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### Giving Thanks: The Ethics of Grateful Patient Fundraising

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# Giving Thanks: The Ethics of Grateful Patient Fundraising

Stacey A. Tovino, JD, PhD<sup>1</sup>

## ABSTRACT

*Grateful patient fundraising, defined as the solicitation of philanthropic donations by health care providers from current and former patients, raises a number of legal and ethical issues. Elsewhere, I detailed the confidentiality issues raised by the use and disclosure of patient identifiable information by hospital development officers, major gifts officers, institutionally-related foundations, and commercial fundraisers, and proposed corrections to federal health information confidentiality regulations to better balance the competing aims of health care philanthropy and health information confidentiality.<sup>2</sup> In this Article, I analyze several outstanding issues raised by physician involvement in grateful patient fundraising. That is, physicians who solicit philanthropic donations from their own patients risk conflicted health care decision making, health care resource allocation injustices, financial exploitation, and breach of privacy. To lessen these risks, this Article proposes new ethical guidelines governing physician involvement in grateful patient fundraising. This Article is also the first piece of legal scholarship to identify and reconcile two bioethical catch-22s associated with grateful patient fundraising.*

## INTRODUCTION

Imagine a forty-year-old woman who has been diagnosed with stage IV colorectal cancer and who has less than a 10% chance of living five years from the date of her diagnosis. The woman's physician, who specializes in oncology and practices at a hospital affiliated with a major academic medical center, recommends

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<sup>2</sup> See Stacey A. Tovino, *Silence Is Golden . . . Except in Health Care Philanthropy*, 48 U. RICH. L. REV. 1157 (2014).

a combination of surgery, chemotherapy, and radiation to treat the woman's cancer. Assume the woman receives these treatments and, five years later, is still alive and has no evidence of disease. The question addressed by this Article is whether the physician should be permitted to initiate private conversations with the woman regarding the hospital's philanthropic needs. The theory behind these conversations is that the woman may be grateful for her excellent health outcome and willing to donate money to the hospital. On the other hand, perhaps the physician should be prohibited from soliciting donations from his own patients due to ethical concerns associated with distortion of the physician-patient relationship.

This Article proceeds as follows: Part I examines the growing business of health care philanthropy and the practice of grateful patient fundraising.<sup>3</sup> Part I explains why health care institutions rely on philanthropic donations, including because of expensive medical equipment, inadequate Medicare and Medicaid reimbursement, high uncompensated health care costs, and rising health care compliance costs associated with health care reform.<sup>4</sup> Part I chronicles the ways in which health care institutions attempt to increase revenue through health care philanthropy. Part I focuses on one type of health care philanthropy known as grateful patient fundraising and details the ways in which physicians become involved in identifying and soliciting donations from grateful patients.<sup>5</sup>

Part II examines the ethical issues raised by grateful patient fundraising.<sup>6</sup> Physicians who solicit philanthropic donations from their own patients risk distorting the physician-patient relationship, traditionally characterized by strong fiduciary duties flowing from the physician to the patient.<sup>7</sup> The involvement of physicians in grateful patient fundraising raises other ethical concerns that may be analyzed within the framework of the principles of biomedical ethics, including the principles of respect for persons, beneficence, and justice.<sup>8</sup> Particular ethical concerns examined include the potential for conflicted decision making,<sup>9</sup> health care resource allocation injustices,<sup>10</sup> financial exploitation,<sup>11</sup> and breach of privacy.<sup>12</sup>

Part II(F) of this Article is the first piece of legal scholarship to identify two catch-22s associated with grateful patient fundraising.<sup>13</sup> First, approaches to health care philanthropy that reduce the risk of confidentiality breaches raise the greatest risk of distorting the physician-patient relationship.<sup>14</sup> In turn, methods of patient fundraising that minimize interference with the physician-patient relationship pose

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<sup>3</sup> See *infra* Part I.

<sup>4</sup> See *id.*

<sup>5</sup> See *id.*

<sup>6</sup> See *infra* Part II.

<sup>7</sup> See *infra* Part II(A).

<sup>8</sup> See *infra* Part II(C)-(E).

<sup>9</sup> See *infra* Part II(B).

<sup>10</sup> See *infra* Part II(C).

<sup>11</sup> See *infra* Part II(D).

<sup>12</sup> See *infra* Part II(E).

<sup>13</sup> See *infra* Part II(F).

<sup>14</sup> See *id.*

the greatest risk of violating patient confidentiality.<sup>15</sup> Second, approaches to grateful patient fundraising that lessen the risk of financial exploitation raise the greatest privacy concerns. In turn, methods of health care philanthropy that minimize privacy concerns increase the possibility of financial exploitation. Part III resolves these catch-22s by proposing corrections to ethical guidelines governing physician involvement in grateful patient fundraising.<sup>16</sup> These ethical guidelines are designed to lessen risks of conflicted physician decision making, health care resource allocation injustices, financial exploitation, and breaches of privacy. When coupled with corrections to federal health information confidentiality regulations proposed earlier,<sup>17</sup> these ethical guidelines better balance grateful patient fundraising and basic patients' rights.

#### I. THE BUSINESS OF HEALTH CARE PHILANTHROPY AND THE PRACTICE OF GRATEFUL PATIENT FUNDRAISING

Again, imagine a hospital that would like to raise funds for its own benefit. For example, a general acute care hospital affiliated with a major academic medical center would like to embark on a capital campaign to raise funds to expand the infrastructure of, and technological and human resources available through, the hospital's medical, surgical, and radiation oncology departments. To raise funds, the hospital would like to access health information in its electronic patient database to select patients who have received medical, surgical, or radiation oncology services, who have had favorable health outcomes, and who live in certain zip codes known to be associated with a high median family income or who have other indicators that suggest wealth.<sup>18</sup> The hospital believes that these patients, given their positive health care experiences, may be inclined to donate money to the hospital and may have the discretionary funds to do so.<sup>19</sup> These types of patients are referred to as "grateful patients,"<sup>20</sup> and the solicitation of funds from grateful

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<sup>15</sup> *See id.*

<sup>16</sup> *See infra* Part III.

<sup>17</sup> *See* Tovino, *supra* note 2, at 1217-22.

<sup>18</sup> *See* DAN LOWMAN, GRENZEBACH, GLIER & ASSOCS., GRATEFUL PATIENTS: CRITICAL SUCCESS FACTORS FOR NAVIGATING HEALTHCARE'S FASTEST GROWING DONOR SEGMENT 3 (2013) [hereinafter, GGA White Paper], available at <http://www.donorscape.com/assets/files/GratefulPatientPrograms2013.pdf> (providing health care fundraising advice and noting that, "City or ZIP code is a common method for segmenting large files, since, clearly, there are correlations between geographic areas and relative wealth.").

<sup>19</sup> *See, e.g., Grateful Patient Program*, BROADLAWNS MED. CTR., <http://www.broadlawns.org/grateful-patient-program.cfm> (last visited Jan. 6, 2015) ("The Grateful Patient Program provides an opportunity to recognize the care you or a loved one received as a patient of Broadlawns Medical Center."). For an interesting examination of the relationship between perceived health status and patient satisfaction, see Hong Xiao & Janet P. Barber, *The Effect of Perceived Health Status on Patient Satisfaction*, 11 VALUE IN HEALTH 719, 719 (2008), which concluded "that patient satisfaction is influenced by a person's self-perceived health status and other personal characteristics that are external to the delivery of health care."

<sup>20</sup> *See, e.g.,* Lindsey Getz, *In Tight Economic Times, Former Patients Became the Focus of Fundraising*, HOSPS. & HEALTH NETWORKS MAG., Nov. 2008, at 12 ("Since 2003, 40 percent of

patients is frequently referred to as “grateful patient fundraising” or “grateful patient philanthropy.”<sup>21</sup>

After searching its electronic patient database, the hospital identifies the woman described above; that is, the forty-year-old woman who had been diagnosed with stage IV colorectal cancer five years ago, who was given less than a 10% chance of living five years and, who, five years later is healthy and disease free after a rigorous combination of surgery, radiation, and chemotherapy. If the woman’s address is associated with an affluent part of town, or if other demographic indicators or publicly available data reveal actual or probable wealth,<sup>22</sup> the hospital’s major gifts officer may wish to ask the woman’s treating physician to initiate a private conversation with the woman regarding the hospital’s health care philanthropy needs during one of the woman’s follow-up appointments.

Federal health information confidentiality regulations neither prohibit a physician from initiating a private, face-to-face conversation with a patient regarding the hospital’s philanthropy needs, nor from asking the patient for a donation that would benefit the hospital.<sup>23</sup> As a practical matter, no confidentiality concerns are raised because no other person would be present for the conversation. Even though I agree with the federal government that private, face-to-face conversations do not raise confidentiality issues because no other person is present for the conversation, I argue in this Article that significant physician involvement in grateful patient fundraising risks other ethical concerns, including conflicted physician decision making, health care resource allocation injustices, financial exploitation, and breach of privacy. Before addressing these concerns, some

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major gifts that the [University of Kansas Hospital] have received have come from patients or their families.”); *Grateful Patients Build*, THE NONPROFIT TIMES (New Jersey), Sept. 15, 2009, available at <http://www.thenonproffitimes.com/news-articles/grateful-patients-build> (explaining that grateful patients and their families are typically the largest donor base for healthcare philanthropy).

<sup>21</sup> See, e.g., PAGE BULLINGTON, BLACKBAUD, FIRST STEPS FOR SUCCESSFUL GRATEFUL PATIENT FUNDRAISING (Apr. 2011), available at [https://www.blackbaud.com/files/resources/downloads/WhitePaper\\_TargetAnalytics\\_GratefulPatient.pdf](https://www.blackbaud.com/files/resources/downloads/WhitePaper_TargetAnalytics_GratefulPatient.pdf) (“For any healthcare institution, an excellent source of new donors can be grateful patients. Programs that reach out to these individuals can form the cornerstones of successful healthcare fundraising operations.”); Scott M. Wright et al., *Ethical Concerns Related to Grateful Patient Philanthropy: The Physician’s Perspective*, 28 J. GEN. INTERNAL MED. 645, 645 (2013) (“Philanthropy is a vital source of financial support for academic medical centers, and grateful patients may be the single most important source for substantive philanthropic gifts.”); Dan Lowman, Grenzebach Glier & Assocs., *Successful Grateful Patient Fundraising Programs: Practical Steps for Tapping the Fastest Growing Donor Segment in Healthcare 5* (July 1, 2010), available at <http://www.grenzebachglier.com/assets/files/webinars/GG+A%20Webinar%20-%20Successful%20Grateful%20Patient%20Programs%20-%207.1.10.pdf> (explaining why grateful patients give more money than do corporations and foundations).

<sup>22</sup> See Steven Rum & Scott M. Wright, *A Randomized Trial to Evaluate Methodologies for Engaging Academic Physicians in Grateful Patient Fundraising*, 87 ACAD. MED. 55, 57 (2012) (listing wealth indicators—including annual income, real estate assets, direct stock holdings, pension plan value, and investment data estimations—that may be pulled or estimated from publicly available sources for purposes of grateful patient fundraising).

<sup>23</sup> See Tovino, *supra* note 2, at 1173-74.

background information regarding the business of health care philanthropy and the practice of grateful patient fundraising is necessary.

In 2013, the most recent year for which data is available, charitable giving in all industries totaled \$335.17 billion, an increase from the \$316.23 billion spent in 2012.<sup>24</sup> Approximately three-quarters of the 2012 amount—\$228.93 billion—came from individuals; that is, non-corporations and non-foundations.<sup>25</sup> Charitable giving to health organizations, the subject of this Article, totaled \$28.12 billion in 2012.<sup>26</sup> Historically, more than three-quarters of the amount given to health organizations has come from individuals.<sup>27</sup>

Philanthropy has helped found, build, and maintain some of the country's oldest and finest healthcare institutions. New Orleans's historic Charity Hospital "was founded as a result of a creative estate plan of Jean Lois, a French seaman, in 1735."<sup>28</sup> Los Angeles's famous Cedars-Sinai Medical Center "was dedicated, in 1902, through the generosity of the city's Jewish community."<sup>29</sup> San Francisco's French Hospital, California's oldest hospital, was established by a relief society founded for the purpose of serving the sick and furnishing assistance to individuals without resources, among other purposes.<sup>30</sup>

The largest known gift to an American health care institution is the \$400 million gift given in 2007 by businessman Denny Sanford to the Sioux Valley

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<sup>24</sup> LILLY FAM. SCH. OF PHILANTHROPY, GIVING USA 2014: THE ANNUAL REPORT ON PHILANTHROPY FOR THE YEAR 2013, at 7 (2014) [hereinafter ANNUAL REPORT 2013]; *Giving USA: Charitable Donations Grew in 2012, but Slowly, Like the Economy*, LILLY FAM. SCH. OF PHILANTHROPY (June 18, 2013), <http://www.philanthropy.iupui.edu/news/article/giving-usa-2013> [hereinafter LILLY FAM. SCH.]. For previous years' giving totals, see Michael L. Bentz et al., *Fundraising and Philanthropy in Plastic Surgery: An Essential Tool for Academic Excellence*, 127 PLASTIC & RECONSTRUCTIVE SURGERY 2108, 2108 (2011) (reporting that estimated philanthropy in all industries was over \$300 billion in 2009); Joanne Fritz, *Where Do Nonprofits Get Their Revenue? Multiple Streams of Income*, ABOUT.COM, <http://nonprofit.about.com/od/fundraising/a/fundraising101.htm> (last visited Jan. 6, 2015) ("According to Giving USA, total charitable giving in the U.S. reached more than \$298.4 billion in 2011.").

<sup>25</sup> See ANNUAL REPORT 2013., *supra* note 24. For previous years' giving totals by individuals, see, e.g., Fritz, *supra* note 24, which provides data from 2011 and states that, "[o]f that amount 73% came from individuals. The rest of the philanthropic pie is made up of grants from foundations, through bequests, and by way of corporate philanthropy."

