Provision of Private Care by Doctors Employed in Public Health Institutions: Ethical Considerations and Implications for Clinical Training

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ABSTRACT: This paper summarizes the difficulties that may emerge when the same care-provider attends to private and public patients within the same or different clinical settings. First, I argue that blurring the boundaries between public and private care may start a slippery slope leading to "black" under-the-table payments for preferential patient care. Second, I question whether public hospitals that allow their doctors to attend to private patients provide an appropriate learning environment for medical students and residents. Finally, I propose a way to both maintain the advantages of private care and avoid its negative consequences: complete separation between the public and the private health care systems.

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Since 1910, doctors in Palestine and later in Israel were paid salaries. Policy makers expected that this would secure egalitarian patient care, and doctors accepted the salaried model because it provided a stable income. Yet, throughout the 20th century, doctors made repeated attempts to renegotiate the terms of their employment with a view to be permitted to engage in private practice [1].

Blurring the boundaries between public and private health care may lead to "black" under-the-table payments to doctors for preferential care

Initially, these attempts met with resistance. Subsequently however, policy makers gradually acceded. In 1953, department heads of the government hospitals in Israel were permitted to conduct private consultations; in 1954, Hadassah allowed its senior physicians to engage in private practice within the hospital; and since 1964, senior physicians at the hospitals of Clalit Health Services, the largest of the four health funds in Israel, have been permitted to engage in private practice outside their institutions [1]. In the 1990s, it was estimated that about one-third of the senior physicians in public hospitals took advantage of this private practice privilege [2]. The 1995 National Health Insurance law provided further legitimation of private practice by stipulating that persons who wish to do so can purchase extended insurance for medical services not included in the basic package of benefits, such as treatment by a doctor of the patient's choice. By 2012, private spending represented 37% of national health expenditures in Israel [3]. Similar models of mixed public-private funding of health care have been adopted by other countries with universal health insurance [4].

Doctors have attempted to gain permission to see private patients for as long as a century [1], but only in the last two decades has private practice reached its present dimensions. In 2002, Ravid [5] identified a shift in doctors' priorities from academic activities to economic interests, and more recently, private medical care has been the subject of public debate. In this paper, I explore some of the implications of allowing private care by salaried physicians employed in public hospitals. I use the term "private care" to refer to the purchase of health services not included in the basic package of benefits – whether in private or public settings, paid directly by the patient or by his/her supplementary or private insurance, or involving gifts or contributions to institutions or research projects. I examine the problems that may emerge when the same care-provider attends to private and public patients within the same or different clinical settings, and argue that these problems may lead to "black" (under-the-table) payments for preferential care, and may communicate inappropriate messages to medical students and residents.

PRIVATE CARE IN PUBLIC INSTITUTIONS: ETHICAL CONSIDERATIONS

The code of medical ethics includes the principles of non-maleficence, beneficence, respect of patient autonomy, and distributive justice [6]. Ethical dilemmas, i.e., situations in which doctors cannot abide by one ethical principle without violating another have always existed. However, since the 1970s, the shift from doctors' paternalism to respect of patient autonomy has produced a range of previously unrecognized dilemmas, and the shift from uncontrolled to parsimonious

use of medical resources has led to an apparently irreconcilable tension between the fair allocation of health care resources and physicians' commitment to the needs of the patient at hand.

Provision of private care by doctors employed in public hospitals raises a range of ethical dilemmas. On the one hand, private care responds to the requirement to respect patients' autonomy by deferring to their willingness to pay for their care. Furthermore, part of the payments for private care is channeled to the hospital, with subsequent benefits for all patients. On the other hand, delivery of private care by doctors employed in public hospitals may have several unintended consequences.

First and foremost, private care violates the principle of equity. Equity requires that access to medical care and the choices of clinical interventions be guided by patients' needs only, irrespective of ability to pay or likelihood of benefit for the patient. Likelihood of benefit should certainly guide patient triage in emergencies or admission to intensive care units. However, in non-emergent clinical settings, equity prevails on other ethical principles, such as utilitarianism (priority for those most likely to benefit from health care) and respect of patient autonomy (in choosing a private health provider).

Second, private care competes with public care for doctors' time and energy. Therefore, respect of patients' right to pay for the privilege of rapid access to specific care-providers infringes on the rights of other patients. After 18 year old Libby Zion died while under the care of overworked doctors in 1986, the hours of a doctor's shift in the United States (and subsequently also in Israel) were reduced to allow them time for rest, keeping abreast of the literature, leisure and family. However, at least in Israel, doctors have used off-duty hours to supplement their income by additional clinical work. In 2004, as many as 84% of the surveyed Israeli senior physicians were employed at more than one clinical setting, and 40% at three or more settings including private practice [7]. It may be argued that doctors may use their off-working time as they choose, and that attending to private patients is not different from any other activity such as keeping updated, rest and leisure. This claim ignores the relative importance of off-working hour activities: keeping abreast of the literature is essential for maintaining expertise, and devoting time to rest, leisure and family is vital for doctors' well being. Care of private patients is neither of these.

Public hospitals that allow private care cannot provide an appropriate learning environment for medical students and residents

Third, care-providers who attend to private and public patients within the same or different clinical setting communicate a message that the care they deliver to public patients is inferior. Indeed, there are indications that private patients in the hospitals in Jerusalem receive preferential surgical care [8], they are more satisfied with their relationship with the doctor than are public patients [9], and the average waiting time for appointments at the outpatient clinics of the hospitals in Jerusalem is 10 times longer for public patients than for private patients [10]. In attempting to reduce waiting time in the public sector, physicians in private practice may even have a conflict of interest because the longer the wait in the public sector the greater the attraction to the private sector.

