REVIEW

MEDICAL ETHICS II
Private Practice

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Back in the history and in the most primitive societies healers or witch Doctors were available to cure illnesses. The practice of these healers or witch Doctors depends on direct payment and reward system.

The code of Hammurabi of Babylon, dated about 1900 BC, laid down the fees of a physician for various treatments, such as opening an abscess and others. The fee for treating a slave is less than a master. If a treatment failed or the patient died, the doctor's hand might be cut off!

Nine hundred years ago, the great muslim physician, Mohamed Al Asooly, wrote a book "Drugs and Therapy". It was in two volumes, the first one was dedicated to the diseases of the rich and the second one was for the poor.

During the height of Islamic Civilization, the era when Baghdad was the capital, medical teaching and training has become formal, no one is allowed to practice medicine except after several years of training by a well known teacher in the field of medicine and passing an examination supervised by a Committee of well known experts in the profession, the Committee is appointed by the Khalifa, who is the Head of the State. After the collapse of Abassayeds in Baghdad, Hamdani in Syria and Fatimayads in Egypt, the organised system of medical training and qualification fell and they reversed back to primitive healers.

There is no nation which reverses back to primitive way in medicine except the Arabs and the Greeks. The explanation is simple, a period of progress encouraged by an open-minded ruler followed by narrow-minded primitive ruler who antagonises the educated or kills them or makes their effort worthless, therefore, slowly and eventually this class of fragile people disappears and is replaced by primitive way of doing things.

However during that period of organised medical profession, medicine was practiced privately and it was given a fee for service and usually the patient pays for the service, and because of that, there was a number of patients who could not afford the treatment.

Due to the inability of some patients to pay for their treatment the indirect payment or third party payer has evolved, and they were at that time paid by Awkaf, Zaket, The Tribe, The Treasury House or The Khalifa (Head of the State).

A few centuries later a similar arrangement has developed in the West, for instance, in England they developed the Poor Laws which put duties on local parishes to look after the poverty stricken and foundlings within their boundaries. During that

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period and still practiced until now some doctors have developed The Robin Hood Effect, which means taking more fees from the rich and less or none from the poor.

In 1900 Victoria Memorial Hospital[1] was established by the British in Ras Roman, it had twelve beds and continued functioning until 1949. The Hospital mainly functioned as public health work with limited therapeutic service for direct payment.

In 1902 the American Mission Hospital was established on piece of land given by Shaikh Isa Bin Ali (the ruler of Bahrain). It functioned mainly by giving a charity service to the patient, a fee for service directly collected from the patient and Third Party Payer (patients sponsored by the ruler of Bahrain, The Awkaf and the rich).

In 1937 Awali Hospital was established to treat Bahrain Petroleum Company employees against a fee paid by a Third Party Payer which is the insurance companies.

In 1940 Naim Government Hospital was established and it gave its service against a fee through a Third Party Payer which is the Government of Bahrain.

In 1979 International Hospital of Bahrain was established and it functioned through direct payment (a fee for service) and Third Party Payer (patient sponsored by the ruler of Bahrain, Awkaf, including the owners father Wakaf, the rich and insurance companies).

The regulations or Law of Private Practice kept changing since 1960.

In 1960, the law permits the junior staff or the General Practioners to work in the Government hospitals and have private practice clinic. The law does not permit the Consultants to do so.

In 1964 two Bahraini doctors (one consultant physician and the other dentist) opened Private Clinic without a licence, they were ordered to close, and because they refused they were threatened to be dismissed from Government employment. Shaikh Khalifa Bin Salman AL-Khalifa intervened and gave them the permission to have private practice. At that juncture the consultant physician decided to immigrate to Algeria and he did.

The First Change of Position came in 1970's, the Bahraini Consultants were allowed to have private practice clinics while working for the Government hospital while the junior staff were not allowed. The first two, to open clinics utilising the new regulations were Dr. Faisal Zeera and Dr. Jan Safar.

In 1973, Limited Private Practice (LPP) was devised, where the expatriate Consultants are allowed to have limited private practice in the afternoon within the hospital with a ceiling of BD.200 to compensate them, because their salary is lower than the Bahraini consultants by BD 150, which is the housing allowance.

This system is the first of its kind in the world where social medicine and private are combined together under the Government umbrella. Though the BDF Hospital is a military hospital, it has adopted this sytem in 1983.

The second change of position came in 1980, where Bahraini Consultants working in the Government hospitals are not allowed to have private practice clinic but they can join the LPP. At that point Dr. Jan Safar decided to immigrate to Great Britain and he did.

Third change of position might come in late 1980's or 1990's, where Bahraini consultants will be allowed to combine Government employment and private clinic.

In mid 70's Bahrain and the Gulf region witnessed economic boom and due to that substantial number of the companies and banks insured (medical) their employees. As well substantial number of private residents are medically insured, their percentage is not known. All these patients are able to attend private hospitals and clinics and be covered by insurance (third party payer).

The arguments against private practice are[2]:

A. It is extremely difficult to deal with public health medicine.

B. By virtue of its nature it excludes the poor, the destitute and the needy from medical care.

C. It excludes the disadvantage groups such as those with chronic diseases, the mentally handicapped, the physically handicapped, the majority of the psychiatrically ill and many others. For a variety of reasons many of these sick people are also poor.

D. Private practice treats mainly curable illness. It is not geared to long term care, which can be too expensive.

E. The range of private practice is limited when compared with that of medicine as a whole.

F. Consultations with other colleagues in different specialities are rare in private practice, which sometimes jeopardise the patient's management.

G. The progress of the profession and the maintenance of high standard of quality practice is dependent on teaching, research, team work, constant peer review and education, which are rare in private practice. Research in private medicine is resisted by patients, and fought by some private medical practitioners, through systematic process of frightening the clients, both our colleagues and the patients are forgetting that medicine which we are practicing at present is the result of many researches, without which medicine would remain primitive, and still we need further researches to be able to cure some of the incurable diseases.

The advantages of private practice are:

A. The advantages of private practice include the individual choice of doctor, short waiting times for consultation and admission to hospital, pleasant surroundings, more individual care by doctors and other staff, open visiting times in the hospital, television, radio, telephone, personal bathroom and toilet. These facilities are important and some patients value them highly.

B. Freedom of choice is an extremely important matter in private practice. Some patients feel more comfortable and happier obtaining medical care privately and they should be allowed to do so. it is not harmful to the majority of the people.

What is the ethical problem of private practice?

Is it right that a minority of fairly well-endowed people should, by paying, have advantages which the vast majority cannot afford? It is a very ancient problem which extends far beyond medicine to almost every aspect of our lives.

Is private practice morally right or not?

Private practice is an old profession and has a history almost as that of mankind, since morality derives from what is customary and acceptable to a particular culture then private practice must be right and ought to continue.

What is the future of private practice in Bahrain?

I see two alternative sequence of events for the period up to the year 2000, if the economies of Bahrain and the Gulf do not suffer a serious recession, the present ratio of private and Government medicine will continue to prevail. If Bahrain economy and the Gulf region falter, then I believe that the increasingly fragile private practice system will not survive the strain.

Finally, I believe that medicine is indivisible, because wherever you are practicing, there is a patient to care for, I believe that private and Government medicine must continue to work side by side as they have always done. What proportions should be taken by each one of them is dependent on views and opinions of the politician and united well represented medical profession.

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