<sup>26</sup> See ANNUAL REPORT 2013., *supra* note 24. To see giving numbers reported by other sources and for previous years, see, for example, Bentz et al., *supra* note 24, for a report that educational institutions, including academic medical centers, received approximately 17% of total charitable giving and that health initiatives received 7% of total charitable giving; see also Getz, *supra* note 20 (reporting that the total amount donated to hospitals was \$7.9 billion in 2006 and \$8.3 billion in 2007); Rum & Wright, *supra* note 22, at 55 (reporting that charitable giving to the health care industry, including academic medical centers, health systems, and community hospitals, totaled \$4.8 billion in 2009).

<sup>27</sup> See, e.g., Lowman, *supra* note 21, at 3 (providing data from 2008 and noting that of the 8.6 billion in donations given to health care institutions, 85% of those donations came from individuals; that is, non-foundations and non-corporations).

<sup>28</sup> Edie E. Zusman et al., *Philanthropy Funding for Neurosurgery Research and Program Development*, 73 NEUROSURGERY 177, 177 (2013).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

Hospitals & Health System, located in Sioux Falls, South Dakota.<sup>31</sup> The health system has since been renamed Sanford Health.<sup>32</sup> Other illustrative major gifts to American health care institutions include the \$75 million given by the Schmidt Family Foundation to Boca Raton Community Hospital in Florida,<sup>33</sup> the \$60 million gift given by A.B. Hudson to Shriners Hospital for Children,<sup>34</sup> the \$4 million gift given by Richard M. and Yvonne Hamlin to Summa Health System in Ohio,<sup>35</sup> and the approximately \$100 million given in gifts each year to New York University's Langone Medical Center.<sup>36</sup>

Philanthropic donations support a wide variety of health care initiatives and related educational missions.<sup>37</sup> In the context of academic medical centers, which typically include a medical school and at least one affiliated teaching hospital,<sup>38</sup> philanthropy historically has supported educational efforts,<sup>39</sup> research programs,<sup>40</sup> clinical initiatives, and building or other academic infrastructure support.<sup>41</sup>

In the non-academic health care setting, health care buildings, including whole hospitals as well as wings, departments, wards, units, and centers of hospitals, have

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<sup>31</sup> See Kelby Krabbenhoft, *Philanthropy: A Priceless Lesson in Healthcare Leadership – The Sanford Health Story*, FRONTIERS HEALTH SERVICES MGMT., Summer 2008, at 3 (describing how Denny Sanford's \$400 million gift to support the institution that was named Sanford Health—"the largest known gift to an American healthcare organization"—came about); Susan Kreimer, *Mega Gifts Let Hospitals Rapidly Expand Their Missions*, HOSPS. & HEALTH NETWORKS MAG., Mar. 2007, at 26, 26 (discussing the \$400 million Sanford Health gift); Loren Shook, *Building a Culture of Philanthropy from the Inside Out*, FRONTIERS HEALTH SERVICES MGMT., Summer 2008, at 23, 23 (discussing the \$400 million Sanford Health gift further).

<sup>32</sup> See *About Us*, SANFORD LUVERNE, <http://www.sanfordluverne.org/about> (last visited Jan. 6, 2014) (noting that the Sioux Valley Health System was renamed Sanford Health after Danny Sanford's \$400 million gift).

<sup>33</sup> See Stephanie Strom, *Florida: \$75 Million Donated to Hospital*, N.Y. TIMES, Jan. 31, 2007, at A15 ("The Boca Raton Community Hospital announced that it had received \$75 million from the Schmidt Family Foundation, one of the largest gifts given to a hospital. The money will help underwrite a new academic medical center focusing on hospital safety.").

<sup>34</sup> See Tammy Robbins, *Shriners Hospitals for Children Receives \$60 Million Donation Largest Donation in Organization's History*, LADUE-FRONTENAC PATCH, [http://patch.com/missouri/ladue-frontenac/shriners-hospitals-for-children-receives-60-million-d7e9224de9b#.VCybyq\\_lDWHg](http://patch.com/missouri/ladue-frontenac/shriners-hospitals-for-children-receives-60-million-d7e9224de9b#.VCybyq_lDWHg) (last updated Oct. 16, 2011, 10:52 PM).

<sup>35</sup> See *Summa Health System Receives Largest Philanthropic Gift in Organization's History*, SUMMA HEALTH SYS. (July 23, 2013), <http://www.summahealth.org/pressroom/allnews/2013/summa-health-system-receives-largest-philanthropic-gift-in-organizations-history>.

<sup>36</sup> See *Grateful Patients Build*, *supra* note 19.

<sup>37</sup> See Park A. Haussler, *Philanthropy for Patient Care*, HEALTHCARE FIN. MGMT., Dec. 1982, at 6, 6.

<sup>38</sup> See Joseph V. Simone, *Understanding Academic Medical Centers: Simone's Maxims*, 5 CLINICAL CANCER RES., 2281, 2281 (1999) (describing the educational and patient care components of an academic medical center).

<sup>39</sup> See Bentz et al., *supra* note 24, at 2111 ("[E]ducational expenses include hard copy and computer based learning materials, resident travel for presentation of papers and teaching course attendance, visiting professors, named lectureships, as well as international surgery mission efforts," among others.).

<sup>40</sup> See *id.* (explaining that research programs include basic science, translational, and clinical research programs).

<sup>41</sup> See *id.* (explaining that building and infrastructure support includes the development or improvement of buildings or areas within buildings, the purchase or donation of pieces of equipment, chairs, professorships, and/or program directorships).

been the traditional beneficiaries of philanthropic efforts.<sup>42</sup> Historically, giving also has been used to fund the acquisition and maintenance of expensive medical equipment, including x-ray machines, computed tomography scanners, magnetic resonance imaging scanners, and positron emission tomography scanners.<sup>43</sup> Several decades ago, when third-party payers reimbursed health care primarily on a retrospective cost basis,<sup>44</sup> donations designed to cover daily operating costs, such as the cost of a patient's daily hospital bed charge, were discouraged because such donations (*i.e.*, viewed by accountants and auditors as reductions in costs) were required to be reported to third-party payers and subtracted from the reimbursement requested by the health care provider.<sup>45</sup> In the 1980s and 1990s, as third-party payers moved towards prospective payment systems,<sup>46</sup> the health care industry began to change its approach to philanthropy, including by encouraging donations that could be put towards daily operating expenses.<sup>47</sup>

Today, health care institutions engage in fundraising to support an even wider variety of health care initiatives and related educational missions. Academic medical centers continue to engage in fundraising to satisfy educational needs,

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<sup>42</sup> See Haussler, *supra* note 37, at 6 (“Bricks and mortar . . . have been the primary beneficiaries of charitable giving.”).

<sup>43</sup> See Les Cave et al., *Philanthropy Makes a Difference: CHRISTUS Health Reaps the Benefits of Its Successful Community Efforts in Southern Texas*, HEALTH PROGRESS, Jan.-Feb. 2008, at 44, 44 (“Many philanthropists are attracted to the idea of making contributions to build new buildings and acquire high technology like CAT Scans, MRIs and Cath labs, especially if this ‘health care’ comes complete with naming rights.”); Haussler, *supra* note 37, at 6 (“[E]quipment and other capital acquisitions have been the primary beneficiaries of charitable giving.”).

<sup>44</sup> See, *e.g.*, LOUIS C. GAPENSKI, FUNDAMENTALS OF HEALTHCARE FINANCE 70 (Rod McAdams et al. eds., 2009) (explaining that cost-based reimbursement involves a third-party payer who agrees to reimburse the health care provider for the actual costs incurred in providing health care to the insured population. Cost-based reimbursement is retrospective in the sense that reimbursement is based on the actual services that were delivered to the patient in the past).

<sup>45</sup> See Haussler, *supra* note 37, at 6 (“Since the beginning of cost-based reimbursement, the industry has discouraged the endowment of free beds, or the underwriting of operation costs. In our efforts to ‘maximize’ reimbursement, we have noted that any reduction of cost shares the gifts with third-party payors, and we have concluded in most cases that it is not the intention or desire of the donor to have such sharing.”).

<sup>46</sup> See GAPENSKI, *supra* note 44, at 70 (explaining that a prospective payment system may be defined as a payment system in which “the rates paid by [third-party] payers are determined by the payer before [health care] services are provided,” and in which “payments are not directly related to a [health care provider’s] costs or charges”).

<sup>47</sup> See Cave et al., *supra* note 43, at 44 (“And, of course, with the reimbursement challenges hospitals and acute care face today, it often is essential to raise money through philanthropy to supplement the limited insurance and patient payments received.”); Haussler, *supra* note 37, at 6 (“Now is the time for the healthcare industry to consider a change in approach to philanthropy. Two reasons point to this conclusion: [c]ost-based reimbursement will be soon a relic of the past and, [t]here are unmet patient and institutional financial needs. As the healthcare industry moves into the competitive marketplace, reasonable provision for capital expansion, education and operations must be built into the charge structure. . . . Funding from gifts and bequests for payment of specific patient charges can be a means through which an institution may reduce uncollectible accounts, thereby strengthening its bottom line.”).

research programs, clinical initiatives, and building and infrastructure support.<sup>48</sup> Nonprofit health care organizations engage in fundraising to provide resources to their community-based hospitals and clinics and to improve access to health care and other services for the uninsured and under-insured.<sup>49</sup> Many private health care foundations use philanthropy to serve the economically poor and under-served, including women, children, and seniors who live in the community served by the foundation.<sup>50</sup> Health care philanthropy is also used to improve the public's health through prevention and wellness programs, and through the offering of basic health care and disease management for individuals without health insurance.<sup>51</sup> Health care philanthropy is used to support a wide range of medical specialties and patient care needs, including neurosurgery,<sup>52</sup> obstetrics and gynecology,<sup>53</sup> plastic surgery,<sup>54</sup> psychiatry,<sup>55</sup> and rare diseases,<sup>56</sup> among many others. In short, health care

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<sup>48</sup> See Bentz et al., *supra* note 24, at 2111; see also Rum & Wright, *supra* note 22, at 55 (“At academic health centers and hospitals, these monies help to fund varied needs including capital projects, research programs, educational initiatives, financial aid and endowments. These gifts clearly support the tripartite academic health center mission of patient care, research, and education.”); Wright et al., *supra* note 21, at 645 (“Philanthropic contributions to academic medical centers from grateful patients support research, patient care, education, and capital projects.”).

<sup>49</sup> See, e.g., Cave et al., *supra* note 43, at 44 (“[T]he [CHRISTUS] fund’s intent is to provide resources to community-based, not-for-profit organizations whose vision, mission and goals are consistent with those of CHRISTUS Health. Creating access to health care and other services for the uninsured and under-insured in communities served by CHRISTUS Health gives specificity to the grants awarded.”).

<sup>50</sup> See, e.g., *id.* at 47 (noting that the St. Joseph’s Community Foundation located in Paris, Texas, “focuses on programs that serve the economically poor and under-served, women and children and seniors . . . .” and has awarded more than \$320,000 in grants and scholarships since its inception, including \$7,500 to Court Appointed Special Advocates, \$27,224 to a diabetic research collaboration with Texas A&M Health Science Center and Paris Eye Physicians and Surgeons, and \$7,000 to local nursing departments to provide additional training and certification in critical needs areas).

<sup>51</sup> See *id.* at 45 (“[The intent of philanthropy can be] to improve the public’s health through prevention and wellness programs or . . . to offer primary care and disease management for uninsured.”).

<sup>52</sup> See Zusman et al., *supra* note 28, at 177 (“In times of fiscal and political uncertainty, philanthropy has become an increasingly important mechanism for building, maintaining, and expanding neurosurgical research programs . . . . Philanthropy can provide salary support to allow neurosurgeons to pursue research and, ultimately, advance the field to improve outcomes for patients. Funds raised can fill financial gaps to recruit and pay for needed research staff, equipment, and facilities.”).

<sup>53</sup> See Frank A. Chervenak et al., *Ethics: an Essential Dimension of Soliciting Philanthropic Gifts from Donors*, 203 AM. J. OBSTETRICS & GYNECOLOGY 540e.1, 540e.1 (2010) (“Obstetrics and gynecology continues to experience fiscal pressures that challenge its core missions. In such an increasingly economically unforgiving environment, philanthropy will become a major source of revenue.”).

<sup>54</sup> See, e.g., Bentz et al., *supra* note 24, at 2108 (addressing the need for fundraising in the context of academic plastic surgery).

<sup>55</sup> See Herbert Pardes & Constance E. Lieber, *Philanthropy for Psychiatry*, 163 AM. J. PSYCHIATRY 766, 766 (2006) (stating that “[w]ith reduced public funding and limited foundation support, patient-inspired philanthropy serves as an invaluable alternative to cover much of the deserted areas of social need,” including academic psychiatry); see also *id.* at 766-67 (“[P]hilanthropy should not be an area in which mental illness is given short shrift by provider and fund-raising organizations.”).

<sup>56</sup> See, e.g., Elie Dolgin, *Advocates to Bring Rare Disease Philanthropy Under One Umbrella*, 16 NATURE MED. 837, 837 (2010) (noting that “the R.A.R.E. Project, an initiative launched in 2008 to

philanthropy now supports a variety of medical specialties and health care needs in a broad range of communities and settings and has moved well beyond its historic purpose of providing financial support of hospital “bricks and mortar.”<sup>57</sup>

Philanthropy is said to be one of the only ways that some health care institutions can survive in the current health care environment, which requires expensive medical equipment and suffers from inadequate Medicare and Medicaid reimbursement, high uncompensated health care costs, and rising health care compliance costs associated with health care reform.<sup>58</sup> In addition, philanthropy is said to be one of the most vital and important sources of revenue and financial support for health care institutions because it is frequently unrestricted and can be used in any area of high organizational or institutional need.<sup>59</sup>

Today, health care philanthropy is a big business, one that is supported by attorneys,<sup>60</sup> consultants,<sup>61</sup> data connection organizations,<sup>62</sup> and professional

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raise awareness and accelerate the development of therapies for rare diseases,” launched “a website called the Global Genes Fund, intended as a clearinghouse for rare disease philanthropy”).

