



Employer-generated complaints to the statutory registration authority: The regulatory framework for the supervision of employed health professionals in the South African public sector

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Work as an employed health professional comes with a great number of challenges. Health professionals are often oblivious to the legal and regulatory framework that governs their employment situation. At least three legal frameworks are of relevance in each employer-employee relationship in the South African public healthcare sector, namely the Labour Relations Act, the Public Service Act and the profession-specific Acts such as the Health Professions Act, the Nursing Act or the Pharmacy Act, respectively. Starting with two cases where the profession-specific Act has been used by the employer against the employed health professional, rather than the legislation regulating the employer-employee relationship, it will be illustrated how the three Acts and their regulatory environment are structured. Based on this illustration, the impact that the creation of employer-generated complaints has on the employer-employee relationship, and on the system at large, will be discussed.

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As health professionals in South Africa (SA), we are facing huge challenges: the deteriorating situation in the public health service, the questionable sustainability of the private health sector, massive disease burdens and the social determinants of (ill) health. This is compounded by ever-increasing medicolegal litigation, and the suboptimal functioning of statutory professional bodies.

Recently, a sinister development has emerged, which will be referred to as 'employer-generated complaints'. These occur when the line managers of health professionals submit (or instruct others to submit) complaints to the statutory registration authority (e.g. the Health Professions Council of SA (HPCSA)) about healthcare professionals whom they supervise as line managers.

In the following, I will present two cases from the Free State Province public health sector. A review of the legal and regulatory framework for the supervision of clinical personnel in the public sector and for the labour relations of employed healthcare professionals will follow. Taking into account the regulatory framework, the matter of 'employer-generated complaints' will be discussed.

Case 1: Allegation of violation of privacy as possible retaliation for a whistleblower report

The Free State Department of Health has been subject to harsh criticism from civil society groups, such as the Treatment Action Campaign^[1] and Section27.^[2] In February 2015, an online article very critical of the circumstances in the province's health facilities was published, illustrated with photographs.^[3] Subsequently, this clinician was subjected to questionable acts by line managers. This

included a visit by a provincial manager, who introduced himself as investigating officer in a case of 'alleged misconduct'. The meeting had been arranged by the targeted clinician's direct line manager. Despite producing a letter appointing him as investigating officer, signed by a higher-level manager, this 'investigating officer' was unable or unwilling to specify the alleged misconduct. No other communication, such as for example an 'audi'-letter (see below), was ever received regarding this 'misconduct'.

Three months later, communication from the HPCSA, the medical practitioners' statutory professional body, indicated that a complaint about the clinician had been received. A copy of the complaint was attached, which had been submitted by the direct line manager, who in very vague wording implied that his supervisee might have violated a patient's right to privacy. The HPCSA found that no evidence of unprofessional conduct could be established.

Case 2: 'Collective' reporting of alleged unprofessional behaviour

In this case, the 'target' of the HPCSA complaint had been 'transferred' to another health facility without consultation or consent (a process later labelled 'unfair demotion' by the commissioner in arbitration, and subsequently reversed). The role of the targeted clinician in the new facility had not been clarified after 5 months. A grievance had recently been submitted, which eventually led to the mentioned arbitration. A younger colleague, recently qualified as a specialist, acted as head of the clinical section where the targeted clinician was performing teaching ward rounds.

During one of these ward rounds the targeted clinician, a seasoned specialist, was correcting common errors in the management of

patients, a situation the addressed medical officer responded to by first disappearing from the ward round, and then by an outburst of insults against the consultant after the ward round. Without obtaining any details about the actual incident from the more senior consultant, this incident was reported to the HPCSA by the junior consultant the day after the incident took place, in poor English and effectively implicating both clinicians involved. In subsequent discussions between this consultant and the principal consultant, the former apologised for this, quoting both 'instructions from line managers' and a 'need to report any incident to the HPCSA' (*sic*). Like in many a process submitted to the HPCSA, the HPCSA has yet to finalise this 'case', more than 12 months after the submission of statements.

