gavigan, "Welfare Law; and Janet Mosher and Joe



introduce equality and close the “democracy gap” between the rich and the poor. This proposition is addressed in the next section.

Once in the criminal justice system, welfare recipients may be found guilty on evidence which is probed very little, or not at all, by defence counsel. The costs of using the criminal law against welfare recipients are minimal compared to the prosecution of professionals who can afford to hire the best of lawyers to either test the prosecution’s case to the fullest or negotiate a plea bargain to minimize the criminal law’s impact. The high social and economic costs to welfare recipients appear to be ignored whereas the high social and economic costs to the professional are recognized in sentencing decisions. Overall, welfare recipients are much less powerful than professionals when it comes to influencing what the rules are and how they might be enforced.

**TABLE 7**

**Comparing the Treatment of Welfare Fraud with Professional Health care Fraud**

<b>Welfare Fraud</b>	<b>Healthcare Fraud</b>
-mostly impoverished women and men	-mostly privileged men
-publicly seen as “lazy, dependent, undisciplined and lack work ethic”	-seen as hard working and underpaid
-“never deserving”	-deserving
-not entitled	-entitled
-criminal prosecution; pay it back -jail	-BC: pay it back, maybe -Ontario: criminal and pay it back
-complex rules work against offender -“technical” fraud = fraud	-complex rules work for offender -technical fraud = errors
-fraud defined broadly -overpayments; all infractions viewed as fraud	-fraud defined narrowly -strict application of the law
-surveillance/not trusted	-education on how to bill/trusted

-low criminal enforcement costs to the system (high costs to the individual not recognized)	-high criminal enforcement costs (high costs to the individual recognized)
-pay back difficult	-pay back may be used as alternative to criminal law; payback less difficult
-condemnation by community; no power to change public perception	-support from the community; power to change public perception
-welfare snitch line	-nothing equivalent
-“tragic” or no legal representation	-the best legal representation
-social context irrelevant -individual responsibility	-social context a factor
-no power to influence rules, enforcement or public perception	-power to influence rules, enforcement and public perception
-concern with moral condemnation	-concern with deterrence
-“walking on eggshells” <sup>246</sup>	-walking on water?

Examining the situation in the United States, McKnight writes that “a low-income mother is given \$1.00 of income [for every] \$1.50 in medical care” when it “is perfectly clear that the single greatest cause of her ill health is her low income.” He adds, that society’s answer “to her sickening poverty is an ever-growing investment in medical technology.”<sup>247</sup> I tried to determine if health professionals were more likely to use poor or working class, rather than middle or upper class, patients as the pawns in their fraud. For the most part, this information was not available. What was available indicated that 19% of the professionals in British Columbia and 15% in Ontario, whose names made it into the public domain, had poor, elderly or working class patients. There was no information on the type of patients the other professionals had, so there was insufficient evidence to comment on this proposition. Even if most of the professionals who were prosecuted or disciplined worked with the less powerful it would have been difficult to

<sup>246</sup> This phrase is borrowed from Janet Mosher, Patricia Evans, Margaret Little, Eileen Morrow, Jo-Anne Boulding and Nancy VanderPlaats, *Walking on Eggshells, Abused Women's Experiences of Ontario's Welfare System* (Toronto: Final Report of Research Findings from the Woman and Abuse Welfare Research Project, April, 2004).

<sup>247</sup> John McKnight, *The Careless Society: Community and Its Counterparts* (New York, Basic Books, 1995) at 9.

determine if professionals were using the less powerful, or if the professionals who worked with the less powerful were being used as scapegoats by the profession.

## IV. Lessons from Crimes of the Powerful

There is a common (probably accurate) perception that white-collar criminals are treated more leniently than those engaged in street crime. I believe this is still a true statement in Canada, even though some academics in the United States have tried to demonstrate that there has been a “get tough on crime” approach directed at white-collar and corporate crime in that country.<sup>248</sup> There are two ways to reduce discrimination between the two types of crime or criminals. One is the approach thought to exist in the United States, the other is to explore how our compassion for white-collar criminals can be transferred to so called “street” criminals.

There are good reasons to move in the latter direction, as opposed to more heavily penalizing white-collar criminals. Alvesalo and Tombs argue that the call for a heavier hand on white-collar crime may lead to “a game of spiralling criminalization” and a “fuelling [of] the engine of crime control.”<sup>249</sup> Such an approach may provide further legitimacy to a class-biased system “through the appearance that even the wealthiest and most powerful actors can be subject to state control.” In addition, resources designated for such enforcement may be re-directed at more conventional offenders.<sup>250</sup> For example, in the context of this study, additional resources for health care fraud may be directed at consumers of health care rather than providers, since the former are easier targets for enforcement.

