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Commentary

Grateful Patient Philanthropy: A Challenge to Organizational Ethics

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Abstract. An examination of organization development in health care reveals a pattern of increasing reliance of academic medical centers toward new sources of revenue in support of operations. This trend is partly in response to the reduction of traditional funding sources such as public appropriations and tuition. Clinical income from faculty earnings and hospital transfer payments have supplanted heritage funding sources and are now predominantly institutional transactions rather than physician-patient interactions. Grateful patient philanthropy can be viewed as moving toward transactional status, with challenging ethical questions for the involved physician and patient as institutional control increases.

Keywords. Narratives, Grateful Patient Fundraising, Physician-Patient Relationship

Introduction

The institutionalization of grateful patient fundraising programs has opened a new vein of revenue for academic medicine and its practitioners in the last two decades. Wright and colleagues (2013) state that "Grateful patient philanthropy is an essential part of keeping academic medical centers (AMC) moving forward." The implication is that a once tangential activity is now a mainstream component of medical school financial health. One may learn lessons from the institutionalization of patient care generated revenues in academic medicine compared to recent developments in philanthropy in general and grateful patient programs in particular.

Paul Starr (1982) notes that nineteenth-century U.S. Hospitals were often reliant on charitable donations for operating income, but in the instance of the Pennsylvania Hospital and other traditional donor established hospitals, these funds were inadequate to cover the cost of care and required

supplementation from patient payments. Charles Rosenberg (1987) noted the difference between U.S. and historic hospitals of longer standing in the U.K. as requiring patient payments, albeit in a minority of instances. Both authors agree that while hospitals might receive payment for services, physicians were expected to deliver their services to the indigent as an act of charity.

As payment for services rendered became more widely accepted in the later nineteenth century, philanthropy as a revenue source was increasingly the domain of select private institutions and religious organizations. A movement away from philanthropy for operating purposes occurred as patients paid either directly or through a more steady and preferred source with the advent of third party insurance in the twentieth century.

In the institutional sector, philanthropy was increasingly redirected toward capital project support. These funds were more often than not comprised of major naming gifts from corporate or individual donors and directed to physical structures. Smaller gifts from alumni and others in the immediate community were welcomed but often attained with little organized effort other than periodic capital campaigns (Garland, 1988).

Physician payment evolved in a separate but parallel course from institutional payment in which a "grateful patient" component was an essential part of the physician's remuneration. Through the nineteenth century, an unstructured payment approach prevailed in which indigent patients would be treated through the charity of the physician, but patients of means would be expected to pay accordingly. Often cited as "Robin Hood" pricing, taking from the rich and giving to the poor, was a strangely ethical, though totally informal approach to paying for professional services and distributing their availability through society (Moreno, 1990). In a sense, this carried on the Roman tradition of "honoraria" in which classical physicians "were paid with a gift determined by the satisfaction of the employer or client" (Jonsen, 2000).

The movement from a barter economy to a rationalized system of payment characterized the development of physician payment in the twentieth century. The American Medical Association supported the approach of fee-for-service medicine as ethically superior by assuring the direct economic obligation of the physician to act "in the patient's best interest" (Baker, 2013).

Indeed many of the authors of these NIB narratives mention an initial apprehension to engage in grateful patient fundraising out of concern for the physician-patient relationship. Joel S. Perlmutter states, "I am somewhat reluctant to initiate these discussions [. . .] since I do not want that to intrude on the patient-physician relationship." Ahmet Hoke says he feels "fortunate to work for a medical center that performs grateful patient fundraising (GPFR) in a professional, ethically sound way [. . .] allowing the physician-patient relationship to remain focused first and foremost on the patient's health and well-being." Hoke ascertains that when done in a way that preserves boundaries, grateful patient fundraising can strengthen the physician-patient relationship.

With the advent of the first Blue Shield plan in 1939, third party payment for physician services accelerated as employers increasingly added this benefit to workers during the wage control era of World War II. Physician payment based on principles of "usual, customary, and reasonable" standardized and eroded the historic informal structure of physician payment. This trend culminated in the enactment in 1965 of Medicare and Medicaid and the removal of a significant portion of the populace from the ranks of the medically impoverished. The net effect was to minimize the earlier custom of differential payment for physician services as patients became used to the idea of fee-for-service that was often "covered" by insurance.

No Longer Threadbare or Genteel

The impact of these changes in payment found their way to academic medicine to a degree few had anticipated. In a widely cited 1981 New England Journal of Medicine essay, Robert Petersdorf (soon to become President of the Association of American Medical Colleges), observed the changing landscape for academic physician faculty:

> His expectations were to do research and teach and take care of patients only peripherally. He had few private patients. In fact, most patients with whom he came into contact were ward patients who received care primarily from house staff.
>
> His research was carried out on a small scale and supported to a great extent by private philanthropy. There was no competition either for dollars or for priority scores. Academic departments were small and collegial, and life was more like that of a professor of English or philosophy than like that of a practitioner (Petersdorf, 1981).