Legal and regulatory framework The HPCSA and its duty 'to guide the professions and to protect the public'^[4]

The HPCSA is a statutory body created under the Health Professions Act No. 56 of 1974 (HPA),^[4] as amended (section 2), with the SA Nursing Council (SANC) and the SA Pharmacy Council (SAPC) created under the respective Acts for these other professions.^[5,6] It is the statutory registration authority for a wide range of health professions, including medical and dental practitioners, medical scientists, physiotherapists, occupational therapists and speech therapists, radiographers and paramedics. The Minister of Health, on the recommendation of the HPCSA, establishes professional boards for one or more profession(s) falling under the Act (section 15). For medical and dental practitioners, this is the 'Medical and Dental Board'. According to the HPA, the composition and functions of these professional boards are governed by regulations issued by the Minister of Health.^[7] The professional boards have, *inter alia*, the power to register or deregister health professionals, to regulate education and training in the profession(s) and to establish committees as necessary.

Chapter IV of the HPA deals with the 'Disciplinary Powers of Professional Boards'. On its website, the Medical and Dental Board of the HPCSA lists four 'Medical Committee(s) of Preliminary Inquiry' and a 'Dental Committee of Preliminary Inquiry' among its 19 committees.^[8] Process and responsibilities for inquiries into unprofessional conduct have been regulated by the Minister of Health,^[9] and there is the position of an ombudsman 'to mediate in the case of minor transgressions' (regulation 3).

As to the expected standards of ethical behaviour and professional performance, the Committee for Human Rights, Ethics and Professional Practice of the HPCSA has compiled booklets on expected standards of ethical behaviour and professional performance on a number of topics, which have been promulgated in the *Government Gazette* and can be found on the council's website.^[10] Similarly, SANC has published a 'Code of Ethics for Nursing Practitioners in SA'.^[11] The HPCSA's website also gives guidance on how to launch a complaint against a health professional, and it lists, *inter alia*, 'Improper conduct' and 'Disclosure of information [...] without permission' as possible cases of unprofessional conduct.^[12]

The Public Service Act, Public Service Regulations and the Public Service Commission

SA's 1996 Constitution^[13] makes provisions for the Public Administration and the Public Service within the Public Administration (sections 195 to 197). The Public Service Act Proclamation No. 103^[14] was passed by Parliament in 1994. Revised

Public Service Regulations came into effect on 1 August 2016, and contain a comprehensive 'Code of Conduct' (chapter 2).^[15]

This Code of Conduct stipulates that an employee (of the public sector) shall be familiar and compliant with relevant legislation (section 11(d)), shall not abuse the position to favour a political party or other interest group (12(f)), shall show respect for rights and dignity of every person (12(g)), shall not unfairly discriminate against anybody (13(j)) and shall 'be committed to the optimal development, motivation and utilisation of employees reporting to him or her and the promotion of sound labour and interpersonal relations' (14(h)).

Under section 196 of the SA Constitution, the Public Service Commission was established. The powers and functions of this commission include, as per section 196 4(f)II, 'to investigate grievances of employees in the public service concerning official acts or omissions, and recommend appropriate remedies'.^[13]

Section 23(1) of the SA Constitution and the Labour Relations Act

SA's 1996 constitution introduced and guarantees, among many other achievements, the right of everybody to fair labour practices. Concurrently, the Labour Relations Act No. 66 of 1995 (LRA)^[16] was passed to realise these rights. The LRA establishes bargaining councils for the public sector. Bargaining councils bring together representatives of the employees (e.g. trade unions) and of the employer, with the purpose of concluding collective agreements that regulate the relationship between the two sides. For the public sector, i.e. for the situation where the employer is the (SA) state and the employees are public servants, the LRA (section 35) establishes a 'Public Sector Co-ordinating Bargaining Council'^[17] for the general public service as well as sectoral bargaining councils.

For the health services, a sectoral bargaining council, the 'Public Health and Social Development Sectoral Bargaining Council',^[18] was established in terms of section 37 of the LRA.

The co-ordinating bargaining council has concluded resolution 2 of 1999 to adopt the 'Disciplinary Code and Procedures for the Public Service',^[19] and amended it with resolution 1 of 2003.^[20] These resolutions establish clear processes for the handling of disciplinary enquiries in the public service, including sanctions and the suspension of public employees for disciplinary reasons, and even prescribe a 'spirit' for the disciplinary process, in that 'discipline is a corrective measure and not a punitive one'.^[20] The Disciplinary Code also determines the process and time limits for the appeal process against disciplinary sanctions. Through these resolutions, the co-ordinating bargaining council provides guidance on disciplinary matters for the entire public sector.

