RESEARCH

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Patterns of unprofessional conduct by medical practitioners in South Africa, 2014 - 2023

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Background. Over the past decade, South Africa (SA)'s healthcare landscape has shifted significantly as a result of policy reforms, including the Consumer Protection Act and amendments to the National Health Act. These changes have reframed the doctor-patient relationship, introducing economic and systemic pressures that may influence ethical decision-making.

Objectives. To revisit the patterns of professional misconduct of SA medical practitioners from 2014 to 2023, comparing findings with those of a previously published study (covering 2007 - 2013) to identify emerging trends and to reflect on the efficacy of past recommendations.

Methods. A mixed-methods approach was used to analyse published disciplinary records from the Health Professions Council of South Africa, excluding 2019 owing to data unavailability. Quantitative data were analysed using statistical tests to assess differences in transgression frequencies and sanction patterns between time periods. Qualitative analysis was used to categorise transgressions into several general and specific types to assess shifts in the patterns of professional misconduct.

Results. The average percentage of practitioners found guilty of misconduct decreased significantly from 0.164% (2007 - 2013) to 0.087% (2014 - 2023) of registered practitioners. However, the average number of guilty verdicts per practitioner remained statistically unchanged, indicating a persistent pattern of repeat offences. Notable shifts in transgression types included a decrease in fraudulent conduct and an increase in documentation-related negligence.

Conclusion. Although fewer practitioners were found guilty over the period of the present study, professional misconduct transgressions remained concentrated among repeat offenders. The study underscores the value of reinforcing the social contract in healthcare by recommending individualised ethics coaching for transgressors and revising current sanctioning practices to more effectively deter repeat misconduct.

Keywords: medical ethics, professional misconduct, ethical transgressions, healthcare providers

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The South African (SA) healthcare sector has undergone transformations with the passage of new healthcare policies in the past decade, such as determining what quality healthcare services are and disclosing any financial interests in ancillary contractual relationships, causing new ethical issues and concerns to surface.[1] The new legislation hopes to increase awareness and create avenues for strong communication to better protect disadvantaged patients and empower resource-poor communities.[2] In addition, the changes address certain economic aspects of and collaborative practices in healthcare and aim to create incentives for practitioners to provide a better quality of care for patients. For example, allowing practitioners to share fees under certain conditions and to share space for providing services with other registered practitioners promotes better service delivery and collaboration while maintaining ethical conduct. Given this new wave of policies, it is imperative to compare the nature and frequency of ethical transgressions reported after the policy changes with those of the past.

A previous study reported specific patterns in professional misconduct of medical practitioners in SA for the period 2007 - 2013.[3] Although relatively few medical practitioners were found guilty of professional misconduct (between 0.11% and 0.24% annually), the annual average number of guilty decisions per medical practitioner ranged between 1.29 and 2.58, implying that many practitioners found guilty of ethical transgressions had committed multiple

transgressions or were repeat offenders.[3] The three most frequent sanctions imposed were fines between ZAR10 000 and ZAR15 000 (28.3%), fines between ZAR1 000 and ZAR8 000 (23.5%), and suspensions of 1 month to 1 year (17.4%). The majority of the unprofessional conduct involved fraudulent behaviour (48.4%), followed by negligence or incompetence in evaluating, treating or caring for patients (29%).

The promulgation of the Consumer Protection Act in 2011 and amendments to the National Health Act in 2018 normalised a view of patients as consumers from a legal perspective.[2] This modification could have influenced practitioners to subconsciously change the focus of their professional code of ethics from that of a healthcare professional to that of an economic service provider. With modern changes in healthcare constantly adding third parties (for example, insurers or legal structures) to the equation, the doctor-patient relationship grows ever more complex, challenging medical practitioners' ability to conduct thoughtful ethical decision-making in this increasingly commodity-driven world.[2] One critical analysis of SA's healthcare system showed that, as a consequence of these changes and others, healthcare providers at less well-resourced institutions or practices found it difficult to uphold their professional code of ethics and provide care of good quality in the face of an unsupportive management environment, staff shortages, and health system deficiencies.[4] It is therefore reasonable to expect that the patterns of ethical transgressions of medical practitioners in SA may have changed since these healthcare and societal reforms were implemented.

