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Is *Ijarah ala al-ashkhas* applicable to therapeutic services supplied by clinicians and traditional healers and what are the potential consequences if they are defective?

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Abstract

This review considers the nature of the contract between physicians, traditional healers and their patients and whether it is consistent with concepts embodied within *Ijarah ala al-ashkhas.*This includes the four pillars of employer/employee, offer and acceptance, wages and service as defined by Hanafis. The review deals with the differences in training and qualifications between these two groups of therapists and its impact on clinical outcomes and how this related to contractual obligations. The nature of the contract between patient and practitioner is reviewed in terms of an employer/employee relationship. As an employee, a clinician may work as an agent for a state body, such as the National Health Service (NHS), a member of a partnership (*Sharikat al-a'mal*) or independently. The concept of offer and acceptance is paralleled by consent processes and their documentation. The wages paid for such services are considered in view of the two extremes of the lowly status of a cupper and the significant income received by physicians working under royal patronage. The adverse impact of additional payments or bribery on the quality of services is also considered. The service offered brings with it accountability on the part of the practitioner and breaches are dealt with in terms of severity and the intent behind it. The nature of compensation for patients who have suffered harm is discussed in terms of retributive justice or the payment of *diyyah* and the spreading of this to include the wider family or clan of the practitioner. Parallels between criminal negligence and the civil consequences of breaches of duty of care and consequent harm are considered, together with role of mutual defence societies in the payment of compensation.

Introduction

In this review the status of physicians and traditional healers within Islamic societies will be considered from both an historical and contemporary perspective. Such an approach will allow an understanding of their position within society and how they were remunerated for their services. It will include an understanding of those qualities and qualifications which were necessary to distinguish true practitioners from charlatans and, therefore, of the standards by which they should be judged. This will lead directly into an awareness of the consequences of any failures to achieve those standards by individual practitioners. Arising from these criteria, it will be possible to assess whether clinicians and traditional healers should be paid and assessed in the same ways.

Historical Background:

Various ahadith point towards issues related to standards of practice, payment and compensation from the time of the Prophet (PBUH). The expertise of both clinicians and traditional healers is derived firstly from knowledge and

then developed through practice. Based on ahadith reported by al-Mundhiri, knowledge should be disclosed and shared without restriction (1). The question, therefore, arose as to whether practitioners should be paid for such services. In response to this issue ahadith provide a range of comments in relation to traditional healers, such as cuppers. For example, Haram bin Muhayyisah reported in a Sahih graded Hadith that his father was told by the Prophet (P.B.U.H.) that the earnings of a cupper were forbidden (2). In contrast, ibn 'Abbas reported that the Prophet (PUH) was cupped and "he paid wages to the one who had cupped him". (3)

The issue of payment for healthcare services is important for a variety of reasons. Historically, in *The Spiritual Physick,* the distinguished Persian physician, Rhazes, recognised that:

"Men take wealth as a mark and a stamp whereby it is mutually recognised how much each deserves for his labour and the toil that he performs that is profitable for all." (4)

The linkage between status and wealth is commonly recognised, even if fallacious. Support for this view was seen during the Medieval period the status of ordinary physicians in bimaristans or hospitals was generally secondary to that of administrators and their salaries were generally modest, at best. Their income was comparable to dyers and shop keepers (5). There is evidence that salaries were fixed by the state (6). As a result, many followed other professions, in addition to medicine. In contrast, those who wanted to have care from the most competent physicians often established waqfs so as to be able to meet their fees (7). This distinction between state provided and private care emerged in Baghdad with the building of bimaristans and the provision of travelling dispensaries to rural areas, which were driven by the head of state (8). Such a view was confirmed in 2005 in an *Islamic Code of Medical and Health Ethics,* which considered it the responsibility of the state to supply care to those in need (9). However, clearly Muslim physicians should treat all patients equally, regardless of wealth or status, and whether seen as state funded or privately so as to be consistent with Islamic principles (10).

Current Employment of Physicians and Traditional Healers:

These days most physicians in the West combine state employment with private practice, although private practice alone is commonplace elsewhere. For traditional healers generally work is in the private sector. Traditional healers have been included in this review because of the growth of Tibb and hijama practice in the UK in recent decades (11). In this review the nature of the financial and contractual relationship between health care provider and patient will only be considered mainly within the private sector, although attention will be paid to the dual nature of many practitioners' work.