<sup>57</sup> See, e.g., Cave et al., *supra* note 43, at 47.

<sup>58</sup> See, e.g., *With Health-Care Reforms, Hospitals Need Philanthropy More*, FUND RAISING MGMT., Dec. 1993, at 47, 47 (stating that philanthropy is necessary due to the financial pressures brought about by health care reform); *Frequently Asked Questions*, HUNTINGTON HOSP., <http://www.huntingtonhospital.com/Main/GivingFAQ.aspx> (last visited Jan. 6, 2015) (“Philanthropy is a vital source of funding for our mission of excellence in patient care, research and education. While Huntington Hospital has a number of income sources, including insurance reimbursements and investment income, the hospital is heavily dependent on private support from this community to maintain our level of excellence.”)

<sup>59</sup> Rosalyn Stewart et al., *Success in Grateful Patient Philanthropy: Insights from Experienced Physicians*, 124 AM. J. MED. 1180, 1184 (2011) (“Patient philanthropy can be especially transformative because it is often unrestricted, thereby allowing for new and creative ventures.”); Wright et al., *supra* note 21, at 649 (“Grateful patient philanthropy is an essential part of keeping academic medical centers (AMC) moving forward. This generosity is undoubtedly one of the most vital sources of financial support for academic medical centers because it is often unrestricted, and can allow for innovation in areas of high institutional need.”); see also George F. Maynard III, *Philanthropy Is Not Asking for a Favor, It Is Giving a Favor*, FRONTIERS HEALTH SERVICES MGMT., Summer 2008, at 31, 32 (noting that Moody’s Investor Services believes a strong fundraising program is an important consideration in their credit assessment and can positively impact bond ratings); Zusman et al., *supra* note 28, at 178 (“For years, some neurosurgeons have eschewed philanthropy, but the profession must now view it as an important source of revenue.”).

<sup>60</sup> Davis Wright Tremaine, a law firm with a substantial health care practice, recently issued an advisory designed to help its clients take advantage of the Final Regulations’ “good news” regarding fundraising. See Adam H. Greene & Kristen R. Blanchette, *Time to Take Advantage of HIPAA Omnibus Rule’s “Good News”: Fundraising, Research, and Student Immunization Records*, DAVIS WRIGHT TREMAINE LLP (April 2, 2013), <http://www.dwt.com/Time-to-Take-Advantage-of-HIPAA-Omnibus-Rules-Good-News-Fundraising-Research-and-Student-Immunization-Records-04-02-2013> (“The Omnibus Rule now also permits the use of department of service, treating physician, outcome information, and health insurance status. This means that a covered entity seeking to raise funds for a specific program can target its fundraising campaign to patients who have experienced positive outcomes and have conditions related to the program, and that the covered entity can avoid sending communications to individuals whose insurance status makes them unlikely to contribute.”); Mary Mosquera & Tom Sullivan, *HIPAA Final Rule Brings Changes to Marketing, Fundraising*, HEALTHCARE FIN. NEWS, Mar. 2013, at 25 (reporting that Bob Belfort, a partner at Manatt, Phelps & Phillips, explains that many of his hospital clients have an interest in targeting fundraising

associations.<sup>63</sup> Services offered by health care philanthropy experts include grateful patient fundraising seminars,<sup>64</sup> webinars,<sup>65</sup> and workshops,<sup>66</sup> as well as blog posts addressing best practices in hospital fundraising generally, and grateful patient fundraising in particular.<sup>67</sup> The Association for Healthcare Philanthropy (“AHP”) is a major international professional organization dedicated exclusively to assisting charitable efforts in health care organizations.<sup>68</sup> AHP provides education and information to chief development officers, major gift officers, annual campaign managers, event coordinators, grant writers, and other development personnel in all sectors of the health care industry, including health care systems, academic medical centers, general acute care hospitals, specialty hospitals, long-term care facilities, hospices, institutionally-related foundations, and advocacy groups, among others.<sup>69</sup> “AHP’s 5000 members represent more than 2200 health care facilities in the United States and Canada.”<sup>70</sup>

Understandably, AHP is very much in favor of the Department of Health and Human Services’ current approach to fundraising. Following the January 25, 2013,

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communications based on the nature of the health care services received by the patient and the identity of the patient’s physician. Many of Belfort’s hospital clients also have physicians on their medical staffs make personal appeals to the patients. Belfort admits that “I don’t know whether patients will have a negative reaction to getting solicitations that indicate fundraisers have looked at their data in more detail.”)

<sup>61</sup> See, e.g., *Healthcare*, GRENZEBACH, GLIER & ASSOCS., <http://www.grenzebachglier.com/healthcare.html> (last visited Jan. 6, 2015) (marketing themselves as “consultants in philanthropic management” and listing dozens of health care industry clients including academic medical centers, hospitals, research institutes, and hospices, among others); *Foster Physician Engagement*, THIRD SECTOR STRATEGY, <http://www.thirdsectorstrategy.com/physicians.html> (last visited Jan. 6, 2015) (advertising that Third Sector Strategy fosters physician participation in healthcare philanthropy).

<sup>62</sup> See, e.g., *Healthcare*, HARRIS CONNECT, <http://www.harrisconnect.com/marketserved/markets-served-health-care> (last visited Jan. 6, 2015) (marketing itself as the leader in grateful patient fundraising).

<sup>63</sup> See, e.g., *About Us*, ASS’N FOR HEALTHCARE PHILANTHROPY, [http://www.ahp.org/Home/About\\_Us/Home/About\\_Us/About.aspx?hkey=5ed66e69-b202-401f-8aa1-3dfa14bdb488](http://www.ahp.org/Home/About_Us/Home/About_Us/About.aspx?hkey=5ed66e69-b202-401f-8aa1-3dfa14bdb488) (last visited Jan. 6, 2015) (advertising that “AHP is the source for standards, knowledge, and leadership” in health care philanthropy).

<sup>64</sup> See, e.g., *Segmenting for Success: What Nonprofits can Learn from the Donor Analytics of Presidential Campaigns*, SHARETRAINING, <http://www.sharetraining.com/seminar-schedules/share-training-replay/segments-are-dead-using-analytics-to-have-conversations-with-each-of-your-constituents> (last visited Jan. 6, 2015).

<sup>65</sup> See, e.g., *Grateful Patient Fundraising Webinar*, HARRIS CONNECT, <http://www.harrisconnect.com/patientfundraising> (last visited Jan. 6, 2015).

<sup>66</sup> See, e.g., *Training and Keynotes*, ACCORDANT PHILANTHROPY, <http://www.accordantphilanthropy.com/training-and-keynotes/> (last visited Jan. 6, 2015).

<sup>67</sup> See, e.g., Tom Wilson, *Best Practices in Grateful Patient Fundraising*, MAJORGIFTSGURU, <http://majorgiftsguru.com/2009/05/best-practices-in-grateful-patient.html> (last visited Jan. 6, 2015).

<sup>68</sup> ASS’N FOR HEALTHCARE PHILANTHROPY, *supra* note 63.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* The AHP is not the only professional association devoted to supporting health care philanthropy. Regional and state health care philanthropy associations also exist. See, e.g., NEW ENG. ASS’N FOR HEALTHCARE PHILANTHROPY, <http://www.neahp.org> (last visited Jan. 6, 2015); OHIO ASS’N FOR HEALTHCARE PHILANTHROPY, <http://www.ohioahp.us> (last visited Jan. 6, 2015).

release of the Final Regulations, the President and Chief Executive Officer of AHP stated:

the most positive element in the [Final Regulations] is that health care providers and their institutionally-related foundations can obtain and use department of service information in order to focus appeals, communications and outreach to those donors and prospects most likely to be interested in supporting the specific program related to that area of treatment. Reinstating this provision among the professionals in health care will assist in efficiency and growth for health care philanthropy, which better serves communities.<sup>71</sup>

Experts in health care philanthropy, including AHP, strongly recommend physician involvement in grateful patient fundraising. Indeed, grateful patients are said to be the most important source of financial donations to the health care industry.<sup>72</sup> A grateful patient may be defined as a patient or a family member of a patient who is, or may be, grateful for the health care received by the patient and from whom an individual or institutional health care provider would like to solicit funds.<sup>73</sup> The simple theory behind grateful patient fundraising is that patients who are grateful for the health care they have received may be more willing to make philanthropic contributions than less satisfied patients or individuals who have no relationship with the soliciting health care institution.<sup>74</sup> Annette Bloch, wife of H&R Block co-owner Richard Bloch, is a nice example of a grateful patient. The Blochs donated \$20 million to a hospital affiliated with the University of Kansas after Annette received successful treatment for her breast cancer there.<sup>75</sup>

Grateful patient fundraising can be conducted at two different points in time: (1) when the patient is in the hospital or other health care institution as an

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<sup>71</sup> See *Modified HIPAA Privacy Rule Expands Access for Health Care Fundraisers*, ASS'N FOR HEALTHCARE PHILANTHROPY (Jan. 25, 2013), available at <https://web.archive.org/web/20130407034238/http://www.ahp.org/Advocacy/us/hipaa/analysis/Pages/Modifications.aspx> (accessed by searching for original URL in the Internet Archive index).

<sup>72</sup> See, e.g., Anthony N. DeMaria, *Philanthropy and Medicine*, 48 J. AM. C. CARDIOLOGY 1725, 1725 (2006), available at <http://content.onlinejacc.org/data/Journals/JAC/23074/08020.pdf> (“Perhaps the greatest source of philanthropy is the grateful patient.”); Rum & Wright, *supra* note 22, at 55 (“In 2009, gifts from individuals to academic health centers, health systems, and community hospitals in the United States totaled \$4.8 billion. A substantial proportion of this total—nearly \$1 billion—came from grateful patients.” (footnotes omitted)); Stewart et al., *supra* note 59, at 1180 (“Support from grateful patients is the single most important source for substantive philanthropic gifts in medicine.”).

<sup>73</sup> See Bentz et al., *supra* note 24, at 2109.

<sup>74</sup> See GGA White Paper, *supra* note 18, at 4 (“Anecdotal evidence indicates that positive patient experiences lead to increased giving. While much study remains to be done on the exact interaction between patient satisfaction, medical outcomes, and donor behavior, medical environments appear to support better philanthropic outcomes.”); *Grateful Patient Program*, CLARK MEMORIAL HOSP., <http://www.clarkmemorial.org/patient-services/grateful-patient-program> (last visited Jan. 6, 2015) (“We’re often asked by patients who have such an experience if there’s a way they can express their gratitude and appreciation for the care they or a family member received. That’s why we started the Grateful Patients & Family Program. . . . Through our Grateful Patient & Family Program, you can express your appreciation for the special care you or your loved ones received through a special donation to the Clark Memorial Hospital Foundation.”).

<sup>75</sup> Getz, *supra* note 20, at 12 (describing the donation made by the R.A. Bloch Cancer Foundation to the University of Kansas Hospital).

inpatient or outpatient, or (2) after the patient has been discharged or has returned home.<sup>76</sup> During the first time period, solicitations may be made in person during a private conversation between an institutional representative or the physician and the patient.<sup>77</sup> During the second time period, solicitations may be mailed, e-mailed, telephoned, or conducted in person during a meeting.<sup>78</sup>

According to health care philanthropy experts, timing is everything. Soliciting funds from a patient who is sick and lying in a hospital bed or from a patient who has been waiting to see a physician for several hours is likely to be unsuccessful.<sup>79</sup> Patient frustration also has been reported with solicitations that are made very shortly after health care services are rendered, including in one case where a patient received a philanthropic solicitation two weeks after making a single visit to a hospital for a mere physician consultation.<sup>80</sup> Fundraising experts further advise against scheduling philanthropic communications to arrive at the same time as hospital and other health care bills are to be received by the patient.<sup>81</sup> A majority of first-time patient gifts are made within a year and a half of an inpatient stay; thus, waiting years after the patient has been discharged home and all hospital bills have been paid is not recommended either.<sup>82</sup>

Patient selection is key to successful grateful patient fundraising. Patients who are grateful for the health care they have received and who have the financial means to donate are the best candidates.<sup>83</sup> Patients with low income and resources, no matter how grateful, likely will not donate or will not make donations that are significant from the standpoint of the hospital.<sup>84</sup> For these reasons, many hospitals conduct “wealth screenings” of their patients, including patients who are still in the hospital.<sup>85</sup> “Screening in this manner allows development officers to target visits to

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<sup>76</sup> See Bullington, *supra* note 21, at 3 (explaining that organizations can conduct daily patient visits and/or send fundraising communications through the mail after patient discharge).

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> See Lowman, *supra* note 21, at 10 (“Bad idea: Ask for a gift while a person is lying in a hospital bed, has been sitting in your waiting area for 2 hours, etc.”).

<sup>80</sup> See DeMaria, *supra* note 72, at 1725 (“[T]he concept that seeking medical care may automatically trigger a request for a donation does seem to straddle the fine line between appropriate and unseemly.”).

<sup>81</sup> See Bullington, *supra* note 21, at 5 (“Messaging and length of time between discharge and solicitation should be tested. You do not want your grateful patients to receive their solicitation letters the same day they receive their bills. Working with the billing department can help alleviate overlap in this area.”).

<sup>82</sup> See Lowman, *supra* note 21, at 10 (“But time is limited—the vast majority of first-time patient gifts come within 18 months of an in-patient visit[.]”).

<sup>83</sup> See *supra* text accompanying notes 18–21.

<sup>84</sup> See GGA White Paper, *supra* note 18, at 3 (“Insurance status can permit distinctions between self-payers and privately insured patients, versus patients who may qualify for Medicaid or are unable to pay for services.”); Bullington, *supra* note 21, at 2 (“Avoid reviewing patients who are Medicaid eligible or are receiving the equivalent in state funded health benefits.”).

