THE ETHICAL AND LEGAL CONSIDERATIONS ON ABUSE OF REMUNERATIVE WORK OUTSIDE PUBLIC SERVICE (RWOPS) BY STATE-EMPLOYED DOCTORS

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Abstract

Remunerative Work outside Public Service (RWOPS), although well legislated for in South Africa, lends itself to significant abuse by state-employed doctors. The abuse of RWOPS is a reflection of the failure of the state to regulate this practice, and, as the employer, to fulfil its obligations as regards distributive justice and the provision of health care services by regulating this practice. This is both legally and ethically unacceptable. The failure of the state to use the provisions of the Public Service Act No.103 of 1994 to regulate RWOPS and deal with the breach of employment contracts by doctors who abuse this practice is illegal. Doctors who abuse RWOPS lack altruism which is central to the social contract that exists between the medical profession and society. Such doctors are devoid of trustworthiness and integrity which are core virtues in the medical profession. The abuse of RWOPS primarily has an impact on the equitable access to health services, the quality of health care received by state patients and the efficient use of health resources. This abuse of RWOPS is clearly unethical. Accordingly, this report recommends that the Department of Health applies the provisions of the law and also reports doctors who abuse RWOPS to the HPCSA so that disciplinary action can be instituted against these unethical doctors. Moreover, the South African Medical Association should guide their members to understand the obligations they have towards their employer and their patients and to refrain from advocating for unethical doctors involved in illegal practices.

Acronyms

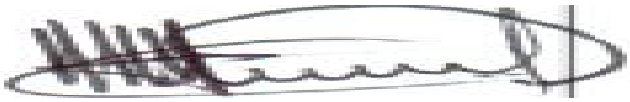
1. CCMA: Commission for Conciliation, Mediation and Arbitration
2. DENOSA: Democratic Nursing Organisation of South Africa
3. HPCSA: Health Professions Council of South Africa
4. KZN: Kwazulu Natal
5. LPP: Limited Private Practice
6. MRI: Magnetic Resonance Imaging
7. PERSAL: Personal and Salary Administration System
8. PSCBC: Public Service Coordinating and Bargaining Council
9. RWOPS: Remunerative Work Outside Public Service
10. SAMA: South African Medical Association
11. UK: United Kingdom
12. USD: United States Dollar

Acts of Parliament

1. The Constitution of the Republic of South Africa of 1996
2. Public Service Act No. 103 of 1994
3. Basic Conditions of Employment Act No. 75 of 1997
4. Labour Relations Act No. 66 of 1995
5. Health Professions Act No. 56 of 1974

Declaration

I declare that this research report is my own work. It is submitted for the degree of Master of Science in Medicine, Bioethics and Health Law in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.



Kwinda Munyadziwa Albert

On this 21st day of October 2016

Acknowledgements

I dedicate this report to my late father, Mr Naledzani Jan Kwinda, and my mother, Mrs Namadzavho Sarah Kwinda, who supported me during the difficult times of my life, especially when I was admitted to the University of Natal to study medicine. It is my prayer that God can keep my mother for more years as my only surviving parent so that she can witness all my successes and contributions to my beloved country, South Africa.

I thank God for giving me the strength and ability to complete this work against all odds. If it was not because of Him, this research report wouldn't have seen the light of day. He provided me with supervisors who were extremely supportive in the names of Prof. Ames Dhai and, for a short while, Ms Robyn Fellingham.

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CHAPTER 1: INTRODUCTION

1.1. Background

Remunerative Work outside Public Service (RWOPS) is a privilege granted to employees of the state after fulfilling the obligations imposed on them by the Public Service Act[1] and any other statutory law. This Act prescribes the conditions under which this privilege is granted. According to section 31 (1) of the Public Service Act, "No employee shall perform or engage himself or herself to perform remunerative work outside his or her employment in the relevant department, except with the written permission of the executive authority of the department"[1]. It is a requirement imposed on the executive authority before granting such permission to take into account whether or not the envisaged work outside the public service will interfere with or impede the employee's efficiency and effectiveness in his or her functions. The executive authority should also consider whether or not the granting of such permission to perform work outside the public service will not constitute a contravention of the Code of Conduct for Public Service[2,3] which prohibits employees of the state from engaging in any activity that will be in conflict with or infringes on the execution of their official duties as public servants.

In this report I show that, although well legislated for in the Public Service Act[1], the Public Service Act Regulations [4] and the Code of Conduct for the Public Service[2], a plethora of reports exists on the abuse of RWOPS by public servants, and, more specifically, by doctors.

1.2. Defining Remunerative Work Outside Public Service (RWOPS)

Remunerative Work Outside Public Service (RWOPS) is defined as “an activity that is performed outside the period which an employee must report on duty for the purpose of fulfilling a prescribed work week or outside a period of overtime or commuted overtime or standby duty that an employee has agreed to perform and for which the employee receives compensation in the form of salary, wage, allowance, honorarium or reward”[5]. Limited Private Practice (LPP) has been used interchangeably with RWOPS. Although there is no clear definition of LPP, the appropriate description of LPP is that it refers to the private work undertaken by state employed doctors on their own account whereas, with RWOPS, the private work is undertaken either on the doctor’s own account or that of another party. This means, in other words, in LPP, a state-employed doctor owns a private practice which is conducted outside the normal 40 hour week for a limited period of hours.

RWOPS is referred to as “Dual Practice” or “Physician Dual Practice” in international literature[6, 7]. With reference to doctors, dual practice means “a situation where a public sector doctor establishes a private practice as an additional source of income”[6] or “a situation where a physician combines clinical practice in the public service with a clinical practice in the private sector”[7]. For the purpose of this report, Remunerative Work outside Public Service and Dual Practice will be used interchangeably and will refer to a situation where state-employed doctors perform remunerative clinical practice in the private sector in addition to their clinical practice in the public sector, either on the doctor’s own account or for another party.

