

Virtual Mentor

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ETHICS CASE

Profiling Patients to Identify Prospective Donors

Commentary by Richard E. Thompson, MD

As Dr. McGrath entered Mr. Drew's hospital room, he bumped into a pleasant-looking woman in a suit walking out. "I beg your pardon. I'm Dr. McGrath, Mr. Drew's physician. Are you his wife?" he asked.

"No," she replied, "I'm Dana, I'm with the hospital's foundation. I was just paying Mr. Drew a visit to see how he is enjoying his stay, and if there's anything we can do to make him more comfortable."

"Oh," said Dr. McGrath, surprised. "Is he a hospital donor?"

"Not yet," she smiled. "We do daily wealth-screening of the patient census—it's just software that checks what ZIP code they're from—and then we visit patients from traditionally wealthier ZIP codes, trying to ensure that they have a pleasant hospital stay. If they want, we arrange for a newspaper to be delivered daily, and we send a welcome basket with snacks and flowers. We rely on grateful patients for a lot of the donations we receive, so this is a way to identify and impress potential donors early."

Dr. McGrath was nonplussed. "So if it looks like he could possibly donate, he gets special treatment? That doesn't seem right to me."

"He's not getting better medical treatment, Dr. McGrath," said Dana. "And if we impress him and he donates money to the foundation, we can use that money to cover the costs of indigent patients, or to improve the hospital. Just last year, a donor we identified through wealth screening gave a daVinci Robot for the surgical floor."

In the physician's lounge, Dr. McGrath brought up his concerns with Dr. Frosch, a highly respected cardiologist.

"Oh sure," said Dr. Frosch, "It's no different than the 'VIP floors' that a lot of top-tier hospitals have for their super wealthy patients—you know, with famous chefs and marble floors and what-not. Dana actually has me keep one or two appointment slots open every week for donors: if we can keep them happy with our hospital, they're much more likely to donate to the foundation, and that translates to better care for everyone."

Commentary

You can easily judge the character of a man by how he treats those who can do nothing for him.

Ralph Waldo Emerson

On routine rounds, Dr. McGrath has accidentally discovered his hospital's version of the twenty-first-century fundraising activity known as wealth screening. Dr. McGrath is nonplussed, speechless, bewildered.

A wealthy acquaintance of mine, an attorney-ethicist, had the same reaction when I asked him to comment on this scenario. With raised eyebrows and a skeptical look, he said, "Wow!" After a few moments he added, "Whatever happened to the Hippocratic Oath?"

I, like Dr. McGrath, am nonplussed. Should we accept without further questioning the assurances of Dana and Dr. Frosch that this is an appropriate, sensitively applied fundraising technique?

I think not. This situation rises to the status of genuine ethical dilemma, meaning one in which more than one judgment may be reasonable and defensible, given the disparate stakeholder interests. Recognition and analysis of this scenario's ethical aspects will only be complete if informed by expansion in the scope of health care ethics concerns.

Twenty-First-Century Health Care Ethics

To the critically important traditional medical ethics issues—privacy, truth telling, professionalism, end-of-life decision making, intentional interruption of pregnancy, to name a few—twenty-first-century advances in medical biotechnology—gene therapy, stem cell therapy, nanomedicine, and assisted reproductive techniques—have added new ethical questions. Moreover, in the face of growing disparities in health status among sectors of the U.S. population, health care policy decisions emphasize social justice in new ways [1]. Finally, the changing business of health care introduces a variety of ethical concerns. As stated by Robert Hall, "Health care institutions are, in fact, business organizations, with most of the problems faced by corporate management in other fields. They differ, however, in that health care holds a special place among human needs" [2].

Hospital Philanthropy, Then and Now

Hospital philanthropy is as old as hospitals themselves. Many health care campuses and regional networks owe their beginnings to early-twentieth-century collaboration between local physicians and wealthy citizens. Beneficence, concern for community, social conscience, vision, self-satisfaction, and duty are among ethical principles reflected in this highly respected collaboration. As Dr. Frosch points out in the case scenario, some hospitals build special rooms or suites specifically for the use of hospital benefactors when they require hospitalization.