<sup>85</sup> See, e.g., Bullington, *supra* note 21, at 3 (“Another vital component of successful grateful patient programs is having the ability to screen potential donors for wealth. This type of screening can be done in a variety of ways. One of the most effective is to conduct daily screenings based on the patient census. Often, this type of screening will provide an estimated wealth figure that corresponds to a wealth ranking. The idea is that the summary screening can be done very quickly on a specific set of data

the highest capacity patients while they are in care. . . . Individuals that do not rate as high on initial wealth screenings can then be approached via direct mail.”<sup>86</sup> Patients can be screened internally by the hospital for wealth based on zip code, which may reveal an affluent neighborhood or part of town, as well as other affluence indicators.<sup>87</sup> Hospitals can also contract with data connection companies to search publicly and commercially available data for purposes of estimating the wealth of current inpatients and recent discharges.<sup>88</sup>

Although wealth screenings may sound distasteful, the most controversial issue in grateful patient fundraising relates to the identity of the persons who are directly involved in soliciting funds from patients. That is, who should initiate a conversation with the patient regarding the health care organization’s philanthropic needs? And, who should make “the ask,”<sup>89</sup> that is, the actual philanthropic request? Although many hospitals have development officers,<sup>90</sup> major gifts officers,<sup>91</sup> philanthropy officers,<sup>92</sup> institutionally-related foundation staff members,<sup>93</sup> and contracted professional fundraisers,<sup>94</sup> who are trained and experienced in health

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sources and returned by a vendor within a short time frame – often before the patient leaves the facility.”); Lowman, *supra* note 21, at 7–9 (identifying “wealth screening” as a key characteristic of a successful grateful patient fundraising).

<sup>86</sup> Bullington, *supra* note 21, at 3; *see also* Wilson, *supra* note 67 (recommending wealth screening of patients).

<sup>87</sup> *See* Lowman, *supra* note 21, at 9 (listing different types of wealth indicators).

<sup>88</sup> *See, e.g.*, GGA White Paper, *supra* note 18, at 4 (“A wide variety of segmentation data is commercially available, and can be added to most records that have a valid address. This data includes estimates of household income, home value, net worth, investable assets, presence of children and many other factors. Some of this information is available at the household level, while other information is based on averages from slightly larger geographies, such as those provided by ZIP+4, which extends the five digit ZIP code out to nine, and includes about five households. The 2013 regulations permit all of these data to be shared with screening companies and direct mail firms, among other business associates. In addition to the above data sources, more detailed wealth screening products are in wide use across healthcare fundraising organizations. Wealth screening provides data from a range of sources and compiles information about employment, real estate, charitable giving, board affiliation, and ownership of certain assets. This information can be appended to records on a periodic basis of your choosing. Some data providers offer daily or even hourly screening of records.”).

<sup>89</sup> *See generally* LAURA FREDRICKS, THE ASK: HOW TO ASK FOR SUPPORT FOR YOUR NONPROFIT CAUSE, CREATIVE PROJECT, OR BUSINESS VENTURE (2010) (providing suggestions, guidelines, and advice relating to asks for gifts).

<sup>90</sup> *See, e.g.*, *Meet Our Team*, U. HOSPS., <http://www.uhgiving.org/uh-giving/about-us/meet-our-team> (last visited Jan. 6, 2015) (listing University Hospitals’ senior leadership, including its development officers).

<sup>91</sup> *See, e.g.*, *Contact Us*, CHILD. HOSP. OF PITTSBURGH FOUND., <https://www.givetochildrens.org/about-us/contact-us> (last visited Jan. 6, 2015) (listing the Children’s Hospital of Pittsburgh’s six-person major gifts staff).

<sup>92</sup> *See, e.g.*, *Leadership and Staff*, SCOTT & WHITE HEALTHCARE FOUND., <http://foundation.sw.org/about/staff> (last visited Jan. 6, 2015) (listing Scott & White Healthcare Foundation’s current Vice Presidents for Philanthropy as well as other Healthcare Foundation staff).

<sup>93</sup> *See, e.g.*, *Contact Us*, STAMFORD HOSP. FOUND., <http://www.stamfordhospitalfoundation.org/page.aspx?pid=289> (last visited Jan. 6, 2015) (listing the staff members of the Stamford Hospital Foundation).

<sup>94</sup> *See, e.g.*, PROFUND NORTHWEST, <https://web.archive.org/20130622201338/http://www.profun>

care philanthropy, most experts believe that successful grateful patient fundraising requires significant involvement from the grateful patient's treating physician.<sup>95</sup> According to fundraising experts, the involvement of physicians is key "because patients trust them, respect them and are grateful to them."<sup>96</sup> At NYU's Langone Medical Center, for example, physicians "are . . . encouraged to bring up philanthropic donations with patients."<sup>97</sup> Indeed, Langone prefers its physicians to initiate conversations with patients compared to a "cold call coming in from the development office."<sup>98</sup> Likewise, Children's Hospital Los Angeles raised more than \$1 billion since January 1, 2000, when a major campaign was launched to continue the transformation from a great children's community hospital to an international leader in pediatrics.<sup>99</sup> According to AHP, the campaign goal would not have been achieved without the key involvement and support of physicians.<sup>100</sup> The Kettering Cardiovascular Institute at Kettering Medical Center in Ohio ("Kettering") also relies on significant physician involvement in grateful patient fundraising. According to AHP, Kettering uses "an approach with physicians that combine[s] intense emotional communications . . . targeted marketing communications and quality improvement team facilitation techniques. All of which generate[] a successful return."<sup>101</sup>

According to Third Sector Strategy, a consulting firm that specializes in health care philanthropy,

Physicians have an unparalleled opportunity to engage grateful patients in the life of the organization and to advance a variety of other high-value, high-impact roles to support vibrant giving. Physicians are well positioned to share the clinical rationale around programs, to explain the human impact of projects, to advocate for improving the caliber of medicine in their area of expertise and to thank donors for their gifts.<sup>102</sup>

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dnorthwest.com (last visited Jan. 6, 2015) (accessed by searching for profundnorthwest.com in the Internet Archive index) (describing themselves as financial development consultants who help "worthwhile causes, not-for-profits, and 501(c)(3) organizations meet their fundraising goals").

<sup>95</sup> See, e.g., DeMaria, *supra* note 72, at 1725 ("[P]hysicians play a major, and often the primary, role in generating philanthropy."); Wright et al., *supra* note 21, at 645 ("A strong physician-patient relationship is believed to be an essential element in facilitating philanthropic gifts from grateful patients to an academic medical institution.").

<sup>96</sup> *Grateful Patients Build*, *supra* note 20.

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Living Proof: The Campaign for Children's Hospitals*, MAKING A WORLD OF DIFFERENCE (Children's Hosp. of L.A.), Sept. 2011, at 1-2, 7, available at [http://www.chla.org/attf/cf/%7B1cb444df-77c3-4d94-82fa-e366d7d6ce04%7D/sept\\_2011\\_chla\\_campaignnewsletter.pdf](http://www.chla.org/attf/cf/%7B1cb444df-77c3-4d94-82fa-e366d7d6ce04%7D/sept_2011_chla_campaignnewsletter.pdf).

<sup>100</sup> *Resource Center Results: Constituent Giving*, ASS'N FOR HEALTHCARE PHILANTHROPY, <http://archive-org.com/page/494159/2012-10-21/http://www.ahp.org/Resource/Pages/TaxonomyRollup.aspx?tid=16> (as archived on Oct. 21, 2012) (accessed by searching for the URL in the Internet Archive index).

<sup>101</sup> *Id.*

<sup>102</sup> *Foster Physician Engagement*, *supra* note 61.

It goes without saying that Third Sector Strategy is excited about the Final Regulations:

New HIPAA privacy rules that became effective March 2013 demand an overhaul of your grateful patient programs. Access to clinical service area and treating physician name means you can now be more strategic and data-driven in your communications, donor acquisition and physician engagement efforts. The repercussions are huge in allowing more meaningful, interest-driven, donor-centric approaches. . . . With new rules, it's time for a new grateful patient game plan.<sup>103</sup>

Physician involvement in grateful patient fundraising runs the gamut from: (1) physicians who simply sign and mail letters that are drafted by development officers requesting donations; to (2) physicians who initiate private but general conversations with patients regarding the hospital's philanthropy needs; to (3) physicians who directly ask patients for donations.<sup>104</sup> Indeed, some physicians knowingly use their positions of power and influence to aggressively persuade patients to donate money.<sup>105</sup> Reportedly, one well-known surgeon in a large city would walk into a hospital room and say, "Mrs [sic] Smith, I saved your life yesterday, and you're gonna give a lot of money to build that new building at the [name of hospital]."<sup>106</sup>

As discussed in more detail below, some physicians view grateful patient fundraising as a positive opportunity to raise money from current patients to help future patients.<sup>107</sup> On the other hand, both the peer-reviewed medical and pro-philanthropic literature contain reports by some physicians regarding their discomfort with grateful patient fundraising.<sup>108</sup> Indeed, some physicians respond to development office requests for involvement in grateful patient fundraising by stating, "This is not why I went to medical school," and, "I thought we had a development department to ask people for money."<sup>109</sup>

Notwithstanding some physicians' discomfort with grateful patient fundraising, health care institutions continue to encourage physician participation.<sup>110</sup> Indeed,

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<sup>103</sup> *Grateful Patient Programs*, THIRD SECTOR STRATEGY, <http://www.thirdsectorstrategy.com/grateful-patient-programs.html> (last visited Jan. 6, 2015).

<sup>104</sup> See Chervenak et al., *supra* note 53, at 540e.4 (describing different levels of physician involvement in grateful patient fundraising); *Grateful Patients Build*, *supra* note 20 (describing the range of physician involvement in grateful patient fundraising).

<sup>105</sup> Chervenak et al., *supra* note 53, at 540e.4.

<sup>106</sup> *Id.*

<sup>107</sup> See *infra* text accompanying notes 196–200.

<sup>108</sup> Rum & Wright, *supra* note 22, at 55 ("Some physicians feel uncomfortable discussing philanthropy with their patients; others are concerned about the ethical considerations that arise when the doctor–patient relationship evolves from one of unidirectional giving to a more bidirectional exchange.").

<sup>109</sup> GGA White Paper, *supra* note 18, at 5.

<sup>110</sup> See, e.g., Mary Chris Jaklevic, *Another Battle: HIPAA Threatens Doc Referrals in Soliciting Donations*, MODERN HEALTHCARE, May 6, 2002, at 14, 14–15 (noting that the California Pacific Medical Center in San Francisco aggressively recruits physician participation and depends on its physicians to feed names to the hospital for follow-up).

investigators at the Johns Hopkins University School of Medicine conducted a randomized trial designed to test whether individual coaching of physicians by development professionals could increase physician participation in grateful patient fundraising more than other, less interactive, educational methods.<sup>111</sup> The study authors measured the effectiveness of three educational interventions in terms of engaging academic physicians in grateful patient fundraising.<sup>112</sup> Effectiveness was measured first “by determining the number of ‘qualified referrals’ whose names participants submitted to the development team during the three months of and three months following the intervention,” and also by considering the amount of money received from such referrals.<sup>113</sup> Fifty-one physicians participated in three educational arms including an e-mail arm (fourteen physicians), a lecture arm (eighteen physicians), and a coaching arm (nineteen physicians).<sup>114</sup>

The fourteen physicians who participated in the email arm received weekly e-mail messages for eleven weeks that included “clippings highlighting large philanthropic donations to public and private institutions, general information about philanthropy in the United States, and articles specifically about philanthropy in medicine.”<sup>115</sup>

The eighteen physicians in the lecture arm participated in one of three one-hour-long sessions taught by three different physicians, “each of whom had a long history of successful fundraising at Johns Hopkins.”<sup>116</sup> Although the lectures varied somewhat by physician, all three physician speakers conveyed core fundamentals of successful fundraising including providing outstanding patient care, cultivating close physician-patient relationships, listening carefully for cues that would suggest philanthropic interest, considering answers that patients might have about ongoing initiatives and philanthropic needs in advance of discussion, and ethical considerations that emerge when interacting with grateful patients.<sup>117</sup>

Finally, the nineteen physicians who were in the coaching cohort “received one-on-one training through which development professionals . . . worked with them to prepare them for collaboration in grateful patient fundraising.”<sup>118</sup> The professionals possessed more than seventy combined years of experience in fundraising and covered a very detailed curriculum including, but not limited to, factors that motivate people to give, barriers to fundraising, strategies for overcoming obstacles, and action plans.<sup>119</sup>

The study authors’ working hypothesis was that the “one-on-one coaching relationship between a development professional and a physician would yield more

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<sup>111</sup> See Rum & Wright, *supra* note 22, at 55.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.* at 55–56.

<sup>114</sup> *Id.* at 57.

<sup>115</sup> *Id.* at 56.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

qualified referrals than would [the other two methods].”<sup>120</sup> The study results confirmed the authors’ hypothesis.<sup>121</sup> The authors reported that the

[p]hysicians in the coaching arm generated 63 referrals of grateful patients who were will still living . . . These referrals occurred across the duration of the study. Development staff deemed 41 of these (65%) to be qualified referrals . . . Of the 19 coached physicians, 17 (89%) referred at least one qualified potential donor. In comparison, the physicians in the lecture arm generated only three qualified referrals . . . and the physicians in the e-mail arm did not generate any qualified referrals.<sup>122</sup>

The study authors concluded that physicians in the coaching arm made significantly more qualified referrals than physicians in the other two arms.<sup>123</sup> In terms of gifts received, five separate gifts totaling \$219,550 were secured from grateful patients whom physicians in the coaching arm referred.<sup>124</sup> No gifts were secured from the referrals made by physicians in the lecture arm or the e-mail arm.<sup>125</sup>

The study authors formally concluded that “deploying development professionals to act as one-on-one coaches for physicians will result in behavioral changes among [physicians] with respect to grateful patient fundraising.”<sup>126</sup> The study authors further stated that health care institutions that wish to increase grateful patient fundraising may wish to encourage similar partnerships between physicians and development professionals.<sup>127</sup>

In the discussion portion of their published study results, the authors stressed the need for physician involvement in fundraising, especially in light of the worldwide recession and declining third-party reimbursement.<sup>128</sup> The study authors also noted that physician involvement in fundraising can raise ethical concerns, including the need to protect confidentiality and preserve the physician-patient relationship.<sup>129</sup> These ethical concerns are examined in detail below.

