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Charity in Health Care: Safety Net or (Moral) Safety Valve?

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Charity in Health Care: Safety Net or (Moral) Safety Valve?

by

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Dedication

This dissertation is dedicated to the people who sought care at the Women's Wellness Clinic at St. Vincent's Episcopal House in Galveston, Texas, during the years that I had the privilege and opportunity to work there.

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When I first came to the Institute for the Medical Humanities, Tom Cole took a chance by allowing me to become a graduate student. As a mid-career clinician hungry for a richer engagement in the vast depths and heights of medicine, I felt pleased and overwhelmed. The life of the Institute, as it turns out, offered more than I could have imagined.

I am extremely grateful to each of my committee members who have all been the best at mentoring and generous with their time and support: Ron Carson, the elegantly sophisticated interlocutor and scholar with a piercing intellect; Bill Winslade, the phone-call-away supporter with an avowed and sustained commitment to each of his many mentees; Laura Hermer, the exacting champion of better health care, particularly for those who fare the least well now; Jason Glenn, whose commitment to social justice is a model; and Janice Smith, whose work exemplifies how values can be lived out in a complex world. I extend sincere appreciation to Deborah Stone whose books and early conversations led me to consider the policy aspects of charity in health care. To this list I must add my deep gratitude to Anne Hudson Jones who shepherded and supported me in a thousand ways during the years of her tenure as the graduate program director. Donna Vickers has been a constant source of efficient help with every detail of graduate student life and I heartily thank her. To the many faculty and students who made and continue to make the Institute an unparalleled place of moral inquiry, particularly Howard Brody, I also am most grateful.

Finally, I deeply appreciate the love and support of my family—Dan, Patricia, Sean, Connor, and Molly—who have shared me with the work of this dissertation and who have helped to keep me grounded in what matters.

Charity in Health Care: Safety Net or (Moral) Safety Valve?

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Abstract:

Charity in health care has a vast and rich history that crosses boundaries with religious traditions and professional moral obligations. Charity can be considered a virtue that entails altruism, beneficence, generosity, mercy, and kindness. The health care safety net is a newer term that refers to a variety of programs and policies that are directed toward people who are poor, underserved, or uninsured. The safety net arguably derives much of its moral meaning from its association with charity. Charity in health care is not only a powerful symbol of deep moral significance to Americans and to medical professionals; it is also a practical real-world experience and it is integral to a wide range of practices and policies. Charity entails ambivalent meanings for recipients who may be considered dependent and subjected to judgments of worthiness; no one wants to need charity. At the conceptual as well as policy level, charity also has ambiguous meanings. Charity in health care is defined by laws, sometimes in conflicting ways, and it is understood by traditions. Our nation has relied as much on charity as it has on private or free market forces for the provision of health care. As a symbol, charity in health care functions politically to create a sense of well-being and to resolve tensions. One aim of this dissertation is to clarify the distortions and assumptions that are present in health care related to charity. Charity care at the community level in free clinics, physicians' offices, and other local programs is analyzed. The role of charity care in medical education, in emergency departments, in hospitals, and in the Medicaid program is scrutinized. Among the themes that are pervasive in each of these settings, one is that charity is, at its essence, optional and discretionary and does not guarantee care for any person. The financing of charity care has resulted in opaque and complex mechanisms. While the ideal of charity as an altruistic response to the health care needs of poor persons is a worthy moral goal, a more just health care system would not rely on charity.

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Introduction

Stan Brock, now seventy-five years old, was a young man when he was thrown off a wild horse in the Amazon and broke several ribs. The nearest doctor was a twenty-six-day ride away. In the hope of making a difference in the lives of people in remote tribes in the Amazon and in isolated areas of Latin America, Mr. Brock formed Remote Area Medical or “RAM” in 1992, a nonprofit charity that airlifts doctors and medical supplies to out-of-the-way places. Brock, a former television wildlife cowboy on the series *Wild Kingdom*, never lacked courage or perseverance. Over time, Stan Brock and RAM personnel, headquartered in Tennessee, discovered that uninsured and underinsured people in America also have a great need for medical care. The organization that was formed to help people in remote third world nations now spends most of its time helping Americans.

RAM was featured by 60 Minutes in March 2008 when a free weekend medical and dental clinic was set up in Knoxville, Tennessee. Almost one thousand people were seen for care that weekend and more than four hundred people were turned away. One man and his family traveled two hundred miles and waited seven hours in below freezing temperatures to be seen. One woman cried as she learned she would not be seen.[1] A journalist visited a RAM free clinic just before the Supreme Court ruled to uphold some of the major provisions in the Affordable Care Act in June of last year. Most of the patients who had slept overnight in their cars to get medical care at the improvised clinic

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[1] CBS News, "Lifeline: Remote Area Medical," in *60 Minutes* (July 13, 2008). See also Jean West Rudnicki, "Winging It: With Stan Brock and His Remote Area Medical Team," *Change Magazine* September 2008.

will be eligible for Medicaid or subsidies to help buy affordable coverage under the law. Many of the patients had never heard of the law and did not know what it meant for them. One of the volunteer physicians worried that the law would be overturned. He did not believe the Supreme Court justices could understand what everyday Americans face: "It's because they're not in the real world," he said. "They're up in Washington with their private insurance. They should come down in the sticks and the foxholes, and see what it's like."[2]

Dr. Arthur Garson, a cardiologist and former Dean of the Medical School at the University of Virginia, wrote about volunteering at a RAM (known as both Remote Area Medical and Rural Area Medical) clinic one weekend:[3]

> The LED on the automobile clock in a car pulling into a field in rural southwestern Virginia says 2:00 a.m. The driver turns the key, killing the motor. The field is huge and dark. At first light, the driver and her two passengers roll over and out the door. Betty is a twenty-nine-year-old, 230-pound mother of six who works at a restaurant. Her boyfriend, Jake, who works at the dry cleaners, has been having pain in his side off and on for almost a year. Betty's fourteen-year-old daughter, Molly, has had such a bad toothache for three months that she is unable to eat and has lost fifteen pounds. They put their arms around each other and walk half a mile to the end of the line. Already people are lined up quietly for a quarter of a mile across the field. They are waiting for the gates to open for the Rural Area Medicine Clinic—a weekend event that occurs once a year for anyone who has no health insurance and can get there. About 1,500 volunteers (doctors, dentists, nurses, and staff) provide more than 6,000 visits in two days. It is a true "health fair" where every person can get a physical examination, teeth are pulled, mammograms performed, eyeglasses made, and blood sugars checked. Follow-up visits are planned to those few clinics that will see uninsured patients.
>
> I attend the yearly Rural Area Medicine Clinic and was there a few weeks ago, along with a number of state officials who also volunteer. As we gathered at the end of the day, one of the officials said, "Isn't it horrible—that we need this?" And another answered, "Isn't it wonderful—that we have this?" And I said, "Yes." During that day, Betty learned that she had diabetes; Jake, abdominal cancer that

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[2] Alec MacGillis, "What New Law?" *New Republic*, June 18, 2012, http://www.newrepublic.com/article/politics/104094/tennessee-health-care (accessed March 14, 2013).

[3] Arthur Garson, "Heart of the Uninsured," *Health Affairs* 26, no. 1 (2007).

> could have been found much earlier with a physical examination; and Molly, such a severe dental infection that eight teeth had to be pulled. No wonder there is a 20 percent higher mortality rate in middle age for those without health insurance.[4]

RAM, as Dr. Garson's essay suggests, is both emblematic of efforts to get medical care to people who need it and, at the same time, an indictment of "the American way" in health care. The most favorable assessment of Remote Area Medical would be that the charity's work is evidence that Americans care about each other. The work at this free clinic, and others, along with charity care at hospitals and in physician offices and together with community health centers and in emergency departments where the law directs that some treatment is given "regardless of ability to pay," have been an important part of the nation's ability to view our health care system as decent when it comes to poor people.

Many more people will be able to know that a decent level of medical care is available to them as a result of the March 2010 Patient Protection and Affordable Care Act. It is considered to be the most important piece of social legislation since the enactment of Social Security in 1935, the Civil Rights act of 1964, and Medicare and Medicaid in 1965.[5] As a result of the law, over the next decade about thirty million more Americans will gain health insurance coverage and about the same number, twenty-seven million, will remain uninsured. Ninety percent of the population of the nation will have health insurance, though the percentage rises to 93 percent for legal residents.[6] For

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[4] Ibid., 230-231.

[5] Lawrence R. Jacobs and Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs to Know* (New York, NY: Oxford University Press, 2010), 120.

[6] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," (2012), http://www.cbo.gov/publication/43472. See also Jessamy Taylor, "Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a

patients and health care volunteers providing charity care, though, not much has changed yet. This is exactly what the journalist at the recent RAM clinic found.

There are a variety of ways to conceptualize health care that is directed toward people who are poor or underserved. The focus throughout this dissertation is on charity in health care. The people, programs, policies, and the history of charity in health care are distinctive in a number of ways. One of the closely related and commonly used concepts in health care is the safety net. The term “safety net” came into common use to refer mostly to Social Security and Medicare in the early 1980s when many believed that the safety net was under assault.[7] By 2000, the health care safety net was the subject of an Institute of Medicine report where it was defined.

> The concept of a health care safety net conjures up the image of a tightly woven fabric of federal, state, and local programs stretched across the nation ready to catch those who slip through the health insurance system…America’s safety net is neither secure nor uniform. Rather, it varies greatly from state to state, community to community… These variations notwithstanding, most communities can identify a set of hospitals and clinics that by mandate or mission care for a proportionately greater share of poor and uninsured people.[8]

In contrast to the safety net, charity in health care is not a recently created concept. Also unlike the safety net, charity can be not only an institution, such as a charity hospital, it can be an attribute of people. Charity can be considered a virtue that entails altruism, beneficence, generosity, mercy and kindness.[9] The concept of charity also has a vast and

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Reformed Health Care Market," *National Health Policy Forum Issue Brief No. 848*, December 18, (2012), http://www.nhpf.org/library/issue-briefs/IB848_FQHCsandReform_12-18-12.pdf (accessed March 14, 2013).

[7] William Safire, "On Language: Safety Nets," *New York Times*, March 29, 1981.

[8] Marion Ein Lewin and Stuart Altman, eds., *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academies Press, 2000), 47.

[9] Oxford English Dictionary, s.v."Charity," (2012), http://www.oed.com/view/Entry/30731?redirectedFrom=charity& (accessed March 14, 2013).

rich history that crosses boundaries with religious traditions and professional moral obligations. The safety net arguably derives much of its moral meaning from its association with charity.

Charity has a cherished symbolic meaning to Americans generally and in particular to the medical profession and its related institutions such as hospitals. Charity in the health care setting is most often associated with an altruistic response to the needs of the ill, injured, or vulnerable. The author Michael Ignatieff writes that as members of a nation or community we are bound to each other because “We not only have needs for ourselves, we have needs on behalf of others.”[10] In a recent book by the public policy scholar Deborah Stone, the term “everyday altruism” is used to describe how ordinary Americans deeply value helping others. Everyday altruism, once recognized, is “Everywhere in nooks and crannies of America.”[11] It is not something tacked on to our lives at odd moments but is embedded in the fabric of living and is central to personal morality. Stories of everyday altruism, moreover, help to connect personal morality to public purposes essential to a flourishing democracy. Everyday altruism becomes the “germ of political action.”[12]

It is likely that Deborah Stone would call Stan Brock an “altruistic entrepreneur.”[13] RAM gives doctors, like Arthur Garson, a way to help others while utilizing their professional skills. In a classic textbook of bioethics, Beauchamp and

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[10] Michael Ignatieff, *The Needs of Strangers* (New York, NY: Picador USA, 2001), 52.

[11] Deborah A. Stone, *The Samaritan's Dilemma: Should Government Help Your Neighbor?* (New York, NY: Nation Books, 2008), 107.

[12] Ibid., 281.

[13] Ibid., 236.

Childress define beneficence, one core principle of bioethics, as connoting “acts of mercy, kindness, and charity.”[14] The American Board of Internal Medicine, in its *Project Professionalism*, states that “altruism is the essence of professionalism,” where altruism is opposed to self-interest and promotes the best interest of the patient.[15] The two bioethicists Pellegrino and Thomasma define altruism as “the trait that disposes a person to take the interests of others into account in using power, privilege, position, and knowledge.”[16] Charity, then, is associated with core principles and virtues in medical practice.

In the *Encyclopedia of Ethics*, the author provides a brief account of the origin of charity in Christian thought. Charity is the third of the theological virtues of faith, hope, and charity and it is considered to be the root of all the virtues, including justice. Charity means Christian love and is obligatory for believers. The author contends that charity now is most often only philanthropy and not a manifestation of love and that the receipt of charity is frequently seen as degrading and stigmatizing, hence the phrase, “cold as charity.” Those who receive it are feared to enter a “culture of dependency.”[17] For the recipient of charity, the meaning can be “the dole” or a hand out.[18]

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[14] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York, NY: Oxford University Press, 2001), 166.

[15] American Board of Internal Medicine, "Project Professionalism," (Philadelphia, PA: American Board of Internal Medicine, 1998), 5.

[16] Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York, NY: Oxford University Press, 1993), 147-148.

[17] Onora O'Neill, "Charity," in *Encyclopedia of Ethics, Garland Reference Library of the Humanities*, ed. Charlotte B. Becker and Lawrence C. Becker (New York: Garland Publications, 1992).

[18] Oxford English Dictionary, s.v. "Charity."

Philanthropy is closely related to charity and it is associated with the propensity to elicit gratitude in order to obtain personal glorification.[19] The theologian Reinhold Neibuhr recognized that philanthropy could be a means for subtle domination. He noted that "behind a benevolent façade, the philanthropist may often be a brutal 'man of power' who chooses to dispense favors at his discretion in order to bind people to himself and to forestall the fair social distribution of resources."[20] The danger of the notion of philanthropy for the medical profession has been noted for over a quarter of a century. William May, in a 1975 essay, emphasized that the physician's commitment to others should involve responsiveness and reciprocity, not the condescension of philanthropy. He finds that at times the "ideal of service…succumbs to what might be called the conceit of philanthropy."[21]

Charity in health care is not only a powerful symbol of deep moral significance to Americans and to medical professionals; it is also a practical real-world experience and it is integral to a wide range of practices and policies. The ambivalent meanings of charity for those who provide it and those who receive it are present wherever charity is present. At the policy level, charity is an ambiguous concept. Charity is defined by laws, sometimes in conflicting ways, and it is understood by traditions. In Deborah Stone's book, *Policy Paradox,* she notes that the most important feature of all symbols is their ambiguity. In art this feature of symbols adds richness and depth and in politics ambiguity may allow collective action among people with diverse motivations,

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[19] Kevin Robbins, "Philanthropy," in *Machiavellism to Phrenology*, ed. Maryanne Horowitz (Detroit, MI: Charles Scribner's Sons, 2005).

[20] Earl E. Shelp, *Beneficence and Health Care*, Philosophy and Medicine; v. 11 (Boston, MA: Kluwer Boston, 1982), 241.

[21] William F. May, "Code, Covenant, Contract, or Philanthropy," *Hastings Center Report* 5, no. 6 (1975).

expectations, and values.[22] A central theme of this dissertation is that charity in health care functions at a political level as well as an interpersonal and relational level and that charity is a pervasive part of American health care.

The symbol of charity in health care has done a great deal of moral work and its power helps to explain how America has not achieved universal health care coverage. As Beatrix Hoffman has commented recently, universal coverage was not even a goal of the Affordable Care Act.[23] America has relied as much on charity as it has on private or free market forces for the provision of health care. The political philosopher Murray Edelman has noted that people "are prone to respond strongly to symbolic appeals and to distort or ignore reality in a fashion that can be politically significant."[24] One aim of this dissertation is to clarify the distortions and assumptions that are present in health care related to charity. Understanding charity in health care involves recognizing what our assumptions are and how our assumptions act to create and maintain our sensibilities.[25] According to the anthropologist Mary Douglas, in order to resist the power that social institutions and structures have to direct thinking, the first step is to understand how they "fix processes that are essentially dynamic, they hide their influence, and they rouse our emotions to a standardized pitch on standardized issues. Add to all this that they endow

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[22] Deborah A. Stone, *Policy Paradox : The Art of Political Decision Making*, Revised ed. (New York, NY: Norton, 2002), 157-161.

[23] Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago, IL: University of Chicago Press, 2012), 212.

[24] Murray J. Edelman, *The Symbolic Uses of Politics* (Urbana, IL: University of Illinois Press, 1985), 30.

[25] Martha Minow, *Making All the Difference: Inclusion, Exclusion, and American Law* (Ithaca, NY: Cornell University Press, 1990). Clifford Geertz, *The Interpretation of Cultures: Selected Essays* (New York, NY: Basic Books, 1973), 451.

themselves with rightness."[26] Edelman notes that symbols function politically to create a sense of well-being and resolve tensions. This is not magic arising from symbols; it is a result of complexity and lack of information. In order to determine whether a political activity is symbolic or substantive, scrutiny is needed.[27]

The methods used in this dissertation are humanities based and include an historical analysis of each of the topics. The analysis and interpretation of the history of the topics lends a greater degree of authenticity to the conclusions because in many cases the historical representations of charity entailed bolder claims about the practices involved in the provision of charity that would have been difficult to interpret in a cross-section of information. In many instances the language used to describe charity practices has a great deal to do with how charity care has remained more symbol than substance. In all the chapters an attempt has been made to bring the patients' voices to the conversation in these pages and often there is little to find. For a humanities dissertation there is likely to be more financial information than usual but charity is, after all, something to do with money. In every chapter there is an attempt to go "down in the sticks and the foxholes" as the volunteer doctor said and to relate this to all of the social, political, and cultural assumptions there are about charity care. The conclusions and the story that is told in each chapter are unlikely to be familiar ones. A lot of this work has been to challenge the assumptions that are so prevalent.

There are two books that cover in breadth most but not all of the topics that are in this dissertation. One is Jonathon Engel's *Poor People's Medicine: Medicaid and*

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[26] Mary Douglas, *How Institutions Think*, The Frank W. Abrams Lectures (Syracuse, NY: Syracuse University Press, 1986), 92.

[27] Edelman, *The Symbolic Uses of Politics*: 40-43.

American Charity Care since 1965.[28] The other is the recent book edited by Mark Hall and Sara Rosenbaum, *The Health Care Safety Net in a Post-Reform World*.[29] Engel's book is focused mainly on Medicaid and Hall and Rosenbaum's book is focused on the safety net which is not the lens through which this dissertation is done.