Alvesalo and Tombs suggest that changes to the present system to assist investigations and prosecutions of complex white-collar crimes, such as giving state agents novel and invasive powers or reversing the onus of proof, may then be used against lower class offenders. Even within the sphere of economic or white-collar crime, social control measures may be directed at the less powerful rather than the more elite offender.<sup>251</sup> In addition, the increased focus on the

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<sup>248</sup> See, for example, Sally S. Simpson, *Corporate Crime, Law, and Social Control* (Cambridge, UK: Cambridge University Press, 2002) at 10-21. In contrast, Darryl K. Brown, “Street Crime, Corporate Crime, and the Contingency of Criminal Liability” (2001) 149(5) *University of Pennsylvania Law Review* 1295 writes, “Criminal law is a comparatively minor tool for addressing white-collar wrongdoing. For street wrongdoing, in contrast, criminal law remains the dominant instrument.”

<sup>249</sup> Anne Alvesalo and Steve Tombs, “Working for Criminalization of Economic Offending: Contradictions for Critical Criminology?” (2002) 11 *Critical Criminology* 21 at 30. They discuss these issues in relation to their policy work for the government of Finland on imposing criminal sanctions for economic crimes. They define economic crime as encompassing corporate and white-collar crimes.

<sup>250</sup> Alvesalo and Tombs, “Working for Criminalization” at 31.

<sup>251</sup> Alvesalo and Tombs, “Working for Criminalization” at 32. This could be an aspect of “scapegoating” as described by Daniel in *Scapegoats*.

use of criminal law obscures the need to find non-criminal solutions to harm. Finally, economic crime crusades may be “used as Trojan horses for expanding the totality of the repressive armoury of the state.”<sup>252</sup> Criminalization of conduct can do more harm than good. Much like medical intervention which can make patients worse (iatrogenesis), legal intervention can have its own negative consequences (the juridogenic effect).<sup>253</sup>

Both Greer and Hagan’s “crime pyramid” and Henry and Lanier’s “crime prism” (referred to in the Introduction) assume that there must be broad social agreement about behaviour before it is treated as a crime. This may be true for the expansion of criminal law, but it is extremely difficult to reverse criminalized conduct, especially conduct by the less powerful,<sup>254</sup> even with societal consensus. This substantial resistance to the decriminalization of conduct should be factored into any definition of crime. Resistance to decriminalization is probably stronger now than it has ever been. The strongest resistance comes from the crime control industry, which is now big business in our society. As Hillyard and Tombs state, “the crime control industry is now a powerful force in its own right; it has a vested interest in defining events as crime.”<sup>255</sup> The crime industry includes public and private police and investigators, the prison industry, and the growing number of professionals who make their living off the crime control industry—psychiatrists, psychologists, profilers, criminologists, lawyers, social workers, probation officers, parole officers, judges and so on.

The crime industry problem is directly linked to what McKnight refers to as the “professional problem.” He provides numerous examples of what Illich referred to as “specific counterproductivity.” Not only do some services not have the intended effect, they may produce more of what they are trying to prevent. McKnight writes, “thus, one can imagine sickening medicine, stupidifying schools, and crime-making corrections systems.”<sup>256</sup> He believes that “through the propagation of belief in authoritative expertise, professionals cut through the social

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<sup>252</sup> Alvesalo and Tombs, “Working for Criminalization” at 32-33. Despite these misgivings the authors argue for the criminalization of economic crimes.

<sup>253</sup> Carol Smart, *Feminism and the Power of Law* (London: Routledge, 1989) as cited in Comack and Balfour, *The Power to Criminalize* at 176. An historical example of juridogenic effects is prohibition, and a present day example is drug law enforcement. Also see earlier examples at footnote 10.

<sup>254</sup> For the ease at which corporations have managed to decriminalize and de-stigmatize behaviour see Laureen Snider, “Researching Corporate Crime” in Steve Tombs and Dave Whyte (eds), *Unmasking the Crimes of the Powerful: Scrutinizing States and Corporations* (New York, Peter Lang, 2003) 49; Laureen Snider, “Abusing Corporate Power: The Death of a Concept” in Susan C. Boyd, Dorothy E. Chunn, and Robert Menzies (eds.) *[A]busing Power: The Canadian Experience* (Halifax: Fernwood Publishing, 2001) 112; and Laureen Snider, “The Sociology of Corporate Crime: An Obituary: (or: Whose Knowledge Claims have Legs?)” (2000) 4(2) *Theoretical Criminology* 169.

<sup>255</sup> Hillyard and Tombs, “Beyond Criminology” at 18.

<sup>256</sup> McKnight, *The Careless Society* at 8. At 17 he acknowledges the influences of Ivan Illich’s discussion of the “iatrogenic capacities of professionals,” Peter Berger and Richard Neuhaus’s description of “the decay of primary social structures facilitated by modern professionalism,” and others.

fabric of community and sow clienthood where citizenship once grew.”<sup>257</sup> The effect is the essence of the professional problem—“poor people defined as deficient by those whose incomes depend upon the deficiency they define.”<sup>258</sup> “Sick,” “criminal,” “unfit,” and other words can be substituted for the various problems created by the activities of professionals who live off the backs of those they define as in need of their services.