## II. THE ETHICS OF GRATEFUL PATIENT FUNDRAISING

The ethical issues raised by grateful patient fundraising are complex<sup>130</sup> and can be subdivided into specific issues relating to conflicted decision making and distortion of the physician-patient relationship, justice concerns, financial

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<sup>120</sup> *Id.* at 58.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> *Id.* at 59.

<sup>127</sup> *Id.*

<sup>128</sup> *See id.* at 57.

<sup>129</sup> *Id.*

<sup>130</sup> *See* Pardes & Lieber, *supra* note 55, at 766 (“[T]he analysis and adjudication of the ethical issues [raised by philanthropy and academic psychiatry] are complex.”).

exploitation, and breach of privacy.<sup>131</sup> Many of these issues are implicated when a deviation from the traditional physician-patient relationship occurs. Therefore, this Part begins by briefly reviewing the nature of the physician-patient relationship and the physician duties appertaining thereto.

### A. *The Physician-Patient Relationship*

It is textbook health law and bioethics that a treating physician has a primary duty of loyalty to his or her patients.<sup>132</sup> A physician's duty of loyalty to his patient has been analogized to fiduciary duties imposed in other areas of the law.<sup>133</sup> In general, a fiduciary agent owes his or her principal a duty to act solely for the benefit of the principal in all matters connected with the agency.<sup>134</sup> Many activities that would be permissible by an agent in a regular, arms-length business relationship are impermissible when contemplated by a fiduciary.<sup>135</sup> The fiduciary's honesty alone is not enough, according to then-Chief Judge Cardozo: "[T]he punctilio of an honor the most sensitive . . . is . . . the standard of behavior."<sup>136</sup>

In the context of the physician-patient relationship, a fiduciary duty "means that the physician focuses exclusively on the patient's health . . . and the doctor-patient relationship is expected to be free of conflict."<sup>137</sup> Laurence McCullough, one of the nation's preeminent bioethicists,<sup>138</sup> explains that the

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<sup>131</sup> See Bentz et al., *supra* note 24, at 2112 ("The interests of multiple parties are involved in fundraising and philanthropy. Complex relationships among [health care providers], patients, and the community require ethical practices, including professionalism, transparency, confidentiality, and accountability.").

<sup>132</sup> See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 312–13 (5th ed. 2001) ("The patient-physician relationship is founded on trust and confidence; and the physician is therefore necessarily a trustee for the patient's medical welfare. . . . Whether or not the physician makes a pledge or takes an oath upon entry into the profession, obligations of fidelity arise in this model whenever the physician establishes a relationship with a patient.").

<sup>133</sup> See, e.g., BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 199 (6th ed. 2008) ("Once the physician-patient relationship is established, the law in fact imposes a higher level of duty on physicians. The language of fiduciary law is often used to describe special obligations that one person owes to another.").

<sup>134</sup> See, e.g., RESTATEMENT (SECOND) OF AGENCY § 387 (1958) ("Unless otherwise agreed, an agent is subject to a duty to his principle to act solely for the benefit of the principle in all matters connected with his agency.").

<sup>135</sup> See *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) ("Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place.").

<sup>136</sup> *Id.*

<sup>137</sup> FURROW ET AL., *supra* note 133, at 199; see also AMA Code of Medical Ethics, Opinion 10.015 (The Patient-Physician Relationship) (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page> ("The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare. Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount.").

<sup>138</sup> See Laurence McCullough, Ph.D., BAYLOR C. MED., <https://www.bcm.edu/people/view/b20d787a-ffed-11e2-be68-080027880ca6/> (last visited Jan. 6, 2015).

ethical concept of the physician as fiduciary includes the commitment “to mak[e] the protection and promotion of the patient’s health-related and other important interests the physician’s primary concern and motivation and to keep[] self-interest systematically second.”<sup>139</sup> Likewise, the late Hans Jonas, a German-born philosopher, describes the physician’s duty of loyalty to his patient as a “sacred trust”:

In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agency of society, nor of the interests of medical science, nor of the patient’s family, nor of his co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician’s care. . . . [T]he physician is bound not to let any other interest interfere with that of the patient in being cured. But, manifestly, more sublime norms than contractual ones are involved. We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.<sup>140</sup>

Jonas is not the only individual to have described the physician-patient relationship in terms of its central feature—trust. Other ethical, legal, and medical sources also identify the main characteristic of the physician-patient relationship as trust and as giving rise to the physician’s ethical obligation to place the patients’ health, safety, and welfare above the physician’s own interests, as well as the physician’s obligations to other groups.<sup>141</sup> For example, the American Medical Association’s (“AMA’s”) current Code of Medical Ethics provides: “The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare.”<sup>142</sup> The Code of Medical Ethics further provides: “Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount.”<sup>143</sup>

The question of whether a physician is acting in accordance with her duty of loyalty, or has breached her fiduciary duty, usually is raised in the context of a suspected conflict of interest.<sup>144</sup> In the context of a physician-patient relationship, a conflict of interest arises when a physician has a personal, financial, or other interest that is at odds—or conflicts—with the physician’s duty of fidelity to one or

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<sup>139</sup> LAURENCE B. MCCULLOUGH, *A PRIMER ON BIOETHICS* 7 (2d ed. 2006), available at [net.acpe.org/interact/ethics/bioethicsprimer.pdf](http://net.acpe.org/interact/ethics/bioethicsprimer.pdf).

<sup>140</sup> HANS JONAS, *Philosophical Reflections on Experimenting with Human Subjects*, in *PHILOSOPHICAL ESSAYS: FROM ANCIENT CREED TO TECHNOLOGICAL MAN* 105, 124 (1974).

<sup>141</sup> See, e.g., Mark A. Hall, *Law, Medicine, and Trust*, 55 *STAN. L. REV.* 463, 470–71 (2002) (“Trust is the core, defining characteristic of the doctor-patient relationship—the ‘glue’ that holds the relationship together and makes it possible.”).

<sup>142</sup> AMA Code of Medical Ethics, Opinion 10.015 (The Patient-Physician Relationship) (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page>.

<sup>143</sup> *Id.*

<sup>144</sup> See BEAUCHAMP & CHILDRESS, *supra* note 132, at 313 (“Several problems about the meaning and strength of obligations of fidelity arise because of conflicts of fidelity, which often produce divided loyalties.”).

more patients.<sup>145</sup> The Code of Medical Ethics contains strict ethical opinions regarding the identification and management of personal,<sup>146</sup> financial,<sup>147</sup> reimbursement,<sup>148</sup> research,<sup>149</sup> and other conflicts of interest. In terms of financial conflicts of interest, for example, Opinion 8.03 provides: “If a conflict develops between the physician’s financial interest and the physician’s responsibilities to the patient, the conflict must be resolved to the patient’s benefit.”<sup>150</sup> Opinion 8.03 further provides: “Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.”<sup>151</sup>

In the specific context of health care philanthropy, the question becomes whether physician involvement in grateful patient fundraising distorts or otherwise interferes with the physician’s fiduciary duties, including the duty to place the patient’s welfare above the physician’s own interest, self-interest, and obligations to other groups.<sup>152</sup> Stated slightly differently, the question is whether a physician’s interest in raising funds on behalf of the hospital where the physician works conflicts with the physician’s primary duty of loyalty to his or her patients. Stated

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<sup>145</sup> See *id.* at 318.

<sup>146</sup> See, e.g., AMA Code of Medical Ethics, Opinion 8.145 (Sexual or Romantic Relations between Physicians and Key Third Parties) (1998), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8145.page>; AMA Code of Medical Ethics, Opinion 8.19 (Self-Treatment or Treatment of Immediate Family Members) (1993), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion819.page>; AMA Code of Medical Ethics, Opinion 8.14 (Sexual Misconduct in the Practice of Medicine) (1992), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion814.page>.

<sup>147</sup> See, e.g., COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, *Opinion 8.054 (Financial Incentives and the Practice of Medicine)*, in CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 223, 223–25 (2008) (not available in current edition); COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, *Opinion 8.056 (Physician Pay-for-Performance Programs)*, in CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 227, 227–28 (2008) (not available in current edition).

<sup>148</sup> See, e.g., COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, *Opinion 8.051 (Conflicts of Interest under Capitation)*, in CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 220, 220–21 (2008) (not available in current edition); COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, *Opinion 8.135 (Cost Containment Involving Prescription Drugs in Health Care Plans)*, in CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 277, 277–78 (2008) (not available in current edition).

<sup>149</sup> See, e.g., AMA Code of Medical Ethics, Opinion 8.0315 (Managing Conflicts of Interest in the Conduct of Clinical Trials) (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion80315.page>; AMA Code of Medical Ethics, Opinion 8.031 (Conflicts of Interest: Biomedical Research) (1998), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8031.page>.

<sup>150</sup> AMA Code of Medical Ethics, Opinion 8.03 (Conflicts of Interest: Guidelines) (1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion803.page>.

<sup>151</sup> *Id.*

<sup>152</sup> See AMA Code of Medical Ethics, Opinion 10.015 (The Patient-Physician Relationship) (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page>.

yet a third way, if a physician initiates a private conversation with a patient regarding the hospital's philanthropic needs or directly asks a patient for a donation, thus focusing on the hospital's financial goals and the opportunity to improve resources available through the hospital in the future, rather than the patient's health, safety, and welfare for a moment or more in time, has the physician breached her fiduciary duty to the patient?

Many believe that physician involvement in grateful patient fundraising does significantly interfere with the physician-patient relationship<sup>153</sup> because of the potential for, or the actual occurrence of, conflicted decision making, injustices in the allocation of health care resources, financial exploitation, and breach of privacy.<sup>154</sup> Each of these concerns is discussed in more detail immediately below.

### *B. Conflicted Decision Making*

A major concern associated with grateful patient fundraising relates to the potential for conflicted health care decision making and distortion of the physician-patient relationship.<sup>155</sup> That is, a physician's interest in obtaining a philanthropic donation may conflict with more fundamental duties arising out of the physician-patient relationship, including the duty to prioritize the patient's well-being above the interests of the physician and the community.

For example, consider a hypothetical situation in which a patient needs a liver transplant. The patient's physician, who specializes in transplant surgery, may have classified the patient as "less ill" for purposes of placing the patient on a waiting list to receive a liver from a deceased donor.<sup>156</sup> Because the sickest patients are placed at the top of the waiting list, the physician's classification of the patient is critical in terms of determining if and when the patient will receive a liver.<sup>157</sup> Assume that the physician tells the patient that the physician will change the classification of the patient to "gravely ill" if the patient makes a significant donation to the hospital. Or, assume that the patient tells the physician that the patient will make a

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<sup>153</sup> DeMaria, *supra* note 72, at 1725 ("I believe that the greatest difficulty physicians have with soliciting philanthropy is concern that it may inappropriately play upon the physician/patient relationship.").

<sup>154</sup> See *infra* Part II(B)–(E).

<sup>155</sup> See, e.g., Julian J. Z. Prokopetz & Lisa Soleymani Lehmann, *Physicians as Fundraisers: Medical Philanthropy and the Doctor-Patient Relationship*, PLOS MED. 1, 2 (2014), <http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.1001600&representation=PDF> ("Physician participation in development activities can create tension between their roles as caregiver and fundraiser, potentially undermining the trust at the heart of the doctor-patient relationship.").

<sup>156</sup> See, e.g., UNITED NETWORK FOR ORGAN SHARING, QUESTIONS & ANSWERS FOR TRANSPLANT CANDIDATES ABOUT LIVER ALLOCATION POLICY 2 (n.d.) ("The Model for End-Stage Liver Disease (MELD) is a numerical scale, ranging from 6 (less ill) to 40 (gravely ill), used for liver transplant candidates age 12 and older. It gives each person a 'score' . . . based on how urgently he or she needs a liver transplant within the next three months.").

<sup>157</sup> See *Improved Statistical Tool to Rank Sickest Patients Waiting for Liver Transplants*, SCIENCE DAILY (Sept. 3, 2008), <http://www.sciencedaily.com/releases/2008/09/080903172148.htm> (explaining how potential liver transplant patients are ranked for purposes of receiving a liver).

significant donation to the hospital if the physician classifies the patient as “gravely ill.”

Putting aside for the moment the potential injustices done to the other patients who are accurately ranked on the waiting list,<sup>158</sup> this extreme example shows how the promise of fundraising could be used to distort the physician-patient relationship. In the case where the physician proposes changing the patient’s classification, the patient may wonder if the timing or quality of his current or future health care will depend on whether he makes a donation.<sup>159</sup> Indeed, the physician’s involvement in grateful patient fundraising “may create the perception, [or serve as evidence of the fact,] that the patient’s welfare is not the physician’s first priority, diminishing patient trust [in the physician]” and encouraging the patient to make a donation, even when the donation is not in the patient’s best interests.<sup>160</sup> A physician who makes such a proposal would be allowing his interest in obtaining a philanthropic donation to conflict with his duty to prioritize the patient’s health, safety, and welfare, regardless of the patient’s donor potential.<sup>161</sup> For these reasons, the timing of a philanthropic solicitation is considered very important. Some ethicists have proposed that sick patients who are currently receiving health care not be solicited; instead, any ask should be made only after the patient’s health condition has been resolved.<sup>162</sup>

In the situation in which the patient initiates the philanthropy discussion by stating that he will donate if the physician classifies the patient as gravely ill, it is the patient who is attempting to distort the physician-patient relationship generally, and the timing of his health care specifically. Even though the physician did not ask for a donation in this situation, the acceptance of the donation could damage the integrity of the physician-patient relationship.<sup>163</sup>

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<sup>158</sup> See *infra* Part II(C) for a discussion of the potential justice issues raised by grateful patient fundraising.

