UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

School of Health Care Sciences

Physiotherapists' Experiences of Forensic Audits by South African Medical Funding Schemes

Submitted in fulfilment of the requirements for the degree MPhysT

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Declaration of Originality

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Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.
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Dedication

To all medical professionals who have been audited and closed their practices or became ill. I understand what you have been through, and I know how hard you have worked to become a healthcare professional and a private practice physiotherapist with your patients' best interests at heart. I know your ethical principles and morals because they are mine and I did this study because "e*vil prevails when good men do nothing"* and "*if not me, now? Then who when?"* Therefore, I dedicate this dissertation to all those practitioners who have been audited, so that you may hear my voice and join me in protecting the professions we value dearly.

"You intended to harm me, but GOD intended it for good to accomplish what is now being done, the saving of many lives. So then, don't be afraid. I will provide for you and your children. And he reassured them and spoke kindly to them" Genesis 50:20-21 (Bible).

Acknowledgments

Supervisors

I primarily express my gratitude to Prof. Karien Mostert, my primary supervisor, for your continuous support during this study which contained such a vast array of complex concepts. The feedback provided throughout the study was informative and inspiring, allowing me to constantly grow. I value the time spent during our regular meeting times, as I know how valuable your spare time is to you. I appreciated your diligence, in ensuring only the best quality was produced.

To my co-supervisor, Prof. Werdie van Staden, I wish to express my gratitude to you for sharing your wealth of knowledge whilst conducting this study and developing the themes that told the story so succinctly. Furthermore, the regular meetings we had throughout the study and the strict application of bracketing protocols, nuances which I now understand, ensured that this study was dependable throughout.

Participants

Thank you to all the private-practice physiotherapy participants who came forward to share their experiences of forensic audits for this study. Many of you were scared and had deep emotional wounds, but still, you were prepared to altruistically put yourselves forward to protect other physiotherapists and the physiotherapy profession.

ATLAS.ti support

To Dr Charmain Williamson, thank you for your help with questions on ATLAS.ti.

To the interviewers who conducted the interviews of the participants and focus group discussions

To my friend, editor, and one of the interviewers, Mrs Fleur Simon, thank you for editing the language and improving the quality of my dissertation, ensuring that it was well-written. I learnt copious amounts through the process of editing the dissertation with you.

Dr Michelle Janse v Rensburg, thank you for your help in conducting the focus group discussion interviews, providing insight after the interviews, and helping me navigate the expectations of completing a research degree mentally, by knowing the many rounds of corrections that would need to take place before I had even started.

Mrs Marie Tshibangu, my previous lecturer, and friend, thank you for conducting the interviews of the participants in person by travelling from the Ivory Coast. Thank you for your ongoing support during the study.

To my impressive family:

Thank you to my brother Mr John Meyer for helping me with all IT related aspects, such as setting up my questionnaires on the Google Forms platform, finding said forms when I thought I had lost them and sending emails from Google platform to the participants. For setting up the Cisco Webex platform which recorded and automatically transcribed all the meetings, as well as setting up the meetings and getting all participants logged in and then sending me the recordings once completed. For formatting my dissertation so patiently, even though I messed up the format repeatedly, and inspiring me through his master's degree in engineering and a second degree in business.

To my brother Mr Rory Meyer, for helping create a computer program that reformatted the Cisco Webex transcripts to combine individual speech patterns under one time stamp, per speaker, and for inspiring me through his work towards completing a PhD in engineering and publishing articles.

To my sister, Mrs Gina Schroeder, for conducting the interviews with the participants and being an impressive business developer.

To my sister, Dr Carla Langley, for helping me with my sick animals and providing skin treatment powder, which she developed in her research on skin treatments, and inspiring me by completing her master's degree in equine veterinary science and continuing to do further research in her field.

To my mother Mrs Mary Meyer, for paying my varsity fees when I could not do so myself and supporting me through the dissertation by being an interviewee participant as an audited physiotherapist.

To my father Dr George Meyer, for supporting me when the times were particularly tough, helping me persevere in doing what is right because of the declaration that we live by, and for keeping abreast with the latest research.

To my son, Master Vincent Ritchie, thank you for listening to my stories during my research, accepting a reduction in time spent with me due to the study requirements, and picking yourself up after a traumatic impact event by changing your hobbies to ones that could fit within your temporary constraints.

Lastly, to my partner, Mr Colin Ritchie, thank you for always fixing the broken things around the house, such as the gate motor and providing solar panels so that I never know what it feels like to have load-shedding. Thank you for supporting me during the challenging time of my audit by helping me find evidence and sharing the information on Facebook. Finally, thank you for fixing my laptop when it crashed, and I was not able to work and printing all necessary books.

To my Favourite People's WhatsApp group:

Mrs Esther du Plessis, for your unwavering support and empathy when listening to my piano piece during the most challenging times in our lives while you were going through your trauma.

Mrs Jolinde Kruger, for emailing my messages and messaging my emails when I needed information back and forth and for ongoing support and advice.

Mrs Ingrid van Heerden, for your emotional support and long conversations, always cheering me on and showing interest in my dissertation.

Mrs Mandy Kotze, for your emotional support, exercise classes, and freezer food you made for me. I deeply appreciate your help when I was too drained to cook.

Ms Ule Aschenborn, for your unwavering emotional support and interest in the dissertation, the loan of your Rife machine, and your freezer cooking when I was too tired to cook.

Thank you to all my friends on the WhatsApp group who laughed, cried, and celebrated in the presentation of my findings, and supported me throughout my study by attending my monthly get-togethers, which is my form of stress management, always supporting me unwaveringly.

To my employees:

Esther, my domestic, for maintaining the house, washing, and ironing, cleaning cupboards, watering the plants, and ensuring the animals had water when my gardener was away, while always being friendly and kind. This gave me more time to focus on my dissertation and not have to worry about the chores of the house.

Martin, my gardener, for keeping my garden well-maintained, planting tortoise food, building enclosures for my animals, learning plants' names, providing a beautiful environment for me to relax in, and helping with my community gardens, another

form of stress management for me. You have added aesthetic beauty to my environment.

Abstract

Background

Forensic audits for billing irregularities have been conducted and researched in other countries, such as Australia, Canada, and the United States of America but not South Africa. Forensic auditors were reported to have been uncompromising in their belief that healthcare professionals were guilty of billing irregularities and had to be harshly penalised. The forensic investigators disregarded any valid reasons for irregular billing patterns, with resultant unfair audit outcomes. Small practices were forced to close their doors, leaving patients without medical support in small towns. Medical practitioners who presented their cases to a court of law were vindicated.

No other studies were found regarding billing irregularity audits conducted on medical professionals or physiotherapists in South Africa. The Health Professions Council of South Africa conducted fraud, waste, and abuse audits on reported physiotherapists which was documented, and a survey was conducted on medical schemes regarding their opinion of fraud, waste, and abuse amongst medical practitioners.

Aim

This study aimed to explore and describe physiotherapists' experiences of forensic audits conducted by medical funding scheme in South Africa, in the private sector.

Methods

An explorative, descriptive qualitative study was conducted with audited private-practice physiotherapists. Ethical clearance and informed consent was obtained. Participants were sampled through purposive and snowball methods. A total of 14 participants were interviewed, reaching saturation. Participants were interviewed using 11 individual interviews and three group discussions. Thirteen participants attended the group discussion in groups of five, six, and two participants, respectively. Four interviewers were used as a form of bracketing, and a semi-structured interview guide was provided to maintain rigor. Data were analysed using open coding and axial coding to describe the themes and subthemes. Findings were verified through member checking.

Findings

Six themes emerged from the rich data collected. The first five themes describe the experiences physiotherapists had, namely: 1) "unfairly persecuted, judged, and

penalised”; 2) “overpowered and oppressed”, 3) “naively entrapped between a rock and a hard place”, 4) “distressed with a knife over your head”, and 5) “detrimental and hurtful”. These five themes emphasised that participants experienced the audits as unfair. Participants further described the experience as being worse than a stressful impact event, which led to detrimental outcomes, such as attrition of physiotherapists through, amongst others, closure of practices, and emigration. The last theme, 6) “seeking remedies pre-emptively and preparedly”, was about how physiotherapists wanted to improve audit processes to reduce its negative impact on physiotherapists.

Conclusion

Physiotherapists experienced the forensic audits adversely and made recommendations on how these may be averted. Further studies may investigate how these audits may be tailored more constructively in curtailing adverse experiences of physiotherapists. If this study’s findings are corroborated, then solutions need to be implemented by stakeholders who have been tasked with protecting the profession.

Keywords

Conflicts of interest, billing irregularity audits, experiences, health insurance, health management organizations, health systems, negative impact, physiotherapists, private providers, qualitative research

List of Acronyms

Descriptions of abbreviations	Abbreviation/Acronym
Acknowledgement of debt	AOD
Artificial intelligence	AI
Board of Healthcare Funders	BHF
Compensation for Occupational Injuries and Diseases	COID
Competition Commission	CC
Continuing professional development	CPD
Council for Medical Schemes	CMS
Department of Finance	DOF
Department of Health	DoH
Electronic data interchange	EDI
Fraud, waste, and abuse	FWA
Health Funders Association of South Africa	HFA
Health Professions Council of South Africa	HPCSA
International Classification of Diseases Tenth Edition	ICD 10
Medical Schemes Act	MSA
National Executive Committee	NEC
National Health Insurance	NHI
National Health Price Reference List	NHPRL
Physiotherapy Association of South Africa	PASA
Post-Traumatic Stress Disorder	PTSD
Prescribed minimum benefit	PMB
Rand Value Units	RVUs
South African Police Service	SAPS
South African Society of Physiotherapy	SASP
Special Investigations Unit of South Africa	SIU

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1 Orientation to the Dissertation

In Australia, Canada, and the United States of America (USA), audits were conducted by forensic auditors who were convinced that medical practitioners had purposefully committed billing irregularities, without taking into consideration that the billing systems were complex and that the education on the use thereof was insufficient (Faux et al., 2021). In South Africa billing irregularity audits have also been conducted similarly. Faux et al. (2021) found that the forensic auditors were adamant that severe penalties were necessary to curb medical practitioners from committing billing irregularities, without taking any contrary evidence into consideration. These billing irregularity audits in Australia, Canada, and the USA, resulted in many medical practitioners, who did not have the financial means to defend themselves, closing their practices, with the outcome being that patients in small and rural areas did not have medical support (Faux et al., 2021). In Australia, some medical practices, became cash practices, requiring the patients to pay up-front and claim back from the medical funders, creating an out-of-pocket crisis (Faux et al., 2021).

In South Africa, certain medical funding schemes (also called medical aid, medical health schemes, medical schemes, or schemes) have been using forensic audits to facilitate the return of money for billing irregularities, similar to the audits described by Faux et al. (2021) (Beira & Gibbs, 2021a; Durrant, 2018; HPCSA Corporate Affairs, 2018a; SASP, 2021). Audits are initiated when a patient, a doctor, or a colleague complains or when the schemes' artificial intelligence (AI) indicates irregular billing patterns (Dean et al., 2019; Jogi, 2021, 2021; Joudaki et al., 2015). The forensic investigators from the medical schemes then focus on the evidence provided by AI, or the complaint, while disregarding all other evidence of innocence, from the medical practitioners or their lawyers, as was described by Faux et al. (2021).

In South Africa, two types of forensic audits exist, billing irregularities audits, or audits conducted for fraud, waste, and abuse (FWA). When healthcare professionals commit FWA, they knowingly submit false claims to access payments they would otherwise not have been entitled to (Broomberg, 2020; Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974). When healthcare practitioners claim treatments and services that are not medically necessary, this would be considered as over-servicing or over-charging of a patient, and this is

considered FWA. It is unethical, unconscionable, and contrary to best practice principles to commit FWA (Broomberg, 2020; Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974). Practitioners accused of FWA would be investigated and then penalised by the Health Professions Council of South Africa (HPCSA), whereby relevant gazetted penalties (set monetary amounts per offence) would be imposed on the guilty practitioner (Hoffmann & Nortjé, 2015; Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974).

During these audits, the medical funding schemes clearly stated and continued with the sentiment that medical professionals were not fraudulent, and that the audits were for billing irregularities, keeping the HPCSA from involvement (HPCSA, 2017c; HPCSA Corporate Affairs, 2018a). The medical schemes informed the physiotherapists that AI provided a list of physiotherapists who were considered to have outlier billing patterns, such as irregular coding, overlapping coding, excessive billing for a sole practitioner, or overuse of the same treatment modality code (Hearing, 2021a; Physio Focus, 2017c; Skeen, 2003). These outlier physiotherapists had to explain their understanding of the highlighted codes. When the physiotherapists provided the information, the medical schemes rejected all alternative explanations, maintaining an unwavering accusation of billing irregularities without a factual foundation from their side (Hearing, 2021b).

Billing irregularity audits have not been investigated or described in terms of the experiences thereof. The outcome of the study conducted by Faux et al. (2021), on billing irregularity audits of healthcare practitioners, indicated that healthcare practitioners may have experienced the audits as stressful. How South African physiotherapists experienced billing irregularity audits was unknown, as there had been no studies found regarding experiences of billing irregularity audits on physiotherapy healthcare professionals.

Studies have been done that observed the impact of distress, non-physical violence, burnout, and moral injury on physiotherapists and other healthcare professionals (Carpenter, 2010; Pearton & Van Staden, 2021; Van Fossen & Chang, 2022). The extent of hurt and damage was different as each person had unique knowledge, experiences, and ‘external’ events which influenced the situation (Bonsall, 2020; Pearton & Van Staden, 2021; The American Institution of Stress, 2019).

Healthcare professionals already experience emotional challenges in carrying out their work, as they are natural helpers with caring personalities, and their work comes with high responsibilities (Bonsall, 2020; Nituica et al., 2021; Williams-Plat, 2021). Healthcare professionals often see their work as their identity, because of the declaration taken at graduation which stipulates a specific code of conduct they follow, making healthcare such as physiotherapy, their profession and not a trade (Clark, 2018; Grobler & Van Staden, 2021).

In South Africa, 59% of healthcare professionals had burnout in 2021 (Grobler & Van Staden, 2021). Recent reasons could have included the Covid-19 pandemic while other reasons included having to deal with medical insurance companies who tried to control the practicing of medicine (Dean et al., 2019), reducing the prestige of the profession, and their ability to achieve ideal goals for their patients (Clark, 2018; Dean et al., 2019). Burnout could happen to physiotherapists because they are high performers striving for excellence (Cullen, Gulati and Kelly, 2020; Hummel et al., 2021).

When physiotherapists experience audits as being intentionally harmful, their performance at work may be compromised and they may experience a number of symptoms of hurt (Ames & Fiske, 2013). Depending on the severity of the symptoms, they may be categorised into compassion fatigue, burnout, and moral injury (Bonsall, 2020; Talbot & Dean, 2018).

With compassion fatigue, kind, caring, and empathetic practitioners experience detachment, are numb, feel guilty, and hopeless, have a loss of meaning and purpose in the work they do (Stoewen, 2020; Talbot & Dean, 2018). Furthermore, they may experience emotional outbursts, have irrational behaviour, loss of concentration, difficulty sleeping with troubled dreams, and traumatic memories surfacing from the past. Emotional triggers make one feel hurt, angry, helpless, and spiritually exhausted, which is seen as a lack of purpose and meaning in one's life (Bonsall, 2020; Talbot & Dean, 2018).

Burnout, one of the components of compassion fatigue, is associated with workplace stress where a person is exhausted physically, emotionally, and mentally, due to prolonged extensive stress (Cai et al., 2020; Cullen et al., 2020; Grobler & Van Staden, 2021; Hummel et al., 2021; Kontoangelos et al., 2020).

Moral injury occurs when people experience spiritual, emotional, and mental distress, after failing to prevent, having witnessed, or were exposed to acts in which deeply held moral beliefs, and expectations were violated. (Bonsall, 2020; Carpenter, 2010; Fleischmann & Lammers, 2020; Talbot & Dean, 2018).

1.1 Background

When medical practitioners were audited for billing irregularities in South Africa, the HPCSA may not get involved, as it is not for FWA allegations. During billing irregularity audits, the medical funding schemes have been given jurisdiction through the Medical Schemes Act (Medical Schemes Act No. 131 of 1998, 1998) to investigate complaints or allegations of irregular billing patterns. The scheme may implement the return of money through offset or through a debit order once an admission of debt (AOD) has been signed.

Certain South African medical funding schemes have been using forensic audits to investigate irregular billing patterns made by medical practitioners for services rendered, and penalties were imposed. Claims investigated were initially accepted by electronic data interchange (EDI) systems (Board of Healthcare Funders, 2019; Datamax, 1995), paid in full in terms of the medical schemes' rules, and according to the National Health Price Reference List (NHPRL) rules.

No billing irregularities have been reported by any of the systems set in place to prevent FWA or billing irregularities, but yet, one to three years later, claims that were paid in full according to the rules, were highlighted by AI as irregular, and were backdated as billing irregularities to be investigated through an audit by the medical schemes' investigators (Dean et al., 2019; Jogi, 2022; Liu et al., 2022). The various organisations and processes, such as billing, involved in running of a private medical practice, have been depicted in Table 1.1.

Table 1.1: Overview of institutions involved in the running of a physiotherapy private practice

Board of Healthcare Funders (BHF)	The BHF provides practice numbers, according to the Medical Schemes Act, allowing physiotherapists to claim from medical schemes on behalf of patients. The BHF updates and shares all personal information of practitioners with affiliated medical schemes, including the practitioner's audit status (Board of Healthcare Funders, 2019).
Competition Commission	The Competition Commission used to gazette the National Health Price Reference List (NHPRL) containing all treatment codes, known as tariff codes and code rules, which must be encoded into all electronic data interchange (EDI) systems which are used to send claims from the medical practitioners to the medical schemes. Medical practitioners and all medical schemes must follow the NHPRL, which was last gazetted in 2006 (National Health Price Reference List (NHPRL), 2006).
Council of Medical Schemes (CMS)	The CMS has authority over the medical schemes and is their governing body. It can provide resolution to audits and patient queries if all other avenues have been unsuccessful (Medical Schemes Act No. 131 of 1998, 1998).
Electronic data interchange (EDI)	Practitioners pay for a switch house to send all accounts, via EDI, to the medical schemes for payments. All rules and regulations of the NHPRL are embedded in the software to avoid FWA or billing irregularities. Claims are corrected and rejected in real-time (immediately) (Datamax, 1995).
Health Professions Council of South Africa (HPCSA)	The HPCSA has authority over physiotherapists as their governing body. It can provide binding peer reviews and conduct investigations for FWA but may not be involved for billing irregularity audits as this falls under the responsibilities of the medical schemes, according to the Medical Schemes Act (Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974). The HPCSA protects the patients.
Medical funding scheme	The medical schemes provide medical cover for contracted patients and are a non-profit organisation. Claims sent through via EDI, by the practitioners, are accepted for payment, or rejected in real-time. The medical schemes must follow the Medical Schemes Act (Medical Schemes Act No. 131 S57(4)(d): Communication Guidelines for

	Medical Schemes, 1998). Since 2006, new ungazetted codes which have been created to describe new techniques and interventions, are not accepted by all medical schemes (National Health Price Reference List (NHPRL), 2006).
Medical schemes administrators	The medical schemes administrators are a for-profit organisation which audits physiotherapists for billing irregularities and manages risk to the medical funding schemes. They must follow the Medical Schemes Act and Rules and Regulations and South African legislation (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010).
National Health Price Reference List (NHPRL)	The NHPRL is a list of treatment codes, known as tariff codes with their definitions and descriptions, which have been created by various stakeholders, such as the SASP, HPCSA, CMS, and medical schemes, and were gazetted by the Competition Commission as law. These rules must be encoded into the EDI systems and followed by all medical professionals, the medical schemes, the CMS, the BHF, and the HPCSA (National Health Price Reference List (NHPRL), 2006).
South African Society of Physiotherapy (SASP)	The SASP is a voluntary association that physiotherapists can join. They have custodianship and helped develop the NHPRL treatment codes (SASP, 2015b). The SASP can provide non-binding peer reviews and develop new codes which are ungazetted and not accepted by all medical schemes.

Patients in the South African private sector pay monthly contributions to a medical funding scheme of their choice, to provide payment for medical treatments. Patient treatments are documented in clinical notes by the practitioners and the relevant treatment codes are sent via medical billing software companies (switch houses) using EDI, to the medical funding schemes for processing and payment (Datamax, 1995). These schemes pay the medical bills of in-hospital and outpatient treatments according to the plan the member has selected.

Payments are often paid from the patient's medical savings which are kept by the medical schemes as a form of trust money which is returned to the member when they leave or given to their dependants if they die (*Genesis Medical Scheme vs Registrar of medical schemes and another [Case]*, 2017). When the savings are depleted, members must pay out-of-pocket for treatments. Notably, the members' savings used for payment of treatments, which have been queried during audits, and offset has been applied, or an AOD has been signed, should be returned to the patients' savings fund, which is not happening (*Genesis Medical Scheme vs Registrar of medical schemes and another [Case]*, 2017; Medical Schemes Act No. 131 S30(1)(e): Personal Medical Savings Accounts Circular, 2011). Most audited funds are paid from savings, making it the patients' money, not the medical schemes' money (*Genesis Medical Scheme vs Registrar of medical schemes and another [Case]*, 2017).

The Medical Schemes Act gives authority to medical schemes to conduct the entire audit processes, whereby money is returned to the medical schemes (Medical Schemes Act No. 131 of 1998, 1998). Physiotherapists were unaware of these audits for billing irregularities as they had been complying with the NHPRL regulations. Physiotherapists have claimed and billed for treatments using the NHPRL since 2006. At no point had physiotherapists been told that the NHPRL codes or the descriptions thereof had changed, simply because the codes have not changed as the competition commission has not gazetted new codes since 2006 (Board of Healthcare Funders, 2019).

The medical funding schemes are non-profit organisations which may have the scheme administrators as part of their organisation, in-house, or hire an external administrator to manage risk to the schemes (Carr, 2013; Discovery Health Medical Scheme, 2023; HPCSA Corporate Affairs, 2018a; Medical Schemes Act No. 131 S36(2): Standards for Authorisation of Auditors for Medical Schemes, 1998; Medical

Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). Conversely, the medical schemes administrators are for-profit financial service providers, which profile and manage risk to the medical schemes (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). These administrators conduct forensic audits on the healthcare practitioners and should follow the rules and Regulations set out by the Medical Schemes Act (Medical Schemes Act No. 131 S36(2): Standards for Authorisation of Auditors for Medical Schemes, 1998; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010).

The scheme administrators conduct audits on the practitioners (Medical Schemes Act No. 131 of 1998, 1998). Administrators may only audit for billing irregularities and not FWA allegations, as FWA is investigated and penalised by the HPCSA (Marais, 2006). When healthcare practitioners are accused of FWA, all audited amounts greater than R100 000 need to be reported to the HPCSA and the South African Police Services (SAPS) for investigation (HPCSA Corporate Affairs, 2017, 2018a). Once it has been established that FWA has occurred, a gazetted penalty is imposed for the specific offence (South African Department of Health (DoH) 1974a,1974b). The HPCSA is the only organisation with authority over the healthcare professionals who must adhere to their rules and regulations. It is compulsory for all healthcare professionals to be registered with the HPCSA as their governing/statutory body (Kwinda, 2016; Regulations Defining the Scope of the Profession of Physiotherapy, 1974).

Interestingly, cases of FWA under R100,000 are not necessarily left un-investigated. Instead, they may be overseen by other regulatory bodies, law enforcement agencies, or organisations with authority over financial crimes, such as the medical schemes administrators. Hoffman and Nortjé (2015) found that only 0.05% of physiotherapists in South Africa, investigated for FWA, by the HPCSA, over a seven-year period were guilty. The most negligible gazetted penalties imposed were for poor note-keeping which ranged from R1 000 to R3 000, of which only two physiotherapists were found guilty. The highest monetary penalty for misconduct was R10 000, and guilty parties were advised to attend relevant courses, be suspended, or be struck from the register (Hoffmann & Nortjé, 2015).

According to Marais (2006), only 17 cases out of the 238 of healthcare professionals that were reported to the SAPS for FWA, from a total of 28,000 cases, resulted in

convictions of FWA (Marais, 2006). Furthermore, the medical schemes' survey indicated that only 1 to 9% of all healthcare professionals investigated for FWA were guilty, but that in 93% of these audits, a settlement was negotiated (Marais, 2006). One of the largest medical funders recovered R14 702 204 from physiotherapists in 2018 through audits (Hudson, 2019; Smith, 2019), and a total of R555m from all healthcare professionals (Geldenhuys, 2019; Hudson, 2019; Smith, 2019). Marais reported that medical schemes lack confidence in the SAPS, justice system, and the HPCSA, and, therefore, do not notify the HPCSA, and SAPS of FWA allegations, because of the cost implication of investigations (Marais, 2006).

Similarly, Rispel, de Jager and Fonn (2016) reported that 63% of FWA in the South African health sector occurred in the public sector. The public sector gets funding from the government and not medical schemes. Of the public sector, 45% of the FWA were from provincial health departments and 31% were from funders. In the private sector, only 6.3% were classified as irregular billing which was not a form of FWA, but rather seen as non-compliance with rules and regulations, suggested due to ineffective management and varying levels of skill in using the billing programmes (Faux et al., 2021; Rispel et al., 2016). Healthcare professionals who were interviewed by Rispel (2016) expressed that the negative impact of the perception of corruption, real or imagined, resulted in mistrust of the healthcare system. Additionally, the healthcare workers expressed that corruption occurred due to power relations and political connectedness (Rispel et al., 2016).

Although audits should be done to prevent FWA, healthcare professionals undergoing billing irregularity audits should not be treated more harshly than FWA audits (Hearing, 2021b). Forcing physiotherapists to sign an AOD and paying the penalties to the medical funding schemes, far greater than those imposed by the HPCSA for FWA can be detrimental and may make physiotherapists feel like criminals. It would be more ethical for medical schemes to change the underlying issue of billing irregularities, by addressing the coding system that is outdated in collaboration with professional organisations, such as the SASP (Jago & Pfeffer, 2019).

The Council for Medical Schemes (CMS) and the Medical Schemes Act (MSA) are responsible for governing the medical schemes and their administrators (Medical Schemes Act No. 131 of 1998, 1998; Medical Schemes Act No. 131 S36(2): Standards for Authorisation of Auditors for Medical Schemes, 1998; Medical

Schemes Act No. 131 S57(4)(d): Communication Guidelines for Medical Schemes, 1998; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). If members have disputes regarding the administration of their monthly contributions, they are able to lodge a complaint at the CMS if no resolution has occurred through contacting the medical schemes. The CMS is responsible for investigating and giving ruling that all parties must adhere to (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010).

Physiotherapists are expected to first try and resolve all audit disputes using legal counsel, at their own cost, or support from the SASP. The SASP can and should protect their members but to a limited ability because the SASP is not a statutory body and, therefore, their ability to protect the professions is severely curtailed. Audited physiotherapists could further find resolutions on their own without support, but this is not advised.

Physiotherapists may contact the CMS as an external mediator, only when all avenues have been exhausted in finding a resolution to the audits (Competition Act 89 of 1998, 1998; Medical Schemes Act No. 131 S57(4)(d): Communication Guidelines for Medical Schemes, 1998; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). The CMS takes four months (120 days) to respond to complaints received by practitioners, however, a reference number must be provided within three days of the complaint being lodged (Medical Aid.com, 2023; Medical Schemes Act No. 131 of 1998, 1998). If the physiotherapist does not agree with the ruling, they may appeal through the CMS which may take longer than four months for the CMS to respond. It is advised to appeal through the whistleblowing CMS email portal to get a response (Medical Schemes Act No. 131 of 1998, 1998)

Compounding the situation is that treatment codes referred to as tariff codes, which form the NHPRL, were discussed and created by various stakeholders including the BHF, CMS, SASP, and medical funding schemes, and last updated in 2006 (Board of Healthcare Funders, 2019; National Health Price Reference List (NHPRL), 2006). These NHPRL codes and their rules were then gazetted by the Competition Commission and accepted as law, and all stakeholders had to change their EDI systems to include these codes and their rules (Medical Schemes Act No. 131 of 1998, 1998; National Health Price Reference List (NHPRL), 2006). The codes were

last gazetted in 2006 by the Competition Commission because it wanted to prevent physiotherapists implementing cohesive billing, to reduce over-charging of patients and FWA, thus exposing the physiotherapists to audits for irregular billing.

The NHPRL describes each code in terms of a rule and how the code is used during treatments (Board of Healthcare Funders, 2019; Medical Schemes Act No. 131 of 1998, 1998). The NHPRL codes and their rules were further integrated and coded into the various EDI systems. These EDI systems notifies physiotherapists immediately if the codes are incorrect, allowing them to correct the code and prevents billing irregularities (Datamax, 1995).

Practitioners must submit claims within 120 days for the claim to be accepted, processed, and paid by the medical scheme, according to Regulation 6 of the Medical Schemes Act, making this a contractual prescription (Medical Schemes Act No. 131 Regulation 6, 1998; Prescription Act 68 of 1969 Table: A Contractual Prescription, 1969; Shapiro Shaik Defries and Associates, 2019). The medical schemes reject all claims that are submitted by practitioners or patients as stale after a 120-day period. Stale claims mean that treatment claims will not be processed nor paid by the medical schemes, enforcing contractual prescription (Medical Schemes Act No. 131 Regulation 6, 1998).

Physiotherapists have used these NHPRL treatment codes (tariff codes) since 2006, in different combinations which result in repetition, particularly if they have a special interest practice, where they treat specific conditions, compared to the average physiotherapy practice which treats a variety of conditions. However, AI cannot distinguish between these subtle nuances in treatment and would, therefore, have highlighted the physiotherapist as having irregular billing patterns (Jogi, 2021; Van der Niet & Bleakley, 2021). The NHPRL codes that are used to depict the treatments conducted, are outdated . Furthermore, the medical schemes appear to have alternative understanding compared to the physiotherapists, which the medical schemes are abusing.

The medical schemes interpreted AI findings as evidence that the physiotherapists had used irregular or incorrect coding, suspicious coding, overlapping coding, significant changes in billing practices, over/under servicing, template billing, and overcharging (Physio Focus, 2017c; SASP, 2016; Skeen, 2003) and accused the physiotherapists of being outliers. Therefore, physiotherapists were audited when

they treated and billed for two conditions, used the same tariff codes when treating patients, and always used the rehabilitation code (Physio Focus, 2017a). These codes were accepted by EDI which have the NHPRL rules in place to avoid FWA or billing irregularities (Datamax, 1995; South African Medical Association (SAMA), 2021). The medical schemes paid the treatment codes in full, then queried the practice for billing irregularities three years after payment, exceeding the contractual period of 120 days. Medical schemes said that the physiotherapist had not used the correct codes and should never have been paid in the first place (Hearing, 2021b; Marais, 2006).

Physiotherapist private-practice owners were unaware that they had been using incorrect billing codes according to the medical funding schemes' understanding thereof. They had not been informed by the medical schemes that these codes were erroneous and no longer accepted by the scheme, as per the NHPRL. Physiotherapists must follow Regulation 6 when submitting claims which states that the scheme must notify the practitioner within 30 days if there is erroneous billing and afford them 60 days in which to rectify the billing (Medical Schemes Act No. 131 Regulation 6, 1998; Van der Walt, 2020). Instead, the medical schemes relied on Section 59.3(a) of the Medical Schemes Act, to recover amounts which have been paid *bona fide* (in good faith) to the physiotherapist which they were not entitled to, according to the medical schemes (Hearing, 2021b; Medical Schemes Act No. 131 of 1998, 1998; Van der Walt, 2020).

Although evidence-based treatments in the physiotherapy field have changed since 2006, and the SASP have provided some new tariff codes to stay current (SASP, 2014, 2015a, 2016), these have not been gazetted by the Competition Commission (Competition Act 89 of 1998, 1998; National Health Price Reference List (NHPRL), 2006). These ungazetted tariff codes are, therefore, not accepted by all medical schemes and, therefore, not paid (SASP, 2014, 2016). Physiotherapists, therefore, need to choose a tariff code closest to the treatment technique used when using new techniques, exposing them to audits for billing irregularities.

Medical funding schemes use AI to process information without human intervention in the decision-making process, to decide about products or services such as finding irregular billing patterns (Fritz et al., 2013; Jogi, 2022; Liu et al., 2022). The decision made by AI regarding irregular billing patterns, may be queried in the form of a forensic audit where forensic investigators are responsible for investigating the

allegations in order to find the truth (Auditing Professions Act Amendment, 2005; Auditing Professions Act No. 26 of 2005, 2005; Joudaki et al., 2015). In 2018, a medical scheme recovered R555 million from 93% of healthcare professionals who were audited for billing irregularities that AI highlighted for irregular billing patterns (Hudson, 2019; Marais, 2006).

Artificial intelligence is supposed to be used as a means of offering simple solutions to complex problems, but it can only function independently because it works in a closed operation where the rules that are coded into the algorithm will provide a specific output (Jogi, 2022; Joudaki et al., 2015; Van der Niet & Bleakley, 2021). It requires human feedback to investigate these allegations, alter the rules, and redesign the system to prevent bias, errors, and misuse of the technique (Joudaki et al., 2015). Artificial intelligence systems are intolerant to ambiguity and are authoritarian, bypassing ethical interactions and blurring the lines of who should be held accountable when injury or harm arises due to AI (Jogi, 2022). Human investigation is needed to prevent system errors, but the investigators must be unbiased, not incentivised and be willing to find the truth (Jogi, 2022; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010; Van der Niet & Bleakley, 2021).

When AI flags physiotherapists for an audit investigation, the auditors should investigate in an unbiased manner to come to the truth (Auditing Professions Act Amendment, 2005). However, physiotherapists' alternative understandings of codes, differing from those taught by the SASP, and repeated treatments found in special interest physiotherapy practices, were seen as irrelevant by the medical schemes and disregarded. Physiotherapists believed they were following the NHPRL rules, but alternative understandings were disregard during the audits, which prevented *Audi alteram partem* ("listen to the other side", or "let the other side be heard as well") (Sewell & Kettle, 2018).

It was observed by Jogi (2021) and Van der Niet and Beakley (2021) that the forensic investigators only believed the AI's data, thereby, indicating that forensic investigators were not open to finding the truth. This erroneous data reduced physiotherapists to data information, raising questions of ethical responsibility (Jogi, 2021; Van der Niet & Bleakley, 2021). As AI had created this erroneous data whereby there is only a true or false answer, the values that were needed to tell right from wrong were negated by the medical schemes, which could create fraud from the

scheme side (Joudaki et al., 2015; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010; Van der Niet & Bleakley, 2021).

During audits, people wanted human interaction where they felt heard, and where empathy was shown towards them (Rispel et al., 2016). Instead, the medical schemes managed the physiotherapists aggressively, even though they had made no billing mistakes according to the NHPRL rules, the acceptance of accounts via EDI, and payment of the accounts by the medical schemes. However, the medical schemes were adamant that the physiotherapists were wrong and did not waver from their accusations of guilt, in terms of billing irregularities (Crouth, 2021d). Regardless of the fact that medical schemes had never given prior warning to the physiotherapists of any such irregularities (Burks et al., 2022; Buthelezi, 2021; Datamax, 1995; Faux et al., 2021; Hudson, 2019).

According to Jogi (2022), and van der Niet and Bleakley (2021), specific rules should be included in the algorithms of AI, such as “do no harm,” which is where the best performance and worst mistakes of algorithms are identified, including algorithm errors and failure mode (Jogi, 2021; Van der Niet & Bleakley, 2021). Algorithm errors occur when its output is inaccurate, resulting in harm. Alternatively, algorithm error occurs when the output provided by the algorithm is correct, but the decision-making process of humans is flawed, resulting in harm.

Algorithm errors result in automation bias, human error, and intentional or unintentional misuse and harm (Deng et al., 2021; Jogi, 2021; Liu et al., 2022). Failure mode occurs when errors constantly occur because of repetition, resulting in overall harm because AI lacks human qualities such as empathy and compassion. AI should not be trusted to have all the answers which is why a fair audit process should take all perspectives into account to determine the truth of the matter, preventing harm and reducing bias (Auditing Professions Act Amendment, 2005; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010; Jogi, 2022; Joudaki et al., 2015; Van der Niet & Bleakley, 2021).

When doctors were audited for billing irregularities, the ramifications that they reported was that payments for new claims sent through via EDI were withheld, resulting in financial strain (Hearing, 2021b). The monies that were supposed to have been paid to the doctors for claims that had been submitted, were instead taken through offset or indirect payment to reduce the ‘debt’ amount the medical schemes

said was ‘owed’ to them (Hearing, 2021b; HPCSA Corporate Affairs, 2017, 2018a). Offset continued until the medical professional signed an AOD (Hearing, 2021b), which meant they admitted that they were guilty, wavered all legal rights, and were forced to pay back the amount via a debit order (Beira & Gibbs, 2021a; Hearing, 2021b).

According to the Section 59 Interim Report, the advocate considered offset to be a form of self-help by the medical funder and was unethical (Hearing, 2021a). Offset was referred to as a clawback provision as money which was paid to the medical professional three-years ago, was returned to the medical funder (Deng et al., 2021; Hearing, 2020; Kenton, 2021). If a medical professional bypassed offset by becoming a cash practice or refused to sign an AOD, the audit would have reached an impasse. The medical scheme keep the audit amount active until it has been paid back regardless of the length of time that has past ignoring prescription. (Hearing, 2021b).

The only recourse to have the audit resolved would be to contact the CMS for mediation. Most healthcare professionals who had been audited had not contacted the CMS, as they were not advised to do so or did not know they could turn to them for mediation. However, the CMS were in the headlines for fraud and corruption (Omarjee, 2019), while its name means they have the medical schemes’ best interests at heart (Medical Schemes Act No. 131 of 1998, 1998; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010).