Chapter 1 begins the story of charity in health care with what communities have done to respond to health care needs for low income patients who are uninsured. Free clinics, community health centers, local access to care programs and the provision of charity in physicians' offices are explained. Much like the beginning of the introduction, the volunteers express deeply meaningful experiences at free clinics. For patients, there is sincere gratitude and also shame and embarrassment. Volunteers and physicians in their offices have concerns about the quality of care that they can provide and, with that, the moral consequences. Community health centers are sometimes discussed interchangeably with free clinics but their history and services are distinct in many ways. Local access to care programs came about with great fanfare in the mid-1990s and their successes were few. In this chapter the poignant inability to bring the voices of those most able to tell the real story of difficulties in getting care is a conundrum with no obvious answers. The chapter also begins to ask what charity is and what the boundaries of charity are. It provides the first glimpse of how charity is, more often than not--not free.

Chapter 2 on medical education and charity is perhaps the most unexpected and troubling chapter. It is in this chapter that the historical lens of charity in medical education is especially haunting. That poor people were once the objects upon which

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[28] Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Durham, NC: Duke University Press, 2006).

[29] Mark A. Hall and Sara Rosenbaum, *The Health Care "Safety Net" in a Post-Reform World*, Critical Issues in Health and Medicine (New Brunswick, NJ: Rutgers University Press, 2012).

medical trainees practiced is one regrettable fact but that virtually the same stories are still told is remarkable. It is truly a blind spot in the history and present reality of medicine. Arguably it is the patina of charity that has shrouded the practice for more than a century. This is also the first glimpse at how strongly the links are between charity care funding and other purposes.

Chapter 3 on the emergency department and charity care is where the public's view of charity care is the most visible and along with it, the belief that everyone has access to health care. The emergency department is the locus of perhaps more myths and assumptions than any other site. It is also the locus of the greatest battle over the moral foundations of medicine. The current moral struggle is over the care of patients deemed to have nonemergency conditions. Because of the widespread assumptions about care in the emergency department, everyone "knows" what the problem is and this makes it more difficult to change practices.

In Chapter 4 on hospitals and charity care, the term "uncompensated care" which is part of every discussion about charity in health care, is finally addressed fully. The language used to describe charity matters and in multiple ways. The origin of the term uncompensated care is traced to its first use related to the Hill-Burton Act in the 1970s. The long and continuing search to find out the difference between tax exempt hospitals and for-profit hospitals and to create some accountability for the public's (forgone) tax subsidy is explained to the extent that it can be. The scandal of hospital billing and collection practices, which is far from over, is viewed from the patient's point of view when possible. The meaning of uncompensated care leading up to and during the

Supreme Court's ruling on the Affordable Care act is illuminated and its implications worried over.

Medicaid, discussed in Chapter 5, can seem like either the least or most relevant to charity in health care. Yet, this public health insurance program has its roots in charity; patients enrolled in the program are often at times without insurance and likely to be considered charity patients; and Medicaid provides the greatest single source of funding for charity care. These funds which are such a precious source of money for so many uninsured people have largely been funneled to the entities with the most political power.

This dissertation is a journey and not a particularly pleasant one. Janet Poppiendeck is a sociologist and researcher who wrote the book, *Sweet Charity? Emergency Food and the End of Entitlement.*[30] She writes that charity acts as "a sort of a 'moral safety valve;' it reduces the discomfort evoked by visible destitution in our midst by creating the illusion of effective action and offering us myriad ways of participating in it. It creates a culture of charity that normalizes destitution and legitimates personal generosity as a response to [injustice]."[31] The philosopher Charles Taylor believes that to express an ideal is to make it available, and for a moral purpose. Charity as a symbol of a response to human needs and as a practical experience of generosity, kindness and altruism is worth articulating and it means scrutinizing the substantive content of what we call charity: "Articulacy here has a moral point, not just in correcting what may be wrong views but also in making the force of an ideal that people are already living by

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[30] Janet Poppendieck, *Sweet Charity: Emergency Food and the End of Entitlement* (New York, NY: Viking, 1998).

[31] Ibid., 5.

more palpable, more vivid for them; and by making it more vivid, empowering them to live up to it in a fuller and more integral way.”[32]

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[32] Charles Taylor, *The Ethics of Authenticity* (Cambridge, MA: Harvard University Press, 1992), 22.

Chapter 1: Charity Care at the Community Level

In a 2006 article in the *Journal of the American Medical Association (JAMA)*, a physician who has spent his career at a community clinic, Dr. Kilgore, tells the story of "Randy." The essay's title is "The Imaginary Safety Net." Randy comes to see Kilgore at the community clinic for "Follow-up of a nose injury."[33] Initially seen in an emergency department and unable to afford the $500 upfront fee of the plastic surgeon he is referred to, Randy winds up at the community clinic. Dr. Kilgore expects to find a minor injury such as an unsightly scar but instead, underneath Randy's bandage, and stifling a gasp as the injury is uncovered, Dr. Kilgore finds that Randy "no longer had a nose." [34] Dr. Kilgore does what he can for Randy, instructing him in wound care and treating his other medical problems while promising that the clinic's outreach worker will search for an affordable plastic surgeon. Believing that "he had a right to the same level of care as his insured brethren," while struggling with the question of whether the fight that resulted in Randy's injury was somehow his fault, Kilgore states:

> I struggle with how judgments of the health care community can sometimes make it more difficult to render compassionate care, whether subtly with sarcastic comments and nonverbal behavior, or overtly with substandard or denied care. And this is a slippery slope to start down. Who among us has not done something stupid that resulted in an injury, however small? Are injuries that happen to insured people somehow immune to judgment and more worthy of society's dollars? The choices of many to overeat and not exercise are resulting in an epidemic of diabetes, hyperlipidemia, and vascular disease with very expensive consequences: Are these patients therefore to blame and not deserving of coverage for their medical treatments?[35]

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[33] David B. Kilgore, "A Piece of My Mind. The Imaginary Safety Net," *Journal of the American Medical Association* 296, no. 14 (2006): 1701.

[34] Ibid.

[35] Ibid.

Eventually Dr. Kilgore's staff found a county surgical clinic that agreed to treat Randy. Embarrassed and taken aback by Randy's effusive gratitude, Kilgore reflects on his career. From feeling proud to be a part of the "safety net for the neediest," Kilgore wonders whether his "very participation in this system plays a darker role—a complicit role—of enabling the disparity of care to persist, of helping to provide false reassurance that we actually have a safety net that provides adequate care to all in need."[36]

In a 2012 interview, sixty-one year old Edgar Shwann was a patient at the Judeo Christian Health Clinic in Tampa, Florida. After suffering two strokes, Mr. Schwann was left disabled and unable to work at his job at a heavy equipment company. Not yet eligible for Medicare, Mr. Schwann came to the free clinic. He stated simply: "Without this place, I'd probably be dead."[37] The minister at the local Presbyterian Church who founded the clinic in 1972 had no idea that forty years later the clinic would be caring for more than 35,000 people each year. Reflecting on the opening of the clinic back then, the now-retired minister said: "I only know that we had people who were falling through the cracks in our system. And there's no excuse for that in a country as wealthy as the United States."[38] Like Stan Brock mentioned in the introduction, the Tampa surgeon who is president of the clinic's board said that she "used to believe that a doctor had to travel overseas to provide humanitarian service to the sick and the poor." Now she has learned otherwise.[39]

Dr. Andres Tobon is a dermatologist who has been volunteering at the clinic for seven years. One of his patients, Anai Carreno, a forty-six year old woman who works full time as an interpreter but is not offered any benefits from her employer, has worried

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[36] Ibid., 1702.

[37] Michelle Bearden, "Free Clinic for Uninsured in Tampa Celebrates 40th Anniversary," *Tampa Tribune*, April 16, 2012.

[38] Ibid.

[39] ———, "Free Health Clinic Provides Hope for People in Need," *Tampa Tribune*, April 7, 2011.

for years about moles on her face and body, some which have started to bleed. Three weeks earlier she arrived at four in the morning to get in line for an eligibility determination at the clinic. Tobon states: “This may be free, but it comes at a price. They have to wait long hours to qualify, and long hours for an appointment…This is not the route anyone wants to take for medical care. But for these hard-working people, it’s the only route.”[40] He tells Anai Carreno that several moles need to be removed and he expects some of them to be cancerous but treatable.

“Henry” became ill a year after he was laid off from his job. Already in the midst of hard times and now sick and uninsured, family members arranged for him to see a private physician who diagnosed a serious cardiac problem. Since Henry was clearly going to need further care and possibly cardiac surgery, he was then sent to a federally qualified health care center. The primary care physician at the health center consulted a volunteer cardiac specialist. After that visit confirmed the diagnosis of a heart valve problem, a volunteer cardiac surgeon who had agreed to perform surgery on fifteen patients annually without charge was consulted. Since Henry’s income was below the poverty level, he was eligible for charity care at the hospital where his surgery was successful. His ongoing care was provided again at the community health center.[41]

Each of these stories enacts the adage that, like politics, all health care is local.[42] The response of each community to local health care needs, particularly for the poor, is a continuous one in American history. From colonial poor laws to public hospitals and dispensaries, local governments and philanthropic support from the community were the primary means of responding to the sick poor throughout the eighteenth and nineteenth

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[40] Ibid.

[41] Cynthia Taureg, "Maintaining Charitable Mission in Tough Times," *Health Progress* July-August (2009).

[42] Atul Gawande et al., "10 Steps to Better Health Care " *New York Times*, August 12, 2009.

centuries in America.[43] As Jonathan Engel points out, reliance on charity at the local community level was similar among most nations in the world throughout the nineteenth century. During the twentieth century European and other developed nations began to include people with a low income in systems of care that no longer fell under the rubric of charity, while America expanded the variety of programs and the payments for charity.[44]

Although the term “community” has been used in many ways to denote social or cultural bonds or affiliations based on shared concerns or identities, the term as used in this chapter primarily refers to geographic communities.[45] Three programs that are primarily local responses to community health care needs often associated with charity care are free clinics, community health centers and local access to care programs. Physicians also report seeing uninsured patients in their offices for no or a reduced fee. As thoroughly detailed by the health law scholar Mark Schlesinger, the role of communities in health policy is historically and currently one of “unresolved ambiguities and persisting tensions.”[46] His research from the mid-1990s has shown that support by the general public and congressional staff for community-based approaches to medical care is much lower than for other social needs.[47] Yet, communities have responded to health care needs in many ways and often these reflect the singularity of their local

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[43] Mark Schlesinger, "Paradigms Lost: The Persisting Search for Community in U.S. Health Policy," *Journal of Health Politics, Policy and Law* 22, no. 4 (1997): 938-939.

[44] Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965*: xii-xiii.

[45] Institute of Medicine Committee on the Consequences of Uninsurance, *A Shared Destiny: Community Effects of Uninsurance* (Washington, DC: National Academies Press, 2003), 19. Institute of Medicine Committee on Using Performance Monitoring to Improve Community Health, *Improving Health in the Community: A Role for Performance Monitoring* (Washington, DC: National Academies Press, 1997), 24-25.

[46] Schlesinger, "Paradigms Lost: The Persisting Search for Community in U.S. Health Policy," 958.

[47] Ibid.

concerns and leaders. The minister in Tampa, Florida who started a free clinic in 1972 illustrates this point.

This chapter provides an overview of free clinics, community health centers, and local access to care programs that have arisen in communities across the nation. Physician charity care provided in the office setting is also described and discussed. Most people have a notion of what each of these programs and providers entails and generally why there is a need for charity care. The aim of this chapter is to look more closely at each of these practices and programs in order to begin to understand how the vitally important moral symbol of charity appears at the ground level.

History of Free Clinics

Both free clinics and community health centers have historical ties to the “free dispensaries” of the late nineteenth and early twentieth century. In a seminal article about dispensaries, the medical historian Charles Rosenberg describes many of the ambiguities associated with these clinics and the reasons for the ultimate disappearance of them.[48] Rosenberg notes that the motives responsible for the flourishing of dispensaries consisted of self-interested ones alongside the humanitarian. He attributes the growth of dispensaries to the fundamental relationship between the dispensary and the world of medical education and status.[49] The dispensary’s demise is viewed as arising from the change to a hospital-centered program of medical education which drew the elite physicians, as well as the interns and residents, away from dispensaries. Rosenberg is not sentimental about the end of dispensaries because, even at its height, the care was

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[48] Charles Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," in *Sickness and Health in America : Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: University of Wisconsin Press, 1997).

[49] See chapter 2 on medical education and charity care for further discussion on the role of dispensaries in medical education.

"second-class, routine, episodic medicine… a victim of shabby budgets, and even in its earliest decades marked by unquestioned distance between physician and patient."[50]

Much of the rhetoric pertaining to the early free clinics centered on "abuse" by patients with the meaning that people able to pay for treatment by a private physician were seeking care at the clinic.[51] One physician calculated the amount that the medical profession was "deprived" of by physicians at dispensaries.[52] Free clinics were viewed as "unfair competition" to local practitioners and patients were accused of using "brazen effrontery and ingenious subterfuges" to receive free care.[53] In New York, providing false information about income to a dispensary could result in prosecution for a misdemeanor.[54] At the same time, the determination of "financial suitability" was not done by any established standards. Instead, methods were "worked out largely in a haphazard way, and all figures used [were] purely arbitrary."[55] In a detailed analysis in 1916 of how to determine whether a person had the financial ability to pay for medical services, the task was extremely difficult. While an income below which a person could reasonably be considered unable to pay for care could be determined, the upper income

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[50] Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," 319.

[51] Borden S. Veeder, "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary," *Journal of the American Medical Association* 67, no. 2 (1916): 90.

[52] Paul Starr, *The Social Transformation of American Medicine* (New York, NY: Basic Books, 1982), 182.

[53] J.H.J. Upham, "The Outpatient Clinic," *Journal of the American Medical Association* 102, no. 13 (1934): 980.

[54] Starr, *The Social Transformation of American Medicine*: 182.

[55] Veeder, "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary," 85.

limit was not a fixed dollar amount. It was dependent upon the type and length of the illness and the cost of treatment.[56]

Worries that charity medical care at dispensaries would lead to "pauperization" were common. For example, a physician in 1934 wrote: "The habit of seeking relief is quickly established and hard to break. This is a danger to the self reliance and independence of the community, and the free clinics should not contribute to such dangerous social deterioration."[57] In part, charity patients at dispensaries were viewed as "paying" for their care through their use as "material for the instruction of medical students…[T]here can be no question as to the right or propriety of any legitimate medical school conducting a dispensary, provided it has a fixed rule that any patient refusing to act as material for purposes of instruction is refused admission."[58] The long waiting times for services at dispensaries also imposed the indirect cost of lost wages on patients.[59]

At the same time, dispensary abuse by patients was seen by some as a situation in which a rare anecdotal case was assumed to represent the majority of cases. When studied, for example, the percentage of dispensary patients who could afford to pay was about 2 percent and the expense of investigating cases to eliminate this was considered impractical.[60] Among physicians with close ties to dispensaries, "abuse" was also viewed as stemming from within the clinic's professionals and included "negligence on the part

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[56] Ibid.

[57] Upham, "The Outpatient Clinic," 980.

[58] Veeder, "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary," 86.

[59] Starr, *The Social Transformation of American Medicine*: 183.

[60] Veeder, "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary."

of physicians, overcharging and petty graft."[61] In an editorial in *JAMA* in 1905, dispensaries were criticized for their disproportionate focus on abuse by patients and lack of focus on the services and quality of the care provided:

> There is a type of dispensary too common in every great American town which starts with a laudable humanitarian spirit and fair medical standards, but which quickly degenerates, usually from lack of funds and inattentive management…The out-practice, at first limited in amount and carefully controlled, increases to unmanageable proportions and falls completely into the hands of the students.[62]

According to the historian Rosemary Stevens, the problems with dispensaries were at least partially responsible for the backlash against "socialized" medicine and in particular the failure to pass a compulsory health insurance law in the early twentieth century. This was expressed by a speaker at a Medical Society meeting in 1916: "Probably a good deal of the opposition to any sort of socializing change in medicine, such as the adoption of the hospital and dispensary system, has risen largely from the feeling against such institutions as they are now."[63]

It remains unclear whether care at dispensaries resulted in more services to the poor or whether there simply was a shift from charity provided by local physicians.[64] One proponent of free dispensaries made the argument that because of the concentration of poverty in the larger cities, physicians in these districts would be "overwhelmed by

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[61] Ibid., 90.

[62] Editorial, "The Free Dispensary," *Journal of the American Medical Association* 65, no. 1 (1905): 44-45.

[63] James L. Whitney, "Cooperative Medicine in Relation to Social Insurance," *California State Journal of Medicine* 14(1916): 432, quoted in Rosemary Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century* (Baltimore, MD: Johns Hopkins University Press, 1999), 88. See also Anonymous Book Review, "A Chapter in Social Medicine," *The Nation* 107, no. 2787 (1918).

[64] Starr, *The Social Transformation of American Medicine*: 469.

charity work if they had to assume the entire burden."[65] In other words, there simply were too many people with little means who needed medical care to expect local physicians to provide care at low or no charge.[66] When compulsory health insurance was still being debated before 1920, the dispensary was viewed by some as a temporary way to respond: "Until such form of insurance is established, the free clinic is apparently the only solution of the problem which, briefly stated, is to furnish an efficient type of service at the lowest possible cost to those persons who are deserving of free treatment."[67]

One of the fascinating aspects of the dispensaries is the multiple ways in which the rhetoric of the early twentieth century is still relevant. For example, even when dispensaries were at their height it was recognized that they did not meet the health care needs of the poor. In 1916 a physician wrote: "Recent 'health surveys' have shown that even in cities with free clinics a large percentage of the sick are without the services of a physician."[68] Numerous studies confirm the current inadequacy in access to care for people with a low income who are uninsured despite the existence of free clinics, community health centers, and other programs.[69] A concern about the quality of care provided at dispensaries, while expressed much less often than abuse by patients, was

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[65] Veeder, "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary," 86.

[66] Ibid.

[67] Ibid., 86.

[68] Ibid.