<sup>159</sup> See DeMaria, *supra* note 72, at 1726 (“The patient must never be put in a position to wonder if their continued care is dependent upon making a contribution.”).

<sup>160</sup> MICHAEL S. GOLDRICH, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, REPORT 7-A-04, PHYSICIAN PARTICIPATION IN SOLICITING CONTRIBUTIONS FROM PATIENTS 2 (2004); Chervenak et al., *supra* note 53, 540e.4 (“This behavior violates the deontologic component of philanthropy, because respect for persons prohibits treating the patient as merely as a means to institutional advancement.”).

<sup>161</sup> See GOLDRICH, *supra* note 160, at 2 (“Physicians must take the outmost measures to ensure that solicitation does not interfere with the patient-physician relationship or interrupt the delivery of high quality professional care. While a physician’s involvement in solicitation activities may benefit the community, it does not immediately help further the patient’s welfare for which the physician primarily is responsible. Such a request, therefore, falls outside the traditional patient-physician relationship.”).

<sup>162</sup> See *id.* at 4–5 (“Physicians should avoid directly soliciting their own patients, especially at the time of a clinical encounter. They should reinforce the trust that is the foundation of the patient-physician relationship by being clear that that patients [sic] welfare is the primary priority and that patients need not contribute in order to continue receiving the same quality of care.”).

<sup>163</sup> See AMA Code of Medical Ethics, Opinion 10.017 (Gifts from Patients) (2003), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10017.page> (“Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity

Although the liver transplant hypothetical is somewhat extreme because it contemplates obvious conflicted decision making that could affect the patient's life expectancy, actual physicians who have participated in grateful patient fundraising in less extreme circumstances have expressed their concerns regarding the potential for conflicted decision making and distortion of the physician-patient relationship, and these concerns have been documented in empirical studies.<sup>164</sup> In one such investigation, study authors from Johns Hopkins University School of Medicine ("JHSOM") designed a qualitative study involving in-depth, semi-structured interviews with twenty JHSOM physicians representing a diverse range of specialties who were identified by the JHSOM Development Office staff as having relationships with multiple patients who made philanthropic contributions [hereinafter, the Johns Hopkins Study].<sup>165</sup> The study authors reported that "physicians involved in grateful patient philanthropy are aware of, and in some cases troubled by, the ethical concerns related to this activity."<sup>166</sup>

Eighteen (90%) of the physicians surveyed in the Johns Hopkins Study identified the impact of gift-giving on the physician-patient relationship as the most significant ethical concern associated with grateful patient philanthropy.<sup>167</sup> The physicians expressed a concern that the purity of the physician-patient relationship might be tainted and that the focus of the relationship might change from one focused entirely on patient well-being to one that also focused on philanthropy.<sup>168</sup> In particular, the study authors reported that "[t]he latter [philanthropy-focused relationship] sometimes caused tension related to the appropriate timing of discussing health-related matters versus philanthropic issues."<sup>169</sup> One particular physician who was surveyed further stated that she recognized that the philanthropic aspect of the relationship could conflict with the patient care aspect of the relationship.<sup>170</sup> A second physician who was surveyed mentioned that the two aspects of the relationship did need to be constantly prioritized such that even if the physician was disappointed with the philanthropic dimension of the relationship he had to make sure not to compromise the patient care dimension of the relationship.<sup>171</sup>

A second area of concern, expressed by the physicians surveyed and related to the concept of gift-giving, exists beyond the physician's professional role.<sup>172</sup> Towards that end, one physician surveyed stated that he felt very uncomfortable

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of the patient-physician relationship. Physicians should make clear that gifts given to secure preferential treatment compromise their obligation to provide services in a fair manner.").

<sup>164</sup> See, e.g., Wright et al., *supra* note 21, at 649.

<sup>165</sup> *Id.* at 645.

<sup>166</sup> *Id.*

<sup>167</sup> *Id.* at 647.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Id.* at 647–648.

initiating gift giving with patients because he is a physician, not a solicitor.<sup>173</sup> A second physician stated that he only felt comfortable if the patient brought up the topic of gift-giving first, and not the other way around.<sup>174</sup> A third physician stated that he felt so uncomfortable, even when the patient initiated the conversation, that he would respond by stating, “this is something I’m not real comfortable with . . . I’m very flattered and this is a very important part of our research effort, but it is uncomfortable for me to discuss this with you. We have wonderful development officers and if you like, I will have them contact you.”<sup>175</sup>

In summary, physician involvement in grateful patient fundraising has the potential to result in conflicted decision making and to distort the physician-patient relationship. To lessen these concerns, the physician-patient relationship and potential philanthropic donations should remain as separate as possible.<sup>176</sup> There should be no express or implied linkage between a philanthropic donation and the provision, timing, quality, or quantity of health care.<sup>177</sup> In the case of any such linkage, conflicted decision making has occurred in breach of the physician’s fiduciary duty. Ethical guidelines and strategies for protecting the integrity of the physician-patient relationship in the context of health care philanthropy are proposed in Part III.

### C. Justice Concerns

Another major concern associated with grateful patient fundraising relates to justice. That is, individual and institutional health care providers may prefer donors over non-donors, and health care resources may be consciously or subconsciously allocated towards donors, thus improving the diagnosis, treatment, and health outcome of donors vis-à-vis non-donors.

According to the Belmont Report, one way in which an injustice occurs is when a benefit to which a person is entitled is denied without good reason.<sup>178</sup> A second way in which an injustice occurs is when equals are not treated equally.<sup>179</sup> One question that is raised in the context of grateful patient fundraising is whether donors can be treated better than non-donors. Stated another way, does a philanthropic contribution by one patient mean that the principle of equality between and among patients no longer applies? As background, several widely

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<sup>173</sup> *Id.* at 648.

<sup>174</sup> *See id.*

<sup>175</sup> *Id.*

<sup>176</sup> *See Bentz et al., supra* note 24, at 2112.

<sup>177</sup> *See id.*

<sup>178</sup> *See* Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, 44 Fed. Reg. 23,192, 23,194 (Apr. 18, 1979). The Belmont Report, authored by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, sets forth basic ethical principles and guidelines for the protection of human research subjects in biomedical and behavioral research. For history and context relating to the Belmont Report, see Stacey A. Tovino, *A “Common” Proposal*, 50 HOUS. L. REV. 787, 800–801 (2013).

<sup>179</sup> Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, 44 Fed. Reg. at 23,194.

accepted methods of distributing benefits in the health care, biomedical, and behavioral research contexts have been offered and include: “(1) to each person an equal share, (2) to each person according to individual need, (3) to each person according to individual effort, (4) to each person according to societal contribution, and (5) to each person according to merit.”<sup>180</sup>

If a well-resourced patient makes a donation to a hospital, is it permissible for the donor to be preferred in a way such that another non-donating patient is not? For example, is it ethical for a physician to schedule a donor’s elective procedure prior to a non-donor’s emergency procedure?<sup>181</sup> If a hospital’s surgical resources are allocated to each patient according to individual need, the non-donor’s emergency procedure should be scheduled before the donor’s elective procedure.<sup>182</sup> The result might be different if a hospital’s surgical resources are allocated to each patient according to societal contribution. That said, almost all ethicists agree that the elective procedure of a donor should always be scheduled after the emergency procedure of a non-donor.<sup>183</sup> The health, safety, and welfare of a non-donor should never be jeopardized to give a perk, favor, or amenity to a donor.

The question is more difficult when the life or health of a non-donor is not at stake and, instead, the hospital simply wishes to give a perk to a donor. Traditional donor perks include, but are not limited to, in-room courtesy visits, gift items, priority access to private rooms, staff escorts, personal notes, and expedited appointments.<sup>184</sup> Consider a situation in which a large, private hospital room becomes available when two patients with the same health condition have been staying in separate, small, shared rooms for the same amount of time. In this situation, is it ethical for the donor to be moved to the large private room while the non-donor remains in a small shared room if everything else, including plans of care and treatments, remain the same? If a hospital’s space resources are allocated to each patient according to individual need, note that a space allocation could not be made because both patients have the same needs. If the hospital’s space resources are allocated to each patient according to societal contributions, the donor might be moved to the large private room. In this scenario, philanthropy experts have no difficulty recommending the move of the donor to the large room under the theory that both patients will continue to receive the same level of health

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<sup>180</sup> *Id.*

<sup>181</sup> *See, e.g.,* Chervenak et al., *supra* note 53, 540e.4 (“Sometimes, however, [the donor-physician] relationship creates the risk of unacceptable consequences (eg, [sic] a donor insisting that an elective procedure be scheduled for the donor’s convenience before an emergency procedure for another patient). When there is a risk of such unacceptable consequences for other patients, the consequentialist component of the ethics of philanthropy creates an ethical obligation of the physician not to accede to such inappropriate demands from donors. The deontologic component of the ethics of philanthropy requires, as a matter of respect for the donor as a person, an explanation of the reason that such a demand should not and therefore cannot be accepted.”).

<sup>182</sup> *See id.*

<sup>183</sup> *See, e.g., id.* (“When there is a risk of such unacceptable consequences for other patients, the consequentialist component of the ethics of philanthropy creates an ethical obligation of the physician not to accede to such inappropriate demands from donors.”).

<sup>184</sup> *See, e.g.,* Wilson, *supra* note 67 (suggesting perks that may be given to philanthropic patients).

care.<sup>185</sup> Unequal perks do not bother philanthropy advocates if the underlying level of care remains the same.<sup>186</sup> Ethicists, on the other hand, worry that unequal perks could turn into unequal care.<sup>187</sup> For example, ethicists worry about the literature that associates perks with patient satisfaction and, in turn, that associates patient satisfaction with improved health outcomes, thereby linking perks and improved health outcomes.<sup>188</sup>

Now let us consider a perk that is between the emergency surgery hypothetical and the larger room hypothetical. For example, consider a hospital that allows donors expedited scheduling of follow-up visits. When a donor calls to make a follow-up appointment after surgery, the donor is scheduled for an appointment that same week. When a non-donor calls to make a follow-up appointment after surgery, the non-donor is scheduled for an appointment two weeks out. Assuming that there are no medical issues that require follow-up, the patients' health outcomes will stay the same notwithstanding the different follow-up appointment dates. If the assumptions are changed, however, and both patients develop an infection immediately after they are discharged from the hospital, the donor's infection will be diagnosed and treated one week earlier than the non-donor's infection. The result is that the donor may have an improved health outcome. Viewed in this light, many ethicists would be very uncomfortable with a hospital that granted expedited appointment scheduling to donors. Philanthropy experts, on the other hand, continue to refer to expedited scheduling as a harmless "amenity."<sup>189</sup>

Ethicists are not the only ones who think about justice issues associated with grateful patient fundraising. Some of the physicians surveyed in the Johns Hopkins Study also identified concerns relating to justness and fairness. For example, some of the physicians surveyed reported feeling uncomfortable if they thought they were responding differently to grateful patients compared to their other patients.<sup>190</sup> Indeed, some of the physicians admitted to returning telephone calls more quickly and allotting extra time and availability to philanthropic patients.<sup>191</sup>

One physician in the Johns Hopkins Study reported that he did not like treating his patients differently from an egalitarian perspective, but from a practical

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<sup>185</sup> See, e.g., *id.* (advising that all patients receive the same "level of health care" but that donors and non-donors be given different "levels of attention").

<sup>186</sup> See *id.* ("Be very careful with internal communications of VIP attention. Don't imply two levels of care, everyone gets the same excellent care. Some high-touch attention is offered to major donors who then fund better services for the entire community.").

<sup>187</sup> See, e.g., Suzanne Wu, *Do Hospital Perks Determine a Patient's Satisfaction?*, USC PRICE E-NEWSLETTER (Univ. of S. Cal. Price Sch. of Pub. Policy, Los Angeles, Cal.), Jan. 2011, <http://priceschool.usc.edu/newsletter/january-2011/hospital-satisfaction> ("[I]f amenities create environments that patients and providers prefer, the result may be better treatment and improved health outcomes.").

<sup>188</sup> See *id.*

<sup>189</sup> See, e.g., Wilson, *supra* note 67 (listing "expedited appointments" as a type of donor "amenity," not as a "level of care" difference).

<sup>190</sup> Wright et al., *supra* note 21, at 648.

<sup>191</sup> *Id.*

point of view he recognized the generosity of the donors and the fact that they are used to a different level of attention, so he gave it to them.<sup>192</sup> A second physician admitted that her responsiveness to donating and non-donating patients is not the same: “For example, I might be late to a meeting to call back the donor, where I might call a non-donor back after my meeting, but yet they both have the same patient need, and I would say neither had an urgent 911 issue.”<sup>193</sup> A third physician stated that she is “asking [donors] to go above and beyond their relationship with me as a patient so I feel like I have to go above and beyond [as the doctor].”<sup>194</sup> A fourth physician admitted that the justice issues associated with philanthropic patients made him uncomfortable:

It just gives me an uncomfortable feeling, or maybe I double-check, maybe, I don't know, maybe there is some unconsciousness there too, that I'm more aware of making the phone calls to them. I'm more aware of when they come to the clinic, and I may be trying harder to be a better doctor, do my job better. I don't like that part; I feel that I'm cheating on my other patients.<sup>195</sup>

Doctors Jesse Roach and Elizabeth Jacobs at the University of Wisconsin School of Medicine and Public Health disagree with the severity of the justice concerns expressed by some of the physician respondents in the Johns Hopkins Study.<sup>196</sup> Roach and Jacobs believe that most of the services offered to donors are amenities (such as nicer rooms and concierge services) that are “not crucial” to the patient's outcome.<sup>197</sup>

Going further, Roach and Jacobs argue that special treatment of donors could benefit all patients through “increased donations, political favor or good public relations. This in turn allows the hospital to improve care for all patients.”<sup>198</sup> Roach and Jacobs explain that, “[g]iving extra perks to these patients increases the utility for everyone. As long as the patient realizes that his actual medical care will stay the same, there should be little ethical problem with this.”<sup>199</sup> In summary, Roach and Jacobs believe that, “[a]s long as everyone receives the same basic level of medical care, there should be no ethical issues with these extra amenities.”<sup>200</sup>

Overall, approaches to grateful patient fundraising that involve the provision of perks to donors can raise justice concerns. At its extreme, grateful patient fundraising can create significant justice concerns if a donor's health care needs are prioritized over a non-donor's health care needs. Grateful patient fundraising can also raise potentially troubling justice issues when donors are given perks that have

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<sup>192</sup> *Id.*

<sup>193</sup> *Id.*

<sup>194</sup> *Id.*

<sup>195</sup> *Id.* at 648–49.