The growing number and variety of professionals being produced requires that we manufacture needs to keep them employed.<sup>259</sup> The professional problem in the criminal justice system is becoming more obvious. Psychology departments are turning out more and more graduates who will conduct questionable risk assessments on many people who will then be subjected to confinement or treatment for behaviour that should not have been criminalized. Criminology departments are starting to turn out more graduates who expect jobs as practitioners in the criminal justice system. According to Young’s manta: “Too many soldiers and not enough peace. Too many cops and not enough liberty. Too many lawyers and not enough justice”.<sup>260</sup> One could add many more: Too many doctors and not enough health. Too many experts and not enough community. To the Law Commission of Canada’s question, “who benefits from labelling behaviour a crime?” one could list all the occupations designed to control, and in some cases, nurture crime. Problem definers are key to the question, “what is a crime?” Critically examining the work of the “problem definers” may be the most effective means of reducing crime in our society. However, McKnight warns us that this is not what politicians want to hear as “the more privileged of our society . . . expect [professional employment and] the prestige accorded professional work.”<sup>261</sup> The crime control industry not only produces many professionals, it also keeps them employed and assists in the re-election of governments.<sup>262</sup>

University departments that churn out more and more professionals to fill the ever-expanding number of professional crime control jobs are obvious culprits in the crime control industry and the professional problem. According to some critics, criminal justice and criminology programmes are part of the problem. Robinson suggests, for example, that a harm-reduction approach to drug use would mean “less police involvement, less military involvement, and less

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<sup>257</sup> McKnight, *The Careless Society* at 10.

<sup>258</sup> McKnight, *The Careless Society* at 18.

<sup>259</sup> McKnight, *The Careless Society*, points out that in 1900, 10% of the workforce in the United States worked in the service industry, and by 2000 it was expected to be 90%.

<sup>260</sup> Young, *Justice Denied* at 316.

<sup>261</sup> McKnight, *The Careless Society* at 22.

<sup>262</sup> Matthew B. Robinson, "Wither Criminal Justice? An Argument for a Reformed Discipline." (2001) 10 *Critical Criminology* 97 at 98.

convictions and punishment of drug abusers. It will also mean fewer criminal justice jobs.”<sup>263</sup> He concludes that if we keep fuelling the crime control industry with more and more graduates, we will do more harm than good. According to Hillyard and Tombs, “crime gives legitimacy to the expansion of crime control.”<sup>264</sup> As Alvesalo and Tombs warn, symbolic scapegoats in the white-collar crime arena may simply reinforce the crime control industry.

Some critics suggest that because criminology had its birth in seeking the causes of (and hence the remedies for) crime within the individual, decades of resistance from within the discipline has had little impact on the fact that engaging in criminology reproduces and exacerbates social and economic inequalities.<sup>265</sup> Criminology, with its “intimate relationship with power” is part of the problem. According to these critics, a focus on social harm “begins with a focus upon the *social* origins of harms, [and] upon the structures that produce and reproduce such harms.”<sup>266</sup>

One of the ways to expose what Braithwaite refers to as a “class-based administration of criminal justice”<sup>267</sup> is to study how we as a society react to white-collar crime.<sup>268</sup> Why is white-collar crime an understudied phenomenon in criminology programmes? At one time I thought it was because it was a complex subject. As I watch a once partly critical criminology programme turned into a factory for criminal justice technicians, the cynic in me now wonders if a true examination of crimes of the powerful would not result in the extinction of much of what we now define as crime and criminal-justice type criminology.<sup>269</sup> Although there will always be a need for

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<sup>263</sup> Robinson, “Wither Criminal Justice?” at 103.

<sup>264</sup> Hillyard and Tombs, “Beyond Criminology” at 17.

<sup>265</sup> Hillyard and Tombs, “Beyond Criminology” at 28; Paddy Hillyard, Christina Pantazis, Steve Tombs and Dave Gordon, “Conclusion: ‘Social Harm’ and its Limits?” in *Beyond Criminology* 267 at 270.

<sup>266</sup> Hillyard, Pantazis, Tombs and Gordon, “Conclusion” at 271. Also see Richard Hil and Rob Robertson, “What Sort of Future for Critical Criminology?” (2003) 39 *Crime, Law and Social Change* 91. Jeffrey Reiman, *The Rich Get Richer and the Poor Get Prison: Ideology, Class and Criminal Justice* (Boston: Pearson Allyn and Bacon, 2004, 7<sup>th</sup> edition) at 7 writes, “a competitive economy that refuses to guarantee its members a decent living places pressures on all members to enhance their economic position by whatever means available. It degrades and humiliates the poor while encouraging the greed of the well off.”