1.3. Literature Review

In this section, I provide a brief overview of the abuse of RWOPS by state-employed doctors and this will be expanded upon in the chapters that follow. As far back as 2004, the problem of the abuse of RWOPS in South Africa was found to be severe in Gauteng, where 50% of specialist doctors own private clinics[8]. It was found that the majority of these doctors worked only for an average of four hours at public health facilities before leaving to consult patients in their private clinics and, consequently, they were not available to render their required services at the hospitals in which they were employed[8]. In general, it is estimated that over 90% of state-employed doctors in South Africa engage in RWOPS at least to some degree[9]. International studies have also documented the existence, as well as the prevalence, of RWOPS in low, middle and high-income countries alike[10, 11]. According to these studies, up to 80% of public sector doctors in Bangladesh engage in some form of RWOPS, and a similar proportion for doctors in Indonesia and Egypt has been reported[10, 11]. It is also estimated that 69% of public sector doctors in Thailand engage in private sector activities, while, in the UK, 63% of public hospital consultants and specialists maintain a private practice alongside their job in the National Health Service[10'11].

The reasons for doctors engaging in RWOPS are not well studied. "For low-income and middle-income countries evidence shows that physicians engage in dual practice as a result of low public sector salaries, which either do not allow for a comfortable standard of living or do not even exceed the minimum costs of living"[12]. In low and middle-income countries, dual practice can, thus, be viewed as a possible system solution to problems such as limited financial resources to reimburse doctors appropriately in the public health care sector. In developed countries, private practice was seen as offering a range of rewards, including financial benefits, increase in

strategic influence, clinical autonomy, a greater sense of being valued, and more opportunities to realise one's individual aspirations as a clinician[6]. The blurring of boundaries between the individuals' public practice obligations and their private income generating activities gives rise to ethical and legal concerns owing to RWOPS being prone to corruption and unethical behaviour[13].

1.4. Aim and objectives of the report

The aim of this report is to explore the ethical and legal implications of the abuse of remunerative work outside public service by state-employed doctors against South Africa's ethico-legal framework in the healthcare context. The objectives of the report are as follows:

1. To describe the ethical and legal obligations of state employed doctors toward patients;

2. To describe the legal and regulatory framework for RWOPS;
3. To explore the notion of corruption and demonstrate that abuse of RWOPS equates to corrupt and unethical doctors; and
4. To describe the impact of the abuse of RWOPS on service delivery and the training of undergraduate medical students, medical interns and registrars.

1.5. Research question and outline of the report

Although many attempts have been made to regulate the practice of RWOPS in South Africa using the current regulatory framework, these have not been successful. As a result, there are a large number of anecdotal reports of abuse of the system by public

servants, including doctors who practice RWOPS, as stated earlier. My research question is, thus: Can Remunerative Work outside Public Service as currently practiced by most state-employed doctors be ethically and legally justified? My research report demonstrates that RWOPS as currently practised by most doctors cannot be ethically and legally justified. I argue that, in the current climate, RWOPS lends itself to significant ethically and legally unacceptable abuse.

Prior to embarking on an in-depth normative analysis of the ethical and legal implications of the abuse of RWOPS, an appreciation of the regulatory framework for RWOPS is necessary, and chapter 2 of my report focuses on the legal and regulatory framework available for the management of RWOPS in South Africa. In this chapter, I show that, although empowered to do so by the law, the state has failed to control and regulate the practice of RWOPS, and, as a result, the practice is abused by many doctors, and, hence, patients' constitutional rights to access health care services are infringed. I further argue that an additional consequence is that the state, i.e. through the Provincial Departments of Health in particular, has failed to discharge its obligation to execute the principle of distributive justice in the provision of health care services to the people of South Africa. As professionals, besides having legal obligations in terms of their employment contracts with the state, doctors also have ethical obligations towards their patients. The objective of chapter 3 is, therefore, to explore these ethical and legal obligations. I also explore the legal requirements of doctors' employment contracts and their obligations towards their patients, starting with the supreme law of the country, the Constitution, and pertinent statutory provisions of Parliament. I argue that the abuse of RWOPS is a breach of the employment contract and is consequently illegal. I further argue that the remuneration received by doctors who abuse RWOPS

either through state salaries or RWOPS activities is in line with the notion of “perverse incentives” so making the conduct of these doctors unethical in terms of the ethical guidelines of the Health Professions Council of South Africa (HPCSA). Chapter 4 focuses on the impact of the abuse of RWOPS on health services access and equity, the quality of health care and the efficient use of health resources. I argue that doctors who abuse RWOPS are not only unethical but are also corrupt as they steal resources from the public sector for individual gain. I also claim that the impact of abuse of RWOPS will not be felt only by this generation but also by future generations as there is underinvestment in future doctors owing to a lack of teaching, training and mentoring.

In my arguments, I demonstrate that the Department of Health (Provincial Departments), as the employer, and the HPCSA, as a regulatory body for health professionals including doctors, has failed in its mandate of respectively regulating the practice of RWOPS and of giving guidance to the medical profession in this practice. Moreover, where the state has intervened it has not done so in a uniform manner. On the basis of my arguments I conclude that, despite this practice being well legislated for, its abuse is perpetuated because of; *inter alia,* the cross-country heterogeneity in the state’s responses to this abuse.

CHAPTER 2: LEGISLATIVE FRAMEWORK FOR REMUNERATIVE WORK OUTSIDE PUBLIC SERVICE (RWOPS)

2.1. Introduction

The Constitution of the Republic of South Africa[14] is the supreme law of the country, and it establishes the substance of the statutory provisions of all the Acts of Parliament. Enshrined in the Constitution is the Bill of Rights which gives every citizen the right of access to health care services. In this chapter I demonstrate that the Department of Health has been empowered by legislation to regulate the performance of RWOPS by state-employed doctors, and I argue that, although the Department is empowered in this way, it has failed in executing this role. I further argue that the South African Medical Association (SAMA), as a representative body of the majority of doctors in South Africa, has failed to abide by the resolutions of the Public Service Coordinating and Bargaining Council. My arguments are based on the Constitution[14], the Public Service Act[1], the Basic Conditions of Employment Act[15] and the Labour Relations Act[16], and I now look at the relevant aspects of each of these Acts to argue my case.

