An analysis of complaints against oral health professionals charged with misconduct at the HPCSA:2004-2009

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ABSTRACT

Aim: This study investigates the nature, frequency, and outcome of complaints relating to misconduct laid against oral healthcare professionals (OHPs), charged with misconduct in South Africa.

Methods: Records of the Health Professions Council of South Africa (2004-2009) were analysed and classified using the ethical rules as a reference. "Clinically-related complaints" and "fraud" were added as extra categories. The nature and outcome of the complaints and the penalties were quantified, and the detailed nature of the complaints was qualitatively reported.

Results: Two percent of the registered dentists and 5.5% of the registered dental therapists were charged with misconduct. Clinically related complaints (59%) and fraud (29%) were most prevalent amongst the accused dentists. Fraud (46%), clinically related complaints (19%), advertising (15%), infection control (8%), and creating expectations that could not be met (8%) were the most common complaints against dental therapists.

Conclusions: Substandard dental treatment and fraud were the main reasons for patient dissatisfaction that led to OHPs being charged with misconduct. Both these undesirable practices may be financially motivated. OHPs should take cognisance of these statistics and should adjust their professional approach accordingly in order to reflect acceptable ethical behaviour.

INTRODUCTION

The conduct of oral health professionals (OHPs) in South Africa appears to attract increased public attention in both the printed[1] and electronic media[2].

For the past few years the Health Professions Council of South Africa (HPCSA) has published the details of health practitioners in general who were found guilty of misconduct[3] as well as the number and nature of registered complaints[4].

According to the 2007 Statistical Report by the ombudsman of the HPCSA, most complaints are laid against medical doctors followed by dentists[4]. Account queries, failure to provide medical reports, poor communication, professional jealousy and irregularities pertaining to medical certificates were highlighted as some of the most serious problems[4]. The report, however, did not reflect the nature and number of specific complaints laid against OHPs in South Africa.

The HPCSA keeps a database of OHPs charged with misconduct. This source of information is ideal to be utilised to determine the nature of complaints against OHPs, as well as the outcomes in order to inform the professions, the relevant training institutions, professional organisations and statutory bodies, as well as the public at large.

AIM

This study was therefore conducted to investigate the nature, frequency, and outcome of the complaints laid against OHPs charged with misconduct by the HPCSA.

METHODS

Ethical clearance was obtained from the Faculty of Health Sciences' Research Ethics Committee of the University of Pretoria (Protocol 154/2009). The HPCSA granted permission for access to its records. It must be noted that as soon as a healthcare provider

is formally charged with misconduct, the identity of the accused may be made public. Despite this, anonymity was maintained during the study.

The study was retrospective and records for the period 2004 - 2009 were analysed. A part-time employee of the HPCSA extracted the data using a custom designed data-capturing form. The case-number, date of initiation, the defendants' registered profession, a description of the complaint, and the complaint category according to the general ethical rules (Table 1)[5] were recorded. An open-ended category was added to accommodate cases that could not be classified according to the ethical rules. In such instances, the categorisation was based on the commonality of the content nature of the complaints. "Fraud" was an obvious category that had to be added due to the regular frequency of complaints about irregular accounts. Complaints related to undesirable clinical treatment/practice outcomes (including accusations of incompetence and/or negligence, which were most of the time difficult to distinguish from one another) were grouped under "clinically-related complaints". Other categories that were not covered by the ethical rules included: "assault", "rude/obscene language", and "creating expectations that could not be met". Quotations from the charge sheets and HPCSA records pertaining to some of the above-mentioned complaint categories were qualitatively reported to gain insight into the more detailed issues that resulted in the complaint. It must be noted that the specific reasons for complaints were so diverse that it would be impossible to address them individually. The finalisation date, admission of guilt, the outcome of the hearing (guilty or not guilty), and the penalties, were also recorded.

A second researcher controlled and verified the data extraction and corrected any errors.

The prevalence of complaints during the study period was calculated by dividing the number of cases during the period 2004 - 2009 by the annual average number of OHPs registered with the HPCSA for the same period.

Table 1: Summary index of the general ethical rules (HPCSA)[5]

- Advertising
- Canvassing and touting
- Information on professional stationery
- Practice names
- Itinerant practice
- Partnerships and juristic persons
- Covering
- Supersession
- Impeding a patient
- Professional reputation of colleagues
- Professional confidentiality
- Retention of human organs
- Signing of official documents
- Certificates and reports
- Issuing of prescriptions
- Professional appointments
- Secret remedies
- Sharing of consulting rooms
- Statutory duties of council or the board
- Performance of professional acts
- Exploitation
- Medicines
- Financial interest in hospitals
- Specialists
- Reporting of impairment
- Research, development and use of chemical, biological and nuclear capabilities of the State
- Rules applicable to a medical scientist

Frequency distributions were calculated and the prevalence of complaints against dental therapists and dentists were compared using the Chi2-test. The level of significance was set at $P<0.05$.