*Ijarah*is a contractual term which refers to the sale of usufruct or a service in return for compensation (12,13). It is a form of gainful occupation because the customer or *as Mu'ajiir* pays an employee or contractor, the *as Musta'jiir*and both derive benefit from the transaction (14,15). Central to this relationship the Prophet (PBUH) insisted the foremost condition for validity of such an employment contract is specification of the wage before commencement and immediate payment, in full, on completion (15,16). The payment of this wage is specified in the Qur'an 95 v 6:

"Those who believe and perform honourable deeds (good work) ... their earnings will never be withheld from them"

Such a contract also brings with it responsibility and issues of liability for the employee (15,17). As a consequence, Hanafi jurists have defined ijarah contracts as having 4 pillars:

1. The employer and the employee
2. Offer and acceptance
3. Wages
4. Service (12)

Clearly, such contracts would cover the work carried out by doctors and traditional healers. *Ijarah* contracts of employment are essentially of two types:

1. *Ala al-ashkhas*– where an employee works for one employer for a specific wage for a known period for a well-defined service. During this period, he cannot work for another employer and is subject to the control of the employer as to what he does and how he does it (12). The contractor benefits temporarily from another person's work and expertise, amongst other aspects (18). An important issue, from the viewpoint of clinicians, who are governed by codes of ethics requiring them to assist the sick, the service should not be obligatory. In addition, a question arises as to doctors who deliver a publicly funded service, as within the NHS, and also have a private practice. There is an argument that under an *ala al-*

ashkhas contract a doctor should not be able to charge for a service, which would be available within the state funded service, although at a significantly later date. Such a service facilitates queue jumping and could be considered to be an example of bribery or corruption. For many jurists, the contract concerns the nature of the work or expertise. However, for Shafis it is about the worker as the usufruct did not exist at the time of the contract and so such concerns are particularly valid.

2. *Ala al-'alam*is a general employee or independent contractor, who works for himself and so can have more than one employer (14). Such a contractor can determine his own method of performance as the terms of his contract permits. Traditionally, by national and international guidelines doctors and other healers have been considered to hold such contracts. However, the method of performance of clinical contracts is constrained and cannot be solely determined by the contractor. The income generated from work under such a contract raises problems. Hanafis hold that if wages are paid from the income of the work the employee performed the *ijarah* contract is voidable. However, most clinicians who conduct private work do so through a wholly owned company, which then pays them a wage. The rationale is to minimise taxation. In contrast, Malikis and Hanbalis consider such a wage permissible (12).

In practical terms, for clinicians and traditional healers, the important aspects are the expertise and temporary nature of the contract. However, for many clinicians their work will lie somewhere between these two forms of *ijarah* contract.

It is important to recognise the existence of a different relationship between doctors or between traditional healers and that is of partnerships, where a group of therapists of the same professional background come together to offer a service. Known variously as *Sharikat al-a'mal*, *Sharikat al-abdan* or *Sharikat al Sanai*' two or more professionals contribute labour to a joint enterprise and share the earnings (12). Shafi jurists contend that such a contract between professionals is not valid as there is uncertainty (gharar) as to exact percentage of work contributed by each member of the partnership and so division of the profits would be potentially unjust. Hanafis, Malikis and Hanbalis do not hold this view, contending that each member acts as an agent for the others and the purpose of the partnership is to collect profit. They also hold that the skills of Each partner may not be identical and can compliment each other so offering a service, which none could offer alone (12). With the nature of healthcare work, the partnership will be an *Inan*, where each is liable only for the obligation incurred by himself (13).

The nature of the contract:

The Employer and the employee:

For doctors, the employer will either be a healthcare organisation, a patient or his or her relatives. In the case of traditional healers, the employer will usually be the patient or relatives. There is an obligation on the employer to seek out a competent practitioner. Imam Malik narrated in his *Muwatta* that Zayd bin Aslam reported that when the prophet (PBUH) called two doctors to a person with a worsening wound, He asked:

"Which one of you is a good doctor?" (19)

This view is reiterated in a further hadith which states:

"Anyone who practices medicine though he does not have enough knowledge will pay for the damage he causes" (20)

ibn Al-Jauziyah emphasised the importance of the selection of a competent and knowledgeable practitioner when he wrote:

"If the sick person had knowledge beforehand that his doctor is ignorant and yet allows him to treat him, then there is no compensation required in this case". (19)

This is a view reflected in English case law. For example, in *Shakoor v Situ (t/a Eternal Health Co)* [2000] the judge disagreed that complementary practitioners should be held to the standards of orthodox doctors, partly on the grounds that:

"The patient has usually had the choice of going to an orthodox practitioner but has rejected him in favour of the alternative practitioner for reasons personal and best known to himself." (21)

The doctor or traditional healer has a personal responsibility to be appropriately trained. A well-known hadith states:

"Seeking knowledge is a duty upon every Muslim, and he who passes knowledge to those who do not deserve it, is like one who puts a necklace of jewels, pearls and gold around the neck of swines." (22)

He or she:

"should do one's job well, and with sincerity to Allah" (23)

