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The Professional Ethics of Billing and Collections

Mark A. Hall, JD

Carl E. Schneider, JD

MEDICINE IS A PROFESSION ON WHICH PHYSICIANS rely for their livelihood and patients for their lives. If physicians do not charge for services, they cannot survive. If patients cannot afford those services, they cannot survive. No wonder many physicians have long agreed that fees are “one of the most difficult problems . . . between patient and physician.”¹

For years comprehensive insurance subdued this problem, but currently widespread underinsurance and consumer-directed health care are reviving it. Even as the ranks of the uninsured continue to increase, the latest hope for controlling medical costs requires insured patients to pay for much more care out-of-pocket. The theory is that patients who pay will be good consumers and will shop for good health care at good prices.

In this consumerist world, physicians must decide how to bill and to collect for their services. Medical ethics addresses these issues primarily as matters of professional etiquette and efficient business. Yet charging and collecting for health care unavoidably affects physicians’ duties to serve patients’ best medical interests. Therefore, these business practices merit ethical attention.

Two Models of Professionalism

History, law, and logic suggest 2 contrasting models for the business of medicine. In a *transactional* model, medical care is like any other service, constrained only by the rules governing any business exchange. Patients pay what physicians charge, and physicians recruit any legal remedy to collect. In a *relational* model, medical service is embedded in a therapeutic relationship in which physicians have personal and moral ties to patients that make maximizing profits inappropriate. Workable models are never as distinct as ideal types imply, but ideal types sharpen issues.

The ethos (if not necessarily the practice) of 19th-century medicine embodies the relational model:

[T]he doctor, regarding himself as the servant of the community, gave his services to all in accordance with their needs, and collected fees from each of his patients in accordance with his ability to pay. . . . [A]ccounts were kept and money was passed, but, even though individuals might often depart from their ideals, the circumstances of the times and the ethics of the profession kept medicine rather free of commercialism.²

The transactional end of the continuum is exemplified by the way many hospitals currently bill patients. Most insured patients receive negotiated or regulated discounts, but hospitals charge uninsured or out-of-network patients a (virtually arbitrary) multiple of what insured patients are charged and what services cost.³ Even charitable hospitals aggressively pursue patients who do not pay inflated bills, provoking outrage, legislation, and promises of reform.

Hospitals can behave this way because courts treat hospitals like ordinary businesses and patients like ordinary consumers.³ In one emblematic case, a mother protested, “I signed where she told me to sign, so they would give [my son] medical treatment . . . [H]e was bleeding out of his ears, out of his mouth, the bone out of his elbow was sticking out through the skin.” The court admonished that patients “cannot seriously argue that an agreement requiring them to pay for services that they admittedly received and benefited from is unfair” or that patients are “under pressure greater than that felt by any debtor.”⁴

Navigating the Continuum

Tumultuous changes in health care finance and delivery have inclined physicians, like hospitals, toward the transactional end of the continuum. According to one report, one-third of physicians offer no discounts or free care to poor patients.⁵ In 2004, only 5% of patients in private practices were uninsured, down from 16% in 1993, and insurance payments accounted for about 90% of most physicians’ revenue.⁶ In a study in which callers posed as patients at ambulatory care clinics following emergency department care, nearly three-fourths of those claiming to be uninsured were unable to obtain an appointment for follow-up care.⁷ Medical practice consultants remind physicians that they may legally turn away delinquent patients except in emergencies, and they advise being “aggressive about collecting from poorly insured patients, especially as their numbers grow,”⁸ since “patients are more likely to pay doctor bills when they’re not feeling well.”⁹ Thus, 75 of the 125 (60%) ambulatory care clinics in the study noted above that accepted uninsured callers demanded payment in full rather than agree-

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ing to accept \$20 up front and billing for the rest.⁷ For insured patients, many physicians treat now and bill later, but they ask for immediate co-payments and they refer overdue bills to collection agencies more readily, as some professional journals and collection agencies urge.¹⁰

There are practical justifications for these behaviors (market pressures, office managers, etc), but these business practices merit ethical reflection. Ethics codes, however, offer physicians little guidance about the transactional-relational continuum. According to the American College of Physicians' "Ethics Manual," "a sense of duty to the patient should take precedence over concern about compensation."¹¹ According to the American Medical Association's ethical opinions, physicians charging interest or late fees are encouraged to use "compassion and discretion in hardship cases" and to waive co-payments that are "a barrier to needed care because of financial hardship."¹² But this leaves much unaddressed.