The purpose of this study was to identify any new or changed patterns in the ethical transgressions of medical practitioners in the context of the previous study's recommendations to deter transgressions and of recent changes in the SA healthcare system.[3] Revisiting trends and patterns in ethical transgressions allows us to extrapolate the source of new patterns, make new recommendations that target the roots of ethical transgressions, and gain new insights into which strategies may deter ethical transgressions and those that may have little or no effect.

Methods

This study analysed ethical conduct transgression cases brought against medical practitioners between 1 January 2014 and 31 December 2023 in SA. The annual formal transgression and judgment records are publicly available on the Health Professions Council of South Africa (HPCSA)'s website.[5] However, it should be noted that the HPCSA did not publish any data for 2019, so the data collected here represent 2014 - 2018 and 2020 - 2023.

The HPCSA is the statutory authority responsible for regulating the education and registration of healthcare professionals across SA. Its core mandate is to uphold and enforce high professional and ethical standards in the healthcare sector, ensuring that complaints made are adequately investigated and appropriately addressed.[6] Governed by the Health Professions Act 56 of 1974,[7] the HPCSA outlines the scope and responsibilities of each healthcare profession. Under the Act, 12 professional boards are tasked with establishing and overseeing the ethics and professional standards for their respective specialty.[7]

Any complaint submitted to the HPCSA is screened, and if deemed appropriate for follow-up, analysed and filed in the register against the reported professional.[8] Depending on the nature of the complaint, it will be referred for either mediation or preliminary investigation. The preliminary committee of inquiry will impose a penalty if the behaviour or action is not of a highly serious nature. The professional has a chance to either accept or reject the penalty, but if they reject the penalty, the matter then moves into the professional conduct inquiry process. Under the Health Professions Act, section 42(1), the committee can impose any of the penalties listed in the Act if the professional is found guilty. If the professional is found not guilty, the individual who placed the complaint has an opportunity to appeal the judgment before the Appeals Committee of Council.[8] The HPCSA annually publishes a formal list of all the professional misconduct cases that resulted in sanctions. The published cases are listed chronologically by the month in which the sanction was determined. Each ethical misconduct case contains the following information:

- practitioner's name
- practitioner's HPCSA registration number
- nature of the complaint
- penalty issued
- location/town.

The frequency of penalties and ethical transgression types for each year of the study period was analysed using a mixed-methods approach. In the quantitative component, we assessed annual frequency data regarding the number of practitioners per professional category who were found guilty of unprofessional and/or unethical conduct by the HPCSA's Professional Conduct Committee, the number of guilty decisions (cases), and the number of specific sanctions and sanction categories. The qualitative component employed a historical research approach and used the categories and subcategories as developed by Hoffmann and Nortjé[3] in a 2016 study as a way to organise the type of transgressions and sanctions. Transgressions were sorted into one of nine general categories and one of 180 identified specific subcategories. This process allowed the review of trends in specific forms of misconduct as well as macro-level 'transgression clusters'.

Formal ethics clearance was sought from the research team's institutional ethics committee, namely the University of Texas MD Anderson Cancer Center committee, and an exemption was received as the study did not include research on human subjects and all the data sourced and analysed in the project were obtained from the publicly available records on the official HPCSA website. Although the published transgression lists include identifying information for practitioners, such as names and registration numbers, these are not reported in this article because this information was deemed to be irrelevant to the aim of the study.