2.2. The Constitution of the Republic of South Africa[14]

Chapter 2 of the Constitution contains the Bill of Rights and amongst the rights therein is the right of everyone to have access to health care services. According to section 27(1) (a) of the Constitution, “everyone has the right to have access to health care services, including reproductive health care”[14]. In terms of section 28(1) (c), “every child has the right to basic health care services”[14]. The Department of Health has been mandated by the Constitution, in section 27(2), to take reasonable legislative and

other measures within its available resources to achieve the progressive realisation of the right of everyone to have access to health care services, including reproductive health care.

The right to have access to health care is a positive right, and is, therefore, not realised if the correlative obligation imposed on the Department of Health to provide sufficient resources, including human resources, is not honoured. Doctors are a significant human resource component in terms of this right. For the accessibility of medical services to be a reality, doctors need to be available at their work stations at the specified times of service delivery to render medical services. *The Mail and Guardian*[17] reported on the experience of a doctor in one of the academic hospitals in South Africa who witnessed two patients dying because the doctors employed to oversee their care had left the responsibility to their junior and desperate colleagues while they were at their nearby private practices at major private hospitals in the city. This was further echoed by the *Northern Review*[18] which reported that operations are sometimes postponed owing to the non-availability of the specialists to operate or give anaesthesia. It further reported that doctors disappeared during the daytime leaving patients waiting for long periods and also that specialists refused to come out at night when they were on call. These media reports provide some of the anecdotal evidence that RWOPS is not well managed by the Department of Health, and patients are consequently denied access to medical services because doctors are not at their work stations. It is my argument that this denial infringes on the patients' constitutional rights of access to health care services.

2.3. Public Service Act 103 of 1994[1]

Permission to perform RWOPS is one of the privileges that state employees, appointed under the Public Service Act, have. This Act makes a provision for state employees, including doctors, to perform RWOPS under certain conditions. According to Section 30 of this Act, “no employee shall perform or engage himself to perform remunerative work outside his/her employment in the relevant department, except with the written permission of the executive authority of the department”[1]. It further gives guidance to the executive authority to take into account whether or not the outside work would not potentially interfere with or impede the effective or efficient performance of the employee’s functions in the department or constitute a contravention of the code of conduct for employees in the public service. According to this Act, the executive authority has only thirty (30) days to respond to any request by employees for permission to engage in RWOPS, and, if there is no response after 30 days, the employee should consider the permission to engage in RWOPS to have been granted[1].

It is, therefore, the responsibility of the doctor who intends to engage in RWOPS to apply for permission before engaging is such a practice. The employer also has the responsibility of responding to the request within 30 days, and the response can either be positive, where permission is granted, or negative, where permission is not granted. A lack of response within 30 days or silence on the side of the employer, though, means that consent has been granted. In the light of the Public Service Act, it is my opinion that the challenge that South Africa faces today is threefold;

(a) doctors performing RWOPS without first seeking permission to do so;

(b) executive authorities not responding to requests by doctors to engage in RWOPS; and

(c) doctors being granted permission to perform RWOPS not adhering to the conditions of the approval to perform RWOPS.

It becomes clear, therefore, that a well legislated practice could be abused because of the failures of not only doctors but also the employer to observe the provisions of the Public Service Act. Based on this abuse, some of the provincial departments have considered a total ban on the practice of RWOPS rather than declining individual applications or requests[19]. The effecting of the ban has been through the issuing of circulars. In my opinion, however, the banning of RWOPS through circulars is illegal as it is in contravention of section 30 of the Public Service Act that regulates RWOPS in South Africa.

In terms of section 31 of the Public Service Act, any remuneration received by doctors who engage in RWOPS without the permission of the employer is "unauthorized remuneration"[1]. This section further gives a directive on measures to be taken against doctors found guilty of this offence. It states that this unauthorized remuneration should be paid by the said employee into the state revenue and that, if the employee fails to do this, the unauthorized remuneration may be recovered by way of legal proceedings or any other manner as approved by the treasury[1]. Although the state is empowered by this section of the Public Service Act to clamp down on any abuse of RWOPS by state employed doctors, anecdotal evidence shows that the state has failed to do so. In 2013 the Kwazulu-Natal Department of Health conducted an in-depth forensic investigation which revealed that 101 doctors employed full time by the department in mainly rural areas were running private practices in urban areas and were claiming in excess of R22 million from the Discovery Medical Scheme alone for treating private patients[20]. This means that the department was aware of who these

doctors were and how much each had claimed from the Discovery Medical Scheme. Despite this, however, the Head of Department of KZN Health, Dr Sibongile Zungu, said, 'We have handed our forensic report to the National Minister and await his recommendations on the way forward'[20]. The Public Service Act stipulates that, if there is unauthorized remuneration, the department must recover it and pay it into the revenue. Dr Zungu, however, decided otherwise and referred the matter to the National Minister of Health. Nothing further has been heard in relation to this matter. It is my argument that, by failing to implement the provisions of the Public Service Act, the state is fuelling the abuse of RWOPS by state-employed doctors in South Africa and must also share the blame for the abuse of RWOPS in this country. It follows that the state has failed to safeguard state resources and to ensure that these resources are used for the benefit of all South Africans, especially those who rely on the state for health care services. Hence, the state has failed in its obligations as regards 'distributive justice' as described by Beauchamp and Childress[21,] a fair, equitable, and appropriate distribution of rights and responsibilities in society[21]. South Africa already suffers from an unequal distribution of doctors between the well–resourced private sector with almost 70% of the doctors and the poorly-resourced public sector with the remaining 30% for almost 85% of the population[22]. This is further complicated by the distributional disparities between urban and rural areas[22]. In ensuring the progressive realisation of the right of access to health care services, the state has been entrusted with the responsibility of the rationing and allocation of this scarce resource within the public service. The example above is evidence that the state is failing in its responsibility to hold these unethical doctors accountable and is as guilty as the doctors with regard to breaches in ethics.

