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PROFESSIONAL CONSEQUENCE FOR DENTISTS INVOLVED IN UNETHICAL DECISION-MAKING IN SOUTH AFRICA

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ABSTRACT

The previously gullible and apathetic South African public, generally speaking, is lately becoming increasingly rights-based sophisticated. Patients are no longer accepting inferior quality work and have become more knowledgeable especially regarding the expected skills and professional conduct of dentists. The present study examined archival material as published between 2007 and 2013 of penalties against ethical misconduct. It was found that the majority of ethical transgressions took place in urban settings and the most predominant transgression was charging for services not performed and submitting these claims to medical aids as well as performing sub-optimal interventions. Legally a practitioner who performs such acts may be held liable for the damage or injury suffered by the patient as a consequence of these acts, on the basis of negligence. Penalties imposed by the Health Professions Council of South Africa vary between 5,000 Rand and 15,000 Rand, as well as suspensions of between 9 to 12 months. It is doubtful that transgressors would change their behaviour in the light of the present Continuous Professional Development programmes where attendance is really the only prerequisite and not moral reflection. This study recommends that the Health Professions Council of South Africa need to re-evaluate the effectiveness of their ethical training programmes and adapt the model to incorporate more inclusive learning.

KEYWORDS: Dentists, ethical transgressions, HPCSA, misconduct

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INTRODUCTION

Most professions stipulate guidelines or ethical rules to ensure competent and professional behaviour, as well as to minimize misconduct.¹ These guidelines serve as roadmaps for human coherence and conflict management between the different parties involved in the clinical settings² (i.e. practitioner, colleagues and patient/client). Furthermore, the guidelines give the public the reassurance that members of a particular profession will have a minimum level of expertise and skills, and that public interest would therefore be optimally protected.¹ Pettifor and Sachuk³ argue that ethical codes serve a threefold purpose, namely to supervise, regulate and correct professional behaviour. These are maintained through a reflection on personal values, motives and behaviour.⁴

However, codes alone are inadequate in ensuring professional behaviour.¹ How a person will react in an ethical dilemma is often influenced by his/her contextual constraints, personal desires and the idiosyncrasies of a particular situation.⁵ Lindén and Rådeström⁶ argue that ethical awareness is a crucial aspect for the application of ethics which relies on a practitioner's ability to be open and dedicated to the study and critical examination of their own professional judgement and behaviour. The inability of newly graduated practitioners to deal with real-life complex ethical issues are often ascribed to the simplistic and linear training models which are often applied.⁴ Furthermore, inadequate training in ethics can be implicated as an important element in unethical behaviour.⁴ Although the causal relationship between ethics training and ethical behaviour is complex and not yet empirically established, it appears as if universities do not always pay adequate attention to this important aspect.¹ It therefore seems that ignorance concerning the importance of ethics and a lack of

awareness of the personal and professional consequences that may emanate from unethical behaviour is largely responsible for this state of affairs.

Lockhat⁷ rightfully raised a warning for practitioners that the previously gullible and apathetic South African public, generally speaking, is lately becoming increasingly rights-based sophisticated. Patients are no longer accepting inferior quality work and have become more knowledgeable especially regarding the expected skills and professional conduct of dentists. Talk shows, print media, social media and Internet sites offer health care consumers ready access to information about treatment protocols and professional ethics. This information empowers clients and patients to ask informed questions, to become information-sophisticated consumers, and to appropriately address dentists' errors and misconduct.⁸ As such, patients or clients feeling aggrieved by the negative effects of a health care professional's perceived misconduct are more likely than before to lodge a formal complaint with the relevant professional board. The regulatory structure followed in South Africa is underwritten in terms of the National Health Act (61 of 2003) by which the Health Professions Council of South Africa, consisting of 12 professional boards linked to specific health professions, is a legal organ with relevant sanctioning (punitive) powers and rights. For health care professionals, the prospects of facing a formal complaint enquiry are often a distressing experience that has the potential to spawn denial, anxiety and depression.⁸ Other psychological and physical sequelae include loss of self-confidence, professional isolation, depression, anger, frustration, and increased incidence of somatic symptoms and physical illness.⁹ General health care delivery may also be negatively affected as acquitted health care professionals are more likely to avoid seeing high-risk

patients or to focus on practicing “defensive medicine”.⁸ In addition, they may become socially withdrawn, limiting access to personal and professional support. Each of these responses, if not duly recognized and effectively managed may ultimately result in impaired clinical and ethical judgments, thereby negatively affecting future clinical work and the well-being of patients.⁸