In South Africa, physiotherapists turned to newspapers and Carte Blanche for support and reported that the medical schemes coerced physiotherapists during forensic audits into signing an AOD, even if the physiotherapists had legal representation and had allegedly ‘committed’ billing irregularities (Crouth, 2021a, 2021b, 2021c). The physiotherapists had never been informed of these ‘billing irregularities’ as should have been done, according to the Medical Schemes Acts’ Regulations (Medical Schemes Act No. 131 Regulation 6, 1998). If the physiotherapists had been informed, then these allegations could have easily been rectified.

Instead, in many cases, physiotherapists’ legal counsel advised physiotherapists to sign the AOD to make the problem of the audit ‘go away,’ to reduce stress, even though they were innocent (Crouth, 2021e; B. Kuschke, 2021). Once the

physiotherapist had signed the AOD, the medical schemes set up a monthly debit order to repay the penalty of 'debt' due to alleged 'billing irregularities,' which was set up for repayment over a three-year period (Prof. B. Kuschke, 2021; Van der Walt, 2020).

In the majority of cases, physiotherapists were re-audited for the same complaint once their debt repayments were completed (B. Kuschke, personal communication, 8 March 2021; Prof. B. Kuschke, 2021). Clawback through offset and a new debit order were again applied without contestation because the physiotherapists had previously signed an AOD and knew any efforts to negotiate with the medical scheme were fruitless, and would increase stress levels, resulting in further financial constraints, so they conceded immediately (Crouth, 2021e).

Physiotherapists had limited options for support when undergoing a billing irregularity audit. Their options included (1) informing the SASP which has no authority or positional power (2) paying for their own legal counsel, (3) having a colleague help them, or (4) doing it on their own. The peer reviews carried out by the SASP and legal counsel recommendations were rejected by the medical schemes (Ames & Fiske, 2013; Van Fossen & Chang, 2022).

South African Society of Physiotherapy peer reviews are non-binding because the SASP is a voluntary organisation, whereas peer reviews done by the HPCSA, the statutory body, are binding. However, the HPCSA could not and would not intervene at this juncture, as the audits are for billing irregularities and not for FWA. According to the Medical Schemes Act, Section 59 (3), the medical funding scheme has authority to conduct the audits without contestation (Medical Schemes Act No. 131 of 1998, 1998).

If workers, such as physiotherapists, were to experience a lack of support, especially from organisations that should be protecting them, it was reported that there would be an increased negative experience (Carpenter, 2010; Van Fossen & Chang, 2022). Organisational support was seen as better than familial support during stressful work-related situations where the organisations should have been protective (Carpenter, 2010; Van Fossen & Chang, 2022).

Lack of organisational support may have resulted in negative thoughts and attitudes towards the organisations by the physiotherapists (Van Fossen & Chang, 2022).

However, audited physiotherapists could have informed their colleagues and patients that they had been through an audit only if the colleagues themselves had undergone an audit, thereby making them allies with similar experiences. Physiotherapists' experiences of forensic audits have not been investigated. Therefore, the author does not know how the physiotherapists responded to the audits and what they did for support.

1.2 Problem Statement

South African medical funding schemes have been conducting forensic audits on private-practice physiotherapists increasingly since 2010 (Durrant, 2018). The majority of audited physiotherapists may have perceived the auditing process as unfair and biased, especially if the medical schemes' investigators forced the physiotherapists, who felt that they had provided sufficient evidence of innocence, to sign an AOD for alleged billing irregularities (Burks et al., 2022; Crouth, 2021d; Faux et al., 2021; Hearing, 2021a). Physiotherapists reached out to the SASP, HPCSA, Carte Blanche, newspapers, and radio stations, seeking help in determining whether forensic audits were conducted in a professional and ethical manner taking into consideration the principle of *Audi alteram partum* (Crouth, 2021d, 2021e; Prof. B. Kuschke, 2021). There is limited information regarding the processes and outcomes of forensic audits on physiotherapists.

As there is a limited number of physiotherapists servicing a large number of patients in South Africa (Narain & Mathye, 2023; Sainikova, 2022), it is important to prevent physiotherapists from leaving the profession. Most physiotherapists are unaware of what an audit is and are, therefore, exposed, and ill-prepared for an audit, leaving them vulnerable. There appears to be limited knowledge on audits conducted on physiotherapists, especially in South Africa.

Physiotherapists may lack knowledge of the Medical Schemes Act which includes laws and regulations such as, Regulation 6, Section 59.3(a), and regulations around the contractual prescriptions (Medical Schemes Act No. 131 of 1998, 1998; The Prescription Act No. 68 of 1969, 1969), which may pertain to forensic audits. Better knowledge may assist physiotherapists during forensic audits. Additionally, lack of knowledge of processes to follow in accessing support such as the CMS complaints and audit appeals, is often unknown and not followed. How are physiotherapists supported during forensic audits and is there comprehensive assistance and advocacy for physiotherapists navigating forensic audits?

If physiotherapists were to feel overpowered and oppressed, they may experience distress and other ramifications such as hurt and damage (Van Fossen & Chang 2022; Dean et al. 2019). When hurt and damage do feature, it is unknown what the hurt and damage would be about as external events may have occurred that could have impacted the physiotherapists' experience of the audit and the audits' processes. These experiences would need to be explored to come to an understanding of how physiotherapists experienced audits.

Furthermore, physiotherapists' experiences of forensic audits could be similar to other traumatic life events the participants had experienced previously, for example, death of a loved one, a car accident, COVID, and/or a serious medical diagnosis (Cohen et al., 2019; Peter, 2017; Wilson et al., 2020). Can the experience of forensic audits be compared to an external traumatic life event among physiotherapists?

In South Africa, the realm of forensic audits concerning healthcare professionals, particularly physiotherapists, remains unexplored. The lack of investigation into this domain prompted this study to initiate a comprehensive understanding. Therefore, the problem statements encapsulate the ambiguity surrounding the experiences of forensic audits conducted on physiotherapists.

1.3 Aim and Objectives

The aim of the study was to explore and describe private-practice physiotherapists' experiences of forensic audits by South African medical funding schemes, since 2010.

Objectives

The objectives of the study were to describe the experiences of physiotherapists who had undergone a forensic audits, (using interviews and Focus Group Discussion (FGDs) to come to the answers in terms of:

a) the processes of the forensic audits,
b) the impact, outcomes, and implications the forensic audit had on the professional standing and practice of physiotherapists,
c) the facilitators and barriers encountered during the process,
d) the support mechanisms available,
e) external traumatic life events,
f) the perceptions and experiences of physiotherapists subjected to forensic audits,

g) and physiotherapists' understanding and responses to these procedures.

1.4 Conceptual Framework

Conceptual frameworks emerge from personal experiences, research, and reflections on the phenomenon being investigated (Leshem & Trafford, 2007). This conceptual framework in 1-1 of the 'physiotherapists' experiences' presents possible concepts that were investigated.

This conceptual framework was used to guide the research and created the interview guide. The interview guide asked open-ended questions which were focused on exploring the experiences participants had of the processes, the resultant outcomes and the hurt and damage, due to the audits (Böhm, 2004). The relationships between the concepts in the framework is depicted in Figure 1-1 and the key concepts are described in Table 1.1. Further descriptions of concepts that pertain to this study can be found in the glossary Appendix A and Appendix B, which described the different laws and legal concepts that may be considered during forensic audits. The title concepts will be discussed in Chapter 2.

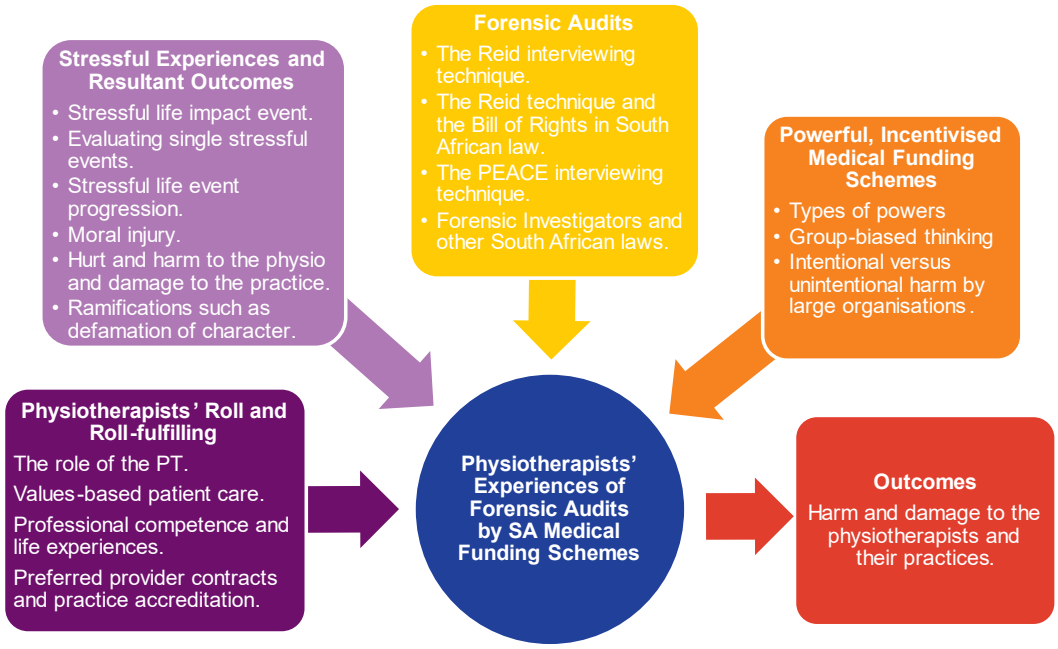

Figure 1-1: Conceptual framework that guided the study

1.5 Key Concepts

Table 1.1: Descriptions of key concepts of this study

Key concepts	Definitions and descriptions concerning this study
Physiotherapists	People who are usually caring individuals who have gone into the profession to help people. Physiotherapists have first-line practitioner status or autonomy in South Africa (SA Medical and Dental Council, 1974; Solvang and Fougner, 2016). They are capable of making a diagnosis and being able to treat patients. The physiotherapist must refer to the applicable healthcare professional if the problem is outside their scope of practice. Physiotherapists are trained to treat and manage a wide variety of conditions, including cardio-vascular, chronic pain, conditions treated in an intensive care unit (ICU), geriatrics, general rehabilitation, neurology, obstetrics, orthopaedics, paediatrics, respiratory, and sports medicine. Physiotherapists may develop a special interest in one of these fields resulting in a special interest practice, deemed outliers. Physiotherapists may refer patients for X-rays, provide sick notes, and refer to a specialist (Regulations Defining the Scope of the Profession of Physiotherapy, 1974). In this study, physiotherapists are private practice owners who often have special interest practices and have been audited by the medical funding scheme for billing irregularities.
Experiences	Experiences are when people experience positive (eustress) or negative (distress) reactions to events that take part in their lives. These experiences can be used to find similarities and differences to describe events that have occurred in peoples' lives. These experiences are active and passive, holistic, and complex, comprising various aspects (Dieumegard et al., 2021). In this study, by using experiences to compare audit events, one can describe what had happened to an individual person or group of people, to provide a descriptive narrative of their experiences, coming to the truth of the experiences (Daher et al., 2017; Dieumegard et al., 2021).

Forensic audits	Forensic audits cover a wide range of investigative activities and are conducted to prosecute people, in this study physiotherapists, for billing irregularities, fraud, embezzlement, or other financial crimes (Tardi, 2021). In this study, a forensic audit refers to investigations by medical funding schemes on physiotherapists. AI identifies billing patterns as irregular, and the people investigating these irregular patterns deem them as billing irregularities. (Jogi, 2022; Joudaki et al., 2015; Van der Niet & Bleakley, 2021). The audits are backdated for three years, negating the Contractual Prescription Act (Shapiro Shaik Defries and Associates, 2019; The Prescription Act No. 68 of 1969, 1969).
Medical Funding Scheme (medical aid/medical health Scheme/medical funder/medical schemes/scheme)	The Scheme refers to a medical aid which is registered with the Council for Medical Schemes as a non-profit organisation which provides medical funding to its paying members (Discovery Health Medical Scheme, 2023). It is the scheme's responsibility to pay for the patient's managed care services according to their health plan. Furthermore, it is the scheme's responsibility to provide relevant information to a contracted third party, such as a healthcare provider, who requires this information to provide healthcare services, according to the members' health plan (Discovery Health Medical schemes 2023).
A ramification	When events are complex or unwelcome, the resultant negative outcome or consequence of the event is referred to as a ramification. (Oxford English Dictionary, 2022b). These unwelcome ramifications may be of an emotional, financial, physical, or social nature. An example of a ramification is when a medical schemes implements offset or indirect payment, whereby the physiotherapist will not receive money for treatments provided for patients belonging to that specific medical schemes. Offset causes financial ramifications if the practice mostly sees patients from this particular scheme. Physiotherapists paying for legal service, to prove their innocence, may cause further ramifications. How the physiotherapists were treated by the medical funder may have resulted in various ramifications or negative outcomes or

	consequences and was explored during focus group discussions and one-on-one interviews.
Hurt	Hurt is an emotional or psychological hurt resulting in unhappiness, offense and suffering due to humiliation or a bad experience (Miriam Webster Dictionary, 2022; Oxford English Dictionary, 2022a). If physiotherapists were to report feeling distress, shame, or anxiety, or experience being insulted, ignored, or rejected during the audit, by the medical schemes, then this could be considered hurtful to the physiotherapists.
Harm	Harm is a deliberate injury to someone (Miriam Webster Dictionary, 2022). An example is when participants would have reported that they closed their practices, emigrated, or developed illnesses as a direct result of the processes the audits followed, resulting in detriment to their day-to-day living and functioning, and detriment to their practices. Harm can further be seen if the audits were to impact the physiotherapy profession at large, through attrition.

1.6 Philosophical Assumptions

Researchers have assumptions about 1) ontology; 2) epistemology, and 3) methodology:

1.6.1 Ontological Assumptions

Ontology deals with questions about the nature of reality; what exists and what the fundamental nature of that existence is. In this study, the stance of constructivism was taken, whereby it was assumed that reality is socially constructed, and that individuals' interpretations of reality would vary. The aim of the study was to uncover and describe the reality of the experiences of physiotherapists who had undergone a forensic audit by medical funding schemes. This study focused on exploring and understanding the participants' subjective constructions of the reality of their experiences (Brown, 2020).

Indeed, the phenomenon under investigation, i.e., physiotherapists' experiences of forensic audits by medical funding schemes, for billing irregularities, was regarded as subjective and contextual. The context included all private-practice physiotherapists in South Africa who had undergone an audit, who were willing to share their subjective experiences thereof. The researcher, therefore, recognised that the participants' experiences of the audits may have varied due to, amongst others, different backgrounds (Brown, 2020; Dörfler & Stierand, 2021).

1.6.2 Epistemological Assumptions

Epistemological assumption are about the means through which knowledge is acquired and validated (Brown, 2020). In this study, it was assumed that knowledge was context dependent, and socially constructed. The researcher aimed to understand the subjective meaning participants attached to their experiences.

The researcher has been involved in audits since 2020. This unique perspective enabled the researcher a richer understanding of the participants' experiences that emerged during the interviews and focus group discussion. Due to preconceived biases, and values, ethics of the study methods had to be strictly implemented to reduce these biases and preconceptions (Brown, 2020; Manzano, 2018).

One of the techniques used to reduce bias is known as bracketing. Bracketing was applied through reflecting on how beliefs could influence the research, using a reflective diary. Other techniques were using four different interviewers to conduct the interviews, and using a semi-structured interview guide (Dörfler & Stierand, 2021). Furthermore, and a data trail was

kept. Findings were shaped by the perspectives of the researcher, and the supervisors (Manzano, 2018). Additionally, findings were sent back to the participants for member checking.

When the researcher is intrinsically involved in a research topic, a unique access and insider insights into the subject matter occurs (Yoo & Suh, 2021). An insider's perspective can extract trustworthy information using introspection, previous knowledge, and own experiences to understand what the participants shared (Bahari, 2010). Often the insider would have a deeper understanding of the processes, challenges, and nuances the physiotherapists' experienced during the audits. This deeper understanding of the researcher, could be an advantage when designing the research, during data collection, and data analysis, as the researcher was able to interpret the social setting, create meaning and obtain insights into these experiences the participants described, as long as bracketing was applied (Yoo & Suh, 2021). The researcher, therefore, took an insider position when interpreting what the participants voiced, from their perspectives, within their context.

1.6.3 Methodological Assumptions

Trustworthiness and rigour in a qualitative study is achieved through creating credibility, dependability, confirmability, and transferability (Collier-Reed, Ingerman & Berglund 2009) to provide meaningful and useful results (Nowell et al., 2017). During qualitative studies, trustworthiness and rigour must take part during the entire process for the results to be credible (Collier-Reed, Ingerman and Berglund, 2009; Nowell et al., 2017).

In this study, the focus was on understanding the subjective experiences, emotions, and interpretations surrounding these audits through interactively engaging participants during online interviews. The findings were revealed as the research progressed (McGill, 2021). Focus group discussions and one-on-one interviews were used in this study to delve into the experiences of physiotherapists who underwent an audit.

Methodological assumptions are about the relevance of the methods used to conduct a study to gain truthful knowledge about the topic. The researcher assumed that semi-structured interviews and FGDs would be appropriate to gain knowledge about the experiences of physiotherapists, during forensic audits conducted by medical funding schemes (Grad Coach, 2021). Open-ended questions, provided in the interview guide (Appendix F), allowed for in-depth exploration and the collection of rich, context-dependant data, as participants were encouraged to share their perspectives and experiences without interruptions.

The interviews were automatically recorded and transcribed using the Cisco Webex online platform, an advanced recording system. These recordings were checked for authenticity, as medical jargon was not transcribed correctly. These transcripts were then analysed to developed themes and subthemes allowing for a clear description of the physiotherapy participants' experiences (Dieumegard et al., 2021; Manzano, 2018; McGill, 2021).

These themes were then discussed comparing it to existing literature to provide a better understanding as to how physiotherapists experienced forensic audits. These themes were then checked through member-checking to corroborate the findings. These methods provided trusted evidence on how physiotherapists experienced forensic audits conducted by the medical funding schemes (Grad Coach, 2021; Manzano, 2018).

Credibility is the 'truth' value according to Lincoln and Guba (1994), where the researcher can portray the experiences of the participant physiotherapists accurately. There had been prolonged engagement by the researcher who understood the experiences. Although this is seen as bias in quantitative research, it is sought after in qualitative research and termed bracketing (Dörfler & Stierand, 2021). It was the researcher's responsibility to provide enough detail for the reader to be able to make their own conclusion and judge whether the information given in interviews and FGDs was correctly documented and analysed. Member checking was incorporated to improve this.

Credibility is incorporated through a variety of ways:

1. Prolonged engagement by the researcher is championed in qualitative research (Dörfler & Stierand, 2021). The researcher had been actively engaged in the field of forensic audits since 2020.
2. Member checking: The codes, categories, and themes were returned to the participant physiotherapists to check if the researcher's interpretation was accurate according to what they meant to say (Dörfler & Stierand, 2021; Nowell, Norris, et al., 2017).
3. Triangulation: Triangulation was reached in terms of resources and methods: Through interviews, FGDs, member checking, and using different interviewers.

Bracketing was accomplished through documenting all meetings, discussions, thoughts, and ideas in a reflective journal throughout the study (Tufford & Newman, 2012). Bracketing was further enhanced by using four external interviewers to conduct the interviews. These interviewers came from diverse backgrounds and were not involved in forensic audits in any way. The first interviewer had a background in human resources and was well-versed with

the labour law. The second interviewer was a physiotherapy private-practice owner, who had her practice in another African country. The third interviewer was a doctor in occupational therapist who is knowledgeable in qualitative research, and the fourth interviewer was a chemical engineer.

The first interviewer conducted three individual interviews. The second interviewer conducted three individual interviews. The third interviewer conducted one individual interview and two FGDs. The fourth interviewer conducted three individual interviews, and the researcher conducted one FGD and was present in all the other interviews. There was a total of fourteen interviews. Eleven individual interviews and three FGDs, interviewing a total of 14 physiotherapists. The first FGD had five participant physiotherapists. The second FGD had six participant physiotherapists and the third FGD had two participant physiotherapists.

Dependability refers to how well the study is documented and whether someone else will be able to repeat the study again or follow the train of thought. Credibility cannot take place if dependability is not present and as such the same methods of obtaining credibility is used to obtain dependability (Collier-Reed et al., 2009; Nowell, Morris, et al., 2017). In addition, a reflective diary documenting different thoughts, ideas, and the progression of the study was kept.

Confirmability refers to whether the researcher's interpretation and the actual evidence are able to be confirmed as being accurate (Collier-Reed et al., 2009; Nowell, Morris, et al., 2017). The findings was compared to other literature sources of similar findings as a literature control (Nowell, Morris, et al., 2017).

Transferability reflects the generalisability of the research findings and how the study can be incorporated in other studies (Collier-Reed et al., 2009; Nowell, Morris, et al., 2017). Representative sampling is not an aim in qualitative research, therefore, the characteristics and context was described in a rich way, so that readers can evaluate whether the findings would apply to their contexts.

1.7 Delineation

This study did not investigate whether the actions of medical funders were legal or not, it only highlighted the processes of the forensic audits as they had been experienced by the participants. This qualitative study determined the impact these audits had on the individual participants, as they experienced it subjectively, and, amongst others, explored how the participants experienced meetings held with the medical schemes, the use of AI, and the

outcomes of the audit in terms of ramifications, hurt and detriment. The study did not measure any of these experiences quantitively but the findings from this study may be used to inform studies of that nature in the future.

1.8 Conclusion

In this chapter, other studies were mentioned that had conducted and described FWA within the physiotherapy sector in South Africa, where the penalties and number of FWA cases were divulged. Additionally, studies were discussed which described the negative outcomes, such as attrition and the out-of-pocket crisis, due to forensic audits which were conducted in Australia, Canada, and the United States of America, for billing irregularities, but these studies did not include South Africa.

As no studies were found that described physiotherapists' experiences of forensic audits conducted by medical funding schemes in South Africa, this study was created to explore and describe this gap within the literature. Furthermore, as medical professionals and physiotherapists have tried to reach out to various sources of support, to no avail, it became imperative that further research on the topic be conducted to provide literature which could be used to support them.

1.9 Outline of the Study

The study's conceptual framework guides the literature review in Chapter 2 that elaborates on the different concepts involved in "physiotherapists' experiences of forensic audits by medical funding schemes". Chapter 3 contains a manuscript with the methodology and findings, and Chapter 4 concludes the dissertation with the key findings, practical implications, and recommendations for future research.

2 Literature review

2.1 Introduction

The literature review of the dissertation looks at the different key concepts captured in the title, ‘Physiotherapists’ experiences of forensic audits by South African medical funding schemes,’ while addressing the objectives in an integrated way. As seen in Figure 1-1, the first aspect involves what it means to be a physiotherapist. This concept ‘Physiotherapists’, which is depicted in the dark purple block, is divided into: The role of the physiotherapist, treating patients with values-based patient care, professional competence and life experiences, and the use of preferred provider contracts in practices which require practice accreditation.

Next, ‘stressful experiences and resultant outcomes’, are discussed, comprising what experiences are in terms of a stressful impact event, evaluating a single stressful life event, how stressful life events progress, moral injury, how events may lead to hurt and harm to the physiotherapist and damage to their practice, and the ramifications such as defamation of character. The third concept ‘forensic audits’, includes forensic investigation techniques used during forensic audits, which may influence the experiences of physiotherapists. These investigation techniques are compared to the stipulations of various South African laws. The fourth concept, ‘powerful, incentivised, medical funding schemes,’ describes the types of powers, group-biased thinking, and intentional versus unintentional harm done could be found in large organisations, that may influence the experiences of physiotherapists and impact them personally and in their practices. The last concept, ‘outcome’, will be discussed throughout the various concepts depicted in the key concepts.

2.2 Physiotherapists

When students apply to study physiotherapy, they do so because they want to help others in medical need, due to their caring nature (Grobler & Van Staden, 2021). Physiotherapy as a scope of practice, is a unique field in which physiotherapists are allowed to work. Conditions managed within their scope of practice vary from very acute patients in intensive care units (ICU), to sports injuries of top sports athletes. Physiotherapists help patients maximise their quality of life and movement by encompassing emotional, physical, psychological, and social well-being (Regulations Defining the Scope of the Profession of Physiotherapy, 1974; Sainikova, 2022; Solvang & Fougner, 2016; World Congress Physiotherapy, 2019).

The scope of practice is ever-changing to remain aligned with the current health epidemiological profiles of the country, while ensuring physiotherapists are self-efficient and stay current through continued education (World Congress Physiotherapy, 2019). The

various roles, tasks, and expectations that encompass a physiotherapist's service offerings, is depicted in Figure 2-1 and discussed in the following sections.

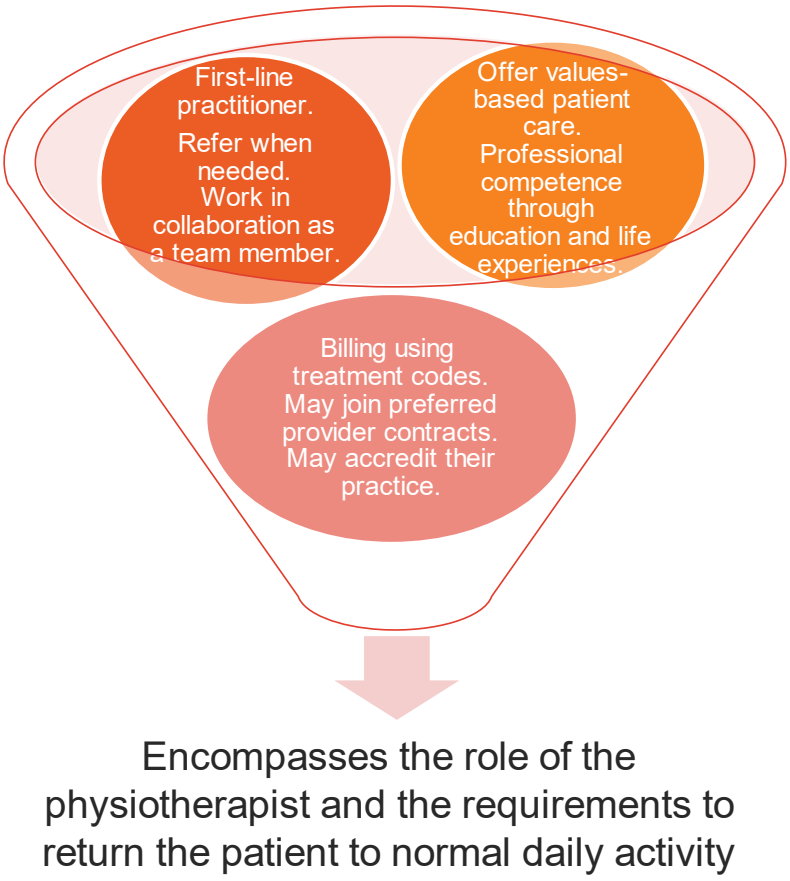

Figure 2-1 Summary of the role of the physiotherapist (Self-created)

2.2.1 The Role of a Physiotherapist and Professional Competence

Physiotherapists have autonomy in diagnosing and treating patients in South Africa, also known as first-line practitioner status, as is found in other countries such as the USA, Canada, Australia, and Denmark (Goodwin et al., 2021; Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974; Milway et al., 2022; Van Vuuren, 2022). Therefore, in South Africa physiotherapists can be, and often are the first point of contact for patients, instead of a doctor (Budtz et al., 2021; Regulations Defining the Scope of the Profession of Physiotherapy, 1974; Sainikova, 2022). However, certain medical funding schemes in South Africa do not recognise this status and request a referral from a doctor in order to pay for treatments. In other countries like England, patients also have to be referred by a doctor for physiotherapy treatments, as they are not seen as first-line practitioners, placing more pressure on their health system (Goodwin et al., 2021).

Physiotherapists as first contact practitioners, may reduce unnecessary costly interventions, use of medication, and potential addiction of pain medication, because they are the first point

of contact instead of a last resort (Cook et al., 2021; Goodwin et al., 2021; Lentz et al., 2019). Physiotherapists are competent in making an accurate diagnosis of various conditions, while being able to treat these conditions (Budtz et al., 2021). Physiotherapists work in collaboration with other medical professionals as a team member in hospital settings, providing valuable input regarding treatments for patients under the admitting doctors care (Sainikova, 2022). Patients are at no greater risk of a missed diagnosis when being evaluated by a physiotherapist than by other providers (Lentz et al., 2019).

Physiotherapists need to be in a state of good mental health for the challenges and responsibilities that come with the status of an autonomous practitioner. A physiotherapist with advanced experience and knowledge knows when to refer a patient, because a lack and/or inappropriate prognostic skills may result in the absence of escalation of patient care (Lentz et al., 2019). The decision to treat a patient must be dependent on the probability of the patient responding to treatment. Referral to a relevant specialist/s must occur when there is the risk of a poor outcome via physiotherapy alone (Lentz et al., 2019; Nwafor & Nwafor, 2016).

As first-line practitioners, physiotherapists may refer patients for X-rays and provide sick notes (Sainikova, 2022). However, certain medical schemes, again, do not pay for X-rays that have been requested by a physiotherapist, insisting that a doctor must refer, disregarding first-line practitioner status of physiotherapists. When the medical schemes disregard this important status, they overstep the boundaries of the legal framework. This blatant disrespect would influence physiotherapists during participation in a forensic audit conducted by the medical scheme.

As autonomous practitioners, physiotherapists further develop professional competence which is the ability to communicate effectively, while drawing on knowledge, experiences, emotions, and values, to apply clinical reasoning and technical skills to treat a patient optimally (Anttila et al., 2018; Kurunsaari et al., 2022; Scodras et al., 2022a). Competence can be taught, which is seen at undergraduate level, where all necessary skills are incorporated in the curriculum, empowering novice students to graduate with first-line practitioner status (Kurunsaari et al., 2022; Scodras et al., 2022a).

Continued professional development (CPD) combined with workplace-based learning is continued throughout the physiotherapists' career, improving competence and professionalism as depicted in Figure 2-2 Continued professional development courses are a prerequisite for all physiotherapists to remain registered as a practitioner with the HPCSA, which guarantees that physiotherapists remain current with evidence-based practice (Health Professions Act, No. 56 of 1974, 1974).

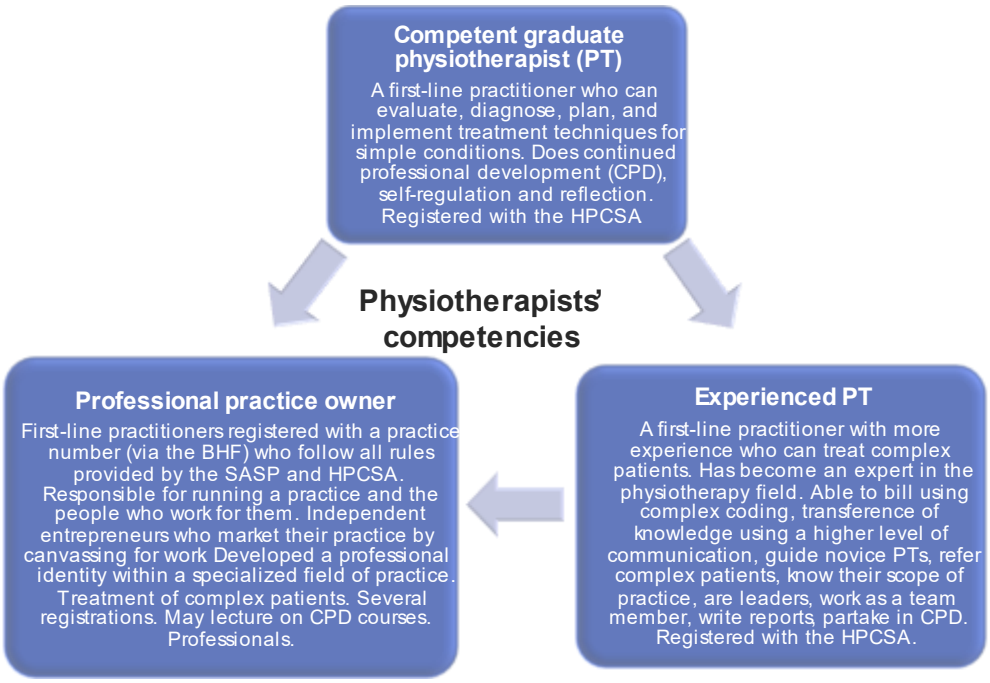

Figure 2-2 Progression of competent graduate physiotherapists to becoming a professional practice owner (Self-created using the descriptions from Kurunsaari et al. (2022), Van den Heuvel et al. (2021), Lentz et al. (2019), and Solvan and Fougner (2016))

Competent graduate physiotherapists usually start their career by working either in the private sector for private-practice owners, or in the government sector. Competent graduates are able to evaluate, diagnose, and treat simple conditions independently, but receive guidance from more experienced physiotherapists when needed (Kurunsaari et al., 2022). The practice owners teach them how to bill for what they have treated and guide them in treating more complex and challenging patients.

Once competent graduate physiotherapists have worked in a group practice for a few years, they are easily able to treat more complex patients, know how to bill for the treatments, and can transfer their knowledge through improved communication skills (Scodras et al., 2022a; White Paper, 2016). More senior physiotherapists then become the next leaders who would guide new competent graduate physiotherapists and can work effectively in a team. Experienced physiotherapists can write detailed medical reports on patients they have evaluated and provide referral letters to the appropriate colleagues (Kurunsaari et al., 2022).

Experienced physiotherapist may elect to move away from a group set-up, and open their own private practice, becoming a private-practice owner. Physiotherapy practices can be a sole proprietor practice, where there is only one physiotherapist, who may elect to use locums for weekend work, public holidays, or maternity leave, as per the rules. Alternatively,

they may open a group practice where there are one or more physiotherapy owners working with a large group of physiotherapy employees.

Solo practice physiotherapists would have to market themselves and visit surrounding doctors to canvas for work or depend on word-of-mouth referrals. The success of a physiotherapy practice is dependent on the physiotherapists' reputation, which is developed over many years. Private-practice physiotherapists need to be the most competent as they need to hone skills to be recognised and acknowledged within their field.

Private-practice physiotherapists have to be competent to be successful. Competence may be affected through experiences which occur from the moment a person is born. Competence through experiences combines several sources of education, from formal courses and training, to life experiences and events (intrinsic learning) (Anttila et al., 2018; Kurunsaari et al., 2022). *"*Five years from today, you will be the same person that you are today, except for the books you read and the people you meet." (Quote from Charlie "Tremendous" Jones).

These experiences contribute to the development of morals and beliefs and steer individuals in a direction where a person may choose a career path in physiotherapy. During the undergraduate degree, competence is developed through the course curriculum, while the students' previous experiences', may lead the student to choose a particular field of physiotherapy to practice in (Anttila et al., 2018; Kurunsaari et al., 2022). Competence is then measured when good outcomes are achieved in patient care, when evidence-based practice combined with clinical experience, is used in the treatments (Anttila et al., 2018; Cook et al., 2021; Solvang & Fougner, 2016).

Physiotherapists can work in a hospital setting, treating in-hospital patients, while working in collaboration with a referring specialist doctor. Physiotherapists may work in an out-patient set up (not in the hospital), where they do not necessarily have a referring doctor. The physiotherapy governing rules encompass how to market themselves ethically, how to set up a practice, who a physiotherapist can work with and for, and who physiotherapists may hire. These rules are meant to protect the physiotherapists and their patients from any hurt and harm that could occur (Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974; Public Service Act 103, 1994).

Furthermore, the rules require a private practice to pay for an EDI system that sends off accounts to the medical schemes for payment, while following the rules of the NHPRL, to ensure ethical billing. Practice owners have to register with the BHF to obtain a practice number which allows them to claim from the medical schemes directly, and practice as a private practitioner, as per the Medical Scheme Act (Medical Schemes Act No. 131 of 1998,

1998). All of these regulations are intended to avoid fraud, waste, and abuse, and billing irregularities.

Not only are physiotherapists expected to effectively treat patients, have all the skills expected of both the novice and the experienced physiotherapist, but they are also expected to know how to run a prosperous practice while following all the rules and regulations set out by the governing body and other organisations (Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974). Additionally, physiotherapists may have both in-patient and out-patient practices, collaborating with a specialist doctor, and therefore, become a special interest practice treating specific conditions.

However, physiotherapists are not trained in business management skills, and the administration of the practice is often left to other organisations or secretaries which may result in the potential for hurt and harm. It is these professional, competent, expert, private physiotherapy practice owners who have based their entire practice on their professional identity, who have been audited. The audit experiences may shape their future where different outcomes may occur compared to the career path that they were following (Kurunsaari et al., 2022).

2.2.2 Values-Based Patient Care

The four domains to value/s-based patient care include cost-effectiveness, integrated care, patient-centred care, and patient outcomes as depicted in Figure 2-3. Costs were a historical measure of value-based care, but did not take into consideration all the elements depicted in Figure 2.3, these being, the care provided, the patients' experience, the patient engagement and the physiotherapists' knowledge and experience (Cook et al., 2021).

Previously, value-based patient care only focused on costs and outcomes (Cook et al., 2021; Lentz et al., 2019). When looking at the 'cost-effectiveness' domain of the value-based care model, it must be realised that value-based patient care is not just about the money. The needs and desires of the patient, and the experiences of the physiotherapists need to be included (Cook et al., 2021; Lentz et al., 2019). Despite millions spent in research, outcomes involving musculoskeletal care continue to decline, which is why it was recommended by Cook et al. (2021), that physiotherapists who manage individuals with musculoskeletal related pain disorders, should adopt the values-based care model as it comprises four values and not just one.

Forensic investigators may have investigated treatments and deemed them as over-servicing, or over-using of codes, or incorrect billing (Faux et al., 2021). By requesting clinical notes forensic investigators would be able to clarify these discrepancies. For example, if the time of the rehabilitation as per the code was not reflected in the notes,

despite the fact that the code itself, according to the NHPRL, clearly indicates that the treatment must be provided for 30 minutes, then this may not be sufficient for the forensic investigators (National Health Price Reference List (NHPRL), 2006). Clinical notes may, therefore, not clarify all charges according to the medical scheme investigators (Durrant, 2018).