In contrast to the general applicability of the *co-ordinating* bargaining council's resolutions, the *sectoral* bargaining council concerns itself with matters that are specific to the health (and social development) service delivery field, such as the 'Occupation Specific Dispensation for Medical and Dental Professionals'.^[21,22] Currently, there are no sector-specific disciplinary codes (or codes of conduct) for the SA public health sector.

In summary, the three bodies of legislation relevant for health professionals in the public sector are those laws regulating the health professions themselves (the HPA, Nursing Act, Pharmacy Act), those regulating the public service and administration and those regulating labour relations, each with their respective regulations, which are

issued by three different ministers: the Ministers of Health, Public Service and Administration and Labour, respectively.

Discussion

Using the above legal frameworks, 'employer-generated complaints' will be discussed from three different perspectives: the situation of the targeted employee, the role of the reporting supervisor and the impact on the general (healthcare) system.

Situation of the implicated employee

Employed health professionals, like all employees, have a constitutional right to fair labour practices. The Disciplinary Code mandates that the employee needs to be both informed and heard about the alleged misconduct (section 5). Typically, this happens through an 'audi' (*et alteram partem* – Latin for 'also hear the other party') letter. An employee would expect open engagement from his or her line manager in the case of an alleged misconduct, including the right to appeal against a sanction. 'Employer-generated complaints' omit this step, in favour of submitting allegations without investigation to the statutory registration authority. The employee's basic right to be heard is denied.

But could the inquiry by the statutory registration authority not replace the disciplinary process by the employer, especially if there are allegations of serious misconduct or breach of professional rules? Any healthcare professional who has experienced an inquiry by a body such as the HPCSA will agree that the very fact of a registration authority inquiry results in an existential fear about his or her own professional future. As the clinician is well advised to seek legal advice, the inquiries are often slow and cumbersome in their proceedings, in stark contrast to the spirit of the Disciplinary Code, in which 'discipline must be applied in a prompt, fair, consistent and progressive manner' (section 2.2). The impact of such inquiries on the clinician's mental health^[23] and on doctor-patient relationships^[24] has been described in the literature.

In summary, 'employer-generated complaints' cause significant emotional damage. Anger and frustration experienced by clinicians exposed to such processes negatively affects both their ability to deliver quality care, and their general quality of life. Instead of the corrective effect intended in the Disciplinary Code, this results in cynicism or 'mental/inner resignation' by the employee, and often in a breakdown of communication with line managers.

Role of the supervisor/line manager

The Code of Conduct for the Public Sector, as seen above, makes clear statements regarding supervisors' responsibilities towards their supervisees, including 'sound labour and interpersonal relations'. How do the Public Service Regulations relate to the constitutional right to fair labour practice, and to the supervisor's choice to pursue an investigation under the health professions legislation rather than the LRA?

Assuming good faith on the side of the supervisor, one would argue that possibly the transgression might be of such seriousness that it would put patients (or at least the public employer's reputation) at risk. In that case, more than ever, the Disciplinary Code should be applied, and the employee would need to be suspended. Proceedings at the HPCSA often drag out over years, and are certainly anything but a 'quick fix' to an urgent situation, especially compared with the tools provided by the labour relations processes. It is critical that

the supervisor investigates the alleged transgressions in a timely manner, and acts on the findings, which could include reporting to the professional body at a later stage. Omitting to establish the facts of the case and to act decisively might aggravate the potential risk. In the assumption of good faith, this would suggest inappropriate labour relations skills, resulting in an 'accidental' use of inappropriate approaches. Poor or absent advice to the manager from institutional labour relations personnel might contribute to this. Even a line manager acting in good faith might thus be guilty of a dereliction of duty by not following appropriate processes to investigate a supervisee's alleged misconduct. The supervisor does not only fail to comply with the principles of the Code of Conduct, but might put patients and the employer at risk. If the supervisor is a registered healthcare professional, such transgression might even constitute unprofessional and unethical conduct, which in return might require an investigation into such conduct by the statutory registration authority.