[69] Lewin and Altman, *America's Health Care Safety Net: Intact but Endangered*; Thomas P. O'Toole, Jose J. Arbelaez, and Christine Haggerty, "The Urban Safety Net: Can It Keep People Healthy and out of the Hospital?" *Journal of Urban Health* 81, no. 2 (2004); Institute of Medicine Committee on Health Insurance Status and Its Consequences, *America's Uninsured Crisis: Consequences for Health and Health Care* (Washington, DC: National Academies Press, 2009).

still a prominent topic.[70] Quality of care at free clinics and community health centers remains a complex issue especially regarding the availability of specialty services.[71] While "pauperization" is no longer in common usage, "dependence" was a noticeable part of recent political discussions, some related to health care.[72] It is also the case that, contrary to much of what is written about "free dispensaries," often the services were not free. This use of the term "free" at clinics where patients do pay is discussed subsequently in this chapter.[73] According to the medical historian Rosemary Stevens, in 1903, 90 percent of New York's dispensaries charged for a "dispensary card" on the first visit. Some dispensaries in Philadelphia charged fees and at the Massachusetts General Hospital all patients paid ten cents per visit.[74]

After the late 1930s dispensaries "disappeared as freestanding institutions" though some became hospital outpatient departments.[75] The history of free clinics, for example in the book by the sociologist Gregory Weiss, *Grassroots Medicine: The Story of America's Free Health Centers*, often begins with the 1960s.[76] Specifically, the "Free

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[70] Editorial, "The Free Dispensary."

[71] Gordon Schiff and Claudia Fegan, "Community Health Centers and the Underserved: Eliminating Disparities or Increasing Despair," *Journal of Public Health Policy* 24, no. 3-4 (2003). See also Peter J. Cunningham, Gloria J. Bazzoli, and Aaron Katz, "Caught in the Competitive Crossfire: Safety-Net Providers Balance Margin and Mission in a Profit-Driven Health Care Market," *Health Affairs* 27, no. 5 (2008).

[72] Seema Mehta, "Romney Slams Obama Backers as Dependent on Government, Tax Dodgers," *LA Times*, September 17, 2012. Niall Ferguson, "Why Obama Must Go," *Newsweek* August 27, 2012.

[73] Further discussion of how "free" does not mean free in the common sense notion is in chapter 2 on medical education and charity care.

[74] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 373.

[75] Starr, *The Social Transformation of American Medicine*: 184.

[76] Gregory L. Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics* (Lanham, MD: Rowman & Littlefield Publishers, 2005).

Clinic Model" began in San Francisco in June 1967 with the opening of the Haight-Ashbury Free Clinic.[77] By the time the first national survey of free clinics was completed in 1971, there were at least 135 free clinics in the nation. The author of this survey described the free clinics as follows:

> Although the service is far from comprehensive, the facilities grossly inadequate, and the equipment meager, the volunteer physicians and nurses working alongside community people show respect and compassion for the free clinic patients. Both the long-haired and the minority patients resent the eligibility procedures, redtape, and hassle encountered in public clinics. It is in this regard that all free clinics, whether street, youth, neighborhood, or sponsored, are similar: they are free of redtape and questions. 'Free' does not only mean no charge but free of eligibility requirements, questions, and bureaucratic hassle.[78]

Many of the free clinics established in the late 1960s and 1970s were responses to the social upheavals of the times. Broadly speaking, some were primarily directed at young people seeking care for illicit drug use and addiction, sexually transmitted infections, and new contraceptives, in addition to a variety of routine medical conditions. Some were primarily neighborhood clinics that provided care to children and families often in areas with a high concentration of racial and ethnic minorities.[79]

Some of the early free clinics faced opposition from city leaders and the police.[80] Quality of care at the clinics was sometimes questioned.[81] In some cases, attempts to

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[77] Benard E. Schatz and Fred Ebrahimi, "Free Clinic Patient Characteristics," *American Journal of Public Health* 62, no. 10 (1972).

[78] Jerome L. Schwartz, "First National Survey of Free Medical Clinics 1967-69," *HSMHA Health Report* 86, no. 9 (1971): 786.

[79] Ibid. See also Barbara Russell and Lynn Lofstrom, "Health Clinic for the Alienated," *American Journal of Nursing* 71, no. 1 (1971). Schatz and Ebrahimi, "Free Clinic Patient Characteristics." Irene R. Turner, "Free Health Centers: A New Concept?" *American Journal of Public Health* 62, no. 10 (1972). Madalon M. Amenta, "Free Clinics Change the Scene," *American Journal of Nursing* 74, no. 2 (1974). Rosemary Corner et al., "Appraisal of Health Care Delivery in a Free Clinic," *Health Services Report* 87, no. 8 (1972).

[80] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 28-46.

measure quality were seen as antithetical to the “anti-establishment” philosophy of free clinics. For example, one clinic expressly stated that qualifications of physician volunteers were not checked.[82] Deliberately, the boundary between community members and professionals was blurred. By 1980 there were an estimated 75 to 100 “feminist women’s clinics” that sometimes trained unlicensed lay paramedics to provide gynecologic care.[83]

Although there were no formal methods for identifying or tracking free clinics, throughout the 1970s more free clinics failed than survived. By 2004 of the free clinics established in the 1960s, fewer than ten were still operating. The free clinics formed in the 1980s tended to be more stable than earlier clinics. During the 1990s through the early 2000s there was a tremendous expansion of free clinics, reaching about 800 by 2004.[84] By 2012 Florida had 104 free clinics.[85] Currently, the National Association of Free and Charitable Clinics estimates that there are more than 1,200 free clinics in the United States.[86]

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[81] Maleah Grover and Tony Greenberg, "Quality of Care Given to First Time Birth Control Patients at a Free Clinic," *American Journal of Public Health* 66, no. 10 (1976). Jeoffry B. Gordon, "Quality of Care in Free Clinics," *American Journal of Public Health* 66, no. 10 (1976).

[82] Schatz and Ebrahimi, "Free Clinic Patient Characteristics," 1354.

[83] Laurisa S. Elhai, "The Quality of Medical Care Delivered by Lay Practitioners in a Feminist Clinic," *American Journal of Public Health* 71, no. 8 (1981).

[84] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 28.

[85] Health Council of South Florida Ethics Committee, "Preserving the Health Care Safety Net," (Miami, FL: Health Council of South Florida, 2012).

[86] U.S. Department of Health and Human Services, "Healthy People 2010: Understanding and Improving Health," (Washington, DC: U.S. Government Printing Office, 2000).

What are Free Clinics?

Free health clinics have far more diverse characteristics than most other health care organizations. It is common for free clinic staff and volunteers to claim: "When you've seen one free clinic, you've seen one free clinic."[87] One characteristic of free clinics is their deep entrenchment in local communities. Largely outside of state and federal regulation and oversight, founded on the efforts of one or more community members, funded almost entirely by communities and reliant upon local professionals and institutions, free clinics are distinctively and profoundly local.[88] Recognizing that the local nature of free clinics can create difficulties as well as provide positive qualities, one volunteer stated: "Free clinics' greatest strength is also their Achilles Heel, and that is that we are truly community-based."[89] At the same time, it is important to recognize that local factors occur within the background of state policies, regional economic trends and within the context of federal policy.[90] A recent study found that unmet need for medical care was a less significant factor in whether a free clinic was present in a community than gaps in access related to other safety net providers and in Medicaid coverage. The study also showed there is greater evidence that the demand for care is less important than "supply" factors in the formation of a free clinic. In other words, unmet need for medical

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[87] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 2.

[88] Ibid., 3-9.

[89] Ibid., 95.

[90] Raymond J. Baxter and Robert E. Mechanic, "The Status of Local Health Care Safety Nets," *Health Affairs* 16, no. 4 (1997).

care can be worsened by national or state policies but qualities within the community other than unmet need determine whether a free clinic is created.[91]

Generally operating as charitable clinics designated by the Internal Revenue Service as 501(c)(3) organizations, the founders of free clinics come from the community. Governance is typically by a community board. Many free clinics take “pride in the fact that they do not rely on money from outside the community, that they are not government agencies with the attendant set of regulations, and that they do have the freedom to offer medical care in the type of atmosphere that they choose.”[92] Unlike their most similar counterparts, community health centers, free clinics are not subject to quality or reporting standards. Indeed, this is one reason that so little is known about free clinics. The existence of a free clinic and its closing may be noted in a community newspaper but usually is not contained in any database.[93] The National Association of Free and Charitable Clinics was founded in 2001 but membership in the organization is voluntary.[94] California requires that free clinics obtain a license from the state and in 2008 there were forty free clinics, though little other information is gathered.[95]

Yet, free clinics are increasingly recognized as a part of the health care safety net. Mention of free clinics was absent in the 2000 Institute of Medicine report on the safety

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[91] Julie Darnell, "What Is the Role of Free Clinics in the Safety Net?" *Medical Care* 49, no. 11 (2011).

[92] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 5.

[93] Don Finley, "Troubled Clinic No Longer Seeing Patients after Money Runs Out," *San Antonio Express-News* 2007.

[94] The name of the organization was changed from the National Association of Free Clinics in February 2012. National Association of Free and Charitable Clinics, "National Association of Free and Charitable Clinics," http://www.nafcclinics.org/ (accessed March 14, 2013).

[95] Elizabeth C. Saviano, "California's Safety-Net Clinics: A Primer," (Oakland, CA: California HealthCare Foundation, 2009).

net but more recent publications include some mention of free clinics.[96] Another reason that information about free clinics is not robust is that the definition of a free clinic is not standardized. In California there is a legal definition of a free clinic: "[A] clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services."[97] Under California law these free clinics are not permitted to charge patients directly for services.[98] The Free Clinic Association of North Carolina defines free clinic as "a private, nonprofit, community-based organization that provides medical care at little or no charge to low-income, uninsured and underinsured persons through the use of volunteer health care professionals and partnerships with other health providers."[99] In contrast to this definition, in some of the research on the health care safety net, free clinics are included in the umbrella term of "community health

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[96] Lewin and Altman, *America's Health Care Safety Net: Intact but Endangered*. Stephen L. Isaacs and Paul Jellinek, "Is There a (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States," *Health Affairs* 26, no. 3 (2007); Jessamy Taylor, "The Primary Care Safety Net: Strained, Transitioning, Critical," *National Health Policy Forum Background Paper No. 7,* September 28, (2010), http://www.nhpf.org/library/background-papers/BP79_PrimaryCareSafetyNet_09-28-10.pdf (accessed March 14, 2013). Peter Cunningham, Laurie Felland, and Lucy Stark, "Safety-Net Providers in Some US Communities Have Increasingly Embraced Coordinated Care Models," *Health Affairs* 31, no. 8 (2012).

[97] Saviano, "California's Safety-Net Clinics: A Primer," 15.

[98] Ibid.

[99] North Carolina Association of Free Clinics. North Carolina Association of Free Clinics, "North Carolina Association of Free Clinics," http://www.ncfreeclinics.org/free_clinic.aspx (accessed March 14, 2013).

centers."[100] Other researchers refer to free clinics as "by definition" clinics that do not charge fees.[101]

However counterintuitive it may seem, only about half of free clinics do not charge fees. By far the most comprehensive study of free clinics was recently published from surveys gathered from 2005 to 2006. The author of the study was the first to define free clinics and to include information only on those meeting the following criteria:

- Private, nonprofit organization.
- Provides medical, dental, or mental health services and/or medications directly to patients.
- Serves mostly (≥50%) uninsured patients.
- Charges no fees or nominal fees of not more than $20.
- No patient billing, denying services, or rescheduling appointments if the patient cannot pay the requested fee/donation.
- Not recognized as a Federally Qualified Health Care Center or Title X family planning clinic.[102]

Out of over 2,500 possible clinics, only 1,188 met the criteria on initial evaluation and 1,007 in all states except Alaska met the criteria after further evaluation with 764 surveys available for analysis.[103] The average fee requested, by just under half of free clinics, was $9.30. Fifty-four percent of free clinics do not charge for services. The total number of uninsured people who received care at free clinics in that year was estimated to be 1.8

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[100] Laurie E. Felland et al., "The Resilience of the Health Care Safety Net, 1996-2001," *Health Services Research* 38, no. 1 Pt 2 (2003).

[101] Rachel Mott Keis et al., "Characteristics of Patients at Three Free Clinics," *Journal of Health Care for the Poor and Underserved* 15, no. 4 (2004).

[102] Julie S. Darnell, "Free Clinics in the United States: A Nationwide Survey," *Archves of Internal Medicine* 170, no. 11 (2010).

[103] Ibid., 947.

million. In comparison, in the same year federally qualified health care centers (FQHCs) served 6 million uninsured people.[104]

Among the free clinics in the survey, more than 90 percent received private donations from civic groups, churches, foundations and corporations. Although almost 60 percent did not receive any government funding, for the other clinics a combination of local, state and federal grants supported some of the clinics' budgets.[105] Some free clinics rely on donated laboratory or diagnostic services from local hospitals, often convincing administrators that the clinic will reduce the cost of emergency department care.[106] In Virginia, Anthem Blue Cross has been a generous donor to the state's free clinics providing more than $8 million since 1992.[107] The Blue Cross and Blue Shield North Carolina Foundation has also contributed annual grants to the state's free clinics.[108] Support for free clinics by organizations not directly linked to providing care to the uninsured has been observed in several communities. Motives for support of free clinics can vary: "This support is consistent with the missions of many providers, even if they do not serve many uninsured patients. Many also support safety-net providers because they

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[104] Ibid.

[105] Ibid.

[106] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 92-94. Robin Cowie Nalepa, "Free Clinic Strapped for Cash, Volunteers," *The State*, May 8, 2006. Donna Soper, "Free Clinic Will Improve Many Lives," *Atlanta Journal-Constitution*, July 6, 2006.

[107] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 104-105. Virginia Association of Free Clinics.Virginia Association of Free Clinics, "Virginia Association of Free Clinics," http://www.vafreeclinics.org/our-partners.asp (accessed March 14, 2013).

[108] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 108. Phil Galewitz, "Caring for the Uninsured: N.C. Leads the Way in Free Health Care," *Palm Beach Post*, February 20, 2005.

do not want direct responsibility for indigent care and the special service capacity required."[109]

Most free clinics provide a limited range of primary care services and most also provide pharmaceutical assistance, although there is a great deal of variation. In the recent survey, full-time free clinics offered the broadest scope of services. The much larger number of limited-hour clinics operated on average for eighteen hours a week. Generally, the limited-hour clinics could not be considered a substitute for other comprehensive primary care providers.[110] The population served by these clinics was described in the survey as "patients with attributes that impede their access to primary care: uninsured, inability to pay, racial/ethnic minority, limited English proficiency, noncitizenship, and lack of housing."[111]

In What Ways Do Free Clinics Reflect the Discretion of Charity?

Since free clinics are not bound by external rules, each clinic can create its own policies on eligibility requirements for services and on the range of services. Free clinic volunteers often cite the lack of external standards as allowing for flexibility so that local needs are adapted to local resources.[112] On the other hand, discretion in decision-making is a hallmark of charity care and not only at free clinics. In the national survey, just over

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[109] Baxter and Mechanic, "The Status of Local Health Care Safety Nets," 16.

[110] There were 188 full time free clinics in the survey out of the total number of 764. Darnell, "Free Clinics in the United States: A Nationwide Survey." Stephanie Geller, Buck M. Taylor, and H. Denman Scott, "Free Clinics Helping to Patch the Safety Net," *Journal of Health Care for the Poor Underserved* 15, no. 1 (2004).

[111] Darnell, "Free Clinics in the United States: A Nationwide Survey," 948.

[112] Kevin C. Kelleher, "Free Clinics. A Solution That Can Work ... Now!" *Journal of the American Medical Association* 266, no. 6 (1991).

half of clinics reported services were provided only to uninsured people and about the same percentage reported having income limits and local residency requirements for services.[113] Many free clinic organizers point out that these eligibility requirements are necessary in order to gain the support of the community by showing services will not be duplicated and to assure other health care organizations and professional volunteers that only those people who cannot afford care will receive it.[114] At the same time, because free clinics do not have external eligibility standards, local community preferences can have a greater influence than in other health care settings. For example, some free clinics require patients to be employed as well as to have a low income.[115] In the setting of charity care provided at a free clinic, the community has the ability to limit care to people on the basis of judgments about the deservingness or worth of the potential patients. In the case of clinics that limit services to people who have a job, a judgment of deservingness is made. Basing charity care on opinions of worth has been a constant feature of the history of charity in medical care even though who is considered worthy has changed over time according to social and cultural values.[116] The fact remains that charity care at a free clinic does not guarantee the provision of medical care to any person and that communities and free clinic staff can choose who may receive care on the basis of specified or unarticulated reasons.

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[113] Darnell, "Free Clinics in the United States: A Nationwide Survey," 948.

[114] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 84-92.

[115] Paula D. Scariati and Cyndy Williams, "The Utility of a Health Risk Assessment in Providing Care for a Rural Free Clinic Population," *Osteopathic Medicine and Primary Care* 1(2007). Church Health Center. Church Health Center, "Church Health Center," http://www.churchhealthcenter.org/patientrequirements (accessed March 14, 2013).

[116] David Rosner, "Health Care for the 'Truly Needy': Nineteenth-Century Origins of the Concept," *Milbank Memorial Fund Quarterly Bulletin* 60, no. 3 (1982).

Some faith based clinics tailor their screening process to church affiliated wishes. For example, at one clinic each session begins with patients and staff gathering for prayer. A spiritual assessment that includes religious preference and church membership is completed and “each patient is invited to complete a church referral form. Bibles are given if so desired.”[117] Faith based provision of health services appears to be common. In the *Hartford Seminary Faith Communities Today* survey of over 14,000 congregations of diverse faith groups, over half were engaged in providing health care services. Not all of these activities involved free clinics, however.[118] In non-faith based settings for medical care, there is a recognized tension between meeting the spiritual needs of patients and not imposing unwanted religious beliefs and values on patients.[119] Some faith based clinics are well aware of this tension. For example, a free clinic in South Carolina run by the Methodist Church purposefully chose not to have Bibles in the waiting area because many patients were of diverse religious backgrounds.[120] It is not known how many faith based free clinics engage in practices of routine religious traditions during clinic operations but it exemplifies the way in which charity care sometimes retains moralizing attributes such as an “exhortation to piety” as this was known to the Puritans.[121] When

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[117] Linda L. Dunn, "Making a Difference: Initiating and Maintaining a Faith-Based Free Health Clinic," *Family & Community Health* 32, no. 4 (2009).

[118] Amy Sherman, "Faith in Communities: A Solid Investment," *Society* January/February (2003). See also M. Ryan Parker, "Issue Brief: Faith-Based Health Services," (St. Louis, MO: Missouri Foundation for Health, 2004).