<sup>196</sup> Jesse Roach & Elizabeth A. Jacobs, *Grateful Patient Philanthropy: Is What's Good for the Goose Good for the Gander?*, 28 J. GEN. INTERNAL MED. 608, 608 (2013).

<sup>197</sup> *Id.*

<sup>198</sup> *Id.*

<sup>199</sup> *Id.*

<sup>200</sup> *Id.*

the possibility of improving diagnosis, treatment, and health outcomes, such as expedited follow-up appointments. For these reasons, the types of perks that are offered to donors should be continually evaluated in light of the empirical literature investigating the relationship between hospital amenities and health outcomes. Ethical guidelines and strategies for minimizing justice concerns in the context of grateful patient fundraising that involves the provision of perks are discussed in Part III.

#### *D. Financial Exploitation*

Still another major concern associated with grateful patient fundraising relates to the financial well-being of the patient. That is, some grateful patients are vulnerable and could be financially exploited during the fundraising process.

Consider a patient whose emergency room physician just brought the patient back from the brink of death after a major motor vehicle accident. Or, as in the hypothetical that opens this Article, consider a cancer patient whose life expectancy was very poor at the time of diagnosis but whose oncologist helped the patient achieve a remarkable remission. In both cases, the patient may be so grateful, thankful, and appreciative for the excellent health care received that the patient may make a donation to the hospital that is more generous than the patient really can afford, meaning a donation that is much larger than any financial advisor would ever recommend considering the patient's income, resources, and living expenses.<sup>201</sup>

Further consider an elderly patient who is in the early stages of dementia and is under the care of a very kind and compassionate neurologist. The elderly patient, who may have limited financial acumen, may be so taken with the caring neurologist that the patient may wish to make a significant donation to the hospital that is beyond the patient's financial means and could be better used by the patient in other ways, such as for nursing home or other long-term care expenses.<sup>202</sup> Finally, consider a young patient with severe bipolar disorder who, during a manic phase, wishes to donate money to the hospital where she has received inpatient and outpatient psychiatric treatment even though the money could be better spent in other ways, including on a college education.

All of the patients described above are vulnerable. The first patient is emotionally vulnerable because of her near-death emergency situation, the second because she had a terminal diagnosis and a miraculous recovery that may be

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<sup>201</sup> See Chervenak et al., *supra* note 53, at 540.e3 ("It is not uncommon for grateful patients or family members to be so appreciative or so dedicated to battling a disease or condition that they are willing to endure imprudent financial sacrifices to make philanthropic contributions, which creates vulnerability to exploitation.")

<sup>202</sup> See *id.* ("Consider, for example, the patient who certainly has decision-making capacity, but whose financial acumen and prudence, in the professional judgment of the physician leader and/or in consultation with a development professional, may be limited, affecting his or her ability to make a truly informed decision and protect legitimate financial self-interest in not donating more than he or she can reasonably afford. This might happen with a potential donor of modest means who wants to make a major gift from the experience of joy in his or her medical care.")

temporary or permanent, the third because she has a neurological condition that can interfere with decision-making capacity, and the fourth because of a psychiatric condition that can manifest itself in cyclic euphoric and ambitious feelings that can lead to spending and other types of sprees.<sup>203</sup> A health care provider or institutional representative who knows of such vulnerability and proceeds in soliciting a major (or even minor) gift from the individual may be financially exploiting the individual. That is, unlike the case of Annette Bloch, who had the desire, the financial acumen, and the resources to make a \$20 million donation to the University of Kansas,<sup>204</sup> financial exploitation can occur when a physically or mentally vulnerable patient cannot afford or does not wish to make a donation but is influenced to make a donation.

Abuse, neglect, and exploitation of elderly and vulnerable adult patients has become a nationwide problem<sup>205</sup> that state legislatures have tried to combat through the enactment of statutory provisions that require the reporting of suspected abuse, neglect, and exploitation.<sup>206</sup> The State of Washington, for example, has an Abuse of Vulnerable Adults Act (the “Washington Act”) that is designed to prevent the abuse, neglect, and financial exploitation of vulnerable adults.<sup>207</sup> The Washington Act defines a “vulnerable adult” to include hospital inpatients as well as other individuals who receive health care from a health care provider.<sup>208</sup> One of the goals of the Washington Act is to protect vulnerable adults from “financial exploitation,” defined broadly to include:

(a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the

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<sup>203</sup> *See id.*

<sup>204</sup> *See, e.g.*, Press Release, Univ. of Kan., Philanthropist Annette Bloch Makes Historic \$20 Million Gift to KU Hosp. Cancer Program (Oct. 14, 2008), *available at* <http://archive.news.ku.edu/2008/october/14/donor.shtml>.

<sup>205</sup> *See, e.g.*, LOUISE THOMAS, CTR. ON AGING & OLDER ADULT MINISTRIES, ELDER ABUSE, NEGLECT, AND EXPLOITATION: BELIEVE IT! REPORT IT! (1999), *available at* <http://www.caregiverslibrary.org/portals/0/abuse.pdf> (“Current estimates are that between 1.5 and 2 million older adults are abused annually, with only one in 10 to one in 14 cases being reported to a public agency.”).

<sup>206</sup> These state laws also pave the way for investigations that may lead to civil, criminal, and administrative penalties for institutional and community perpetrators. *See, e.g.*, Dependent Adult Abuse Act, IOWA CODE ANN. § 235E.1 (West 2008) (defining a “dependent adult” as “a person eighteen years of age or older whose ability to perform the normal activities of daily living or to provide for the person’s own care or protection is impaired, either temporarily or permanently” and prohibiting the abuse, neglect, and exploitation of dependent adults, with exploitation being defined to include situations involving “a caretaker who . . . endeavors to obtain to use . . . a dependent adult’s funds . . . with the intent to temporarily or permanently deprive a dependent adult of the use, benefit, or possession of the funds . . . for the benefit of someone other than the dependent adult”); Reporting of Maltreatment of Vulnerable Adults Act, MINN. STAT. ANN. § 626.557 (West 2014) (setting forth provisions similar to the Iowa Dependent Adult Abuse Act).

<sup>207</sup> WASH. REV. CODE § 74.34.005(1) (2014) (“The legislature finds and declares that: (1) Some adults are vulnerable and may be subjected to abuse, neglect, financial exploitation, or abandonment by a family member, care provider, or other person who has a relationship with the vulnerable adult[.]”).

<sup>208</sup> *Id.* § 74.34.020(17).

property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult;<sup>209</sup>

(b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or<sup>210</sup>

(c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.<sup>211</sup>

Depending on the situation, two of these illustrative examples of “financial exploitation” in the Washington Act could apply to a physician or other hospital representative who uses undue influence to solicit a financial donation from a vulnerable patient. In the first example, a physician would be a person in a position of trust and if the physician uses undue influence to obtain a donation for the benefit of the hospital, financial exploitation could occur. In the third example, a physician or hospital representative who obtains a donation from a patient known by the physician or representative to have a neurological, psychiatric, or other condition that interferes with the patient’s capacity to consent to the donation could also be engaging in financial exploitation.

Indeed, in the Johns Hopkins Study, several of the physician respondents expressed concern about soliciting and accepting philanthropic gifts from sick, vulnerable patients due to the possibility of financial, emotional, and other forms of abuse.<sup>212</sup> One physician who cared for elderly patients expressed his concern by stating, “Dementia is such a devastating disease, and that’s why I have a big ethical concern about [soliciting donations], I feel there is vulnerability.”<sup>213</sup>

Although most physicians and hospital representatives certainly do not use undue influence to raise funds and know to avoid soliciting donations from vulnerable patients, there are reports in the literature of aggressive physicians who push the fundraising envelope. Remember the well-known surgeon who worked in a large city hospital who would walk into a hospital room and say, “Mrs. Smith, I saved your life yesterday, and you’re gonna give a lot of money to build that new building at the [name of hospital]”<sup>214</sup> A vulnerable patient in Mrs. Smith’s position may worry that future care depends on a donation and may make a donation even though the donation is beyond the patient’s financial means or the donation is against the patient’s wishes.

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<sup>209</sup> *Id.* § 74.34.020(6)(a).

<sup>210</sup> *Id.* § 74.34.020(6)(b).

<sup>211</sup> *Id.* § 74.34.020(6)(c).

<sup>212</sup> Wright et al., *supra* note 21, at 649.

<sup>213</sup> *Id.*

<sup>214</sup> Chervenak et al., *supra* note 53, at 540e.4.

Putting aside the Washington Act and other state laws designed to prevent the financial exploitation of elderly and other vulnerable individuals, the bioethical principle of respect for persons would also weigh against the solicitation of funds from patients who, due to their vulnerabilities, may make philanthropic decisions that are not in their best financial or other interests. The principle of respect for persons includes not only the requirement to acknowledge autonomy, but also the requirement to protect those with diminished autonomy.<sup>215</sup> Elderly individuals with dementia, individuals with other neurological and psychiatric conditions, and even otherwise mentally healthy individuals who have terminal or acute diagnoses may, depending on the severity of their conditions, have temporarily or permanently diminished autonomy.<sup>216</sup> The principle of respect for persons may require protecting such individuals while they are incapacitated.<sup>217</sup> Applied to the context of grateful patient fundraising, this means that some vulnerable patients may need to be excluded from fundraising efforts altogether.<sup>218</sup> Healthier and less vulnerable patients may need to be provided information regarding the financial gravity of philanthropic decisions to help them make informed decisions about whether and how much to donate.<sup>219</sup>

In addition to respect for persons, the bioethical principle of “beneficence” also has relevance to grateful patient fundraising. Individuals “are treated in an ethical manner not only by [sic] respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being.”<sup>220</sup> The principle of beneficence includes two complementary sub-principles: (1) do not harm and (2) maximize possible benefits and minimize possible harms.<sup>221</sup> Applied to the context of grateful patient fundraising, a physician or hospital representative who solicits funds from a vulnerable patient who lacks the resources or desire to make a donation may be financially or emotionally harming the patient. The principle of beneficence would dictate that patients without the resources or desire to make a gift not be solicited to protect them from harm. Stated another way, maximizing the welfare of a vulnerable patient would require abstaining from grateful patient fundraising.<sup>222</sup>

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<sup>215</sup> Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 44 Fed. Reg. 23,192, 23,193 (Apr. 18, 1979).

<sup>216</sup> *See generally id.* (“An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. . . . [S]ome individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty.”).

<sup>217</sup> *Id.*

<sup>218</sup> *See id.* (“Some persons are in need of extensive protection, even to the point of excluding them from activities which may harm them; other persons require little protection beyond making sure they undertake activities freely and with awareness of possible adverse consequences.”).

<sup>219</sup> *See generally id.* at 23,194 (explaining that respect for persons requires the patient to give informed consent, which requires the patient receiving adequate information).

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> *See* AMA Code of Medical Ethics, Opinion 10.018 (Physician Participation in Soliciting Contributions from Patients) (2004), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10018.page> (“Physicians should avoid directly

These findings are supported by ethical opinions issued by the AMA in other, similar, contexts. In the context of patients who give personal gifts to their treating physicians (not philanthropic gifts to the hospitals in which they have received care), the Code of Medical Ethics states that “the gift’s value relative to the patient’s or the physician’s means should not be disproportionately or inappropriately large.”<sup>223</sup> The Code of Medical Ethics further states that physicians who are bequeathed gifts “should consider declining the gift if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family.”<sup>224</sup> Likewise, large gifts given by vulnerable patients with limited financial means certainly should not be encouraged and should be declined or heavily scrutinized if given or offered.

One initial response to the possibility of financial exploitation might be to encourage hospitals and other health care institutions to perform wealth screenings on all patients so that patients with limited financial resources are not asked to make gifts that are large relative to their financial means. One problem with this approach is that wealth screenings are by no means completely accurate. For example, wealth screenings can produce “false positives”;<sup>225</sup> for example, they can identify individuals who own expensive properties but who can no longer afford to pay the mortgages on such properties. Wealth screenings also can produce “false negatives”; that is, they can identify individuals whose wealth is undervalued due to unidentified or unconfirmed assets.<sup>226</sup> A second problem is that positive wealth screening results (including screenings that identify individuals who have made past philanthropic donations) do not always correlate with a present desire to give.<sup>227</sup> For example, the economy may have taken a turn, or the individual may have lost her job since a prior donation. A third problem is that wealth screenings raise privacy issues, as discussed below.

### *E. Breach of Privacy*

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soliciting their own patients, especially at the time of a clinical encounter.”); *see also* Chervenak et al., *supra* note 53, at 540.e3 (“If such understanding is not achieved, the process should be discontinued, even if the donor wants to continue. Just as in the case of protecting patients who want unacceptably risky procedures that are clearly not in their interests, the physician leader should prevent exploitation of the donor.”).

<sup>223</sup> AMA Code of Medical Ethics, Opinion 10.017 (Gift from Patients) (2003), *available at* <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10017.page>.

