Chapter 5
Ethical Programs for Patients in Bahrain

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ABSTRACT

2030 vision for the kingdom seeks to promote Bahrain as a healthcare destination. New private hospitals have entered the health service industry. This leads competition to soar. Patient care has become a priority. The need to acquire accreditation for health services rendered by hospitals accentuates the importance of maintaining international standards in term of quality and cost. The purpose of the study is to reflect on the development of ethical resolutions, procedures, policies, and programs to enhance and to improve healthcare by National Health Regulatory Authority (NHRA). The study employs qualitative analysis of literature in relation to the evolution of ethical programs for health professionals in general and for patients at hospitals in Bahrain.

INTRODUCTION

Article 25 of the Universal Declaration of Human Rights of 1948 illustrates the human right to wellbeing, medical care and health services. This 1964 constitution of the World Health Organization defines health as "the enjoyment of the highest attainable standard of health" (WIKIPEDIA, from en.m.wikipedia.org, Right to Health). Principles related to the right for health include spread of medical knowledge, adequate health services, and child health. Therefore, this paper examines the theoretical evolution of ethical programs, elaborating on ethical programs frequently discussed in the literature. It also highlights the differences between doctor-patient

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models in the USA, the UK, and Canada. Finally, this study reflects on NHRA's (National Health Regulatory Authority) "attempts to promote and develop ethical programs by health providers in the Kingdom of Bahrain."

PATIENT ETHICAL PROGRAMS: LITERATURE REVIEW

According to Moorhead and Griffin (2102), there are four stages of group development: mutual acceptance of members, open communication and establishing norms, members' cooperation and creativity, and finally, working as team based on the ability to self-reflect and self-correct. Groups made of professionals and work teams develop their own norms and values at the second stage of group development. Norms and values assist in defining expected behavior, differentiating a given group from others, aiding the group to avoid unexpected situations, and finally helping the group to survive.

The Law Society (1986) outlines the differences between professional and occupational groups in term of four factors.: professional members are identified by register or record; members need to abide by ethical standards; membership indicates having skills and learning in a given field; being responsible for actions and behavior towards they serve. (Picker Institute, 2006).

A professional body is constituted of members of the same profession and has five objectives the first of which is to illustrate codes of ethics related to a given professional i.e. physicians demanded in a professional capacity by regulatory authorities. The second is to specify to future members how to behave. The third is to outline the consequences of violating such codes. The fourth is to assist in clarifying the needs for medical education, trading, and solving problems. The fifth is to maintain and improve the public's image of physicians (Picker Institute, 2006).

Kaba and Sooriakumaran (2006) state that there are three models for the doctor-patient relationship. Stanwick and Stanwick (2009) added a fourth model. The first according to Stanwick and Stanwick (2009) is the "Engineering" model. In this model "the doctor provides factual information.....but the patient makes all relevant decisions." (p.105). This relationship of patient domination is argued by Kaba and Sooriakumaran (2006) to prevail in the 1700s. In the second model, the doctor takes on a "Priestly" role that assume that the doctor will do their best for a patient who plays a passive role. This to Kaba and Sooriakumaran (2006) exists in the 1000s. The third model is "Collegial", which states that the doctor and patient make all decisions based on trust. This is partially compatible with the model of "mutual participation" of 1956 as explained by Kaba and Sooriakumaran (2006). The last and fourth model discussed by Stanwick and Stabnwick (2009) is the "Contractual"