This article reports on the ethical transgressions committed by dentists registered with the Health Professions Council of South Africa (HPCSA) in the period 2007 to 2013, the primary rationale being to empower dentists by informing them about the most frequent ethical misconduct transgressions and to grow in their awareness of ethical professional conduct.

MATERIALS AND METHODS

The objectives of this research project are as follow:

- a) To analyse the case content of all guilty verdicts related to professional standard breaches and ethics misconduct against HPCSA-registered dentists in the period 2007 to 2013;
- b) To analyse the penalty content of all guilty verdicts related to professional standard breaches and ethics misconduct against HPCSA-registered dentists in the period 2007 to 2013; and
- c) To recommend potential strategies to limit these transgressions.

The study was primarily conducted within a qualitative research paradigm while it specifically focused on a historical research approach. The focus of historical research is the interpretation of events that occurred over a specified period of time.¹⁰ Archival material (documents and records) is the primary data source in historical

research.¹¹ In this study the archive refers to the collated information pertaining to complaints, alleged misconduct and outcomes of formal hearings as posted on the official website of the HPCSA.

The specific data gathering process for this study focused on the following data for each guilty verdict from the respective annual lists for the period 2007 to 2013: HPCSA registration category, number of cases per verdict, basic case content, specific penalty/ies imposed per verdict and province. In addition, the qualitative case content of each complaint was recorded in terms of the specific professional standard breach and/or ethics misconduct theme.

In the first phase of data analysis, annual frequency tables were compiled for the following variable combinations: a) the various penalties imposed to guilty practitioners across the total study period; b) geographical distribution of the guilty dentists across the total study period; and c) transgression categories and specific misconduct linked to the guilty verdicts against dentists across the total study period. In the second phase of data analysis, the specific case content of each guilty verdict was subjected to a qualitative content analysis.¹¹ This involved a systematic coding and thematic description of each case. Initially each of the two researchers independently conducted the qualitative content analysis on selected annual guilty verdict documents, followed by several consensus discussions.

Research projects that exclusively focus on the analysis of publicly available documents are generally exempt from the requirement for ethics clearance from a registered research ethics committee.¹² As such, no formal ethics clearance was sought for this study.

RESULTS

The frequency (%) of the various penalties imposed to guilty dentists (n=61) across the total study period is indicated in Table 1. During this period the average number of registered dentists was 5280 per year. The 61 guilty dentists across the study period were found guilty of 223 counts in total (range between 1 – 133 counts per practitioner). The three most frequent penalties were a suspended suspension between 1 month and 1 year (30%), a fine between R1,000 and R8,000 (28%), and a fine between R10,000 and R15,000 (20%). On closer inspection, the most common transgressions linked to these penalties

were charging for procedures/services not rendered and submitting these claims to medical aids; performing sub-optimal intervention; failure to recognise/diagnose/manage post-operative complications; and failure to refer patients to a specialist for evaluation and/or treatment. The highest fine ever levied, however, for this registration category was R60,000 imposed in 2012 for fraudulent conduct where the practitioner submitted three fraudulent claims to a medical aid scheme.

The geographical distribution of the dentists found guilty across the total study period is indicated in Table 2.

Penalty	% of all penalties
Caution or Caution & Reprimand	11%
Fine R1,000 – R8,000	26%
Fine R10,000 - R15,000	20%
Fine R20,000 – R60,000	8%
Suspension 1 month to 1 year	30%
Suspension 1.5 to 4 years	5%
Removal from register	None

Table 1: Percentage of penalties imposed to guilty dentists (2007-2013)

The results indicate that the slightly over half of all the transgressors is from Gauteng, followed by KwaZulu-Natal (23%) and the Western Cape (13%).