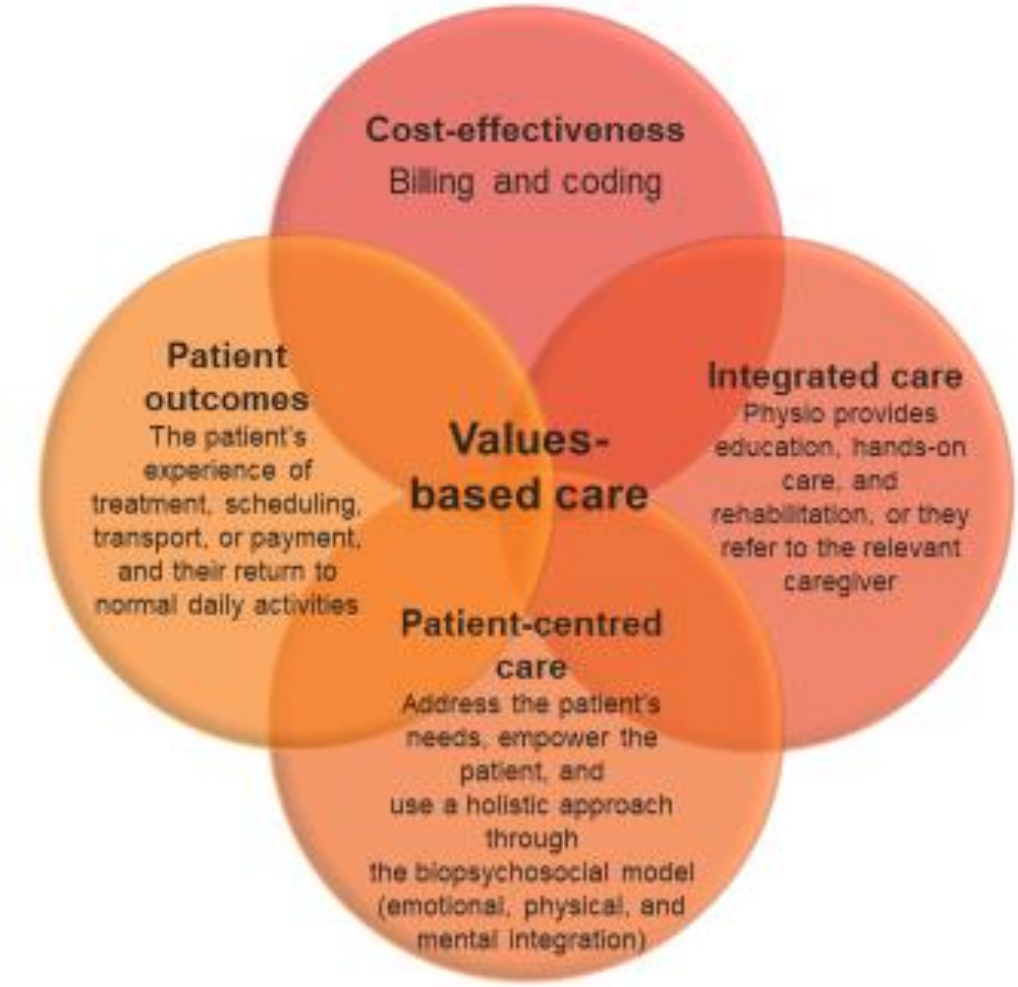

Figure 2-3 Depiction of values-based patient care from the descriptions by Cook (2021), Lentz (2019), and Solvang (2016)

When depicting clinical care and charging the medical schemes for treatments performed, physiotherapists would use the International Classification of Diseases (ICD 10) codes. These ICD 10 codes describe the intensity and complexity of the diagnosis and links it with the care provided which is part of the administrative measure (Cook et al., 2021; Discovery Health, 2017; Holman et al., 2022; Lentz et al., 2019; USA Government, 2016). This ICD-10 coding is a method used to determine value-based reimbursement, outcome measures, and performance in terms of clinical, financial, and administrative performance. It further reports new medical technology and new medical conditions such as COVID, improves

reimbursement systems, and follows the care of diseases and processes used (Holman et al., 2022; USA Government, 2016).

Disease classification using ICD 10 coding is a prerequisite to prevent fraudulent claims and reduces rejections of claims. Claims for medical treatments have increased globally over the past decade. Various reasons include musculoskeletal pain disorders which are associated with disability and persistent pain (Budtz et al., 2021; Cook et al., 2021). The most common form of musculoskeletal pain is lower back pain (Cook et al., 2021).

When medical schemes push for cost reductions by refusing to pay for billing codes, they limit treatment procedures that should and can be offered by healthcare professionals. The healthcare professionals may experience reduced control over patient-care delivery, which puts pressure on their ability to uphold their ethical declaration (Dean et al., 2019). Furthermore, poor outcomes for patients may occur, as patients may not be referred to for treatments with other practitioners reducing integrated care, potentially causing moral injury to the healthcare provider (Burks et al., 2022; Cook et al., 2021; Dean et al., 2019; Van der Niet & Bleakley, 2021). The ‘integrated care’ domain emphasises which healthcare provider is required, to offer the correct patient treatment at the appropriate time in patient care, to achieve positive outcomes (Cook et al., 2021; Lentz et al., 2019). By improving the timing of care, the outcomes may be improved and patients may have a better experience, with a reduction in costs (Budtz et al., 2021; Cook et al., 2021; Lentz et al., 2019).

In integrated care, physiotherapists are placed as the first point of contact for patients, where they can evaluate and treat patients, avoiding more invasive, costly treatment options (Budtz et al., 2021). The physiotherapist then manages the patient’s overall treatment plan, referring to other healthcare providers where needed (Lentz et al., 2019). When physiotherapists work in collaboration with these healthcare providers, they can escalate treatment, sharing the responsibility of patient-care and a reduction in harm to the patient (Lentz et al., 2019).

In the 'patient-centred care’ domain, three elements occur. The physiotherapist must be supportive throughout the patient’s treatment plan, treating them as a holistic being, and not just a diagnosis (Anttila et al., 2018; Scodras et al., 2022b; Solvang & Fougner, 2016). The physiotherapist should promote programmes that could assist patients to improve their health, and make informed decisions, making it possible for the patient to actively participate in implementing the treatment plan. Thirdly, physiotherapist must adopt a comprehensive approach to treating patients, whereby they include the patients’ life history, including traumas, personality, family relationships, and work. This holistic approach is called the biopsychosocial model (Solvang & Fougner, 2016).

The biological aspect of the biopsychosocial model includes the physical body with its injuries and dysfunction, which responds to physical treatment and exercise programmes. The psychological aspect is determined by how motivated the patient is to improve their situation, and take part in their treatment plan, and how they are coping with their circumstances (Solvang & Fougner, 2016; Van den Heuvel et al., 2021). Psychological aspects are treated through counselling and education of the condition, while helping them understand what is needed to improve their quality of life. The social aspect includes educating the patient in what could be expected of them, in terms of their interactions with their surroundings, family life, work life and obligations, and how to manage those expectations (Solvang & Fougner, 2016).

The 'patient-centred care' includes elements where the perspective of the patient, physiotherapist, community, and healthcare institutions are incorporated into an approach to deliver the correct treatments at the right time (Cook et al., 2021; Lentz et al., 2019; Scodras et al., 2022b). When physiotherapists treat patients, they are expected to take into consideration the patients' needs and wants, while knowing what they can do for the patient in terms of treatment and patient care (Cook et al., 2021; Lentz et al., 2019).

The physiotherapist needs to apply their knowledge, to get the patient to become actively involved in their treatment plan (Solvang & Fougner, 2016; Van den Heuvel et al., 2021). The physiotherapist needs to establish a meaningful and efficient treatment process, ensuring the patient feels connected and establishes a bond based on trust (Solvang & Fougner, 2016; Van den Heuvel et al., 2021). Patient-centred care is where the patient is heard, and the information is acted on, ensuring the patient is motivated, educated, and treated holistically (Cook et al., 2021; Lentz et al., 2019; Solvang & Fougner, 2016).

To implement patient-centred care, the physiotherapist requires reflections and insights from their own previous experiences (Solvang & Fougner, 2016; Van den Heuvel et al., 2021). Physiotherapy treatments come with challenges and responsibilities, to ensure that the patient is treated with evidence-based techniques. When physiotherapists qualify, they take a declaration to abide by specific ethical rules and regulations. This declaration is a revised version of the Hippocratic Oath of which "first do no harm" is one of the key elements (Clark, 2018). This declaration must be taken seriously by all physiotherapists in all aspects of their treatments or when referring to other healthcare practitioners (Clark, 2018).

As part of the declaration, and the last part of the values-based patient care domain, physiotherapists need to take 'patient outcomes' into consideration. Patient outcomes includes the measurement of patient outcomes and patient experiences. The elements in this domain include the entire experience of the patients' treatment, from booking an

appointment, to parking, the environment the patient is treated in, and the actual treatment. Patients need to feel heard and are their problems must be addressed (Cook et al., 2021). If values-based care is provided for patients, they would receive the correct care at the right time by the relevant provider (Budtz et al., 2021; Cook et al., 2021; Goodwin et al., 2021). Patients who have good experiences with their care may have better outcomes when dealing with both acute and chronic conditions in terms of their experience and their treatment (Cook et al., 2021).

2.2.3 Preferred Provider Contracts and Practice Accreditation

Physiotherapists may join preferred provider contracts to ensure claims are submitted directly via EDI to the patients' medical scheme, improving the patients' treatment experience and overall care. Preferred provider contracts have been offered to physiotherapists by certain medical schemes to enable claims to be submitted directly to the medical scheme via EDI, resulting in direct payment to the provider and not the patient. The majority of schemes offer direct payment to the practitioner without a preferred provider contract (Medical Schemes Act No. 131 of 1998, 1998).

The incentive to sign these contracts was that this medical scheme offered to pay all approved EDI claims directly to physiotherapists, instead of to the patient (Physio Focus, 2017a; SASP, 2012a). When signing the contract, the physiotherapist agreed to only charge the medical funding schemes' tariff rates (treatment rates), and agree to all rules and regulations set out by the contract, as well as the rules of the medical funding scheme (CMS, 2014; Physio Focus, 2017d). Interestingly, the majority of medical schemes did not require a preferred provider contract to be in place, to pay the medical providers directly.

The alleged benefit was not only for the service provider, but also for the patient, as the patient would not need to pay out of pocket for treatment (Cook et al., 2021; Lentz et al., 2019). However, by having the physiotherapists become preferred providers, certain medical schemes moved the risk of non-payments onto the physiotherapists when patients ran out of benefits or claims were not submitted within the 120-day contractual period (Discovery Health Medical Scheme, 2023; Faux et al., 2021; Physio Focus, 2017d). Furthermore, having preferred provider contracts, allowed the medical scheme to offset money when claims were sent through via EDI (Hearing, 2021b).

The medical funding scheme further promoted preferred provider contracts by offering to fund treatments from the risk pool, for programmes such as the 'back and neck rehabilitation programme'. Patients who qualified were referred to physiotherapists on the preferred

provider list. The physiotherapists would need to attend certain CPD courses, offered by the SASP, to qualify for the funder pool benefits, as well as accredit their practice by the SASP.

By accrediting a practice, the idea was to improve quality delivery of services to patients. Patients expect increased quality of service, globally, and by having an accredited practice the idea would be to move physiotherapists towards customer satisfaction, and market leadership (Physio Focus, 2017b). The accreditation process is a complex process with steps which may take two years to complete. This process needs to be repeated every five years at the physiotherapist's own costs.

The SASP in conjunction with the medical funding schemes, created the link between the preferred provider contracts and the practice accreditation process (Physio Focus, 2017b). Although the physiotherapists requested that the accreditation process not be linked with the preferred provider contracts, the medical schemes rejected this proposal, stating that the medical schemes opted to focus on the quality of delivery from a business perspective (Physio Focus, 2017b). The medical schemes claimed that this could best be achieved via the link between the preferred provider contracts and practice accreditation of the physiotherapy practices (Physio Focus, 2017b). Accreditation by the SASP implied that peer-reviews would be accepted during audits, as well as the recommendations made by the SASP, as stipulated in the preferred provider contract.

In 2017, the HPCSA released a press statement regarding their concern that preferred provider contracts or global fee agreements would result in under or over-servicing of patients (HPCSA, 2017b). The HPCSA was of the opinion that the healthcare practitioner may be limited with treatment options they could offer, which the funder would be willing to pay for, negating their declaration to provide care according to the patient's best interest (HPCSA, 2017b; Talbot & Dean, 2018). These limitations would directly contravene the ethical rules of the HPCSA.

Audited physiotherapists who had signed preferred provider contracts, may not have found that having preferred provider contracts was useful during an audit, as they may not have been protected as per the contract (HPCSA, 2017b). All guidelines stipulated in the preferred provider contract may have been violated as the medical scheme may have ignored that the practice was accredited. Even though the preferred provider contract stipulates that the SASP peer review could be done and would be taken into consideration by the funder, the funder may decide to not adhere to the recommendations provided in the contract (SASP, 2012a).

The HPCSA was further concerned that the contracts may not always be ethical or compliant with the law in terms of patient-practitioner confidentiality (HPCSA, 2017b). The HPCSA advised that healthcare professionals should not enter into global fee contracts or financial arrangements with any medical provider (HPCSA, 2017b). If a healthcare practitioner did not have a payment arrangement with a funder, they were free to decide which coding fee structures they could use in the practice (SASP, 2014).

According to a medical schemes, when practitioners signed a preferred provider contract with the medical funding schemes, the medical schemes were entitled to access the treatment records held by healthcare professionals, in terms of the diagnosis, treatment, and health status of the member (HPCSA Corporate Affairs, 2017). However, private clinical documentation should not be disclosed to any other person without the express consent of the member (Van der Walt, 2020). As medical practitioners are concerned with patient confidentiality, they have been loath to hand over private clinical documents of patients personal treatments to the medical schemes and often refuse to hand over clinical notes to the medical scheme. This results in an impasse between the medical scheme and the physiotherapists.

During a court case the Supreme Court made a ruling regarding handing over of private confidential information to the medical schemes: *"The South African court, in the matter of Colonial Mutual Life Assurance Society Ltd vs de Bruyn, held that, in the case where an insurance company refers an applicant to a doctor for medical examination, and that doctor has been appointed for that purpose by the insurer, the doctor is not in breach of his or her obligations to the patient, if she or he discloses to the insurer, medical information discovered by the doctor (either through examination of the applicant or the applicant volunteering that information). However, it would be unlawful for the doctor to disclose medical information to the insurer which is obtained in some other capacity, for example if the applicant chose to consult the doctor later, in a personal capacity*" (CMS, 2004, p. 11).

Despite this ruling, the medical scheme is still requesting clinical data of patients, and enforcing physiotherapists to sign new preferred provider contracts when physiotherapists are forced to sign the admission of debt (AOD). It would appear as if these preferred provider contracts could ensure that the medical funding schemes remain relevant to the medical industry when the National Health Insurance (NHI) is implemented by the South African government (National Health Insurance Act, 2019).

This poses a threat to patients when it comes to physiotherapy treatment that is not available in the public domain. Particularly so for chronic conditions which require ongoing care, from special interest practitioners, who have not signed the preferred provider contract, because the medical scheme may not pay if the physio is not a preferred provider. Examples include, medically disabled patients, and patients who still have a long recovery journey in the values-based patient care model.

Physiotherapy is a complex profession with various aspects that need to be taken into consideration when implementing a forensic audit. When forensic audits do not take into consideration the values-based patient care model, or the declaration the physiotherapists live by, while disregarding peer reviews, potential hurt and damage may occur to the physiotherapists with ramifications to themselves and their practices. This hurt and damage may alter viewpoints of physiotherapists towards the medical schemes they should be working hand-in-hand with. This may lead to distrust which may result in detrimental effects (Carmona-Barrientos et al., 2020; Dean et al., 2019; Koenig & Al Zaben, 2021; Tamara et al., 2021).

2.3 Experiences of Traumatic Events

People experience different emotions from diverse types of events constantly. The events can be either positive or negative, resulting in a variety of emotions which influence people positively or negatively, potentially giving rise to turning points in their lives (Kurunsaari et al., 2022). These experiences will be discussed in this section and are depicted in the light purple block in 1-1.The top five experiences that result in happiness include: intimacy, going to the theatre, or a concert, attending an exhibition, exercising, and gardening (Seresinhe et al., 2019). The top five stressful experiences identified include: death of a spouse, divorce, marital separation, detention in jail or other institution, and death of a close family member (Peter, 2017).

Life experiences activate various emotions within a person, depending on the nature, length, and severity of the event. These emotions vary from positive emotions such as love, joy, contentment, and happiness, to negative emotions such as anger, fear, frustration, confusion, and hate (Brisch, 2023; Sacharin et al., 2012). Positive emotions are considered to be self-sustaining, while negative emotions are considered to be unsustainable and causes injury and disease (Hawkins, 2020; Niikawa, 2020).

When there are several stressful events that occur within two-years, physical and mental distress, injury, illnesses, or ramifications may occur, depending on the number of stressful

events (Holmes & Rahe, 2018; Peter, 2017). Sometimes, a single event may be detrimental enough to create ramifications, in the form of injury or disease (Dohrenwend, 2006).

When an event forces people to change their way of working, or it threatens their well-being and livelihood, then the event may be considered a stressful impact event (Holmes & Rahe, 2018; Peter, 2017). To determine if a specific event was a stressful impact event, the individuals who were exposed to the event would be interviewed using semi-structured interviews to explore and describe these single life events and their outcomes to come to the truth (Dohrenwend, 2006; Gill et al., 2008; McGill, 2021).

2.3.1 Stressful Life Impact Events

A stressful event is defined as an occurrence were people have to change their usual activities to bring about readjustment, in response to threats, injury, or harm, in order to protect themselves (Dohrenwend, 2006). Several authors have identified stressful life events which may be seen as precursors to the onset of injury, illness, or disease such as distress, anxiety, depression, and Post-Traumatic Stress Disorder (PTSD) (Cohen et al., 2019; Holmes & Rahe, 2018; Peter, 2017; Wilson et al., 2020).

In South Africa, day to day stressors include potholes, hijacking, water restrictions, no service delivery, and government fraud and corruption, high crime rates and gender based violence, which are outside of people's control (Medical Brief newsletter, 2019). In addition, physiotherapists are exposed to stressors, such as, the responsibilities physiotherapists take on during the fulfilment of their role, to ensure patients' well-being, and billing ethically while using outdated codes, which do not describe current treatment modalities, exposing them to unfair audits for billing irregularities (Holmes & Rahe, 2018; Peter, 2017). The multitude of stressors and stressful events that South African physiotherapists are exposed to, may lead to illness and injury. The significant stress endured during an audit may be deemed as a traumatic impact life event. The various potential stressors have been depicted in Figure 2-4.

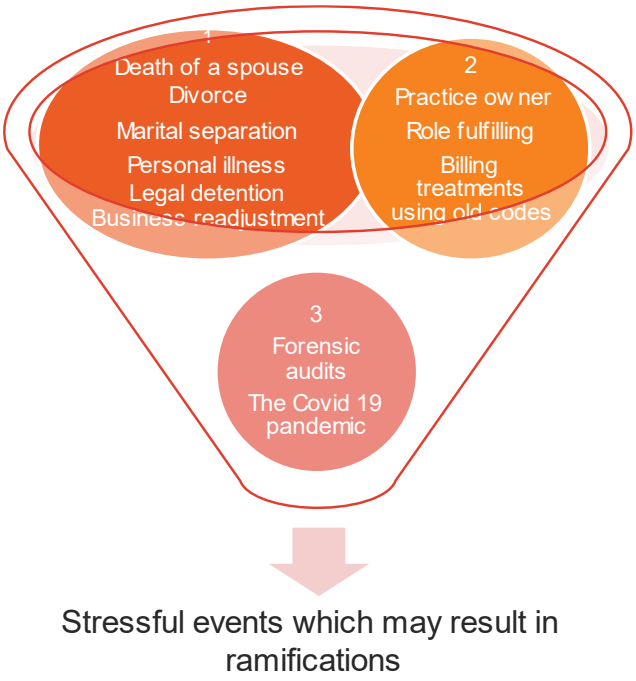

Figure 2-4: Stressful events in SA which may lead to hurt and harm to the physiotherapist and their practice (Self-created)

2.3.2 Evaluating Single Stressful Events

Stressful life events and the development of schizophrenia were originally investigated by Holmes and Rahe in 1967. Later, in 1978, George Brown and Tyrril Harris continued the work by investigating the circumstances of individuals, and correlating these with depression and anxiety (Dohrenwend, 2006). These pioneers created the “Life Events and Difficulty Schedule”, which determines the stressfulness of a life event (Cohen et al., 2019; Peter, 2017). The research indicated that depression was caused by events where major loss occurred, and anxiety was caused by events where threats of loss in any form occurred, and was exacerbated when the individuals had no support (Cohen et al., 2016, 2019).

Stressful life events may reoccur or persist over time, to the extent of becoming ongoing difficulties or chronic stressors (Saraiya & Lopez-Castro, 2016; Straus et al., 2022; Wilson et al., 2020). It is only feasible to focus on evaluating the impact of major events, as minor events are easily forgotten, unless they are evaluated shortly after the event (Dohrenwend, 2006). Major events would be events such as war, the Covid-19 pandemic, death of a loved one, or other major event. Various major events have been studied to establish the

ramifications people experienced. The progression of a stressful impact event and the ramifications have been well documented (Pedrosa et al., 2020; Wilson et al., 2020).

Evaluating stressful events through using semi-structured interviews are helpful in eliciting details of what happened, which provides narratives of the events (Gill et al., 2008; Kallio et al., 2016; McGill, 2021). These interviews could then be analysed to determine whether they were stressful impact events, and what the resultant ramifications experienced by the interviewees were. By conducting semi-structure interviews, the interviewer tries to collect as much contextual information about the event as possible, which was previously unknown.

The researcher may then be able to describe the event in such a way that others would be able to understand and correlate it as a potentially stressful life event. Furthermore, the researcher may describe the various ramifications the interviewees may have experienced subjectively (Gill et al., 2008; Kallio et al., 2016).

2.3.3 Stressful Life Event Progression

When a stressful life impact event occurs, there are three phases that occur with resultant outcomes, as depicted in Figure 2-5. The outcry phase is a normal reaction to trauma, but can lead to abnormal reactions such as panic, rageful destructiveness, and episodes of giving up, or the participant may be swept away by emotional responses (Carmona-Barrientos et al., 2020; Dohrenwend, 2006). The outcry phase would be no different for physiotherapists who may have subjectively described the forensic audits as stressful.

The stressful impact event may progress from the outcry phase to the denial phase with intrusive thoughts. This is seen during a quiet period where the participant may experience various symptoms as depicted in Figure 2-5 (Dean et al., 2019; Van Fossen & Chang, 2022). When people experience the intrusive phase, all interaction with people are affected, resulting in a reduction in support when needed most (Dean et al., 2019; Pearton & Van Staden, 2021; Van Fossen & Chang, 2022). If physiotherapists were to experience the denial phase with intrusive thoughts, they would experience startle reactions or hypervigilance, throughout the day.

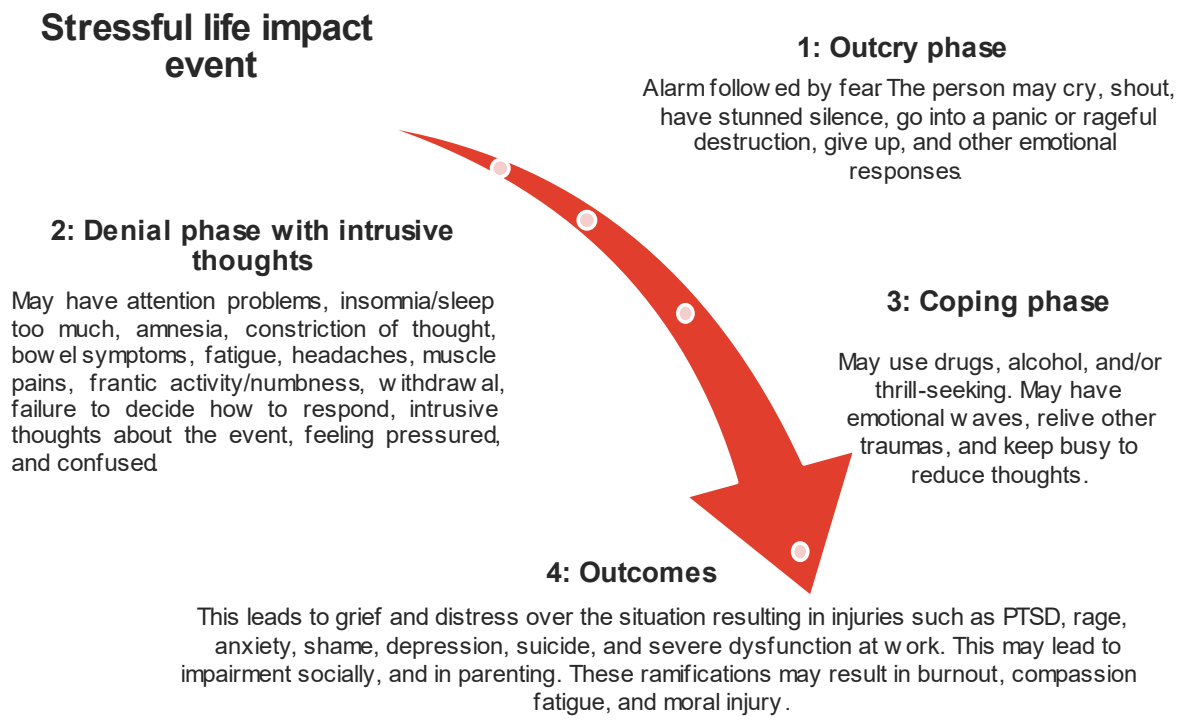

Figure 2-5: The progression of a stressful impact event with signs of distress (self-created using descriptions from Van Fossen and Chang (2022), Carmona-Barrientos et al. (2020), and Strauss et al. (2022).

In the physiotherapy setting, this denial phase with intrusive thoughts could involve the inability to be mentally present when treating patients, resulting in less effective treatments. Reliving audit processes and what was said, or reliving other traumatic events from the past, occurs. The physiotherapists may have occupied their days with activities to keep their minds busy, but at the end of the day they would still not be able to sleep. These phases eventually lead to grief, PTSD, anxiety and depression, as a result of the situation (Carmona-Barrientos et al., 2020; Peter, 2017; Van Fossen & Chang, 2022).

Even though physiotherapists may have been taught stress management techniques, these techniques may be ineffective during audits, as it is an ongoing drawn-out event, with no support (Cohen et al., 2016). Most people, who do not know stress management techniques, may turn to drugs or alcohol to cope with stressful events. Physiotherapists, despite having been taught these stress management technique may too turn to drugs and alcohol or other destructive behaviours to cope, as depicted in Figure 2-5 (Carmona-Barrientos et al., 2020; Cohen et al., 2019). When these coping strategies fail to work, or the alcohol and drugs exacerbate the stress, certain outcomes such as PTSD may occur, as has been found by many researchers (Straus et al., 2022; Van Fossen & Chang, 2022; Wilson et al., 2020).

Post-traumatic stress disorder does not occur from day-to-day activities, even though these experiences may be stressful, such as chronic illness, marital problems, or simple bereavement. Instead, PTSD is an outcome of severe events, such as rape, assaults, torture, traumatic medical experiences, death of a loved one, or traumatic car accidents, because they evoke feelings of helplessness and shock (Dean et al., 2019; Van Fossen & Chang, 2022).

When people were diagnosed with PTSD, they often experienced episodes of guilt, anxiety, shame, rage, and depression, which often resulted in explosive, hostile behaviour, particularly if triggered (Cohen et al., 2016, 2019). Traumatic events have been researched by many, where the outcomes of injury, illness, and/or disease have been documented (Grobler & Van Staden, 2021; Straus et al., 2022; Van Fossen & Chang, 2022). These outcomes occurred as a result of either a severe traumatic event, or many traumatic events that occurred in a short space of time (Cohen et al., 2016; Van der Kolk, 2015).

If the stress of the audit was high enough, physiotherapists may have experienced various ramifications such as thoughts of suicide, and/or severe dysfunction in areas of work, and/or parenting, with resultant high legal fees (Cohen et al., 2019; Van Fossen & Chang, 2022). The severity of these ramifications may have further resulted in outcomes such as burnout, compassion fatigue, and moral injury, especially if physiotherapists experienced a lack of support (Cohen et al., 2016).

2.3.4 Moral Injury

Moral injury occurs when people experience physical, emotional, mental, and spiritual distress, after failing to prevent, witness, or being exposed to acts in which deeply held moral beliefs and expectations were violated as is depicted in Figure 2-6 (Bonsall, 2020; Carey et al., 2016; Koenig & Al Zaben, 2021; Talbot & Dean, 2018; Williamson et al., 2021). Moral injury has been described as a four dimensional bio-psycho-social-spiritual infliction, with a variety of interwoven symptoms (Carey & Hodgson, 2018).

The physical symptoms caused by moral distress or injury were similar to the denial phase with intrusive thoughts, and the coping phase, discussed in the progression of a stressful impact event in Figure 2-5. Within the physiotherapy realm, events that threatened a physiotherapists' moral and ethical code which encompassed their trust and deeply held beliefs, would have resulted in moral injury, if the physiotherapist was unable to prevent the ramifications (Carey et al., 2016; Koenig & Al Zaben, 2021; Williamson et al., 2021) and represented in Figure 2-6.

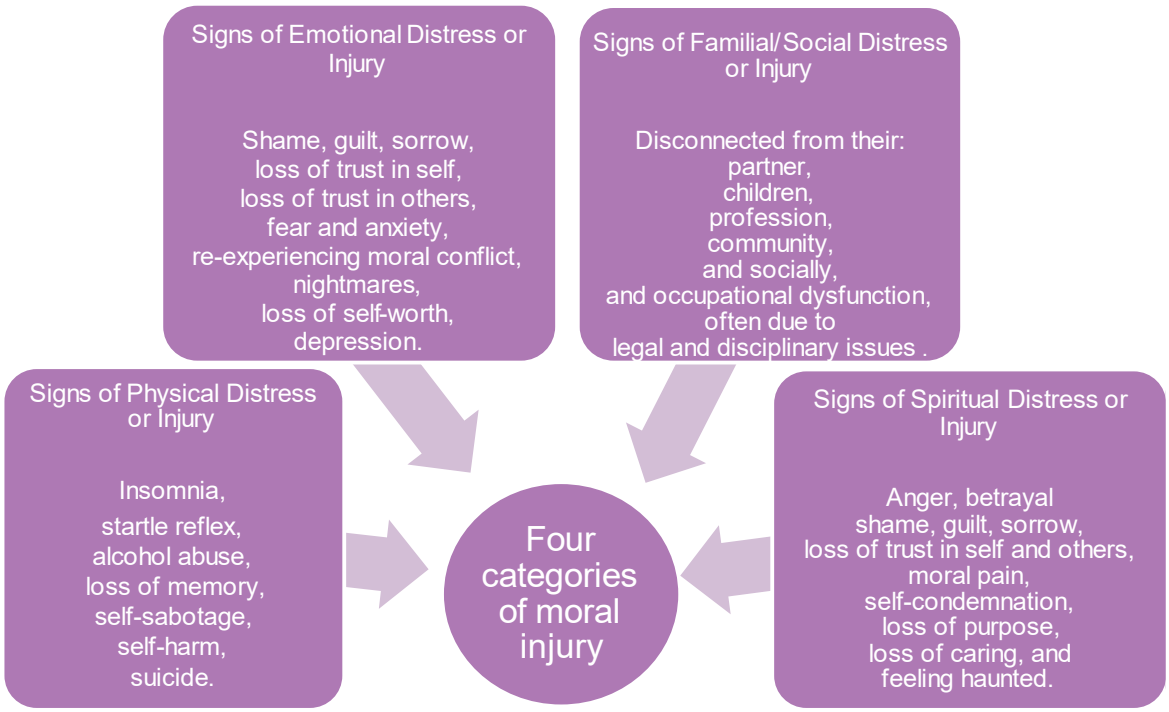

Figure 2-6: The four areas distress is expressed in, comprising moral injury. Created using the descriptions from Bonsall (2020); Talbot and Dean (2018) and Carey and Hodgson (2018)

The events that threatened physiotherapists' moral values may have included the forensic investigators disregard for the ethical code physiotherapists work by, which they swear to uphold when they qualify. Furthermore, medical schemes' rejection of peer reviews done by the SASP, rejection of all evidence provided by physiotherapists, contempt displayed towards physiotherapists, and forcing physiotherapists to sign an admission of debt, even when they were innocent, would have threatened a physiotherapists' moral values.

When the emotional distress or injury occurred, the physiotherapist may have experienced fear and anxiety with a loss of self-worth and depression (Cantu, 2019; Pedrosa et al., 2020). The moral distress may have altered physiotherapists beliefs, where their self-talk may have changed to beliefs of being guilty, a bad physiotherapist, and a failure (Bonsall, 2020; Talbot & Dean, 2018; Williamson et al., 2021). Physiotherapists may have further developed a loss of trust in the medical schemes conducting the audits (Cohen et al., 2016; Van Graan, 2018).

The physiotherapists may have altered their coping strategies through social withdrawal, substance abuse, and/or self-destructive behaviour, as was described in the coping phase in Figure 2-5, resulting in familial or social distress, injury or ramifications (Koenig & Al Zaben,

2021; Williamson et al., 2021). Legal and disciplinary issues often caused distress with occupational and social dysfunctions which resulted in family breakdowns, such as divorce, emotional meltdowns, or unemployment (Van Fossen & Chang, 2022).

If physiotherapists were to experience negative constraints beyond their control, spiritual distress or injury may occur. Particularly when there was a challenge of simultaneously knowing what care their patients needed, but been unable to provide it (Cantu, 2019; Dean et al., 2019). Constraints beyond physiotherapists' control, include the lack of treatment codes, as treatment codes were last updated, and gazetted in 2006. Physiotherapists are unable to charge effectively for treatments provided because they do not have the code to describe the new treatment modalities. Either the physiotherapists must choose another code to depict the treatment, or they do not charge for that modality, as there is no code to describe it. Lack of treatment codes may result in physiotherapists undercharging or being exposed to forensic audits (Talbot & Dean, 2018).

Another constraint would be if there were alternative understanding of the descriptions of the treatment codes used to describe the various physiotherapy treatment modalities (Nortje & Myburgh, 2019). These alternative understandings could be between the SASP and the medical schemes, or even between physiotherapists themselves. The SASP has been teaching the descriptions and use of the tariff codes to the physiotherapists since 2006. The SASP can do this because the custodianship of the codes belongs to the profession (National Health Price Reference List (NHPRL), 2006). Physiotherapists have been using these tariff codes in this manner since 2006. However, the medical schemes have recently begun to disagree with the SASP's descriptions of the codes. "*One should bear in mind that an initial understanding of texts may not be the only plausible interpretation"* (Nortje & Myburgh, 2019, p. 2).

Another constraint would be maintaining confidentiality of patients' confidential information when clinical files are requested by the medical scheme during forensic audits. To comply with the POPI Act (RSA, 2013), physiotherapists must obtain written consent from each of the patients selected on the audit list, for the past three years. Obtaining consent takes an exorbitant amount of time when most physiotherapists would have to do this in their own time, after patients had been treated. The medical schemes request these clinical notes to be submitted to them within seven days.

Each patient must agree that their files, which may contain private clinical information, may be given to the medical schemes during forensic audits (Clark, 2018). Physiotherapists may

feel that this is a violation of the POPI Act and refuse to provide the requested clinical documentation during the audit, resulting in an impasse. If the physiotherapist does hand over the clinical notes, the forensic investigators will scrutinise each document looking for all discrepancies that could be used against the physiotherapist, potentially increasing the audit stress and debt amount (HPCSA, 2017c; Van Graan, 2018).

Other spiritual distress or injuries may occur if medical schemes, which are respected by physiotherapists, where to treat physiotherapists with disrespect and aggression, which would be unexpected, nor warranted, due to the physiotherapists' professional status (Budtz et al., 2021; Van Fossen & Chang, 2022). These alleged aggressive audits occurred when the declaration of "first do no harm" was disregarded by the very algorithms set in place to highlight billing irregularities, resulting in many false accusations of physiotherapists (Joudaki et al., 2015). Confrontational interviews were experienced by the physiotherapists due to these observed preconceived biases, because forensic investigators seemed to believe the physiotherapists were guilty, therefore, all forms of evidence were rejected (Jogi, 2022; Van der Niet & Bleakley, 2021; Van Graan, 2018).

Moral distress or injury has mostly been used to describe the outcomes of veterans' experiences, due to the atrocities of war, and was often linked with PTSD. It was only recently that moral injury had been expanded to incorporate healthcare professionals and ordinary people. Moral distress or injury had included events such as car accidents, the Covid-19 pandemic, and stressful events that would compromise your morals and ethics, and threaten your life (Mantri et al., 2020). During the Covid-19 pandemic, moral distress or injury was more prevalent and resulted in many medical professionals wanting to leave the profession (Mantri et al., 2021). Functional impairment doubled (Mantri et al., 2021), and doctors were not able to perform at their best, and could not provide best treatment to their patients, resulting in burnout (Cook et al., 2021; Mantri et al., 2020; Pedrosa et al., 2020).

In the medical realm, instead of only focusing on the wellbeing of patients, healthcare professionals had to take other aspects into consideration. These aspects included, the medical records, coding and billing, medical insurance, the medical funder, the hospital, and healthcare system, and even the medical professionals own financial wellbeing (Dean et al., 2019; Jago & Pfeffer, 2019). Moral injustice occurred every time healthcare professionals were forced to decide which codes needed to be used that would be acceptable to the medical funding schemes, given which medical funder was involved (Talbot & Dean, 2018).

