

Episode: Ethics Talk: Is VIP Care Really Better?

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[mellow theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. When, if ever, should clinicians be fundraisers for their organizations? In 2017 donations to hospitals exceeded \$10 billion. Health care philanthropy and development is, to say the least, lucrative. Pressure on clinicians to solicit donations from patients and to be part of health care organizational "development" is increasing, as are impulses to organize the so-called grateful patient programs." But demands these efforts place on clinicians and patients are rife with ethical trouble for patient-clinician relationships and potentially for service quality and health outcomes.

Many health care organizations gather data about patients and identify potential donors. Patients identified as having tappable means might be solicited for large donations or assigned VIP status. So, not only should we be ethically concerned about possible intrusive data collection and abuse, VIP status for anyone is one of the key hallmarks of segregation. Segregation in health care includes many means of separating patients into different classes and tracks based on their insurance status and their ability to pay. At the top of this tiered care are VIP patients. But as many of the articles in this month's issue discuss, the other end of practice routes poor patients, mainly those who are uninsured, through underfunded and understaffed service delivery streams. Since many patients on the short end of that stick are people of color, the result is de facto racial segregation that reinforces structural racism through health care and through health professions education.

As if exacerbating racial bias in health care delivery streams isn't enough to warrant close clinical and ethical scrutiny—and to be clear, it is—one surprising consequence of health care segregation is that VIP care is known to incorporate standard of care deviations that negatively affect outcomes for all patients, even VIPs. One possible explanation for this phenomenon, which is sufficiently widely documented to have acquired the name VIP Syndrome, is that clinicians caring for VIPs might feel uncomfortable asserting their professional judgment as they normally would with other patients. For example, some clinicians might agree to order unnecessary tests, even those whose potential risks outweigh their potential benefits. So, if a listener doesn't find segregated care unjust on ethical grounds, they might still find it questionable on clinical grounds.

But if VIP care isn't really better care, why would a patient with wealth be incentivized by the label VIP to donate to a health care organization's so-called Grateful Patient Program? One of the reasons this question is worthy of ethical conversation and investigation is that it points to the inherent vulnerability of patients. Before any patient can be grateful, they must first be ill or injured or otherwise in need. It's probably reasonable to assume in general that patients of means are better positioned by the social and cultural status conferred them by their wealth to wield more power than patients who are poor. And in this conversation, we keep in mind that any patient's need makes them vulnerable, and that this is a foundation of all clinicians' fiduciary and professional duties to patients.

Joining me today to talk about Grateful Patient Programs and the pressures clinicians face to fundraise on behalf of health care organizations for which they work is Dr Lisa Lehmann. Dr Lehmann is the Director of Bioethics at Google; she is an Associate Professor of Medicine and of Health Policy and Management at Harvard in Cambridge, Massachusetts; and she formerly served as the Chief Medical officer for the VA New England health care system. Dr Lehmann, thank you so much for being on the podcast today. [music fades]

DR LISA LEHMANN: Thanks, Tim. So wonderful to be here.

HOFF: To begin with, what are Grateful Patient Programs, for those who are unfamiliar with them, and what should clinicians know about the potential ethical risks of engaging in fundraising efforts with patients?

LEHMANN: Wonderful question, Tim. Many patients and clinicians may not even be aware that their hospitals have Grateful Patient Programs, and these programs are fundraising initiatives that allow hospitals and health care organizations to raise money from current patients or past patients. The goal is to identify donors that have had a positive experience with the hospital and who also have the financial capacity to be philanthropic and the willingness to give back to the organization. They've actually, in recent years, become fairly well developed where hospitals have actually a very systematic approach that's data driven, where they're screening patients—sometimes all patients may be screened on admission—for their capacity to donate and identify patients that have significant financial means that have visited the hospital either as an inpatient or as an outpatient. And then these patients, when they're admitted, they may actually be visited by hospital leadership. They may be given special treatment with special rooms.

And physicians, in addition to the screening of patients, these programs also encourage physicians to cultivate the skill of engaging with patients who may be able to contribute philanthropically. So, they ask, they often ask patients, they often ask physicians to play a direct role in cultivating the relationship with a patient so that the health care organization can raise funds. And they actually may have special programs that even train physicians on how to engage patients, because we know that fundraising at its core is based on relationships. And the physicians are the ones that have cultivated

already that relationship with patients, and they're also in the best position to really speak passionately about the health care mission or the research mission that the hospital may be trying to support.

HOFF: You say that there are more data-driven approaches to identifying patients who are in a good position to potentially donate. What kind of data is being collected that would point to that? Is it insurance information that sort of acts as a proxy for that, or what are organizations looking at?