<sup>267</sup> Quoted in Gary Slapper and Steve Tombs, *Corporate Crime* (UK: Pearson Education Limited, 1999) at 18.

<sup>268</sup> For recent overviews of critical criminology’s contributions to the study of white-collar and corporate crime, see Dorothy E. Chunn, Susan C. Boyd, and Robert Menzies “‘We all live in Bhopal’: Criminology Discovers Environmental Crime” in Susan C. Boyd, Dorothy E. Chunn, and Robert Menzies (eds.) *Toxic Criminology: Environment, Law and the State in Canada* (Halifax: Fernwood Publishing, 2002) and Robert Menzies, Dorothy E. Chunn, and Susan C. Boyd, “Introduction” in Susan C. Boyd, Dorothy E. Chunn, and Robert Menzies (eds.) *[Ab]using Power: The Canadian Experience* (Halifax: Fernwood Publishing, 2001).

<sup>269</sup> One review suggested that linking “‘criminal justice’ mentalities” with the crime control industry was an over-reach. Given the recent creation of two University chairs at the School of Criminology (SFU) funded by the RCMP in the areas of crime analysis and computational criminology, this may not be such an over-reach. Alison Gill, “Associate Dean’s Report” (Simon Fraser University: Faculty of Arts and Social Sciences Annual General Meeting, April 11, 2005) reported the chairs as “in progress.” When the Undergraduate Criminology Association discussed the possibility of getting involved in a complaint against the Vancouver City Police, the School of Criminology Faculty minutes stated, “However, students are aware that they need to discuss this with the Director before committing, due to possible

using the criminal law to deal with extreme crimes of interpersonal violence, much of the criminal law is now engaged with petty crimes and activities that lack moral consensus. Even where there is moral consensus (no one really thinks auto theft is a good thing), beefed up enforcement can easily displace auto thieves to crimes of interpersonal violence. Addressing the social harms that lead to auto theft and crimes of interpersonal violence may be a more productive avenue for reducing such crime. For example, although a 1988 report on social assistance in Ontario identified the adequacy of benefits as “the single most important weapon in the fight against fraud in the system,” it went on to recommend a special fraud unit to deal with such “fraud.”<sup>270</sup>

It is difficult to conclude that the monitoring systems in British Columbia and Ontario catch more than a small fraction of health care fraud. The investigation of health care fraud is limited by agreement. Approximately 100 audits are conducted in each province per year. In 2003, a spokesperson for the CPSO stated that it conducts a maximum of 100 audits each year and that approximately 80% of these physicians are found to have billed inappropriately. Although the newspaper report suggested that the “average penalty handed down is \$70,000,”<sup>271</sup> it is much more likely that this is the average amount recommended for recovery. The reconceptualization of “penalty” to include paying back what one obtained by fraud does little to deter health care fraud.

Brown compares some of the practical barriers to enforcing the criminal law against corporate offenders to illustrate their distorting effects on the application of the criminal law against them. Some of these barriers are applicable to other white-collar crime such as health care fraud. The mere existence of alternative ways of reacting to health care fraud influences enforcement practices: “litigants are often well matched against the government and can use their resources to negotiate for dispositions that moderate the populist pressure for excessive criminal punishment” and that “involve more creative mixes of civil and criminal sanctions and remedies” than occur in street crime enforcement.<sup>272</sup> Brown suggests that money buys privacy such that wealthier offenders can more readily avoid detection and investigation. Money also buys trust. The health care billing system is built on trust with very few controls. It is much easier to falsify records and bills in health care fraud than street crimes.

If caught, white-collar criminals can often match or exceed the resources of prosecutors,

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conflicts of interest, etc.” (School of Criminology Faculty Minutes, February 10, 2005).

<sup>270</sup> See Martin, “Passing the Buck” for her critique of *Report of the Social Assistance Review Committee, Transitions* (Toronto: Queen’s Printer for Ontario, 1988).

<sup>271</sup> Brian Hutchinson and Francine Dube, “Colleagues say audit led Welland MD to suicide: Was ordered to pay \$108,000 to OHIP” (17 April 2003) *National Post* A1.

<sup>272</sup> Darryl K. Brown, “The Problematic and Faintly Promising Dynamics of Corporate Crime Enforcement” (2004) 1

unlike street criminals. Equality between the powerful and less powerful might demand that such barriers become more equal. For example, rather than prosecutors in British Columbia asking whether there is a “substantial likelihood of conviction”<sup>273</sup> before approving charges, they might want to ask, “if this accused had the resources to litigate this criminal charge, would there be a substantial likelihood of conviction?”