Bequests from grateful patients, some wealthy and some not, were once unsolicited. More and more, however, nonprofit organizations actively seek to build a list of patrons. Software vendors now offer products to assist that effort. Available databases provide information such as size of a family's fortune, current philanthropic activity, and specific financial holdings. This is the twenty-first-century activity known as wealth screening.

Recently these software companies have begun urging hospitals to apply wealth screening to hospitalized patients. One such company promises hospitals will be able to "screen your prospects against 25 databases that provide comprehensive wealth and philanthropic information, in full compliance with HIPAA regulations.... Send us the names of your newly admitted patients at the end of your workday, and you'll have comprehensive philanthropic profiles waiting for you the next morning..." [3].

Although soliciting donations from patients is defended on the grounds that the funds pay for the care of those who are unable to pay and improve the quality of care that the community receives, this mixture of wealth screening and patient care raises several ethical issues.

Professional ethics. Parts of the Hippocratic Oath are obsolete, but it remains symbolic of the profession's commitment to patients [4]. In health care, the professional ethic means "respect for truth telling, confidentiality of personal information, and refusal to exploit others' problems to achieve personal gain" [5]. Mixing patient care and fundraising can be construed as attempts on the hospital's part to exploit patients and, hence, as unprofessional behavior.

Now hospitals are not physicians, and the physicians are not themselves asking patients to become benefactors. But the patient-physician-hospital relationship is key to patient trust, and the integrity of that relationship is put at risk when the physician's role in patient care is mixed in time and place with the hospital's attempts to raise funds. I am certain that this risk is the heart of Dr. McGrath's discomfort.

Ethics of exclusivity as fairness to patients. The justice, or fairness, of special treatment for donors that we see in the case scenario comes under a concept I call the "ethics of exclusivity" [6]. When does special attention to Mr. Drew become unfair because other patients are excluded from receiving services provided to Mr. Drew? I do not begrudge Mr. Drew his free newspaper. However, the hospital must believe that providing this perk improves Mr. Drew's hospital stay in some measure. So is it truly possible to separate nonmedical perks from patient care activities? Patient care, after all, means caring for the whole person, not just treating the person's disease.

More troublesome is the exclusionary practice Dr. Frosch mentions of asking physicians to hold unscheduled appointment time for wealthy patients. This special access deprives other patients of equal opportunity to appointments. Shorter waiting

times are not just a matter of convenience. Delay in medical or surgical intervention can increase some patients' risk of an adverse medical outcome.

The ethics of exclusion as fairness to physicians. Hospital-medical staff relations are notoriously fragile exactly because of scenarios like this one. Dr. McGrath is unpleasantly surprised to find Dana involved with his patient. He is perhaps even more surprised that Dr. Frosch is not only familiar with the practice but also participates in it. Why has the entire medical staff not been oriented to the reality of wealth screening? The hospital may risk losing the trust of excluded physicians.

What Should Dr. McGrath Do?

I have not argued that wealth screening is *per se* unethical. Rather, I have suggested that ethical reasoning validates Dr. McGrath's intuitive uneasy feeling. Dr. McGrath should pursue his concerns. But how?

This case demonstrates the need for physicians to learn and understand how organizations work. Dr. McGrath will get nowhere if he tries to handle this matter himself. Even if it pains him, he must follow organizational protocols (go through channels).

Dr. McGrath should explain his discovery and his concerns to the vice president for medical affairs (VPMA). The VPMA is ordinarily an MD or DO who has chosen to be a hospital executive, providing a useful bridge between business-trained executives and clinically trained medical staff members. The VPMA's duties usually include helping physicians understand how to use organizational machinery to get a variety of concerns effectively addressed.

The VP for medical affairs should suggest involving the ethics committee. By now, most hospital ethics committees have expanded in composition and charge to encompass all aspects of twenty-first-century health care ethics, including ethical aspects of organizational behavior. "This committee's efforts to help keep organizational systems and goals ethical can be a key to gaining much-needed public and political support, and even market share" [7].

The ethics committee, in turn, should strongly recommend development of a wealth-screening policy, with input from hospital foundation staff, medical professionals, and ethics committee members. Guidelines in the policy should balance the interests and concerns of all stakeholders in this activity.

In sum, I argue that if wealth screening and patient care must be mixed, then the activity would be safer and more effective if guided by a policy developed with practitioner input.

References

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