When healthcare practitioners' ability to provide best practice for their patients is negatively impacted, repeatedly, over time, then this may amass to moral injury (Dean et al., 2019). Moral distress or injury further occurred when trusted corporations, who held legitimate authority, such as the medical schemes, betrayed the trust of healthcare professionals through dishonest dealings and unfair treatments (Cantu, 2019; Carey & Hodgson, 2018; Van Graan, 2018).

Moral distress or injury can only be solved in the long-term if the business framework of healthcare is altered (Dean et al., 2019; Jago & Pfeffer, 2019). Solutions do not lie in promoting mindfulness or resilience among physicians, but in creating a healthcare environment that recognizes the value of clinicians' time with patients, and in cultivating trust, compassion, and understanding. Moral injury can be prevented by a healthcare system that puts healing above profit, and trusts clinicians to always put the interests of their patients first (Dean et al., 2019).

Research has indicated that with PTSD, your life is at stake, whereas with moral injury, your morals and ethics are at stake (Carey et al., 2016; Koenig & Al Zaben, 2021). It appears then, that more is at stake with these audits than just the physiotherapists morals and values. Physiotherapists' livelihoods, in terms of their professional passion or drive, their income generating abilities, their psychosocial interactions, and other day-to-day functioning is affected, resulting in hurt and harm to the physiotherapists and damage to their practices and the physiotherapy profession.

2.3.5 Hurt and Harm to the Physiotherapist and Damage to the Practice

Hurt was an emotional or psychological hurt, where the person may have experienced humiliation or have had a bad experience (Niikawa, 2020; Van Fossen & Chang, 2022). This hurt to the person may have influenced how they, in turn, treated others, thought about work, thought about themselves, and how they responded to others. The emotions that were created may have caused severe harm and damage to both the people and the organisation they worked in (Niikawa, 2020; Sacharin et al., 2012).

Harm is a deliberate injury to someone. Harm's similes are injury; damage; detriment; and misfortune (Sun et al., 2022; Van Fossen & Chang, 2022). An example of harm is when forensic investigators may have been derogatory towards physiotherapists, while forcing them to sign an AOD. This type of harm may be seen as a form of psychological torture (Van Graan, 2018) resulting in harms to the physiotherapists and their practices. The

physiotherapists may have taken great offense to these accusations, potentially resulting in moral injury, which would be a great harm to the physiotherapist.

Other harm may have been experienced such as headaches, lack of sleep, altered eating habits, or other physical symptoms, or illnesses. If medical funders were to accuse physiotherapists of billing irregularities, but the penalties imposed were worse than those imposed for FWA, then financial harm may occur. Other financial harm may occur if physiotherapists were forced to become a cash practice during the audits, to prevent offset which would reduce cash flow, as no money would have been paid to the practice, from the investigating medical schemes (Hearing, 2021b; Van Graan, 2018).

If the provider became a cash practice to avoid offset, harm to patients may occur if they were unable to pay out-of-pocket as occurred in Australia, and, therefore, would have been forced to go elsewhere for treatment (Faux et al., 2021). Various physiotherapy practices may have experienced harm and damage if patients left due to the lack of payment or refund of treatments from medical schemes. These are possible outcomes that could occur if the above constraints were present during the forensic audits. If payments to physiotherapists were to be blocked by the medical schemes, and the scheme were to inform the patients that no payment would be refunded to the patient if they continued to see that specific physio, then defamation of character may have occurred.

2.3.6 Defamation of Character as a Ramification

Defamation may occur when false statements are made with the perceived intent to damage the reputation of a person, exposing them to public contempt, hatred, ridicule, or condemnation (Reamer, 2008; Ronquillo & Varacallo, 2022). Defamation could also occur if the medical schemes ignored communication rules and regulations, as set out by the Council of Medical Schemes (CMS), through the Medical Schemes Act, when communicating with physiotherapists (Medical Schemes Act No. 131 S57(4)(d): Communication Guidelines for Medical Schemes, 1998). Various physiotherapists may have experienced been treated with contempt by the medical schemes.

Defamation of character may occur when interactions between forensic investigators and physiotherapists may have caused harm and injury to the physiotherapists (Reamer, 2008; Ronquillo & Varacallo, 2022), in that the physiotherapists' reputation was besmirched. The two forms of defamation are written defamation, known as libel defamation, and verbal defamation known as slander defamation (Reamer, 2008; Ronquillo & Varacallo, 2022).

Letters written to physiotherapists by the forensic investigators may have been defamatory and deemed as psychologically torturous. Defamation would directly occur when physiotherapists were unfairly blacklisted for not signing an admission of debt, as a means of coercing the physiotherapists to obey the forensic investigators demands. Communication with physiotherapists' patients, by the medical schemes, regarding the audit investigation, could further defame the physiotherapist.

Should blacklisting occur, i.e., the medical schemes would refuse to refund the patients for out-of-pocket payments, that patients paid for treatments, could possibly defame the physiotherapist further and could harm the patient (Faux et al., 2021; Joudaki et al., 2015). Defamation could further occur if forensic investigators would contact referring doctors, questioning referrals of patients sent to the physiotherapist under investigation, who had worked in collaboration with the referring doctor. This may have resulted in the referring doctor questioning the physiotherapists' moral and ethical standing in the healthcare profession due to a potential stigmatisation of audits.

A physiotherapy practice is built on the reputation of the therapist's name, which is their most valuable asset (Ronquillo & Varacallo, 2022). Their profession is their identity and they will not knowingly, or willingly, do anything to jeopardize their reputation or practice, as it takes many years to build up a reputation, but seconds to break it down (Anttila et al., 2018; Dalton et al., 2011; Reamer, 2008; Solvang & Fougner, 2016). Defamation could instantly ruin the reputation of the physiotherapists, who would be unable to fight these accusations, as fighting defamation charges is expensive and difficult to prove (Ronquillo & Varacallo, 2022).

Physiotherapists may be especially sensitive to defamatory comments made by the medical schemes because the psychological hurt caused may influence their self-image, which could negatively impact their reputation. This defamation could result in the physiotherapists not been able to function normally.

2.4 Forensic Audits

The concept titled 'Forensic audits', depicted in the third, yellow block of Figure 1-1 will be discussed in this section of the dissertation. Forensic investigations are supposed to be carried out in an unbiased, objective manner, to gather evidence, to determine if the person been audited was guilty, and to report factual truth (Auditing Professions Act Amendment, 2005; Auditing Professions Act No. 26 of 2005, 2005; Gehl & Plecas, 2017; Morin, 2018; Van Graan, 2018). To remain unbiased, objective and fair, interviewing techniques should take into consideration the ethical, legal, and psychological challenges to arrive at the truth,

regardless of whether the investigation results in a confession or not (Auditing Professions Act No. 26 of 2005, 2005; Gehl & Plecas, 2017; Porter & Crumbley, 2012; Van Graan, 2018).

Medical schemes conduct forensic audits forensic investigators, who may use various interviewing techniques that may be interrogative of nature, to determine if there has been alleged financial crimes. Forensic accountants developed most of their skills through experience, as a standardised model of training has not been provided (Porter & Crumbley, 2012). The interview techniques are honed over years, and influenced by others they work with. The forensic investigator's goal is to interview alleged suspects when evidence is limited and circumstantial in nature, as a form of gathering evidence. According to the rules for forensic investigators, Medical Schemes Act Section 36 no (2), it states that investigators are not allowed to be incentivised nor have criminal backgrounds (Medical Schemes Act No. 131 S36(2): Standards for Authorisation of Auditors for Medical Schemes, 1998).

Various interviewing techniques may be used during criminal interviews, such as the Reid technique which was created by John E. Reid who was a polygraph expert and former police officer (Reid and Associates, Inc., 1947). The Reid technique was described as an interrogation technique that used high pressure environments, followed by sympathy, to obtain a confession (Van Graan, 2018; Vrij, 2004). The Reid technique is considered a form of psychological torture and coercion, which often results in people being wrongfully convicted of crimes (Van Graan, 2018; Vrij, 2004). Therefore, the Reid technique is inappropriate to use during investigations of financial, white collar crimes (Gehl & Plecas, 2017; Van Graan, 2018; Vrij, 2004).

When using the Reid technique, the forensic investigators intention is to elicit a confession, which is a complete account of all the facts, which establishes guilt. Admission of guilt is the most damaging evidence against the interviewee in a court of law (Porter & Crumbley, 2012; Van Graan, 2018). If detailed facts were not able to be given, then the forensic investigator would have attempted to obtain an admission of guilt, which is where the interviewee acknowledges that they have committed financial crimes (Van Graan, 2018). These admissions, when made to a person in authority, must be voluntary, to be accepted in a court of law (Gehl & Plecas, 2017; Porter & Crumbley, 2012; Van Graan, 2018; Vrij, 2004).

Medical schemes' forensic investigators are in a position of authority, as was afforded to them through the Medical Schemes Act, Section 59(3) (Medical Schemes Act No. 131 of 1998, 1998). The medical schemes have the ability to control the proceedings, by controlling whether physiotherapists are paid, or whether the money is taken through offset. Another example of control over the proceedings would be if the medical schemes threatened to

blacklist physiotherapists, which could be seen as psychological torture as described in the literature (Van Fossen & Chang, 2022; Van Graan, 2018).

As the medical schemes are viewed as a company of authority, they should be subject to the same rules as police officers, when obtaining 'voluntary' confessions (Porter & Crumbley, 2012; Van Graan, 2018), and would be obliged to inform the physiotherapists of their legal and Charter Rights (Basic human rights). For an admission to be considered fair and accepted by law, it must be made voluntarily, without interviewees being placed under duress or oppressive conditions (Porter & Crumbley, 2012; Van Graan, 2018).

If forensic investigators were to conduct interviews where the interviewees were already presumed guilty, it could be assumed that the forensic investigators may appear to be using the Reid technique, to coerce a false confession (Van Graan, 2018). Furthermore, the Reid technique was not scientifically reliable, as the investigators were often be led astray by false presumptions of guilt that were unwaveringly forced onto the interviewees (Porter & Crumbley, 2012; Van Graan, 2018). Another non-aggressive interviewing technique which should be used during forensic investigations, is the PEACE technique, an acronym. The PEACE technique is more effective in eliciting a true confession of guilt, while remaining unbiased, ethical, and legal, and takes psychological challenges into consideration (Porter & Crumbley, 2012).

2.4.1 The PEACE Interviewing Technique

The PEACE technique is expanded as follows:

P: Preparation and planning ensuring the investigator knows all the facts before the interview.

E: Engage and explain the physiotherapists rights and the purpose of the interview.

A: Account, clarify, and challenge, where the physiotherapist is freely given the opportunity to give their side of the story, while discrepancies are queried.

C: Closure of the interview

E: Evaluation of the interview is conducted throughout the interview, to strive for constant improvement.

The PEACE model is an effective and ethical interviewing technique used to get the interviewee to provide a complete account of their story, while any discrepancies are challenged, without using any form of interrogation (Van Graan, 2018). It has been suggested that all investigators using the Reid technique, should exchange it for the PEACE

technique, as it is a non-accusatory form of interviewing, resulting in fewer false confessions (Gehl & Plecas, 2017; Keedy, 1937; Morin, 2018; Porter & Crumbley, 2012).

The PEACE technique was created to align forensic interviewing with lawful procedures and is accepted by the South Africa laws. The focus is to obtain relevant information while respecting the rights of the interviewees. Research has shown that the majority of interviewees are not hostile, and are willing to cooperate during forensic interviews (Van Graan, 2018). If physiotherapists were suspected of being guilty, an accusatory interview known as the Reid technique may have been conducted to elicit information, even though the physiotherapists would have been willing to cooperate during the audit processes (Gehl & Plecas, 2017; Porter & Crumbley, 2012; Van Graan, 2018). Physiotherapists would have been shocked if they were treated as criminals with no fair processes or hearings, potentially causing much hurt and harm.

2.4.2 The Reid Interviewing Technique Used to Intimidate and Coerce During Forensic Audits

The Reid technique is an interrogation technique that uses maximisation techniques to intimidate the interviewee, and minimisation techniques to get the interviewee to trust them. The maximising techniques advises interviewers to intimidate the interviewees, through conducting interviews in small rooms which are locked, sound proofed, with minimal furnishings. The sole aim of the Reid technique is for the interviewers to make the interviewee feel uncomfortable and threatened. This results in the interviewees feeling isolated, increasing their experience of anxiety, and distress (Reid and Associates, Inc., 1947; Van Graan, 2018).

Adding to this discomfort, and intimidation, the interviewers must have more people on their team, in the room, than the interviewees and their counsel, indicating power. If interviews are conducted via online platforms, the intimidation methods implemented, would include, sitting too close to the screen, lounging on a chair in the background, or not being seen at all (Morin, 2018; Wareham, 2015). The Reid technique allocates roles to the various interviewers to ensure maximum intimidation and control. These roles include an intimidator, and a person who would attempt to gain trust, while they wear power suites, creating a setup of good cop, bad cop (Gehl & Plecas, 2017; Van Graan, 2018).

Part of the oppressive nature of this technique is the use of threats or promises during questioning, while prolonging the audits (Porter & Crumbley, 2012). Often, evidence is fabricated to convince interviewees that their protestations of innocence are futile, resulting in false admissions of guilt. When the investigators concoct evidence, they contravene their

professional standards of ethics (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010; Porter & Crumbley, 2012).

The entire aim of the Reid technique is to intimidate through accusation, while controlling the emotions and actions of the interviewee (Porter & Crumbley, 2012; Van Graan, 2018). Control occurs when the investigators demand evidence from the interviewees, who have to constantly forsake long-term interests, such as hobbies and sports, to complete the short-term demands of the medical schemes' investigators, such as providing evidence of innocence. These demands may cause emotional strain with self-regulatory decline, extreme fatigue, perceptive impairment, and emotional anxiety, resulting in false confessions when the interviewee reaches a point of fatigue and gives up (Dohrenwend, 2006; Van Graan, 2018).

The minimisation strategies are used to get physiotherapists to trust the investigators, while reducing the apparent consequences of admitting to billing irregularities. The investigators may offer excuses for the misdemeanours, to minimise or underplay the seriousness thereof, or state that signing the AOD is just a formality, and not that significant. All these techniques are used to wear people down, and coerce them into admitting guilt (Gehl & Plecas, 2017; Porter & Crumbley, 2012; Van Graan, 2018).

The Reid technique comprises nine steps and is implemented when the interviewee's guilt is deemed as definite (Porter & Crumbley, 2012; Reid and Associates, Inc., 1947; Van Graan, 2018). When this technique is followed, a false confession is often obtained because the interviewee just wants the investigator to stop, as the audit is perceived as been too stressful (Gehl & Plecas, 2017; Porter & Crumbley, 2012; Van Graan, 2018). Steps 1 to 4 comprise the intimidation tactics used, which is the maximisation strategies, and steps 5 to 9 are the minimising strategies used, as displayed in Table 2.1.

Table 2.1*: The Nine-step Reid interviewing/interrogation technique (Self-developed using the descriptions from Van Graan (2018))*

Nine-step Reid technique: Maximising strategies (Steps 1 to 4) used to intimidate. Investigators do the following:	
Step 1	• are unwavering in their accusations of guilt. • use misleading False Evidence Ploys (FEP) to confuse interviewees and limit claims of innocence. • are manipulative, forcing opinions on interviewees. • analyse interviewees' confidence levels to determine actions required, to force an admission of guilt.
Step 2	• introduce a motive as a moral excuse for the interviewee having caused the forensic crime. • rationalise the reason for the crime. • adapt the story to fit the interviewee's cognitive characteristics. • play on the interviewee's emotions by either offering sympathy, blaming someone else, or reassuring the interviewee that the crime was not intentional
Step 3	• interrupt and ignore all denials made by the interviewee because every objection the interviewee makes reduces the chance of admitting guilt. • apply pressure to provide evidence of innocence, to keep the interviewee occupied. • prolong audits by taking long to respond. • repeat the moral excuse, to wear the interviewee down.
Step 4	• disregards all evidence of innocence. • claim that the consequences of not confessing will be more severe than the current ones, which are highlighted repeatedly. • apply pressure on the interviewee to admit guilt, while giving limited time to decide.
Minimising strategies (Steps 5 to 9) are used to gain trust. Investigators do the following:	
Step 5	• show sympathy towards the interviewee, to gain the interviewee's trust. • make eye contact, move closer, and talk in an empathetic voice, to prevent withdrawal.
Step 6	• establish rapport while underlining the reason the crime was committed. • reject all denials and objections as before.
Step 7	• offer two options to the interviewee as to why the crime was committed. One reason is more acceptable than the other. Both reasons admit to the crime, while providing a motive for committing the crime.
Step 8	• promote a discussion where the interviewee is given the opportunity to describe the offence in detail. • dictate the conversation while providing an opportunity for the interviewee to give details. • provide ample time to confess, as the interviewee may initially be reluctant to do so.
Step 9	• will convert the verbal confession to a written one, in the form of an admission of debt (AOD). • will do this as soon as possible to prevent the interviewee from denying guilt later. An AOD is as detrimental as a confession and cannot be disputed in a court of law as the interviewee has admitted to guilt.

Steps 1 to 4 of the Reid technique are considered to be a form of psychological torture.

The investigator's aim is to make the interviewee feel helpless, hopeless, confused, and emotionally withdrawn, to secure a signed admission of guilt. Interviewees, therefore, believe they must be guilty if they are treated in this manner, by a person in authority and will concede to their wishes (Van Graan, 2018).

If the Reid technique was to be used during forensic audits such as those conducted on physiotherapists, steps1 to 4 may have been used to intimidate the physiotherapist, accusing them unwaveringly of committing billing irregularities. Here, false evidence of billing irregularities may have been presented to support these allegations. Denials would have been disqualified, and the investigators may have claimed that the consequences of not confessing to billing irregularities may be more severe. The medical schemes may have extended the audit, or threatened to audit the physiotherapist for other codes, or blacklisted the physiotherapists, to wear the physiotherapists down until the physiotherapist would sign an AOD.

The initial penalties of the audit would have been highlighted by the medical schemes, which were only for billing irregularities of a specified smaller amount, as opposed to a potentially larger amount. Physiotherapists would have been encouraged to confess, while the medical schemes threatened to increase the audit amount by including other codes, in order to coerce the physiotherapists to sign for the initial audited amount.

If the investigators presumed, as an example, the physiotherapists to be guilty before a meeting took place, then all doubt regarding potential innocence would have been blocked, resulting in a biased investigation as described in the literature (Van Graan, 2018). Furthermore, if the investigators were incentivised, they may have conducted forensic investigations in violation of the Medical Schemes Act 131 Section 58, resulting in further bias, being unethical, and unfair in conduct (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010).

Bias may lead to a blatant emphasis of obtaining confessions at all costs, resulting in severe negative consequences (Van Graan, 2018). Research has shown that 94% of people gave a false confession to accusations when the Reid technique was used (Van Graan, 2018). Furthermore, in 2018, research indicated that 93% of audited medical practitioners were coerced into signing an AOD, and repaid the billing irregularity allegations, because they had no other recourse or support (Hudson, 2019; Marais, 2006).

2.4.3 The Reid Interviewing Technique and the South African Bill of Rights

The use of the Reid technique had been considered to be a type of trickery and deception, which manifested as distrust towards the investigator, breaking down the very trust physiotherapists needed, when working with medical funding schemes (Van Fossen &

Chang, 2022; Van Graan, 2018). By coercing physiotherapists to falsely confess to billing irregularities, the future consequences of the investigators' decision, and therefore, the physiotherapy profession, had not been considered.

Using the Reid technique as a means of conducting forensic investigations for white collar crimes was considered to be immoral and violated the South African Bill of Rights (Currie & De Waal, 2013; The South African Constitution, 1689). The Bill or Rights in relation to the Reid technique was previously described by van Graan (2018). The table below has expanded on van Graan's table (2018) by adding different Rules and Regulations of the Medical Schemes Act and judgments from the Supreme Court of South Africa Table 2.2.

Table 2.2: The Reid technique in comparison to the South African Bill of Rights and The Medical Schemes Act, court rulings and other South African laws (Self-created using aspects from the table created by Van Graan (2018))

The Bill of Rights (BOR)(Currie & De Waal, 2013; The South African Constitution, 1689)	**Reid's technique uses strategies to intimidate and gain trust through torturing interviewees psychologically, with the sole purpose of gaining admission of guilt or debt (AOD)** (Reid and Associates, Inc., 1947; Van Graan, 2018)
BOR Section 10 Right to human dignity. Interviews must be conducted in a composed and humane manner. Interviewers should not threaten the interviewee's right to be treated as worthy of honour or respect and should be free from torture and degradation. **Requirements for administrators of medical schemes** (Council of Medical Schemes 2010) **Section 2(c)(3)** The investigators must use appropriate communication as prescribed in the event of claims being queried or rejected.	• The Reid technique's inherent accusatory and guilt-presumptive nature, including its use of intimidation, maximisation tactics (Steps 1 to 4) • Investigators are unwavering in their accusations of guilt disqualifying the interviewee's denials. • Investigators exaggerate/underplay the seriousness of the offence and claim that the consequences of not confessing are more severe while threatening them with blacklisting or increased audit amounts, which may qualify as torture. • Investigators analyse interviewees' confidence levels to determine methods of 'scare tactics' required to force an admission of guilt. • Investigators use misleading False Evidence Ploys (FEP) to confuse interviewees and limit claims of innocence, manipulating and forcing opinions on interviewees. • Investigators purposefully prolong audits by taking too long to respond, wearing the interviewee down.
Case rulings "Interruption of prescription, by acknowledging liability is one thing, attempting to revive an extinguished debt by acknowledgement is another" (*JNP Jansen van Vuuren and another NNO*, 1993; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 5). "One should bear in mind that an initial understanding of texts may not be the only plausible interpretation" (Nortje & Myburgh, 2019, p. 2)	

BOR Section 12 (1) The freedom and security of a person. Interviews should not be of such a nature that it denies the interviewee the option to leave. The interviewee may never be detained, nor be exposed to violence, torture or be treated in an inhumane way in the interview. **BOR Section 33 (1) and the Harmful Business Practice Act, 1988** (CMS, 2004)– Right to administrative action that is lawful, reasonable, and procedurally fair. "Any business practice which, directly or indirectly, has or is likely to have the effect of: (a) harming the relationship between business and consumers, (b) unreasonably prejudicing any customer; or (c) deceiving any customer." **Auditing Professions Act No 26 of 2005 and Communication Guidelines for Medical Schemes 3(4)(3)** (Independent Regulatory Board for Auditors 2005; Council of Medical Schemes 1998)**.** The forensic auditor must follow a code of ethics and disciplinary rules, including not being incentivised which would	• The Reid technique strongly supports the fact that the investigators will detain the interviewee until a confession is obtained, • The Reid technique has its roots in the policing environment where an arrested person may be detained by the police. However, forensic investigators do not have the same broad mandate as police and may not detain a person. • The Reid technique's aggressive and accusatory nature may render the interview inhumane in certain circumstances (Steps 1 to 4). • The deceitful nature of FEPs used during Reid interviews may also be deemed inhumane by a court of law. • This includes overstating the seriousness of the offence and claiming that the consequences of not confessing are severe, which, if accompanied by threats to confess, may qualify as torture. • Forensic investigators are biased due to incentivisation.

result in a conflict of interest.	
Section 14 Right to privacy. Interviewees have the right to privacy, including the right that his/her private domain is not infringed upon, excluding the obtaining of information that directly influences the public sphere and workplace**.**	• If the Reid technique was used to obtain personal information which existed outside of the public sphere and workplace, then there may be justification for claiming that an individual's right to privacy in terms of section 14 had been violated. • The Reid technique encourages the "encroaching upon the suspect's personal space" (Kassin & Gudjonsson, 2004;43) which may well be in contravention of section 14.
Court rulings *"A patient should be entitled to freely disclose his/her symptoms and condition to his/her doctor in order to receive proper treatment without fear that those facts may become public property. The doctor/patient confidentiality relationship is then fulfilled"* (CMS, 2004; *JNP Jansen van Vuuren and another NNO*, 1993, p. 14). *"In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients will not come forward if doctors are going to squeal on them*" (CMS, 2004; *JNP Jansen van Vuuren and another NNO*, 1993, p. 13). "*It would be unlawful for the doctor to disclose medical information to the insurer which is obtained in some other capacity (not for insurance purposes), for example, if the applicant chose to consult the doctor in a personal capacity."* (CMS, 2004, p. 12)	
BOR Section 35 (1) (c) and Criminal Procedure Act 51 of 1977 Section 217 – Right not to be compelled to make any confession/ admission. Confessions/admissions should be made: (1) freely and voluntarily, (2) in sound and sober senses, and (3) without undue influence	• The Reid technique's central aim is to obtain a confession, as it is based on the presumption that the suspect is guilty of a crime. • Confessions made during the application of the Reid technique may be construed as not being free and voluntary. A "free and voluntary" statement is derived from common law and can be regarded as a statement that is not induced by a threat or a promise, obtained by a person in authority. • The maximisation and minimisation factors may have an influence on whether a

	confession is given freely and voluntarily, due to the presence of intimidation. • Maximisation entails accusing the interviewee of committing the offence, exaggerating the seriousness of the crime, disqualifying any denials, informing the interviewee that the consequences of not confessing are severe, and establishing anxiety in the interviewee in order to elicit a confession to a crime. These actions may be experienced as threats by the interviewee, especially if he/she considers the interviewer's conduct to be intimidating to such an extent that the only option to "escape" from the interview, is to confess. • Minimisation, refers to an interviewer's act of justifying the crime, depicting the interviewee's supposed offence in a sympathetic light, minimising the seriousness of the alleged offence, and the consequences of confessing. Minimising techniques may prove problematic within the South African legal context, because minimising the consequences of confessing may be interpreted as being a promise – in this case a promise of a lighter sanction for the interviewee, should he/she confess. • Did the interviewee confess when he/she was in sound and sober senses. A person may be deemed as not being in his/her sound and sober senses if he/she was unable to know what he/she was saying (R v Blythe, 1940). Two aspects are relevant: Firstly, the fact that the Reid technique is known to elicit false confessions, and secondly, the effect of the Reid technique on vulnerable interviewees due to torture. • People confess to crimes they did not commit (Scheck et al., 2001; Russano et al., 2005; Kassin, 2008) when pressure is applied, and reiteration of the presumption of guilt by the interviewer results in the innocent interviewee becoming convinced of his/her own guilt. In such cases, the interviewee would not be deemed to be in his/her sound

	and sober senses. • The Reid technique has a “one size fits all” approach, which creates the risk that these interviewees confess to crimes without being in a sound state of mind. • Confessions should be made without unduly influencing the interviewee. “Undue influence” refers to a practice that is “repugnant to the principles upon which the criminal law is based.”(Van Graan, 2018) Undue influence goes beyond violence and includes interviewing the interviewee for an unduly long period of time, subjecting the interviewee to fatigue, while exploiting the interviewee’s weaknesses. • Confessions from vulnerable interviewees may be deemed as unlawful and inadmissible in a court of law due to the presence of undue influence, in accordance with section 35 (1) (c).
BOR Section 35 (5) If any Rights contained in the Bill of Rights are violated, the evidence obtained during such action may be excluded during court processes, specifically if these will lead to an unfair trial or if it is detrimental to the administration of justice. This may lead to the acquittal of the interviewee should he/she be accused of any crime.	The Reid technique may be in violation of various sections of the Bill of Rights Sections 10,12 (1), and 35 (1) (c). As a result of these violations, the Reid technique is also in breach of section 35 (5), which signifies that, due to the fact that rights contained in the Bill of Rights have been breached, any evidence obtained, that flows from these violations, may in all probability, be inadmissible in a court of law. This is significant for commercial forensic investigations, since confessions and other evidence obtained during the application of the Reid technique, may be regarded as inadmissible by South African courts of law, potentially rendering the whole investigation for billing irregularities, null and void.
BOR Section 23 (1) and The Labour Relations Act Section 186 (2) (66 of 1995)	Applying the Reid technique in the workplace as part of a commercial forensic investigation may create concerns in terms of potential unfair labour practices. This is due to the fact that

Unfair labour practices and unfair dismissal Interviews should be conducted in a fair manner that will not qualify as unfair labour practices or lead to an unfair dismissal. The Labour Relations Act is based on fairness, human dignity, equality, and freedom, forming the basis of the Bill of Rights.	the LRA is inherently based on fairness, human dignity, equality, and freedom, which also form the basis of the Bill of Rights. Since the discussions above makes it clear that serious concerns exist regarding the potential violation of the Bill of Rights through the implementation of the Reid technique, it is evident that the same concerns are present in terms of unfair labour practices.
Additional statutory information pertaining to this study	
Requirements for administrators of medical schemes (Council of Medical Schemes 2010) **Section 2(a)(4)** Administrators must comply with the provisions of the Medical Schemes Act and the Regulations published thereunder. **Medical Schemes Act Regulation 6(2), (3), and (4)** Statutory prescription obligation. The healthcare provider must submit claims within a 120-day period, from the date of treatment, or the medical scheme will not pay the account. (2) If a claim is erroneous, the medical scheme must inform the healthcare provider within 30 days that the claim is erroneous. (3) Once the healthcare provider has been informed, they must be afforded 60 days in which to correct and resubmit the erroneous claim. (4) If a medical scheme fails to notify the healthcare provider within 30 days that an account is erroneous or fails to provide an opportunity for correction, the medical scheme *must prove* (own emphasis added) that the account is in fact erroneous in the event of a dispute. (South African Department of Health 1998) **Annexure B no 14** Medical schemes must draft a monthly financial report indicating all debt owed by providers, with age analyses of outstanding debts two weeks after the end of each month (Council of Medical Schemes 2010).	
Therefore, the medical schemes had the necessary knowledge, through artificial intelligence, pertaining to all the facts from which the so-called debt arose, and the forensic investigators did not exercise “reasonable care,” as per section 12(3) of the Prescription Act in notifying the medical practitioners. (The Prescription Act, No. 68 of 1968, 1968; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016).	

Court Rulings and Circulars

If forensic investigators continue to be deliberate or negligent with their acts of tardiness in pursuing claims of billing irregularities, without incurring the consequences of prescription or other laws, they would be undermining the power and authority of the law (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016).

"*Once there has been the necessary effluxion of time, the debt is extinguished"* (*JNP Jansen van Vuuren and another NNO*, 1993; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 5). *"A creditor cannot, by its own conduct (or lack thereof), postpone the commencement of prescription"* (*JNP Jansen van Vuuren and another NNO*, 1993; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 7).

"Prescription is the date upon which a debt becomes due and must not be confused with when repayment thereof is demanded" (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 1). When a claim is paid by the medical scheme, the 'debt' becomes payable from that payment date and should fall within the 120-day contractual prescription period, and not three years later, as expected with normal prescription, as the contractual prescription of 120 days has expired, as per Regulation 6.

Medical Schemes Act 131 Regulation (10)(3) Personal medical savings accounts (Medical Schemes Act No. 131 Regulation 6, 1998; Medical Schemes Act No. 131 S57(4)(d): Communication Guidelines for Medical Schemes, 1998). Personal medical savings held by the medical scheme are the members' money and must be returned to the members when they leave the medical scheme. If the member has died, this money must be given to their dependants. It is not the medical schemes' money.

Court ruling

The high court ruled that all funds in the personal medical savings accounts of the members must be treated as trust money and must be available for the exclusive benefit of the member and his/her dependants. Interest accrued on these amounts must also be paid to the members or guardians as per the Circular released on 28/09/2011. (*Genesis Medical Scheme vs Registrar of medical schemes and another [Case]*, 2017; Medical Schemes Act No. 131 S30(1)(e): Personal Medical Savings Accounts Circular, 2011)

From Table 2.2, it is clear that the Reid technique violates section 10, 12 (1), 23 (1), 35 (1)(c) and 35 (5) of the Bill of Rights (Currie & De Waal, 2013). All these abovementioned factors may well threaten the interviewee's right to be worthy of honour/respect, which may render the interview a breach of the Bill or Rights. It further violates section 217 of the Criminal Procedure Act (51 of 1977), and the Labour Relations Act (66 of 1995), section 186 (2), making the Reid technique unlawful in South Africa according to the literature (CMS, 2004; Van Graan, 2018).

2.4.4 Forensic Investigators and Other South African Laws

When dealing with forensic audits, the Prescription Act of 1969 must be considered. Prescription is the relevant time that must pass, for a debt to become expunged, unless prescription was interrupted (South African Credit Ombud, 2020; The Prescription Act No. 68 of 1969, 1969; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016). The average prescription is three years, unless a contractual prescription indicates otherwise, such as the bond of a house, which is 20 years, or a statutory obligation, such as Regulation 6.

Regulation 6 of the Medical Schemes Act stipulates that medical practitioners have 120 days from the date of treatment in which to submit claims. Thereafter, claims will not be paid by the medical schemes as the contractual period has expired (Medical Schemes Act No. 131 Regulation 6, 1998). Furthermore, once the claims have been submitted, the medical schemes have 30 days in which to make payment and 30 days from payment in which to notify the medical practitioner of billing irregularities and is, therefore, a contractual prescription (Medical Schemes Act No. 131 Regulation 6, 1998; Prescription Act 68 of 1969 Table: A Contractual Prescription, 1969; The Prescription Act No. 68 of 1969, 1969).

If the claims have not been paid, the patient may be liable to pay, except if the claims were submitted late, in which case, the patients have the right to seek recourse from the CMS. According to Regulation 6 of the Medical Schemes Act, it is within the law that the medical schemes' forensic investigators must notify medical practitioners of any queries regarding claims within 30 days of receiving the claim, and afford practitioners 60 days in which to rectify any irregularities, allowing for the claim to be rectified and paid within the 120-day period, a valid turnaround period (Medical Schemes Act No. 131 S30(1)(e): Personal Medical Savings Accounts Circular, 2011).

If forensic investigators continue to be deliberate or negligent with their acts of tardiness in pursuing claims of billing irregularities without incurring the consequences of prescription or other laws, they would be undermining the power and authority of the law (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29*

September 2016), 2016). The only time the prescription period may be extended, and which a person will be held liable for further payment of the debt, is when:

- An acknowledgement of debt is made, either verbally or in writing.
- A payment has been made towards the outstanding 'debt' amount, which brings into question how offset impacts the prescription period, in this study.
- A summons has been issued and served on the practitioner.

This means that once the prescription period has passed, the debt is extinguished and no longer payable. This expunction occurs if you have not verbally agreed that you are guilty, nor signed an admission of debt (AOD), nor made a payment, and you have not been summonsed (The Prescription Act No. 68 of 1969, 1969). The creditor such as the medical schemes, cannot postpone the commencement of prescription by its own accord or lack thereof (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 7).

This means that the moment the money was allocated, by the medical schemes, for payment to the medical practitioner for services rendered, the 30-day prescription period started, not the date on which the medical schemes' forensic investigators sent the practitioners an email, demanding payment (The Prescription Act No. 68 of 1969, 1969; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016). Therefore, the date on which the debt was due must not be confused with the date on which the medical schemes required the debt to be repaid (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016).

The Medical Schemes Act Section 58, further stipulates, that all scheme administrators must consolidate a detailed report on debt owed by providers, with an age analysis of outstanding debt amounts, two weeks after the end of the each month (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). This indicates that the medical schemes had the necessary knowledge available within the contractual prescription period, through AI, regarding all the facts from which the so-called debt arose, and the forensic investigators did not exercise "reasonable care," as per section 12(3) of the Prescription Act (The Prescription Act, No. 68 of 1968, 1968; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016), in notifying the medical practitioners of any irregularities or discrepancies.

When medical practitioners send accounts via EDI, the claims are accepted in real-time, and acknowledgement of payment is indicated. When the payment is received, a statement is

sent to the medical practitioner that says, “This claim has been paid according to the scheme rules,” and as such no debt has been incurred according to these statements. “There is no sense in looking for the point in time when the debt is due, if the debt does not even exist” (Gabryk & Gumede, 2016, p. 1; *The Standard Bank of South Africa LTD vs Miracle Mile Investments 67 (PTY) LTD, and Present Perfect Investments 116 (PTY) LTD*, 2016, p. 15).

Part of the Medical Schemes Act, Section 58 2(a), (3), and (4), of the administration requirements, stipulates that medical scheme administrators must have the infrastructure to deal with the complexity, and number of claims, as well as comply with the Medical Schemes Act and the Regulations published thereunder (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010, p. 13). It is not acceptable for medical schemes to wait for three years to implement an audit which is in violation of the Rules and Regulations of the Act (Hearing, 2021a; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010).

It appears that the forensic investigators are trying to revive the prescription, through coercing signage of an AOD from medical practitioners. “Interruption of prescription, by acknowledging liability is one thing, attempting to revive an extinguished debt by acknowledgement is another” (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 5). According to the Supreme Court (2016) “the creditor should not be able to rely on his own failure to demand performance from the debtor in order to delay the running of prescription” (*JNP Jansen van Vuuren and another NNO*, 1993; *Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 7). By the time the medical practitioners sign the AOD, the so-called debt for part of the audit amount, has already expired, because the forensic audit was backdated for three years. However, some practitioners do not even know what prescription is, as it does not fall within their framework or training.

Although the prescription can be extended when payments are made towards the debt, these payments must be voluntary (Gabryk & Gumede, 2016; Magubane, 2019; The Prescription Act No. 68 of 1969, 1969). The forensic investigators activate offset, without notifying the physiotherapist, as a means of forcing repayment of the alleged debt, extending the prescription period indefinitely, until all debts have been paid. In various instances, it was observed that offset was not cancelled when the AOD had been signed, resulting in both offset and monthly repayments being collected with the outcome being that the medical schemes received more than the agreed AOD amount per month, causing significant financial damage to the practice.

Audited physiotherapists were still receiving statements that indicated indebtedness, five years after the audit. The debt amount would, therefore, have been up to eight years old, which had been prescribed but has still been demanded. Prescription had not been extended, as an AOD had not been signed, however, offset was implemented, unbeknownst to the physiotherapist, and without authorisation, making this form of repayment, involuntary (Van Graan, 2018; Vrij, 2004) .

