The Professional Ethics of Billing and Collections

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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:

[The 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. . . .] Accounts 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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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.hascchange.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 help patients find inexpensive care and arrange payment agreements. The need for tests and treatments cannot all be predicted, and time spent discussing money can delay or deflect other crucial work.

When accounts remain unpaid, relational physicians heed the 1832 ethical admonition not to “exercise unfeeling rigor or being grossly unreasonable, or . . . to overgirous 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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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 unhealthful 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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