The crime control industry runs into challenges when its professionals direct their attention to their own kind—other professionals. In addition to the legal tools and money that the powerful have to fight criminal allegations in the courtroom, heavy-handed enforcement against the powerful leads to a backlash.<sup>274</sup> The backlash and resentment that greets aggressive enforcement has many academics recommending a more cooperative approach to such crimes or what they might refer to as unwanted behaviours.<sup>275</sup> What we probably are less likely to see, acknowledge, and do something about is the fact that heavy-handed enforcement against the less powerful also breeds anger, contempt, and defiance.<sup>276</sup> Examining how professionals react to having the criminal law applied to them and how we, as a society, react in return may assist us in developing more empathy for the less powerful.

In order to introduce equality into the enforcement of fraud laws, the backlash of the less powerful must be given the same weight as the backlash of the more powerful. For example, when the government appointed Mr. Justice Cory to review the Ontario MRC’s auditing system the terms of reference stated that the MRC’s auditing function would not be impeded. Shortly thereafter, legislation was introduced that halted all audits until after Justice Cory’s report. How likely is it that reviews of welfare recipients’ claims would be halted while an inquiry determined their effectiveness for the purpose of rebuilding the confidence of welfare recipients in the review process? In its submission to the Cory Review, the OMA stated that the audit process should focus on education and prevention, and that physicians should be given six months to alter their billing behaviour if the Ministry is not satisfied with the physicians’ explanations of their billing

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*Ohio State Journal of Criminal Law* 521 at 526.

<sup>273</sup> For a discussion of pre-charge screening by prosecutors in British Columbia, Quebec and New Brunswick and the standard used to approve charges see Joan Brockman and V. Gordon Rose, *Canadian Criminal Procedure and Evidence for the Social Sciences* (Toronto: Nelson, 2001, 2<sup>nd</sup> edition) at 68-69.

<sup>274</sup> Jost and Davies, “The Empire Strikes Back.”

<sup>275</sup> See for example, Brown, “Street Crime,” who writes, “command-and-control regulation . . . engenders an adversarial resentment in regulated firms that leads to greater resistance [to] regulatory standards and less cooperative compliance by firms.” Ayres and Braithwaite write that punitive regulation “fosters an organized business subculture of resistance to regulation—a subculture that facilitates the sharing of knowledge about methods of legal resistance and counterattack;” Ian Ayers and John Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (New York: Oxford University Press, 1992) at 25.

<sup>276</sup> Lauren Snider. “Towards Safer Societies” (1998) 38(1) *British Journal of Criminology* 1; also see John Braithwaite, *Restorative Justice and Responsive Regulation* (New York: Oxford University Press, 2002).



behaviour. How likely is it that we would allow welfare recipients to continue violating the complex welfare rules for six months after they were discovered to be in violation of them? According to the OMA, physicians should have knowledge of the statistical norms expected of them so they can bill accordingly. This system exists in British Columbia. Do we give welfare recipients the same opportunity to self-correct so as to avoid penalties or the disapproval of their supervisors? The OMA suggested that there should be no recovery from a physician who is practising “in accordance with prevailing standards of care.”<sup>277</sup> Again, are we prepared to translate this excuse to accommodate prevailing practices by welfare recipients?

In conclusion, this study demonstrates the power of the powerful when it comes to defining and enforcing laws against their own. If the less powerful could do the same, we would have a drastic reduction in the behaviour that we define and enforce as crime. The study of white-collar crime in the “what is a crime?” debate exposes the class-biased criminal justice system, the crime control industry, and the professional problem. We are warned that a harsher approach to white-collar crime will have the unintended consequences of fuelling the crime control industry against the less powerful. It may be time to seriously reconsider the inequality of the criminal law and restrain its use. This may be the only road to arriving at “a more equitable and accountable process for defining crime and enforcing criminal law.”<sup>278</sup>

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<sup>277</sup> The OMA was of the view that given the record-keeping requirements, the current system “would mandate a recovery from virtually any Ontario physician reviewed by it;” Ontario Medical Association, “OMA Submission to the Honorable Justice Cory—Review of the Ontario Medical Audit and Review Process” (July/August, 2004) *Ontario Medical Review* (online).

<sup>278</sup> Des Rosiers and Bittle, “Introduction” in Law Commission of Canada, 2004 vii at xxiii.