The credit ombud has no jurisdiction over the medical schemes, so prescription complaints must be addressed to the CMS (South African Credit Ombud, 2020). The prescription period is only acknowledged if it has been brought to the attention of the judge by the debtor, otherwise, it will not be considered as part of the evidence (Magubane, 2019).

"*The basic principle of procedural fairness is that the person affected by a decision must have sufficient notice of the contemplated action, as well as been afforded adequate opportunity to be heard before the decision is taken. Exactly what constitutes sufficient notice and an adequate hearing, will depend on the facts of the specific matter"* (CMS, 2004, p. 6). The lack of knowledge and resultant confusion regarding prescription has led many medical practitioners to seek legal advice, causing potential hurt, harm, and damage to the practitioners (Gabryk & Gumede, 2016).

2.5 Medical Funding Schemes as Organisations of Power

Medical funding schemes and their administrators, have natural positional power due to their sheer size, number of people who work in the forensic investigation team, and the amount of money they have at their disposal (Broomberg, 2020). Furthermore, forensic investigators have the power and authority to withhold money, reject evidence, and blacklist physiotherapists, which places them in an authoritarian position, able to dictate processes and their outcomes. This positional power was already discussed in terms of using the Reid technique (Gehl & Plecas, 2017; Van Graan, 2018), but power is further explained in terms of 'hard and soft powers' as depicted in the orange block in 1-1

2.5.1 Types of Powers Seen in Large Organisations Versus Individuals

Power within organisations and individuals are a common phenomenon and occurs when an individual or organisation is able to get a person to do something they would otherwise not do (Peyton et al., 2019). Power issues occurred when individuals were more concerned for themselves than for the organisations' success, or, when individuals were dedicated to achieving a set of managerial and ethical values or targets as set out by the organisation (Singh, 2009).

‘Hard powers’ are found in large organisations where the power aspects could be divided into three parts: Legitimate, reward, and coercive powers (Peyton et al., 2019; Singh, 2009) which is depicted in Figure 2-7 The only way legitimate and authoritarian power is able to maintain its dominance, is through the use of coercive and reward powers, which are negative powers. This form of decision making is complex and unpredictable, depending on the judgment of the person in power (Fleischmann & Lammers, 2020). Coercive powers can bring down the good effects of referent power, as they *“establish harsh preconditions that cannot be morally negotiated”* (Singh, 2009, p. 169).

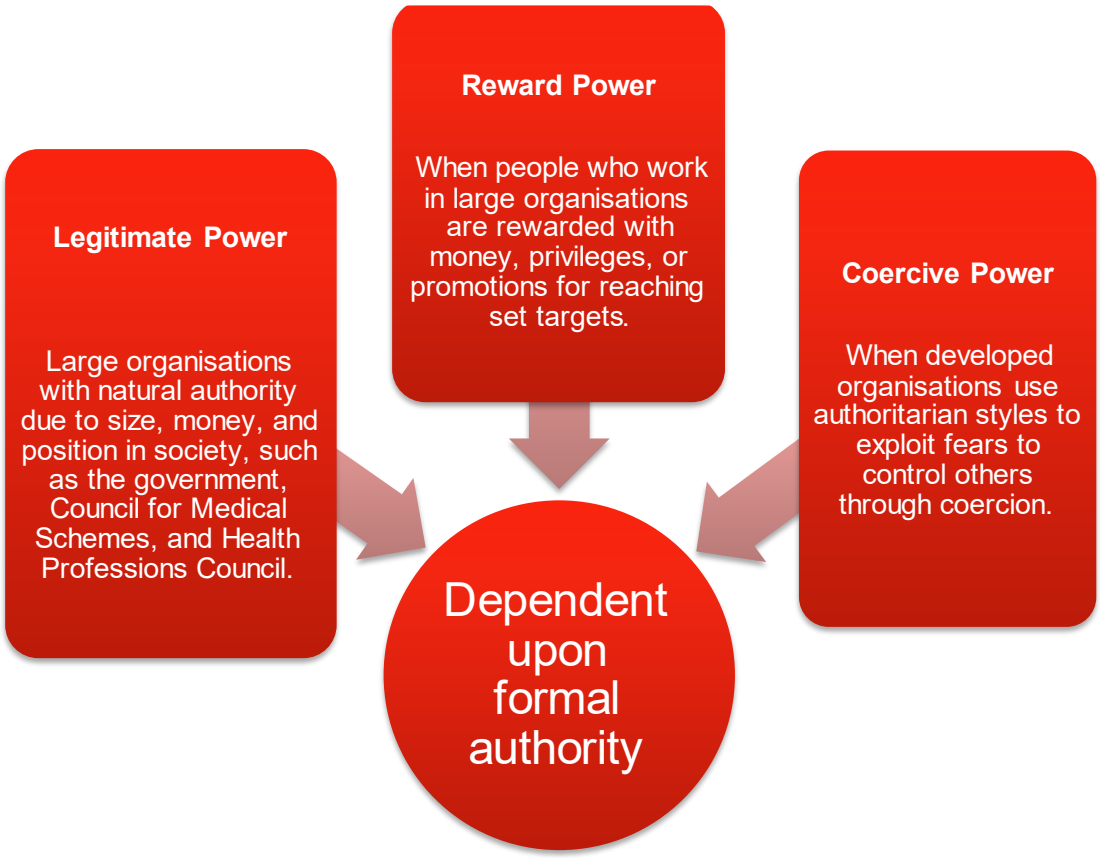

Figure 2-7: Hard powers used by large organisations to dominate smaller people (Self-created using the descriptions from Peyton et al. (2019) and Singh (2009))

An explanation of this concept of ‘hard power’ through an example may follow as such: If the forensic investigators, who have legitimate power, used reward power such as incentivisation within their organisation to reach monetary targets, they would need to use coercion of physiotherapists by removing obstacles such as valid evidence, or ignore legal counsel of physiotherapists to maintain their formal authority and reach their targets, as was discussed in other studies (Fleischmann & Lammers, 2020; Van Fossen & Chang, 2022; Van

Graan, 2018). The use of negative powers, illustrate lack of integrity (Singh, 2009), and provide limited opportunity to exercise choice (Peyton et al., 2019; Tamara et al., 2021). Soft powers are seen in individuals who show competence in their field in the form of expert power, referent power, and reciprocal power which is displayed in Figure 2-8

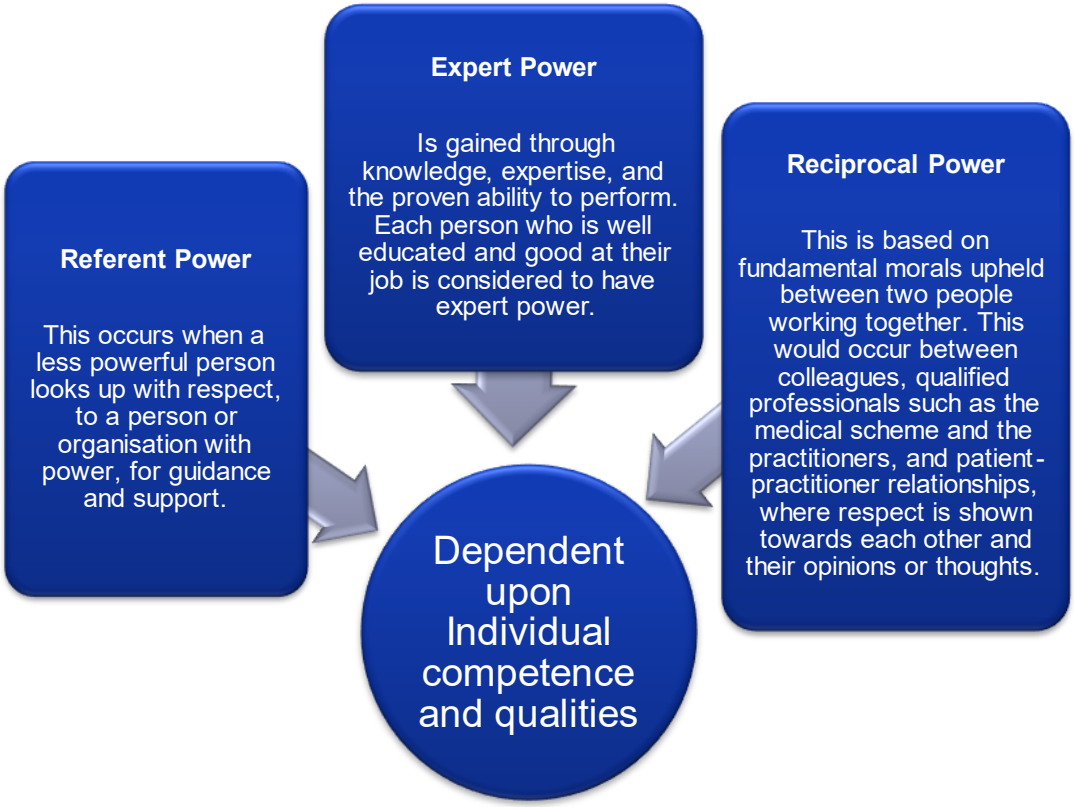

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Figure 2-8: Soft powers desired by physiotherapists (Self-Created using the descriptions from Peyton et al. (2019) and Singh (2009))

Lack of choices may result in physiotherapists feeling overwhelmed by negative thoughts, such as anger, rage, resignation, or despair, due to uncontrollable or unpredictable situational factors, as explained in other studies (Cohen et al., 2016; Peyton et al., 2019; Van Fossen & Chang, 2022; Van Graan, 2018). When physiotherapists experience these feelings of overwhelm, they may have conducted their tasks mindlessly, with little regard for their performance. If coercion powers were used over a long period of time physiotherapists may have closed their practices (Peyton et al., 2019; Singh, 2009). The impact of organisational powers and the potential outcomes are depicted in

Outcomes of using hard powers	Outcomes of using soft powers

‘Hard powers’ may be used to exploit the fears of individuals and may be seen as an abusive form of psychology, which is highly detrimental. The use of hard powers may result in increased conflict, with different reactions, such as fleeing, fighting back, or giving up, resulting in hurt, harm, and distress. The complex hard powers may curb creativity, stall personal growth, limit ethical practice, manipulate the psyche, bear false witness, and exhibit bias.	Soft referent powers may be used, as an example, to benefit physiotherapy practices through training young physiotherapists in billing, treating more complex patients, and educating young physiotherapists in the special interests of the practice they work in. Respectful, reciprocal power occurs between healthcare practitioners who work together for the benefit of the patient. Respectful reciprocity is expected when dealing with forensic investigators during all communications and especially during audits for allegations of billing irregularities.

Table 2.3 Examples of potential outcomes comparing hard and soft powers (Self-created created from various descriptions from Tamara et al. (2021) Peyton et al. (2019), and Clark (2018)

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Outcomes of using hard powers	**Outcomes of using soft powers**
‘Hard powers’ may be used to exploit the fears of individuals and may be seen as an abusive form of psychology, which is highly detrimental. The use of hard powers may result in increased conflict, with different reactions, such as fleeing, fighting back, or giving up, resulting in hurt, harm, and distress. The complex hard powers may curb creativity, stall personal growth, limit ethical practice, manipulate the psyche, bear false witness, and exhibit bias.	Soft referent powers may be used, as an example, to benefit physiotherapy practices through training young physiotherapists in billing, treating more complex patients, and educating young physiotherapists in the special interests of the practice they work in. Respectful, reciprocal power occurs between healthcare practitioners who work together for the benefit of the patient. Respectful reciprocity is expected when dealing with forensic investigators during all communications and especially during audits for allegations of billing

	irregularities.

Table 2.3 Examples of potential outcomes comparing hard and soft powers (Self-created created from various descriptions from Tamara et al. (2021) Peyton et al. (2019), and Clark (2018)

Due to the harm hard powers incur, hard powers are inferior to soft powers (Peyton et al., 2019; Singh, 2009). When organisations take their powers for granted, arrogance and disrespect for others occur (Singh, 2009). The negative use of hard powers, may result in failure, low motivation, influence productivity, and cause disillusionment (Fleischmann & Lammers, 2020; Peyton et al., 2019; Singh, 2009). This disrespect, arbitrariness towards other professionals, immature behaviour, and lack of insight, may further result in a reduction in productivity, globally, of individuals who rely on soft powers during interactions. The degeneration of managerial wisdom, in organisations using hard powers, may further occur, because they are only interested in themselves, and not the bigger picture (Singh, 2009).

The physiotherapy practice is a living, breathing, dynamic, symbiotic entity (Singh, 2009) that should be treated as such, and not have the human aspect removed (Tamara et al., 2021), as may have been done during an audit by the medical schemes. If expert and reverent power were to be used during the audits, where reflection and choice in decision-making were promoted, it would provide support to the physiotherapists, and promote career and personal growth (Peyton et al., 2019; Singh, 2009). By having an impartial decision-maker, the physiotherapist's dignity and soft powers would be recognised. If physiotherapists were to be heard, the small to medium-sized physiotherapy practices would have been protected (Competition Act 89 of 1998, 1998).

Physiotherapists may portray stress symptoms such as nervousness, irritability, insomnia, and loss of concentration if coercive powers are used on them (Singh, 2009; Tamara et al., 2021). The use of coercive powers may further lead to other ramifications (Peyton et al., 2019), an example may be if physiotherapists experience audits as stressful, which could impact their performance (Dohrenwend, 2006; Singh, 2009). The potential impact audits could have on physiotherapists if 'hard powers' were to be used is depicted in Table 2.4

Table 2.4: Medical scheme's power and the potential impact it may have on physiotherapists (Self-created using descriptions from Tamara et al. (2021), Hearing (2020), Dean et al. (2019)

Medical schemes' organisational powers	How does this power impact physiotherapists?
Medical schemes have natural legitimate organisational power, due to their sheer size, and number of employees. Furthermore, trust, and respect is afforded to the medical schemes by healthcare professionals, due to their position in the industry (reciprocal power), their status in society, their status on the financial market, the control they have over funding patient treatments, and the rights afforded to them through the Medical Schemes Act. The medical schemes may incentivise their employees to reach specific monetary targets, which could be achieved if physiotherapists were influenced into signing an AOD, to repay substantial amounts of money, for accusations of billing irregularities. The AOD may further extends the prescription period, when billing irregularity dates have already prescribed (Reward, and coercive powers).	When hard powers are used to create fear and anxiety, the physiotherapists may become conflicted and distressed, and be influenced into signing an AOD. Physiotherapists may have to change their practice to a cash practice, or they may have to fight back, through spending exorbitant amounts on legal counsel. All of the above may result in ramifications for the physiotherapists, and the profession at large. Physiotherapists may be forced to hand over clinical notes, potentially violating the patient-practitioner confidentiality obligation, in an attempt to prove their innocence. Physiotherapists may lose their trust and reciprocity towards the medical schemes if the practitioners feel they have violated their confidentiality obligations. Furthermore, if this confidential information is then rejected or ignored by the medical schemes as invalid innocence, this rejection may compound the loss of trust practitioners have towards medical schemes.

2.5.2 Group-Biased Thinking

A team is considered to be a group of two or more people, with specialist and interdependent roles, who work together to perform a complex task, in order to achieve goals set out by the organisation (Fleischmann & Lammers, 2020; Jones & Roelofsma, 2000). Group biased thinking is a term used for large corporations where teams of people work together and their decision-making differs from what would usually be considered acceptable by others and is influenced by a number of factors (Jones & Roelofsma, 2000) and is depicted in Figure 2-9.

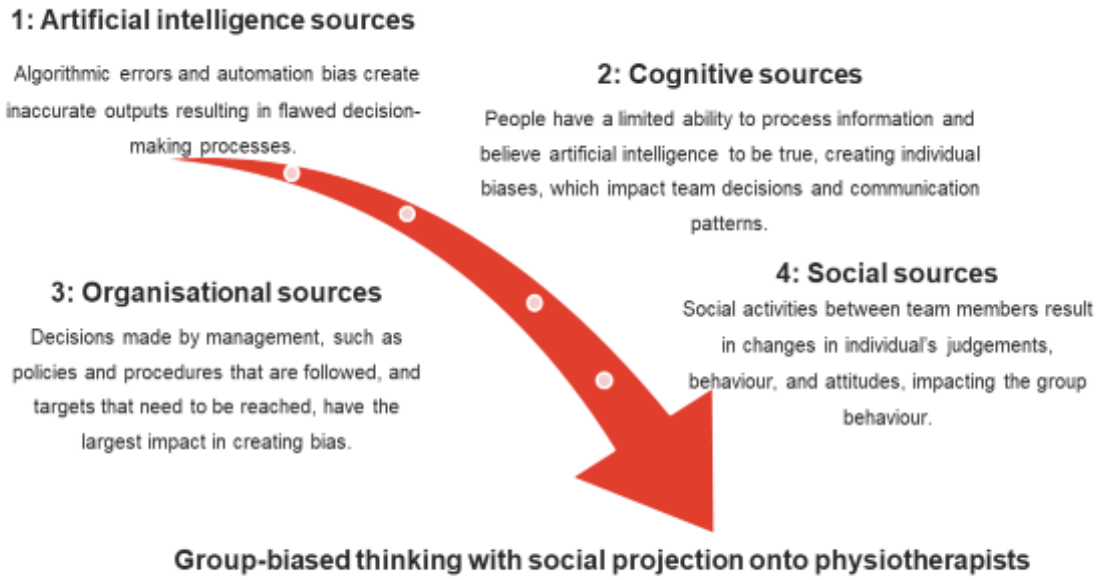

Figure 2-9: Factors contributing to group-biased thinking. (Self-created by descriptions from Jogi (2022), Liu (2022), van der Niet (2021), and Jones (2000))

The most significant factor that creates bias and error, occurs at management levels where decisions are made (Jones & Roelofsma, 2000). Furthermore, bias and error are created through social activities between team members. Individual judgement, behaviour and attitudes may be changed as a result of other people's influence, and can significantly impact the group decision-behaviour of the team (Jones & Roelofsma, 2000).

Social projection would occur if these biases were projected onto the physiotherapists who have been audited. Social projection suggested that people who were certain about their viewpoint, were more focused on that viewpoint, and were less likely to consider alternative suggestions (Jones & Roelofsma, 2000; Porter & Crumbley, 2012; Van Graan, 2018). Therefore, all decisions resulting from bias would be detrimental (Liu et al., 2022).

Team bias occurred when, for example, incentivised targets set up by the organisation, violated the Medical Schemes Act (Auditing Professions Act No. 26 of 2005, 2005; Medical Schemes Act No. 131 S36(2): Standards for Authorisation of Auditors for Medical Schemes, 1998). Additionally, bias would occur when teams trust AI algorithms as absolute truth, creating team processing errors, as forensic investigators may have only seen guilt and believed nothing else to be true (Liu et al., 2022; Porter & Crumbley, 2012; Van Graan, 2018) because they relied solely on the information provided by AI. Human countermeasures, i.e.,

fact-checking, may have often been disregarded when targets needed to be met, and AI was believed to be true (Jogi, 2022; Jones & Roelofsma, 2000; Van der Niet & Bleakley, 2021).

When AI is used to gather information and evidence, it can pose an immediate concern during an audit, as it may result in algorithmic errors, resulting in bias, with detrimental effects on the audited physiotherapists. AI cannot add clinical knowledge or expertise or understand valid reasons for irregular billing patterns. Algorithmic errors are any outputs that are inaccurate, resulting in harm, if undetected. Alternatively, the output may appear correct but the algorithm may have been informed by flawed decision-making processes and information (Dean et al., 2019; Jogi, 2022; Liu et al., 2022; Van der Niet & Bleakley, 2021).

Modern AI systems are able to self-learn, and can create very complex relationships between input data, and output predictions (Liu et al., 2022). This allows the machine to highlight patterns in the data, which may be unreliable. When applied to physiotherapy practices, if the clinical knowledge or expertise of the physiotherapist, special interest practices, or the use of outdated NHPRL codes were not considered, this may have resulted in automation bias, which the forensic investigators relied on and trusted (Dean et al., 2019; Liu et al., 2022; Van der Niet & Bleakley, 2021).

If a team member of the forensic investigation team believed that there were billing irregularities made by the physiotherapists, the result of this individual's judgment, may have contributed to, or directly resulted in, a team decision bias. This team bias would then influence decisions made or the outcomes of the audits (Jones & Roelofsma, 2000). Cognitive bias and errors would occur if AI indicated irregular billing patterns, which were regarded as billing irregularities by the forensic investigators. This trust in AI would create bias which would result in evidence to the contrary being disregarded (Liu et al., 2022; Porter & Crumbley, 2012; Van Graan, 2018).

Team structure and communication patterns of the medical schemes' forensic investigators, play a direct role in developing mental patterns and assumptions (Jones & Roelofsma, 2000). When the perception of the target group is inaccurate, a false consensus amongst forensic investigators may, therefore, arise (Jones & Roelofsma, 2000; Van Fossen & Chang, 2022; Van Graan, 2018). This discrepancy in understanding may appear subtle, but may induce a significant change in the team members' mental thoughts, resulting in unpredictable team decisions (Jones & Roelofsma, 2000).

Decisions included escalating the situation, to make previous behaviour and decisions appear rational (Jones & Roelofsma, 2000). These team dynamics included using words such as ‘risk’, ‘threat’, ‘likelihood’ or ‘billing irregularities’, which further created group bias thinking. The medical schemes may have claimed that they were protecting the members from ‘risk’ by applying offset, which was an escalation of bias to support the medical schemes’ assertions that physiotherapists were guilty of billing irregularities.

According to the medical schemes, the money needed to be recouped, however, the members were not informed, or consulted, and the money, if paid from the members’ savings, was not returned to the member, violating the Medical Schemes Act (Medical Schemes Act No. 131 S30(1)(e): Personal Medical Savings Accounts Circular, 2011). The physiotherapists may then have become a cash practice to avoid offset, placing the financial burden of payment for treatment, on the member. The members were, therefore, not protected from the alleged risk.

What the medical schemes considered billing irregularities, risk, and threat, may not have been regarded as such by the physiotherapists. Physiotherapists were following the rules and regulations of the NHPRL, which were already monitored by EDI, which was set up to prevent FWA, and billing irregularities. Furthermore, the physiotherapists were paid by the medical schemes, for claims submitted via EDI, according to the schemes rules, suggesting that there were no billing irregularities (Jago & Pfeffer, 2019).

2.5.3 Intentional Versus Unintentional Harm by Large Organisations

Organisations have a greater capacity to positively or negatively influence people, compared to individuals, because they have greater resources, and can, therefore, do more harm or good, depending on their intentions (Ames & Fiske, 2013; Jago & Pfeffer, 2019). Intentionality was and is one of the most substantial components of blame. Large companies who had negative intentions and purposefully caused harm were considered to be more unethical and to blame, compared to individuals who had committed the same unethical behaviour (Jago & Pfeffer, 2019).

Corporates which act “criminally or immorally not only harm individuals but also create broader social harms, to which people are sensitive” (Ames and Fiske, 2013 pg. 5). People perceived intended harm as far worse than unintended harm, because of their moral responses to harm because moral judgments are emotional, subjective, and complex (Ames & Fiske, 2013).

If forensic investigators were to assume that physiotherapists were guilty before they had met, they were intentionally choosing to lay blame on the physiotherapists, and this in turn caused harm to the physiotherapists (Tamara et al., 2021). The medical schemes were intentionally pursuing financial targets through clawing back money from physiotherapists via offset and AODs. The forensic investigators of the medical schemes may have been blamed as the direct cause for the negative experiences of the individual physiotherapists, which may also have resulted in attrition of the profession (Broomberg, 2020; Hearing, 2020).

The forensic investigators sought to appear less unethical and biased by accusing individual physiotherapists of unsubstantiated transgressions instead of focusing their attention on resolving the issue of an outdated billing system (Jago & Pfeffer, 2019). These forensic investigations, which may have been accusatory in nature, could be perceived as a betrayal of physiotherapists', healthcare professionals', patients', and the public's trust, which may have caused more harm, than initially thought (Tamara et al., 2021; Van Fossen & Chang, 2022).

Medical schemes' forensic investigators would cause intentional harm if they purposefully prolonged response times and lengthened the audits while demanding that physiotherapists respond within days. Furthermore, harm would be caused if goal posts were constantly shifted, confusing physiotherapists, or threats may have been made to take back money, audit for larger amounts, and/or blacklist the physiotherapists (Gehl & Plecas, 2017; Van Fossen & Chang, 2022; Van Graan, 2018).

Intentional harm would be caused if communications by the forensic investigators were disrespectful, violating the Medical Schemes Act (Auditing Professions Act No. 26 of 2005, 2005; Medical Schemes Act No. 131 S57(4)(d): Communication Guidelines for Medical Schemes, 1998). This intentional harm could have further caused cognitive changes and bias within the medical schemes' forensic investigation team, resulting in additional harm and damage to the physiotherapists. Intentional harm could further have been observed if forensic investigators falsely accused physiotherapists of guilt. These accusations could be seen as intentional harm to the physiotherapists, by their families and outsiders looking in (Ames & Fiske, 2013; Jago & Pfeffer, 2019).

2.6 Conclusion

The conceptual framework comprised "Physiotherapists' experiences of forensic audits by South African medical funding schemes". The first concept, 'physiotherapists', dealt with how physiotherapists qualify as competent medical professionals who are able to diagnose and

treat a large variety of medical conditions, using values-based patient care. Physiotherapists may become professional private-practice owners with a general, in-hospital, out-patient, or special interest practices, treating general or specific conditions. Physiotherapists work in collaboration with other medical professionals as they are recognised as autonomous practitioners by the HPCSA. Physiotherapists may choose to sign a preferred provider contract with the medical schemes and accredit their practice through the SASP.

The second concept in the framework, ‘experiences’, described how there are good and bad experiences which could alter the trajectory of a persons’ life. Negative events may be classified as stressful impact events when negative signs and symptoms occur. Negative impact events follow a specific trajectory as the events unfold, with specific signs and symptoms indicating hurt, harm, distress, and other ramifications experienced by people. Defamation of character may be such an event which may cause damage to the physiotherapists’ practice if physiotherapists experience defamation during audits.

The third concept, ‘forensic audits’, discussed how forensic auditors follow different interviewing techniques such as the non-aggressive, constructive PEACE technique, or the intimidating and oppressive Reid technique, to gather information. The use of the Reid technique may be seen as a violation of the South African Bill of Rights. In South Africa, investigators are required, by law, to follow all rules and regulations set out by the Medical Schemes Act, which is based on the Bill of Rights. Investigators must also follow the rules and regulations of the Auditing Professions Act, Prescription Act, and all other laws pertaining to medical professionals and their billing practices. Forensic investigators are not allowed to be incentivised or have criminal backgrounds when conducting forensic investigations on medical professionals.

The fourth concept, ‘medical funding schemes’, discussed how medical funding schemes have power due to their size, stature, and financial backing. They also have power vested in them by the Medical Schemes Act. These large organisations create group thinking bias due to organisational cultures which require targets to be reached, and incentivisation of their staff members. Furthermore, investigators may believe that AI is correct, and individual team members may be influenced by other team members’ individual judgements. These large organisations may then use this legitimate, hard power into overpowering and manipulating individuals into complying with organisational demands, while soft powers found amongst individual physiotherapists may be ignored.

The fifth, and last concept in the framework, ‘outcomes’, was intertwined throughout Chapter 2, as the literature explored the different outcomes that can be experienced by physiotherapists being investigated during forensic audits. The literature revealed that these outcomes could result in distress, hurt, harm, and damage to individuals. If for example the physiotherapists were to experience that their autonomy, as well as the relevant professional code of conduct that they live by, were disregarded, it could cause much hurt and harm. Similarly, if the physiotherapists were to experience symptoms similar to a negative impact event, it would have ramifications. So too, physiotherapist could experience detrimental outcomes similar to moral injury, burnout, and/or compassion fatigue.

The literature review provided in-depth discussions of the main concepts which underpins the study, and the findings are presented in Chapter 3. Chapter 3 again provides a brief background of the study, and briefly discusses the methodology used to conduct the study. As this was a qualitative study where participants were interviewed, ethics clearance was obtained from the University of Pretoria with the reference number 135/2022 which is attached in Appendix C. Informed consent was obtained from participants, attached in Appendix D. A demographics questionnaire Appendix E was completed and lastly, a semi-structured interviews guide Appendix F, was used to conduct the interviews.

3 Manuscript - Physiotherapists' Experiences of Forensic Auditing by Medical Funding Schemes in South Africa

The following manuscript was sent to a journal for peer review and publication.

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3.1.1 Keywords

Audit, conflicts of interest, entrapment, health insurance, health systems, impact, perceptions, physiotherapy, private providers, qualitative research

3.1.2 Key Messages

- Participating physiotherapists experienced forensic audits by medical funding schemes as unfair, perceiving that they were persecuted, judged, and penalised for billing patterns that the auditors unilaterally deemed as irregular.
- Participants felt overpowered, oppressed, and naively entrapped 'between a rock and a hard place' when the auditors disregarded clinical notes, peer-reviews conducted by the professional physiotherapy association, being a first-line practitioner, and practices with a special interest, which nihilated the trust between the medical scheme and the practitioners.
- Participants experienced distress during these audits, including hurt and detriment to themselves and their practices, with adverse ramifications including abandonment of the profession.
- Participants proposed remedies such as improved education, external unbiased mediators, and support from the Council of Medical Schemes and the South African

Society of Physiotherapists, with the aim to protect physiotherapists pre-emptively and preparedly from undergoing a similar adverse auditing experience.

3.1.3 Reflexivity Statement

All authors are citizens of a low-to-middle-income country, speaking different home languages, and comprise a male and two females. The principal author has been a physiotherapist in private practice for more than 27 years. The second author is a professor of physiotherapy, and the third author is a professor of philosophy and psychiatry, and the recently appointed Editor-in-Chief of the international journal *Philosophy, Psychiatry, and Psychology (ranked 7th of 328).*

3.1.4 Data Availability Statement

The data on which this article is based will be shared on reasonable request to the corresponding author.

3.2 Abstract

3.2.1 Background

Forensic auditing for billing irregularities was conducted in Australia, Canada, and the United States of America (USA), whereby, negative outcomes in the forms of attrition, and out-of-pocket funding of patients were reported. Medical professionals were harshly penalised, without taking any alternative explanations of irregular billing patterns into consideration, resulting in small practices being unable to financially defend themselves, and closing their doors, preventing patients from receiving medical care. South Africa was not included in this study, and no studies were found that had taken medical professionals' or physiotherapists' experiences of billing irregularities into account.

3.2.2 Aim

This study aimed to explore and describe the experiences South African private practice physiotherapists had, due to forensic auditing conducted by medical funding schemes.

3.2.3 Methods

A qualitative study was conducted, using a semi-structured open-ended interview guide. Ethical clearance and participant consent was obtained. All interviews were conducted online that were recorded and automatically transcribed using the Cisco Webex platform. A total of 14 physiotherapists who had been audited were interviewed. Eleven physiotherapists attended individual interviews and 13 participants attended the three FGDs in groups of five, six, and two participants respectively. Data was analysed using open coding and axial coding where the themes and subthemes emerged. Saturation was obtained after the first FGD which was subsequently confirmed through analysis of the other interviews and discussions.

3.2.4 Findings

Six themes emerged from the transcripts of the interviews and FGDs. The first five themes describe the negative experiences physiotherapists had and were described in the themes 1) "unfairly persecuted, judged, and penalised", 2) "overpowered and oppressed", 3) "naively entrapped between a rock and a hard place", 4) "distressed with a knife over your head", and 5) "detrimental and hurtful". The last theme, 6) "seeking remedies pre-emptively and preparedly", was about the different solutions participants recommended to prevent other physiotherapists from having to go through a negative auditing experience.

3.2.5 Conclusion

It would be prudent for stakeholders, who have been tasked with protecting the physiotherapy profession, to investigate these findings further. If the findings are corroborated, then solutions need to be implemented.

4 Physiotherapists' Experiences of Forensic Auditing by Medical Funding Schemes in South Africa

4.1 Manuscript Introduction

Audits of billing irregularities in Australia, Canada, and the United States of America (USA) have been reported as having detrimental effects on the medical profession and patients whereby Australia had an out-of-pocket crisis and patients had to fund their treatments outside their medical funding scheme provisions (Faux et al., 2021). Moreover, small practices were not able to fund legal counsel and were forced to close, leaving patients without care in rural areas (Faux et al., 2021).

In South Africa, one medical scheme retrieved R555 million, in 2018, from 93% of the healthcare professionals audited for billing irregularities (Geldenhuys, 2019) of which R14 702 204 was retrieved from physiotherapists (Smith, 2019). However, only 1 to 9% of the healthcare professionals who had been investigated were guilty of fraud, waste, and abuse (FWA) (Marais, 2006). Medical schemes are mandated to investigate allegations of billing irregularities according to the Medical Schemes Act (Hearing, 2021a; Medical Schemes Act No. 131 of 1998, 1998). However, their mandate excludes the investigation for FWA over ZAR100 000. Mandates for FWA investigations are held by the Health Professions Council of South Africa (HPCSA) and the South African Police Service (SAPS) (HPCSA Corporate Affairs, 2019; Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974).

When FWA is suspected in billing irregularities for amounts larger than ZAR100 000, then practitioners must be reported to the HPCSA and SAPS for investigation (HPCSA, 2017a; HPCSA Corporate Affairs, 2018b; Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974). However, the medical schemes have little faith in the SAPS, HPCSA, and justice system, therefore, the medical schemes do not report FWA for further investigations to the HPCSA or SAPS (Marais, 2006).

Medical funding schemes in the South African private health sector initiate a forensic audit upon receipt of a complaint or when artificial intelligence highlights 'irregular' billing patterns (Durrant, 2018; Liu *et al.*, 2022). These schemes receive claims from patients for health services rendered, requesting re-imbursement, or the medical schemes receive these claims directly from practitioners who submit through electronic data interchange (EDI) (Bloom & Momentum, 2020; Datamax, 1995).

Artificial intelligence (AI) is used to highlight billing irregularities, but are known for making errors and invoking a failure mode (Jogi, 2022; Liu et al., 2022; Van der Niet & Bleakley,

2021). Algorithmic errors occur when the outputs of AI are inaccurate and can result in harm if detected too late or when the output is apparently correct but flawed by professional parameters (Liu et al., 2022). Algorithmic errors are difficult to foresee or prevent, resulting in automation bias, human error, and unintended or intended misuse (Faux et al., 2021; Jogi, 2022; Liu et al., 2022; Tamara et al., 2021). A failure mode occurs when flawed processes are repeatedly or purposefully used, having similar outcomes that are then accepted as the norm, resulting in above-acceptable threshold levels that cause harm (Jogi, 2022; Liu et al., 2022).

One harmful ramification of these AI errors and failures in forensic audits may arise when money has been clawed back through offset before the practitioner is found guilty (Deng et al., 2021; Kenton, 2021). Offset occurs when payments are allocated for new claims but are withheld and deducted from the 'debt' amount deemed to have been charged 'irregularly' (Hearing, 2021b). Offsetting may happen administratively unbeknownst to the practitioner (Hearing, 2021a). It is also used as leverage in forcing practitioners to sign an Admission of Debt (AOD) upon which the offset funds are supposed to be released.

Compounding these audits is an impasse regarding the gazetting of updated treatment codes used in the billing. The medical schemes require the use of codes but do not accept ungazetted tariff code (SASP, 2014, 2016). Tariff codes have not been updated and gazetted since 2006 owing to the Competition Commission prohibiting billing practices that are considered 'cohesive' (Competition Act 89 of 1998; SASP, 2014, 2016).

Amidst this intricate context in which medical schemes have increasingly audited physiotherapists for billing irregularities (Durrant, 2018; Jago & Pfeffer, 2019), the question not examined before, is how physiotherapists in South Africa experience these forensic audits. The question is important considering the results reported in Australia, Canada, and the USA of detrimental effects on the medical profession and patients (Faux et al., 2021). The aim of the study was to explore qualitatively the physiotherapists' experiences of forensic audits performed by the South African medical funding schemes.

4.2 Methods

The study followed a qualitative design as no previous studies in which the experiences of participants were explored had been found. Online semi-structured individual interviews and focus group discussions were conducted (Yoo & Suh, 2021). The verbatim transcriptions of these were then subjected to thematic analysis (Nowell, Norris, et al., 2017). The study was approved by the Faculty of Health Sciences Research Ethics Committee of the authors' institute

4.2.1 Participants

All private practice physiotherapists registered with the HPCSA and who were forensically audited by medical fundings schemes in South Africa were eligible. The participants were purposively recruited through cold calls and snowball sampling. Fourteen physiotherapists met these criteria and gave written informed consent to participate in this study.

The participants have practised physiotherapy between 17 and 55 years. All participants indicated that they had a special interest practice while 13.3% had acquired a master's degree and were actively involved in training pre-graduate and post-graduate physiotherapists. The majority of the participants (85.7%) had both in-patient and out-patient practices while only 14.3% had an out-patient practice. Majority of the participants were solo practitioners while 35.7% practiced in a group practice. All participants had been audited by the same medical scheme and one participant had been audited by an additional medical scheme which then re-audited her once repayment had been completed.

Eleven of the 14 participants contacted the South African Society of Physiotherapy (SASP) for support. Ten contracted legal counsel while one additionally contracted a forensic actuary and one paid for an advocate, while two had no support at all. Only one reached out to the HPCSA and the Council for Medical Schemes (CMS). The legal fees amounted to as much as ZAR500 000.

Eight participants signed the AOD, one was unfinalised, two were still undergoing offset, one was blacklisted, and two were cleared because the one had retired, and the other one had perfect, detailed notes. None of the participants who signed the AOD had been found guilty by the HPCSA, or a court of law. The minimum amount for which participants were audited was ZAR54 000, and the maximum amount was for ZAR4.5 million in a group practice.

