Professional competence and professional misconduct in South Africa

Professional life has long been fraught with many difficulties, and the literature is replete with valid criticisms of individuals and the professions (see, for example, Freidson[1] and Kronman[2]). With advancing complexity in medical knowledge and skills and in providing healthcare, maintaining high professional standards is an increasingly recognised challenge in all societies. Enhanced educational efforts to sustain professionalism, improved methods of vigilance, and robust methods of reporting complaints and dealing with offenders are essential.[3-7]

In addition to the usual complaints regarding professional competence and misconduct, some serious and deeply worrying problems about medical professionals in South Africa (SA) are currently being exposed. These include reports of poorly qualified cardiothoracic surgeons being allowed to enter practice, and the lack of robust mechanisms to prevent those who may be incompetent from continuing to practise.[8,9] At the same time, some highly competent surgeons have lost their jobs in the public sector despite lack of appropriate procedures to endorse such action.[10,11] Also of great concern are complaints about full-time health professionals in the public sector fraudulently short-changing their patients, junior colleagues and the state in their public appointment capacities by working unduly long hours in their private practices.[12-14]

Both of these concerns strike at the heart of what health professionalism is about, in particular as health professionals are granted the social privilege of self-governance and internal maintenance of high professional standards, and because trust in professionals by the public is a central factor in healthcare. The background to both these issues is complex. How they could and should be addressed, and what remedial or punitive approaches are appropriate for institutions and individuals when problems are confirmed, are also important questions.

While highlighting and investigating such problems, we should not lose sight of the range of competencies in all professions (from acceptably skilled to highly skilled), and the fact that many health practitioners (it is to be hoped a majority) undertake their work with integrity, dedication and commitment. As with so much in society, the bad behaviour of a few can harm the reputation of whole groups of professionals who conduct themselves honourably and apply their skills for the benefit of many individuals and for society as a whole. In healthcare it is very common to hear complaints of poor treatment and adverse outcomes, but these are seldom placed in the context of the many positive achievements within institutions and practices. As examples of the best that medicine can offer, such services have long been widely appreciated and acknowledged, and SA graduates enjoy excellent reputations locally and abroad. However, these successes should not prevent the investigation of valid complaints, and an understanding of the corrosive effects of unprofessional behaviour on the lives and wellbeing of others.

Inadequate training of specialists

The extent to which local postgraduate training facilities may not be producing specialists with the skills and attitudes required to practise effectively and safely is currently being raised following complaints of inadequate training of cardiothoracic surgeons.[9,15-17] The debate about such issues is heated and there is a paucity of facts about the adequacy of postgraduate training facilities, the extent to which experienced clinician teachers/mentors are available, and whether adequate numbers of relevant cases are available for learning purposes. Although such concerns have been focused on cardiothoracic surgery, they are relevant to all specialties, especially those with surgical and other interventional responsibilities. In addition to the adequacy of training facilities, there is a need to review methods of supervision and certification of hours of training and practical experience.

Relevant questions include how many operations specific to the specialty in question newly qualified surgeons are required to have performed; how many such operations they have indeed performed before they are allowed to go into practice; and what attempts are being made to enable new graduates in such specialties to work for a few years under the supervision of experienced colleagues before they go into solo practice. While full answers to such questions and associated concerns are not available, it would seem that, in part, lack of due diligence along the training and certification chain may be contributing to delays in finding solutions.

Training facilities

The first issue on which to focus is the ability to train new generations of specialists with necessary skills. All postgraduate training requires the development of practical skills under supervision, as well as certification of competence. Against the background of many decades of widely acknowledged, high-quality medical education and training in our medical schools, it was pointed out in the late 1990s and early 2000s that reductions in tertiary beds and freezing of posts in academic hospitals were impairing the ability to sustain specialised services in the public sector and reducing the capacity to train new generations of specialised practitioners.[18]

For example, in 2004 it was reported that at Groote Schuur Hospital (GSH), Cape Town, cardiac surgical operations on adults had been reduced from 700 per year to fewer than 250 per year. In orthopaedics, budgetary reductions had resulted in the limitation of joint replacements to 60 procedures per year in 2003, compared with 350 in 1993. Although the majority of orthopaedic surgery is for traumatic injuries, joint replacement surgery is a critical skill that needs to be sustained. In ophthalmology, there had been a 60% reduction in experienced staff and a 50% reduction in beds over the previous decade. In general surgery, the waiting time for surgery for breast cancer had increased to 8 weeks (compared with 2 weeks in the early 1990s). The only information I was able to obtain about cutbacks at other medical schools at the time was that in November 2003 elective surgery was put on hold for 6 months at the University of the Witwatersrand's major academic hospitals.[18]