Results

Frequency of guilty verdicts

Relatively few practitioners received guilty verdicts compared with the total number of registered practitioners. Table 1 shows the frequencies of guilty practitioners among all registered medical practitioners for each year from 2014 to 2023 (with the exception of 2019). It can be seen that there was an increase in guilty verdicts during the COVID-19 pandemic. The authors infer that this may be due to the impact COVID-19 could have had in terms of heightened awareness and emergency controls when healthcare

delivery was heavily scrutinised. The overall mean percentage of guilty medical practitioners during the 2014 - 2023 period was 0.087%, compared with 0.164% in the 2007 - 2013 period.[3] This finding represents a statistically significant decrease in the mean percentage of guilty practitioners in 2014 - 2023 from that in 2007 - 2013 (t=3.10, p<0.05).

Table 1 also reports the number of ethical misconduct transgressions per practitioner among the practitioners who received guilty verdicts for the years 2014 - 2023, with the exception of 2019. The mean number of ethical misconduct transgressions per guilty medical practitioner was 1.89 during this period, which was marginally lower than the average of 1.91 ethical misconduct transgressions per medical practitioner reported in the 2007 - 2013 study,[3] although the difference was not statistically significant (t=0.21, p=0.83).

Professional misconduct categories

Table 2 shows the most frequent professional misconduct transgressions during the period 2014 - 2023, excluding 2019. The two most frequent categories of misconduct transgressions, which each made up approximately one-third of all the transgressions, were fraudulent conduct (35.0%) and negligence or incompetence in evaluating, treating or caring for patients (32.1%). The remaining transgressions included a variety of misconduct categories involving patient records, professional registration, improper professional role conduct, performing procedures without patient consent, abuse, disclosure of confidential information without permission, and even criminal convictions. When compared with the professional misconduct patterns from the 2007 - 2013 study,[3] fraudulent conduct and improper professional role conduct represented a significantly smaller proportion of the overall misconduct pattern than in the 2014 - 2023 period, namely 48.4% v. 35.0% for fraudulent conduct (z=–5.31, p<0.05) and 9.8% v. 6.4% for improper professional role conduct (z=–2.37, p<0.05). In contrast, compared with the professional misconduct pattern in the 2007 - 2013 study,[3] patient record negligence and professional registration misconduct represented a significantly larger proportion of the overall misconduct pattern than in the 2014 - 2023 period, namely 4.3% v. 10.4% for patient record negligence (z=4.65, p<0.05) and 2.0% v. 7.8% for professional registration misconduct (z=5.47, p<0.05).

Table 3 provides a more detailed description of the most frequent specific professional misconduct actions in each misconduct category.

Table 1. Percentage of guilty medical practitioners and mean guilty decisions per practitioner, 2014 - 2023 (excluding 2019)

Year	Number of registered medical practitioners	Number of guilty medical practitioners (%)	Number of guilty decisions	Mean number of guilty decisions per guilty medical practitioner
2014	40 716	85 (0.209)	116	1.36
2015	41 886	37 (0.088)	63	1.70
2016	43 141	52 (0.121)	165	3.17
2017	44 653	23 (0.052)	33	1.43
2018	45 503	18 (0.039)	30	1.67
2020	43 901	39 (0.089)	86	2.21
2021	48 021	27 (0.056)	56	2.07
2022	49 533	47 (0.095)	79	1.68
2023	51 514	19 (0.037)	27	1.42

Table 2. Frequencies of most prevalent professional misconduct categories among guilty medical professionals

Professional misconduct category	Number of guilty decisions	% of all professional misconduct decisions
Fraudulent conduct	229	34.96
Negligence or incompetence in evaluating, treating or caring for patients	210	32.10
Negligence regarding patient documents or records	68	10.38
Professional registration misconduct	51	7.79
Improper professional role conduct	42	6.41
Perform procedures and interventions without patient consent	22	3.36
Abuse*	18	2.75
Disclosure of confidential information without permission	9	1.37
Criminal convictions	6	0.92

*See Table 3 for specific examples of abuse.