2.4. Basic Conditions of Employment Act (BCEA) 75 of 1997[15]

The Department of Labour, through the Basic Conditions of Employment Act, regulates working time for all employees. According to section 9 of this Act, "an employer may not require or permit an employee to work more than 45 hours in any week; and nine hours in any day"[15]. Hence, most public servants employed on a full time basis work for eight hours a day and 40 hours per week. For those employees who cannot dedicate eight hours of their day to public service, the Department of Public Service and Administration[22] has made a provision for flexible working patterns with more flexible hours as a means of managing peaks and troughs of work more efficiently and effectively and, further, provide working conditions which are more responsive to the employers' and the employees' needs. This can be through part time employment on either the 3/8th (working 3 out of the 8 hours per day), 5/8th (working 5 out of 8 hours per day) or 6/8th (working 6 of 8 hours per day) basis with sessional employment being allowed from a minimum of one hour per week to 20 hours per week.

The Public Service Commission[8] in its report revealed that the rate of abuse of official time is so severe that the majority of doctors work only an average of four hours in the state before they leave to consult their private patients. While it is obvious that these doctors, although contracted for eight hours per day, are failing to fulfil their contractual obligations, the state allows them to continue working on full time contracts instead of amending their contracts to either part time or sessional ones. This demonstrates that doctors are abusing the privilege granted to them by the state to perform RWOPS, and, because of greed, some doctors are acting unethically by transgressing the rules and neglecting their responsibilities towards the state for the

sake of personal gain[23]. When ‘Mammon’ (money or material wealth associated with greedy pursuit of gain) beckons, these doctors are unable to resist the temptation even while earning decent salaries and having good retirement prospects[23].

Furthermore, anecdotal evidence from media reports suggests that doctors are engaging in RWOPS during official hours when they are supposed to be at their workstations to serve patients in public sector facilities[20, 24, and 25]. In addition some doctors do not even submit applications for permission to engage in RWOPS and continue to engage in the practice without permission[20, 24, and 25]. There is, however, no available information as to whether action has been taken against those doctors even after forensic investigations have been conducted and even when it is well known by their managers that they are abusing the practice of RWOPS. The state could recover the remuneration received through the abuse of RWOPS or force these doctors to change their employment contracts from full time to either part time or sessional contracts. Based on this, I submit that the Department of Health (Provincial Departments), as the employer of these doctors, is failing to safeguard the resources of the state to ensure that there is access to health care services by all in South Africa as these doctors are paid for work that they do not do.

After the implementation of Occupation Specific Dispensation in 2009, there was a remarkable improvement in the salary of doctors, and now the entry level salary of doctors, inclusive of overtime or total cost to employer, is at R657 683 for a Medical Officer Grade 1 and maximum of R 2 035 646.37 for a Head of a Clinical Department Grade 2[26]. This confirms that state employed doctors are earning good salaries as a result of the state fulfilling its obligations to the employment contract. According to

Kant's Categorical Imperative, people should not be treated as a means to an end only but always as an end in itself[27]. State-employed doctors cannot claim that the state treats them as a means to an end as the state reimburses the doctors appropriately for this service. Unfortunately doctors who abuse RWOPS do not reciprocate this. They enter into a contract with the state to work eight hours per day knowing very well that they are not going to work those eight hours as they also have commitments to see private patients. Using the Kant Categorical Imperative analysis, it is clear that the state is treated as a means to an end by doctors who abuse RWOPS. Their behaviour is unethical and morally unconscionable.

2.5. Labour Relations Act, 66 of 1995[16]

Section 35 of the Labour Relations Act gives effect to the establishment of the Public Service Co-ordinating Bargaining Council (PSCBC). The PSCBC is an independent organisation with the main objective of maintaining good labour relations in the Public Service through collective bargaining between the employer and employee representatives (trade unions) resulting in collective agreements/resolutions[28]. The Disciplinary Code and Procedures for the Public Service (PSCBC Resolution 1 of 2003)[29] is one of the collective agreements reached in 2003. This resolution lists acts of misconduct of which an employee may be found guilty and so be subjected to the provisions of the code. Some of the acts of misconduct listed in this code are when an employee:

"(a) fails to comply with, or contravenes, an Act, regulation or legal obligation;

(b) absents or repeatedly absents himself/herself from work without reason or permission or without written approval from his or her department; and

(c) performs work for compensation in a private capacity for another person or organisation either during or outside working hours"[29].

Currently, the South African Medical Association (SAMA) is admitted into the PSCBC under the auspices of its sister union, the Democratic Nursing Organisation of South Africa (DENOSA) [28]. This means that SAMA is party to the Disciplinary Code and Procedures for the Public Service and has a duty to guide its members accordingly. Furthermore, in 2009 the abolition of limited private practice (LPP) was tabled and agreed to in the PSCBC and endorsed by the political leadership of the health sector. Although SAMA declared a dispute which went up for arbitration by the Commission for Conciliation, Mediation and Arbitration (CCMA) in September 1999, the Department of Health and SAMA reached an agreement under the auspices of the CCMA to abolish LPP unconditionally from the 31 December 1999 and the parties were confident that the agreement reached was in the best interest of the public[30, 31]. The implication of this agreement is that, from 31 December 1999, no doctor employed full-time by the state can simultaneously own a private practice. But in defending its members, SAMA ignores this agreement as Dr Phophi Ramathuba of SAMA was quoted in News24[32] as rejecting the announcement of the department of health to charge doctors who are members of SAMA for running private practices. According to Dr Ramathuba, "there is no legislation that prohibits state employed doctors from running private practices"[32,] .This is a clear indication that SAMA is not abiding by the agreement made in the PSCBC. This agreement is binding on all full-time state-employed doctors and those who currently own private practices are in contravention of this agreement. Public service managers, including managers in clinical services, are not only empowered by the Public Service Act but by the PSCBC

resolutions and agreements to take action against any doctor contravening these agreements as these resolutions are binding on both the employer and employees represented by their unions.

2.6. Concluding Remarks

I have demonstrated that the Department of Health, as the employer, fully empowered by legislation, has failed to manage the performance of RWOPS by state-employed doctors, and some of the doctors are exploiting the gap that exists owing to this failure. Both the state and doctors are culpable as regards breaches of the Constitution, Public Service Act, Basic Conditions of Employment Act and the Labour Relations Act. In the chapter that follows, I discuss the ethical and legal obligations of doctors towards their patients.