For physicians, there are systems for validated formal on-going assessment, based on examinations, annual appraisal and revalidation. For traditional healers, there are no comparable systems. For example, in the case of *hijama*, there has been a dramatic growth in the number of short courses allowing people from non-healthcare backgrounds to set-up numerous unregulated practices (11). As a result, the selection of a knowledgeable and trained practitioner can be problematic. Linked with these issues the nature of contracts and payments must be viewed in the context that few traditional healers in Western clinical practice have followed any recognised formal training program (11) and so responsibilities and remuneration cannot be directly comparable to that of allopathic physicians. However, despite the views of ibn Al-Jauziyah that a patient who puts himself in the care of an ignorant person is not entitled to compensation for any negligent care which he receives (20), someone who holds himself out as performing a "lost sunnah" and promotes the concept that this form of medicine is superior to allopathic practice should not, in my opinion, be exempt of responsibility for their actions.

Offer and Acceptance:

Offer and acceptance show consent (12). They can be expressed orally or in writing. In the clinical setting, who is making the offer and who is accepting it, does not readily fit easily into a market setting. According to the Hanafi school the party who first expresses a willingness to make a contract is making an offer or *ijab* (12). In private clinical settings it is the doctor who is making a general offer to treat the sick and it is the patient who accepts. However, it could be considered that it is the patient who has approached the doctor for treatment and the clinician accepts that offer. For other schools, the situation is moreclear as it is the doctor who has the product – an ability to diagnose and treat and will always be considered the offeror (12). In the case of health organisations, doctors could be considered to act through a general agency (*al-Wakalah al-Khaassah*) on its behalf (23). Of course, the health organisation could not of itself perform the service, which some would consider an essential attribute of the principal.

Traditionally, both offer and acceptance have been by the spoken word. It is their meaning rather than the words or forms that have mattered (23). Qur'an 2 v 282 – 283 outlines the requirements for a debt contract. It should be written and witnessed, although when the transaction is immediate it can be an oral agreement (24). Such requirements have distinct parallels in clinical practice, where histories and physical examinations are based on oral agreements between the parties, but significant interventions such as invasive investigations or surgical procedures require signed documents, namely "Consent Forms", although these are seldom witnessed. Within a consent form the details of the service to be provided are specified together with limits on what can and cannot be done. Such an approach is consistent with the requirements for an *ijarah ala al-ashkhas* contract.

Wages:

This has been touched on earlier in the review. The concept of a public service emerged early in Islam with the *ashab e Suffah*(The People of the Bench). Members acted for the Prophet (PBUH) as scribes and emissaries (25). The Centre for Labour Research in Pakistan has produced an Islamic Labour Code (26) in an attempt to encapsulate principles for payment of wages, especially for those working in a public service. These include:

1. Wages are a right.
2. Wages should be sufficient to provide the basic necessities of life.
3. Wages should be fixed in the light of inflation, regional price differences and need.
4. Punctual and timely payment.
5. Payment should be in full.
6. Equal pay for equal work.

However, Qur'an 4 v 32 would support pay diversity based on competence and justify incentive pay systems (26, 27). Of course, Pakistan has an Islamic constitution and the application of an Islamic Labour Coded in non-Islamic countries is unlikely to be adopted by government bodies, such as the National Health Service (NHS).

The contract should specify the amount of compensation in the form of wages, time of work, payment intervals and the quality and quantity of work to be done (26). There should be no doubt in such contracts according to Qur'an 2 v 279. Indeed, it has been suggested that an employer should consider employees ''as members of their own family." (28) However, although a salary is a continuous way to reimburse health workers and professionals, it may affect the quality of service offered as it divorces outcomes from the clinician's input (29). Some support for this view comes from a study in Iran

where targeted payments were considered by some clinicians to lack transparency and lead to dissatisfaction (29). In a number of countries, inadequate government salaries or limited clinical facilities have led to a system of informal payments to clinicians, in other words, bribes. In *rashwah,*a person has private gain from his public office or through seeking recompense for duties ordinarily considered as non-compensatory (30).Such payments are common in Pakistan (31), Turkmenistan and Tajikistan (32). Nodeh et al have drawn attention to the difficulties in eradicating this problem once it becomes an ingrained habit (33).

The consequences of such bribery and the associated corruption are social and economic injustice and damage societal organisations, such as a state funded health service. Although the definition as to what is bribery varies between various Muslim jurists (34), the overarching theme is that the briber is expecting to receive some benefit from the bribee, to which he is not legally entitled. Hanafi and Shafi jurists have emphasised the need to ensure that such bribes are not hidden under the rubric of being a salary (35).

Service:

Associated with any service, Islam requires there to be accountability or *hisbah* (35). Al-Mawardi considered *hisbah* as a system for enjoining what is just and right if it is neglected and forbidding what is unjust and indecent if it is found to be practiced (36,37). It should operate at both the personal and institutional level (38). Responsibility for poor or adverse outcomes within medical practice comes under two headings:

1. Contractual – where the physician strayed outside the terms of the contract.
2. Derelictual – where the harm arose because of a physician's wrong actions (39).