The frequency of transgression categories linked to the guilty verdicts against dentists across the total study period is indicated in Table 3. The results in Table 3 indicate that the majority of transgressions were fraudulent conduct (55%); followed by improper professional conduct (23%) and negligence and/or incompetence in evaluating, treating or caring for patients (19%). Guilty verdicts with regards to negligence in the proper keeping of patient records (2%) and performing interventions without patient (or parent) consent (1%) were very infrequent. Table 4 provides a

more detailed description of the specific misconduct linked to each transgression category.

DISCUSSION

An analysis of the frequency of the various penalties imposed to guilty dentist across the total study period (Table 1) indicates that the HPCSA mostly opted to impose financial penalties against the majority of transgressors (54%). Some of the imposed penalties were relatively large amounts, especially in those cases where transgressors brought the profession's name into disrepute by being fraudulent –

Province	% of all guilty dentists (n=61)
Gauteng	51%
KwaZulu-Natal	23%
Western Cape	13%
Eastern Cape	5%
Free State	3%
Northern Cape	0%
North-West Province	0%
Mpumalanga	0%
Limpopo	5%

Table 2: Geographical distribution of guilty dentists (2007-2013)

Transgression Category	% of all transgressions
Fraudulent conduct	55%
Improper professional role conduct	23%
Negligence and/or incompetence in evaluating, treating or caring for patients	19%
Negligence regarding patient documents/records	2%
Perform procedures/interventions without patient consent	1%

Table 3: Frequency of transgression categories linked to guilty dentists (2007-2013)

as can be seen with a R60,000 penalty in 2012. However, in the period studied no transgression was deemed serious enough to necessitate a removal from the register.

The geographical distribution of the guilty dentists across the total study period (Table 2) indicates that the majority of transgressors are located in the more urbanized areas of the country, with Gauteng having had the most transgressors (51%). One possible reason could be that the majority of health care providers are located in these areas and also that the patient population in these urban areas are more aware of professional misconduct and their patient rights.

The main contribution of this paper lies in the results regarding the transgression

categories and specific misconduct committed by guilty practitioners (Table 3).

Fraudulent conduct

The majority of guilty verdicts were in respect of fraudulent conduct by practitioners. Fraudulent actions often pertain to charging for non-rendered services or procedures, claiming from medical aid schemes for non-rendered procedures and interventions. All these transgressions inflict material harm on the patient in that limited resources (i.e. medical aid benefits, financial resources) are abused to the benefit of the

<p>Fraudulent conduct</p> <ul style="list-style-type: none"> • Charge for non-rendered procedures/services • Fraudulent medical aid claims • Colluding with unregistered person in respect of medical aid claims • Charge for services rendered by an outsourced non-registered laboratory
<p>Improper professional role conduct</p> <ul style="list-style-type: none"> • Advertising transgressions • Rude, demeaning and insulting remarks towards patient • Failure to provide feedback to patient's family when requested • Employ unregistered person
<p>Negligence and/or incompetence in evaluating, treating or caring for patients</p> <ul style="list-style-type: none"> • Inferior / Inadequate patient examination and subsequent sub-optimal intervention / treatment decisions • Failure to diagnose and treat patient in a timely manner • Perform sub-optimal intervention procedure • Failure to recognise/diagnose/manage post-operative/intervention complications • Failure to refer patient to a specialist for evaluation and/or treatment when indicated • Provide sub-optimal implants/prosthesis/dentures • Negligent clinical practice – Not wearing gloves during patient treatment
<p>Negligence regarding patient documents/records</p> <ul style="list-style-type: none"> • Failure to keep proper medical records and/or clinical notes
<p>Perform procedures/interventions without patient consent</p> <ul style="list-style-type: none"> • Failure to inform patient of intervention risks • Treat a minor without parental consent • Failure to inform patient about fee structure

Table 4: Specific misconduct by guilty dentists (2007-2013) within each transgression category

transgressor. The fact that practitioners did not inform their patients of charging an above-medical-aid-fee structure significantly impacts on the patient's ability to have made an informed and autonomous decision regarding the affordability of the suggested interventions and procedures. The HPCSA is taking a firm stand on this in that the imposed penalties vary between R5,000 and R15,000, as well as a possible suspension between 9 to 12 months.