Acknowledgement that cutbacks to tertiary medicine in the public sector were unacceptable has led to some reversal of these adverse trends over recent years. For example, by 2013 cardiac surgical operations at GSH had been increased to 320 per year. In ophthalmology, consultant staffing had returned to pre-1994 levels, with one additional full-time consultant at Red Cross War Memorial Children's Hospital, and there has been a drive to improve cataract surgery services.[19] In orthopaedics at GSH, 10 - 12 large-joint (hip, knee and shoulder) replacements are done each week. Yet 314 patients are currently on the waiting list for hip replacement. With six hip replacements per week this amounts to a 12 - 14-month waiting period, adjusting for public holidays, etc. The waiting list

for 623 patients to have knee replacements (four knee replacements per week) is close to 3 years. In general surgery, the waiting time for breast surgery has been reduced to 4 weeks. The time has surely come to acquire and examine more such information from all our local academic institutions.

Assessing professional competence

All the fellowship examinations at the Colleges of Medicine of South Africa (CMSA) are exit examinations. Success in these examinations, taken towards the end of training, together with completion of required training time in appropriate facilities, enables registration with the Health Professions Council of South Africa (HPCSA) and entry into a career as a specialist. The CMSA surgical fellowships have rules stating that a portfolio of surgical experience must be submitted at the time of applying for the final fellowship examination. No mention is made in the rules of the number of operations that should have been done or assisted with, or whether the examiners themselves evaluate the portfolios.

It would seem timely to instigate an open investigation of the patient loads, surgical facilities and staffing levels of all training institutions, as well as of the thoroughness and accountability of the evaluation of practical experience, including scrutiny of well-prepared, validated case portfolios, before qualifying surgeons to enter practice as specialists.

Abuses of limited private practice

Limited private practice, introduced some years ago in order to retain within the public sector those clinicians whose skills were not being adequately used or remunerated, has not been unanimously supported and has had both advantages and disadvantages that vary across the country. In the Western Cape (and presumably throughout the public health sector), practitioners who are paid for overtime (16 hours per week in addition to a salary for a 40-hour working week) are permitted to do a maximum of 16 hours of remunerated work outside of public service (RWOPS) (however, not between 07h00 and 17h00). Practitioners applying for this privilege are required to sign a contract agreeing to remain accountable to the head of component/department tasked with the performance management assessment including the control, supervision and monitoring of RWOPS. An article in this issue describes how RWOPS is managed in the University of Cape Town (UCT)/GSH Department of Surgery, where 8 hours of private practice is the limit allowed by internal agreement.[20]

Although abuses have been recognised in the past, there is now renewed concern and growing evidence that the privilege of RWOPS has been considerably abused by some (perhaps many) healthcare professionals.[12-14] Inadequate opportunities to sustain surgical and other skills, inadequate working conditions in poorly organised and maintained health facilities, and perceptions of inadequate remuneration are causes of frustration for professionals in the public sector.[21] However, it should be acknowledged that greed, dishonesty and lack of professional integrity are, at least to a certain extent, also significant factors for some.

Erosive adverse effects of dereliction of public duties (for which full-time remuneration packages are provided) are wide-ranging. They extend from harm to individual patients in the public sector who are deprived of the time and attention they should receive from experienced clinicians, through inadequate supervision of junior staff, to overloading and frustrating those practitioners who do not abuse this privilege and who struggle to maintain high-quality services and student mentorship in a crumbling public sector.[22,23]

Taking action against professional incompetence/misconduct

In general, when concerns about professional competence or integrity arise in practice, the first step should be for a colleague or a group of colleagues to personally approach the person whom they consider is not meeting required standards of practice. While this is not easy to do, it is the most collegial and respectful way to follow up on professional responsibility to society and the profession. A skilled ombudsman could facilitate such inquiries. If discussion and good advice are not successful in identifying correctable problems and modifying behaviour, then complaints need to be made formally upstream – first to institutions such as the facilities within which the work takes place, for example hospitals and medical faculties. The Professional Standards Committee in the UCT Faculty of Health Sciences (FHS) provides an example of a formal structure and process to address issues of professional misconduct in that faculty.[24] Failure to achieve a satisfactory solution at this level should be followed by reporting to such higher levels as South African Medical Association committees or the HPCSA.[25]

The HPCSA's Annual Report for 2012/2013[26] noted that the Council's legal department had received a total of 2 997 complaints of professional misconduct for all the health professions (310 more cases than in the previous year). Of these, 403 were referred to the office of the ombudsman, and 117 police files were opened regarding unregistered individuals. Most cases were settled at the disciplinary level with admission of guilt fines, while 51 practitioners were suspended from practising.