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## Appendix A

### Coding Sheet for Health Care Fraud/Misconduct Cases

ID Case number \_\_\_\_\_ (see list for numbers) Crown: \_\_\_\_\_

Defence: \_\_\_\_\_

#### Background of Professional

**Q1.** Sex of Accused: 1. male          2. female

**Q2.** Year of birth

**Q3.** Age when behaviour commenced?

**Q4.** Born: 1. Canada 2. USA, Australia, England, etc. 3. other

**Q5.** Trained: 1. Canada 2. USA, Australia, England, etc. 3. other

**Q6.** Race: 1. Caucasian 2. Other

**Q7.** ~~deleted~~

**Q8.** Year graduated from professional school:

**Q9.** Years between graduation and when offence(s) commenced?

**Q10.** Profession of accused:

1. Doctor - General/Family Practitioner
2. Doctor - psychiatrist
3. Doctor - psychotherapist (not qualified as psychiatrist)
4. Doctor - surgeon
5. Doctor - other specialist \_\_\_\_\_
6. Doctor (no speciality named)
7. Massage therapist
8. Psychologist
9. Physiotherapist
10. Chiropractor
11. Dentist
12. Optometrist
13. Other \_\_\_\_\_

**Q11.** Patients from 1. poor/working class/elderly    2. middle/upper class 3. mix

**Q12. Geographic Location of Offence/Hearing** 1. BC 2. Alberta 3. Saskatchewan 4. Manitoba 5. Ontario 6. Québec 7. Newfoundland/Labrador 8. Nova Scotia 9. PEI 10. New Brunswick 11. Northwest Territories 12. Yukon 13. Nunavit

#### THE OFFENCE/ MISCONDUCT

**Q13.** Year of earliest offence/misconduct:

**Q14.** Number of years conduct engaged in:

**Q15. [code up to 2]** Issue identified by: 1. patient 2. other prof. 3. co-worker 4. relative 5. co-worker/relative 6. patterns of practice audit 7. patient survey/verification 8. other audit 9. other

**Q16.** 1. patient 2. other prof. 3. co-worker 4. relative 5. co-worker/relative  
6. patterns of practice audit 7. patient survey/verification 8. other audit 9. other

**Q17.** Amount in issue:

**Q18. ADMINISTRATIVE PROCEEDING?** 1. Yes 2. No

**Q19.** Year completed:

**Q20.** Amount in issue:

**Q21.** billing for service that did not occur:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q22.** billing for more than actually performed:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q23.** billing for medically unnecessary service/overservicing

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q24.** stating a false diagnosis:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q25.** inadequate records:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q26.** exceeded patterns of practice:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q27. Other**

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q28.** Was money collected from professional: 1. all 2. some 3. none 4. being collected

**Q29.** Was there: 1. an admission 2. hearing on the merits 3. combination 4. D/K

**Q30.** Amount ordered repaid?

**Q31.** If prohibiting from billing, how long? \_\_\_\_\_(Months)

**Q32.** If appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q33.** If second appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q34.** If third appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q35. SRO PROCEEDINGS?** 1. Yes 2. No

**Q36.** Year completed:

**Q37.** Amount in issue:

**Q38.** billing for service that did not occur:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q39.** billing for more than actually performed:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q40.** billing for medically unnecessary service/overservicing

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q41.** stating a false diagnosis:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q42.** inadequate records:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q43.** exceeded patterns of practice:

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q44. Other**

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q44a.** Was there: 1. an admission 2. hearing on the merits 3. combination 4. D/K

**SRO Penalty:**

**Q45.** SRO Deregistered/Revocation of licence/Resignation accepted? 1. Yes 2. No

**Q46.** SRO Suspension? 1. Yes 2. No

**Q47.** How long? \_\_\_\_\_ (months)

**Q48.** Suspension reduced to \_\_\_\_\_ months if conditions met.

**Q49.** SRO Practice Restrictions? 1. Yes 2. No

**Q50.** SRO Fine 1. Yes 2. No

**Q51.** How much? \_\_\_\_\_

**Q52.** SRO remedial courses? 1. Yes 2. No

**Q53.** SRO inspections/oversight? 1. Yes 2. No

**Q54.** Reprimanded? 1. Yes 2. No

**Q55.** Other? 1. Yes 2. No



**Q56.** Amount of costs to be paid, if ordered:

**Q57.** Was there discussion of 1. mitigating factors 2. aggravating 3. both  
[not coded] list para numbers: mitigating\_\_\_\_\_Aggravating:

**Q58.** If appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q59.** If second appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q60.** If third appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q61. CRIMINAL PROCEEDING?** 1. Yes 2. No

**Q62.** Year completed:

**Q63.** Was proceeding: 1. Criminal Code 2. Provincial Medical Legislation

**Q64.** Was proceeding in: 1. Provincial court 2. Superior court

**Q65.** Finding: 1. against professional; 2. for professional; 3. combination 4. no contest

**Q66.** Was there: 1. an admission 2. hearing on the merits 3. combination 4. D/K

**Sentence:**

**Q67.** Jail? 1. Yes 2. No

**Q68.** How long? \_\_\_\_\_ (days)

**Q69.** Conditional Sentence 1. Yes 2. No

**Q70.** How long? \_\_\_\_\_ (months)

**Q71.** House arrest/curfew 1. Yes 2. No

**Q72.** How long? \_\_\_\_\_ (months)

**Q73.** Community service 1. Yes 2. No

**Q74.** How long? \_\_\_\_\_ (hours)

**Q75.** Fine 1. Yes 2. No

**Q76.** How much? \_\_\_\_\_

**Q77.** Probation 1. Yes 2. No

**Q78.** How long? \_\_\_\_\_ (months)

**Q79.** Cond./Abs. discharge 1. Yes 2. No

**Q80.** Was restitution ordered: 1. all 2. some 3. none 4. dealt with elsewhere

**Q81.** Other? 1. Yes 2. No

**Q82.** Was there discussion of 1. mitigating factors 2. aggravating 3. both

[not coded] list para numbers: mitigating\_\_\_\_\_Aggravating:

**Q83.** If appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q84.** If second appeal, was result: 1. against professional; 2. for professional; 3. combination

**Q85.** If second appeal, was result: 1. against professional; 2. for professional; 3. combination

**Other misconduct (fraud related):**

**Q86.** Improper Billing/statements to WCB/other insurance co.

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q87.** Tax evasion/fraud/reassessment

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q88.** Other?

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Other conduct in allegations/findings:**

**Q89.** billing for sex (explicit or implied)

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q90.** improper dispensing of drugs

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q91.** Other?

1. guilty 2. not guilty 3. combination 4. D/K 5. stayed 6. not relevant

**Q92.** Did practitioner have a history of fraudulent or inappropriate billing?

1. yes findings 2. yes warnings/concerns expressed 3. yes, but only allegations 4. no

**Q93.** History of violations unrelated to fraud? 1. Yes 2. No

**Q94.** Was/Is professional involved in bankruptcy proceedings? 1. Yes 2. No

## Appendix B Interview Questions

DATE:       , 2004   (LCC Health Care Fraud; What is Crime?)

#

### Definitions of Medicare fraud

1. Would you consider the following behaviours to be medicare fraud?

[if not fraud, what would you call it?]:

billing for services that did not occur

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

2. billing for more than was actually performed

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

3. billing for medically unnecessary service or over-servicing

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

4. stating a false diagnosis in order to bill for something that is done, but not covered

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

5. inadequate documentation for billing

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

6. billing for individual psychiatric therapy while conducting group sessions

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

7. billing for sexual encounters that occur with patient during therapy

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

8. Is intent necessary in your definition of fraud?

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

9. Is there any other behaviour that you would include in medicare fraud?

10. Do you think medicare fraud a serious (costly or frequent) problem in BC?

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

11. One official is quoted as saying "there's probably a little bit of fudging or padding, which occurs in every practice." would you agree that this occurs?

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

12. Is this acceptable behaviour?

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

13. Is it fraud?

(1) yes       (2) no   (3) depends/not as clear       (4) D/K

### Monitoring/Investigation/Prosecution

I want to ask a few questions about how we should deal with fraud by health care professionals.

14. Do you think it is necessary to recovery money that was paid to health care professionals because of their fraud?

(1) yes (2) no (3) depends/not as clear (4) D/K

15. Is recovery of money sufficient?

(1) yes (2) no (3) depends/not as clear (4) D/K

16. Should health care professionals be prosecuted in criminal courts for health care fraud? Why or why not?

(1) yes (2) no (3) depends/not as clear (4) D/K

17. Who, if anyone, benefits from criminal prosecution? Is there a downside to not prosecuting?

18. Who, if anyone, is harmed by criminal prosecution?

20. Do you think criminal prosecutions are effective/successful? What is achieved? [purpose? Symbolic?]

21. Should prosecution of medicare fraud be under the *Criminal Code* or provincial legislation? Why?

22 [may overlap with 21]. Under what circumstances (are there any circumstances under which you) would you recommend that a health care professional be prosecuted criminally for Medicare fraud?

23. What are some of the obstacles to investigating and criminally prosecuting health care fraud?

24. Do you think that medicare fraud is dealt with differently than other types of fraud such as welfare fraud by investigators in government departments who deal with such fraud?

(1) yes (2) no (3) depends/not as clear (4) D/K

25. by the police?

(1) yes (2) no (3) depends/not as clear (4) D/K

26. By prosectors and defence counsel?

(1) yes (2) no (3) depends/not as clear (4) D/K

27. By judges?

(1) yes (2) no (3) depends/not as clear (4) D/K

28. How would you compare health care (medicare ) fraud to welfare fraud? What do you see as the similarities and differences between the two?

29. Is there anything about the way we deal with health care fraud that you think could be applied to the way we deal with other fraud, such as welfare fraud?

30. An editorial in the Vancouver Sun in 1996 stated that "the contrast between government's

deferential coddling of the doctors, and their handling of suspected welfare abuse is striking” and “enough to make one believe there’s one law for the rich and another for the poor.” Do you think this reflects the reality of how we treat doctors who engage in medicare fraud as opposed to people who commit welfare fraud? [context 2 doctors in BC: Mendes keeps 216,164 and Wong keeps 400,000 of overbilling]

(1) yes (2) no (3) depends/not as clear (4) D/K

### Multiple Responses

31. Presently the law allows for doctors who engage in medicare fraud to be prosecuted criminally, required to pay back money they obtained through the fraud, and to be disciplined by their College of Physicians and Surgeons. What are the benefits and drawbacks to these multiple responses to health care fraud?

