Physician Charity Care in America: Almost Always an Illusion, Ever More Commercial

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Abstract: The first Code of Medical Ethics promulgated by the American Medical Association (AMA) in 1847 included a provision that essentially obligated physicians to care for those in their communities who could not afford to pay for professional services. The spirit of that provision remains embodied in today’s Code. However, a “charity care” ethical obligation may not make as much professional sense as it once did. Health care institutions have assumed a much greater role in providing charity care and many physicians are now under legal and quasi-legal obligations to provide care in some cases. Under the recently enacted Affordable Care Act (ACA)—if fully implemented—it is theorized that as many as 95% of Americans will be covered by some basic insurance plan. Perhaps today’s physicians should tailor the charity care mandate into a new jacket, which envisions that all doctors share equally in the care for those without adequate means. An individual obligation may have to make way for a more communal one in professional codes. Moreover, it may be wise to consider if there are any lessons to draw from other health care systems (e.g., the Dutch), where questions about charity care still exist within a universal health care system context.

Keywords: health care; physician; hospital; charity care; United States; ethics; code of ethics; American Medical Association; commercialization; Affordable Care Act
As the stories we live by, myths are inescapable metaphors, and the most we can do is to choose which ones to honor, not to live without them in some Alpine air of cold, clear “reality” [1].

1. Introduction

A recent article in *The New York Times* by Abby Goodnough titled “Hospitals Look to Health Law, Cutting Charity” [2] included several surprising points:

- “In St. Louis, Barnes-Jewish Hospital has started charging co-payments to insured patients, no matter how poor they are.”
- “Many hospitals appear focused on reducing aid only for patients who earn between 200 percent and 400 percent of the poverty level, or between $23,340 and $46,680 for an individual.”
- “[S]tarting this year, only patients below the poverty level will receive…charity care, said Paul Trainor, [Southern New Hampshire Medical Center system] vice president of finance.”

Of course, these headlines deal with hospital charity care, but the same pattern has been emerged in physician charity care as well [3]. Hospital and physician charity care—as Americans have come to know it in the distant and recent past—is changing radically. Given the present realities, perhaps US hospital and physician ethical obligations should be reframed accordingly?

Since its first *Code of Medical Ethics* was published in 1847, the American Medical Association (AMA) has affirmed that there is a professional obligation for individual physicians to care for those with medical needs but with limited financial resources ([4], pp. 105–06). The exact language often cited from the 1847 Code that created this duty reads: “But to individuals in indigent circumstances, such professional services should always be cheerfully and *freely* accorded” (emphasis added) ([4], p. 106). There was no question at the time that *freely* meant “free-and-clear” or “absolutely free” if the patient could not pay. This notion has continued to the present day in the AMA *Code of Medical Ethics* and its ethical opinions in some form or another, though with much watered-down language from the original [5]. Today’s applicable AMA code statement bears little resemblance to the 1847 ideal. The complete relevant passage contains broad language for maximum flexibility in interpretation:

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician’s practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of the physician’s practice schedule.

In the poorest communities, it may not be possible to meet the needs of the indigent for physicians’ services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity. Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways, such as seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor. Physicians can
also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor [5].

As altruistic and noble as the professional norm to provide charity care appears at first glance, any ethical obligation has proven so hollow over the years that it is essentially non-existent, or illusory. The recent enactment and partial implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, which creates new care opportunities [6], only exacerbates these concerns [7]. Given these developments and evolving physician practice patterns, it may be prudent to re-examine the referenced individual physician’s charity care obligations, with an eye towards either its elimination or re-wording to allow for a more modern conceptual interpretation or revitalization. In doing so, it may be prudent to examine the obligation’s historical roots, its meaning, and why the current provisions may be a hollow shell. A brief comparison with the Dutch health care system will illustrate that a comprehensive health care model still needs some regulatory infrastructure for “charitable care”, even when there is a funded unambiguous communal obligation underpinning the system.