With regard to serious allegations against the Port Elizabeth cardiothoracic surgeons, it seems that both the HPCSA and local employing authorities may not have paid sufficient attention to the College portfolio rules for qualification to practise, and therefore allowed allegedly incompetent cardiothoracic surgeons to continue to operate despite a litany of operative disasters attributed to them.[8,15]

In 2012 a prominent and highly skilled thoracic surgeon at GSH/UCT wrote to the Dean of the FHS at UCT and the CEO of GSH criticising training in the Department of Cardiothoracic Surgery. This letter was not answered and he was subsequently fired from his position. An investigation is now in progress under the new Dean. However, delays by UCT's FHS in making a decision on professional grounds, despite the findings of the arbitrator in the surgeon's favour[10] (Arbitration Award, Public Health and Social Development Sectoral Bargaining Council – case no. PSHS 143-13/14, 6 October 2013), have resulted in public sector patients and thoracic surgical trainees being deprived of access to the skills of the most highly competent thoracic surgeon on the GSH/UCT staff. Additional delays have been imposed by pursuit of an appeal by the Western Cape Province Department of Health (DoH) against the arbitrator's decision. By resorting to legal solutions, both the University and the DoH are regrettably failing to make a decision on professional/ethical grounds regarding the surgeon's concerns about standards of training.

The sacking of the Head of the Department of Cardiothoracic Surgery at the University of KwaZulu-Natal, one of SA's most experienced cardiothoracic surgeons, is also worrying. Allegations of his racism, blasphemy, bigotry and unprofessional conduct were evaluated, but while the hearing was still in progress an executive decision was taken to terminate his employment.[11] To the best of my knowledge the proceedings of these hearings and the reasons for the decision taken are not publicly accessible. Such lack of accountability could be interpreted as a sign of institutional arrogance.

The juxtaposition of incompetent surgeons being allowed to continue operating while highly skilled surgeons have been removed from the public service to which they have given high-quality and devoted service is bizarre, to say the least.

In the pursuit of complaints about excessive time taken for RWOPS, as much evidence as possible should be obtained about individual practitioners who are thought to be fraudulently exceeding their limits. The first step would be to establish mechanisms to ensure that each full-time member of staff is meeting all his/her designated responsibilities. Such evidence could include careful documentation of: (*i*) the extent to which their public duties are being met; (*ii*) the amount of time they are away from their workplace; and (*iii*) income as self-reported or based on other evidence. One would hope that in academic hospitals some formal tracking of private practice earnings could be possible, as described at the UCT/GSH Department of Surgery.[20] Tracking time spent at formal places of work is not easy, but such data are needed to allow hospitals, provincial employing authorities or the HPCSA to take action within the realms of their regulatory standards. It would seem that some such investigations are under way,[22] but these should be intensified and made transparent, if necessary with the assistance of an organisation such as EthicsSA.[27]

When all the methods described above to assess and address professional incompetence or misconduct are unsuccessful, a complementary approach would be to establish a public commission of inquiry (with sufficient resources, skills and person-power) to investigate a hospital or a provincial health service. The Bristol affair in the UK[28] and the more recent investigations into the Mid-Staffordshire NHS Foundation Trust[29] are examples of responsible and accountable inquiries, although such undertakings are not without controversy.[30,31]

Conclusions

As in all other countries, both high and low income, many aspects of healthcare services in SA are problematic. In addition to health funding that is currently being reconsidered, the adequacy of facilities and the extent of support for postgraduate education/training in complex specialties need to be addressed and augmented if found wanting. If this cannot be achieved adequately within the public sector, the development of mutually agreeable strategic alliances with the private sector for training purposes should be considered, with the proviso that achievement of public benefit can be assured as the major goal. Constant vigilance and willingness of the professions to critically examine themselves and to review methods of supervision and certification of training and practical experience are essential aspects of professionalism required to sustain high-quality clinical services in the best interests of patients, the public at large and the profession.

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