Enduring Principles of Professionalism

Cookbook ethics are no better than cookbook medicine. Each physician must decide where to rest on the continuum between the transactional and the relational paradigms. Much depends on circumstances. For instance, what is the patient's situation, and how well does the physician know it? Is the physician a well-compensated specialist or a struggling primary care physician? Much also depends on how physicians think about their incomes. In commercial marketplaces, workers try to maximize their incomes, as chief executive officers of large corporations have done. How commercially should physicians behave?

Before individuals become patients, physicians may legally turn away anyone they think cannot pay their bills. On the other hand, physicians have sought, and society has granted, a monopoly on medical practice. In exchange, physicians have undertaken a professional commitment to help those in need. That social undertaking is not owed to any particular person, however. Patients' individual rights do not arise until physicians begin to examine and treat them. But then physicians (unlike businesses) become fiduciaries, held to a higher standard than the morality of the marketplace. As a result, even the most transactional physicians owe more than arm's-length duties to their patients. For example, while companies can abandon customers, physicians may abandon patients in need only when other medical help is available.

Legally, physician-patient treatment relationships start and end episodically, even with the patient's regular physician. Professionally, however, when relational physicians accept patients they create bonds with moral and personal elements. Professional obligations carry forward from one episode of illness to another, and relational physicians are reluctant to refuse patients without excellent reason.

Physicians search for the best way to help patients toward good medical decisions, but insufficient insurance and consumer-directed health care complicate that process by bringing cost more clearly into consideration. Many patients live precariously from paycheck to paycheck, and even modest medical purchases make a major difference. Seeking medical care can be economically frightening, especially to ill, anxious, and vulnerable patients who also may avoid mentioning cost or financial hardship for fear of offending their physicians.

Patients' concerns can be eased by clarifying payment obligations early, but to do this is difficult, as Hippocrates warned:

Should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or that you will neglect him and not prescribe any immediate treatment. . . . For I consider such a worry to be harmful to a troubled patient, particularly if the disease be acute.¹³

Unlike legal affairs for which lawyers establish financial arrangements before accepting a case, the exigency and uncertainty of much medical care preclude advance financial agreements. The need for tests and treatments cannot always be predicted, and time spent discussing money can delay or deflect other crucial work.

Worse, if consumer-directed health care proliferates, fees will increasingly depend on how insurers adjudicate coverage for each charge, how much of a deductible remains unmet, and the insurance-specific discount for each charge. Real-time claims adjudication may someday evolve; meanwhile many patients enter and leave treatment with little idea of how much debt they are incurring.

Both transactional and relational physicians have good reasons to help patients decide what treatment suits both the patient's illness and financial situation. But what if patients cannot afford what they truly need? The relational physician assists the patient in several ways (<http://www.hschange.org/CONTENT/1017>). Many physicians strive to help patients find inexpensive care and arrange payment terms. Many ask uninsured or out-of-network patients for only a down payment at the time of treatment. Relational physicians will sometimes waive full payment.

When accounts remain unpaid, relational physicians heed the 1832 ethical admonition not to "exercise unfeeling rigor in the collection of fees."¹⁴ According to Cathell, whose homespun advice influenced a generation of physicians:

If you attempt to shave too closely in money matters—grabbing when a patient . . . [is] so low that it is no longer decent to take fees, . . . or being grossly unreasonable, or . . . too vigorous in your efforts to collect fees from persons in narrow circumstances—[this] would not only be brutal barbarity, but would be very apt to prejudice your reputation and create a wide-spread community feeling of hostility against you.¹⁵

Many individuals still consider indiscriminate and aggressive pursuit of medical debt unethical, especially from patients who have no reasonable capacity to pay. Thus, physicians and medical office managers sensitive

to a patient's financial situation advise giving friendly reminders, offering extended payment terms, or reducing or forgiving charges to indigent patients. Practice experts also advise writing off uncollectible accounts rather than sending them to futile and even bankrupting collection, not sending bills to collection precipitously or before talking with the patient, and not substituting bellicose collection for properly terminating a treatment relationship.