2. History of the Physician Charity Care Obligation

The “Era of Good Feeling” origin of the physician charity care obligation in the 1847 AMA Code of Medical Ethics is unclear. A first possibility may be that the provision was imported from Thomas Percival’s 1803 treatise: Medical Ethics; Or, A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons [8,9]. Percival’s Code was not written primarily to record the medical ethics obligations of the day. Instead, it was developed at special request so that some practitioners might work more civilly and collegially with one another and a particular hospital’s staff [10]. Initially Percival—highly respected by the Manchester Infirmary trustees and the warring parties—developed guidelines only for that early 1790s facility’s operations, where a fractious dispute arose among the physicians, surgeons, and apothecaries who practiced there during a typhus or typhoid fever epidemic. Naturally, Percival’s Code—written specifically to help meet immediate mediation needs of the moment—reads more like a book of etiquette than an orthodox medical ethics text [11]. Much of Percival’s Code deals with how physicians should behave when interacting with one another, and has little to do with professional obligations to patients.

A second interpretation about the provision’s origin comes from Professor Robert B. Baker, who suggested that, the 1847 AMA Code language about charity care might be better attributed to John Bell and Isaac Hays rather than Percival ([10], pp. 34–31). Baker and colleague Chester R. Burns opined that the physician charity care obligation might have arisen from Bell and Hays’ University of Pennsylvania medical professor and mentor Benjamin Rush. Rush who crafted an Americanized code of ethics of-sorts in his Sixteen Introductory Lectures to Courses of Lectures Upon the Institutes and Practice of Medicine [12], a work very similar to Percival’s, but written for a different reason [13]. Rush stressed physicians’ civic responsibilities to their communities, which included providing gratuitous services to the poor. Rush, Bell, and Hays saw American physicians as morally sensitive
“Christian gentlemen” (even though Hays was Jewish) who met community obligations and served humanity. In their view, physicians were to act, as did the Good Samaritan of Judeo-Christian Scripture, showing mercy and compassion to others in need ([10], pp. 25–29; [12], pp. 174–75).

How Rush, Bell, and Hays ultimately came to the conclusion that it was an American physician’s obligation to provide gratuitous professional services to the poor or indigent is just as uncertain as Percival’s. It may have simply been a historical tradition they wished to continue. We know from medieval history that when both Roger II of Sicily (about 1140 AD) and his grandson the Holy Roman Emperor Frederick II (about 1224 AD) first “licensed” physicians in their realms they required doctors to treat the poor without fee [9]. One should note that if this is the origin, physicians were under a legal obligation to subsidize care for the poor rather than a purely ethical one. Of course, there are differences between legal and ethical obligations; but when the ethical merges into the legal or vice versa, it may take considerable effort to tease out subtle differences.

This legal or quasi-legal obligation also extended to the midwives of the 1600s as well [14]. Baker reported that these midwives were expected to care for the poor in order to assure the integrity of the baptismal font—an ecclesiastical function—for both Catholic and Protestant infants. In his review, Baker said that the oldest medical ethics documents in America are the midwives’ oaths, which had been imported from Britain. These midwives’ oaths required that practitioners help any woman in labor, rich or poor. Again, this was a church standard administered by the bishops, not solely an ethical one. Baker also wrote that the oldest American medical society charter—the Instrument of Association and Constitution of the New Jersey Medical Society (1766)—accepted as a given that physicians remained committed:

…to an office of benevolence and charity...always most readily and cheerfully, when applied, to assist gratis, by all means in [their] power the distressed poor and indigent in our respective neighborhoods, who may have no legal means of maintenance from their county; but where such reasonable provision takes place, there [physicians] shall expect a reasonable award…[14].