Sanctions imposed on guilty practitioners

The annual numbers and overall percentages of the different sanctions imposed on guilty medical practitioners during the study period are shown in Table 4. Over half of the sanctions (57.7%) were fines, which ranged from ZAR2 000 to ZAR150 000. The most frequent sanctions were fines of ZAR10 000 to ZAR15 000 (19.7%), suspensions of 3 months to 1 year (13.2%), fines of ZAR2 000 to ZAR8 000 (10.7%), fines of ZAR30 000 to ZAR60 000 (10.7%), and suspensions of 1.5 to 3 years (10.7%). Combined, these sanctions constituted almost two-thirds (65.1%) of all the imposed sanctions. The least frequent sanctions were attendance of a non-ethics-based course (0.2%), an order to get an approved mentor (0.2%), and fines from ZAR120 000 to ZAR150 000 (0.4%). These measures were each imposed only one or two times during the study period. The remaining penalties were a combination of cautions or caution and reprimands (10.3%), suspensions of 3 months to 1 year (13.2%), suspensions of 1.5 to 3 years (10.7%), suspensions of >3 years (2.6%), removal from the HPCSA register (1.7%), attendance of training courses (3.0%), and community service in a public hospital (0.6%). Fines of up to ZAR25 000 were imposed for fraudulent billing, poor medical practice (surgical and non-surgical), and employment of and practice of medicine by unregistered persons. Higher fines (ZAR30 000 to ZAR150 000) were imposed

for prescribing treatment or drugs that are not the standard of care, fraudulent billing, and poor medical practice. The most serious sanction, namely removal from the HPCSA register, was imposed in cases where medical practitioners were found guilty of the following: conducting unapproved clinical trials, falsifying a medical certificate, and failing to provide proper treatment for several patients.

When compared with the professional misconduct pattern in the 2007 - 2013 study,[3] we found that more fines of ≥ZAR30 000 were imposed in the 2014 - 2023 period (17.9% v. 4.2%). In contrast, fewer lower fines (≤ZAR8 000) were imposed in the 2014 - 2023 period than in 2007 - 2013 (10.7% v. 23.5%). Another notable difference is that relatively more suspensions of 1.5 to 3 years were imposed in the 2014 - 2023 period compared with the 2007 - 2013 period (10.7% v. 4.6%). Frequencies of removal from the HPCSA register were similar between the present study and the previous one (1.7% v. 2.4%), as were those of required attendance of a training course (3.0% v. 1.5%).[3] Notably, an order to get an approved mentor was imposed on one guilty medical practitioner in the present study period for performing a procedure without adequate preoperative work-up, performing a laparotomy without exhausting all other non-surgical options, and several other counts of misconduct related to a surgical procedure; no similar penalty was imposed in the 2007 - 2013 period.[3]

Discussion

Medicine has been described as 'An occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation enshrined in its codes of ethics.'[9] This description emphasises the unique relationship between the medical community and the society that it serves. The field of medicine is more than a mere technical discipline – it is a moral enterprise. Medical providers are responsible for upholding high standards of professionalism, driven by a commitment to serve others rather than to receive a profit. Professionals in the field are expected to act with honesty, integrity and selflessness, placing the interests of others above their own. Competency through self-regulation to ensure adequate performance, productivity and cost-effectiveness is also expected of medical professionals.[10] Moreover, medical professionalism involves an active dedication of medical professionals not only to serve their patients but also to improve the healthcare system for society.[11] Similarly, medical professionals hold certain expectations of society within the social contract, such as trust, autonomy, shared accountability for health outcomes, self-regulation and a balanced lifestyle, and mutual respect and collaboration.[10]

We hypothesise that the view of patients as consumers, driven by the implementation of the Consumer Protection Act and

Table 3. Specific professional misconduct actions by guilty medical practitioners in each misconduct category