CHAPTER 3: ETHICAL AND LEGAL OBLIGATIONS OF DOCTORS TOWARDS THEIR PATIENTS

3.1. Introduction

In this chapter I now briefly discuss the ethical and legal obligations of doctors towards their patients. Health care practice is a moral and social contract between health professionals and the public that they undertake to take care of [33]. Doctors employed in the public sector are legally bound to use their knowledge, skills and expertise for patients seeking care at those facilities. Ethically, the best interests of the patient ought to be of paramount importance to doctors.

3.2. Legal obligations

The relationship between doctors and their patients should be consensual, and it is often described as contractual[34]. Once created, this relationship imposes legal obligations and duties. In the public service, patients have a contractual relationship with the hospital, and the state delegates that responsibility through an employment contract to doctors as professionals to treat the patients. As employees of the state, doctors are expected to be faithful to the Republic and honour the Constitution in the execution of their daily duties and to put the public interests first in the execution of these duties. Doctors have a legal obligation to place their undivided attention, time, skills and expertise at the disposal of the state as the employer[1]. Doctors on full time contracts should dedicate eight hours per day and 40 hours per week using their knowledge, skills and expertise to treat patients in the public health facilities where the state has placed them. By virtue of their contracts with the public service as the employer, doctors employed by the state have a legal duty to fulfil the obligations of

their contracts, and failure to do so equates to a breach of the contract and is, therefore, illegal. That is why, in terms of the Public Service Act, it is mandatory for doctors who intend to engage in RWOPS to obtain prior approval to perform RWOPS outside official hours so that the interests of both the Public Service and the community are not prejudiced.

According to the Code of Conduct for Public Service[2], doctors, as employees of the state, are prohibited from engaging in any transaction or action that is in conflict with, or infringes on, the execution of their official duties. It is clear from this and other anecdotal evidence that doctors abusing RWOPS are guilty of contravening this aspect of the law regulating their employment contract with the state. If the breaching of a contract is illegal and the abuse of RWOPS by state-employed doctors is equivalent to the breach of their employment contracts, the abuse of RWOPS by state-employed doctors is illegal.

3.3. Ethical obligations of doctors as professionals

As human beings, doctors have unacquired natural duties and they owe these duties to society as a whole[35]. This obligation is unrelated to their professional qualifications. As professionals, though, doctors have moral obligations acquired by being qualified and licensed as professionals by the Health Professions Council of South Africa (HPCSA) which requires them to regard concern for the best interests or well-being of their patients as their primary professional duty. Professional ethics emphasises the principle of beneficence rather than just non-maleficence and describes health care as a moral obligation in a good society where it represents a sense of caring for the community[36]. That is why, before commencing with the practice of their profession, doctors cite the Hippocratic Oath[37] or modernised versions of it, thereby making a public promise that they will place the interests of their patients above their own. The

two closing sentences of the original Oath, which were removed from its modern version known as the Declaration of Geneva[38], are worth mentioning here. “While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot”[37]. I agree with Miles that the content of these two closing sentences of the Hippocratic Oath speak of two moral issues. “First, it defines several distinct ways by which a doctor is to understand how these vows are binding. This means that the doctor must not commit perjury, blur or confound the words, and must not transgress against the vows. Second, doctors swear to stand under the judgement of all human beings for time eternal and openly invite the public to judge them for any breach of the vows they make when citing and signing the Hippocratic Oath”[37]. Cruess and Cruess[39, 40] describe becoming a doctor as an invitation for public scrutiny. It is from this Oath that ethical codes of conduct for doctors were derived to guide them in achieving the highest standards of their profession. These ethical codes are also based on the ethical principles of beneficence, non-maleficence, respect for persons and autonomy. Altruism and ethical conduct should always serve as a backdrop against which medicine is practised.

The HPCSA as a statutory body, established under the auspices of the Health Professions Act[41], is mandated to set ethical and professional standards for the conduct of practitioners registered under the Act, including doctors. The HPCSA has developed guidelines for good practice in the health care professions which have been formulated into booklets. Among the core ethical values and standards required of health care practitioners are:

"(a) *Best interests and well-being of the patients* which requires health care practitioners to act in the best interest of the patients even when the interests of the latter conflict with their own personal interests;

(b) *integrity* which requires health care practitioners to incorporate these ethical values and standards as the foundation for their character and practice as responsible health care providers;

(c) *truthfulness* which requires health care practitioners to regard truth and truthfulness as the basis of trust in their professional relationships with patients; and

(d) *justice* which requires health care practitioners to treat all individuals and groups in an impartial , fair and just manner"[35].

Although ethics has moved from virtue-based ethics to principle-based ethics over the centuries[27], it is important to note that the HPCSA still recognises virtue ethics as integral to the practice of the health professions. Integrity, for example, is a commendable character trait that will make one entrust one's life to an individual who possesses this character trait. Trustworthiness as a virtue would make the employer trust that a doctor would adhere to the conditions agreed upon when the permission to perform RWOPS was granted.

The HPCSA uses these and other core ethical values and standards to determine whether practitioners have acted unprofessionally and to take remedial actions against the guilty verdicts. It is clear that doctors abusing RWOPS fall short of upholding these core ethical values as prescribed by the HPCSA. Although there is anecdotal evidence of abuse of RWOPS, however, there are no available reports on doctors being brought before the disciplinary committees of the HPCSA for abusing RWOPS[42].

In my opinion, remuneration received through the abuse of RWOPS is equivalent to a "perverse incentive" as defined by the HPCSA. The HPCSA defines a perverse incentive as "money or any other form of compensation, payment, reward or benefit which is not legally due or which is given on the understanding, whether expressed, implied or tacit, that the recipient will engage or refrain from engaging in certain behaviour in a manner which is either: illegal; and/or contrary to ethical or professional rules; and/or which in the opinion of the HPCSA may adversely affect the interest of a patient or a group of patients"[43]. According to this definition, when doctors receive salaries as full-time doctors despite not having fulfilled their full-time contractual obligations, the salaries received are "perverse incentives"; and, when doctors abandon patients in public health facilities to treat patients in their private clinics, the income received from such private activities is "perverse incentive" as well. As stated above, this is what the Public Service Act refers to as "unauthorised remuneration" which the state can recover from the doctors engaging in RWOPS without permission. If "perverse incentives" are unethical in accordance with the guidelines of the HPCSA, doctors who abuse RWOPS conduct themselves unethically.