[119] Michael M. Olson et al., "Mind, Body, and Spirit: Family Physicians’ Beliefs, Attitudes, and Practices Regarding the Integration of Patient Spirituality into Medical Care," *Journal of Religion and Health* 45, no. 2 (2006).

[120] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 152.

[121] Robert A. Gross, "Giving in America: From Charity to Philanthropy," in *Charity, Philanthropy, and Civility in American History*, ed. Lawrence Jacob Friedman and Mark D. McGarvie (New York, NY: Cambridge University Press, 2003), 32.

such practices are implemented, it is an additional demonstration of the discretion that free clinics have in choosing their patients and their procedures.

The scope of services offered may also be tailored to a particular community's wishes. For example, it is not uncommon to find that free clinics, even when they directly provide pharmaceuticals, pharmaceutical assistance programs, or prescriptions, do not provide any access to controlled substances for pain management.[122] Primary care physicians nationally treat by far the greatest proportion of patients with chronic pain. Access to adequate pain care has been called "a public health imperative."[123] In addition, many free clinics target their services to populations that have been shown to be the least likely to receive high quality pain management such as people who are homeless or racial or ethnic minorities.[124] Physicians in many health care settings often underestimate the severity of minority patients' pain and differences in pain treatment have been shown to be related to patient race or ethnicity. [125]Even though the proper management of pain has been controversial because of the possibility of diversion and addiction, the blanket

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[122] Dunn, "Making a Difference: Initiating and Maintaining a Faith-Based Free Health Clinic." Mary Hurst, "Samaritan Clinic's Patients Declare Medical Service Is Invaluable," *Florida Times Union*, April 26, 2006. Ellen Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education," *Journal of Health Care for the Poor Underserved* 16, no. 2 (2005). Tuscarawas Clinic.Tuscarawas Clinic, "Tuscarawas Clinic for the Working Uninsured," http://www.tuscarawasclinic.org (accessed March 14, 2013). Beth Gray, "Grant Lets Clinic Expand Programs for Uninsured," *Tampa Bay Times* 2012. Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 6.

[123] Brenda Breuer, Ricardo Cruciani, and Russell K. Portenoy, "Pain Management by Primary Care Physicians, Pain Physicians, Chiropractors, and Acupuncturists: A National Survey," *Southern Medical Journal* 103, no. 8 (2010): 738.

[124] Rebecca Matter et al., "Measuring Pain in the Context of Homelessness," *Quality of Life Research* 18, no. 7 (2009). Karen O. Anderson, Carmen R. Green, and Richard Payne, "Racial and Ethnic Disparities in Pain: Causes and Consequences of Unequal Care," *Journal of Pain* 10, no. 12 (2009).

[125] ———, "Racial and Ethnic Disparities in Pain: Causes and Consequences of Unequal Care," 1196.

practice of not stocking or prescribing controlled substances raises questions about discriminatory and lower quality care.[126]

Free Clinic Volunteers

One fact that seems constant at free clinics is their reliance on health care volunteers. Nearly all free clinics reported in the recent survey that volunteer health care professionals provided some medical care. Physicians were the most common professional volunteers followed by nurses. More than three–quarters of free clinics do employ paid staff, especially an executive director.[127] In an earlier survey of free clinics from 2001, the average number of volunteers at a free clinic was 150 with one quarter of these physicians.[128] A regional survey of free clinics reported that the largest free clinic has a panel of 1,800 physician volunteers.[129] The large number of physician and other volunteers together with the relatively modest average number of patients, 120, seen each week at free clinics raised the question of efficiency to the authors of the 2001 survey. The authors pointed out that the average patient panel size was within the range commonly cared for by one or two full-time health care providers.[130]

The authors of the 2001 survey also concluded, surprisingly, that it is relatively more costly to provide care to a free clinic patient compared to national benchmarks. The

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[126] Andrew Rosenblum et al., "Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions," *Experimental and Clinical Psychopharmacology* 16, no. 5 (2008).

[127] Darnell, "Free Clinics in the United States: A Nationwide Survey," 950.

[128] Mohan M. Nadkarni and John T. Philbrick, "Free Clinics: A National Survey," *American Journal of the Medical Sciences* 330, no. 1 (2005): 27.

[129] Geller, Taylor, and Scott, "Free Clinics Helping to Patch the Safety Net," 48.

[130] Nadkarni and Philbrick, "Free Clinics: A National Survey," 27.

free clinic budget averaged about $90 per patient visit.[131] A possible reason that even without the cost of professional services the clinics are more expensive to run is that the clinics have additional expenses. In addition to overhead expenses, there are often purchases of pharmaceuticals and diagnostic tests. Fundraising and recruiting volunteers is of course a relatively larger component of the clinics' staff time. Rotating volunteers who are seeing patients for the first time at each clinic and the social complexity of patients also likely make services relatively more inefficient. The limited hours that most free clinics are open may translate to relatively higher overhead costs.[132]

The more recent survey of free clinics nationally also determined that the cost per uninsured patient is higher at free clinics than at FQHCs.[133] This is contrary to most of the assumptions about free clinic costs where it is expected that "relying on volunteers permits an extraordinary amount of work to be done at relatively little cost. This 'super-efficiency' is… a basis for requesting funding from private and public donors."[134] Analysis of the cost of care at free clinics as undertaken in a limited way in these two surveys raises questions that have received very little attention. In most cases, it is the value of the care provided by volunteers that leads to the assumption that services at a free clinic are less costly: "The net value of the volunteer help is in the thousands or

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[131] For example, in 2002 the average charge for a routine office visit was $64, with 75 percent of internists charging between $45 and $85. Gerry Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices," *Health Affairs* 22, no. 6 (2003).

[132] Nadkarni and Philbrick, "Free Clinics: A National Survey."

[133] Darnell, "Free Clinics in the United States: A Nationwide Survey," 951.

[134] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 138.

hundreds of thousands of dollars at most clinics and is valued at more than a million dollars at a few of the largest clinics."[135]

Some of the common problems mentioned about free clinics are that the services provided are more limited in scope than at other primary care sites, that continuity of care is difficult with rotating professional volunteers, and that specialty referrals may be challenging to obtain.[136] General entrenchment of "two-tiered" medical care is sometimes seen as a problem as is the lack of choice for patients. There is also a concern that seeking care at a free clinic may impede the provision of care at a site that is more comprehensive.[137] Less often mentioned is that volunteer physicians may be less reliable than professionals who are paid, that physicians may not be comfortable in a setting where resources are limited, and that many physicians are unfamiliar with the cost of prescription medications.[138]

Also, despite the commitment of free clinic volunteers to serve people who are uninsured and cannot access care elsewhere, clinics can become overwhelmed with the need for services. Many free clinics do routinely turn patients away though little quantitative data is available on how many patients are not seen after showing up at a free clinic. According to Gregory Weiss, "There is a fairly wide sense that free clinics could make a more powerful statement about the health care needs of the uninsured and

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[135] Ibid., 13.

[136] Darnell, "Free Clinics in the United States: A Nationwide Survey." Robert J. Stroebel et al., "Adapting the Chronic Care Model to Treat Chronic Illness at a Free Medical Clinic," *Journal of Health Care for the Poor and Underserved* 16, no. 2 (2005).

[137] Keis et al., "Characteristics of Patients at Three Free Clinics."

[138] Doug Campos-Outcalt, "Volunteer Clinic Caveats," *Journal of the American Medical Association* 266, no. 6 (1991).

working poor and about the contributions of free health clinics if there was more systematic data collection."[139] In one local newspaper report, a free clinic on a typical day took the first fifty people inside and left sixty-four who were not seen.[140] Other free clinics report turning people away as well.[141] The executive director of one Michigan free clinic that is not accepting new patients stated, "even if they are crying, we won't let them in."[142] During interviews with free clinic directors, several said that the inability to provide care to everyone was their biggest problem:

> I've heard some legislators address the problem by saying that they are sure that free clinics are taking care of the problem. But we are taking care of not even a tip of the iceberg. Every time that sixty people walk in our door, sixty more could walk in behind them, and sixty more behind them, and we still wouldn't be helping everybody. So this is not the right way to serve all of those with needs even though we serve very well some of the people with needs.[143]

The average number of patients turned away each week from each free clinic nationwide was estimated to be eight in one survey.[144]

Many of the clinics continually run by attending to immediate needs. Long term planning may be difficult when the challenges of recruiting and scheduling volunteer

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[139] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 112.

[140] Karen Garloch, "Free Clinics 'Can't Serve Them All:' The Demand for Medical Service Is Overwhelming as More and More Workers Lack Insurance," *Charlotte Observer*, September 8, 2008.

[141] Rebecca James, "Free Clinics Quietly Fill Gap in Health "Safety Net:" Professionals Volunteer to Help the Many Uninsured People in Ithaca, Syracuse," *Post-Standard*, June 10, 2006. Jennifer Lenhart, "A Weekly Dose of Healing," *Washington Post*, February 27, 2000. Nalepa, "Free Clinic Strapped for Cash, Volunteers." and Judy Gibbs Robinson, "Doctor's Free Clinic Bucks National Trend," *Daily Oklahoman*, April 4, 2006.

[142] Peter D. Jacobson et al., "Survival Strategies for Michigan's Health Care Safety Net Providers," *Health Services Research* 40, no. 3 (2005): 930.

[143] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 181.

[144] Alida M. Gertz, Scott Frank, and Carol E. Blixen, "A Survey of Patients and Providers at Free Clinics across the United States," *Journal of Community Health* 36, no. 1 (2011): 86.

health care providers and other staff, maintaining clinic supplies, purchasing pharmaceuticals or utilizing pharmaceutical assistance programs, and fundraising are a constant necessity. An executive director of one urban free clinic stated that there was no strategic plan other than “Getting through the week, keeping the doors open, and keeping patients alive.”[145] As compared to federally qualified health care centers, free clinics remain less stable and dependent to a greater degree on community support.[146]

At the same time, volunteer professionals at free clinics often express the view that the challenges of the clinics are welcomed in some ways because they reflect a shared sense of purpose and foster a sense of camaraderie.[147] Put simply by one volunteer: “Volunteering here is difficult and it is rewarding because it is difficult.”[148] The day-to-day struggles of the clinic can be viewed as integral to a simpler setting: “One of the joys of working in a free clinic is that we are short on bureaucracy.”[149] Patient care can seem like a more visible priority: “[Volunteer physicians] say that they gladly volunteer for the free clinic for three hours at night because there are no administrative hassles, no managed care, no preauthorization just ‘take care of the patient and feel better about it.’”[150] The atmosphere of free clinics can be viewed as unachievable in other

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[145] Peter D. Jacobson et al., "Survival Strategies for Michigan's Health Care Safety Net Providers: Report to the Blue Cross Blue Shield of Michigan Foundation," (2003).

[146] Finley, "Troubled Clinic No Longer Seeing Patients after Money Runs Out."

[147] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 149. Herbert Y. Reynolds, "Free Medical Clinics: Helping Indigent Patients and Dealing with Emerging Health Care Needs," *Academic Medicine* 84, no. 10 (2009).

[148] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 148.

[149] Ibid., 124. Reynolds, "Free Medical Clinics: Helping Indigent Patients and Dealing with Emerging Health Care Needs."

[150] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 139.

settings: "The thing about free clinics is that it is people coming together—all their different gifts and talents—in a way that you can't do in other places. That is what makes free clinics so special."[151] In contrast to practicing in their own offices, working at a free clinic may seem closer to altruistic service:

> When I am in my own office, patients are here because of insurance, and they have a certain level of expectations…and because you are getting paid, there is not necessarily obvious appreciation. At the free clinic, you really feel like everything you are doing is going above and beyond, which is great. Patients are extraordinarily appreciative, and we have just as much time as we could possibly need with each patient—a very nice thing.[152]

Many professionals also describe the ability to practice in a more compassionate way: "I really enjoy the fact that patients get excellent, compassionate care, and in many other settings where I have worked, they have gotten excellent technical care but not compassionate care."[153]

Many volunteers at free clinics express a profound sense of fulfillment from their work at the clinics. Dr. Jack McConnell, the founder of a large free clinic, expressed this sentiment: "The free clinic is more than a place to receive health care. It benefits not only those who come there for care but also those who deliver the care. In a broader frame of reference, it helps to transform the entire town into a community."[154] One free clinic volunteer physician in Missouri described his experience: "Every week I work there's a person who comes in and is frightened. You sit down with them and say, 'We're here to help you,' and you see them relax; the anger, tension, and fear flow away. It's wonderful

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[151] Ibid., 78.

[152] Ibid., 138.

[153] Ibid., 150.

[154] Ibid., 188.

to give a gift like that to another human being."[155] A dentist who volunteers in Virginia said: "For many people when they are preparing for death, their greatest fear is whether their life has been worth living. When I ask if I have made any mark on life, I think that I have had the opportunity to be a participant in something that really did change people's lives."[156] For another physician volunteer, work at the free clinic was like returning to a time when patients' needs were the simple priority: "When I talk to potential physician volunteers, I liken practicing at the clinic to the good old days of being a doctor-when you work just for the sake of making someone better, and no one gave you a dime." [157] An administrator at a free clinic stated: "It feels good to provide service to someone who is not going to get it anywhere else and to provide it in a way that really makes a difference to them."[158]

Physician volunteers sometimes learn directly how poorly our national health care system functions because of their work at free clinics:

> I am learning a lot, and I like that, but the issues are more complex and more complicated and more involved than I had thought. I knew that the national health care scene was sort of a disaster, and now I am realizing it even more deeply. I never had really worked directly with people who need this kind of facility. I had seen them from a distance but had never gotten involved with them. I can see that even though we cannot help them enough, there is something that we can do to help.[159]

Not uncommonly volunteers refer to work at free clinics as analogous to "third world" conditions. One Iowa volunteer who works at the Mustard Seed Wellness Clinic stated:

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[155] Jane Levere, "Helping out at Home," *Diversion* 32, no. 6 (2004): 8.

[156] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 145.

[157] Ibid., 147.

[158] Ibid.

[159] Ibid., 148.

"We have a Third World country right here at home, so I'll stick around here and volunteer."[160] A physician couple who volunteer in Florida at a free clinic believe that their work mirrors their previous Peace Corps experiences.[161] A family physician volunteer in Los Angeles at a large free clinic event stated that there is as much need for medical care in America as in the remote areas of India.[162] The website of the Dallas County Medical Society has the following statement on their volunteer page:

> Each year, hundreds of Dallas-area physicians give up a week or two to be part of a medical mission team that provides medical care to patients in Third World countries. For many physicians, these trips require weeks or months of planning to ensure they have the required vaccinations, passport, medical equipment, and coverage for their own patients while they are gone. These efforts are noble and much needed but the physicians may not realize they can do medical mission work right here in the Dallas/Fort Worth area with patients in dire need of medical attention.[163]

The opportunity for physicians, medical students, and others to learn directly about the conditions that are faced by people who attend a free clinic are often cited as factors important to volunteers. At a free clinic event in Houston in 2009, the physician organizer, Mehmet Oz, described a sense of shame at breaking the record for the number of people seen at a free clinic in one day. As he reminded his readers, this was no post-disaster event; it was merely another day in Houston:

> My hope is that we get to a day when I never have to watch an echocardiogram on a floor normally reserved for rodeo trade shows. My hope is that no one else ever has to break our record. While I am proud that the patients who came understood

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[160] Sandy Miller, "More Volunteers Sign on at Free Clinic," *Twin Falls Times-News* May 1, 2006.

[161] Susan Brandenburg, "Medical Volunteers Serve at Downtown Free Clinic," *Florida Times-Union*, January 21, 2006.

[162] Bill Whitaker, "Free Health Clinic Lures Hundreds in L.A.," CBS News, http://www.cbsnews.com/stories/2009/08/13/eveningnews/main5240824 (accessed March 14, 2013).

[163] Dallas County Medical Society, "Volunteers Needed," http://www.dallas-cms.org/volunteerhealth.cfm (accessed March 14, 2013).

> someone loved and cared about them and got them desperately needed care. I feel a sense of shame that [the free clinic] had to happen at all.[164]

These conflicting and ambivalent feelings about the work of free clinics are not unusual and they are similar to what was expressed by the cardiologist Arthur Garson in the introduction. Dr. Oz sees his contribution in part as one in which he may be able to elicit empathy from policymakers by making the plight of uninsured people “real.” He also believes that he contributes by his ability to “bear witness to the true nature of the life-threatening struggle facing one in seven Americans.”[165]

Medical Student-Run Clinics

“Witnessing” is a term that has been used by volunteers at a medical student-run clinic for homeless people to describe the effort to listen attentively while maintaining a focus on the “entirety of a person’s life situation, not merely on their ailment.”[166] Student-run free clinics are a subset of free clinics. In a 2006 survey of 124 medical schools in the United States, just over half of those responding reported at least one student-run clinic.[167] The authors defined a medical student-run clinic as follows: “[A] health care delivery program in which medical students take primary responsibility for logistics and operational management and which is capable of prescribing disease-

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[164] Mehmet Oz, "The Shame in Breaking Records," *Huffington Post* (2009), http://www.huffingtonpost.com/dr-mehmet-oz/the-shame-in-breaking-rec_b_301870.html (accessed March 14, 2013).

[165] Ibid.

[166] Beverly Ann Davenport, "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless," *Medical Anthropology Quarterly* 14, no. 3 (2000): 316.

[167] The response rate was 76 percent, or 94 schools. Scott A. Simpson and Judith A. Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education," *Journal of General Internal Medicine* 22, no. 3 (2007).

specific treatment to patients."[168] In a more recent survey of all types of free clinics, the patients seen at student-run clinics were more likely to be from racial and ethnic minority groups and to have a low income as compared to other free clinics.[169] The average number of patient visits per week at student-run free clinics `was nineteen and the average annual budget was about $10,000 mostly obtained through private grants and fund raising, making the student-run clinics among the smaller of free clinics.[170]

Medical student-run clinics are always associated with a medical school and are overseen by medical school faculty. In the medical school survey, however, most of the teaching at free clinics was provided by other students with a little more than a third of teaching attributed to an attending physician.[171] One physician volunteer has noted that the teaching that takes place at free clinics is not necessarily a part of the medical school curriculum and that there may be little formal assessments or evaluations.[172] The survey did show that many clinical skills were learned for the first time at the clinics. More than three-fourths of students attending free clinics first learned how to present a patient to another physician at the clinics and almost half first learned how to perform a physical exam, test blood glucose, and administer injections.[173] The level and quality of

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[168] More limited community service projects were excluded. Ibid., 352.

[169] Gertz, Frank, and Blixen, "A Survey of Patients and Providers at Free Clinics across the United States."