LEHMANN: Right. I don't think it's insurance information per se, although I would say that certainly these kinds of programs are not prominent in health care organizations that are primarily serving marginalized or vulnerable populations with low income; they're targeting patients that have more financial capacity. But they may be looking at what are patients' past giving history, what are their real estate holdings, other things that indicate that they have the financial capacity to actually make a donation to a hospital in much the same way that other organizations, philanthropic organizations, profile individuals to see who is going to be the right person for us to ask.

HOFF: Mhmm.

LEHMANN: And then they are also data driven in the sense that they're following patients to assess, or they're looking holistically at the program to assess the return on investment.

HOFF: Sure.

LEHMANN: So, if we're approaching patients, how many of those who we have solicited have actually donated? How many new prospects have we identified? Are our donors repeating their donations? Are donors increasing their annual gifts? And what's the time from our receiving, from a patient being discharged with a very positive experience, let's say, from a surgical procedure to them actually making a donation? So, tracking all of that information is part of the Grateful Patient Program and I think part of trying to set it up to be as successful as possible.

HOFF: Mm. So, what steps can clinicians and organizations take to mitigate the potential ethical risks of these kinds of fundraising efforts?

LEHMANN: So, I think that at its core, I mean, first of all, it's important to step back and realize that the ultimate goal here of these programs you could say is positive, right? That hospitals are trying to raise money to support services and research that is ultimately going to improve patients' outcomes, and that these programs are also intended to foster a culture of gratitude among patients and allow patients to give back. But nevertheless, they raise significant ethical concerns because they create a tension between clinicians' role as a trusted caregiver who is really focused, and should be focused, on patients' best interests and playing this other role of being a fundraiser who is focused on the interests of the organization. So, that's where the ethical tension

comes in here and where being aware of the ethical risks is really important so that we can, so that hospitals can get it right. And what I mean by that is that they can create programs that are grounded in ethics that mitigate this tension.

So, the primary ethical risks that arise from these programs, I think, fall into three different categories. One has to do with putting undue pressure on patients to contribute, right? If I'm a physician caring for a patient, my patient comes to me with the expectation that I'm going to have their best interests as primary, that I'm there to care for them and their health care needs. And they shouldn't be worried that if they decide not to contribute to or respond to a request to give financially to a research program or the hospital, that they will in some ways be damaging their relationship with their physician. So, if I'm a physician, and I'm asking my patient to contribute to the hospital or to contribute to my research program, there's the potential of putting undue pressure on the patient and the patient not feeling free to decline because they may be worried that if they refuse to give to their physician who's in a position of power, that it may have an adverse impact on their health care. And that's especially true if it's an ongoing relationship between the patient and the physician where, let's say it's an oncology patient, a cancer patient, that is in treatment for some time, or if I'm a physician caring for other family members, a patient may feel maybe worried, rightly so, that declining to contribute may harm that relationship. So, the first ethical problem is the pressure that it may put on patients and the potential harm that that may have on the physician-patient relationship.

The second ethical concern is an expectation that patients who donate to a hospital or to a particular physician's cause may have preferential treatment. So, the patients who have donated significantly to an organization may expect concierge treatment or treatment with special rooms, and hospitals are known to, some hospitals have VIP floors. They may expect that physicians provide favors, such as them skipping the queue for an appointment and getting an appointment more quickly than others, having longer appointments, or early access to treatment even that may not be always clinically indicated. One example that I think we might even think about recently is access to COVID vaccines. Before they were broadly accessible in the way in which we as a society decided to roll out COVID vaccines to those who were most in need and most vulnerable, you can imagine that some donors may try to skip the queue or jump the queue and get access before they were really in the category for which we were allocating the vaccines. Or some patients may request to move up on a transplant list. So, that expectation for preferential treatment is another ethical concern.

HOFF: Mmhmm.

LEHMANN: The third thing that I think is really important also is the potential to breach patient confidentiality and erode patients' trust as a result of these programs. Patients may not actually even be aware that their physician or the institution has access to their financial information and that development staff in the hospital that partner with physicians in these Grateful Patient Programs who are non-medical staff may actually have access to their medical and clinical information.

HOFF: Hmm.