It must be noted that the HPCSA complaints database did not distinguish between dentists and dental specialists. As a result, the term "dentist" includes "dental specialist" for the purpose of this study.

RESULTS

Two cases were discarded due to insufficient information being available during data collection.

Charges were laid against 102 dentists (2%) and 26 dental therapists (5.5%) (Chi^2–test, $P<0.001$).

No charges were laid against oral hygienists and dental assistants.

Table 2: Complaints against Dentists by complaint category, outcome and penalty

Complaint Category			Outcome			Penalty					
	Complaints	Distribution	Not guilty	Guilty	Uncompleted	Suspended Suspension	Removed from Register	Fined	Restitution	Further Training	Caution/ Reprimand
	n	%	n	n	n	n	n	n	n	n	n
Clinically-related	60	59	11	30	19	10	0	13	1	2	5
Fraud	30	29	3	16	11	9	1	7	1	0	1
Poor record keeping	3	3	0	0	3	0	0	0	0	0	0
Rude language	2	2	0	2	0	0	0	2	0	0	0
Unethical advertising	2	2	1	1	0	0	0	1	0	0	0
Assault	1	1	0	1	0	0	0	1	0	0	0
Improper practice naming	1	1	0	1	0	0	0	1	0	0	0
Employ unregistered person	1	1	0	1	0	0	0	1	0	0	0
Poor infection control	1	1	0	0	1	0	0	0	0	0	0
Practise while suspended	1	1	0	0	1	0	0	0	0	0	0
Total	**102**	**100**	**15**	**52**	**35**	**19**	**1**	**26**	**2**	**2**	**6**

Table 3: Complaints against dental therapists by complaint category, outcome and penalty

Complaint Category			Outcome			Penalty					
	Complaints	Distribution	Not guilty	Guilty	Uncompleted	Outright suspension	Suspended suspension	Removed from register	Fined	Restitution	Further training
	n	%	n	n	n	n	n	n	n	n	n
Fraud	12	46	0	12	0	1	4	0	5	3	3
Clinically-related	5	19	1	4	0	0	1	1	1	1	1
Unethical advertising	4	15	2	2	0	0	0	0	2	0	0
Poor infection control	2	8	0	2	0	0	2	0	0	0	0
Creating undeliverable expectations	2	8	0	1	1	0	1	0	0	0	0
Rude/obscene language	1	4	1	0	0	0	0	0	0	0	0
Total	**26**	**100**	**4**	**21**	**1**	**1**	**8**	**1**	**8**	**4**	**4**

Nature of the complaints against dentists charged with misconduct:

Clinically-related grievances (59%) and fraud (29%) accounted for the most common complaints laid against dentists charged with misconduct. Respectively, 73% and 84% of finalised clinically-related cases and fraud resulted in "guilty" outcomes (Table 2). Penalties varied appreciably with suspended sentences and fines being the most prevalent.

Nature of the complaints against dental therapists charged with misconduct:

Fraud (46%), followed by clinically-related complaints (19%), unethical advertising (15%), poor infection control (8%), and the creation of expectations that could not be met (8%), were the most common complaints laid against dental therapists (Table 3). For the study period, all the dental therapists charged with fraud were found guilty. The penalties for dental therapists followed a similar trend as those for the dentists. The name of one dental therapist was erased from the Register.

Fraud:

The fraud-related complaints generally arose due to the issuing of irregular accounts to patients and/or irregular submissions to medical aid fund administrators. Quotations from the HPCSA's records pertaining to fraud are listed in Table 4.

Clinically-related complaints:

Table 5 records a wide variety of complaints that resulted in charges of misconduct.

Table 4: Complaints related to fraud

- Overservicing
- Overcharging
- Claiming for services rendered to non-members
- Changing service dates
- Discrepancies between clinical records and billing records
- Submitted claims whilst suspended from practicing
- Used incorrect tariff codes when claiming fees
- Claimed for procedures not performed,
- Claimed for non-claimable goods
- Split billing

DISCUSSION

The results of this study provide some insight in terms of the number of OHPs charged with misconduct and the nature of the complaints laid against them at the HPCSA during the period 2004 to 2009, and identify clinically-related grievances and fraud to be the main reasons for complaints against OHPs.