Professional misconduct category	Specific misconduct actions
Fraudulent conduct	• Fraudulent billing – charged for services not rendered • Fraudulent billing – charged for procedures not performed • Fraudulent billing – charged for medication not dispensed • Dispensed generic medication and submitted a claim to the medical aid scheme for more expensive medication • Provided a false medical certificate
Negligence or incompetence in evaluating, treating and caring for patients	• Below-standard medical practice (e.g. failure to provide standard of care; failure to provide appropriate or adequate care to patient) • Poor medical practice placing patient at unnecessary surgical risk (e.g. failure to perform an appropriate preoperative assessment) • Failure to treat surgical complications, leading to death
Negligence regarding patient documents or records	• Failure to keep proper patient records • Issued a medical certificate/prescription without examining or diagnosing the patient
Professional registration misconduct	• Allowed or employed an unregistered person to practise • Practised as a private practitioner while only registered for public service • Practised as a healthcare professional when not registered • Misrepresentation – advertisement as healthcare professional when not registered
Improper professional role conduct	• Failure to respond to Council or Board inquiry • Acted in a manner that could put the profession in bad light • Derogatory and/or rude language or action towards a patient • Inappropriate relationship with patient or colleague • Inappropriately conducted a postmortem examination
Perform procedures and interventions without patient consent	• Failure to obtain patient consent for performed service • Failure to inform patient of potential treatment risks and complications • Failure to obtain consent for charging above medical aid fees • Failure to obtain consent for intervention procedure (e.g. failure to obtain preoperative consent)
Abuse	• Sexual abuse (e.g. indecent or sexual assault of patient by touch; engaged in a sexual or emotionally intimate relationship with patient; made inappropriate sexual comments or gestures to patient; sexual harassment of patient) • Verbal abuse (e.g. verbal assault towards a patient or colleague) • Physical abuse (e.g. applied physical force or assaulted a patient)
Disclose confidential information without permission	• Breach of confidentiality (e.g. disclosure of confidential information to third party without proper permission)
Criminal convictions	• Unlawful employment of another person • Unlawful possession of medicine • Harvesting and removing body organs during postmortem examination without consent

Table 4. Annual frequency of sanctions imposed on guilty medical practitioners, 2014 - 2023

Penalty	2014 (*n*=86)	2015 (*n*=42)	2016 (*n*=78)	2017 (*n*=25)	2018 (*n*=27)	2020 (*n*=60)	2021 (*n*=41)	2022 (*n*=73)	2023 (*n*=36)	Total (*n*=468)	% of all penalties
Caution	1		1		1					3	0.64
Caution and reprimand	8	3	8	8	2	13		3		45	9.62
Fine ZAR2 000 - 8 000*	16	10	11	3	1	4	2	3		50	10.68
Fine ZAR10 000 - 15 000	28	12	21	5	4	6	4	11	1	92	19.66
Fine ZAR20 000 - 25 000	8	8	4	3	1	4	6	6	3	43	9.19
Fine ZAR30 000 - 60 000	3	2	5	2	5	7	4	14	8	50	10.68
Fine ZAR70 000 - 100 000	1		15	1	1	1	4	4	6	33	7.05
Fine ZAR120 000 - 150 000					1				1	2	0.43
Suspension 3 months - 1 year	12	5	6	1	2	10	3	14	9	62	13.24
Suspension 1.5 - 3 years	5	2	2		8	10	7	11	5	50	10.68
Suspension >3 years	3		4		1	1	1		2	12	2.56
Removal from register	1		1	1		1	2	2		8	1.71
More training							1	2		3	0.64
Attend a non-ethics-based course							1			1	0.21
Attend a medical ethics course						3	4	3		10	2.14
Community service in a public hospital				1			2			3	0.64
Get an approved mentor									1	1	0.21

*Note: At the end of 2023, the ZAR was equal to ~EUR0.0487 and USD0.0531.