A third possibility about the origin of the initial AMA charity care provision may be grounded in fervent opposition to physician advertising. Bell and Hays had extremely negative views about this, and the 1847 AMA Code condemns the practice ([4], pp. 105–06). About the same time as the first AMA Code appeared, it was not uncommon for physicians to advertise openly for new patients and referrals. Quite a few of these announcements included statements that the advertising physician was accepting new patients whether they could pay for his services or not. In today’s advertising jargon, it might be said that the advertising physician was using charity care (or discounted fees) as a “loss leader” to attract new patients [15]. Perhaps as a counter move to physicians who were advertising for new patients, even poor patients who could not pay for services, the 1847 Code recognized that it was the responsibility of all ethical physicians to provide care for the poor and indigent, thus in effect negating any goodwill or higher moral claim that might flow to physicians who advertised that they cared for the poor.

Despite uncertainty about the origin of the provision and its goal, requirement interpretation and application have changed over time. Today the relevant passage is construed as requiring the individual physician to provide charity care, but upon close examination the actual meaning of charity is ambiguous.
3. Definitions of Charity Care

Early American physicians (such as the New Jersey medical society members, Rush, Bell, and Hays) used the terms *gratis* and *freely* in conjunction with their interpretations of charity care. Physician attention was rendered without expectation of remuneration; it was *gratis*, offered free, to those who could not pay for services. This seems consistent with earlier professional views about moral responsibility as derived from religious teachings. These early physicians believed, in part, that medical services were provided to those in need because as humans, those who could *should* care for the vulnerable.

Some scrutiny reveals, however, that the term *gratis* may not have meant without remuneration. In order to remain in practice, physicians who cared for the poor must have relied either upon the philanthropy of wealthier community members or government for subsidy, or providers cost-shifted the expense of caring for those with less means by charging those with means more for services. In private practice—as small business owners—early American physicians were at liberty to set their own sliding-fee scales based on their patients’ ability to pay so long as their enterprises flourished. The New Jersey physicians who created their medical society in the mid-1700s must have had something like this in mind when the stated in their charter: “where such reasonable provision takes place [that is, when funds are available], there we [the physicians] shall expect a reasonable award [or payment for services]” [14]. Recall too that the 1847 AMA *Code* deals extensively with fees and physician payment for services; physicians of the day were quite concerned about how they were to be reimbursed ([4], pp. 105–06). American physicians of the era certainly did not offer services to all patients *gratis* or for free. Also, cost shifting was a common practice for hospitals, at least until the advent of Medicare and Medicaid [16]. With the growth of governmental programs, hospitals became service “vendors”. One court decision from the 1960s made the shift quite clear: “The modern hospital, whether operated by a city, a church, or a group of private investors, is essentially a business” [17].

Presently, physicians often do not agree with one another when they talk about the charity care that they provided [18]. One dictionary defines *charity* as:

1. Provision of help or relief to the poor; almsgiving.
2. Something given to help the needy: alms.
3. An institution, an organization, or a fund established to help the needy.
4. Benevolence or generosity toward others or toward humanity… [19].

Reflecting on charity care duties today, physicians may be thinking or talking about any number of situations: (1) providing services and not asking for or expecting payment in return, that is, providing services *gratis*; (2) discounting an expected payment for services rendered to a patient, as is often done when a physician accepts what an insurance company might pay for services rather than the usual and customary charge; (3) accepting as payment in full what a government health program like Medicare or Medicaid pays the physician for services provided to a patient; or even (4) accepting whatever payment is received from whatever source when the physician provides care to patient in an emergency department or in the hospital because of some legal or quasi-legal obligation (such as medical staff bylaws obligations imposed because of Emergency Medical Treatment and Active Labor Act [EMTALA] requirements or rotational call systems) [20]. As a result, there are many different accepted definitions of *charity care*, which ideally may be separated, but unfortunately conflate in daily language.
4. Rationale for Revisiting the Physician Charity Care Duty

There are several practical and moral reasons showing that the evolved charity care provision may have become an empty platitude that no longer serves its original purpose. To avoid losing credibility in the medical profession, individual physicians and the AMA (as representative of organized medicine and the whole field) should reconsider the physician charity care obligation as derived from its historical codes of ethics.