In today's world of high medical costs, large medical bureaucracies, and the unsolved problem of millions underinsured, physicians alone cannot rescue patients overwhelmed by medical bills. But the long-standing professional ethos of the relational physician still can honor the bonds of trust and care that tie patients to physicians, even in the emerging era of consumerism.

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REFERENCES

1. Cabot H. *The Doctor's Bill*. New York, NY: Columbia University Press; 1935.
2. Committee on the Costs of Medical Care. *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care, Adopted October 31, 1932*. Chicago, IL: University of Chicago Press; 1932.
3. Hall MA, Schneider CE. Patients as consumers: courts, contracts, and the new medical marketplace. *Mich Law Rev*. 2008;106(4):643-689.
4. *Greene v Alachua General Hospital*, 705 So 2d 953, 953 (Fla Dist Ct App 1998).
5. Cunningham PJ, May JH. A growing hole in the safety net: physician charity care declines again. *Track Rep*. March 13, 2006:1-4.
6. Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2004 summary. *Adv Data*. 2006;374(374):1-33.
7. Asplin BR, Rhodes KV, Levy H, et al. Insurance status and access to urgent ambulatory care follow-up appointments. *JAMA*. 2005;294(10):1248-1254.
8. Terry K. Getting paid when patients have bare-bones coverage. *Med Econ*. 2008; 85(7):18-20, 22.
9. Brown M. Practice pointers: tame the account receivable beast. *Med Econ*. 2002; 79(22):64, 67, 68.
10. Hajny T. The what, why and when of collecting patient balances. *J Med Pract Manage*. 2003;19(1):32-34.
11. Snyder L, Leffler C. Ethics manual, fifth edition. *Ann Intern Med*. 2005; 142(7):560-582.
12. American Medical Association, Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions With Annotations*. Chicago, IL: American Medical Association; 2008.
13. Fabre J. Hip, hip, Hippocrates: extracts from the Hippocratic doctor. *BMJ*. 1997; 315(7123):1669-1670.
14. Baker RB, Caplan A, Emanuel L, Latham S. *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society*. Baltimore, MD: Johns Hopkins University Press; 1999.
15. Cathell DW. *The Physician Himself From Graduation to Old Age*. Philadelphia, PA: Davis; 1882.

Can the Food Industry Play a Constructive Role in the Obesity Epidemic?

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IN RESPONSE TO INCREASING RATES OF OBESITY, MANY FOOD companies have announced policies of corporate responsibility. McDonald's claims, "[we] empower individuals to make informed choices about how to maintain the essential balance between energy intake (calories consumed as food) and energy expenditure (calories burned in physical activity)."¹ Coca-Cola states, "we have launched new broad-based physical and nutrition education programs that reach even the least athletic students."² PepsiCo says, "we can play an important role in helping kids lead healthier lives by offering healthy product choices in schools, by developing healthy products that appeal to kids and by promoting programs that encourage kids to lead active lives."³ Kraft says, "helping children and their families make healthy food choices while encouraging physical activity has become part of how Kraft gives back to communities."⁴ In light of such statements, should the food industry be welcomed as a constructive partner in the campaign against obesity?

The Dark Side of the Food Industry

Simon⁵ examined food corporation practices in the United States, especially with regard to school nutrition, and concluded that companies "lobby vociferously against policies to improve children's health; make misleading statements and misrepresent their policies at government meetings and in other public venues; and make public promises of corporate responsibility that sound good, but in reality amount to no more than [public relations]." At the request of the World Health Organization, Lewin et al⁶ compared the promises and actual practices of 2 leading food companies in the United States, documenting systematic discrepancies. Despite claims to the contrary, McDonald's at least up to 2005 continued to use *trans* fats in cooking oil (and was required to pay settlement costs for deceptive advertising); to market unhealthy products to children with toys, games, movie tie-ins, and trips to Disney World; and to promote supersized versions of Happy Meals.⁶ Kraft, the second com-

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