<sup>224</sup> *Id.*

<sup>225</sup> *See* Steffanie Brown, comment to *WealthEngine v. WealthPoint (Blackbaud)*, LINKEDIN FUNDRAISING ANALYTICS F. (Aug. 20, 2012), <http://www.linkedin.com/groups/WealthEngine-v-WealthPoint-Blackbaud-If-1863676.S.149390794> (discussing the possibility of “false positives” and “false negatives” with different wealth screening services).

<sup>226</sup> *See id.*

<sup>227</sup> Stephen Ferrando, *WealthEngine v. WealthPoint (Blackbaud)*, LINKEDIN FUNDRAISING ANALYTICS F. (Sept. 20, 2012) <http://www.linkedin.com/groups/WealthEngine-v-WealthPoint-Blackbaud-If-1863676.S.149390794> (distinguishing between “big fish” and “big fish likely to give”).

Another major area of concern associated with grateful patient fundraising is that fundraising that relies on wealth and other unauthorized types of screenings can raise privacy issues. In this context, “privacy” refers to a patient’s interest in avoiding the unwanted collection by a third party of health or other information relating to the patient.<sup>228</sup> “Privacy” can be distinguished from “confidentiality,” which may be defined in the health care context as the obligation of a health care provider “to prevent the unauthorized or otherwise inappropriate use or disclosure of voluntarily given and appropriately gathered health . . . information relating to a patient.”<sup>229</sup> Grateful patient fundraising has the potential to raise both privacy issues (discussed in this section) and confidentiality issues (discussed in a companion article).<sup>230</sup>

Privacy issues arise when hospital development officers, major gifts officers, institutionally-related foundation officers, or other professional fundraisers gather information about patients, without such patients’ knowledge, in an attempt to determine or estimate patient wealth, giving capacity, past donations, and other relevant information. To the extent the information gathered is publicly or commercially available, federal and state privacy laws are not implicated. For example, many counties make property records available online, and any member of the public at any time may search those records to determine the value of property owned by a particular person or located at a particular address.<sup>231</sup>

Although the search and collection of publicly available property records and other similar information is not illegal under federal or state law, principles of biomedical ethics suggest that patients should be notified prior to such searches and that they should be allowed to opt out of searches they find undesirable. For example, the Code of Medical Ethics provides that, “[p]hysicians should be aware of and respect the special concerns of their patients regarding privacy. Patients should be informed of any significant infringement on their privacy of which they may otherwise be unaware.”<sup>232</sup> Jurisprudence relating to the constitutional right of privacy also weighs in favor of notifying patients of wealth screening and other information gathering. For example, the Fourth Amendment prohibits searches that violate a reasonable expectation of privacy.<sup>233</sup> Because most individuals do not know or expect that their hospitals will conduct wealth screenings on them in exchange for receipt of hospital services, notification to patients of such wealth screenings would reinforce a patient’s basic right to privacy.

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<sup>228</sup> See Tovino, *supra* note 2, at 1161 n.11 (distinguishing confidentiality and privacy).

<sup>229</sup> *Id.*

<sup>230</sup> See *id.* at 1194–1217.

<sup>231</sup> See, e.g., *Record Search*, CLARK COUNTY NEV. ASSESSOR’S OFF., <http://www.clarkcountynv.gov/depts/assessor/Pages/RecordSearch.aspx> (last visited Jan. 6, 2015) (allowing any member of the public to search Clark County, Nevada property records by owner name, street address, or parcel number).

<sup>232</sup> AMA Code of Medical Ethics, Opinion 5.059 (Privacy in the Context of Health Care) (2002), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion5059.page>.

<sup>233</sup> See, e.g., *Katz v. United States*, 389 U.S. 347, 351–52 (1967).

The principle of respect for persons also weighs in favor of patient notification of wealth screenings and the provision of an opt-out opportunity. In addition to the requirement to protect individuals with diminished autonomy, discussed above in the context of vulnerable patients, the principle of respect for persons also includes the requirement to acknowledge autonomy.<sup>234</sup>

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect [an individual's] autonomy is to give weight to [that individual's] considered opinions and choices. . . . To show lack of respect for [an individual's autonomy] is . . . to deny an individual the freedom to act on those considered judgments or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so. . . . Respect for persons requires that [individuals], to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them.<sup>235</sup>

Applied to the context of grateful patient fundraising, these ethical principles suggest that patients should be notified by their hospitals if wealth screenings will be conducted in exchange for a patient's request or receipt of hospital services. In addition, patients should be given the opportunity to opt out of such wealth screenings if they find them distasteful. Why? First, because it is likely that patients do not expect to be screened for wealth based on their request for and receipt of hospital services. Second, in the language of bioethics, patients who are not notified of wealth screenings or who are not given the opportunity to opt out of such screenings are not being respected because they are not given the opportunity to choose what is happening to them or to their information.

In a document called a "notice of privacy practices," federal health information confidentiality regulations require hospitals and other covered entities to notify patients that they may be contacted for fundraising purposes and that they have the right to opt out of being contacted for fundraising purposes.<sup>236</sup> However, nothing in federal health information confidentiality regulations requires patients to be informed that their publicly and commercially available information may be collected and searched for wealth screening purposes.<sup>237</sup> The notice of privacy practices, if read by the patient, only alerts the patient to the fact that the patient's health and demographic information *already in possession* of the health care

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<sup>234</sup> Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 44 Fed. Reg. 23,192, 23,193 (Apr. 18, 1979).

<sup>235</sup> *Id.* at 23,193–95.

<sup>236</sup> See 45 C.F.R. § 164.514(f)(2) (2013) ("A covered entity may not use or disclose protected health information for fundraising purposes . . . unless a statement required by § 164.520(b)(1)(iii)(A) is included in the covered entity's notice of privacy practices."); *id.* § 164.520(b)(1)(iii) ("If the covered entity intends to engage in any of the following activities, the description . . . must include a separate statement informing the individual of such activities . . . [including whether] the covered entity may contact the individual to raise funds for the covered entity and the individual has a right to opt out of receiving such communications . . .").

<sup>237</sup> See *id.* § 164.520(b)(1)–(2) (listing the required and optional elements of notices of privacy practices).

provider will not be *further* used or disclosed except as allowed by federal regulations. The notice of privacy practices does not alert patients that searches will be conducted for *additional* information, such as the individual's property values and past philanthropic donations. In addition, nothing in these federal regulations requires patients to be given the opportunity to opt out of such wealth screenings.

#### *F. Catch-22s in Grateful Patient Fundraising*

Before I offer new ethical guidelines governing physician participation in grateful patient fundraising, it is worth recognizing two bioethical catch-22s associated with grateful patient fundraising. The first catch-22 is in the relationship between confidentiality and a physician's other fiduciary duties. In a companion article, I cautioned that any time protected health information (such as the name of the patient's treating physician or the name of the department in which the patient received health care) is disclosed from the treating physician through a hospital's medical records system to the hospital's employed, affiliated, or contracted fundraisers, the fundraiser can quickly determine the patient's diagnosis or, at least, the type of health care services requested or received by the patient.<sup>238</sup> In the same article, I further cautioned that targeted communications sent by fundraisers to patients can suggest to any third party who intentionally or inadvertently reads the communication, the patient's diagnosis, or the type of health care services requested or received by the covered entity.<sup>239</sup> One way to mitigate these concerns is to have the physician conduct all of the fundraising. Making the treating physician responsible for sharing the hospital's health care philanthropy message and soliciting donations from patients would eliminate the disclosure of protected health information to hospital development officers, major gifts officers, institutionally-related foundations, and professional fundraisers.

The problem, of course, is that significant physician involvement in grateful patient fundraising risks a breach of fiduciary duty and distortion of the physician-patient relationship as discussed in detail in Part II(A) of this Article. To mitigate these risks, we would have to place all fundraising responsibilities back on non-physician fundraisers, thus increasing confidentiality concerns. So, the first catch-22 is that approaches to health care philanthropy that minimize the risk of breach of confidentiality raise the greatest risk of distorting the physician-patient relationship. In turn, methods of patient fundraising that minimize interference with the physician-patient relationship pose the greatest risk of violating patient confidentiality.

The second catch-22 is hidden in the relationship between financial exploitation and breach of privacy. Remember that Part II(D) of this Article examined the potential vulnerability of grateful patients and the ways in which these patients could be financially exploited during the fundraising process. In particular, Part II(D) noted that patients with acute diagnoses, terminal conditions,

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<sup>238</sup> See Tovino, *supra* note 2, at 1207–08.

<sup>239</sup> *Id.* at 1208.

neurological disorders, and psychiatric illnesses could be put in the position of making philanthropic decisions that are beyond their means and not in their best financial interests. One way of mitigating these concerns is for hospitals to conduct wealth screenings on all patients and target for donations only those patients who appear to have significant financial resources. The problem is that unexpected wealth screenings raise privacy concerns, yet hospitals that do not use wealth screenings and send fundraising communications to all patients risk patients without resources making donations that are beyond their means. The catch-22, then, is that approaches to grateful patient fundraising that minimize the risk of financial exploitation raise the greatest privacy concerns. In turn, methods of health care philanthropy that minimize privacy concerns increase the possibility of financial exploitation. The new ethical guidelines proposed below seek to resolve these catch-22s.

### III. PROPOSED ETHICAL GUIDELINES

In a companion article, I proposed corrections to federal regulations that govern the use and disclosure of protected health information for fundraising purposes.<sup>240</sup> Because these federal regulations are limited to the topic of health information confidentiality, a complementary set of ethical guidelines is needed to address the risk of conflicted physician decision making, health care resource allocation injustices, financial exploitation, and breach of privacy raised by physician involvement in grateful patient fundraising. Revisions to the AMA's Code of Medical Ethics could achieve this goal. For example, current AMA Opinion 10.018, governing physician participation in soliciting contributions from patients,<sup>241</sup> could be significantly revised to provide:

**Opinion 10.018 - Physician Participation in Soliciting Contributions from Patients**

Philanthropic donations play an important role in supporting and improving health care. Physicians are encouraged to participate in fundraising and other solicitation activities while protecting the integrity of the patient-physician relationship, avoiding conflicted health care decision making, and protecting against financial exploitation, breach of privacy, breach of confidentiality, and health care resource allocation injustices. In particular:

- (1) Appropriate Means of Soliciting Contributions. Appropriate means of soliciting contributions include making information available in a reception area and speaking at fundraising events. When physicians participate in solicitation efforts as members of the general community, they should seek to minimize perceptions of overlap with their professional roles.

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<sup>240</sup> *Id.* at 1219–22.

<sup>241</sup> AMA Code of Medical Ethics, Opinion 10.018 (Physician Participation in Soliciting Contributions from Patients) (2004), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10018.page>.

- (2) Protecting the Physician-Patient Relationship. Physicians should avoid directly soliciting their own patients, especially at the time of a clinical encounter. At all times, physicians should reinforce the trust that is the foundation of the patient-physician relationship by clarifying that a patient's health, safety, and welfare are the physician's primary priority and that patients need not make philanthropic donations in order to continue receiving care or to continue receiving the same quality or quantity of care.
- (3) Timing Philanthropic Solicitations. The greater the separation between a philanthropic solicitation and the clinical encounter, the more acceptable the solicitation is likely to be. With the exception of patients who initiate conversations with physicians regarding philanthropy, unacceptable physician behavior includes requesting donations from patients who are currently receiving health care from the physician.
- (4) Protecting Confidentiality and Privacy. Physicians who participate in grateful patient fundraising should work to protect patient confidentiality and privacy. In particular, physicians should ensure that any patient information used for solicitation activities, such as a solicitation letter mailed to a patient's home, reveals only basic demographic information (such as the patient's home address), not other protected health information (such as the patient's diagnosis, the patient's prognosis, the name of the patient's treating physician, the department of service in which the patient requested or received health care, or the particular diagnostic services or treatments received by the patient). Prior written authorization must be obtained from the patient before using or disclosing non-demographic protected health information relating to the patient for fundraising purposes. Physicians also must request and receive prior written authorization before performing or authorizing any type of wealth or other information screening relating to the patient.
- (5) Protecting Vulnerable Patients. Physicians whose work in areas such as neurology, psychiatry, geriatrics, and emergency medicine—areas in which patients are likely to be especially vulnerable—should exercise upmost caution when speaking to current and former patients regarding their health care institutions' philanthropic needs. Patients with limited decision-making capacity may be unable to comprehend the financial and other implications of a donation decision.
- (6) Protecting against Health Care Resource Allocation Injustices. Physicians should exercise caution in allocating health care and non-health care resources between donors and non-donors. Physicians should not allow the quality, quantity, or timing of health care to vary based on the making of a donation or the refusal to make a donation. Physicians should recognize that amenities given to donors, such as expedited follow-up appointments, extra visits by physician and allied health professionals, and private rooms, may have an impact on patient satisfaction and health care outcomes.
- (7) Patient-Initiated Conversations. When a patient who is currently receiving treatment from a physician initiates a conversation relating to philanthropy or asks how to make a philanthropic donation, the physician should refer the patient to appropriate sources of information or hospital development personnel. When a former patient who is no longer receiving treatment initiates a conversation relating to philanthropy or asks how to make a philanthropic donation, it is acceptable for the physician to respond to the patient's questions so long as the

physician reiterates that the patient's health, safety, and welfare is the primary focus of the physician and the health care institution in which he or she works.

#### CONCLUSION

Philanthropy plays an important role in the American health care system and should be encouraged. One problem with health care philanthropy, especially grateful patient fundraising that relies on significant physician involvement, is that it can risk distortion of the physician-patient relationship, conflicted health care decision making, health care resource allocation injustices, financial exploitation, and breach of privacy. These ethical concerns can be lessened through proper guidance of the physician-patient relationship. To this end, this Article offers new ethical guidelines governing physician involvement in grateful patient fundraising. Designed to work alongside proposed corrections to federal health information confidentiality regulations,<sup>242</sup> these guidelines will support the physician-patient relationship and basic patient rights in the context of grateful patient fundraising.

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<sup>242</sup> See Tovino, *supra* note 2, at 1217–22 (proposing corrections to federal health information confidentiality regulations).