South African legislation takes a serious stance on the issue of fraudulent claims for procedures not performed, to the extent that fraudulent behaviour could result in criminal prosecution under Section 66 of the Medical Schemes Act (Act 131 of 1998), as well as the Health Professions Act (Act 56 of 1974). According to these acts, anyone who is found guilty of fraudulent conduct can be punished by a fine, imprisonment (for a period not

exceeding five years) or both a fine and imprisonment.

Improper professional role conduct

The Health Professions Act 56 of 1974 defines “unprofessional conduct as improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act.” In the study period, the penalty employed for this kind of behaviour ranged between R6,000 and R12,000. The Department of Health’s efforts to empower and educate patients of their rights will possibly see an increase in complaints against health care professionals as patients will increasingly expect higher levels of professionalism and integrity from health care providers. In addition, the influence of media (e.g. TV medical dramas)⁸ may also influence the perceptions and expectations of patients regarding appropriate professional behaviour.

Negligence and/or incompetence in evaluating, treating or caring for patients

The principle of non-maleficence requires that health care providers do not purposefully create or inflict unwarranted harm or injury on patients (either through commission or omission). Legally a practitioner who performs such acts may be held liable for the damage or injury suffered by the patient as a consequence of these acts, on the basis of negligence. Negligence refers to the blameworthy attitude or conduct of someone who has acted wrongfully on account of carelessness, thoughtlessness or imprudence the person failed to adhere to the standard of care legally required of him/her.¹³

In the current context of negligence or incompetence, many health care professionals, hospitals or other health-care

providers protect themselves against liability for possible negligence by requiring the patient or parent/guardian to sign a waiver of claims, indemnity form or a so-called “disclaimer” prior to any practitioner-patient interactions.¹³ No specific current legislation in South Africa exists on the subject of indemnity clauses. Also, there is no case of a health care professional using such waiver clause to claim protection against liability in this manner, raising the question on the position that the court will take on such waiver contracts.¹⁴ One position on such contracts may be to view it as void (unenforceable) because it offends against public policy. As such, a waiver by a patient safeguarding a health care professional against liability for negligence, so it would seem, would be tantamount to a patient “licensing” a health care professional to practice sub-optimal medicine.

CONCLUSION

The law primarily works retrospectively in attempting to prohibit future behaviour of the kind which has been exhibited previously, whereas the focus of ethics is prospective to establish and contribute to an ethical society at large. Although the law and ethics are not mutually exclusive constructs, the respective focus on how to get to a more just society is different. The law applies sanctioning power, whereas ethical awareness informs future behaviour and allows a person to take a meta-view on an issue. Since the HPCSA is an organ of the state constituted by the National Health Act (61 of 2003) it has the legal power to institute a sanction against any transgressor. However, the effectiveness of these sanctions to significantly change a transgressor’s unethical behaviour is debatable. The process of changing behaviour *inter alia* includes some reflection, which, according to the Kohlberg-Blatt method,¹⁵ requires that

health care providers ought to be able to think of their patients' needs in their conduct. Health care providers can only embrace higher levels of moral conduct and development by reorganizing their thinking after they have had the opportunity to grapple independently and actively with significant moral issues or dilemmas. In order to attain these high levels of moral development, the HPCSA should ideally revisit the structure and requirements of its Ethics Continuous Professional Development (CPD) programme where the annually required ethics credits can be attained by merely

attending a 2 to 3 hour long workshop and/or presentation focusing on an ethics-related topic. At these CPD training little input/reflection is required from the practitioners, other than physical attendance, which results in the ethics credits being awarded. It is obligatory for all those who want to stay registered (to enable them to practice) to accumulate the said credits. The focus should ideally shift from rather passive learning events to active opportunities where practitioners are challenged to develop and mature in their moral reasoning and development skills.

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