But what if other unfair actions have occurred from the line manager's side against the employee? For example, if one were to assume that the line manager might not have acted in good faith, but rather out of morally deficient motives, such as to intimidate the employee, or to protect the interests of a specific political party or interest group? In such case, obviously, most of the considerations mentioned above regarding the supervisor's potential transgressions would still apply, such as the dereliction of duty to follow proper labour relations processes, or the unprofessional and unethical behaviour of a health professional. However, in the case of such bad faith, the supervisor would also violate the Code of Conduct's abovementioned principles: 12 (f), to 'not abuse his or her position ... to promote or prejudice the interest of any political party or interest group'; 12 (g), to 'respect and protect the dignity of every person and his or her rights as contained in the Constitution'; and 13 (j); to 'deal fairly, professionally and equitably with all other employees or members of the public, irrespective of race, gender, ethnic or social origin, colour, sexual orientation, age, disability, religion, political persuasion, conscience, belief, culture or language'. In the absence of lawful reason and with malicious intent, such an action might even qualify as a criminal offence under the Intimidation Act No. 72 of 1982.^[25]

Impact on the system at large

There are numerous negative consequences of 'employer-generated complaints' on the system at large. Firstly, a breakdown of trust between the clinician(s) and management occurs. In an under-resourced system where too few clinicians are battling daily to prevent disasters, an experience in which line managers report supervisees to the registration authority without investigating the circumstances will (further) demotivate the workforce. Clinicians may fear that they would be 'sold out' in the case of fatal health outcomes, if accused of negligence even without any omission. They would fear being trapped between the allegations of patients or family members on one side, and an unsupportive employer on the other. As a sought-after resource, clinicians are likely to vote with their feet and leave such an offensive public system.

Secondly, 'employer-generated complaints' undermine the functioning of the systems regulating conduct of employed clinicians, the labour relations system and the statutory registration authority's complaints system. The essential consensus on the disciplinary system between the employees (and their unions) and the employer is destroyed. In many cases, the disciplinary system has been abused as an oppressive rather

than a corrective tool, denying the employee's right to fair labour practice, as realised in the right to correct procedures and the right to appeal a decision. The utter bypassing of the disciplinary system devalues its role further.

Complaints systems at statutory bodies are generally seen as a redress for patients or their family members in cases where they feel harmed by clinicians, not as a heavy-handed management tool for line managers. Further caseload to systems that struggle to achieve decent turnaround times worsens the trauma experienced by the clinicians under investigation.^[23] Being seen as a tool for intimidation by the employer rather than an independent body overseeing the profession might reduce the statutory body's credibility.

Thirdly, matters that should have been investigated and resolved in the workplace are instead 'inflated' to medicolegal cases. The financial burden shifts from the labour relations environment, where the financial risk lies with the labour representation/trade union, to the malpractice environment. A lawyer's involvement to protect the interests of the clinician adds further to the upwardly spiralling fees for malpractice cover from the Medical Protection Society and others.

Summary and conclusion

As discussed above, 'employer-generated complaints' typically occur when a line manager, based on vague suspicions and hearsay, reports a healthcare professional to the statutory registration authority without having properly investigated the facts of the alleged transgression. In this way, the prescribed processes, as delineated in the Disciplinary Code, are ignored. Often, such action from the line manager's side lacks the 'corrective spirit' demanded in the Disciplinary Code, and instead seems to display an intention to intimidate.

This constitutes a dereliction of duty by the respective line managers, as the action not only infringes on the employee's constitutional right to fair labour practice, but may even put patients and the employer's reputation at risk. This weakens the public service and undermines the integrity of the labour relations framework and the credibility of the statutory authorities.

Recommendations

To prevent abuse of the complaint system for intimidation of employees, complaints processes should include a mandatory declaration from the complainants, declaring their role as supervisor and possible reasons for not having investigated the allegation. Line managers and labour relations officers should be adequately trained regarding the regulatory framework provided by the Public Service Act and the LRA, as well as the reporting and protection mechanisms of the professional bodies. These matters should be included in the performance assessment of such officials. If we want to sustain the public service, compliance with ethical and legal principles is more important than obedience to misguided principals. A health-sector-specific code of conduct might assist this process.

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