The abuse of RWOPS has altered the perception of a profession that has always been known for its benevolence, altruism, honesty and integrity to that of a profession that is now known for self-interest. Opportunities for doctors to obtain high incomes have caused financial pursuits to triumph over professional responsibility and ethics for many doctors[44]. According to Cruess and Cruess[40], "the principal threats to medicine's professional status come from public mistrust of the profession as a whole". They further state that there are two factors that contribute to this mistrust, and these are, "public perception that medicine failed to self-regulate in a way that can guarantee

competence and that it puts its own interest above that of patients and the public"[40]. This was echoed by Dhai and McQuoid-Mason[33] who cited financial pursuit as one of the failures of professionalism with concomitant adverse media coverage undermining public trust in the medical profession. As currently practised by many, RWOPS has altered the behaviour of some doctors, and altruism has been eroded from this group of medical professionals because the focus is no longer on the well-being and the best interest of the patients, but rather on what is best for the doctors. The abuse of RWOPS is a threat to the status of medicine as a profession as the behaviour of doctors falls short of what should define the medical profession. As Stevens argues relative to the perceived crisis of moral leadership in American health care, the medical profession has been socially reclassified, "moving from the role of benevolent public agent towards that of self-interested players in the economic market place"[45].

3.4. Concluding remarks

Doctors who abuse RWOPS have deviated from their moral duties towards their patients and are also in breach of not only their legal obligations towards the state but also the ethical guidelines of the HPCSA as the regulatory body. The abuse of RWOPS has an impact on health service access and equity, quality of care and efficiency of use of health resources as I will discuss in detail in the following chapter.

CHAPTER 4: IMPACT OF THE ABUSE OF RWOPS

4.1. Introduction

RWOPS or Dual Practice is not restricted to doctors; other health professionals and non-health professionals employed by the state may perform or undertake work outside their public employment. RWOPS by doctors, however, attracts the most interest because it has the greatest potential to impact negatively on the quality of care provided to both public and private patients, and this is a concern for all individuals. Although there is a paucity of literature relating to the context of economics on the topic of RWOPS and its effects on the public service because this subject is still in its infancy in this discipline, there is agreement amongst most health economists that dual practice/RWOPS has both positive and negative effects on the equity, efficiency and quality of health care provision. There is, however, still no consensus on its net effect[6, 46]. While it is challenging to write with confidence about the impact of abuse of RWOPS in South Africa because evidence-based information on this subject is limited, the impact of the abuse of RWOPS, nevertheless, is apparent from available anecdotal evidence[20, 24, 25, 31, 32 and 42].

In South Africa, where there is a shortage of medical doctors and specialists, a well-regulated dual practice would probably improve health service access and possibly its efficiency. But because of the poor regulation of this practice as demonstrated earlier, it lends itself to abuse by state-employed doctors, and its positive impact cannot be realized. The impact of abuse of RWOPS is felt on health service access and distributive justice, quality of care and efficiency of use of health resources[47], and I now look at the impact of the abuse of RWOPS in these three areas.

4.2. Impact of abuse of RWOPS on health service access and distributive justice

The South African public health system suffers from a lack of resources, both human and otherwise, which are readily available in the private health system[48]. As a result, the waiting lists for interventions on patients become unacceptably long and some of the patients suffer complications and even die while still awaiting their turn[49]. In a well-regulated environment, dual practice provides an alternative not only to these long waiting lists, but also to the crowded public facilities. But the abuse of RWOPS masks all the potential benefits and perpetuates the negative consequences of this practice. While there are several other causes for a lack of access to quality health care in the state sector, these do not relate directly to the subject matter of this research report and, therefore, will not be discussed.

“Patients complain about the shortage of doctors and long queues at hospitals while doctors are paid for a whole day’s work but they run, pretending to be going on tea breaks, whereas they are going to see patients at their private practices”[42]. This is one of the symptoms of unregulated RWOPS practice. Absenteeism and shirking during official work hours have been described as the potential negative impacts, not only of the abuse of RWOPS, but of the practice itself, which only becomes worse in an unregulated environment. “The core hours required for the occupational class of medical practitioner, (as distinct from overtime) including all ranks and specialties, are between 07:00/08:00 and 15:30/16:30, from Mondays to Fridays. These core hours reflect the pattern of practice in most disciplines, and they coincide with the times when all the support staff and other resources required for efficient patient care are in place and functioning at an optimal level”[8]. When doctors perform RWOPS during these core hours they are simply stealing from the coffers of the public service as the

state pays them for the hours that they are not working, while they generate income from their private work. The consequence of this is that patients who are entitled to receive health care from the public health system are denied access to health services as doctors are not in their workstations because they are busy treating their private patients during official hours. This leads to inequity in the access to health care services as many of the resources, including those human resources which are meant for patients who solely depend on the public health system, are channelled towards the private health care system. This is clearly an erosion of the principle of distributive justice as described earlier. This practice by state-employed doctors is that of stealing public time for private gain, and is equivalent to "corruption" as these doctors are abusing the power entrusted to them, for public gain[50]. Doctors, by virtue of their profession, have the trust of the community based on a social contract that exists between the medical profession and society. In this contract, society has granted the medical profession autonomy in the practice of the profession, monopoly in the utilisation of the knowledge base of the profession, the privilege to self-regulate and to be rewarded both financially and non-financially. In return, society expects the medical professionals to put the best interests of their patients above their own self-interest and to demonstrate morality and integrity[39, 40]. This contract is similar to the one that exists between politicians and citizens. The citizens expect the politicians to act in their best interests and not their own interest. Like politicians, doctors are also afforded high social status and are expected to practise their profession and exercise their professional medical judgement without being influenced by personal financial interests. In terms of the HPCSA guidelines as stated above, this is equivalent to "perverse incentives" which is also known as "improper financial gain" which is illegal. Perverse incentives are unethical and punishable according to the HPCSA, and

doctors who steal public time for private gain are unethical and should be disciplined by the HPCSA.

Doctors who steal public time to perform RWOPS during official hours are corrupt and unethical as they are driven by self-interest and perverse incentives. Unfortunately, the actions of these doctors have severe consequences not only for access and equity, but for the quality and effectiveness of health care services as well, as I elucidate in the section that follows.