Clinically-related complaints

This issue is dealt with in Section 21 of the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act (Act No 56 of 1974) under the heading, "Performance of Professional Acts". The rule states that: "A practitioner shall perform, except in an emergency, only a professional act -

(a) for which he or she is adequately educated, trained and sufficiently experienced, and

(b) under proper conditions and in appropriate surroundings[5]."

In this study, what is labelled as "clinically-related complaints" were often referred to in the HPCSA records as negligence or incompetence. During this study it was often difficult to validly distinguish negligence from incompetence based on the source information. Synonyms for "negligence" are "lack of proper care" or "carelessness", while "incompetence" means "lacking the necessary skill[6]." The common thread in all of these cases was that they were clinically related and the complainant perceived it as the treatment or treatment process being problematic.

The 59% prevalence of clinically-related complaints in the current study is more or less consistent with findings from other international studies. In a five-year survey from 2002 to 2006 conducted in Iran, 57% of complaints were clinically related[7]. A Dutch study showed that half of the complaints were either due to lack of care, inadequate care or incorrect treatment[8].

The clinical disciplines of concern identified by the current study were not too dissimilar from other studies. In the Netherlands it has been reported that oral surgery, followed by fixed prosthodontics, endodontics and periodontics (in recent times) have been the main areas associated with complaints against dentists[9]. An American study indicated that prosthodontics,

Table 5: Clinically-related complaints

- Incompetence
- Negligence
- Failure to diagnose, manage and treat the patient
- Misdiagnosis resulting in inappropriate treatment
- Lack of proper treatment planning
- Inappropriate case selection
- Subjected the patient to unnecessary inappropriate investigation
- Incorrect advice – the tooth had a hopeless prognosis
- Did not inform the patient pre-operatively of possible complications
- Lack of informed consent for the procedure
- Did not gain the parents' consent for front tooth extractions
- Incompetence with tooth extraction
- Did not stop procedure when realized that the teeth are ankylosed and did not refer
- Extractions without anaesthetic
- Extracted healthy front teeth
- Mismanaged the patient during an extraction, which caused further complications
- Failure to diagnose the perforation and surgical emphysema
- Accused of damaging the lingual nerve during dental treatment
- Failed to take adequate care in a high risk area, thus causing bone perforation
- Gum graft is causing complications
- Performed unsuccessful crown lengthening procedure
- Lack of pre-surgical planning for the placement of implants
- Failed to plan adequately for the placement of an implant from a prosthetic point of view
- Failed to augment bone
- Failure to do sinus lift
- Failure to do bone graft
- Failed to choose the correct size implant
- Failed to refer to a specialist
- Improper root treatment
- Failure to inform patient about separated instrument in root canal
- Left broken instrument in root canal space
- Failure to take care when using rotary instruments in toot canal resulting in a fractured instrument
- Failure to complete root canal treatment after instrument separation occurred
- Failure to ensure that root canal is adequately obturated
- Failure to recognise the symptoms of injection of sodium hypochloride into soft tissues
- Substandard work
- Not honest with the patient after poor quality work
- Shoddy work when removing fillings causing severe pain and neglected to rectify the problem
- Failure to provide adequate restoration
- Decay left under some new fillings
- Overhangs on at least 4 newly placed composites
- Contact points between teeth not adequately restored
- Failure to provide a satisfactory fixed prosthesis
- Acted unprofessionally by placing a badly fitting bridge
- Failure to diagnose the patient's continuous severe pain and discomfort after the cementation
- Failure to treat an emergency case
- Poor denture work
- Rendered unsatisfactory service and did not attend to a painful tooth that the dentist was informed of
- Failure to timeously prescribe antibiotics
- Prescribing medicine without examining the patient
- Left broken needle in the patient's mouth
- Relocating without informing the patient, resulting in uncompleted treatment.

followed by endodontics and restorative dentistry lead to the most claims against dentists[10].

The differences between the nature of charges against dental therapists and dentists may be directly related to the difference in the scope of practices. Dentists have a broader clinical scope and do not really have limitations on what they are allowed to do as long as they deem themselves to be adequately qualified compared with dental therapists who are limited to basic procedures[11]. It is possibly therefore not surprising that a larger proportion of dentists are charged with misconduct that involved clinical cases when compared with the dental therapists.