Petersdorf was commenting upon the rise in faculty practice and institutional transfer revenue to medical schools that eventually dwarfed traditional funding sources of tuition, public appropriation support, endowment income, and research funding. By the time of the 1996 AAMC Report "The Financing of Medical Schools," clinical income from faculty earnings and hospital transfer payments had exceeded the four traditional revenue sources in total at the average medical school (Association of American Medical Colleges, 1996).

Interestingly philanthropy is not regarded as of sufficient magnitude to warrant a specific category of revenue for comparative analysis. The AAMC Task Force, chaired by David Korn, the former Dean of the Stanford University School of Medicine, is relatively dismissive of the impact of philanthropy on the medical education enterprise. The Report notes the following with regard to the import of gifts:

"Gifts to medical schools are characteristically restricted, sometimes to a broad area of application (heart disease, dementia), but more often to work on specific diseases or to support the scholarship of specific faculty" (Association of American Medical Colleges, 1996).

The 1996 AAMC Task Force concludes its work with 24 recommendations, emphasizing the increasing reliance of medical schools on practice-generated revenues while cautioning that this is probably not sustainable for the extended future. Events have demonstrated the continuation of an even greater dependence on clinical revenues, especially in public universities that witnessed substantial decreases in public appropriations. Against this backdrop, the development of new fund sources, including grateful patient philanthropy becomes of heightened interest.

What One Measures, One Gets

Clark Havighurst, (2004) the William Neal Reynolds Professor Emeritus of Law at Duke University, popularized the above statement as applied to institutional management. One of the most vivid examples of his mantra can be found in the move from near non-recognition of philanthropy as of relatively little importance to the academic enterprise to one warranting major institutional investment and monitoring.

In 1999 the AAMC initiated a web-based Annual Development Survey to measure the impact and costs of fundraising efforts on behalf of medical schools and owned or affiliate hospitals. By 2020, the AAMC Report identifies mean annual private institution funds raised of $111.5 million and $58.9 million by responding public institutions. It may be argued that only organizations placing a high value on fundraising (N=122, 56 private and 66 public) responded to the survey, resulting in artificially high results (Association of American Medical Colleges, 2021).

Clearly this attention reflects a major shift in the perceived value of fundraising, much as the 1980s and 90s saw the recognition of the importance of clinical sources of revenue and the organization of the AAMC Group on Faculty Practice in 1986. There is now an AAMC Development Leadership Committee that advises AAMC staff on the content of the annual survey. 56 of the institutions responding to a specific question report they "have access to conduct grateful patient fundraising efforts," while only 8 do not (Association of American Medical Colleges, 2021).

Indeed, the results have become a point of comparison across academic institutions. The University of Miami Miller School of Medicine reported in 2016 that its fundraising placed it number 11 among reporting medical schools with hospitals and health centers). To my personal astonishment, one of the

institutions ranked ahead of Miami in that report was the University of Wisconsin-Madison, which had not even tracked this metric at the level of the medical school when I served as its Associate Dean for Administration and Finance from 1992 to 1995.

When Does a Gift Become a Quota?

Much in the same way that physician fees became a subject of institutional budgeting that support current operations, is it possible that philanthropy will move in the same direction? After all, as Director of Administration and Finance at the University of California-San Francisco, I was once chastised by a prominent faculty surgeon for waiving a balance of $3.89 for the spouse of a university Regent at the request of our Chancellor. The surgeon in this case viewed the fee for his service as solely his product, and exclusively his to control. With over half of all physicians practicing in organized groups, such a disagreement would seem unrealistically quaint to most physicians, given the transfer of authority over financial issues and productivity standards such as RVUs to a central administrative entity.

The notion of a gift is in itself elusive. In his classic work "The Gift Relationship: From Human Blood to Social Policy" (1997), Richard Titmuss argued for "altruistic gifts" as ethically superior and ironically more efficient in realizing a social goal (enhanced blood donation) than a transactional approach. The narratives in this issue demonstrate a recurrent theme—the authors are concerned with avoiding coercive or exploitative relationships with patients who may be motivated by altruistic giving or who may expect preferential treatment after donating a financial gift. Brent R. Carr for one describes his uncertainty when a grateful patient hands him a check made out to him personally. He declines the check and refers the patient to the development office, though Carr says, "I did not energetically market the development office, not wanting to appear coercive or steer the choice." The patient later attempts to make another donation, this time placing an envelope with cash on the desk.

The American Medical Association Code of Medical Ethics addresses this concern in Standard 10.018, stating that "Donations play an important role in supporting and improving a community's health care. Physicians are encouraged to participate in fundraising and other solicitation activities while protecting the integrity of the patient-physician relationship, including patient privacy and confidentiality, and ensuring that all donations are fully voluntary" (Council on Ethical and Judicial Affairs, 2017). However, the AMA follows its opinion and seems generally favorable to fund development by opining that "The greater the separation between the request and the clinical encounter, the more acceptable the solicitation is likely to be" (Council on Ethical and Judicial Affairs, 2017).