amendments to the National Healthcare Act, has reshaped the ethical orientation of medical professionals in how they practise. Healthcare as a commodity or product that can be sought shifts the identity of medical practitioners from professionals to producers, with emphasis on marketplace-like transactions and relationships. A marketplace ethic has different standards and regulations when compared with the professional ethic of a medical provider; a marketplace ethic is typically associated with a relaxed standard of truth-telling due to parties attempting to gain the maximum benefit for themselves.[2] A telling analogy is that of a car salesman: while not necessarily dishonest, they may engage in strategic bluffing during price negotiation with the aim of receiving the highest possible commission. While the Consumer Protection Act and the National Health Act aim to provide a regulatory environment to protect patient rights, it is hypothesised that this shift to patient as consumer inadvertently disrupted the social contract between the medical provider and patient.[2]

While attending medical ethics courses may help to rehabilitate first-time offenders, this will not necessarily be the case for repeat offenders.[12-16] A study reporting on the recommendations developed by a multidisciplinary working group recommended that patterns of unethical behaviour in medicine should be treated as gross incompetence and can only be addressed with swift and fair sanctions corresponding to the severity of the transgression.[17] In these cases, we propose that significantly more severe penalties be imposed on all guilty medical practitioners, with compulsory completion of healthcare integrity/ethics courses, as well as a requirement to be guided by one or more professional mentors (e.g. medical ethicists, senior medical practitioners, professional healthcare mentors) for a set time period and to produce a report to the HPCSA at the conclusion of the mentoring period. It may also be helpful for the HPCSA to consider improving standardisation to provide consistent sanctions to medical practitioners regarding which sanctions are assigned to particular transgressions.

It is important to highlight the limitations of the present study. First, the absence of data for the year 2019 creates a gap in the analysis, potentially leading to an incomplete understanding of trends over the study period. Throughout our data collection efforts, small inconsistencies regarding language, misidentification of transgressors, or duplicate reporting were noted. It is difficult to determine what influence, if any, internal HPCSA institutional or internal procedural challenges had on the decreased guilty verdicts in 2014 - 2023 compared with 2007 - 2013. Moreover, the study relies solely on publicly available HPCSA data, which may not capture all ethical misconduct actions, particularly those resolved informally or not formally reported to the HPCSA. Lastly, this study only considers the HPCSA's formal guilty verdicts against medical practitioners. While the number of complaints lodged each year is available, this number is categorised by professional board, not healthcare profession. Unfortunately, medical and dental practitioners are under the same professional board, so we were not able to determine the number or percentage of guilty verdicts among all complaints filed against medical practitioners.

Conclusion

The most important finding of the present study is a statistically significant decrease in the overall mean percentage of guilty practitioners from the 2007 - 2013 period to the 2014 - 2023 period. Fraudulent conduct and negligence or incompetence in caring for patients remained the top two professional misconduct categories, while disclosure of confidential information without permission and criminal conviction remained the least common professional misconduct categories. In terms of the sanctions imposed on guilty practitioners, financial sanctions and suspensions remained the

most frequent sanction categories, with further (ethics) training and removal from the register only imposed in a few cases.

We would like to reiterate the importance of the recommendations from the previous study covering the 2007 - 2013 period. Those recommendations are as valid today as when they were originally offered, especially the following recommendation regarding further ethics training: the HPCSA should reconsider the aim and nature of sanctions imposed on medical practitioners found guilty of unprofessional conduct. We hypothesise that fines and suspensions are sanctions that in themselves do not facilitate sound professional and ethical conduct. Further research is recommended to evaluate how and whether different sanctions affect repeat offences. In addition to fines and suspended suspensions, we would like to strongly recommend that all guilty practitioners be required to complete a duly accredited medical ethics course focusing on professionalism.

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Author contributions. All authors meet the criteria for authorship as outlined in the *SAJBL* authorship policy. NN was the primary project leader, followed by WAH. NR wrote the manuscript, and MP organised and led the data analysis efforts. AB, YG, MN and GT contributed equally to the data collection processes. WAH contributed to conceptualisation, methodology, resources and supervision.

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Conflicts of interest. None.

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