The reasons for the relatively high prevalence of clinically-related complaints against dentists, were not quantitatively measured during this study. The reasons for the complaints are open for speculation based on the qualitative themes listed in Table 5. Based on the findings of the current study it could be argued that numerous problems related to diagnosis and treatment planning lead to complaints. Some of these cases were clearly expensive "advanced" surgical and prosthetic procedures such as implantology that are generally beyond the ability and experience of the average dentist in South Africa. In some of these cases it can be argued that the operators were incompetent to perform the procedures and did not know the limitations of their abilities. However, it is also highly conceivable that "advanced" procedures that render high monetary returns are attempted by some general dental practitioners to improve their profitability, and to build their reputations as superior clinicians who can perform complicated procedures.

Poor-quality root canal treatment was recorded as a common problem in the current study, especially fractured root canal instruments. Patients often complain when they are not satisfied with the treatment[12] and when they feel that they are not properly informed about the complications[13]. In this study there were several cases in which root canal instruments separated in the root canal system without the practitioner informing the patient. Some of these canals were even left uncompleted. Again, it is conceivable that money might have played a role in this undesirable behaviour by dentists, although incompetence or negligence may also have played a part. Root canal treatment is an expensive and time-consuming procedure that should not be rushed. Failure of the procedure will mean that the procedure will have to be redone at the dentist's expense, which may result in substantial financial losses, even if it succeeds at a second attempt. The informed patient will ultimately only be willing to pay for the procedure once. It can be deduced that dentists with busy practices, working at minimum rates, as determined by third-party funders, may be vulnerable in this regard. Talking and explaining complications, although essential for informed consent, will not bring in the money, while working carefully and slowly will certainly also reduce the profit margins. The same argument may apply to the substandard restorative work and prostheses identified in this study.

Clinically-related claims are therefore not only about negligence or incompetence but may be strongly linked to financial forces.

Fraud

Although the Ethical Rules do not specifically refer to "fraud" *per se*, this issue is addressed in Section 7 of the Ethical Rules of Conduct for practitioners registered under the Health Professions Act (Act 56 of 1974) under the heading, "Fees and Commission". The rule states that: "A practitioner shall not charge or receive

fees for services not personally rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or locum tenens." [5]

The Medical Schemes Act (Act 131 of 1998) is more explicit in dealing with the issue of fraud. Under the heading "Offences and Penalties" Chapter 12, Section 66 the Act reads:

"Any person who:

(b) makes or causes to be made any claim for the payment of any benefit allegedly due in terms of the rules of a medical scheme, knowing such claims to be false;

(c) knowingly makes or causes to be made a false representation of any material fact to a medical scheme;

(d) renders a statement, account or invoice to a member or any other person, knowing that such statement account or invoice is false...

...shall be guilty of an offence, and liable on conviction to a fine or to imprisonment for a period not exceeding five years or both a fine and imprisonment[14]".

The Dennis Greer fraud-triangle shows that three factors play a role when an individual commits fraud, namely:

1. perceived pressure,
2. perceived opportunity and
3. a feasible method[15].

The question therefore remains what the perceived pressures were in the cases that led to complaints in this study. Was it financial gain or was it the financial survival in a difficult private dentistry market?

Dental therapists have a lower potential in terms of financial returns for the services they render compared with dentists in general. Hence it can be argued that an increased likelihood for fraud, unethical and advertising, and the creation of false expectations exist among dental therapists compared with dentists. This argument is supported by the results of this study that showed that fraud was the most prevalent problem amongst the dental therapists and a significantly larger proportion of dental therapists (5.5%) were charged with misconduct compared with dentists (2%).

It is remarkable that so many OHPs think they can get away with illegal transactions such as those listed in Table 4. Information systems of medical aid scheme administrators are gradually becoming more sophisticated, and new systems are continuously being proposed[16] to identify discrepancies in the submission of accounts. Such systems often provide solid proof of offences, which is evident in the relatively high "guilty verdict" rate showed in this study.

CONCLUSIONS

Patient perceptions of substandard clinical treatment and fraud are the main reasons for complaints against OHPs charged with misconduct in South Africa. Financial gain and/or financial strain may be an underlying reason for both of these undesirable behaviours.

Dentists and dental therapists should take cognisance of these statistics as well as the nature of complaints. If necessary, OHPs should adjust their professional approach to find reward in delivering the best care to their patients based on sound ethical values. Similarly, training institutions should, where applicable, make the necessary changes to their curricula, while professional bodies should bring this information to their members.

In evaluating these cases the authors came to the conclusion that some of the offences could not be categorised as a transgression of a particular ethical rule. For absolute clarity it is recommended that the HPCSA review the ethical rules to include offences not captured in the ethical rules.

Conflict of interest: None declared.

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