(1) As noted in the previous section, physicians usually charge all patients a fee for their services, and later forgive the debt for those who do not pay. The notion of “charity” therefore, seems questionable in degree and misleading. For Americans who grew up in small town America during the depression or even in the 1950s and 1960s, before the “system” transformation resulting from Medicare and Medicaid implementation, this debt-forgiveness model offered a means of support for many community professionals (such as physicians, lawyers, pharmacists, and dentists). One well-known example of this barter system arrangement is seen in Harper Lee’s *To Kill a Mockingbird* when farmer Walter Cunningham repays when he can attorney Atticus Finch for services rendered with crops from his farm [21]. As in the novel, Americans of that time lived sober lives of honesty, frugality, and self-reliance, with more community transparency. Physicians of the day were integral to the community and its survival and flourishing. However, this practice of providing services with some expectation of remuneration is probably not the charity care definition that the original provision framers like Rush, Bell, and Hays intended. And with successive revisions of the AMA Code of Ethics over the years, this fact must have been recognized and the language modified and tweaked to accommodate newer views. Even today, some physicians want to further commercialize the accepted definition by allowing tax credits for physician charity care [22]. They argue, quite persuasively, that they are entitled to the same tax breaks as hospitals and foundations that provide charity care. In considering this proposal, the American Medical Association Council on Medical Service opted to support the expansion of insurance coverage under the ACA instead of individual tax credits [23].

(2) Over time, fewer and fewer physicians now honor the obligation to provide charity care to indigents. As the aspirational does not correspond with the norm, the provision appears no longer representative. This has been well documented by researchers familiar with physician practices overall and with specific specialties (such as surgery) [3,24]. The data have not been challenged. This discrepancy raises a related question: are ethical standards based on what doctors do, or on what they should do? Regardless, it becomes increasing more difficult to defend a professional norm as obligatory if fewer and fewer physicians over time are not meeting the standard [25].

(3) Organized medicine lacks the tools and interest to enforce the professional standard. One is hard-pressed to find the record of a physician being disciplined by a professional association or by a board of medical examiners because he or she did not provide charity care. And again, if the standard must be continually enforced by peers to assure its compliance, the ethical obligation then appears more-and-more like a legal or quasi-legal standard rather than an ethical one motivated by charity and goodwill toward the needy.
(4) It would be extremely awkward now—as it was in times past—for individual physicians to separate the “the poor, the destitute, the lowly, the worthy, and the unfortunate” from those that have resources but say they do not [26]. In other words, it is nearly impossible for individual practitioners to categorize true charity care patients from others who have the means to pay for their own health care. What is the reasonable threshold? Despite the efforts of one state medical association, which may hold to this view toward distinguishing real charity care cases, and offer guidance for means testing patients, the practical barriers are too high to sort out and police fairly [27].

(5) As a result of dramatic changing practice patterns, physicians are not usually in the authority or executive positions to make decisions for the broader enterprise that may provide charity care to patients in some cases. Physicians are more frequently employees rather than independent private practitioners within large organizations. The shift toward integration of health care over time has complicated any physician provision on charity care. The 1847 AMA Code is grounded in the framework of individual physicians working in solo or small group private practices. It would have been difficult for Rush, Bell, and Hays to imagine physicians as employees of hospital networks, dependent on insurance companies for fee schedules and payments, or some version of government-provided universal health care. Until the second half of the Twentieth Century, medical options were more-or-less contained within a single practitioner who carried all he or she could offer around in a “black bag”. Today this is no longer the case. One might wonder if organized medicine waits too long to change some policy positions [28], whether it will appear out-of-touch and lose political clout by continuing to support untenable, even though aspirational, views. The present AMA Code of Medical Ethics should reflect current, normative practice standards.