4.2.2 Data Collection and Analysis

Once informed written consent was given, demographic details were obtained and the online interviews and focus groups were set up with the participants via Cisco Webex, an advanced recoding system. Data were collected through semi-structured interviews and three focus group discussions. A total of 14 interviews were conducted. Thirteen of the fourteen participants attended the FGDs. Participants who attended the three FGDs, ranged from five, six, and two participants, respectively. Eleven participants were interviewed through individual interviews.

As there were four interviewers conducting the interviews, open-ended questions were posed by following an interview guide to ensure trustworthiness of the data and limiting bias through bracketing (Gill et al., 2008; Kallio et al., 2016; Milena et al., 2008; Tufford & Newman, 2012). The four interviewers were only responsible for interviewing the participants. The author attended all interviews while each interviewer conducted a minimum of three interviews, one interviewer conducted four interviews, and the researcher conducted one FGD, as the allotted interviewer was unavailable on that day.

All interviews were conducted online and video-recorded and auto transcribed by Cisco Webex and checked by the author for authenticity. Reflective field-notes and memoing were made throughout the study, capturing the observations and reflections of the interviewees (Ortlipp, 2015). The data were analysed using open coding at first, then axial coding identified the subthemes and themes (Medelyan, 2019; Nowell, Norris, et al., 2017). While the main author did the open coding and administrative tasks, all three authors performed the axial coding during ongoing conjoint meetings.

Bracketing was applied in the analysis by which our theoretical understanding of the data was deliberately suspended as to understand the experiences from the participants' point of view (Tufford and Newman, 2012; Dörfler and Stierand, 2021). Data of the individual interviews and the first focus group discussion had been analysed first. The themes so identified, saturated the data and was subsequently confirmed by analysing the data of the second focus group discussion (Saunders et al., 2018). The findings were sent to participants for member checking as a form of triangulation and ensuring trustworthiness of the data.

Table 4.1: Themes and subthemes that emerged from physiotherapists' experiences during and after forensic audits

Subthemes	Quotations from physiotherapists' experiences
Theme 1: Unfairly persecuted, judged, and penalised	
Participants experienced being • persecuted for being deemed outliers • judged by biased non-clinical professionals (non-peers) • judged by incentivised investigators • unfairly audited with unilateral processes and outcomes • penalised excessively, not fitting the "crime"	• *"It just comes down to being a witch hunt and money coming back to the medical schemes". 9:52 ¶ 104 PT 13* • *"I think I have a fairly good working knowledge of physiotherapy coding, and I believe Medical Funder 1 also has an understanding of it. There might be differences with regard to our interpretation of it and that was clear through the audit process". 7:10 ¶ 135 PT 4* • *"They* [forensic investigators] *asked … about outliers, and immediately my next question was, "compared to whom? Which other practice in South Africa has 15 physios, working in a very specific orthopaedic range? So, who are you comparing us to? Because if you're saying, we're an outlier, then surely you have a norm?"" 10:123 ¶ 387 PT 14* • *"You know, you're dealing with a group of people where there's not one physiotherapy representative on their panel. They are actuarial scientists, accountants, attorneys, and maybe a forensic auditor who has a BCOM. … but I don't believe that someone who is getting a financial remuneration as an outcome should be the judge".* 1:355 ¶ 676 FGD 1 • *"We treat people in the forensic department and … one of the patients* [whom] *one of our colleagues was treating had then won the incentive for that particular time, and their entire family went to the Maldives".* 2:214 ¶ 486 FGD 2 • *"We cooperated, we sent everything through and then all of a sudden, the next letter changed … they shifted the goalposts. … none of the codes that they asked for our interpretation of in the first letter were an issue anymore, but every single code they could find on our notes that wasn't there or that wasn't explained well enough … and then it went haywire".* 2:195 ¶ 470 FGD 2

	• *"I do think we had a really good case because other than poor notetaking … it wasn't that we had never done the treatments. Our Physios had done the treatments. They had spent the time. We've got the diary to prove it ...* [rejecting evidence] *that was quite upsetting".* 5:36 ¶ 82 PT 11 • *"Why don't they slap you over the wrists and give you a little fine? A little fine, not R 1.2 million fine and say, you know, you've done this wrong, remediate, otherwise, you will be … hauled over the coals". 14:172 ¶ 158 PT 21* • *" No one said, "You know what, it's not your fault. You haven't done anything wrong. It's not your fault that you didn't know how to use one code," ... Well, if you don't … you misinterpreted using that one code. Well, that means you should burn in hell for the rest of your life. You know what I mean? That's how you feel". 3:32 ¶ 122 FGD 3* • *"What we are seeing is, it's unfairly conducted and one-sided … where the punishment given is completely out of proportion to the … crime committed".* 13:1 ¶ 112 PT 16 • *"As physiotherapists, we still need to make a living, even though we do undercharge and I think most of the physios doing a good job, actually undercharge their patients. In the end, this is our job. … but we come from it from an empathy and a sympathy and trying to give a good service for our patients* [point of view]*". 8:170 ¶ 524 PT 8* • "[paid claims] *This is money from individual patients. So, if the patients were seen in-hospital, money comes from their savings account, so, that money then has to go back to the individual patient, not to the medical scheme, because then they are actually making more money off their clients, which is fraudulent."* 9:149 ¶ 116 PT 13 • *"I acknowledge that there is fraud, and the fraudsters need to be stopped, but it needs to be proven, and Medical Funder 1 should not categorize us all as fraudulent individuals by interrogating us and making us sign agreements that depict us as such."* 10:96 ¶ 512 in Interview 11 with PT 16

Theme 2: Overpowered and oppressed	
Feeling oppressed with • experiences akin to torture • bias against physiotherapists • denigration • threatened Feeling overpowered when forensic investigators • withhold money through offset • purposefully extend the audit period • blacklist and defame the participant • force an admission of debt (AOD) • re-audit physios because they had signed an AOD	• *"I heard how they were treated, locked up in rooms, shouted at, forced to say that they were guilty of doing this, and they had to sign that they accept guilt and pay it back". 8:128 ¶ 363 PT 8* • *"I believe they have a genuine hatred for physios … She* [forensic investigator] *… said, "You physios are all the same. You're filthy, money, hungry, greedy people, and you all … try and make as much money as you can, it's disgusting"". 3:106 ¶ 402 FGD 3* • *"That 65-page forensic report proved to me that I am an ethical, decent human being, I'm not a criminal. They would not even look at it". 2:182 ¶ 445 FGD 2* • *"They* [forensic investigators] *threatened, in the meeting: They will audit every single person on the list and if they want to go back, they'll go back and do it again. And they did do it on one of my colleagues". 2:85 ¶ 176 FGD 2* • *"They* [the Medical Scheme] *never paid me from three weeks after that April letter. I never received a cent from them, and they kept threatening that they would take back what's been accumulated … There was about R500,000 … and they kept saying, "If you don't pay if you don't settle, we will take back that money"". 14:54 ¶ 281 PT 21* • *"You* [the participant] *feel like you fight … you're knocking your head against a brick wall because they* [the forensic investigators] *don't actually have to say anything or do anything or respond to you in any way. … It took them about 5 months to finally get back to us, and when they got back to us, they gave us 2 weeks to get back to them". 5:189 ¶ 83 PT 11* • *"They blacklisted me. "They sent a letter out to all my patients stating that they would no longer be reimbursing services rendered by "PT 16" "and "PT 16" knows the reason why." … Then I had to write a letter to my patients, just to say, I'm in a legal dispute". 2:9 ¶ 68 FGD 2* • *"He's* [physiotherapist] *been audited twice, and you know what he landed up doing? He landed up going*

	the second time to them … and said, "Look guys, if you're going to just continue to do this. You're re-auditing me on exactly the same codes … that you did before, that we settled on, that I'm not doing. So, how about I pay you a certain amount of money a month, every month, until such time as the SASP codes change." I think he settled on five grand a month". 14:166 ¶ 720 PT 21
Theme 3: Naïvely entrapped between a rock and a hard place	
Entrapped in • not knowing • unfairness • having to pay high legal bills • false accusations • divergent rules • a conflict of duty towards patients	• *"So, in the end, it's shocking, it's unfair … they cannot be judge, jury, executioners. So, in the end, these processes need to be understood. Like everyone said, we don't really know what they're after, except for money".* 1:495 ¶ 760 FGD 1 • *"There wasn't really much in that time … that you can actually do to try and get your stress levels down because you've always got this knife (over your head) and you don't know … you're too small to fight this big bully … you know it can have a financial impact. I think that's the biggest issue that, if you start an audit process … you don't know what you're in for".* 1:324 ¶ 625 FGD 1 • *"You really feel like you're up against ... a David and Goliath. Where they* [the forensic investigators] *truly are a law unto themselves. … I suppose in energy that you have, and financial resources, you got to pick your battles … because everything is documents, and everything is communication and everything that your lawyers finally sign off or type … you pay for. So, if it was a consideration for us as a big practice … even more so if you were a single person* [sole proprietor] *trying to pay those legal bills".* 10:166 ¶ 453 PT 14 • *"Medical Funder 1 tells the lymphedema therapists that we can charge 303 twice if it's two limbs … but then just to be … audited by them, although they have told you that it's allowed. So, they set a trap. They want to trap you".* 11:17 ¶ 75 PT 17 • *"We really love what we do, we pride ourselves in what we do. Our patients come first. So, when someone lays that at your feet* [to falsely accuse]. *… That hits hard. Yeah, that's not nice".* 10:38 ¶ 159 PT 14 • *Now, I just don't bill for a second condition and just about every patient I see, there's a second condition,*

	[laughing] *but I just don't bill for it. I mean, it's shocking".* 13:184 ¶ 577 PT 16
Theme 4: Distressed with a knife over your head	
Participants experiences of distress were about feeling • consumed and emotionally drained • helpless and hopeless • unsupported • anxious and stressed • ashamed, embarrassed, and triggered • attacked • a stressful impact event • conceded defeat • questioning their professionalism	• *"It was consuming my everything … I didn't sleep properly. … My brain was buzzing at night, … I was trying to get through patients and deal with all these letters and trying to get support from the SASP. It was very, very hard. It was very, very emotionally draining from a mental perspective I felt totally knocked* [pause]. *It was an attack on my integrity. … I was helpless. I felt helpless and I felt,* [pause] *frustrated and very despondent and very sad about my profession".* 13:362 ¶ 624 PT 16 • *" I lost weight. … I was rocking in the bath with anxiety and stress. … "I can't believe that they can do this to me" … I was in tears all the time. I was stressed. I was anxious. I did have headaches". 2:24 ¶ 77 FGD 2* • *"It was like you were running on empty everywhere. I mean, energy levels wise … my wife said … "You've got to start sleeping, you've got to start eating because you're just wasting away." So, from a stress point of view, it was really bad, and I tried really hard not to let it get to me because I saw what it did to some of the colleagues that have had this thing done* [audits]*".* 5:122 ¶ 280 PT 11 • *"I remember walking into the crazy store to buy a gift … but there was another shopper, another lady in the store and my mind went, can you imagine if this lady was Forensic investigator 4* [laughing], *I thought I was going mad. … It was consuming my everything". 13:215 ¶ 623 – 624 PT 16* • *"My dad wanted to drop a bomb on Forensic Investigator 1's house. ... He was helpless … But he was really trying to help me … because it was so unfair. I was crying … I would phone my dad and my mom in tears every day in the middle of patients. My receptionist was stressed, and I had to calm her down".* 13:363 ¶ 618 – 620 PT 16 • *"You … have absolutely no hope because nothing is working … and in the meantime, while you're trying to scramble to survive, people are just making you feel like you are the worst human being on the planet and*

	because there's so much shame around it, you don't want to reach out to anyone else … Because you're so embarrassed about it? … It's really like there's PTSD around it, and I'm not being dramatic … If … I drive past that Medical Funder 1 building, …I go into a cold sweat". 3:119 ¶ 127 FGD 3 • *"It was extremely* [stressful], *I actually found it more stressful than watching my father die. Seven months watching my father die was easier than this experience. And you can imagine how hard it was watching a parent that you loved and adored and whatever* [die]". 14:55 ¶ 282 PT 21 • *"There's a whole legal back and forth and back and forth and Oh God, it was horrible. It was so, so horrible … I filed it under E for experience. It was the most horrible experience I went through".* • *"The stress and the worry of, "Oh, my gosh. Is my practice going to recover?" The word 'blacklisted,' … It's like … being shot in the heart. … I think … Medical Funder 1 … audit was literally the worst thing in terms of stress and anxiety and* [pause] *just feeling attacked".* 13:227 ¶ 647 PT 16 • *"You reach a fatigue point where you'd say, "I actually don't care anymore, It's only money." So now you're going from the personal side to personal justification, which is also wrong. So, there was a big questioning of my professionalism, my field, and even my billing system. But now, that I look back on it … I am still angry about the process. And that anger will never go away because the process has still appeared unfair".* 1:501 ¶ 739 FGD 1
Theme 5: Detrimental and hurtful	
Participants experienced that the hurt was about • physical or psychological hurt • being defamed • stigmatisation	• *"I've been seeing a psychologist since it started* [the audit]. *… But I think that's all the sympathetic signs … the panic, high anxiety. I mean, I never had depression or anxiety in my life. Ever. And that is when I learned what anxiety and depression were. It* [the audit] *definitely sent me into a major depressive episode. Definitely. Without a shadow of a doubt. And it's the first time that I learned what anxiety was. I've never understood it before".* 3:120 ¶ 306 FGD 3 • *"I definitely think it* [the audit] *affected me, … my son … turned around and said "you never smile anymore. Are you okay?" … Obviously, … it had taken over my life. How are we going to do this? How are we going to*

Participants experienced that the detriment was about • spending exorbitant legal fees • incurring unfair debts • been harmed • the negative impacts on the physiotherapist and their patients	*afford this? How are we going to keep the practice going? Are all these people going to lose their jobs because Medical Funder 1's coming with something that's completely illogical. And we've got to fight this fight that makes no sense. … You're treating your patient, but at the back of your mind, you're thinking, I've still got to do all of this other stuff. You're not focusing on your work properly; you've got admin stuff that you're not focusing on. So, yes, it affected, I think every part of my life with the stress … that it was sitting there. Especially because of the frustration that … you're not wrong and you're giving the evidence to them as logically as you can, and they're not even looking at it. That was probably the worst, … it's not an argument you can win because it's like trying to talk to someone who's made up their mind and there's no way they're listening to what you're saying".* 5:190 ¶ 298 – 299 PT 11 • *"None of these* [meetings] *go well. Be prepared for them to try and slander your name and drag you through the mud".* 3:122 ¶ 193 FGD 3 • *"We know many of our single colleagues* [sole proprietors] *… it was much harder. It really almost destroyed their lives".* 10:146 ¶ 461 PT 14 • *"It* [audits] [emphasis added and drawn out] *has had ramifications for me financially. And, um, on a personal level, it has made me doubtful going forward with regards to the viability of third-party funding, in the model of physiotherapy … not only of physiotherapy but of medicine as a whole within private medicine in South Africa".* 7:37 ¶ 403 PT 4 • *"We are still bearing the brunt of those circumstances … But the financial ramifications are probably the most pronounced ones under the circumstance, and they have realistic effects on all of us. My family, myself". 7:38 ¶ 415 – 419 PT 4* • *"The bad things that happened. They say, "Oh, only one physio had a stroke, and the other one had a miscarriage." Seriously … I'm sorry "dis nie reg nie"* [it's not right]". 4:93 ¶ 174 PT 7 • *"Not really having that love and drive I once had for physio. I think that's also gone".* 3:121 ¶ 455 3. FGD 3

	• *"If you asked me what would happen to the professional if this continued. Physios are going to emigrate, they're going to stop working in private practice, they're going to all have nervous breakdowns, have miscarriages, lose babies, and get divorced, and sorry I don't mean to sound dramatic, but that is what happens".* 13:205 ¶ 611 PT 16 • *"Those were her last words to me, that she's arranged payment. I mustn't worry, she will pay me as soon as she's out of hospital. She went into a coma about two hours later, and she died the next day. And I was so upset about this whole process because this lady, that was so sick, the major concern was that she needed to pay me*. [upset]". 4:152 ¶ 100 PT 7

4.3 Findings

Table 4.1 and Table 4.2 summarise the six themes and their subthemes that emerged from the analysis, supported by the most apt verbatim quotes of participants. Theme one described how participants felt unfairly persecuted, judged, and penalised, for been outliers when they had special interest practices which were considered different from general physiotherapy practices. The participants experienced these judgments and penalties by investigators who did not understand their practice. They felt unfairly penalised for billing irregularities that the auditors downplayed as being a less severe transgression compared to FWA audits, yet the penalties were severe.

The second theme expresses participants experiencing being overpowered when the forensic investigators withheld payments, blacklisted participants, oppressed their voice by rejecting evidence, ignoring input from legal counsel, and treating participants as if criminals. The third theme highlighted how participants felt naively entrapped 'between a rock and a hard place,' when participants felt unfairly treated in not knowing what to expect. The participants experienced the medical schemes as abusing their power and lacking in transparency, which was compounded by participants futilely paying high legal bills.

The fourth theme captures the distress and threat that the participants reported in feeling consumed, emotionally drained, helpless, hopeless, and ashamed. The fifth theme expresses the harm and detrimental effects that participants experienced as resulting from the audit, feeling hurt by being stigmatised and labelled as guilty from the offset, financial losses, and attrition of the physiotherapy profession. Theme six spoke to participants seeking remedies pre-emptively and preparedly, to forewarn and protect other physiotherapists from having to go through the experiences of a traumatic audit.

4.3.1 Theme One: Unfairly Persecuted, Judged, and Penalised

This theme captured how participants experienced much unfairness in being identified for an audit and that these were '*unfairly conducted'.* They experienced persecution; *'a witch hunt,'* not only for been deemed outliers, when it was a large, *'15 physios,'* special-interest practice e.g., a '*specific orthopaedic range,*' treating the same conditions repeatedly, *'I'm a neuro rehab practice'(PT22), 'I do paediatrics' (PT15, PT9),* but for seeing too many patients as a sole practitioner, using locums.

Participants experienced being judged unfairly by investigators who were not clinically knowledgeable, as investigators were '*actuarial scientists, accountants, attorneys, and maybe a forensic auditor'.* In addition, the investigators did not understand the nuances of the codes as understood by physiotherapists; *'I have a fairly good working knowledge of*

physiotherapy coding'. Physiotherapists had used these codes *'forever'* (PT7), as the medical scheme had not informed physiotherapists that the scheme was not satisfied with how the codes were applied.

The participants experienced that they were judged by people who were incentivised to find the physiotherapist guilty, when they *'won the incentive … their entire family went to the Maldives'*. Additionally, if there was any doubt during the investigation, the investigators would by default be accusatory and even derogatory in defending their position. All participants agreed, *"There is fraud, and the fraudsters need to be stopped, but it needs to be proven".*

Participants felt the processes were '*unfairly conducted and one-sided'* as the forensic investigators constantly '*shifted the goalposts'.* Therefore, the penalty and the offence were not aligned. Furthermore, discrepant understanding of codes resulted in participants experiencing been '*hauled over the coals'* without warning, making them feel they should *'burn in hell for the rest of your life*', when the majority of empathetic physiotherapists undercharge their patients*: 'Most of the physios doing a good job, actually undercharge their patients'.*

Participants experienced that penalties imposed were inappropriate, '*the punishment given was completely out of proportion to the* … [alleged] *'crime' committed.'* Participants were penalised with varying amounts, '*R 1.2 million'* and R4.5 million for billing irregularities which turned out to be for '*poor notetaking',* simply because they had not written the duration of treatment down. However, the duration of treatment is incorporated into the NHPRL code descriptions, reducing the need to record the duration down. '*We've got the diary to prove it.'* Auditors rejected the evidence as inadequate, and physiotherapists experienced this as '*quite upsetting'.* The unfairness was extended to the oblivious members, when money that had been paid from members' savings was not returned to them, but instead was kept by the medical schemes, '*because then they are actually making more money off their clients, which is fraudulent'.*

4.3.2 Theme Two: Overpowered and Oppressed

The participants experienced being oppressed in that they were '*locked up in rooms, shouted at, forced to say that they were guilty'.* The forensic investigators were experienced as biased against physiotherapists, *'I believe they have a genuine hatred for physios … She* [forensic investigator] *… said, "You physio[therapist]s are all the same. You're filthy, money-*

hungry, greedy people, and you all … try and make as much money as you can, it's disgusting".

Participants experienced oppression when investigators rejected evidence of innocence: '*That 65-page forensic report,* [prepared by a forensic actuary, consulted by a physiotherapist] … *they would not even look at it.'* The forensic investigators threatened participants regardless of the situation. '*They* [medical schemes] *will audit every single person on the list,'* and they, *'will take back that money.'*

Participants experienced being overpowered when the forensic investigators had the power to withhold payments of claims, *'I never received a cent from them'.* The investigators threatened to keep money as a means of paying off the alleged debt. In addition, the forensic investigators extended the audit, '*5 months,'* and longer, increasing the distress and controlling the processes, until the participants signed an AOD.

If the participant ran a cash practice, the forensic investigators sometimes blacklisted the participants, '*they … blacklisted me,'* and informed patients, *'they* [the medical scheme] *would no longer be reimbursing services*.' Once physiotherapists had completed the 'debt' repayment, a number of them were re-audited for the same codes. '*You're re-auditing me on exactly the same codes … that I'm not doing',* demanding more money.

4.3.3 Theme Three: Naively Entrapped Between a Rock and a Hard Place

The participants were trapped in uncertainty, '*you don't know what you're in for',* having to pay high legal bills, '*everything that your lawyers finally sign off, or type … you pay for'.* Participants constantly felt apprehensive, '*you've always got this knife* [over your head]', because of the unfairness of the processes. '*It's shocking, it's unfair … they cannot be judge, jury, and executioner*'.

Furthermore, participants felt entrapped, having to prove their innocence when exposed to divergent rules by which '*they set a trap'.* They felt ineffective in defending themselves, for '*you're too small to fight this big bully',* and even more so in facing the contradictory behaviour from the scheme, which was described as *'a law unto themselves'.* Defending themselves seemed futile, as, '*we don't really know what they're after, except for money'.*

The participants felt hard hit when the medical scheme falsely accused them, causing a constant barrage of conflicting thoughts in relation to coding and billing of patients, resulting in, '*I just don't bill for it'.* They highlighted a conflict of duty towards patients, when

physiotherapists prioritised patient care, '*our patients come first*', over and above financial gain that was invalidated by the audit process.

4.3.4 Theme Four: Distressed with a Knife Over Your Head

The participants' distress was all encompassing in their lives, '*it was consuming my everything'.* Every aspect of their lives, such as shopping, patient treatments, and home life were affected, which drained them physically, '*my wife said … "you've got to start sleeping, you've got to start eating because you're just wasting away".* This was also expressed as '*I was in tears all the time*'. Participants reported having no energy, '*running on empty,'* as they felt isolated and without support, *'trying to get support,'* from organisations such as the SASP, and the statutory board, while family, despite wanting to support, were powerless to do so: *'My dad … was helpless'.*

Participants felt hopeless and helpless: *'You … have absolutely no hope'* and '*I felt helpless … frustrated, very despondent, and very sad about my profession'.* The employers and family shared these experiences, and the participants had to support them too: '*I had to calm her* [secretary] *down'.* Participants' distress was related to feeling anxious: '*I was rocking in the bath with anxiety and stress'.* Participants were embarrassed and ashamed: *'while you're trying to scramble to survive, … you feel like you are the worst human being on the planet'.* They were reluctant to tell others about the audit, as *'there's so much shame around it',* resulting in symptoms described as akin to post-traumatic stress disorder: *'If … I drive past that Medical Funder 1 building, … I go into a cold sweat'.*

Furthermore, participants' distress was about feeling violated, '*just feeling attacked'* when they felt treated like a criminal: '*The word 'blacklisted', … It's like … being shot in the heart'.* They compared the distress invoked by the audits as equivalent or worse than a major adverse life event such as the death of a parent: '*seven months watching my father die was easier than this experience'* and '*it was the most horrible experience I went through'.*

Distress was also about conceding defeat when legal counsel had been unsuccessful and the participants could no longer fight the battle: '*I actually don't care anymore, it's only money'.* Participants were angry about the unfair processes that had cost them so much: '*That anger will never go away because the process has still appeared unfair'.* Having to give up and give in made them question their purpose: *'There was a big questioning of my professionalism, my field, and even my billing system'.*

4.3.5 Theme Five: Detrimental and Hurtful

The participants experienced the hurt as, '*the panic, high anxiety. I mean, I never had depression or anxiety in my life'.* This hurt consumed their daily thoughts: *'How are we going to do this? How are we going to afford this? How are we going to keep the practice going?'* The hurt was also expressed as *'you never smile anymore',* and negatively affected their work performance: *'You're treating your patient … You're not focusing on your work properly'.*

Participants felt hurt when they were stigmatised and labelled as guilty from the offset: *'Trying to talk to someone who's made up their mind',* while they ignore evidence to the contrary: *'You're giving the evidence to them as logically as you can, and they're not even looking at it'.* Additionally, participants felt slandered: '*Be prepared for them to try and slander your name and drag you through the mud'.*

Participants experienced financial detriments: '*The financial ramifications are probably the most pronounced',* in that they were paying exorbitant legal fees, and money was withheld through offset. Furthermore, large 'debt' penalties were detrimental to large practices, but more so to sole-practitioners: *'We know many of our single colleagues … it was much harder. It really almost destroyed their lives'.*

Detrimental effects described by participants were that they had doubted themselves and had become distrustful of the medical schemes: '*not really having that love and drive I once had'* and *'it has made me doubtful going forward with regard to the viability of third-party funding'.* Participants expressed that if the audits were to continue in this manner, harm and detriment would be experienced on an even larger scale: *'They're going to all have nervous breakdowns, have miscarriages, lose babies, and get divorced'.*

The detrimental impacts were attributed by participants in how their colleagues became ill and one had been reported to have died: 'O*ne physio*[therapist] *had a stroke, and the other one had a miscarriage'.* Furthermore, they reported attrition through closure of practices and emigration: *'Physio*[therapist]*s are going to emigrate and they're going to stop working in private practice'.* Additionally, participants experienced that their patients were impacted detrimentally, when patients had to pay out-of-pocket, they experienced increased stress as a result, and one died: *'Those were her last words to me, that she's arranged payment ... and she died the next day'.*

Table 4.2: Theme 6: Participants' suggestions for improving different elements of forensic audits

Theme 6: Seeking remedies pre-emptively and preparedly	
Remedies were about • improvement and standardisation of billing courses introduced to under-graduates. • the SASP owning up to the custodianship of codes • a new, simplified billing system • support from various organisations • using an external unbiased mediator • medical schemes to be taken to court • recognition of special interest practices	*"You … can't practice private practice if you can't bill ... because you need to own what you do. … I just feel like young physios, it needs to be almost something that's a pre-requisite somewhere. … It's another missing link for me. That really was highlighted in this process and ever since because we still employ new physios, and we have to train them. And it really has me on my toes with, what do I say and how do I navigate these treacherous questions of lots of chronic pain stuff. Chronic pain stuff didn't exist in the 2006 gazetted codes. It's really very tricky".* 2:239 ¶ 524 – 525 FGD 2 *"Then it brings up all the discussions we've had in these SASP meetings. Who is the custodian of codes and the definition of codes, and who tells who what to do, because I feel like it's the tail wagging the dog. You know, the medical funders are deciding what they do, where the SASP needs to be able to say these are the codes, you have to have this on your system".* 2:233 ¶ 512 FGD 2 *"Then the billing system, it is … up for interpretation, and the way they interpreted it. I think they, of course, actually have somebody sitting reading this s*** through every day, trying to find a new loophole to catch us out on".* 2:265 ¶ 579 FGD 2 *"That you don't feel so trapped that you just have absolutely nowhere to turn. That we could just have … an impartial mediator. … I know that HPCSA says they can't step in. Ultimately, the Council for Medical Schemes is supposed to be the impartial mediator, but to get there is difficult".* *3:49 ¶ 171 FGD 3* *"I mean … how binding is that* [SASP peer reviews]. *The only person that can* [give a binding] *peer review is the Health Professions Council".* 1:503 ¶ 263 FGD 1 *"No one's taking any accountability for this. … We need the Council for Medical Schemes behind us. … There has to be some kind of support for us as practitioners and it's not just the physios, doctors are getting audited, dietitians are getting audited. Everyone's getting audited. And I don't disagree with an audit. I just disagree with the*

	process and with the punishment because … they're executioners". 2:179 ¶ 437 FGD 2 *"I really don't see how any of this can be resolved, because people aren't arbitrating it on equal grounds. They're being judge, jury, and executioner from the outset. So Medical Funder 1 should have, in my opinion, appointed an external panel to be that judge to say, "this is a legal entity that they are justly doing". "* 1:302 ¶ 591 FGD 1 *"Take them to court and you'll win. But no one can afford to take them to court".* 1:241 ¶ 437 FGD 1 *"We've specialized, I did a postgraduate course. I did 3 years of extensive training in … becoming a specialized movement specialist overseas, which I cannot say I'm a specialist in South Africa because of our rules".* 8:57 ¶ 197 PT 8 *"… opening a business and understanding rules. That there is a Labour law you have to adhere to … I just think is, somewhere in your final year as a physio,* [running a business] *has got to feature a little bit more. … I think it must lay the foundation that you understand the … other realms of other laws that you work within as a physio. That you must get it right?"* 10:35 ¶ 139 PT 14

4.3.6 Theme Six: Seeking Remedies Pre-emptively and Preparedly

Participants proposed remedies to their adverse experiences of the audits. These included that billing courses be improved and standardised and that billing courses be introduced to under-graduates: '*It needs to be … a pre-requisite somewhere'.* Participants also proposed a new, simplified billing system: *'The billing system, is … up for interpretation'.* The current system exposed physiotherapists to billing irregularities and divergent understandings: '[medical scheme is] *trying to find a new loophole to catch us'.*

Participants proposed that the SASP takes complete custodianship of the codes: *'The SASP needs to be able to say these are the codes, you have to have this on your system'.* Participants wanted all users of the billing codes to recognise and make provisions for physiotherapists' first-line practitioner status and special interest practices: '*I cannot say I'm a specialist in South Africa because of our rules'.* Participants also wanted support from statutory organisations: 'w*e need the Council for Medical Schemes,'* as an external, unbiased mediator, and the HPCSA to provide binding peer-reviews: '*The only person that can* [give a binding] *peer review is the Health Professions Council'.*

Furthermore, the participants wanted business education at an undergraduate level to understand the laws physiotherapists work within '[running a business] *has got to feature a little bit more',* and lastly, participants wanted the medical schemes to be taken to court so that the physiotherapists could be heard and vindicated: '*Take them to court and you'll win'.*

4.4 Discussion

In this exploration of physiotherapists' experiences of forensic audits by South African medical funding schemes, six themes emerged. Five themes captured the adverse experiences of participants, and the sixth theme was about remedies that the participants proposed by which the adverse experiences may be averted. In the first five themes, participants experienced that they had been unfairly persecuted, judged, and penalised; overpowered and oppressed; naïvely entrapped between a rock and a hard place; distressed with a knife over your head; and suffered hurt and detriments.

In theme one, the participants felt unfairly persecuted for billing irregularities without the medical schemes considering that participants' irregular billing patterns were valid due to special interest practices, and in the absence of recently updated gazetted codes. Billing irregularity audits have been conducted in Australia, Canada, and the USA, where Faux et al.(2021) described how forensic investigators were also not open to alternative reasons for irregular billing patterns, as investigators also unwaveringly considered all medical practitioners to be guilty, whereby harsh penalties needed to be imposed.

Participants were forced to sign an AOD, to pay back penalties of up to R4.5 million, for 'alleged' billing irregularities, often when note-keeping of physiotherapists were simply not deemed 'good enough', according to the forensic investigators. In contrast, when practitioners were accused of FWA, and investigated by the HPCSA, gazetted penalties of only R1 000 to R3 000 for poor note keeping, were imposed (Hoffmann & Nortjé, 2015). Therefore, the penalties of R54 000 to R4.5 million mentioned among participants in this study for poor note-keeping, were considered unreasonable and unfair. In the current study, it was further reported that investigators were incentivised, potentially making them more biased, compounding the unfairness of audits and that most physiotherapists undercharged for their services making the penalties a financial hardship.

As claims were sent through via EDI, and were paid for in full, according to the schemes' rules, within the contractual prescription period, it would appear that there were no billing irregularities made. The Supreme Court of SA ruled that 'there is no sense in looking for the point in time when the debt is due, if the debt does not even exist' (*The Standard Bank of South Africa LTD vs Miracle Mile Investments 67 (PTY) LTD, and Present Perfect Investments 116 (PTY) LTD*, 2016, p. 15). According to the Medical Schemes Act section 58 (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010) the medical scheme must provide a detailed report of all debt owed by providers, two weeks after each month.

As the medical schemes have the means available through AI, a judge may rule that they did not exercise 'reasonable care' in notifying the practitioners within the contractual prescription period as was done in other cases (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016). The judge stated when pursuing prescription claims, pursuers such as the medical scheme 'cannot by its own accord or lack thereof, postpone the commencement of prescription' (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 7). Furthermore, it was ruled that when pursuing prescription claims, if the pursuer was tardy and ignored the consequences of prescription, or other laws, then the pursuer would be undermining the power and authority of the law (*Trinity Asset Management (Pty) Ltd v Grindstone Investments (Pty) Ltd (1040/15) [2016] ZASCA 135 (29 September 2016)*, 2016, p. 7).

In this study, the amounts that were under scrutiny during the audit were amounts that had been paid from members' savings funds, even though it had been ruled that all personal medical savings should be treated as trust money and must be returned to the member (*Genesis Medical Scheme vs Registrar of medical schemes and another [Case]*, 2017). This

theme underscores the importance of revising and formalising the billing codes in regulatory provisions, enforcing the contractual period, and investigating whether money paid from a members' medical savings was in fact returned to the member.

The second theme captured how participants felt overpowered and oppressed. Participants experienced that forensic investigators used intimidation to coerce them into signing an AOD, and investigators re-audited physiotherapists after completion of 'debt' repayments despite changes physiotherapists had implemented to avoid audits. This theme resembles the observation by Peyton et al. (2019) that the only way organisations were able to maintain legitimate power was through using intimidation such as coercion and reward tactics until people conceded. It is well-described that oppressive interviewing techniques, such as the Reid technique, serve the purpose of forcing interviewees to admit guilt even when they were innocent (Van Graan, 2018). Van Graan (2018) cautioned accordingly, that forensic investigators should not have authority to conduct intimidating interviews or control the processes, as they are not the police.

Therefore, disciplines such as lawyers/advocates and/or forensic investigators need to investigate how these audits are conducted. The auditing processes need to become transparent as these processes cannot be changed unless they have been revealed and understood through investigations. Additionally, the Competition Commission should conduct an impact study to investigate the restrictive billing practices as prescribed by the medical schemes, and the abuse of the dominant position of medical schemes during forensic audits.

The third theme, 'naively entrapped between a rock and a hard place', described how physiotherapists felt trapped in not knowing what to expect, and in paying high legal bills to defend themselves from accusations that stemmed from divergent interpretations of outdated codes. These audits amounted to experiences of entrapment by contradictory methods used by the medical schemes, together with a disregard for alternative interpretations of codes and evidence of innocence. The reported consequences were that participants experienced distrust and disrespect towards the medical schemes.

This is congruent with findings by Van Fossen and Chang (2022), that when trust is lost in the workplace and inter-personal trust is compromised, service quality and responsiveness in primary health services are impacted negatively. Moreover, when third-party funding was dictating for which treatment codes schemes would pay, the autonomy of doctors was undermined, and doctors were curbed from offering best practice to their patients (Talbot and Dean (2018). This theme emphasised the importance of improving the billing system and investigating the processes of the audits and the rules and regulations pertaining to the Medical Schemes Act.

Theme three also highlights the need for physiotherapists to have affiliations with and support from civil society, whereby professional and general citizens are protected, as these audits are a matter of social citizenship. Further investigations by relevant stakeholders are indicated to determine if forensic audits are conducted fairly and according to general principles. If the findings in our study are corroborated, then additional remedies, support, and interventions are needed.

The distress captured by the fourth theme is similar to that reported by Van Fossen and Chang (2022), Dean et al. (2019) and Carpenter (2010). The distress was compounded in the current study and other studies when practitioners did not experience sufficient support from professional statutory and societal organisations (Van Fossen & Chang, 2022). Furthermore, the signs and symptoms of the distress experienced were comparable to those described in literature for burnout, moral injury, and compassion fatigue (Bonsall, 2020; Brindley et al., 2019; Stoewen, 2020). The distress was profound not only because the monetary values involved in the audits were high (with penalties reaching R4,5 million in our study), but also because it was experienced as worse than adverse life events such as the death of a loved one and divorce (Carmona-Barrientos et al., 2020; Grover et al., 2018).

Forensic audits need to be better managed by the SASP and other stakeholders, preventing distress. As such, it is recommended that the HPCSA supports medical practitioners' undergoing an audit by providing binding peer-reviews. It is further recommended that the SASP take full ownership of the custodianship of the codes, with support from the Competition Commission, thus preventing alternative interpretations of codes by medical schemes. As the Competition Commission no longer gazettes new codes they could investigate and prosecute abuse of dominant positions (Competition Commission, 1989).

To directly address the distress experienced, programmes and interventions (Dawson & Allenby, 2010; Van der Kolf, n.d.) could be created, for example a WhatsApp group to support all audited physiotherapists. Furthermore, studies using music (Paul et al., 2020) or art (Brailas, 2020) could create awareness within medical professionals that: 'I am not alone', and/or provide therapeutic intervention. Studies could also be conducted to measure the levels of burnout, , compassion fatigue, or/and moral injury the audited physiotherapists developed.

Theme five highlighted how participants experienced the audits as hurtful and detrimental, resulting in the trajectory of their lives been altered, causing attrition, detrimental to the profession, as described by Faux et al.(2018). Physiotherapists need to be protected, because in 2020, there were only 8 053 registered physiotherapists in South Africa serving 60 million people (Cantu, 2019; Goodwin et al., 2021; Narain & Mathye, 2023).