[170] Ibid. Simpson and Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education."

[171] ———, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education."

[172] Reynolds, "Free Medical Clinics: Helping Indigent Patients and Dealing with Emerging Health Care Needs."

[173] Simpson and Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education." See also Carolyn Szcaepanske, "Jay's Anatomy," *Kansas City Pitch*, September 14, 2006.

supervision by faculty of student-run clinics likely varies substantially. While the results of the medical school survey are concerning, in a description of a student-run clinic in San Diego, all patients were seen by both faculty and students and the sessions concluded with a "learning circle" for reflection.[174]

Most recent publications on medical student-run clinics tend to emphasize the opportunity for experiential learning while engaging in the service of providing medical care to uninsured and vulnerable people.[175] Medical student-run clinics are believed to foster altruism, medical humanism, and professional generosity.[176] The clinics may "sustain students' passion, compassion, and desire to make a difference as well as provide the needed skills to help the student make his or her dreams of practice with the underserved a reality."[177] Medical student attitudes about underserved populations and their willingness to volunteer have been enhanced by structured free clinic or international service opportunities, though long term data are not available.[178] In the survey of student-run clinics, leaders estimated that all volunteers were motivated by a

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[174] Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education," 212.

[175] Yasmin S. Meah, Eric L. Smith, and David C. Thomas, "Student-Run Health Clinic: Novel Arena to Educate Medical Students on Systems-Based Practice," *Mount Sinai Journal of Medicine* 76, no. 4 (2009).

[176] Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education."; Simpson and Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education." Reynolds, "Free Medical Clinics: Helping Indigent Patients and Dealing with Emerging Health Care Needs."

[177] Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education," 219.

[178] Ibid. Thomas P. O'Toole et al., "Experiences and Attitudes of Residents and Students Influence Voluntary Service with Homeless Populations," *Journal of General Internal Medicine* 14, no. 4 (1999); Janice K. Smith and Donna B. Weaver, "Capturing Medical Students' Idealism," *Annals of Family Medicine* 4 Suppl 1(2006).

desire to serve the poor. The leaders also estimated that almost all volunteers sought to enjoy themselves, spend time with patients, and learn clinical skills.[179] Generally, student-run clinics are cast as beneficial to underserved people and medical school trainees, a classic “win-win.”[180]

Edward Eckenfels, a professor at Rush Medical School, has described the formation of a student-run prenatal clinic in Chicago. Medical records of thirty clinic patients enrolled at the clinic showed that the care was excellent and in interviews the patients “characterized the students as personable, sensitive, knowledgeable, and deeply caring.”[181] When students were asked about their experiences, they responded that volunteering at the clinic led to an affirmation of their commitment to primary care and the clinic was perceived to be a place that nurtured and sustained compassionate care.[182] In a recent survey of the entire medical student body at the University of California San Diego (UCSD), 90 percent of the respondents perceived the presence of the school’s student-run free clinics to be a valuable part of their educational experiences.[183]

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[179] Simpson and Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education."

[180] Mary K. Nordling, "Starting a Student-Run Homeless Clinic," (1999), http://www.amsa.org/AMSA/Libraries/Committee_Docs/homelessclinic.sflb.ashx (accessed March 14, 2013).

[181] Edward J. Eckenfels, "Keeping Comminty Service Voluntary," in *Educating for Professsionalism: Creating a Culture of Humanism in Medical Education*, ed. Delese Wear and Janet Bickel (Iowa City, IA: University of Iowa Press, 2000), 170.

[182] Ibid.

[183] Sunny D. Smith et al., "Medical Student Perceptions of the Educational Value of a Student-Run Free Clinic," *Family Medicine* 44, no. 9 (2012).

Ethical Tensions in Student-Run Free Clinics

On the other hand, the need for trainees to develop clinical skills is not perfectly aligned with the need for uninsured patients, particularly those who are vulnerable in other ways, to receive quality medical care: "Recognition of the inherent tension between the social need to train future doctors and an individual patient's need to receive care from someone competent is not new."[184] Just as was the case for the early twentieth century dispensary patients, to the extent that "payment" by poor patients for medical services occurs through their use in medical education, a focus on social responsibility can be diminished.[185] In 1979 one observer commented: "The usefulness of the free clinic as a safety valve and training facility may actually legitimate the current organization of health care."[186] In a 1995 student editorial in *JAMA*, the author commented: "I have heard faculty members complain, on occasion, that students develop bad habits at these clinics because of inadequate supervision. Certainly the quality of care and the ethics of students 'practicing' on those who cannot afford other care should be reviewed."[187] Much like the

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[184] John S. O'Shea, "Individual and Social Concerns in American Surgical Education: Paying Patients, Prepaid Health Insurance, Medicare and Medicaid," *Academic Medicine* 85, no. 5 (2010): 854. See also Winston Chiong, "Justifying Patient Risks Associated with Medical Education," *Journal of the American Medical Association* 298, no. 9 (2007).

[185] Veeder, "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary." See also: L. W. Eichna, "Medical School Education for Whom, Student or Patient," *Bulletin of the New York Academy of Medicine* 67, no. 2 (1991).

[186] Rosemary C. Taylor, "Alternative Services: The Case of Free Clinics," *International Journal of Health Services* 9, no. 2 (1979): 227.

[187] Eric J. Poulsen, "Student-Run Clinics: A Double Opportunity," *Journal of the American Medical Association* 273, no. 5 (1995): 430.

1979 commentary, a 2009 editorial suggested that student-run clinics may impede efforts for substantial reform of health care and help to sustain the status quo.[188]

There has been one published article to specifically address the ethical management of student-run clinics.[189] The authors take a balanced view of the clinics citing the potential of the clinics to promote altruism and compassionate care of patients who are uninsured and vulnerable in other ways. However, in order to meet this potential, the authors propose significant responsibilities on medical school faculty, community preceptors, and administrators of the medical school. `One example is that faculty supervisors should: "Make clear to student volunteers that service takes priority over practicing skills and work with student leaders to ensure that all volunteers understand and share the clinic's mission."[190] Other recommendations for faculty supervisors were to ensure that referral mechanisms are in place for patients needing further care. Clinic faculty preceptors should not be silent with patients and students when care at the clinic deviates from other health care settings but should address these explicitly. Medical school administrators should integrate the educational goals of the clinic with the medical school's curriculum.[191]

Medical students' accounts of the sometimes profound impact of their work at free clinics can be intensely personal and meaningful. A first-year medical student paired

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[188] Arch G. Mainous and Richard Baker, "Service Learning Helps Sustain the Status Quo," *Family Medicine* 41, no. 9 (2009).

[189] David Buchanan and Renee Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics," *Journal of Health Care for the Poor and Underserved* 17, no. 3 (2006).

[190] Ibid., 483.

[191] Ibid.

with a second-year student described seeing a nineteen year old young woman who was a sex worker, frequently used "speed," and she was suicidal:

> I hardly said a thing. I just mostly witnessed the interaction between the second-year student and her, and it was really sensitive, like a really good encounter that uncovered all of this unhappiness and…it really blew me away…at some point I was realizing I was learning so much more in these encounters than my classes.[192]

In another narrative essay, a medical student conveys how working at a free clinic challenged his views intensely:

> I wanted to hate you, your stench, and your damned laziness. Get off your butts and work!...And yet I felt guilty, for my apathetic complicity in the game of 'turn-your-head-and-look-the-other-way-and-all-the-poor-people-will-go –away'…I have this hope that perhaps in the end I will not have become just a better clinician because of you, but because of you I will also have become more human.[193]

Another student volunteer at a free clinic stated: "The shelters were humbling and, at times shocking eye openers to the poverty and destitution that can exist in a wealthy country."[194]

A difficult task for teachers and students alike is to allow these experiences to result ultimately in improved care for people from diverse backgrounds.[195] Many of the qualities commonly associated with student-run free clinics such as improvised locations and lack of resources have been associated with discouraging residents to continue

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[192] Davenport, "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless," 310-311.

[193] Sean Stout, "Time at the Rio Grande Clinic," *Journal of the American Medical Association* 273, no. 5 (1995).

[194] Nordling, "Starting a Student-Run Homeless Clinic." 11.

[195] Joseph R. Betancourt, "Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal," *Academic Medicine* 81, no. 6 (2006).

primary care.[196] These narratives also suggest that unless students have an opportunity to reflect on their experiences at free clinics, stereotypes about patients may be reinforced.[197] There is a possibility that these interactions may result in "othering," which is defined as "a process whereby a group is defined as different from another group that is considered the norm."[198] Learning at student-run free clinics may be somewhat analogous to cultural competency education which, in theory, provided a fairly ready answer to disparities in health care through mainly formal curricular changes. Several thoughtful critics, however, have commented that this curricular focus may worsen health care disparities.[199]

Students may encounter circumstances that are novel and compelling because they are deeply unfamiliar at the same time that they are learning about medical school and clinical basics. In other words, both medical students and patients attending free clinics are groups that are well recognized as vulnerable, though in different ways.[200] At a student-run free clinic in Kansas City, the students one night explained that they "don't really know what they're doing," including trying to find information on drug assistance

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[196] Carla C. Keirns and Charles L. Bosk, "Perspective: The Unintended Consequences of Training Residents in Dysfunctional Outpatient Settings," *Academic Medicine* 83, no. 5 (2008).

[197] Buchanan and Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics."

[198] Carla Boutin-Foster, Jordan C. Foster, and Lyuba Konopasek, "Viewpoint: Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence," *Academic Medicine* 83, no. 1 (2008).

[199] Betancourt, "Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal." Delese Wear, "Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education," *Academic Medicine* 78, no. 6 (2003). Arno K. Kumagai and Monica L. Lypson, "Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education," *Academic Medicine* 84, no. 6 (2009).

[200] Buchanan and Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics."

programs without having had their pharmacology course yet.[201] A medical student at a free clinic in Texas said that there are “layers to catch mistakes” because of the attending physicians. At the same time, a student remarked that “[k]nowing that I had that kind of power [to treat real patients] was a little scary.”[202] Awareness by students of the vulnerability of a free clinic’s patient population and their own status as a novice can pose an ethical dilemma which has been recognized to be a common one for students as well as residents.[203] In one article, “medical students expressed their fear of exploiting the Clinic’s patient population, given its vulnerability and their own lack of clinical expertise.”[204]

Students are also inexperienced in the organizational and administrative tasks involved in running clinics and they generally do not receive any training for these tasks.[205] Clinic student leadership ordinarily changes at least once a year and this can be disruptive.[206] Free clinics are more likely to take place in unconventional settings than other types of clinics and resources can be minimal. Yet students are tasked with the

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[201] Szcaepanske, "Jay's Anatomy."

[202] Kelly Hawes, "Clinic Provides Health Care for the Uninsured," *Galveston County Daily News*, May 4, 2006.

[203] Davenport, "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless." D. A. Christakis and C. Feudtner, "Ethics in a Short White Coat: The Ethical Dilemmas That Medical Students Confront," *Academic Medicine* 68, no. 4 (1993). Priscilla P. Chiu et al., "Experience of Moral Distress among Pediatric Surgery Trainees," *Journal of Pediatric Surgery* 43, no. 6 (2008).

[204] Davenport, "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless," 317.

[205] Buchanan and Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics." Meah, Smith, and Thomas, "Student-Run Health Clinic: Novel Arena to Educate Medical Students on Systems-Based Practice."

[206] David Moskowitz et al., "Students in the Community: An Interprofessional Student-Run Free Clinic," *Journal of Interproffessional Care* 20, no. 3 (2006).

“selection and allocation of resources [which] require students running [student-run clinics] to exert a great deal of insight, judgment, and system manipulation to acquire the right kinds of services that will adequately meet their patients’ needs and fit the construct of the clinic.”[207]

It is not clear that there are any other health care settings in which trainees are responsible for tasks with as much importance or that there are settings in which an inexperienced and temporary workforce seems to be preferred. It is also not clear that faculty preceptors are aware that trainees in medicine have a long history of disproportionately relying on charity patients for medical training.[208] At the same time there seems to be a growing consensus that while the education of medical trainees is essential for the health of the nation, “individual patients are not obligated to participate in the training of society’s future physicians.”[209] One commentator has likened *patient’s* duties to participate in medical education to “duties of charity, which allow for considerable individual discretion about how and when those duties are discharged.”[210] Because patients attending a free clinic have often been disenfranchised from the medical care system, they may have benefitted the least from medical education and may stand to gain the least if physician-trainees go on to serve mainly insured private patients.[211]

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[207] Meah, Smith, and Thomas, "Student-Run Health Clinic: Novel Arena to Educate Medical Students on Systems-Based Practice," 352.

[208] O'Shea, "Individual and Social Concerns in American Surgical Education: Paying Patients, Prepaid Health Insurance, Medicare and Medicaid."

[209] Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics : A Practical Approach to Ethical Decisions in Clinical Medicine*, 7th ed. (New York, NY: McGraw-Hill Medical, 2010), 212.

[210] Chiong, "Justifying Patient Risks Associated with Medical Education," 1047.

[211] April Maa and Laurence B. McCullough, "Medical Education in the Public Versus the Private Setting: A Qualitative Study of Medical Students' Attitudes," *Medical Teacher* 28, no. 4 (2006).

Student-run clinics frequently "cannot offer comprehensive primary care but can significantly improve the health of those otherwise without care."[212] In order for student-run clinics to make sense in a community context, they must provide some medical services that cannot be obtained elsewhere. Otherwise, the clinics may indeed impede access to more comprehensive care.[213] It is relevant to note that private internal medicine physicians report having doubts about their ability to provide the quality and continuity of care that they would like to provide to uninsured patients.[214] Thus, even established practices face difficulties with providing care to uninsured people. There are a few very small studies showing that student-run clinic patients receive care that is comparable in quality to other sites and one study that showed worse health and quality of life for free clinic patients as compared to a hospital outpatient department.[215]

There is some suggestion that changes in length of stay on the inpatient services of teaching hospitals and the focus on productivity in outpatient settings may have lessened the ability to teach medical students at these sites.[216] In addition, Medicare billing rules that disallow most medical student documentation, restricted access for

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[212] Jerry Cohen, "Eight Steps for Starting a Student-Run Clinic," *Journal of the American Medical Association* 273, no. 5 (1995): 434.

[213] Buchanan and Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics."

[214] Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices."

[215] Kira L. Ryskina, Yasmin S. Meah, and David C. Thomas, "Quality of Diabetes Care at a Student-Run Free Clinic," *Journal of Health Care for the Poor and Underserved* 20, no. 4 (2009). Kate M. Liberman et al., "Quality of Mental Health Care at a Student-Run Clinic: Care for the Uninsured Exceeds That of Publicly and Privately Insured Populations," *Journal of Community Health* 36, no. 5 (2011). Alexandra A. Garcia, "Clinical and Life Quality Differences between Mexican American Diabetic Patients at a Free Clinic and a Hospital-Affiliated Clinic in Texas," *Public Health Nursing* 25, no. 2 (2008).

[216] Reynolds, "Free Medical Clinics: Helping Indigent Patients and Dealing with Emerging Health Care Needs."

medical students to electronic medical records, and concerns over legal actions may all result in the loss of a “sense of ownership” and being “undervalued and discourage[d]” by medical students.[217] A sense of ownership has been associated with student’s participation in free clinics.[218]

Limits on the activities and the role of medical students within traditional health care settings are in contrast to the much greater autonomy and responsibility of students at free clinics. There are no publications that address this contrast specifically. A topic that should be addressed is whether the restrictions on medical student participation are warranted in traditional health care settings. For example, are the limitations on documentation for the purpose of Medicare billing reasonable? If the restrictions are not justified, then seeking to change them could lessen the need for students to learn skills at free clinics. If the restrictions are reasonable, then to disregard them would require some justification other than that some patients have no other source of medical care. Some schools offer service learning opportunities and other community activities that seek to foster social responsiveness that are not as directly tied to student-run clinics.[219] The question put forth in an editorial by a pediatrician was this:

> Will these same students who currently spend multiple hours out of class helping the poor be the same physicians who in 5 years join practices that refuse to treat poor people? Their social service here and abroad as student is important, but is probably more helpful to them than to the communities they try to serve.[220]

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[217] Peter Gliatto, Philip Masters, and Reena Karani, "Medical Student Documentation in the Medical Record: Is It a Liability?" *Mount Sinai Journal of Medicine* 76, no. 4 (2009): 359,362.

[218] Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education," 217.

[219] Delese Wear and Janet W. Bickel, *Educating for Professionalism: Creating a Culture of Humanism in Medical Education* (Iowa City, IA: University of Iowa Press, 2000).

[220] Frederick P. Rivara, "Sustaining Optimism," *Archives of Pediatric & Adolescent Medicine* 158, no. 5 (2004): 414.

Although medical schools must approve the formation of student-run clinics, their status within the curriculum and within the clinical infrastructure is as varied as the clinics themselves. Most student-run clinic publications describe faculty sponsors and faculty preceptors as volunteers, though some faculty participate as a part of their salaried position. Community physicians are also sometimes mentioned as preceptors. [221] While some medical student-run free clinics are located in homeless shelters or other sites that are largely attempts to reach people who are disconnected from medical services, others are located in areas surrounding the medical centers where students are enrolled.[222] This raises the question of whether the services provided at some free clinics could be undertaken at the medical centers instead of at locations that are off-site and whether one unaddressed problem is the gap between the health care needs of academic medical center communities and the services provided. In a recent survey of a large private medical center, all of the institutional respondents believed that the centers had some obligation to their surrounding communities.[223]

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[221] For example, the UCSD clinic utilizes a few salaried faculty as well as faculty and community physician volunteers. Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education." The ETSU rural outreach has faculty and volunteer community physician preceptors. Bruce Bennard et al., "A Student-Run Outreach Clinic for Rural Communities in Appalachia," *Academic Medicine* 79, no. 7 (2004). The EHHOP utilizes physician volunteers and paid social workers. Liberman et al., "Quality of Mental Health Care at a Student-Run Clinic: Care for the Uninsured Exceeds That of Publicly and Privately Insured Populations."

[222] Michelle A. Bardack and Susan H. Thompson, "Model Prenatal Program of Rush Medical College at St. Basil's Free Peoples Clinic, Chicago," *Public Health Report* 108, no. 2 (1993). Kelin Hall, "Free Clinics Benefit Future Physicians as Well as Patients," *Medicine on the Midway*, Summer (2011), http://www.uchospitals.edu/pdf/uch_027899.pdf. Simpson and Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education." O. W. Stephanie Yap and David J. Thornton, "The Arbor Free Clinic at Stanford: A Multidisciplinary Effort," *Journal of the American Medical Association* 273, no. 5 (1995).