(6) In today’s world of modern medicine with specialization and its dependence on sophisticated diagnostic aids and expensive treatments, it would be very difficult—if not impossible—for a single physician or a group of private practice physicians to deliver the quality of care necessary in totality for most patients. Modern medicine, and the claims of patients for modern medicine, are much more complex than their historical counterparts. As a result, a single physician cannot provide comprehensive charity care in a simple, straightforward way. With this, one may be reminded of the phrase “O God, thy sea is so great, and my boat is so small” [29]. Only the federal government, with its influence and nationwide enforcement authority, could intervene to remedy the problems associated with assuring adequate care for all indigents and vulnerable in all states and jurisdictions [30]. One might note that the federal government has already recognized a responsibility to care for the poor with the enactment of Medicare and Medicaid. The public policy debate today is not really about the recognized authority or role as much as it is about how far the responsibility extends and its associated costs.

(7) Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and typical hospital medical staff bylaws, many physicians are under a legal or quasi-legal obligation to render care to patients in emergency departments. In this situation, any additional duty about charity care does not seem to make as much sense. EMTALA was enacted initially to deal with the “patient-dumping” problem that occurred when suburban hospitals transferred unstable, uninsured or indigent patients to inner city medical centers for additional care even
though the transferring hospitals had the facilities and capabilities to meet patient needs [31]. The law created an unfunded mandate for hospitals with emergency departments if they have the wherewithal “capacity” and “capability” to serve unstable patients more locally, requiring them to absorb the associated expenses if the patient requires hospitalization and cannot be transferred to another facility. Hospitals share this burden with their credentialed providers—whether the hospitals’ physicians are employed or in private practice—since medical services may only be offered through physician staff members and associates. Moreover, the law extended an entitlement or “right” of sorts to some patients with emergencies who present at hospitals covered by the statute. Obligations exist because of the corresponding duties that are imposed on others to honor the rights [32]. Once an ethical responsibility is elevated to a legal right, as with EMTALA, hospitals and their physician staff are bound by law to meet the standard. Failure to meet EMTALA mandates carries severe legal penalties.

(8) Any individual physician obligation ultimately involves unrealistic expectations. Even with the recent enactment and partial implementation of the 2010 ACA which was crafted to provide some form of health insurance protection to about 95% of Americans as designed, the number of remaining persons in the US who will be uninsured or under-insured will certainly overwhelm any informal physician charity care net. One only needs to cite the plight of the 5% of persons in America who would not be covered by some form of insurance or government plan—such as illegal immigrants—if the ACA were fully implemented to illustrate this point [33].

(9) The charity care duty, in its current form, does not seem to fit with the liability concerns that have arisen under modern legal doctrines. Medical negligence and liability concerns that must be taken into consideration even though a physician may be providing care to a patient with no expectation of remuneration. Malpractice laws have created a safeguard for patients, and the poor should not be deprived of this protection. Some states, in an effort to encourage retired physicians who no longer carry malpractice insurance to practice in charity care clinics, have passed charitable immunity statutes specifically to protect these physicians from liability. This may be considered an extension of the states’ “Good Samaritan statutes” that provide immunity to physicians who stop at the scene of an accident to render emergency aid without the expectation of remuneration [34]. To treat poor and non-poor differently with respect to malpractice claims would have been discriminatory [35].