LEHMANN: And part of the way in which this occurs is that if I, for example, am an infectious disease doctor or a psychiatrist, and let's say I'm caring for patients with sensitive and potentially stigmatizing medical conditions, such as if I'm an ID doctor, and I'm taking care of HIV patients, or I'm a psychiatrist taking care of patients with depression. If I'm referring a patient to development staff, then the hospital staff automatically knows my patient's condition because those are the only patients that I take care of. In some of these academic medical centers, physicians are very specialized. So, there is a risk here of breaching patient confidentiality and therefore eroding that sacred trust and space between a patient and a physician. Patients may really be offended that their doctors and their health care organization are more focused on them as from the perspective of their financial capacity and what they can give than the focus on them as a patient and person. So, I think those are the three, really the three main ethical concerns and worries.

HOFF: Sure, sure. So, I'd like to sort of loop back onto ways to mitigate those potential risks, but maybe that can be wrapped up in the response to this next question about clinicians needing to cultivate the skills to be effective fundraisers. And I'm glad you brought up development officers because clinicians, as you know, are not standardly trained as development officers. So, I'm wondering if there's formal training and standards to help clinicians develop those skills and to navigate those ethical tensions in an appropriate way. Or is it sort of left up to the clinicians to develop the skills to do that ask and then sort of follow through in the way that they best see fit?

LEHMANN: I think this really depends on the health care organization.

HOFF: Mmhmm.

LEHMANN: Some organizations have really developed programs that include, for example, coaches to train clinicians in how to do this because, as you said, that's not, [chuckles] that's not the primary purpose of going to medical school and that clinicians are not given that kind of background and experience. Some clinicians may be better communicators and more naturally able to develop that kind of relationship with patients and have a proclivity towards doing that well. But hospitals have actually developed, some hospitals have developed formal programs where they actually train clinicians in how to engage patients for this purpose, and they do frequently include sensitivity to the ethical concerns. So, I think that there are ways to mitigate these risks. I don't think that we have clear standards yet to guide these practices, but hospitals that have developed, some hospitals that have developed programs have been very thoughtful and forward thinking about the ethical concerns and try to build into the Grateful Patient Programs a sensitivity to the ethical concerns so that they're walking a really fine line here in trying not to blur the lines between the physician as clinician and the physician as fundraiser.

HOFF: Mmhmm.

LEHMANN: Some of the ways in which they do that, I think, and I think some of the ways in which, to go back to your question about how to mitigate the ethical concerns, are really drawing a clear line between the physician as health care provider and physician as fundraiser by not having physicians directly solicit their own patients. And so, one of the ways that Grateful Patient Programs might do this is, first of all, by acknowledging the conflict and the tension so that clinicians are aware of it, that the programs actually call it out and acknowledge that they're trying to mitigate that tension. And instead of encouraging clinicians to solicit their patients directly, they rather encourage clinicians to put the onus back on the patient to contact the development office. So, it's not uncommon for a grateful patient that— And this is why they were called Grateful Patients, because there are many patients who really feel tremendous gratitude for the care that they've received from a clinician and from a hospital who has restored their health, and they want to give back.

HOFF: Mmhmm.

LEHMANN: And patients will sometimes ask clinicians, "What can I do to help?" And I think it's ethically acceptable in that situation for the clinician to actually give the patient the contact for the development office and say, "If you want to help, here's the number to call. Reach out to the development office," and then allow all the giving, the solicitation to be handled by the development office. So, I think one clear step is, first of all, for these programs to acknowledge the tension. Don't kind of, we shouldn't be putting our heads in the sand and saying that there's no problem here. There is a problem.

HOFF: Mmhmm.

LEHMANN: And the first step to mitigating the ethical concern is identifying it and then figuring out what can we do to address it. And avoiding, you know, having this clear line, and avoiding direct solicitation by physicians is a clear approach.

The other point that I think is really important here has to do with consent, and that is consent by the patient to actually let development, the development office, know about a patient and their interest in donating. So, if a patient says they want to help, and they request that a physician contact the development office, or if the physician, if the patient doesn't want to directly contact but they want to be contacted, it's important to have that consent from the patient to be in touch with the development office, for the development office to reach out to the patient. Because that then gives the patient agency and control over how their information is shared and who the information is shared with.

HOFF: So, it sounds like those potential steps of drawing that bright line in the sand between patient care and fundraising efforts and consent might sort of address mostly, it seems like the one and three of that three-part breakdown that you said. It sort of addresses the fact that care is primary, and it addresses the problems of confidentiality. It seems like there might still be an issue with the resultant potential priority treatment.

And so, I'm wondering how the practice of clinician-driven asking influences segregation in academic health centers. Is it just sort of a natural consequence of the American health care system, wherein you pay more money, you get better care? Or is that something that can be addressed as well?

LEHMANN: So, that's a wonderful question, and I think we should unpack it because there's an assumption built into your question that if you pay more money, you actually get better care. And I think there's probably anecdotal evidence to suggest the opposite, actually.