Participants experienced detriment and hurt through high financial strain due to auditors downplaying billing irregularities, when compared to fraud, waste, and abuse audits, yet the penalties imposed were in excess of the gazetted penalties for FWA. Attrition occurred reducing the already dire number of physiotherapists, which is detrimental to the physiotherapist as well as the profession. It is, therefore, recommended that physiotherapists who have left the profession be encouraged to return, and others must be dissuaded from leaving. It is further recommended that an unbiased external mediator must preside over medical schemes' forensic audits to ensure consistency and fairness.

Lastly, in the theme 'seeking remedies pre-emptively and preparedly,' participants made recommendations to protect other physiotherapists from experiencing the audits negatively. Participants wanted an external, unbiased mediator. Additionally, participants wanted a new simpler billing system. Participants wanted the SASP to take better ownership of the custodianship of the billing codes (SASP, 2015b), and the medical schemes to have no jurisdiction over the codes, once established. Participants wanted billing courses to be standardised and implemented to undergraduates, and business courses to be added at an undergraduate level, whereby the relevant laws under which the physiotherapists must practice are known and understood.

The participants wanted the HPCSA, their statutory body, to enforce first-line practitioner status (Medical, Dental, and Supplementary Health Service Professions Act, 1974, 1974) with the medical schemes, and provide recognition for further qualifications and special-interest practices, as was done in Australia (Bennett & Grant, 2004). Goodwin (2021) determined that when physiotherapists were positioned as a first-contact professional, a reduction in strain on doctors and the healthcare system occurred. If physiotherapists were registered for their special interest practices, their stature as physiotherapists would be recognised, reducing incorrect accusations of outlier status.

The participants wanted the medical schemes to be taken to court, where physiotherapists could tell their stories and be heard, altering the processes conducted that were experienced as unfair and detrimental to all medical professionals. Suitable disciplines whose scope and responsibility include the establishment, monitoring, and relevance of coding and billing systems, should, therefore, investigate and implement the changes in the current medical billing systems, and establish a new billing system which is accepted by all.

Lastly, participants wanted the medical schemes to notify physiotherapists of any irregular billing patterns within the contractual prescription period, and not wait three years to activate an audit when there has been no indication that the practitioner has committed 'billing

irregularities. Various organisations which have been appointed to protect the medical profession should take cognisance of these findings.

Organisations tasked with investigating fraud and corruption, such as the Special Investigations Unit of South Africa (SIU) (Koko, 2022, 2023; SIU, 1997) could be approached to investigate and confirm the findings, and provide recommendations. Additionally, it is recommended that the CMS and the Competition Commission join forces to investigate the apparent divergent interpretations of third-party billing rules and regulations by the medical schemes. It is further recommended that the CMS and Competition Commission ensure that new and relevant billing codes are accepted and acknowledged by all medical schemes.

Healthcare professionals may be better protected from unfair audits, if a new billing system were to be established, as practitioners are currently forced to use outdated codes. The findings of this study emphasised the importance of the participants not feeling alone and been aware that support is available. When people were aware of resources and felt supported, their experience improved (Hawkley & Cacioppo, 2010; Mushtaq et al., 2014).

4.5 Limitations

As the study was only about the experiences of physiotherapists, the transferability to other healthcare professionals is limited. Another contextual constraint on transferability was that participants, by chance, were all audited by the same medical scheme, and one participant had been audited by two different medical schemes.

4.6 Conclusion

Physiotherapists experienced the forensic audits adversely and made recommendations on how adverse experiences may be averted. These included that they felt unfairly persecuted, judged, and penalised, overpowered, and oppressed, naively entrapped between a rock and a hard place, distressed with a knife over one's head, and that the audits had been detrimental and hurtful. The participants recommended that these be remedied pre-emptively and preparedly', by having their statutory body recognise their special interest practices and promote the first-line practitioner status with medical schemes. Participants further suggested that an audit guide be provided and that the medical schemes be taken to court where judgement would be fair.

Further studies may investigate how these audits may be tailored more constructively in curtailing adverse experiences of physiotherapists. These studies may be conducted by universities or various stakeholders that are concerned with the interests of physiotherapists. The findings and recommendations from this study signal the need for support from relevant organisations to prevent or reduce attrition.

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5 Conclusion and recommendations

5.1 Introduction

Chapter four summarises the key findings, discusses practical implications, course recommendations, and further research, and describes the study's limitations. The study aimed to explore and describe private practice physiotherapists' experiences of forensic audits by South African medical funding schemes.

The objectives of the study were to describe the experiences of physiotherapists who had undergone a forensic audits, (using interviews and Focus Group Discussion (FGDs) to come to the answers) in terms of:

a) the processes of the forensic audits,
b) the impact, outcomes, and implications the forensic audit had on the professional standing and practice of physiotherapists,
c) the facilitators and barriers encountered during the process,
d) the support mechanisms available,
e) external traumatic life events,
f) the perceptions and experiences of physiotherapists subjected to forensic audits,
g) and physiotherapists' understanding and responses to these procedures.

5.2 Key Findings, Practical Implications, Education, and Research Recommendations

The data for this study was gathered using semi-structured individual interviews and focus group discussions. During the analysis of the data, six themes emerged from the interviews. The first five themes described participants' various experiences during the forensic audits. In contrast, the sixth theme provided recommendations that the participants wanted to have implemented to protect other physiotherapists from experiencing audits with the same degree of detriment. The themes were:

1. unfairly persecuted, judged, and penalised
2. overpowered and oppressed
3. naively entrapped between a rock and a hard place
4. distressed with a knife over your head
5. detrimental and hurtful
6. seeking remedies pre-emptively and preparedly

5.3 Key Findings

The findings in theme one, “unfairly persecuted, judged, and penalised”, describe how physiotherapists feel unfairly persecuted for billing irregularities when they had valid reasons such as having a special-interest practice. In contrast, evidence of innocence or special interest practices was completely disregarded. Additionally, gazetted codes are a contentious point due to the divergent and alternative interpretations thereof, amongst physiotherapists and between physiotherapists and the medical schemes, and the lack of new codes being accepted by the medical schemes or gazetted by the Competition Commission. Additionally, codes accepted by the medical schemes were last gazetted in 2006, making them outdated. The participants feel that they were unfairly judged because of investigation bias due to the incentivisation of investigators, and because the investigators were ignorant regarding the autonomy of physiotherapists and their scope of practice. At no point was the fact that physiotherapists generally undercharge their patients due to their empathetic nature, nor the code of conduct they live by, taken into consideration.

Participants further experienced the penalties as being harsh and unfair, as the penalties imposed by the medical schemes during forensic audits for billing irregularities, were not in line with gazetted penalties, and, therefore, far harsher than penalties given for fraud, waste, and abuse. Often participants were berated for poor note-keeping, according to the medical schemes’ forensic investigators, when the note-keeping was sufficient according to the SASP’s peer reviews, resulting in many participants being coerced into signing an admission of debt, to make the audit ‘go away’.

Participants had no support and were left with limited options such as using legal counsel to attempt to clear their name or reduce penalties. However, the medical schemes continued to apply offset and blacklisting, as a means of controlling the processes and outcomes of the audits, increasing the financial strain, and general distress of participants. Additionally, the audits were backdated for three years, as the contractual prescription[1] was disregarded.

[1] Contractual prescription is an agreed-upon period that must pass for a debt to expire, such as Regulation 6 of the Medical Schemes Act whereby once 120 days have passed, from the date of treatment, healthcare practitioners’ claims will no longer be processed for payment by the medical schemes. If there are any irregular billing patterns or discrepancies, then the medical schemes have 30 days in which to notify the practitioner and

Reasonable care was not exercised in notifying participants of irregular billing patterns according to the administration requirements as set out by the Medical Schemes Act.

Offset remained in place until the imposed 'alleged' debt had been recouped from those participants who refused to sign an AOD, regardless of any prescription period. Participants were forced to become a cash practice, which placed an unfair burden on their patients. Additionally, money paid for physiotherapy services came from the members' savings and was placed in the funder pool and not returned to the members, as is required by law.

The findings of theme two, "overpowered and oppressed", indicate that the interview technique used during the forensic audits, conducted by the medical funding schemes, was experienced by the participants as similar to the intimidation and oppressive techniques described by the Reid organisation which was established in 1947 (Reid and Associates, Inc., 1947; Van Graan, 2018). This theme emphasises that the use of the Reid technique often results in false confessions being made when interviewees are innocent.

The Reid technique was discussed in Chapter 2, and a table was created describing the Reid technique, the Bill of Rights, the Medical Schemes Act, and other laws, with added court judgements. A second table is attached in Appendix G where the table describes the nine-step Reid technique and provides participants' quotes of their experiences of oppression and overpowering during the audits which is similar to those described in the Reid technique.

Theme three, "naively entrapped between a rock and a hard place", describes how the participants did not know what to expect or do during audits; some spent high legal fees to defend themselves, only to still be seemingly coerced into signing an AOD. The participants, therefore, experienced distrust and disrespect towards the medical schemes while that very trust is needed during collaboration between medical professionals and the medical

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must thereafter afford them 60 days in which to rectify these discrepancies. AI has implemented this in real-time, through EDI, according to the Medical Schemes Act.

schemes for third-party funding. Furthermore, the autonomy of physiotherapists is compromised when the medical schemes dictate what codes they are willing to pay for.

Theme four, “distressed with a knife over your head”, describes how participants experienced distress, with signs and symptoms similar to those described for burnout, compassion fatigue, and moral injury as well as the outcomes similar to these conditions such as anxiety, depression, and PTSD. Participants further reported experiencing the audits as worse than a stressful impact event. The distress was compounded by the lack of organisational support and the high legal fees and penalties that were paid.

A table was created using the descriptions of burnout, compassion fatigue, and moral injury discussed in Chapter 1. The first column describes the symptoms of burnout, compassion fatigue, and moral injury while the second column provides the participants’ experiences which created the theme “distressed with a knife over your head” and is provided in (Appendix H).

In the fifth theme, “detrimental and hurtful”, participants were shocked and ashamed of how they were unfairly accused and treated during the audits. The participants experienced a high financial strain, as billing irregularity audits were penalised more harshly than FWA audits, making participants feel like criminals heightening their distress.

Participants experienced the audit to be detrimental and hurtful as physiotherapists experienced a change in their private and professional circumstances and/or trajectory of their lives. There are only 8,053 physiotherapists who service 60 000 people. Therefore, physiotherapists are needed to reduce the strain on the healthcare system. These forensic audits for billing irregularities were detrimental and hurtful as participants were unable to practice for prolonged periods and there was attrition of physiotherapists.

The last theme, “seeking remedies pre-emptively and preparedly”, emphasised how physiotherapists wanted audit processes to change to protect other physiotherapists from experiencing the audits as detrimental. Participants wanted an external mediator to be present during forensic audits. Participants wanted courses that are already being taught by the SASP, to be clarified regarding correct billing, tariff codes and their rules, thereby, preventing alternative understandings between the SASP, physiotherapists, and the medical schemes. Physiotherapists wanted the SASP to take ownership of the custodianship of the billing codes, as is their right according to the Competition Commission.

Physiotherapists wanted education on how to run a business which includes the relevant legislative rules that physiotherapists need to follow. Participants wanted these various courses to be taught by the appropriate institutions at an undergraduate and postgraduate level, encompassing all their needs. Most importantly, participants want a new billing system to prevent physiotherapists from being exposed and unfairly audited for billing irregularities, due to an outdated billing system.

Furthermore, participants wanted the HPCSA, their statutory body to promote physiotherapists' autonomy with the medical schemes, and to have their special interest practices, and post-graduate qualifications, acknowledged and recognised. Participants wanted the HPCSA to provide binding peer reviews during forensic audits. Participants wanted the medical schemes to notify them within the contractual prescription period, of any irregular billing patterns, and not wait three years to audit them, increasing the detriment that the participants experience.

Lastly, the participants want the SASP to continue with their summons of medical schemes, hoping that physiotherapists will be able to tell their side of the story, *Audi alteram partum* ("listen to the other side", or "let the other side be heard as well") and be vindicated. The courts will then have an opportunity to determine if changes to legislation are required, such as Section 59(3) of the Medical Schemes Act, thus protecting the medical professionals. As forensic audits for billing irregularities have been detrimental to physiotherapists, organisations which have been tasked to protect the medical industry, such as the CMS, Competition Commission, HPCSA, SASP, SIU, and Health Funders Association (Health Funders Association, 2023) need to take action to protect physiotherapists.

5.4 Artificial Intelligence's Summary of the Findings

The summary made of the transcripts that were uploaded onto ATLAS.ti is incorporated, as it is part of the AI functionality. The ATLAS.ti summary is an autonomous means of verifying the analytic yield that emerged from the author's findings, thereby supporting the trustworthiness of the study's data (Paulus & Evers, 2018). The summary of ATLAS.ti analysis was only performed after the main analysis had been done by the author. The data were analysed using open coding at first, then axial coding identified the subthemes and themes. The main author completed the open coding, while all three authors performed the axial coding during ongoing conjoint meetings.

The summaries created by ATLAS.ti of the FGDs, supported the negative experiences physiotherapists experienced during the audits, as was described in the first five themes. According to the AI summary, participants emphasised issues such as being accused of being different from other physiotherapists' and, therefore, deemed outliers. Participants were distressed by the forensic auditors' lack of clinical knowledge and their apparent conflicts of interest, due to incentivisation. Incentivisation of auditors made the auditing processes unfair and one-sided, which impacted the participants' income and the outcome of the audit. Furthermore, these negative experiences were compounded by the participants' dissatisfaction with the SASP, and the lack of support from medical schemes. Participants further mentioned the role their attorneys played in the audits, and how the medical schemes disregarded the participants' legal support.

During the individual interviews, participants expressed frustration with the unfairness, lack of transparency, and emotional, physical, and financial toll of the audit process, resulting in negative effects on their practices and personal well-being. The participants believed that the medical schemes 'targeted' them, and they were disappointed in the lack of support from an external unbiased mediator. The participants stressed the importance of the patient-therapist contract and confidentiality, as well as the importance of patient rights. Participants further discussed their billing practices and the need for a new billing system.

ATLAS.ti also supported the sixth theme, where participants expressed a need for business management education and the desire for the billing system to change. Part of the corroboration of the sixth theme was that participants wanted a clear forensic audit guide, as well as a change in the audit processes to ensure transparency, fairness, and accuracy of the audit processes. Participants mentioned the potential for attrition of physiotherapists due to the stress of the current auditing processes, and the need to protect physiotherapists.

5.5 Practical Implications

The practical implication of this study is that when physiotherapists felt, "unfairly persecuted, judged, and penalised", it led to physiotherapists feeling overpowered and oppressed. When physiotherapists' professional autonomy, code of conduct, and evidence of innocence of billing irregularities were rejected or ignored, then physiotherapists felt entrapped. As the organisations that have been tasked with protecting physiotherapists, did not support them, the distress experienced by the physiotherapists was compounded. The distress resulted in hurtful and detrimental outcomes to the physiotherapists, professionally and personally during and long after the audits. Detriment and hurt included symptoms of depression,

PTSD, and attrition. As physiotherapists are empathetic people, they offered recommendations to prevent other physiotherapists from experiencing potential future audits negatively and detrimentally. These findings are important as there have been questions in the industry regarding forensic audits in terms of the audit processes and fairness. Physiotherapists are concerned that unfair audit processes are conducted by medical schemes.

5.5.1 Recommendations for the Professional Body of Physiotherapy

These stakeholders include the BHF that all private practitioners must be registered with, the CMS that must ensure all laws of the Medical Schemes Act are abided by the Competition Commission (CC) that used to gazette all tariff codes used, and the HPCSA which creates the code of conduct and rules that all healthcare practitioners must abide by. Organisations such as the Special Investigations Unit of South Africa (SIU, 1997) may only get involved once the CMS has completed investigations of complaints made by practitioners. The SIU comprises representatives from the CMS, HPCSA, BHF, and the Health Funders Association (Health Funders Association, 2023) an organisation that has been tasked to protect the medical profession.

5.5.2 Recommendations For the Physiotherapy Profession

All recommendations are based on the findings of this study including those made by participants, discussed in theme six. The physiotherapy profession, comprising of the members of SASP, PASA, and none-members, should work together to:

1. Provide supportive interventions, such as an audit guide and/or a WhatsApp support group, to assist physiotherapists undergoing an audit.
1. Inform SASP members which process to follow when lodging a complaint with the SASP's National Executive Committee (NEC). These complaints include member dissatisfaction with the day-to-day functioning of the SASP, or if specific issues arise due to, for example, the audits, coding, and preferred provider contracts. Members need to become more active to ensure problematic issues are brought to the attention of the SASP. These issues can then be placed on the agenda for discussion and voting amongst the members. This action should improve the accountability and day-to-day functioning of the SASP and PASA, to ensure the organisations remain current with the needs of their members, thereby protecting and guiding their members appropriately, also about issues about billing.
2. Consult with the HPCSA and universities to ensure the following are implemented and accepted by all stakeholders:

- Facilitation of the continuous expansion of the scope of practice of physiotherapists, when evidence-based practices change, and/or when practitioners expand their knowledge through continuing professional development (CPD) and postgraduate education.
- First-line practitioner status to be promoted with the medical schemes to ensure that physiotherapists' autonomy is recognised, e.g., in terms of diagnosing, selection of treatment modalities, recognition of special interest practices and promotion thereof with medical schemes, and subsequent codes when billing. Additionally, that medical schemes accept and pay, e.g., physiotherapy autonomy when referring patients for X-rays, or completion of insurance forms for medical boarding of patients.
- Peer reviews during forensic audits for billing irregularities should be commissioned and delegated by the HPCSA, making the peer reviews binding and, therefore, must be accepted by the medical schemes.

- Investigate preferred provider contracts between physiotherapists and medical schemes, promoted by the SASP during practice accreditation when the HPCSA advises practitioners not to sign agreements that may violate ethical rules. Preferred provider contracts must further be investigated to ensure physiotherapists' autonomy and custodianship of the codes is maintained. If contract are signed, the contract must be obeyed during forensic audits i.e., that peer reviews and recommendations provided by the SASP, are accepted by the medical schemes or if not, these preferred provider contracts must be discontinued to protect the physiotherapists. Certain medical schemes use preferred provider contracts to agree to pay the medical practitioners directly, when most medical schemes pay medical practitioners directly, without a preferred provider contract.

- Education and training to be researched, developed, and/or emphasised in both the CPD courses and the current physiotherapy curricula for the topics depicted in Figure 5-1

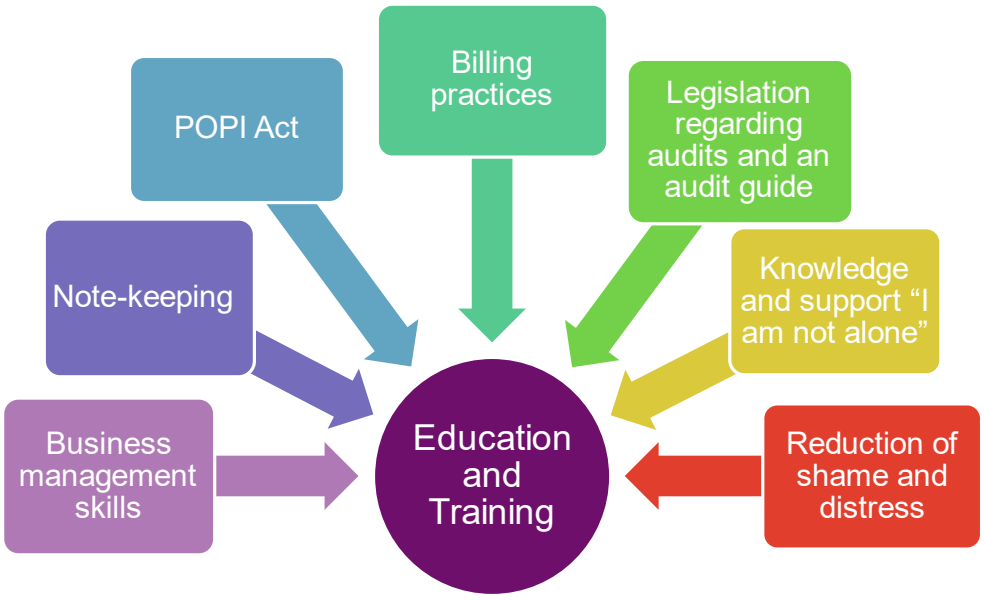

Figure 5-1: Education and training recommendations to be provided and/or emphasised by the SASP and universities at under and postgraduate levels

3. Consult with the Competition Commission, and/or the HFA, and/or the SIU and other stakeholders to:
    - Conduct:
        a) Impact studies on unfair billing irregularity audits done on physiotherapists to review legislation and report uncompetitive behavioural concerns to the Minister of the Department of Trade, Industry, and Competition.

b) Re-evaluation of all previously audited physiotherapists by an external, unbiased mediator.
c) Research and investigations on interviewing techniques used by medical schemes, during forensic audits, on physiotherapists to determine whether audits are conducted fairly and per general accepted principles.

- Develop:
  d) A new billing system for physiotherapists that is less complex, for example, time-based, a set price per treatment, or adopt codes as already used for the Compensations for Occupational Injuries and Diseases (COID) (Physiotherapist Gazette: Compensation for Occupational Injuries and Diseases (COID) Tariffs, 2021) through conducting research.
  e) A policy regarding the delegation of authority during forensic audits to facilitate operational efficiency and protect physiotherapists from abusive powers and unfair audits.
- Instil within the medical schemes:
  a) That full ownership of the custodianship of the billing codes is with the physiotherapy profession, represented by the SASP, PASA and all physiotherapists who do not belong to any association.
  b) The rules and regulations of the National Health Price Reference List (NHPRL), which have already been encoded into the electronic data interchange (EDI) systems, of both the medical schemes and physiotherapy practices, which have been specifically set up to avoid FWA and billing irregularities.
  c) An external unbiased mediator, who is up to date with all relevant laws of these forensic audits, to preside over all forensic audits conducted by medical schemes for billing irregularities.
  d) Regulated penalties for billing irregularity audits.

4. Consult with the CMS to investigate, provide clarity on, and resolve/enforce, and review legislation of:
   - Regulation 6 of the Medical Schemes Act (1998), in terms of contractual prescription, to protect physiotherapists from audits being backdated for three years. Further, enforce notification of irregular billing patterns within the 30 days as per the law.
   - Savings money that was paid to physiotherapists, from members' savings funds, which has not been returned to the members, as per the law.

- The rules and regulations of the Medical Schemes Act regarding, communication, transparency, handing over of confidential clinical notes, and fairness during the auditing processes.
- Acceptance by the medical schemes of peer reviews conducted by the SASP, as the SASP peer reviews are 1) conducted by a panel of true peers who are 2) experts in the specific field the physiotherapist being audited practices in, 3) investigates the billing codes, that are under question by the medical schemes, in comparison with the clinical notes, 4) protects the POPI Act, 5) makes recommendations as requested by the preferred provider contract, if signed, 6) and make recommendations according to the rules of conduct physiotherapists must abide by. The SASP peer reviews are substantial, fair, and unbiased but are currently being rejected by the medical schemes as these peer reviews are not binding as it is conducted by a voluntary membership organisation.

5. Consult with the Board of Healthcare Funders (BHF) to ensure the physiotherapists are protected from unfair audits by:
    a) Not divulging physiotherapists' audit status with other medical schemes via the physiotherapists' BHF profile.

7. Consult with civil society
    - To educate legal representatives in these civil societies on physiotherapy matters and have physiotherapy members join these civil societies so that they can be supported legally during forensic audits with lawyers who understand the industry.

5.5.3 Research Recommendations

Research can be conducted by various stakeholders who have been tasked with protecting and educating the physiotherapy profession, to investigate:

- The understanding of the autonomy of physiotherapists by medical schemes in terms of patient treatments, referrals, claim form completion, sick notes, and medical boarding of patients, and why, if physiotherapists have autonomy, some medical schemes require patients to be referred by their general practitioner for physiotherapy and X-Rays, and claim forms and sick notes need to be completed by a specialist or general practitioner, before the medical schemes will accept and/or pay for the various claims. Physiotherapists can prevent over-servicing and reduce costs for the members and the medical schemes.

- The best methods to increase awareness and promotion of the physiotherapy profession.
- Compare the penalties for FWA and billing irregularities paid by physiotherapists.

Or develop/find:

- A distress-reduction programme for all physiotherapists who experience stress or distress, such as experienced during an audit, amongst others (Dawson & Allenby, 2010; Van der Kolk, 2015).
- A programme using music (Paul et al., 2020), and/or art (Brailas, 2020) to change the stigma of 'shame' attached to forensic audits amongst physiotherapists, and/or create awareness that "I am not alone", and/or provide therapy for treating distress.

5.6 Limitations

No literature was found on forensic audits for billing irregularities conducted in South Africa. Furthermore, the results from this study were drawn only from physiotherapists, therefore, transferability can only cautiously be transferred to other healthcare professionals. As so happened, the participants had all been audited by one medical scheme, with one participant having been audited by two, making this a contextual constraint on transferability. Involving the medical schemes during the study may have enriched the data more.

5.7 Conclusion of the Dissertation

This study set out to explore and describe the physiotherapists' experiences of forensic audits that were conducted by medical schemes in South Africa. Physiotherapy private practice owners came forward to share their experiences of forensic audits for billing irregularities, and six themes emerged. The first five themes described their negative experiences in the themes 1) unfairly persecuted, judged, and penalised, 2) overpowered and oppressed, 3) naively entrapped between a rock and a hard place, 4) distress with a knife over your head, and 5) hurtful and detrimental. The last theme, 6) seeking remedies pre-emptively and preparedly describes how physiotherapists wish to change the forensic audit processes to prevent other physiotherapists from having to experience the audits in a similarly detrimental way, through suggesting distinct types of support from various organisations.

Although only physiotherapists were interviewed, their experiences such as distress, hurt, and harm have been well documented. Literature describes distress, and how these distress

symptoms progress, making this study's findings and recommendations important, as they could be cautiously expanded to include all medical professionals.

This study signals the need for organisations appointed to protect the physiotherapy profession, to intervene and provide solutions to the current forensic audit processes for billing irregularities, conducted by South African medical funding schemes. Further investigative studies need to be conducted by these stakeholders, sworn to protect the physiotherapy profession, to confirm the findings and implement solutions that will protect physiotherapists. This study has emphasised the importance of acting urgently to avoid attrition of physiotherapists.

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APPENDIX A: GLOSSARY

Table 6.1: description of the various key concepts applicable to this study

Billing irregularities	Billing irregularities are when physiotherapists or healthcare professionals are accused of using incorrect codes, using codes too often, or seeing too many patients, resulting in irregular billing patterns which are deemed as billing irregularities (Massangaie W., 2021; Navigating Forensic Audits, 2021; SASP, 2022).
Claim suspension or blacklisting	The medical funder uses claim suspension or backlisting as leverage when physiotherapists disagree with the forensic processes or outcomes (Hearing, 2021b). When there was no resolution during a forensic audit of a physiotherapist, who runs a cash practice, the medical scheme blacklisted the physiotherapist, whereby the medical funding scheme no longer processed or pays claims from that specific practice, or refunds patients who have paid out-of-pocket (Beira & Gibbs, 2021a; Hearing, 2021b). The medical funder used this as coercion to force physiotherapists into signing an AOD whereby the alleged debt was repaid under duress. The medical funder has negated that they blacklist physiotherapists: “We are uncertain as to your referral of a decision of “blacklisting”, as no such process exists within the medical administration system” (Jacobs 2021). When they do not pay the provider, or refund the patient, they will send an email to the patient informing them that they no longer pay any accounts for that practice, defaming the physiotherapist further.
Clawback or repayment or offset	Offset or clawback is a contractual provision whereby money already paid to an employee (or in this study a physiotherapist), must be returned to an employer (or in this case the medical funder) sometimes with a penalty (Deng et al., 2021; W.Kenton, 2021). In this study, clawback refers to instances where the South African medical funding schemes blocked payment to physiotherapists through offset. Offset occurs when new claims sent through for payment, are processed and payment is allocated but not paid to the physiotherapist. Instead, this money is deducted from the alleged ‘debt’ amount the medical funding scheme says the physiotherapist owes them. This block, known as offset, is kept in place until the audit had been resolved through signing an AOD, or until the money had been returned through offset.

	The physiotherapist who signs the AOD, is then bound by the contractual obligations to pay the stipulated amount as per the AOD. It was observed that physiotherapists were re-audited once the payment of the AOD was complete, and offset was again applied (PT 3, PT 17). In one of the cases, a physiotherapist signed the AOD and had a debit order instated. However, the offset was not terminated, and the physiotherapist did not receive payment for claims, and had to pay monthly debit instalments.
Defamation of character	Defamation causes harm to the physiotherapist's good name, reputation, and dignity with resultant damage to the physiotherapist's practice (Reamer, 2008; Ronquillo & Varacallo, 2022). Defamation occurs when the medical funder sends emails to the physiotherapists' patients saying they will not refund the member for treatments received by their physiotherapist because of the unresolved audit. Defamation occurs when offset was set in place resulting in current patients' claims not been paid. During offset, the physiotherapists had to inform current patients of the audit dilemma, ensuring payment in the form of out-of-pocket payments.
Discrepancy or alternative understandings	Discrepancy in understanding occurs when words and descriptions of codes may have different meanings, both of which can be seen as correct. In billing irregularity audits, words such as FWA, billing irregularities, or descriptions of treatment codes, may be understood differently by the different stakeholders. The subtle nuances may induce a significant change in the medical scheme administrators' mental thoughts, resulting in unpredictable group decisions and group thinking bias (Fleischmann & Lammers, 2020; Jones & Roelofsma, 2000). This bias may prevent Audi alteram partem, meaning let the other side be heard as well, resulting in unfair audits and unfair outcomes.
Experiences	Experiences are created through the subjective and contextual influences of a person's background and environment, according to what is visible and what their conflicting realities are (Saks and Allsop, 2012). The physiotherapists' experiences are the centre of this qualitative study. Physiotherapists will "construct meanings based on their past experiences in order to understand their world, others, and themselves" (Daher et al., 2017, p. 3). The experiences may vary greatly, while many may be experienced in the same way. The experiences of the audits were heard during interviews and focus groups discussions, whereby similarities and differences were described to create a rich source of data.

Electronic Data interchange (EDI)	EDI systems have been programmed to prevent fraud, waste, and abuse, and billing irregularities, as all the rules and regulations have been encoded into the systems which block incorrect, or invalid treatment codes, in real-time (immediately). All incorrect patient details are automatically corrected or flagged in real-time, affording the partitioner the opportunity to correct these mistakes immediately. As the EDI systems have the capacity to notify practitioners of any discrepancies, and currently do reject incorrect codes immediately, the three-year backdated period becomes unrealistic and unfair (Hearing, 2021b; Jago & Pfeffer, 2019; Jogi, 2022). Furthermore, the Medical Schemes Act stipulates that all medical funding schemes must provide a list of all debts owed by medical practitioners, within two weeks after the end of each month, with an age analysis (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). This means that the medical scheme was aware of irregular billing patterns and have purposefully extended prescription to benefit themselves (Fleischmann & Lammers, 2020; Jago & Pfeffer, 2019).
Forensic audits	Forensic audits cover a wide range of investigative activities and is conducted to prosecute a physiotherapist for billing irregularities, fraud, embezzlement, or other financial crimes (Tardi, 2021). In this study, a forensic audit refers to investigations done by medical funding schemes on physiotherapists, where AI highlighted irregular billing patterns, indicating outliers. In this study, the focus was on South African private practice physiotherapists where the audit backdated for three-years (Hearing, 2021b). The audits harshly penalise physiotherapists for simple billing irregularities when there is a discrepancy in understanding of codes.
Forensic audit process	The forensic audit processes comprised two ways that a practice may be audited. By a formal complaint from a patient or colleague, or by AI that highlighted certain treatment codes as irregular billing patterns which were deemed billing irregularities (Beira & Gibbs, 2021a, 2021b; Durrant, 2018; Faux et al., 2021; South African Medical Association (SAMA), 2021). The audit was then initiated by an email sent to the physiotherapists, asking them to explain their understanding of the treatment codes that were highlighted by AI. The physiotherapist needed to prove their innocence by supplying confidential clinical notes while the medical scheme administrators scoured these notes for other discrepancies, rejecting all valid evidence such as peer reviews done by the SASP, or other

	descriptions of treatment codes, coercing physiotherapists to sign an AOD. If a physiotherapist was a cash practice, the medical funding scheme would blacklist them, as a form of coercion. The medical scheme further used offset as a means of controlling the physiotherapists and collecting money through new claims sent through via EDI, until all the money from the alleged debt had been collected.
Fraud, waste, and abuse (FWA)	Fraud, waste, and abuse is when health care professionals knowingly submit false claims to access payment one would otherwise not have been entitled to (Broomberg, 2020). This includes claiming for healthcare treatment and services that are not medically necessary resulting in over-servicing or over-charging of a patient. This may objectively be considered unethical or unconscionable or contrary to best practice principles (Broomberg, 2020). When FWA occurs, all amounts over R100 000 must be reported to the HPCSA and the SAPS for investigation and penalisation (HPCSA Corporate Affairs, 2018a). The HPCSA' penalties are gazetted (have set monetary values), preventing unfair penalties for crimes committed. Amounts under R100 000 are investigated by the medical schemes as they have been given authority to do so, according to the Medical Schemes Act (Medical Schemes Act No. 131 of 1998, 1998). As all investigations done by the medical schemes are for billing irregularities and not FWA, all support from organisations with authority and set penalties, have been kept at bay, allowing the medical schemes to audit physiotherapists for amounts far greater than R100 000, and imposing penalties far greater than the gazetted penalties, resulting in financial ramifications to physiotherapists.
Intentional or unintentional harm	When large companies are perceived as being biased, causing intentional harm, more harm and damage is experienced by individuals, compared to if the intentional actions had been conducted by an individual (Ames & Fiske, 2013). Physiotherapists perceived the audits as intentionally harmful as physiotherapists were not given the opportunity to be heard, and the penalties did not fit the alleged 'crime'. These unfair, biased, intentional audit processes resulted in physiotherapists perceiving the harm and damage as worse with increased distress and ramifications (Van Fossen & Chang, 2022; Van Graan, 2018).
Medical Funding Scheme / Medical aid / medical scheme / scheme /	The medical funding scheme is a non-profit organisation registered with the Council for Medical Schemes. The scheme provides medical funding to its paying members. It is the schemes' responsibility to provide managed care

funder	services to the patient according to their health plan. It is also the schemes' responsibility to provide relevant information to a contracted third party, such as the medical provider, who requires this information in order to provide healthcare services according to the members' health plan (Jacobs 2021).
Medical scheme administrators	The scheme administrators are authorised by the Medical Schemes Act and the Council of Medical Schemes to administer medical funding schemes either by a third-party or self-administered within the scheme. Scheme administrators promote institutional safety (Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010). The scheme administrators are a financial, for-profit services provider (Discovery Health Medical Scheme, 2023; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010) which is responsible for conducting the audits on the physiotherapists, while managing risk to the medical scheme.
Organisational power	Large companies have formal authority due to their size and financial standing, resulting in organisational power. They have legitimate power over others and are seen as formidable (Peyton et al., 2019; Singh, 2009). Organisational power will use reward and coercive power to maintain its status of power (Peyton et al., 2019; Van Fossen & Chang, 2022; Van Graan, 2018). Medical funders have established a code of conduct, a fraud policy, improved the data interrogation and detection software, and provide training courses on fraud prevention and detection for their staff (Marais, 2006). They have increased their budget for a separate internal audit division and forensic investigative units, and they have up to 30 staff members in these forensic units (Marais, 2006). The forensic audit units have a greater capacity to influence people positively or negatively, compared to individuals (Ames & Fiske, 2013; Singh, 2009). If the medical schemes use intimidation tactics during audits, physiotherapists may experience the audit as more severe, with ramifications such as anxiety, depression, and PTSD (Ames & Fiske, 2013; Singh, 2009; Van Fossen & Chang, 2022). Physiotherapists are at a clear disadvantage when up against these corporate giants which conduct the audits, as the organisations have endless resources at their disposal overpowering the individual physiotherapist (Ames & Fiske, 2013; Peyton et al., 2019; Singh, 2009).

Being overpowered	When physiotherapists have no power, no legal knowledge, and no team or organisation backing them, they may experience being overpowered and oppressed (Jones & Roelofsma, 2000; Peyton et al., 2019; Singh, 2009), resulting in outcomes such as moral injury, burnout, or compassion fatigue (Dean et al., 2019; Singh, 2009; Tamara et al., 2021; Van Fossen & Chang, 2022).
Peer Review	The SASP, and the HPCSA can conduct peer-reviews which are non-binding and binding, respectively. During these peer-reviews, patients' clinical files are evaluated by qualified physiotherapists who work within the same special interest field as the files being investigated, and who have been appointed by the SASP, and HPCSA. The clinical notes are compared to the billing codes been questioned during the Medical Schemes' audit, and a comprehensive report is created, with recommendations. These SASP peer reviews are rejected by the Medical Scheme stating that the SASP "has not taken into consideration the concerns of the Medical Scheme Administrator and the medical schemes were not afforded the opportunity to present their concerns to be taken into account" (Jacobs, personal communication). The Medical Scheme Administrator insists on doing their own peer review, which is done by a chiropractor, and other non-medical people, not a physiotherapist (PT7), preventing these reviews having been done by a true peer, making the peer reviews conducted by medical schemes unfair.
Physiotherapists	Physiotherapists are caring individuals who have first-line practitioner status in South Africa (SA Medical and Dental Council, 1974; Solvang and Fougner, 2016). They are capable of making a diagnosis and treating patients. The physiotherapist must refer to the relevant medical professional when the problem is outside their scope of practice or requires special intervention. Physiotherapists treat and manage a wide variety of patients including cardio-vascular, chronic pain, intensive care unit (ICU), geriatrics, general rehabilitation, neurology, obstetrics, orthopaedics, paediatrics, respiratory, and sports medicine, as well as others. Physiotherapists may further refer patients for X-rays, and provide sick notes (Regulations Defining the Scope of the Profession of Physiotherapy, 1974).