Fourth, health care is perceived as a public service. Just as it would be unthinkable that police officers be permitted to function as private detectives after working hours, so also provision of private care by doctors employed in public hospitals may erode patient trust in the health care system. Trust is essential for patient care, and in its absence a large proportion of health care resources must be allocated for legal self-protection. Fifth, blurring the boundaries between public and private resources may promote doctors' use of public facilities to treat private patients [11]. Finally, the possibility of extended coverage within public institutions for health care may blur the boundaries between legal and illegal fees for service, and private care in public hospitals may degenerate to black medicine [12].

BLACK MEDICINE

The term 'black medicine' refers to informal payments for care that includes illegal activities such as bribing a doctor, and marginal actions such as giving a gift to a doctor or making a contribution to his or her department in order to obtain better treatment [11]. It has been estimated that informal payments comprise 1.5–4.5% of total health care expenditures in Hungary, 30% in Poland, 56% in the Russian Federation, and 84% in Azerbaijan [13].

Black medicine exists also in Israel. In the 1990s, before the implementation of the National Health Insurance Law, Lachman and Noy [14] surveyed convenience samples of 703 hospital doctors and 805 inpatients and estimated that as much as a third of the hospital medical activity was "black." In 2014, Filc and Cohen [12] surveyed a representative sample of Israeli adults. They found that 7% of all respondents reported that either they or one of their family members had made an informal payment with a view of receiving improved health care. As many as 6% stated that they had been explicitly or implicitly requested by a doctor in a public hospital to pay him/her or to contribute to a research fund, and 14% of the respondents stated that they knew of an acquaintance or a relative who had offered or had been asked to pay a discreet informal payment to a doctor [12].

Use of black medicine was not related to patients' satisfaction with care, involvement in medical decision making, political attitudes, education, gender, age, religiosity, self-assessed health, economic status, or geographic location. The only variable associated with use of black medicine was trust in the health care system, with higher levels of trust being associated with lower use of black medicine. On interview, survey partici-

pants suggested that blurring the boundaries between public and private health care reduced their trust in the health care system and contributed to the emergence of black medicine [12].

PRIVATE CARE IN PUBLIC INSTITUTIONS: EFFECT ON ROLE MODELING

The medical literature almost uniformly addresses role modeling as a powerful teaching strategy. Indeed, as many as 90% of medical graduates remember role models who shaped their professional attitudes [15]. Role modeling occurs in a defined learning environment/institutional culture and "hidden curriculum," i.e., the cultural mores that are transmitted but not openly acknowledged. The learning environment affects the behavior of role models, role models deliver their messages to students, and sometimes it is impossible to discern between the influence of role modeling and that of the learning environment. Therefore, any discussion of role modeling should also gain an insight into the hidden curriculum, institutional culture and clinical learning environment.

A way to maintain the advantages of private care and avoid its negative consequences would be to completely separate the public from the private health care system

The clinical learning environment presents medical trainees with unique challenges. In 1996, Morton et al. [16] stated that "the dilemmas faced by medical students [are] how to survive in a threatening environment, how to please authority figures … and how to avoid humiliation." In 2011, Treadway and Chatterjee [17] stated that "the rules governing the responses to these experiences are unclear… so [medical] students take their cues from the behaviors they observe." Indeed, students' observations of behaviors and role modeling have been claimed to affect learning more than formal teaching "not only because [they are] reinforced more frequently, but because [they] relate to doing rather than saying" [18].

What then, are the messages that a learning environment projects to medical trainees who observe their role models providing care to both private and public patients. There is undisputed evidence that health care providers unintentionally and unconsciously discriminate among patients, e.g., white patients have better access than Afro-American patients to specialized services [19]. However, a learning environment that approves of role models who attend to both private and public patients may also provide legitimacy to deliberate and conscious patient discrimination.

CONCLUSIONS

The changes in the terms of employment of Israeli doctors have led to the present situation, whereby they enjoy the security of tenured employment in elite public institutions, the prestige of academic degrees, and the added income from private care as the extended insurance provides a market where doctors can sell services even in public hospitals [1]. Private care violates the principles of distributive justice and equity; it may erode patients' trust in the health care system and degenerate into black medicine; and by providing legitimacy to discrimination among patients it may project a message to clinical trainees that is irreconcilable with current professional norms.

A possible way to maintain the advantages of private care and still avoid its negative consequences would be to completely separate between the public and the private health care sectors. Just as a police officer may open a private detective office only after resigning from the police force, so also physicians may attend to private patients, or hold other medical jobs only after resigning from public hospitals.

It would be only fair to disclose that before retiring from practice I was on the staff of the Department of Medicine at the Hadassah Medical Center. In the 1970s and 1980s, I attended to private outpatients for two hours a week. However, the developments in Israeli health care since 2000 led me to adopt the views presented in this paper. I am aware that only a few Israeli doctors share these views, that they run contrary to well-entrenched norms, and that these norms are not likely to change overnight. Still, considering the debate on the state of the health care services, I believe it imperative to reexamine how we arrived at the present pass. Hopefully, such a reexamination will at least improve doctors' time management not only within working hours but also with regard to rest, continuing medical education, leisure and family.

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