The narratives obtained for this issue of Narrative Inquiry in Bioethics have displayed great sensitivity to the issues of potential coercion in obtaining grateful patient donations while cautioning that these donations do provide extra funding to provide research or patient care services otherwise unavailable through institutional budgets (See Perlmutter, Curti, Hoke, Draper, and Kobashigawa.) Of course, at one time this observation might have applied to the generation of professional fees before these sources were captured by bureaucratization and made part of the support of ongoing operations.

Nelson and Taylor (2022) identify the potential for donations that do not fit the Titmuss category of altruistic gifts and the need to provide ethical guidelines regarding their acceptance. Sanky and Appel (2020) propose in their article on "tainted largess" in medical school donations three tests of a gift before its acceptance. First, they suggest the need to scrutinize the donor's expressed views, actions, and conduct. Secondly, they ask what is the source of the donor's funding to exclude corrupt sources of funds but also money that exceeds the reasonable capability of the donor to make the gift. Third, what are the donor's motivations for giving?

These can be difficult assessments for the physician to make, and are a source of concern to the authors of our narratives in this issue. Author Reshma Jagsi has no questions about whether her patient who had just finished explaining how her "daily radiation treatments were going to pose a substantial financial burden to her family" could

afford to make a financial gift. The patient was handed a pamphlet about fundraising opportunities at the reception desk and asks Jagsi about it. Jagsi explains in her story, "I did not want to make her feel bad about her financial status. I did not want her to worry that her inability to donate would have any influence on my care for her. I wanted to maintain her trust."

Malinowski (1962) raised the question of the limits of a model of altruistic gifts, and other anthropologists have observed the functional exchange nature of gifts in promoting social harmony. The legend at the old Peter Bent Brigham Hospital in Boston that was passed on to new house officers suggested that Mr. Brigham had donated his fortune to establish the hospital bearing his name as restitution for his discovery that a pie had five quarters. The narratives in this issue reflect this dilemma and often site the involvement of professional development officers as a desirable solution to such difficult judgments.

Dr. Leslie Matthews co-authored a narrative with philanthropy colleague Leah Murray. They write, "Providers are encouraged to think of their philanthropy colleagues as an extension of the care team, where our philanthropy professionals can triage their gratitude and match them to the most appropriate opportunity."

Grateful Patient Donations as a Restoration of Relationship in the Physician-Patient Dynamic

In the contemporary world of increasingly corporatized and bureaucratized interactions between patients and physicians, the once highly personal interaction of the two on the payment of professional fees is now shrouded by back-office billing or collection personnel and the presence of third party payers that set the terms for payment. Ironically, the depersonalization of this aspect of the caregiving process is attractive to many physicians who prefer to leave this work to others. Younger physicians in particular find relief from this perceived burden as an attractive element of practice within an organizational setting.

Is it possible that the grateful patient gift is an attempt by the donor to reestablish the personal dimension by the patient into a world of increasingly sterile encounters? As noted previously, a gift may convey benefit to the giver of a nearly therapeutic character while not meeting the definition of an altruistic gift.

Conclusion: To Whose Benefit?

Academic medical institutions are increasingly reliant on grateful patient donations as a funding source. In the best case, these funds allow the organization and its physicians to head in new directions of patient care and research that would not be otherwise sustainable. As one looks at the history of grateful patient initiatives, this is the justification cited in the early days of such programs.

A cautionary parallel case exists in the realm of professional fee generation that has increasingly supplanted lost revenue from other sources, especially public appropriations. As pressure continues on these sources of operating funds, will grateful patient donations be increasingly captured to support operating expenses of the institution?

A public policy question is whether grateful patient donations address the shortfalls in the mission attainment of medical schools. At the level of policy, primary care and mental health are identified as glaring deficits in the U.S. health care system. The U.S. Health Resources and Services Administration (2019) identified a deficit of 13,758 primary care physicians and 6,100 psychiatrists in known provider shortage areas alone. While the missions of U.S. Schools of Medicine vary from research intensive schools to those with an avowedly community focus, these concerns are common to all.

Public health is another acknowledged shortage area that is under resourced (Watson, 2022). The current COVID-19 pandemic has increased public awareness of this vulnerability in the U.S. health care system, but funding for future academic initiatives in this area remain uncertain.

As one reviews the grateful patient narratives in this issue, a general theme emerges of patient gratitude for what might be considered tertiary

services associated with rescue medicine that are more in the realm of specialty care. As Wright and colleagues note (2013), ethical considerations of patient vulnerability typically enjoin psychiatrists from approaching patients for donations.

Management of chronic disease may not attract donors to the degree more dramatic interventions can attain. Research breakthroughs in primary care are more often generated through health services research rather than in basic science research that might generate a cure for a problematic disease.

Can ethical practices prevail in grateful patient philanthropy as institutional pressures for additional funds increase? The stories in this issue of Narrative Inquiry in Bioethics certainly give us hope. At the same time, we must remember Chaucer's Pardoner's cynical admonition, "Radix Malorum est Cupiditas" and maintain our organizational firewalls at full strength (1959).

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