	During forensic audits, autonomy is negated by the medical scheme when physiotherapists work in collaboration with an admitting doctor, in the hospital setting. Any second condition, which has not been referred to by the admitting doctor but treated by the physiotherapist, is then seen as a billing irregularity, and all payments made for the second condition, treated over the three-year period, must be returned to the medical scheme.
Stressful impact event:	A stressful life/impact event is an event that causes severe emotional, physical, or mental trauma such as experienced from a serious car accident, Covid pandemic, cancer diagnosis, divorce, death of a loved one, or other stressful events (Cohen et al., 2019; Peter, 2017).
Tariff codes	Tariff codes are treatment codes that have been set up by various stakeholders according to the National Health Price Reference List (NHPRL) and was last updated in 2006, as they are waiting for the national health insurance (NHI) to take effect (Beira & Gibbs, 2021a; EZMed SpesNetGroup, 2021). These codes describe the various treatment techniques done by the physiotherapist and have been allocated rand value units (RVUs), to remunerate the physiotherapist for the work that has been done on a patient. The physiotherapy profession has custodianship of the tariff codes, this means the SASP, PASA, and all physiotherapists, unless the physiotherapists sign preferred provider contracts, then the custodianship belongs to the Medical Scheme (HPCSA, 2017b; SASP, 2012b, 2012a). The tariff codes are sent through to the Medical Funder via EDI, whereby the treatments are processed and paid according to the medical schemes' rules as well as the rules of the NHPRL. These tariff codes have specific descriptions that are open for misinterpretation, creating divergent understandings. AI has been set up to flag these codes with divergent descriptions which activates an audit. The medical scheme is then required to investigate, without bias, to come to the truth (Auditing Professions Act Amendment, 2005; Auditing Professions Act No. 26 of 2005, 2005; Medical Schemes Act No. 131 S58: Requirements for Administration of Medical Schemes, 2010) by hearing what the physiotherapists have to say (*Audi alteram partem*).

APPENDIX B: RELEVANT LEGISLATION DURING BILLING IRREGULARITY FORENSIC AUDITS

Table 6.2: Legislation physiotherapists need to know regarding billing irregularity forensic audits conducted by medical funding schemes

Medical Schemes Act Section 59 (a) and (b) (Medical Schemes Act No. 131 of 1998, 1998)
Medical Schemes Act Section 59(3) of the Act states: 'Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of (*a*) any amount which has been paid bona fide in accordance with the provisions of this Act, to which a member or a supplier of health service is not entitled to or, (*b*) any loss which has been sustained by the medical scheme through theft, fraud, negligence, or any misconduct which comes to the notice of the medical scheme, deduct such amount from any benefit payable to such a member or supplier of health service.' **How the medical schemes use this law to their benefit as per the findings in this study** As Section 59(3)(a) allows the medical scheme to take money back from physiotherapists, which was paid out for services rendered, the medical schemes say that physiotherapists were not entitled to charge the code linked with the payout, and can, therefore, take the money back through offset or signage of an admission of debt (AOD). The use of Section 59(3)(a) gives the medical funders significant power to unilaterally deduct past payments, made to providers, off future benefits, through offset (Carr, 2013; Crouth, 2021b; Hearing, 2021a). The medical funders, furthermore, rely on Section 59(3)(a) to recover monies that have already been paid out, further back than the 30-day limit (Carr, 2013; Hearing, 2021a). The medical funders state that healthcare professionals are being audited for billing irregularities, not fraud, waste, and abuse (FWA) which affords them this unilateral power to conduct forensic audits, without external intervention from the Health Professions Council of South Africa (HPCSA), which is responsible for investigating FWA allegations of over R100 000 (HPCSA Corporate Affairs, 2017). The medical schemes stipulate that physiotherapists were not being audited based on Section 59(3)(b) of the Medical Schemes Act, where the physiotherapist would be accused of FWA. The medical funders have not accused the physiotherapist of any of the aspects noted in section 59(3)(b) of the Medical Schemes Act (Beira & Gibbs, 2021a) and therefore, the Health Professions Council of South Africa (HPCSA), and the South African Police Services (SAPS) are not principally involved.

The funder's current position is that logistical information which makes an account legitimate, such as provider names, patient names, practice numbers, and authorisations for pre-approved services, are the requirements that fall within the 30-day window as per Regulation 6 of the Medical Schemes Act (Beira & Gibbs, 2021a). Therefore, other information such as coding/billing falls under the Section 59 clause, which allows them to check these aspects retrospectively (Hearing, 2021a).

How artificial intelligence (AI) has been set up to prevent billing irregularities

These codes in question were charged by the physiotherapists and paid in full according to the rules and regulations of the National Health Price Reference List (NHPRL). The NHPRL rules for each code have been encoded into the electronic data interchange (EDI) systems, put in place to avoid billing irregularities, and/or FWA, and have a two-tier fail-safe system whereby the codes are monitored on both the physiotherapists and the medical schemes' side, and rejected in real-time, if the codes have been used incorrectly. As personal information such as name, date of birth is corrected automatically by AI, and the system is set up to reject all codes that have been used incorrectly, the codes have in fact been used correctly by the physiotherapists and have been paid in full, and if there were irregular billing patterns then the medical schemes had enough time to notify the physiotherapists within 30 days, as per the Medical Schemes Act, Regulation 6.

Survey on medical schemes regarding FWA allegation

According to Marais (2006), medical schemes lack confidence in the SAPS, justice system, and the HPCSA. The medical schemes, therefore, do not notify the HPCSA, and SAPS of FWA allegations, because the cost implication of investigation prevents the medical schemes from doing this (Marais, 2006). Only 17 cases out of the 238 that were reported to the SAPS, from a total of 28 000 cases, resulted in convictions (Marais, 2006). Furthermore, the medical schemes' survey indicated that only 1 to 9% of all healthcare professionals investigated for FWA were guilty, but that in 93% of these audits, a settlement was negotiated (Marais, 2006). One of the largest medical funders recovered R14 702 204 from physiotherapists in 2018 through audits (Hudson, 2019; Smith, 2019), and a total of R555m from all healthcare professionals (Geldenhuys, 2019; Hudson, 2019; Smith, 2019).

Section 59 (3) Investigation interim report

According to the Section 59 (3) Investigation Interim Report of the Medical Schemes Act, absolute precision in the calculation of the amount clawed back is not a requirement, but it is suggested that the amount must be reasonable and based on a methodology which is reasonable (Hearing, 2021b, p. 315).

None of these methodologies used to determine the calculated amounts owed are made available to the physiotherapists, preventing proper engagement between the medical funder and the physiotherapist (Hearing, 2021b). Furthermore, claw-backed amounts calculated over a three-year period are disproportionately harsh on providers when the system can and should notify healthcare professionals sooner. This would eliminate the extent of ramifications on healthcare professionals because of the audit (Hearing, 2021b, p. 317). The results of the investigation indicated that audits should be limited to one or one and a half years and not a three-year period. Longer audits were found to result in disproportionate effects on the providers (Hearing, 2021b, p. 292). If a healthcare professional is fraudulent, then the calculation of debt is fair but is unfair on a provider who was audited for irregular billing patterns. In the report it was suggested that Section 59(3) was used unfairly by the forensic auditors (Hearing, 2021b).

Due to the current legislation of Section 59(3), the forensic auditors from the medical funders are well within their rights to do these forensic audits and do not have to take into consideration other views (Jacobs 2021). However, they should not be issuing sanctions, but rather have an external third party to provide a suitable sanction if any. This legislation Section 59(3) was contested in 2021 by a group of medical doctors, the Solutionist Thinkers (Hearing, 2021b). The interim investigation found these forensic audits for billing irregularities to be unconstitutional.

The advocates tasked with investigating Section 59(3) of the Medical Schemes Act needed to identify trends emerging from the complaints which would require legal and policy interventions. They were further requested to provide recommendations to the CMS on administrative, legal or policy interventions that were required, and lastly, determine if amendments to legislation and regulations were required (*Section 59 Investigating Panel*, 2021). To date, the medical professionals are still waiting for the final report to be published.

Regulation 6 of the Medical Schemes Act (Medical Schemes Act No. 131 Regulation 6, 1998)

Healthcare professionals have 120 days in which to submit claims for payment, thereafter, no claims will be processed or paid by the medical funding scheme, making this a contractual prescription between the medical funding schemes and the healthcare professionals.

Regulation 6 (2) of the Medical Schemes Act: "If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant healthcare provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment, and state the reasons for such an opinion" (Hearing, 2021a, p. 241; Medical Schemes Act No. 131 Regulation 6, 1998).

Regulation 6 (3) of the Medical Schemes Act: "After the member and the relevant healthcare provider have been informed, as referred to in sub regulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned, for correction" (Hearing, 2021a, p. 241; Medical Schemes Act No. 131 Regulation 6, 1998).

"Regulation 6 (4): If a medical scheme fails to notify the member and the relevant healthcare provider within 30 days that an account, statement, or claim is erroneous or unacceptable for payment in terms of sub regulation (2), or fails to provide an opportunity for correction and resubmission in terms of sub regulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute" (Hearing, 2021a, p. 241; Medical Schemes Act No. 131 Regulation 6, 1998).

Regulation 6 as perceived by participants in this study

The medical schemes have not notified physiotherapists of irregular billing patterns. The medical funders did not provide reasons for the audits, only that artificial intelligence (AI) brought the provider under scrutiny (W. Macleod, personal communication, 16 November 2020). They do not say why AI scrutinized the provider (Hearing, 2021a). The contractual prescription of 120 days has been disregarded by the medical schemes.

Contractual Prescription (The Prescription Act No. 68 of 1969, 1969)

Prescription is a legal principle whereby the liability to pay an outstanding debt is extinguished after the passing of time (Shapiro Shaik Defries and Associates, 2019; The Prescription Act No. 68 of 1969, 1969). Prescription is normally three years unless there is a contract altering the period, such as a bond of a house which is 20 years. When there is a contract in place, this prescription is referred to as a contractual prescription. As the healthcare professionals only have 120 days in which to submit claims, according to the Medical Schemes Act, after which the medical schemes will not process or pay claims, this becomes a contractual prescription. Furthermore, Regulation 6 stipulates the medical schemes must notify the healthcare provider, within 30 days of receiving a claim if there are discrepancies, allow the provider 60 days in which to rectify these discrepancies, and allow 30 days in which to pay the provider, emphasising the contractual prescription of 120 days.

Prescription may be extended when a person who owes the money admits that they are liable, or if they sign an admission of debt (AOD), if there is a summons for them to pay, or if a voluntary payment is made towards the debt owed. Prescription of three years then starts on the date they admitted liability, they were summonsed, or they make a voluntary payment (Shapiro Shaik Defries and Associates, 2019; The Prescription Act No. 68 of 1969, 1969). Once an AOD has been signed, this can be used in a court of law to impose the repayment of the debt. If a ruling has been made, then the prescription period will be extended with every debt letter or offset amount and is considered fraud if it is not repaid (Shapiro Shaik Defries and Associates, 2019; The Prescription Act No. 68 of 1969, 1969).

Prescription followed during forensic audits as perceived by participants in this study

The medical funding schemes use the three-year prescription period to audit physiotherapists, explaining that the contractual prescription is only relevant to patient details, and not irregular billing patterns. Offset is activated to protect the members from 'risk' (Broomberg, 2020; Hearing, 2020), and to claw the money back from new claims physiotherapists send through for processing. Prescription is further ignored, as the medical scheme will continue to offset money until all money has been returned from the so-called 'debt'. If payment was made (although involuntarily), the prescription is extended after each payment. "The net effect is that members get services for free, and the provider provides healthcare for free" (Hearing, 2021b, p. 268). Before the provider can put the physiotherapist on indirect payment, the physiotherapist should be treated procedurally fairly and the decision to put the physiotherapist on indirect payment should be reasonable (Hearing, 2021b, p. 275). The only way to circumvent offset, is for the physiotherapist to become a cash practice.

Procedural and substantive fairness

There are no external verification processes that work to ensure that the monetary values identified by the medical funder for clawback are in fact the accurate figures reflected in the so-called billing errors made. It is considered an unfair process when conclusive findings are not provided, and the healthcare professionals are not afforded an unbiased opportunity to make representations on such findings. “It gives rise to serious consequences, both financially and reputation based” (Hearing, 2021b).

Fair process has two aspects, these being procedural fairness and substantive fairness. Procedural fairness requires the need for a fair hearing and this hearing needs to be chaired by an impartial decision-maker (Hearing, 2021b). Fairness includes amongst others, giving adequate notice of the nature of the purpose of the audit. It should provide an opportunity for the healthcare professional to explain why they have used codes in a certain manner without prejudice or bias (Competition Commission, 1998).

Audi alteram partem is the Latin phrase meaning “listen to the other side” or “let the other side be heard as well” (Sewell & Kettle, 2018). It is the principle that no person should be judged without a fair hearing in which each party is given the opportunity to respond to the evidence against them. If there is no fair hearing, then it is unfair to the party that is unheard (Sewell & Kettle, 2018). It is a principle of fundamental justice (Sewell & Kettle, 2018).

When requiring information from a physiotherapist, the length of time offered to respond must be taken into consideration, because the sophistication of the person affected by the administrative action and the consequences of the decision may vary (Hearing, 2021b). Due to poor communication from the medical schemes, physiotherapists are often confused as to what is expected of them and are conflicted with the rules of the POPPI Act and patient-practitioner confidentiality when it comes to medical schemes requesting confidential clinical notes during audits.

Procedural fairness only occurs when an onlooker perceives no evidence of bias. The medical funders who are responsible for the audit should not be closed minded or participate in another role in the decision-making process. When the medical funders act as an accuser, investigator, and judge, it can all give rise to a reasonable perception of bias (Ombudsman Western Australia, 2019).

The medical funders state that due to the safety of substantial amounts of public funds, the procedural fairness is circumvented due to public interest

(Ombudsman Western Australia, 2019). The medical funder state they are protecting public interests, but the members are not benefitting from these audits as the money goes into a funder pool and is not directly returned to the members when these very treatments were paid from the members' savings section, and by law should be returned to the member.

Substantive fairness means that there should be a fair and valid reason for auditing physiotherapists and fairness in the resultant outcomes imposed (Schulenburg, 2019). The process of fairness is determined on an individual basis by taking the physiotherapists' circumstances into account. This means that the medical funder needs to prove that the physiotherapist breached the rule when using the tariff code, when the rules for each code have been encoded into the electronic data interchange systems to avoid FWA and billing irregularities. Additionally, the medical schemes must prove that the physiotherapist understood this rule in the same way that the medical schemes' understood the rule (Schulenburg, 2019), when no communication was sent to the physiotherapists informing the physiotherapists that the rules had changed, nor had the EDI system been changed, therefore the rules had not changed. Audit outcomes must, furthermore, be consistent and appropriate for billing irregularity audits and not confused with FWA in terms of penalties.

The Section 59 investigation Interim Report indicated that by not allowing for a fair process through a hearing, the healthcare professionals are not provided an opportunity for a safe and meaningful explanation of their situation (Hearing, 2021a). Monetary amounts that are deducted through offset and taken back from the healthcare professional prior to completion of the audit are then considered to be a form of self-help by the medical funders (Hearing, 2021b). According to the Section 59 Investigation Interim report, it was identified that, "the power to claw back from future payments due to providers is a significant encroachment into the interests of providers" (Hearing, 2021b, p. 261). "If the consequences of the proposed decision are significant, then a formal hearing process is warranted" (NSW Ombudsman, 2019, p. 2).

Competition Act (89 of 1998) (Competition Act 89 of 1998, 1998)

Section 4 of the Competition Act (89 of 1998) says that abuse of dominance is prohibited. Dominant companies, such as the medical funders, working in a sector that has been designated by the Minister are not allowed to refuse to pay for the services from a supplier (such as a physiotherapist) that is a small or medium-sized business. They are further not allowed to impose prices or other trading conditions on these small to medium-sized businesses. The Competition Act states that large firms are not allowed to impede the ability of small businesses and that the medical funder would need to prove that its actions did not impede the ability of small businesses to participate effectively in the industry.

How the medical funders were using the law in their favour as perceived by participants in this study

The medical funder must, therefore, prove that they have not refused to pay for services provided by, for example, a physiotherapist, when in fact, payments were blocked by the medical funders through offset, during forensic audits. According to the interim report it was said that the medical funder would not put healthcare practitioners on indirect payment if it was just a coding error (Hearing, 2021a, p. 277). However, this is not what has happened. Physiotherapists were immediately put on indirect payment and offset occurred when the audits commenced, as the medical funders said they are protecting their members' funds (PT1, 2, 3, 4, 5, 6). Medical funders were querying certain tariff codes used because they are high monetary value codes. The medical funders further query fees charged for sales of equipment to patients, stating physiotherapists are overcharging their patients. The onus is on the medical funders to prove that the price or trading condition is not unfair (Competition Act 89 of 1998, 1998).

Potential role of the Competition Commission during audits

If the Competition Commission has reason to believe, for example, that the medical funders are impeding physiotherapists in their small businesses, then the Competition Commission may investigate these concerns without having received a complaint. After investigation, the Competition Commission may apply to the Competition Tribunal for a declaratory order against the medical funders. The Competition Commissioner can conduct impact studies which could be beneficial, as an example, audits conducted on physiotherapists. They can review legislation and report any uncompetitive behaviour concerns to the Minister of the Department of Trade, Industry, and Competition. The Competition Commission can determine a policy regarding the delegation of authority in forensic audits to facilitate operational efficiency and protect the healthcare professionals from abusive powers. As the Commissioner must remain impartial and perform without fear, favour, or prejudice, they could be valuable in protecting innocent healthcare professionals from unfair audits.

Debt Collectors Act (Debt Collectors Act, 1998)

The Debt Collectors Act states that legal action against people should only be instituted in cases where it can be ascertained that the person is liable to settle the amount (Debt Care, 2018). It is on the onus of the medical funding scheme to prove the physiotherapist has made billing irregularities. If the medical funder refuses to send copies of the alleged debt, the physiotherapist has the right to complain to the Council for Medical Schemes (CMS) but is not allowed to complain to the Debt Collectors Council. As such healthcare professionals exposed to billing irregularity audits can only turn to the CMS for support. However, the very name of the CMS means that they have the best interests of the medical schemes at heart and may, therefore, be perceived as being biased.

The physiotherapist also has the right to refuse to pay until the medical funder has given details, in writing, with supporting documentation of their claims (Debt Care, 2018). It is advised not to sign any admission of liability. The physiotherapist has the right to a statement, showing the amount owed, and how it was calculated (Debt Care, 2018). Final notification should be by registered post and debt repayments should be affordable and fair to both parties.

APPENDIX C: ETHICS APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

11 August 2022

Approval Certificate
New Application

Dear Ms L Meyer

Ethics Reference No.: 135/2022
Title: Physiotherapists' experiences of forensic audits by South African medical funding schemes

The **New Application** as supported by documents received between 2022-06-27 and 2022-08-10 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2022-08-10 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2023-08-11.
- Please remember to use your protocol number (135/2022) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Dr R Sommers
MBChB, MMed (Int), MPharmMed, PhD
Deputy Chairperson *of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

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Fakulteit Gesondheidswetenskappe
Lefapha la Disciense tša Maphelo

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

13 July 2023

Approval Certificate
Annual Renewal

Dear Ms L Meyer,

Ethics Reference No.: 135/2022 – Line 1
Title: Physiotherapists' experiences of forensic audits by South African medical funding schemes

The **Annual Renewal** as supported by documents received between 2023-06-22 and 2023-07-12 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2023-07-12 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2024-07-13.
- Please remember to use your protocol number (135/2022) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Professor C Kotzé
MBChB, DMH, MMed(Psych), FCPsych, Phd
***Acting Chairperson**: Faculty of Health Sciences Research Ethics Committee*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

APPENDIX D: INFORMED CONSENT

Participants' information and informed consent document for focus group discussions and interviews for the study conducted on "Physiotherapists' experiences of forensic audits by South African medical funding schemes".

Dear Prospective Physiotherapist Mr. / Mrs. / Ms. .....

1) **Introduction**

You are invited to volunteer for a research study. I am doing this research for master's degree purposes at the University of Pretoria. This document gives you information and is provided to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions which are not fully explained in this document, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we will be discussing during the focus group discussion.

2) **The nature and purpose of this study**

This study aims to explore or describe the emotional, financial, physical, and social experiences the forensic audits have had on you as a physiotherapist in South Africa.

Part of the study will be a focus group discussion/interview. A focus group is where people – usually about 8 or 10 – get together with the researcher to discuss a specific topic. The interview will be a one-on-one session where we will ask you to explain your firsthand experiences of the audit. The discussion will be arranged at a time that is convenient to you and will take place via an online platform such as Microsoft Teams.

3) **Explanation of procedures and what will be expected from participants**

If you agree to participate, you will be asked to complete a demographic questionnaire and participate in an interview and/or focus group discussion which will take about 60 minutes and 90 minutes, respectively. You and the other participants will be asked some questions about the **experiences you went through during the forensic audit.** With your permission, the discussions will be audio-recorded to ensure that no information is missed.

This form has 3 parts: Part 1 has the informed consent and Part 2 contains a few demographic questions. Part 3 will be used as the interview/FGD guide

4) **Risks and discomforts involved**

You do not have to share any information you are not comfortable with.
During the interviews and focus group discussion, you may find that some questions are sensitive; for instance, questions about the emotional, physical, and financial impacts the audits had on you, your work, and your family life.

If questions feel too personal or make you uncomfortable, you do not have to answer them.
If you need psychological support or counselling during or after the focus group discussion, I will be able to refer you to (Steve Biko Psychiatry/Psychology Clinic 012 354 3191) or you can alternatively contact your practitioner of choice.

5) **Possible benefits of this study**

You will not benefit directly from being part of this study. But your participation is important for us to **better understand the experiences these forensic audits have had on physiotherapists in South Africa**. The information you give may help the researcher improve the academic knowledge base and may be used to create further support programmes.

6) Compensation

You will not be paid to take part in the study. There are no costs involved for you to be part of the study.

7) **Voluntary participation**

The decision to take part in the study is yours and yours alone. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way.

8) **Ethics approval**

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides healthcare practitioners on how to research people. The researcher can give you a copy of the Declaration if you wish to read it.

9) **Information on who to contact**

If you have any questions concerning this study, you should contact, Lesley Meyer on 0825510388 or via email at cope.sa@vodamail.co.za

10) **Confidentiality**

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number, or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report, or other research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not be possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you permit for other people to see the records.

All hard copy information will be kept in a locked facility. At the Physiotherapy Department at the University of Pretoria, for a minimum of 15 years, only the research team will have access to this information.

10) **Consent to participate in this study**

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read, and understood the above-written information about the study.
- I have had adequate time to ask questions and I have no objections to participating in this study.
- I am aware that the information obtained in the study, including personal details, will be anonymously processed, and presented in the reporting of results.
- I understand that I will not be penalised in any way should I wish to discontinue the study and my withdrawal will not affect my treatment and care.
- I am participating willingly.
- Completing the demographics section, implies consent.

I understand that the focus group discussion will be audiotaped. I give consent that it may be audio recorded.

- YES [ ]
- NO [ ]

Participation in the interview or focus group discussion implies informed consent.

APPENDIX E: DEMOGRAPHICS

Below is an embedding of the demographic's questionnaire.

Part 1 of data gathering: Demographic data gathering.

The following questions will form part of the data gathered for a Masters' degree to determine Physiotherapists' experiences of forensic audits. Completion of this form implies informed consent for the interview and focus group discussions that will take place consecutively.

1. 1: What is your name? Although your name is being recorded it will be removed to keep you anonymous.

   _____

2. 2: What is your date of birth?

   _____

   Example: January 7, 2019

3. 3: What the special interest of your practice?

   Mark only one oval.

   - ◯ Animal Health
   - ◯ Aqautic
   - ◯ Cardio
   - ◯ Mental health
   - ◯ Neurological rehabilitation
   - ◯ Neuromuscular
   - ◯ Older persons
   - ◯ Paediatrics
   - ◯ Pulmonology
   - ◯ Pain management
   - ◯ Pelvic and women's health
   - ◯ Sport
   - ◯ Other: _____

4. 4: When did you qualify as a Physiotherapist?

   _____

   Example: January 7, 2019

5. 5:What is your highest qualification?

Mark only one oval.

- ◯ BPhyst/BSc
- ◯ Masters
- ◯ PhD
- ◯ Other: _____

6. 6: Do you have In-patient practice or Out-patient practice?

Mark only one oval.

- ◯ In-patient
- ◯ Out-patient
- ◯ Both

7. 7: Are you a solo practice or group practice?

Mark only one oval.

- ◯ Solo
- ◯ Group

8. 8: Which switch house do you use for EDI?

Mark only one oval.

- ◯ Datamax/Panacea
- ◯ Healthbridge
- ◯ IKat
- ◯ Mediswitch
- ◯ Outsourced

9. 9: Which medical aid audited you?

Mark only one oval.

- ◯ Discovery Health
- ◯ Gems
- ◯ Medscheme
- ◯ Other: _____

10. 10: Do you know which code activated the forensic audit?

Mark only one oval.

- NO
- 0003
- 0006
- 0009
- 0010
- 303
- 405
- 501
- 503
- 507
- 702
- Other: _____

11. 11: Who does your billing/coding?

Mark only one oval.

- Yourself
- Secretary
- outsourced
- Other: _____

12. 12: Did you contact the South African society of physiotherapy (SASP) about your forensic audit?

Mark only one oval.

- Yes
- No
- Other: _____

13. 13: Which of the following did you get council from for your audit?

Mark only one oval.

- ◯ Lawyer
- ◯ Advocate
- ◯ Legal services
- ◯ HPCSA
- ◯ SASP
- ◯ CMS
- ◯ CA
- ◯ Forensic investigator
- ◯ Other: _____

14. 14: What did it cost you in total?

_____

15. 15: How much did the medical scheme want to clawback?

_____

16. 16: what was the outcome to your forensic audit?

Mark only one oval.

- ◯ My practice was cleared and I paid no money to the medical aid.
- ◯ I signed AOD (Acknowledgement of debt)
- ◯ My practice was blocked (I can't submit claims to the medical aid directly or they offset it)
- ◯ My practice was blacklisted (My patients do not get reimbursed for treatments supplied by my practice))
- ◯ Other: _____

17. 17: On a scale of 0-7, How fair was the forensic audit process?

Mark only one oval.

	0	1	2	3	4	5	6	7	
The audit process WAS very FAIR	◯	◯	◯	◯	◯	◯	◯	◯	The audit process was NOT FAIR

18. 18: On a scale of 0-7 , do you feel that the forensic audit outcome was fair?

Mark only one oval.

	0	1	2	3	4	5	6	7	
The OUTCOME was FAIR	◯	◯	◯	◯	◯	◯	◯	◯	The OUTCOME was NOT FAIR

19. 19: On a scale of 0-7 , Did the forensic audits cause damage to your practice?

Mark only one oval.

	0	1	2	3	4	5	6	7	
NO DAMAGE to my practice	◯	◯	◯	◯	◯	◯	◯	◯	LOTS of DAMAGE to my practice

20. 20: On a scale of 0-7 , Did the forensic audits cause you hurt?

Mark only one oval.

	0	1	2	3	4	5	6	7	
No hurt	◯	◯	◯	◯	◯	◯	◯	◯	Lots of hurt

21. Details of your responses will be captured and an opportunity for further experiences to be shared will be provided during the interviews and focus group discussions. Thank you for taking part in this survey

APPENDIX F: SEMI-STRUCTURED INTERVIEW GUIDE

The semi-structured interview guide for the study conducted for a master's degree: "Physiotherapists' experiences of forensic audits by South African medical funder schemes".

The following questions are open-ended questions about the experiences of private-practice physiotherapists who underwent an audit for billing irregularities conducted by medical schemes. Question 1 is an open-ended question about understanding the physiotherapists' experiences of forensic audits conducted by medical funding schemes.

1. Tell me about how you experienced forensic audits of your practice.

The following questions are possible additional questions about the experiences the participants had during the process of the forensic audits.

2. How did you experience the forensic process in the beginning?
3. How did you experience the forensic audit unfolding?
4. How did you experience the outcome of the audit?
5. What did you experience were the ramifications of the forensic audit in the beginning? (If the participants do not understand the term ramifications, you may say outcomes or injuries).
6. What did you experience were the ramifications of the audit later?
7. How was your experience with coding/billing and artificial intelligence with the forensic team, during the audit?

The following questions pertain to previously experienced stressful events and symptoms experienced during forensic audits and how the forensic audit affected participants' role-fulfilling, job satisfaction, patient care, and professional competence.

8. How would you compare the forensic audits to other stressful events you have experienced such as a car accident, COVID pandemic, or cancer diagnosis?
9. What were the ramifications experienced in your work/professionally? (Outcome or injury in patient care, professionality, or competence in role fulfilling)
10. What were the ramifications of these audits on you? (Outcome or injury in your personal life)

The following questions pertain to potential hurt and damage the physiotherapists experienced personally and in their practices.

11. How did you deal with the audits personally?
12. How do you think the audit could have been done differently?
13. Explain the damage done to your practice.
14. Explain the hurt the forensic audits did to you personally.
15. Did you feel the forensic audit was fair? What was/wasn't fair?
16. What were the ramifications of the forensic audit?
17. Did you feel the outcome of the audit was fair? What was/wasn't fair?
18 Did you feel the forensic auditors were biased towards you, or you to them? Please elaborate.
19. Were there other ramifications?
20. What were the actions you took during the forensic audits?
23. Did you seek medical attention because of the audits?

The following questions pertain to the physiotherapists' experiences of forensic audits with signs and symptoms that may be similar to compassion fatigue, burnout, and moral injury.

24. Did you feel differently towards your patients during or after the audit? If so, how? What was it like resonating with your patients' experiences?
25. Did you feel differently within yourself regarding energy levels, emotional energy, and thoughts in dealing with patients, during or after the audit?
26. How did you feel the forensic audit affected you regarding what is good or bad and right or wrong in how you collaborate with your patients during and after the audit?

27. Is there anything else you would like to add?

Additional follow-up and probing questions may be asked during the interview depending on the information provided by the physiotherapist.

APPENDIX G: NINE-STEP REID TECHNIQUE AND PARTICIPANTS' FORENSIC AUDIT EXPERIENCES

"Physiotherapists' Experiences of Forensic Audits by Medical Funding Schemes", a study conducted where six themes emerged. The second theme "overpowered and oppressed" described how physiotherapists experienced being treated during their forensic interviews and quotes were compared to the nine-step Reid interrogative interviewing technique.

Table 6.3: Quotes taken during physiotherapy interviews comparing them to the nine-step Reid technique

Reid intimidation techniques used during forensic investigations	**Quotes from interviews conducted, transcribed, and coded in ATLAS.ti, with physiotherapy participants who explained their experiences of forensic audits done by South African Medical funding schemes.**
• The Reid technique's central aim is to obtain a confession, as it is based on the presumption that the suspect is guilty of a crime. • Investigators are unwavering in their accusations of guilt, disqualifying the interviewee's denials. • Investigators exaggerate or underplay the seriousness of the offence and claim that the consequences of not confessing are more severe while threatening interviewees, which may qualify as torture. • Investigators analyse interviewees' confidence levels to determine methods of 'scare tactics' required to force an admission of guilt. • Investigators use misleading False Evidence Ploys	1. *"Nine months later I settled the R90,000, and they only un-blacklisted me like 2 or 3 weeks after that, because I refused to sign an admission of debt* [AOD]*". 2:316 ¶ 74 FGD 2* 2. *"The whole meeting was just very like attacking and attacking … My attorney was so flawed, she … didn't even know how to respond … It was just an attacking tone". 13:52 ¶ 286 PT 16* 3. *There was the threat at one point, that if we don't come to some agreement, they would stop paying or they would start taking money from whatever you're* [the physiotherapist] *invoicing them". 5:189 ¶ 203 PT 11* 4. *"They* [forensic investigators] *told me they are not accusing me of fraud, just billing irregularities, and that I was an outlier, but the meeting was traumatic. They grilled me, and grilled me, and grilled me on explanations of the coding and combinations". 14:173 ¶ 160 PT 21* 5. *"The methods used to determine the data … were skewed. … Any statistician would*

(FEP) to confuse interviewees and limit claims of innocence, manipulating and forcing opinions on interviewees. • Investigators purposefully prolong audits by taking too long to respond, wearing the interviewee down. • The Reid technique strongly supports the fact that the investigators will detain the interviewee until a confession is obtained. • This includes overstating the seriousness of the offence and claiming that the consequences of not confessing are severe, which, if accompanied by threats to confess, may qualify as torture. • Forensic investigators are biased due to incentivisation. • The Reid technique encourages the encroaching upon the suspect's personal space, by obtaining personal information which exists outside the public sphere and workplace. • Reid's technique uses intimidation tactics to scare the interviewees into submitting to their demands.	*be able to clearly indicate the fact that those were clearly biased towards the funder and not towards a fair circumstance in terms of determining whether there was fault or not". 7:36 ¶ 395 PT 4* 6. *"Our process started in March last year, I literally signed the last paperwork last week* [19 months later]. *So, it's a very, very long process, very drawn out. Lots of legal letters to and from … I remember nights till 2 o'clock sitting, trying to write clinical explanations. One of our reply letters to Medical Funder 1 was a 180-page document. … I can't tell you how much work went into that, and they didn't even look at it".* 2:319 ¶ 471 – 472 FGD 2 *7. "I go into the meeting, … through security into their secure section which is opened and closed and locked by them". 14:174 ¶ 118 – 126 PT 21* *8. "Then he* [forensic investigator] *wanted me to prove that I have seen the patients, which is not only an insult. It's a [belediging] [sic]* [disrespect/offence/outrage], *it's really the worst ever". 4:34 ¶ 78 PT 7* 9. *One of our teammate's patients* [a forensic investigator], *… would say, "This is what they're doing, … it's a mathematical model and … for them, it's like any … salesperson. You* [forensic investigator] *have a target and if you hit your target, you win, and you win the incentive". 10:161 ¶ 543 – 544 PT 14* *10. "They* [forensic investigators] *requested a lot of information, which was not just billing history of patients, but private confidential medical notes". 9:149 ¶ 61 PT 13* 11. *"I acted on what was suggested to me by my attorney as well as out of immense fear. I was scared of Medical Funder 1".* 13:160 ¶ 510 PT 16

APPENDIX H: SYMPTOMS OF COMPASSION FATIGUE, BURNOUT, AND MORAL INJURY, AND SYMPTOMS DESCRIBED BY PARTICIPANTS DURING FORENSIC AUDITS

Interviews were conducted, transcribed, analysed, and coded using open and axial coding during a qualitative research study: “Physiotherapists’ Experiences of Forensic Audits by South African Medical Funding Schemes”. Six themes emerged of which the theme “distressed with a knife over your head”, described symptoms similar to those described for compassion fatigue, burnout, and moral injury and are listed in this table.

Table 6.4: Physiotherapy quotes describing their experience of forensic audits conducted by medical funding schemes and the descriptions of compassion fatigue, burnout, and moral injury

Symptoms of the different syndromes	Physiotherapists’ experiences of forensic audits,
Symptoms of compassion fatigue are when people experience: • Detachment, • numb, • guilty, • hopeless, • loss of meaning and purpose in their work, • emotional outbursts, • loss of concentration, • difficulty sleeping, • and emotional triggers causing one to feel angry, helpless, and spiritually exhausted.	• *"My marriage is falling [emotional] apart. Because you just block off ... You just become numb [crying]. ... But you have to keep on going. You don't have a choice [crying]. I can't do anything else. I can't become a teacher. So, yes, what do you do? You’re trapped."* 2:275 ¶ 624 – 626 FGD 2 • *"I have had emotional outbursts ... And I internalised it rather than externalized it. So, I retreated, you know, I didn't sleep, so, the sleeping hasn't come right yet, and … my kids will tell you that I literally disappeared out of their lives for 3 years or 4 years."* 14:107 ¶ 495 PT 21
Burnout is a component of compassion fatigue which occurs when the stress is prolonged, resulting in: • Physical, • emotional, • and mental exhaustion	• *"And especially when it (the audit) goes on for so long because … there were times when the lawyer would just say, you know what “PT 20”, I think just sign. I said, “no,” … I don't understand the stuff written here. Yes, so this thing has to be edited, and the lawyer was saying, you know what “PT 20,” just sign it and let's move on. "* 2:164 ¶ 391 – 392 FGD 2
Symptoms of moral injury occur when people are exposed to acts that violate moral beliefs and expectations causing:	• *"Moral injury? Yeah, I never stood up as I should have, for myself, because I thought I was a criminal because you’re literally made to look like*

• Physical distress (insomnia, startle reflex, loss of memory, self-sabotage, suicide, alcohol abuse), • emotional distress (shame, guilt, sorrow, loss of trust in self, loss of trust in others, fear and anxiety, loss of self-worth, depression), • social distress (disconnected from family and friends, and occupational dysfunction), • mental distress (constantly thinking of the situation), • spiritual distress (anger, betrayal, shame, guilt, loss of trust in self and others, loss of purpose, loss of caring, feeling haunted).	*a criminal. … That has hit my self-esteem so badly. "* 14:144 ¶ 611 PT 21 • *" It's always a sword hanging over your head as a physio. But I think when you get the letter, you really are quite shell-shocked that it's now your turn."* 10:4 ¶ 60 PT 14 • *"Medical Funder 1 refused to acknowledge the proof I sent them and duly threatened to blacklist me, IE. You don't even know what I went through. ... I.E., stopped reimbursing patients for treatments rendered by me, if I didn't send them what they wanted."* 13:94 ¶ 413 PT 16 • *"It was stressful in that you don't know the outcome. You don't know what their* (medical funders') *plan is. So, you are doing what you have to do because they've asked it, but you don't know what their response is going to be"* 6:14 ¶ 178 PT 9