HOFF: Hmm!

LEHMANN: [laughs] Although this is a really interesting question that I think is very, very difficult to study, and one in which health care organizations are not really rushing to allow people to study. In other words, what I mean, do we have empirical evidence on health outcomes for patients who are actually receiving preferential treatment or preferential care, let's say, through these VIP or Very Important Persons programs that may exist where patients who have donated significantly to a hospital are actually placed on separate floors, are given different kinds of food, may actually have different kinds of health care? And I would suggest that in many cases, we see that once we take patients outside of the normal sort of standard practices of health care delivery and segregate them to these floors for Very Important Persons, VIPs, we actually risk diminishing the quality of care.

HOFF: Hmm.

LEHMANN: What happens is we create tiered health care systems where wealthy patients may actually receive different care from those of lower socioeconomic status. And that in and of itself is deeply troubling, I think, as we strive to have equity in health care and reduce disparities. And at the same time, I think that the systems that we put into place sometimes result in these patients not receiving all of the attention, actually, that they might get when they're on a regular floor. And that may seem counterintuitive or ironic in some ways, but let me just give you some concrete examples where patients on VIP floors, they may not have a medical student or a resident involved in their care.

HOFF: Mmhmm.

LEHMANN: And we know that actually, medical students and residents, sometimes the medical student is the one who can spend the most time with patients, who has the time to really sift through a patient's chart and really identify things that may have been missed by someone else. And so, there may be actual potentially lower quality care as a result of patients being on these floors, both because they may not get as frequent interventions or observations, they may not have their vital signs or their blood checked as often because we don't want to disturb them. And so, I think that there's a real uncertainty here about whether putting people or treating them differently is actually in

the best interest of their health first of all. That's one issue, right? Are they actually going to receive better care when they're in an inpatient as a result of that?

The other thing is I think we need to be thinking about, well, what does that do to the culture of our organization? What's the message that that sends to everyone else, both clinicians—and all of the clinicians, not just the physicians and the trainees, the nurses and all of the staff that are caring for patients—about the quality of patients and that everybody is a human being deserving of equal care? So, I think that these kinds of programs where we segregate patients and provide them with different care actually raise a lot of ethical concerns for hospitals that we should be rethinking.

HOFF: This is a question we ask often to folks on the podcast, but what should health professions students and trainees know about their roles in fundraising efforts and how to balance those responsibilities with their responsibilities to individual patients in the clinical encounter?

LEHMANN: I think it would be really rare for students and trainees to be directly involved in Grateful Patient Programs or the solicitation of patients.

HOFF: Mmhmm.

LEHMANN: Having said that, however, and even in my own experience in academic medical centers as a student and trainee, we are, students and trainees may be asked to care for potential donors and be involved in their care and may be asked to treat patients somewhat differently than they would be treating other patients. And so, this relates to the conversation that we just had in terms of whether or not these patients may actually, on the inpatient side, receive care that is suboptimal. I actually personally was involved in the care of a Very Important Person when I was a resident in which I was actually asked not to do a complete physical exam on admission of the patient.

HOFF: Hmm.

LEHMANN: And that just goes against everything we're trained as clinicians and is clearly not in the best interests of patients. But somehow that was seen as potentially an invasion of the patient's privacy or potentially something that the patient may not want a trainee to be doing, given that they had their own private physician also caring for them.

I think the most important thing here is for students and trainees to remember that as physicians, we really, we have this tremendous privilege and sacred responsibility to care for patients and to put their best interests at the heart of everything that we're doing. [mellow theme music slowly fades back in] And so, if we're put in a situation where we're being asked to do something involved in the care of a patient who is a potentially Grateful Patient or someone who has tremendous philanthropic capacity that we think is at odds with the patient's best interest, I hope that students and trainees really have the moral courage to speak up and to raise a question about whether or not

that is really in the patient's best interest. And that we remember that this is a sacred responsibility that we have to put our patients' best interests first.

HOFF: Dr Lehmann, thank you so much for your time and expertise on the podcast today.

LEHMANN: My pleasure, Tim. Thank you so much for making time to speak about this important issue.

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Dr Lisa Lehmann for joining us. Music was by the Blue Dot Sessions. To read the full issue on segregation in academic health centers, head to our site JournalofEthics.org. If you enjoyed this episode, we'd really appreciate it if you took a moment to rate and review the show on Apple Podcasts. It really helps expand our reach and get our expert contributors to more people. For our latest news and updates, be sure to follow us on [Twitter](#) and [Facebook @JournalofEthics](#), and we'll be back next month with an episode on child abuse and neglect. Talk to you then.