[223] Allison Lale, Rachael Moloney, and G. Caleb Alexander, "Academic Medical Centers and Underserved Communities: Modern Complexities of an Enduring Relationship," *Journal of the National Medical Association* 102, no. 7 (2010).

It is possible that medical schools' relationship to student-run clinics could convey powerful tacit messages through the "hidden curriculum." The medical sociologist Frederic Hafferty defines the term as "the commonly held understandings, customs, rituals, and taken-for-granted aspects of what goes on in the life-space we call medical education. . . training institutions are both cultural entities and moral communities intimately involved in constructing definitions about what is "good" and "bad" medicine."[224] The hidden curriculum communicates implicitly what is important and has a stronger influence on what is learned by students than the formal curriculum.[225] While medical schools may formally endorse a commitment to underserved people and the provision of charity care in their community as well as the concept of student-run clinics, institutional resources may not reflect such a commitment. Many of the descriptions of student-run clinics have a sort of orphan quality. As an example, in the survey of student-run clinics, referrals for patients who needed care beyond the clinic's capacity for treatment were directed to the associated academic medical center in less than 40 percent of cases.[226] While students may have a great sense of ownership, their medical schools often do not.

The inability to obtain care by a specialist is frequently cited as a problem for student-run clinics.[227] In a survey at one medical school with a free clinic, only 10

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[224] Frederic W. Hafferty, "Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum," *Academic Medicine* 73, no. 4 (1998): 404.

[225] Ibid.

[226] Simpson and Long, "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education," 354.

[227] Szcaepanske, "Jay's Anatomy." Arthur M. Fournier, Alina Perez-Stable, and Pedro J. Greer, Jr., "Lessons from a Clinic for the Homeless. The Camillus Health Concern," *Journal of the American Medical*

percent of students agreed that they were comfortable with their ability to get uninsured patients referred for care.[228] The faculty at academic medical centers may be quite aware of the difficulty in obtaining care for uninsured patients. In a survey of faculty at academic medical centers, almost one-quarter reported that in the past year they were unable to admit patients who were uninsured or they had to limit their care because they were uninsured. At these medical centers nearly one in five clinical faculty felt that they were discouraged by their group practice or hospital from seeing too many indigent patients, and more than one in ten reported that their group practice placed formal limits on the number of patients or the amount of care they could provide.[229] It is reasonable to question the ability of faculty preceptors and medical students to overcome these barriers in caring for patients at student-run clinics.

It is possible that, to some degree, the time and commitment of faculty required to maintain a student-run clinic inhibits broader efforts to improve access aimed at their own institutions or at the policy level. In some cases physicians may approach the circumstance with resignation. Commenting on the situation faced by many of the patients at a free homeless clinic in a lecture for students, a physician explained: “We’re not going to fix it, but we’re gonna bear witness.”[230] In this case witnessing may be a

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Association 270, no. 22 (1993). Liberman et al., "Quality of Mental Health Care at a Student-Run Clinic: Care for the Uninsured Exceeds That of Publicly and Privately Insured Populations." Yap and Thornton, "The Arbor Free Clinic at Stanford: A Multidisciplinary Effort." Buchanan and Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics."

[228] B. Brent Simmons et al., "Students Who Participate in a Student-Run Free Health Clinic Need Education About Access to Care Issues," *Journal of Health Care for the Poor and Underserved* 20, no. 4 (2009).

[229] Joel S. Weissman et al., "Limits to the Safety Net: Teaching Hospital Faculty Report on Their Patients' Access to Care," *Health Affairs* 22, no. 6 (2003).

[230] Davenport, "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless," 316.

"salve" for a sense of helplessness that volunteers have.[231] A resident preceptor for a medical student-run clinic described how he enjoyed working with students in part because they have not been complicit in a dysfunctional system: Students "have no clue how broken the system can be…They haven't watched themselves become a functioning part of it on a daily basis, metamorphosize[d] like Kafka's worker, as we all do to a greater or lesser extent."[232]

Free Clinics Appeal to People with Polarized Views of the Health Care System

Some of the publications pertaining to student-run medical clinics mention that part of the environment they hope to create is based on nurturing altruism, critical reflection, and an unconditional positive regard for all people in their volunteers, and empowerment of the community among their patients.[233] These were some of the purposes of the free clinics that were established in the 1960s and 1970s when free clinics tended to take a political stance of solidarity with their patients. Some long-time leaders of free clinics believe that there is currently a more diverse political and ideological viewpoint among people volunteering at free clinics. When interviewed about the role of a national free clinic association prior to its formation, one of these leaders stated:

> What exacerbates things now more than ever is that you have people in the free clinic world on polar opposites of the political spectrum. I think in the early days free clinics were much more homogenous, at least that's my observation and now

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[231] There were two ways in which the volunteers may have felt helpless. One was due to the social circumstances and a second was due to limitations in medical care. Ibid.

[232] Szcaepanske, "Jay's Anatomy."

[233] Beck, "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education." Buchanan and Witlen, "Balancing Service and Education: Ethical Management of Student-Run Clinics." Davenport, "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless."

> there are some free clinics that are made up by and led by very conservative-minded people and those that are led by very liberal-minded people…The liberal-minded people would like to see universal health care. The conservative-minded people would object to that.[234]

According to Gregory Weiss, free clinic leaders generally know they must rely on volunteers and financial contributors with diverse political views. One leader said, “Quite frankly we run from political discussions as fast as we can.”[235]

Many volunteers at free clinics believe strongly that adequate health care should be a right. A physician director of a free clinic in California stated: “Our mission, philosophy, and delivery of care is for the uninsured and for those who have been rejected by the mainstream of society; our motto is that health care is a right, not a privilege.”[236] Some volunteers have been active in the group Physicians for a National Health Program (PNHP) which advocates for single-payer national health insurance.[237] A physician and volunteer medical director at a Missouri free clinic, Judy Dasovich, was arrested in 2009 for interrupting Congressional testimony on health care reform proposals. She and others were protesting the fact that no witnesses in favor of a single-payer plan were allowed to speak. Dasovich routinely turns away patients who come to her clinic: “Working in the free clinic has highlighted for me more than anything that the so-called safety net is anything but."[238]

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[234] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 130.

[235] Ibid., 142.

[236] Ibid., 141.

[237] Physicians for a National Health Program. Physicians for a National Health Program, "Physicians for a National Health Program," http://www.pnhp.org/.

[238] Doug Trapp, "Democratic Leaders Stay Cold on Single-Payer," *American Medical News*, June 22, 2009.

Some free clinic volunteers have emphasized that free clinics are a viable option to entitlements. Kevin Kelleher, as director of the Bradley Free Clinic in Virginia, published an article in 1991 that put forth his point of view:

> Free clinics should be allowed to evolve and improve in response to local need. Staffed by volunteers, they would not compete with the private sector, but would enhance it by decreasing bad debt and abuse. They would encourage the working poor to continue working, rather than slip backward onto welfare dependency, and at the same time would improve their health and quality of life. Free clinics would be a source of pride in each community and would enhance the image of health care providers, serving as shining examples of their compassion.[239]

The Bradley Free Clinic was named one of the “thousand points of light” by President George Bush and had earlier received a commendation from President Reagan. Voluntarism is valued across the political spectrum but often with differing worldviews. Solidarity with free clinic patients seems to be replaced by *noblesse oblige* in Kelleher’s article: “Volunteers are recognized and honored by their communities. The patients themselves recognize the volunteer effort, and they are appreciative and less likely to abuse resources than under an entitlement. Volunteers develop a camaraderie that is reinforcing.”[240] Some faith-based clinics may believe that the church should act so that governmental programs remain limited: “[One free clinic director] believes churches need to follow the New Testament pattern, in which churches assist with the needs of the sick without expecting the federal government to provide it all.”[241] David Hilfiker, a family physician whose work on charity is varied and nuanced, once expressed the opinion that the rest of us need the poor:

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[239] Kelleher, "Free Clinics. A Solution That Can Work ... Now!" 840.

[240] Ibid., 839.

[241] Dunn, "Making a Difference: Initiating and Maintaining a Faith-Based Free Health Clinic," 343.

> I am beginning to realize that we in medicine need the poor to bring us back to our roots as a servant profession. Medicine drifts understandably yet ominously toward the technical and the economically lucrative, and we find it difficult to resist. Perhaps we need the poor at this very moment to bring us back to ourselves. The nature of the healer's work is to be with the wounded in their suffering. Can the poor in their very vulnerability show us how?[242]

David Wagner, a sociologist and author of a critique of charity notes: “Charity is a moral enterprise with a clear social script. It produces heroes and model citizens who give, and deferential and meek citizens who accept.”[243] While perhaps the quote is not nuanced enough for patients and providers at free clinics, there is reason to ask whether altruistic acts associated with heroes displace a concept of altruism in which care is provided as a matter of course with empathy and respect. An editorial by a family physician pointed out: “If there were no uninsured patients, the entire notion of altruistic work by physicians would be, and should be, very different…Countries with universal access health care systems do not need to train and encourage physicians to provide uncompensated care for uninsured patients.”[244]

In countries with universal health care coverage there is little need for free clinics. In France, a 2005 publication reported on four free clinics in Paris primarily for people who were eligible but not enrolled in the public health insurance system.[245] In 2008 National Public Radio contrasted the few free clinics in Germany, eight in the entire country, with those in the United States. On one day, a German free clinic physician saw

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[242] David Hilfiker, "Unconscious on a Corner," *Journal of the American Medical Association* 258, no. 21 (1987): 3156.

[243] David Wagner, *What's Love Got to Do with It?: A Critical Look at American Charity* (New York, NY: New Press, 2000), 73.

[244] Mainous and Baker, "Service Learning Helps Sustain the Status Quo," 656-657.

[245] Isabelle Parizot, Pierre Chauvin, and Serge Paugam, "The Moral Career of Poor Patients in Free Clinics," *Social Science & Medicine* 61, no. 6 (2005).

eight patients. All of them were directed to further appropriate care when needed. Most of the patients were illegal immigrants. In a free clinic in Washington, D.C., where there are ten in the city, the director turns away a quarter of the people seeking care each day. After working an eleven-hour day, the director is frustrated: "It's definitely emotionally difficult sometimes…I sort of try and live life sort of focusing on the ones that I can help and I'm kind of cold-hearted to the others, because if I were to spend my time trying to figure out how to serve all the people who can't get in the door, I think I would just go crazy."[246]

Free Clinic Honors and Awards May Distort the Public's Perception of Problems and Deflect a Focus from Patients to Providers

Free clinics and volunteers commonly are given awards and honors. In addition to the public recognition of free clinics during the Reagan and Bush administrations, in 1997 first lady Hillary Clinton recognized the Stuart's Volunteers in Medicine Clinic in Florida and its founder received state and national awards.[247] President Obama presented Dr. Pedro Jose Greer with a Presidential Medal of Freedom in 2009 for his work at a Miami free clinic.[248] Managers of health care volunteer programs generally view the simple act of praising the volunteer as a way to reward providers for their services. Other ways to honor the volunteers, reinforce their commitment, and help to recruit additional volunteers include newsletters with vignettes of volunteers, and annual dinners and other

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[246] Meghan Collins Sullivan, "Health Clinic Treats Germany's Few Uninsured," (2008), http://www.npr.org/templates/story/story.php?storyId=91963961 (accessed March 14, 2013).

[247] Michael Bender, "Dr. Fred Carter, Started Jstuart Free Health Clinic," *Palm Beach Post*, June 9, 2006.

[248] Associated Press, "'Dr. Joe' Treats Uninsured Patients with Dignity," (2009), http://www.msnbc.msn.com/id/33197187/ns/health-health_care/t/dr-joe-treats-uninsured-patients-dignity/ (accessed March 14, 2013).

ceremonies where plaques or certificates are awarded.[249] There is no doubt that these volunteers should be praised for their work and recognized for their efforts. As already mentioned, the work at free clinics is difficult, sometimes beyond comparison to other settings and virtually all free clinics are in constant need of more volunteers. Volunteers are going beyond what they must do and take on responsibilities for care that many other providers shun.

At the same time, there is the chance that publicity about free clinics and the awards and honors of volunteers could deflect attention away from and eclipse the problem the volunteers are addressing. The public may hear that there is a problem at the same time they are hearing that there is a solution. This may contribute to the public perception that people without health insurance can get the care they need. Most free clinics of the 1980s and 1990s began as temporary measures to respond to a crisis in health care and many volunteers still have a goal of ensuring no one needs charity care. One physician volunteer stated succinctly: “All of us who provide free health services have a goal of closing up shop at charity clinics.”[250] Another physician volunteer in Virginia stated: “I don’t think free clinics are the answer to medical care, but it is a stopgap measure, and until something else comes along, we just have to make this work.”[251] One director stated that “free clinics are a band-aid on an intolerable system.”[252] Another director of a free clinic that opened recently stated: “We’re making a

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[249] Marcia Pulich, "Managing Health Care Volunteer Programs," *Health Care Manager* 27, no. 2 (2008).

[250] Sara Walker, "Want to Help Improve Access? Become a Volunteer," *ACP-ASIM Observer* 22, no. 5 (2002).

[251] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 141.

[252] Jacobson et al., "Survival Strategies for Michigan's Health Care Safety Net Providers," 934.

difference, but at the same time, we're basically a lifeboat for people who are drowning. We are not a full-service clinic. We are not a solution to the broken health care system."[253] Gratitude can seem misplaced to some providers such as Dr. Kilgore at the beginning of this chapter. Dr. Kilgore is embarrassed by the effusive praise of Randy whose care for a disfiguring injury is delayed.[254] The volunteers who believe that all people ought to receive adequate health care when they need it may wonder whether achieving this goal occasionally for uninsured people is more properly the subject of praise or whether it reflects a lost sense of outrage.

Why Have Free Clinics and Volunteers had so Little Involvement in Advocacy for Broader Health Care Reform?

People working in free clinics have the potential to speak with legitimacy and authenticity about problems with access to care. Patients, together with the volunteers, could speak about the complexities and the depth of the difficulties they are facing. Janet Poppendieck, mentioned in the introduction, the author of a book on charitable emergency food relief organizations, found that the volunteers were unable to overcome different points of view about their work from financial sponsors and among the volunteers in order to bring problems to the public. She remarked: "Even the most creative fund-raising consultants cannot devise appealing solicitations that simultaneously tell donors that charities cannot do the job and that they must hold government responsible and that they should give more funds so that charities can try to

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[253] Kendi Parvin, "Community Connections Free Clinic Providing Health Care and More to Uninsured," *Wisconsin Medical Journal* 111, no. 1 (2012): 9.

[254] Kilgore, "A Piece of My Mind. The Imaginary Safety Net."

do the job."[255] Free clinics also are tied to financial contributors with a wide spectrum of views about their role and the appropriate role of government in health care and even among the free clinic volunteers there are differing views. This is one essential reason why free clinic volunteers have not generally been advocates as a group for better access to care for all. Local business leaders and large insurers are unlikely to continue to fund free clinics if advocating for universal health care coverage becomes a large part of the work of free clinics. Medical schools would likely take a dim view of student-run clinics exposing how the medical center failed its community obligation to provide care to the uninsured. The health policy researcher Robert Brook has noted that the "officer of every foundation faces pressure to show that money was spent wisely and made a difference."[256] Like all of the sources of charity in health care, free clinics function to legitimate the status quo whether this is the desired outcome or not. Charity care at free clinics comfortably allows those who passionately view health care as a right to work alongside those who see the clinics as better alternatives to an expanded role of government.

For the individual volunteer, the work at the clinic is highly esteemed. Reformers and policy advocates may not be. The sociologist and critic David Wagner has asked: "Why is it in Western society that the Mother Teresa figure is seen as a symbol of love, but those who organize people toward action, or those who write about injustice, or those who protest injustice are usually treated as dangers to society or, at best, misguided

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[255] Many of the themes in this chapter can be attributed to this book. Poppendieck, *Sweet Charity?: Emergency Food and the End of Entitlement*: 302.

[256] Robert H. Brook, "Health Policy and Public Trust," *Journal of the American Medical Association* 300, no. 2 (2008): 213.

cranks?"[257] For the volunteers who want to take on advocacy roles, there may be no clear path to take. For instance, the group Physicians for a National Health Program can be viewed as too idealistic.[258] The medical profession has never been unified about government's role in health care or the "right" course to take in improving access.

Many volunteers simply believe that they cannot have an impact on national reform efforts. Dr. Greer, the recipient of Obama's Medal, stated: "I stay out of politics." This was after he participated in reform discussions during the Clinton administration. Instead, volunteers view their work as doing as much as they can even when they realize the root problem is larger. A volunteer in California stated: "We recognize that the clinic is not making a huge dent in the total needs in society, but we are making a big difference in some people's lives. You do not have to save the world to make a difference in someone's life."[259] In a recent book about the uninsured in America edited by two long-time volunteers this sentiment is echoed: "We make a significant difference in the lives of the people we serve, and I have learned that the effort also makes a significant difference in the lives of our staff and volunteers."[260] The book ends with a statement that state efforts at reform are most promising and "[u]ntil then, it is time to get back to work."[261]

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[257] Wagner, *What's Love Got to Do with It?: A Critical Look at American Charity*: 175.

[258] Atul A. Gawande, "Getting There from Here: How Should Obama Reform Health Care?" *The New Yorker* 2009.

[259] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 153.

[260] Nancy J. Johnson and Lane P. Johnson, *The Care of the Uninsured in America* (New York, NY: Springer, 2009), vii.

[261] Ibid., 276.

David Wagner views “doing good” as the “only game in town” for “those who want to embrace some cause broader than themselves:”[262] “One reason why voluntarism…is so glorified in our culture is that these individuals are seen as acting (that is, not just doing nothing while people suffer).”[263] There is also the fact that however unjust the provision of health care is in America, everyone participates in the system. Free clinic providers operate outside the mainstream in many ways but they often turn people away knowing better than most providers that there is nowhere else to go and knowing the details of the stories of those who cannot get specialty care or other services. While these instances are many and may be unavoidable, it can leave physicians and other providers with a deep sense that the moral obligations of the medical profession are not being met.[264] There is also the complicating factor in a tangible and in a moral sense that much of the shunning of uninsured people is not as unavoidable as it is portrayed.[265] The bioethicist Eric Loewy has provided a caution from the holocaust literature about the danger of pointing to “the system:”

> …a political, economic, or cultural system insinuates itself between myself and the other. If the other is excluded, it is the system that is doing the excluding, a system in which I participate because I must survive and against which I do not rebel because it cannot be changed…I start to view horror, and my implication in it, as normalcy.”[266]

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[262] Wagner, *What's Love Got to Do with It?: A Critical Look at American Charity*: 169.