4.3. Impact of abuse of RWOPS on quality of care

The ability to generate additional income for doctors and other health workers while minimising the budgetary burden on the public sector to retain skilled staff, especially given the scarcity of resources in the public sector, has been cited among the positive outcomes of RWOPS[51]. The quality of care provided does not only depend on the skills of the providers but also on the ability of the skilled providers to transfer those skills to others through education and training as these guarantee skilled professionals in the future. All state-employed doctors in South Africa are salaried through a Personal and Salary Administration System (Persal System) irrespective of their employment contract. The moment personal and other information is entered on the Persal system the system will run as instructed until new information is entered. The monitoring system for work attendance is extremely poor or non-existent, and, as a result, these doctors still receive full salaries even if they are absent from their public service work stations. Because income in private practice is on fee for service, whereas income in public practice is on Persal, most of the doctors involved in RWOPS end up abandoning patients in the public service for fee for service patients in the private service, but they still receive the income for the patients that they have

abandoned in the public service. This puts the doctors involved in RWOPS in a tricky position as they have to negotiate potential conflicts of interest between the two components of their work[52]. They may be manipulative and compromise the quality of services in the public sector in order to encourage a diversion of patients to the private sector in order to increase their income resulting in criticism from fellow doctors like the angry Dr Caldwell who was quoted in the KZN Health Bulletin by saying, "they have a sense of entitlement: the state 'owes them'. What about the patients they are cheating; the state resources they are abusing; the junior doctors without supervision? ...Offenders are conspicuous by their absence: unsupportive of junior doctors, late or absent at meetings, unavailable for outreach. The examples they set to their juniors are followed; the next generation of specialists qualify and do the same thing: get full-time consultant posts and open private practices…"[20]. These statements by Dr Caldwell sum up most of the consequences of the abuse of RWOPS and what is important is the example that is set to be followed by future doctors.

The Public Service Commission probe into RWOPS abuse in Gauteng's health services revealed that more than 50% of specialists own private practices[8]. Of the eight medical schools in South Africa, three are in Gauteng, meaning that Gauteng contributes significantly to the training of doctors, registrars and interns. According to the then Head of SAMA's Specialist Private Practice Committee, Dr Mbokota, tertiary hospitals, where most of the doctors' training occurs, are 'haemorrhaging' specialist skills to RWOPS. He argued further that, "Besides the cost to service delivery, registrars were not being properly supervised, meaning that, when they qualify, they lack sufficiently honed skills"[53]. The training of medical interns is equally affected by the absence of senior doctors to supervise them, and these interns move to a year of

community service lacking sufficient skills and competence to work independently in remote hospitals of the country. This underinvestment in future doctors will not only be felt by this generation, but also by future generations. Absence of specialists and senior doctors generally also undermines the quality of health care as the state relies on the ill-trained doctors for the provision of health care services. There are also arguments that RWOPS has benefits for the training of registrars given the shortage of facilities including state of the art equipment in the public service. It is true that public service suffers from a shortage of not only doctors and state of the art equipment, but also of basic equipment[54]. Unfortunately, in most cases the equipment is available, but in a non-functional state. According to Professor Ken Boffard, from the Surgical Department at the University of Witwatersrand, the training of fellows and registrars is no longer solely using public sector facilities. He further claimed that MRI training would not be possible without the private sector[53]. Although the abuse of RWOPS has negative effects on the training of registrars and junior doctors, RWOPS in a well regulated environment can contribute positively to the training of quality future doctors and specialists.

I have demonstrated that the abuse of RWOPS by state employed doctors compromises the quality of care given to patients. The poor quality, or even absence, of training of junior doctors has serious consequences for health care provision in South Africa as a whole, and the effect of this will be felt not only by the current generation but by future generations as well.

4.4. Impact of abuse of RWOPS on the efficient use of health resources

South Africa has a two-tiered health care system with the public health system being utilised for those who cannot afford the private health care system, although even those who are categorised as the poor in the community utilize the private health care system for out-patient services and the public health system for in-patient services owing, amongst other things, to long waiting times in public health facilities [55]. In an environment that is well regulated, like Indonesia, dual practice increased the use of services at public facilities and services provided privately by doctors and other health care providers owing to the so-called sorting of patients in which the poor make more use of public services while the more affluent seek care at private facilities. This decongests the public health system as only those who cannot afford private health care are able to access services at public health facilities[56]. Although quality may not be guaranteed under these circumstances, efficiency in the public health system is improved.

The problem with the absenteeism caused by the abuse of RWOPS in South Africa is that those doctors who remain in the hospitals are burdened with additional work and are sometimes forced to perform tasks for which they are unqualified[17]. The financial costs of reduced productivity owing to absenteeism can be high as shown by a study in Machakos District, Kenya, which estimated that the absenteeism rate, averaging 25%, costs each health facility 51 000 USD per month[57]. The abuse of RWOPS leads to unmanned working stations of doctors. Some of the adverse events that occur during this absenteeism lead to medical negligence claims. South Africa has recently experienced a significant increase in medical negligence claims in terms of both size and frequency[58]. Medical negligence attorneys advertise their services in the media and encourage the community to approach them if they are not happy with the way

they were treated either by hospitals or health care providers. This increase in medical negligence claims has negative effects on the ability of the state to finance health care as funds, which are meant for service delivery in the already resource-limited and overburdened public health care system that serves the overwhelming majority of the population, are used to pay for medical negligence claims and related legal costs[57].

The theft of drugs and medical supplies by health care professionals is common globally. In Venezuela, approximately two-thirds of hospital personnel surveyed were aware of theft of medical supplies and medications. Similarly, in Costa Rica, 71% of doctors and 83 % of nurses reported that equipment or materials had been stolen in their hospital. Theft has been found to increase when its potential benefit is high, when the probability of detection is low, and when the expected penalty is minor [59]. There is likely to be a similar occurrence in South Africa given the weak or non-existent controls at public health facilities. Resources which are meant to be used for patients in the public sector could be diverted to patients in the private sector. The cost per patient day equivalent for most public health facilities in South Africa is higher than the norm. A contributing factor[60] to this is may be that most of these hospitals are inefficient in the utilisation of resources and there is a lack of drugs and other supplies owing to theft for use in the private sector.