(10) Increasing scarcity of physicians complicates charity care and makes provision of such care impossible. EMTALA and the expanded coverage under the ACA have given rise to concerns that the physician workforce truly is a scarce good. It has been theorized that there are not enough doctors now to tend to the sick and chronically ill that need services. Some say that with the ACA there will simply not be enough physicians—particularly primary care physicians—to meet patient needs that will have legitimate insurance or government health program claim for physician services [36]. Given labor constraints, there will not be a safety net of providers available to offer any charity care in off-hours.
5. The Dutch Approach

A quick look at the Dutch health care system reveals that having a comprehensive, “inclusive” health care delivery arrangement does not eliminate the need for providing “charity care”. Even with an ideal that has “universal health care”, there remains a need to care for the “poor”. Moreover, the Dutch charity care formula illustrates how this concern is better addressed through a structured community obligation to provide a charity care safety net rather than depending upon provider support. Some refer to the Dutch model as “the health care system [that] most closely resembles what architects of the Affordable Care Act hope to create for the US” [37]. Even so, some people are still uninsured or uncovered. Local safety nets that complement the national system are not watertight and require government administration and additional regulatory framework. Delivery of some health care would be impossible without the “charity” of health care institutions and physicians.

Since 2006, the Dutch government has required citizens and residents to purchase a basic health care insurance through a private insurer [38]. Under this mandate, private insurers are obliged to accept applications from individuals seeking basic health care coverage. The government determines what benefits are offered in the minimum package. For those individuals who earn less than a specified salary level, financial assistance or subsidy is available to help purchase basic coverage. At least theoretically, the Dutch system insures everyone who requests coverage for basic health care needs.

Despite its comprehensive approach, the system still struggles with several categories of uninsured or uncovered individuals, implicating charity care considerations [39]. Uninsured individuals, such as Dutch nationals who categorically refuse health insurance, or those who are exempt (including military personnel or religious groups), or Dutch residents who have not enrolled because of poverty or neglect, still are entitled to “medically necessary” care as a right via a safety net mechanism that resembles EMTALA coverage in the US [40]. The fail-safe is triggered when health care providers—physicians or institutions—charge the uninsured for their health care services and do not receive payment from them. At that point, the government eventually reimburses 80% of the charges determined to be “medically necessary”. Providers are thus obliged to absorb 20% of the charges as loss offsets. Of course, the fail-safe is not perfect. Additional charity care—in the form of unreimbursed service charges beyond what the government determines is “medically necessary”—may be extended at provider expense. Also, certain non-urgent care needs (such as certain preventive medical interventions, vaccinations or screenings, or psychiatric medications) may not be covered by government reimbursement even though deemed “medically necessary” by providers. Health care providers may choose to provide charity care in these situations; moreover, institutions and physicians are encouraged to do so [41].

The “commercialization” of the Dutch health care system has highlighted controversy around charity care. The 2006 Dutch health care reforms made the cost of interventions more visible to individual physicians. The reforms also permitted more privatized elements, such as increased competition between private insurers, to increase efficiency and quality of care [38]. Overall, the changes meant a reduction of the state’s involvement in health care delivery and a shift in some responsibilities from the state to providers [42]. Institutional and individual providers became responsible for the burdens of care for the uninsured in a different way, and the changes have raised new questions about the scope of basic medical care and governmental subsidization. The reforms also brought increased skepticism
around the provision of charity care, while concurrently highlighting the community’s collective obligation, with the government assuming primary responsibility for the bulk of the expense.

The Dutch system has no ethical code like the AMA Code of Medical Ethics, which lays out a duty for doctors to provide charity care. Moral (and legal) obligations for charity care arise out of the nation’s commitment to provide everyone health care as a right. The Netherlands is a signatory to the International Covenant on Economic, Social, and Cultural Rights, which has not been ratified by the United States. Based on this covenant everyone within its jurisdiction should have access to health care without discrimination, and society should care for the poor and vulnerable (e.g., seniors, war and trauma victims, and those with language difficulties).

6. Conclusions and Recommendation

As shown, individual physician based charity care obligations are unmanageable and unsuitable given the complexities of today’s health care in the US. It may be prudent to abandon the anachronistic notion that physicians are personally obligated to provide charity care to indigent patients as part of their practices, or at least to revamp the obligation in more deliberate language that will allow clear accountability. A community obligation seems to make much more sense than an individually oriented duty. When outmoded professional norms have changed over time, organized medicine has revised its code of ethics to conform to current stances. The historical physician charity care obligation needs a modern jacket.