31. Benefits

32. Drawbacks

### Sanctions

33. What do you think is the appropriate criminal sanction for health care fraud involving billing for \$100,000 in one year for services that were not provided?

34. Should health care professionals go to jail for such fraud?

(1) yes (2) no (3) depends/not as clear (4) D/K

35. What do you think would be the appropriate sanction following a disciplinary hearing by the College for such misconduct?

36. Should a doctor lose his or her licence for this type of fraud?

(1) yes (2) no (3) depends/not as clear (4) D/K

### Recommendations

37. What do you think could be done to reduce medicare fraud?

38. Should MSC be allowed to impose an administrative penalty such as fine in addition to requiring the doctor to repay the fraudulently obtained amount?

39. In the US whistle blowing legislation allows for the whistle blower to collect between 15-25% of the amount recovered. Would this be a useful way of reducing health care fraud in Canada?

(1) yes (2) no (3) depends/not as clear (4) D/K

40. Do you have anything you would like to add.

41. Is there anyone else you think I should talk to?

Thank you for your time.

Note on Interviews: Interviews were conducted with 10 individuals in British Columbia, by telephone. Four were background interviews because for one reason or another the interviewee did not want participate in a formal interview and four of the six who responded to the Interview Schedule were interviewed as a group. In retrospect, questions such as the ones in this Interview Schedule should be asked in face-to-face interviews but such an approach was

beyond the budget and time framework for this project. Having realized the difficulty of conducting these interviews by phone, I opted to read the submissions to the Cory Review in Ontario. The time I would have been attempting to line up interviews overlapped with public and private submissions to the Cory Review and I suspect that I would have had difficulty in convincing respondents to talk to me over the phone about OHIP fraud.

**Appendix C****Glossary**

AIC	Audit and Inspection Committee (BC)
ADR	Alternative Dispute Resolution
BCMA	British Columbia Medical Association
BIP	Billing Integrity Program (BC)
CIR	Completed Inspection Report (ONT)
CPSBC	College of Physicians and Surgeons of British Columbia
CPSO	College of Physicians and Surgeons of Ontario
EPC	Education and Prevention Committee (ONT)
MHCSAB	Medical and Health Care Services Appeal Board (BC)
MOHLTC	Ministry of Health and Long_Term Care (ONT)
MRC	Medical Review Committee (ONT)
MSC	Medical Services Commission (BC)
MSP	Medical Services Plan (BC)
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
OPP	Ontario Provincial Police
OPRP	OHIP Payment Review Program
POPC	Patterns of Practice Committee (BC)
SRO	Self-regulating organization

## Appendix D

### Biography of Author

Joan Brockman, B.A. (Sask.), M.A. (Alberta), LL.B. (Calgary), LL.M. (UBC), is a professor at the School of Criminology at Simon Fraser University and a non-practising member of the Law Societies of Alberta and British Columbia. She teaches courses on Crimes and Misconduct in the Professions, Corporate Financial Crimes and Misconduct, Criminal Procedure and Evidence, and Gender in the Courts and the Legal Profession. Her publications include: *Gender in the Legal Profession: Fitting or Breaking the Mould* (Vancouver: UBC Press, 2001) and (with V. Gordon Rose), *Canadian Criminal Procedure and Evidence for the Social Sciences* (Toronto: Nelson, 2001, 2<sup>nd</sup> edition). Articles on the professions include: "An Update on Self-Regulation in the Legal Profession (1989-2000): Funnel In and Funnel Out" (2004) 19(1) *Canadian Journal of Law and Society* 55; (with Caroline Murdoch) "Who's On First? Disciplinary Proceedings by Self-Regulating Professions and other Agencies for 'Criminal' Behaviour" (2001) 64(1) *Saskatchewan Law Review* 29; "A Cold-Blooded Effort to Bolster Up the Legal Profession:" The Battle Between Lawyers and Notaries in British Columbia, 1871-1930" (1999) 32(64) *Social History* 209; "Fortunate Enough to Obtain and Keep the Title of Profession:' Self-Regulating Organizations and the Enforcement of Professional Monopolies" (1998) 41(4) *Canadian Public Administration* 587; "Better to Enlist Their Support Than to Suffer Their Antagonism:" The Game of Monopoly Between Lawyers and Notaries in British Columbia, 1930-1981" (1997) 4(3) *International Journal of the Legal Profession* 197; and "The Use of Self-Regulation to Curb Discrimination and Sexual Harassment in the Legal Profession" (1997) 35(2) *Osgoode Hall Law Journal* 209.