In practice there is often an overlap between the two and, indeed, and dereliction arises because the physician strayed outside the terms of the contract. Wrong actions are increasingly being seen as criminal in nature. The extent of liability has been linked to the doctor's intent or *maqasid.* Criminal intent is distinguished by the presence of wilfulness, knowledge and disobedience (40). When all three are present then the doctor faces the consequence of full criminal liability and retributive justice or *qisas.* Shafi jurists have clarified the interpretation of these conditions as being when the error committed by the physician is gross and not to be expected of one in his position (41). In such a case the severity of the punishment would be proportionate to the crime. However, Hanafis consider that payment of *diyyah*as monetary compensation is an acceptable alternative (42). This view is based on Qur'an 2 v178. In addition, for Hanafis, liability is removed when the patient approves of the action and the intent was to achieve the patient's interest and preserve life (40). Maliki also require the approval of the ruler (40), in other words, state regulation of the profession. This has immediate relevance to the practice of hijama and other traditional therapies in the UK, which are totally unregulated professions (11).

Simple mistakes have generally been interpreted by jurists as unintentional in nature (40). They may take one of two forms:

1. Error in performance, which is common to all professions. Failures could be due to negligence, recklessness or lack of caution.
2. Error in estimation in which the doctor makes the wrong diagnosis or recommends the wrong type of treatment. His performance will be compared with that of a body of responsible doctors to assess whether such an action would have fallen within their range of practice (40).

In order to prove liability, the requirements within Islamic law are that the following need to be established:

1. *Al-Taadi* (Breach of Duty)
2. *Al-Darar* (Harm)
3. *Al-Ifdhai* (Causation)

These criteria parallel those required in western clinical negligence cases. Similarly, proof comes through:

1. *Al-Iqrar* (Admission)
2. *Al-Shahadah* (Witnesses)
3. *Ra'yu al-Khabir* (Specialist opinion)
4. *Al-Kitabah* (Documents) (43)

The traditional outcome for proven breaches of duty resulting in harm was summarised by Ibn Rushd, who wrote:

If the medical practitioner is competent yet he commits a mistake, then he is only liable for what is less than a third of the value of *diyyah*. More than one third of the full *diyyah*, should be met by his relatives. But if he is not knowledgeable, then he is lashed and imprisoned." (44)

In contrast Malik wrote that:

"A qualified and competent medical practitioner is absolved of all liability, even if he errs. Whereas an impostor is fully and personally liable." (45)

Interestingly, the role of the family can be directly compared to that of many medical defence societies, which act as mutual organisations with a common fund, somewhat similar to *takaful*, as distinct from western insurance companies.

Conclusions:

The question raised in this essay is whether *Ijarah ala al-ashkhas* is applicable to the therapeutic services supplied by clinicians and traditional healers. Hanafi jurists consider such contracts to have four pillars, namely: employer and employee, offer and acceptance, wages and service (12). Although some clinicians are employed by organisations and act as its agents in providing a service, most therapeutic relationships are directly between a patient, who is the employer, and the therapist, who is the employee. The service is offered by the clinician and accepted by the patient, and this is often embodied in a signed document, the "Informed Consent." This document outlines what is being offered, as well as the risks and benefits associated with the service. For this service the employee receives a payment either directly from the patient or from the state organisation, for whom he acts as agent. Clearly *Ijarah* is an appropriate term to apply to the work of clinicians and traditional healers.

In the West, allopathic practice is the main form of therapy offered to patients. It is provided both through state-based institutions, such as the NHS, and private practice. Although *ijrarah*contracts are not utilised in either setting, they are relevant to Muslim practitioners and should form the moral basis for their practice. However, the absence of externally validated qualifications and the nature of training received by many traditional practitioners in the West raises serious questions as to their fitness to offer therapies to would-be patients. The impact that this would have on any contracts depends upon the patients and the information given to them.ibn Al-Jauziyahwas of the view that if a sick person knows that his therapist is ignorant and yet allows him to treat him, then no compensation is required.

The second issue to be raised is the potential consequences of a defective service. Adverse outcomes may be due to dereliction or contractual breaches. When there is wilfulness, knowledge and disobedience the dereliction can have criminal intent and lead to retributive justice. Shafi jurists consider that the error must be gross and not expected from someone of his professional status. For contractual breaches the remedy generally lies in payment of compensation or *diyyah*, although, contrary to present-day practice, Malikis consider that a competent and knowledgeable practitioner should be absolved of liability. Such views leave the poorly trained traditional therapist exposed to the full consequences of taking on a role for which they were not appropriately prepared.

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