Besides the obvious outflow of public resources owing to theft, the use of the public sector's means of transportation, office infrastructure, equipment and personnel, such as nurses and cleaners, when private patients are brought into the public sector for management by the doctor practising RWOPS represents additional hidden outflows of public sector resources to the private sector[61].

Concluding remarks

Although there is a paucity of evidence on the impact of abuse of RWOPS, it is clear from the above that, while RWOPS has a potential of bringing positive benefits to the public sector, these benefits are not realised owing to this practice being susceptible to abuse.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

Remunerative Work Outside Public Service or Dual Practice was introduced by the state to allow for public servants, including doctors, to perform remunerative work outside the employment by the state. The benefits of RWOPS are not only monetary but they are also in the form of professional development as these doctors are able to maintain their clinical and technical skills through access to resources that are not readily available in the public sector. The state is also able to retain these skilled professionals within the public health system. Unfortunately, however, this practice that has the potential of enriching and empowering the state to ensure access to quality health care services by all South African has been abused by state-employed doctors. This situation has been made worse by the inability of the state to regulate the practice.

This report has demonstrated that the Department of Health, as the employer, fully empowered by legislation, has failed to manage the performance of RWOPS by state-employed doctors, and some of the doctors are exploiting the gap that exists. RWOPS policies developed by Provincial Departments of Health have not brought about a solution to the problem of the abuse of RWOPS. All that the state needs to do is to observe the provisions of the Public Service Act as stated above.

The performance of RWOPS by doctors without permission from the executive authority is illegal. The failure of the employer or the state to exercise the provisions of section 31 of the Public Service Act by recovering the remuneration made by doctors performing RWOPS is not only illegal but also unethical. After a cabinet decision to

abolish LPP in 1999, the ownership of private practices by full-time state-employed doctors is illegal and unethical. From this report, it can be concluded that both the state and doctors are culpable as regards breaches of the Constitution, Public Service Act, Basic Conditions of Employment Act and the Labour Relations Act.

This report has successfully demonstrated that doctors who abuse RWOPS have deviated from their moral duties towards their patients and are also in breach of not only their legal obligations towards the state but also the ethical guidelines of the HPCSA as the regulatory body. These doctors are not trustworthy and are devoid of integrity which are basic virtues expected from a medical professional. The shift from the best interest of the patient to self-interest is a serious threat to the profession which has always been known for its benevolence. SAMA has also failed in its duty of guiding and uniting the doctors to have the best interest of patients at heart based on the commitment that the medical profession has made through the agreements signed in the PSCBC

Although there is a paucity of evidence on the impact of abuse of RWOPS, this report has made it clear that, while RWOPS has a potential of bringing positive benefits to the public sector, these benefits are not realised owing to the practice being susceptible to abuse. It has been demonstrated that absenteeism is the major form of abuse of RWOPS in the public service. It is equivalent to corruption, and this has an impact on the ability of the state to provide accessible, equitable and efficient health care services using the available resources within the public service. This behaviour by state-employed doctors is unethical as it is motivated by self-interest and perverse incentives both of which are in violation of the ethical guidelines of the HPCSA. The denial of public sector patients to much needed health care owing to unavailability of

doctors and the receiving of low quality care is both illegal and unethical as it denies patients their constitutional right of access to health care services and is reflective of the injustices of the past where quality health care services were available only to the privileged minority.

While a significant limitation of this report is the paucity of evidence-based and empirical research on this topic, the report has successfully argued that RWOPS, as currently practiced by state-employed doctors, lends itself to significant abuse and hence, both unethical and illegal conduct.

5.2. Recommendations

The legal and ethical implications pertaining to the abuse of RWOPS by state-employed doctors require an intervention, not only from the state as employer but also from all the relevant stakeholders, and I, therefore, recommend as follows:

1. The Department of Health as employer should apply the provisions of the law to the letter without fear or favour. The state should recover the income obtained by doctors as a result of engaging in RWOPS without approval in accordance with section 31 of the Public Service Act.
2. Absenteeism, corruption and theft should be dealt with using the provisions of the Disciplinary Code and Procedure in the public service, and those found guilty of misconduct should be reported to the HPCSA for unprofessional conduct.
3. The HPCSA should include a rule related to dual practice in the Ethical Rules developed in terms of section 49 of the Health Professions Act.

4. The Department of Health and the HPCSA should develop a working protocol to manage complaints related to the abuse of RWOPS lodged with the HPCSA for unprofessional conduct.
5. SAMA should assist doctors by ensuring that they understand the obligations they have towards the employer as outlined in their employment contracts and refrain from advocating for unethical doctors who are involved in illegal practices.
6. If RWOPS is not abolished in South Africa, a system of regulating and managing RWOPS needs to be developed through a collaboration of the Department of Health, SAMA, HPCSA and the Medical Deans with a view to having a national policy on RWOPS to which both doctors and the state will be committed.

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ANNEXURE 1

University
of the Witwatersrand,
Johannesburg

Human Research Ethics Committee (Medical)
(formerly Committee for Research on Human Subjects (Medical)
Secretariat: Research Office, Room SH10005, 10th floor, Senate House • Telephone: +27 11 717-1234 • Fax: +27 11 339-5708
Private Bag 3, Wits 2050, South Africa

Ref: W-CJ-130410-4

10/04/2013

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator: **Munyadziwa Kwinda (student no: 603788)**

Project title: **The ethical and legal considerations on abuse of remunerative work outside the public service (RWOPS) by state employed doctors.**

Reason: This study is an analysis of information in the public domain. No humans are involved.

UNIVERSITY OF THE WITWATERSRAND
PROF PE CLEATON-JONES
HREC (MEDICAL)
2013 -04- 10
JOHANNESBURG

Professor Peter Cleaton-Jones
Chair: Human Research Ethics Committee (Medical)

copy: Anisa Keshav / Zanele Ndlovu, Research Office, Senate House, Wits

Annexure 2

TURNITIN ORIGINALITY REPORT

By

Kevin Behrens

From Draft Turnitin Submissions

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