[263] Ibid., 174.

[264] Seth M. Manoach and Lewis R. Goldfrank, "Social Bias and Injustice in the Current Health Care System," *Academic Emergency Medicine* 9, no. 3 (2002).

[265] See, for example, chapter 4 on hospital charity care describing hospitals that have avoided providing care to uninsured patients eligible for charity even when funds are clearly available.

[266] Victoria Barnett, *Bystanders: Conscience and Complicity During the Holocaust*, Contributions to the Study of Religion. (Westport, CT: Greenwood Press, 1999), 90, quoted in Erich H. Loewy, "Oaths for Physicians--Necessary Protection or Elaborate Hoax?" *MedGenMed* 9, no. 1 (2007), http://www.medscape.com/viewarticle/550118_1 (accessed March 14, 2013).

Clearly, America’s health care system has failed to ensure access to appropriate care for millions of uninsured people.

Yet most free clinics operate in a space outside of the system while still relying on the same processes for obtaining health care once the limitations of the clinics are reached. In every case it is uncertain where the system cannot be altered or gotten around and how much advocacy for a particular patient should be undertaken before calling it a dead end. The pediatrician Lawrence Kleinman has urged his fellow physicians to volunteer and provide charity care in their offices but also asks fellow practitioners to “think like an advocate” in critically assessing the rhetoric on resources for medical care:

> If we are not to be misled, we must always use our critical judgment to examine accepted beliefs. We must not accept the formulation of public issues as they are presented. For example, we are familiar with the present being labeled a time of diminishing resources. This language wrongly implies that resources are decreasing and that services must be cut. It is more correct to say that competition for available resources has increased. This formulation enables us to establish priorities rather than to accept the judgments of others. It helps us to see that the ultimate distribution of resources will be based in part on political factors. The semantic change has substantive implications.[267]

Kleinman also recommends a variety of other tactics to address the problems of lack of access to care for uninsured people including building coalitions, speaking out on injustices, and becoming politically active in policy formation.[268]

In short, the health care system does not entirely relieve any practitioner from her or his moral commitments but does constrain them. The nurse and scholar Lorraine Hardingham points out, using the term “moral distress,” that while individual

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[267] Lawrence C. Kleinman, "Health Care in Crisis. A Proposed Role for the Individual Physician as Advocate," *Journal of the American Medical Association* 265, no. 15 (1991): 1991.

[268] Ibid.

practitioners are not absolved of responsibility, “individuals can only do so much within an environment where there is no ‘fit’ between an individual’s personal and professional values and the values of the wider community in which that person works.”[269] Moral distress has been increasingly used in health care settings to describe a situation in which a health care provider knows both the clinically and ethically appropriate action but the action cannot be taken usually due to institutional or system constraints.[270] Moral distress in health care providers has been associated with poor access to health care and suboptimal care for vulnerable people, and “being unable to appropriately care for uninsured patients.”[271] When physicians and other providers cannot obtain an appropriate standard of care for free clinic patients, there is an incompatibility between knowing what ought to be done and being able to do it. The consequences of moral distress can be for good or ill, according to Webster and Baylis. Health care providers can sharpen their commitments through reflection when faced with moral distress. Alternatively, providers may deny that there are inconsistencies between beliefs and actions through self-deception, distorted reasoning, or deliberate ignorance, or trivialize the inconsistencies and accept them in an unreflective way.[272]

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[269] Lorraine B. Hardingham, "Integrity and Moral Residue: Nurses as Participants in a Moral Community," *Nursing Philosophy* 5, no. 2 (2004).

[270] Ibid. Sofia Kalvemark et al., "Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System," *Social Science & Medicine* 58, no. 6 (2004).

[271] Elizabeth Gingell Epstein and Ann Baile Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *Journal of Clinical Ethics* 20, no. 4 (2009): 334. See also: Catherine Wiggleton et al., "Medical Students' Experiences of Moral Distress: Development of a Web-Based Survey," *Academic Medicine* 85, no. 1 (2010).

[272] George C. Webster and Francoise E. Baylis, "Moral Residue," in *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, ed. Susan B. Rubin and Laurie Zoloth (Hagerstown, MD: University Publishing Group, 2000).

Free Clinics from the Patient's Point of View

Another point to emphasize is that charity care at free clinics can heighten the vulnerabilities for both the physician and the patient. There is very little narrative or empirical information on how patients view the care at free clinics. Most of the available information from the media and in website vignettes describe situations similar to that of Mr. Schwann at the beginning of the chapter who stated: "Without this place, I'd probably be dead."[273] What is known from surveys is based, of course, on the questions that are asked. In one survey of almost 250 free clinic patients attending three free clinics in Massachusetts in 2001, the reasons most often given for coming to a free clinic were being uninsured or having a financial reason. Over a third of patients did not know where else to go. Almost two-thirds of patients reported they had delayed seeking medical care. Thirteen percent of patients reported feeling safe from immigration services at the free clinic. Among the patients on chronic medications, two-thirds were unable to take the medications as prescribed, usually due to cost. The patients were more likely than the general population to report that their health was fair or poor.[274]

In another national survey published in 2011, primary care and pharmacy services were most often provided to free clinic patients. Over half of free clinic patients were working or students and had a very low income. Three-fourths of the patients would seek care elsewhere if the free clinic was not available but one fourth would not seek care for cost reasons. Almost all patients reported being satisfied with the care at the free clinic and three-fourths of the patients reported that care at the free clinic was better than that

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[273] Bearden, "Free Clinic for Uninsured in Tampa Celebrates 40th Anniversary."

[274] Keis et al., "Characteristics of Patients at Three Free Clinics."

received at their previous site of care.[275] In another survey of one student-run free clinic's patients, the satisfaction rating was high.[276]

The book by Gregory Weiss on free clinics includes several excerpts from the volunteers about their perceptions of the patients. In the introduction the author explains that he attempted to include interviews of patients but found they were often ill and he believed it would have been inappropriate to interview them. Many of the responses as told by the volunteers were of patients being grateful for the services they received and the way they were treated at the clinic but also feeling embarrassed and humiliated at having to go to a free clinic. One volunteer stated:

> People like what they get here, but nobody likes having to come here. In the community at large, there may be some type of stigma attached to patients who have to come here…So I have a lot of thankful people, and I have a lot of people who would be even more thankful if they never had to come back…People have been referred here by someone else in the health care system, they have been bounced here, and nobody feels good about that. The difficulty is complicated by the fact that they also might not find what they need here.[277]

Another volunteered relayed a similar summary:

> Though most of our patients are very grateful, some do express frustration with the system. They feel denigrated by the way that they have been treated as they go through the government bureaucracy, for example, being insulted in the process to get food stamps. They are degraded. Are they embarrassed to come here? That depends on the patient. Some are embarrassed just initially; it is hardest for people who have never had to ask for anything.[278]

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[275] Gertz, Frank, and Blixen, "A Survey of Patients and Providers at Free Clinics across the United States."

[276] Marie Soller and Lars Osterberg, "Missed Opportunities for Patient Education and Social Worker Consultation at the Arbor Free Clinic," *Journal of Health Care for the Poor and Underserved* 15, no. 4 (2004).

[277] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 157.

[278] Ibid.

Another volunteer said: “We have patients who come here and feel so humiliated that they explain themselves through the entire evening, [saying] “I never come here.’”[279] Dr. McConnell, the founder of the South Carolina free clinic, said that some patients “have little sense of self worth and only a marginal amount of dignity…One person said it was the first time that people had treated her like she was really somebody instead of just being a number on a chart.”[280] Most comments from the volunteers were that patients were extremely grateful, though some expressed the view that a “handful” of patients “think it is an entitlement.”[281]

Although these accounts of how patients perceive attending free clinics were interpreted by the volunteers and were not told directly to the author, they are consistent with other reports and anecdotes.[282] For example, a large qualitative study of women in North Dakota who were recipients of charity as a result of a devastating flood showed that the stigma of charity was a significant part of their experience. The women self-identified as “white, middle-class, self-sufficient, American women.” When the women spoke of receiving assistance, they used expressions such as “swallowed my pride,” “embarrassing,” and “humbling.”[283] Janet Poppendieck wrote that once when she was doing research on emergency food relief, she was mistaken for someone seeking food from a church pantry:

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[279] Ibid., 156.

[280] Ibid., 158.

[281] Ibid., 159.

[282] See also chapter 2 for the history of the stigma of charity related to medical education and chapter 5 for stigma related to Medicaid.

[283] Alice Fothergill, "The Stigma of Charity: Gender, Class, and Disaster Assistance," *The Sociological Quaterly* 44, no. 4 (2003): 663.

> He couldn’t have been kinder, the tall pastor with the straight brown hair and the slight sag to his shoulders. I knocked on the door of his study in a classic white wood-frame Congregational church on the Maine seacoast late one Friday afternoon…I hesitated, embarrassed, because I hadn’t followed my usual research routine of calling ahead to request an appointment…I stumbled in my attempt to explain my presence; he hurried to my rescue: “Do you need food?” His tone was respectful, his smile encouraging, his eyes caring. Yet I felt devastated, humiliated. It was a visceral reaction that stripped me of status, degrees, prestige, identity. I learned in that instant a major fault of emergency food: that it humiliates the people who ask for it.[284]

In September of 1993, the editor of the New York Times, A. M. Rosenthal, endorsed the ultimately failed Clinton Health Security Act in an editorial. He told the story of his shame at being labeled a charity patient when he was eighteen. In his opinion, the health care reform plan meant that “like education and police protection, health care is a right, never a charity to be carefully noted on a hospital record.”[285]

Among the free clinics that charge for services or ask for a donation, often the premise is that “patients who contribute something to the cost will feel better about themselves.”[286] The concept that charity “wounds” because reciprocity in social relationships is fundamental and charity shames the recipient by excusing them from the obligation to repay has been attributed to the anthropologist Mary Douglas.[287] A related concept is that of “pauperization” which was viewed as the result of indiscriminant almsgiving throughout the nineteenth and early twentieth century. It was the moral duty of charity givers to withhold alms to the unworthy and generally give alms sparingly to

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[284] Poppendieck, *Sweet Charity?: Emergency Food and the End of Entitlement*: 230.

[285] A. M. Rosenthal, "On My Mind: A Charity No More," *New York Times* 1993.

[286] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 13.

[287] Poppendieck, *Sweet Charity?: Emergency Food and the End of Entitlement*: 251.

the worthy, otherwise the giver would be responsible for pauperizing the recipient.[288] In a recent discussion on National Public Radio, a clinic in Maine described their bartering system which accepts hours of providing a service as payment. Patients can provide yard work, cleaning, or other services through a bartering exchange. Physicians can then barter their hours in the exchange for services they need.[289]

It is not clear, however, whether it is the fact that patients are unable to pay for care or that the care is given in the name of charity that matters in causing embarrassment and shame. Public education and police and emergency services are provided to people who cannot afford to pay for the services and they are not called "charity" and do not cause shame. The political philosopher Michael Walzer points out that because medical care is not a luxury for those who are ill, to be deprived of care is a "double loss—to one's health and to one's social standing." Therefore, to be "cut off from the help [physicians] provide is not only dangerous but also degrading."[290] On this account, the locus of shame is at the level of membership in a political community. Uninsured people with a low income are not members of the political community to the extent that they are deprived of medical care in the first place. Volunteers at free clinics can respond to this deprivation because they believe it is an injustice or because they believe it is just. Charity comfortably allows for both of these responses. In both cases physicians may truly enact compassionate and altruistic service and patients may benefit from empathy

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[288] Rosner, "Health Care for the 'Truly Needy': Nineteenth-Century Origins of the Concept."

[289] National Public Radio, "Bartering for Health Care: Yardwork for Treatment," http://www.npr.org/2011/09/26/140737591/bartering-for-health-care-yardwork-for-treatment (accessed March 14, 2013).

[290] Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York, NY: Basic Books, 1983), 89.

and treatment. Patients will still be charity patients, however, even if they pay a fee or barter for services.[291] Unlike patients with public and private insurance, gratefulness and appreciation rather than reasonable expectations of the standard of care will prevail.

National Support for Free Clinics from RWJF and Formation of National Organizations

Support from foundations and the development of a national organization has been marked by lack of continuity. The first national organization of free clinics was called the Free Clinic Foundation and it provided a directory and information on other resources such as pharmaceutical assistance for free clinics.[292] The Foundation is no longer in existence. The Robert Wood Johnson Foundation (RWJF) maintained a "Volunteers in Health Care" program and website from 1997 to 2006. The program provided information to organizations and individuals who were utilizing volunteers to provide health care to uninsured people. Their companion website, "RxAssist," provided user friendly access to pharmaceutical patient assistance programs. The Volunteers in Health Care resource center closed in 2007 and the RxAssist program closed in 2008. Long term sustainability was hampered externally, according to the author of a report on the program, by an inability to generate adequate interest from government agencies or from professional medical associations. Attempts to generate funds for sustainability by charging free clinics for the resources that had been developed was not successful. On the other hand, the RWJF program was probably responsible for a much greater awareness of

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[291] In chapter 2 on medical education, the history of terms used to describe charity patients is traced along with the inability to escape the designation as a charity patient despite payment for services or public insurance.

[292] Nadkarni and Philbrick, "Free Clinics: A National Survey."

free clinics within the safety net.[293] As already mentioned, the current national organization, the National Association of Free and Charitable Clinics was founded in 2001. Members have access to a variety of resources such as a manual on how to start a free clinic and legislative updates.[294] The Society of Student-Run Free Clinics was established in 2010 and currently has a website and other resources such as a research database and annual conference.[295]

One of the successes of the RWJF program was the result of educating legislators and community leaders about a little-known provision in the 1996 Health Insurance Portability and Accountability Act. The provision allowed free clinics to offer malpractice liability coverage through the Federal Tort Claims Act (FTCA) which means that the volunteer is deemed a federal employee for the purpose of medical liability. The Act does require that the free clinic meets and documents certain standards and that all physicians are licensed. Relatively few free clinics have qualified under FTCA because of the documentation requirements.[296] Liability protection and licensing requirement alterations for volunteers at the state level have been the most common of the advocacy efforts of free clinic professionals. For instance, Jack McConnell lobbied South Carolina's legislature to waive re-licensing requirements for retired physician

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[293] Mary B. Geisz, "Volunteers in Health Care Program Establishes Technical Resource Center, Provides Financial Support to Organizations Offering Free Care," Robert Wood Johnson Foundation, http://www.rwjf.org/reports/grr/053639.htm (accessed March 14, 2013).

[294] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 122.

[295] Society of Student-Run Free Clinics. Society of Student-Run Free Clinics, "Society of Student-Run Free Clinics " http://www.studentrunfreeclinics.org/ (accessed March 14, 2013).

[296] Eileen Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net," in *National Health Policy Forum Background Paper* (Washington, DC: George Washington University, 2004). See also Isaacs and Jellinek, "Is There a (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States."

volunteers.[297] Many other states indemnify the volunteer provider or change the negligence standard for malpractice in order to encourage volunteerism.[298]

The American Medical Association (AMA) has supported free clinics through grants from the AMA Foundation. In general, the organization has been somewhat tepid in enthusiasm for free clinics while supporting liability protections for volunteers strongly. In a 2009 internal report, the AMA stated:

> AMA policy supports free clinics as a partial solution for providing access to low-income and underserved populations and advocates that each physician share in providing care to the indigent. The council commends physician volunteers, but believes that the comprehensive and long-term strategy for achieving access to care, as promoted through AMA policy…should continue to focus on expanding health insurance coverage and choice, rather than encouraging access to the limited care provided at free clinics.[299]

The report cites the limited financial resources of free clinics, the lack of comprehensive services, especially specialty care, and the unlikely ability for free clinics to expand significantly.

Community Health Center Origins

The AMA report on free clinics mentions that they are "often confused" with FQHCs. Some researchers include free clinics under the umbrella term "community health centers" when assessing the safety net.[300] Historically, the roots of community health centers lay in the neighborhood health centers that arose in the late nineteenth and

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[297] Elizabeth Heubeck, "Doctors Do Good," *Unique Opportunities: The Physician's Resource* (2002).

[298] Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net."

[299] American Medical Association Council on Medical Services, "Report of the Council on Medical Services: Free Clinics and the Uninsured," (2009), http://www.ama-assn.org/resources/doc/cms/a09-cms-rpt-1.pdf (accessed March 14, 2013).

[300] Felland et al., "The Resilience of the Health Care Safety Net, 1996-2001."

early twentieth centuries. According to the medical historian George Rosen, although dispensaries were often a part of these neighborhood health centers, the Progressive Era reformers who envisioned the centers were most interested in combining preventive and curative medical care within specific boundaries and with the active involvement of members of the community. A 1927 definition was: "A health center is an organization which provides, promotes and coordinates needed medical service and related social service for a specified district."[301] Unlike the free dispensaries, the neighborhood health centers were not tied to medical education. The centers grew out of the needs of the urban population which had risen exponentially with its influx of immigrants and it witnessed conditions of profound economic deprivation during this time period.[302]

Some of the causes for the demise of these early neighborhood health centers were similar to those of the dispensaries. One was the idea that "undeserving individuals were abusing the service intended only for the indigent," a complaint largely attributed to private practitioners with practices in the same communities.[303] The medical profession as a group opposed the centers as supplanting the power of the practitioners.[304] In some cases, the "vision of a community in which citizens working together as members of a vitally cooperating group [seeking] the common welfare rationally and intelligently" was viewed as a "Red plot."[305] According to the sociologist Paul Starr, the neighborhood

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[301] George Rosen, "Public Health: Then and Now. The First Neighborhood Health Center Movement--Its Rise and Fall," *American Journal of Public Health* 61, no. 8 (1971): 1630.

[302] Ibid.

[303] Ibid., 1632.

[304] Starr, *The Social Transformation of American Medicine*: 194-196.