There are at least three substantive reasons for suggesting the change. First, organized medicine—at least the AMA—has other provisions within their Code of Medical Ethics that supports the bygone understanding of the charity care obligation within the progressive context of a more fair and just, community-wide responsibility. AMA Council on Ethical and Judicial Affairs Opinion 2.095 states: “Because society has an obligation to make access to an adequate level of health care available to all its members regardless of ability to pay, physicians should contribute their expertise at a policy making level to help achieve this goal” [43]. The AMA certainly met this professional obligation when it supported the enactment of the ACA [44].

Second, the community when assessing whether or not any obligation to care for indigents is met can hold the medical profession as whole accountable more easily [45]. In frontier America, citizens within the community were able to hold accountable individual physicians with their choice of doctor. Today, given fragmentation of care, specialization, insurer involvement, and mind-boggling technological advances, this simply is not possible.

Third, when physicians create a professional standard yet fail to meet that norm, the community—quite rightly—may view physicians as hypocrites. One might say that failing to meet the standards that physicians establish for themselves “soils”—in the words of Lincoln—professional robes. Lincoln in addressing fellow Republicans in 1854 criticized the recent passage of the Kansas-Nebraska Act authorizing the extension of slavery into the territories. He recognized that Americans (including himself) and their representatives had struggled with the slavery issue for generations. However, his most fierce condemnation came in the form of a stalwart defense of the Declaration of Independence:

This declared indifference [toward slavery], but as I must think, covert real zeal for the spread of slavery, I can not but hate. I hate it because of the monstrous injustice of slavery
itself. I hate it because it deprives our republican example of its just influence in the world—enables the enemies of free institutions, with plausibility, to taunt us as hypocrites—causes the real friends of freedom to doubt our sincerity, and especially because it forces so many really good men amongst ourselves into an open war with the very fundamental principles of civil liberty—criticizing the Declaration of Independence, and insisting that there is no real right principle of action but self-interest (emphasis original) [46].

The same might be said of the individual physician’s charity care obligation today. Pellegrino used the same line of thinking in asserting the moral nature of doctoring in 1986:

[The physician] binds himself to competence as a moral obligation [and] places the well-being of those he presumes to help above his own personal gain. If these two considerations do not shape every medical act and every encounter with the patient, the profession becomes a lie: The physician is a fraud and his whole enterprise undiluted hypocrisy [47].

Discussing either charity care or expanding access to care as physician obligations does not make sense, unless one assumes that medicine as an endeavor has a moral basis different from the provision of other market-driven services. Defining that moral basis is essential. If one rejects this foundation—that medicine is not a special service but a marketplace activity subject principally to typical supply-and-demand forces—then defining obligations becomes so hard that there is risk of hypocrisy in proclaiming moral ideals. Any change—even the elimination of the charity care obligation—is not really that novel a position shift after reflection given the duty’s illusory value and continued commercialization [48]. Shelving individual physician responsibility and substituting a communal obligation is an approach that America has adopted with the Medicare and Medicaid programs. For specifically identified vulnerable populations—the poor and elderly—Congress expressed a willingness to move in part from a market justice paradigm to a social justice one [49]. Citizens ask governments to do what individual citizens cannot do alone or even through sanctioned organizations. The Dutch system is a good example of how a community obligation works beyond these systems. Despite an inclusive system, the need for charity care remains. Health care delivery carries a unique ethical responsibility, and given its intricacies today extends well beyond the capacity of individual physicians. An approach to provide charity care via a communal obligation respects the complexities of the delivery system. This too is a recognition that the range of acceptable resolutions to a critical problem is just too great to deal with except through wider-community concerted action.

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Conflicts of Interest

The authors declare no conflict of interest.

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