[305] Rosen, "Public Health: Then and Now. The First Neighborhood Health Center Movement--Its Rise and Fall," 1627.

health center movement “faded, eventually to be revived in a quite different form in the 1960s.”[306]

Like the resurgence of free clinics in the mid-1960s, neighborhood health centers grew out of the tumultuous civil rights era. Led by two physicians, Jack Geiger and Count D. Gibson, the concept of a center where people living in poor and minority neighborhoods would become part of the workforce and leadership and would work with professionals to receive both public health services and medical care, was brought to the Office of Economic Opportunity (OEO). The OEO was the agency responsible for overseeing many of President Johnson’s War on Poverty programs.[307] The neighborhood health center concept was approved as a demonstration project and by 1974 there were 154 grantees.[308]

The first centers were primarily located in impoverished neighborhoods and eligibility for free care was to be based on the designated geographic area. Though there were differing visions of the centers, the reformers wanted to make comprehensive health and social services available to all within the catchment area.[309] Just as in the early twentieth century, however, complaints by local physicians that the centers were encroaching on their practices were made. A physician in Denver in 1966 said, as a

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[306] Starr, *The Social Transformation of American Medicine*: 194.

[307] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen*, Critical Issues in Health and Medicine (New Brunswick, NJ: Rutgers University Press, 2007). See also Robert W. Mickey, "Dr. Strangerove; or, How Conservatives Learned to Stop Worrying and Love Community Health Centers," in *The Health Care Safety Net in a Post-Reform World*, ed. Mark A. Hall and Sara Rosenbaum (New Brunswick, NJ: Rutgers University Press, 2012).

[308] Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen*: 15.

[309] Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986*, Contemporary Community Health Series (Pittsburgh, PA: University of Pittsburgh Press, 1988), 58-59.

decision was made to reject an OEO grant, that it is “unbelievable to think that the centers are not going to hurt the private practice of physicians” and that they were “just another step toward socialism.”[310] The AMA was ambiguous in its response to the neighborhood health centers but in some areas medical societies vigorously opposed them. In 1967 Congress limited eligibility for services to people meeting a means test except that the centers were allowed to provide services to a certain percentage of non-poor patients.[311]

The original proponents of the neighborhood health centers believed that Medicare and Medicaid, enacted in the same year as the first health center demonstrations, would eventually make the centers sustainable financially. A federal study in 1973 showed that, in fact, the health centers were not receiving reimbursement from Medicaid for all of the services they provided and for all of the patients seen; in some cases because the state’s Medicaid plan did not include health center payments.[312] Despite these early setbacks, the neighborhood health center programs survived, becoming the renamed “community health center” program in 1975.[313] By 1989 payments by Medicaid were cost based which meant that the centers became more stable

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[310] Ibid., 61.

[311] Ibid., 260-264.

[312] Ibid., 77-80.

[313] Ibid., 2.

financially.[314] When Medicaid changed to a managed care prospective payment system, enhanced payments were authorized by Congress for community health centers.[315]

According to the health policy scholar Robert Mickey, community health centers were initially viewed as a strategic precursor to a national health insurance program by conservatives.[316] The centers survived attempts to dismantle them completely, though some of the original broad range of services was left unfunded. It was also true that some liberal reformers could be ambivalent about health centers, seeing them as “two-tiered” medicine and a “safety valve to relieve pressure on systemic health care reform.”[317] In the 2000 presidential campaign, George W. Bush pledged to increase community health center funding and double the number of patients seen at the centers while Al Gore made no promises about health centers. President Bush’s “compassionate conservatism” resulted in an increase of funding for community health centers from $1.1 billion to $2.1 billion from 2001 to 2009. The number of community health centers more than doubled from about 750 in 2001 to 1,200 in 2007. The total number of health center patients doubled from about 10 million in 2001 to 20 million in 2010.[318] The focus on enhancing community health centers was lauded by most commentators but others were skeptical. Schiff and Fagan remarked about the increase in community health centers: “[L]ike other

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[314] Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen*: 20.

[315] Jessamy Taylor, "The Fundamentals of Community Health Centers," *National Health Policy Forum Background Paper,* August 31, (2004), http://www.nhpf.org/library/details.cfm/2461 (accessed March 14, 2013).

[316] Mickey, "Dr. Strangerove; or, How Conservatives Learned to Stop Worrying and Love Community Health Centers."

[317] Ibid., 34.

[318] John K. Iglehart, "Health Centers Fill Critical Gap, Enjoy Support," *Health Affairs* 29, no. 3 (2010).

forms of incremental reform it will not be successful or sustainable in the long run, for the same reason that makes it politically popular now—because it fails to change the status quo in the health system."[319]

What Are Community Health Centers?

Community health centers include migrant, homeless, and public housing health centers.[320] Many community health centers have multiple sites so that there are more than 8,000 health center sites among the 1,200 grantees.[321] Requirements for the designation of community health center grants are located under section 330 of the Public Health Service Act. Some community health centers, FQHC look-alikes, do not receive federal grants but do have to meet all of the same requirements and do receive enhanced payments from Medicaid and Medicare and other benefits.[322] All community health centers are eligible for malpractice liability protection under the Federal Tort Claims Act mentioned in regard to free clinics. All of the centers participate in a federal drug pricing program that reduces costs of pharmaceuticals and all have an automatic designation of a

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[319] Schiff and Fegan, "Community Health Centers and the Underserved: Eliminating Disparities or Increasing Despair," 311.

[320] Rural health clinics are another type of clinic that may receive enhanced Medicaid payments but may also operate as a for-profit entity that is not required to provide care to everyone regardless of ability to pay. Taylor, "The Fundamentals of Community Health Centers." 6.

[321] National Association of Community Health Centers, "America's Health Centers," (2011), http://www.nachc.com/client/documents/USHealthCentersFS.pdf (accessed March 14, 2013).

[322] There were 122 FQHC Look-Alikes in 2007. Health Resources and Services Administration U.S. Department of Health and Human Services, Bureau of Primary Health Care,, "Health Centers: America's Primary Care Safety Net, Reflections on Success, 2002-2007," (2008), http://ask.hrsa.gov/detail_materials.cfm?ProdID=4159 (accessed March 14, 2013).

Health Professional Shortage Area and are eligible to employ National Health Service Corp personnel.[323]

One of the distinguishing features of community health centers is that they must be located in a federally designated underserved area or serve a medically underserved population. The centers must provide comprehensive primary health care services, referrals, and other enabling services such as case management, translation, and transportation. The services must be provided to all in the service area regardless of ability to pay and there must be a sliding scale of charges prospectively adjusted to family income. The governance is quite distinctive because more than half of the board must be patients of the health center.[324] Community health centers must be nonprofit; no more than 5 percent can be public entities.[325]

Community health centers serve a disproportionate number of patients with a low income, members of racial and ethnic minority groups, and people insured by Medicaid. In 2010 almost three-fourths of health center patients had an income below the poverty level and more than 90 percent had an income below twice the poverty level. Close to 40 percent of patients receiving care at community health centers were uninsured, while 16 percent of the nation was uninsured. Also, close to 40 percent of community health center patients were covered by Medicaid. One third of health center patients were Hispanic or

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[323] Ibid. Iglehart, "Health Centers Fill Critical Gap, Enjoy Support."

[324] Sara Rosenbaum, "Reinventing a Classic: Community Health Centers and the Newly Insured," in *The Health Care Safety Net in a Post-Reform World*, ed. Mark A. Hall and Sara Rosenbaum (New Bruswick, NJ: Rutgers University Press, 2012). Taylor, "The Fundamentals of Community Health Centers."

[325] ———, "The Fundamentals of Community Health Centers." 28.

Latino; more than one in five patients were African American.[326] These statistics are consistent with the mission and legal requirements of community health centers.

The majority of revenue supporting community health centers, about 60 percent, is from patient care.[327] Medicaid makes up almost 40 percent of this patient care revenue; Medicare is about 6 percent of revenue and self-pay revenue from uninsured people also provides 6 percent; private insurance provides another 7 percent of revenue. Annual federal grants provide almost a quarter of revenue to health centers while state and local grants and contracts and private sources such as foundations make up the remaining portion.[328] The American Reinvestment and Recovery Act of 2009 provided an additional $2 billion in funding for community health centers with three-fourths earmarked for capital improvements and the remaining to increase capacity. The Affordable Care Act increased total funding to community health centers but Congress cut some of these funds in budget negotiations.[329] The role of community health centers in the American health care system is widely expected to become greater than at any previous time once the main provisions of the Affordable Care Act are implemented. This greater role is primarily expected to come about through the expansion of Medicaid to people with incomes up to 133 percent of the federal poverty level in the states that do expand.[330] By

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[326] Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities," no. March (2012), http://www.kff.org/uninsured/upload/8098-02.pdf (accessed March 14, 2013).

[327] Iglehart, "Health Centers Fill Critical Gap, Enjoy Support."

[328] Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities."

[329] Ibid., 12-14.

[330] Ibid; Rosenbaum, "Reinventing a Classic: Community Health Centers and the Newly Insured." Iglehart, "Health Centers Fill Critical Gap, Enjoy Support." Dan Hawkins and DaShawn Groves, "The Future Role

2019 one estimate is that 44 percent of community health center patients will have Medicaid coverage.[331]

Are Community Health Centers Free? Are Uninsured Community Health Center Patients Receiving Charity?

It is not uncommon for publications to state that community health centers provide free care. For example, the website "HealthCare.gov" maintained by the U.S. Department of Health and Human Services states: "Community Health Centers are hospitals, health centers, or clinics that provide free or low-cost health care."[332] As mentioned earlier, free clinics and community health centers may be grouped together for research or other purposes. For example, a listing of community health centers for Michigan also lists a free clinic.[333] Some free clinics may evolve into community health centers.[334] Unlike free clinic patients, there is less evidence that community health center patients perceive themselves as being charity patients and there is only a little suggestion that providers view uninsured patients at community health centers as receiving charity.

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of Community Health Centers in a Changing Health Care Landscape," *Journal of Ambulatory Care Management* 34, no. 1 (2011).

[331] Peter D. Jacobson et al., "Examining the Structure and Sustainability of Health Care Safety Net Services," in *The Health Care Safety Net in a Post-Reform World*, ed. Sara Rosenbaum and Mark A. Hall (New Brunswick, NJ: Rutgers University Press, 2012).

[332] U.S. Department of Health and Human Services, "Community Health Centers," http://www.healthcare.gov/using-insurance/low-cost-care/community-health-centers/index.html (accessed March 14, 2013).

[333] Michigan Primary Care Association, "Guide to Michigan Health Centers: MPCA Members 2012-2013," (2012), http://mpca.net/associations/14191/files/2012-13%20directory%20for%20web.pdf (accessed March 14, 2013).

[334] Julie Johnson Zerwic, Barbara Simmons, and Mark J. Zerwic, "Helping Hands Health Center," *American Journal of Nursing* 107, no. 1 (2007).

At least one publication from 2002 did refer to the care for uninsured patients at community health centers as charity care.[335]

Yet, in some ways an uninsured patient with a low income would encounter many of the same circumstances at either a free clinic or at a community health center. Of course, the same patient may go to both types of clinics. A vignette from a publication by the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, which oversees the community health center program, about a patient at a community health center in Virginia illustrates this point:

> Laura, who is unemployed, has no health insurance and cannot afford to see a regular physician. She recently experienced chest pain and sought care at the local free clinic, only to discover that the care she needed was beyond what they were able to offer. Her mother learned about Bassett Family Practice through an article in the local newspaper. Laura was seen by a physician and referred to a cardiologist at the University of Virginia, where she also received magnetic resonance imaging (MRI) and follow up neurology care. Bassett Family Practice helped her obtain the chronic medication she needed. Laura noted “I received more helpful care at Bassett Family Practice in 2 hours than I’d had in the past 2 years.”[336]

One of the surprising similarities between the community health center and the free clinic may be the amount patients are charged for services. According to a national free clinic survey discussed earlier, the average fee was close to $10 among the half of free clinics that charged fees.[337] In a small survey in 2001 of twenty community health centers in ten states, the executive directors and medical directors were interviewed. The

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[335] J. S. McAlearney, "The Financial Performance of Community Health Centers, 1996-1999," *Health Affairs* 21, no. 2 (2002): 224.

[336] U.S. Department of Health and Human Services, "Health Centers: America’s Primary Care Safety Net, Reflections on Success, 2002-2007." 39.

[337] Darnell, "Free Clinics in the United States: A Nationwide Survey."

amount of the “nominal fee” ordinarily charged to patients with an income below the federal poverty level was between $5 and $20.[338]

As mentioned above, section 330 of the Public Health Service Act authorizes community health centers and sets requirements. The part of the Act that addresses requirements related to fee schedules states that a health center is required to have a schedule of fees that is “consistent with locally prevailing rates,” which is a reason that community health centers do not all have the same fees. For patients with an income below the poverty level, there is a “full discount” but “nominal fees” are allowed. No discounts are allowed for patients with an income above 200 percent of the poverty level. The law also directs that “no patient will be denied health care services due to an individual’s inability to pay,” while also making “every reasonable effort to secure from patients payments for services.[339] These competing views in the law on ensuring access while collecting fees may leave community health centers with the ability to interpret their process in differing ways.

There is very little data on how many community health centers charge a fee to people whose income is below the federal poverty level, what the amount of any such fees is, or how many community health centers use a collection agency. The small survey in 2001 is one source of this information. [340] In another study, the amount charged to patients at the poverty level in New York in the late 1990s at community health centers

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[338] Michael K. Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* 21, no. 6 (2002).

[339] *Public Health Service Act*. Section 330, codified at 42 U.S. Code § 254b (2010).

[340] Gusmano, Fairbrother, and Park. "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured."

was \$20 to \$24.[341] In one report from Texas, copayments were common though no specific data was collected about the amount by the state association. According to the National Association of Community Health Centers and consistent with the Public Health Service Act, there are no statutory or regulatory requirements that community health centers charge a nominal fee to people with incomes below the federal poverty level. The general rule appears to be that for those people whose income is below 100 percent of the federal poverty level, a community health center need not charge anything, but centers can choose to charge a nominal fee.[342]

Again, there are very few sources of information on what the particular processes that community health centers use in regard to charging and collecting fees or bills. Some community health centers bill patients who cannot pay at the time of their visit. One of twenty health centers surveyed stated that patients were turned away if they refused to pay and that unpaid bills are sent to a collection agency.[343] In the New York study, community health centers were the most likely of the safety net sites to turn people away if the center did not have a contract with their Medicaid managed care plan. Community health centers were also the most likely to require an upfront payment for services among the safety net sites.[344]

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[341] Eva Weiss, Kathryn Haslanger, and Joel C. Cantor, "Accessibility of Primary Care Services in Safety Net Clinics in New York City," *American Journal of Public Health* 91, no. 8 (2001).

[342] Merle Lenihan, "Clearing the Fog: Achieving Reasonable Public Disclosure of Available Free and Reduced Cost Health Care in Galveston County, Texas," (2009), http://www.communitycatalyst.org/doc_store/publications/Clearing_the_Fog.pdf (accessed March 14, 2013) .

[343] Gusmano, Fairbrother, and Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured."

[344] Weiss, Haslanger, and Cantor, "Accessibility of Primary Care Services in Safety Net Clinics in New York City."

At least one group of commentators has suggested that the Bush era funding increases to community health centers came with an ideological consequence related to the collection of fees: "If these are to generate sufficient revenue to offset the cost of collecting these user-fees (increasingly driven by ideological and fiscal demands to eliminate free services), how can this be operationalized without compromising the mission of these clinics to care for the poor."[345] The concept that "free care" is inimical to efficiency does not seem off-base. In a 2008 publication by the Health Resources and Services Administration Bureau of Primary Health Care, which oversees the community health center program, in answer to the question is health center care free? The answer is: "While all health centers and FQHC Look-Alikes must provide access to services without regard for a person's ability to pay, services are not free."[346] In a recent Washington Post article, the director of a community health center was asked how his clinic differed from free clinics: "The primary difference is that a free clinic is free to their patients…Our philosophy is that a person who contributes to their care, even if it's a minimal amount…the research has shown that they tend to be more compliant and engaged in their health if they're paying for some of that."[347]

On the other hand, the National Association of Community Health Centers has taken a stance against cost sharing for medically necessary services for low income patients when such patients are enrolled in Medicaid. In a letter to the Centers for Medicaid and Medicare Services (CMS) regarding changes in federal law that allow a

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[345] Schiff and Fegan, "Community Health Centers and the Underserved: Eliminating Disparities or Increasing Despair," 310.

[346] U.S. Department of Health and Human Services, "Health Centers: America's Primary Care Safety Net, Reflections on Success, 2002-2007." 11.

[347] Jim Barnes, "More Than a New Building," *Washington Post*, October 12, 2012.

greater degree of cost sharing in the Medicaid population, the National Association of Community Health Centers has requested that "CMS urge states not to apply such cost sharing to the receipt of FQHC services."[348] Nationally, about half of Medicaid beneficiaries have an income below the federal poverty level and another quarter has an income up to twice the poverty level.[349] In other words, most of the uninsured people who are subject to copayments of $5 to $24 at community health centers are in the same income category as Medicaid enrollees whose copayments are objected to by the National Association of Community Health Centers. In a report prepared for the National Association of Community Health Centers, cost sharing among low income Medicaid enrollees and uninsured patients is recognized to have a potentially negative effect on their health and health seeking behavior when copayments are unaffordable.[350] In a report on economic stress and its impact on community health centers and their patients, the authors note that the "extreme sensitivity to cost in the health-seeking behavior of the low-income population should be a matter of concern" and that "fears about inability to make even modest copayments" are particularly prevalent for the newly uninsured.[351]

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[348] Roger Schwartz, "Re: Medicaid Program; Premiums and Cost Sharing," March 24, (2008), http://www.nachc.com/client/documents/NACHC_Comments_DRA_CostSharing_PremiumFINAL.pdf (accessed March 14, 2013).

[349] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People," June (2010), http://www.kff.org/medicaid/upload/7334-04.pdf (accessed March 14, 2013).

[350] Sara Wilensky and Mara McDermott, "Unkindest Cuts: The Impact of State Medicaid Reductions on Health Centers and Their Patients," *State Policy Report #5* (2005), http://www.nachc.com/client/documents/issues-advocacy/state-issues/add-medicaid-info/statepolicyreport5.pdf (accessed March 14, 2013).

[351] Sara Rosenbaum, Peter Shin, and Julie Darnell, "Economic Stress and the Safety Net: A Health Center Update," June (2004), http://www.kff.org/uninsured/upload/Economic-Stress-and-the-Safety-Net-A-Health-Center-Update.pdf (accessed March 14, 2013).

Community Health Centers and Free Clinics Have Difficulties with Specialty Referrals

A problem that community health centers share with free clinics is their inability to obtain specialty care for uninsured patients.[352] Community health centers are located in areas that are underserved and often the uninsured rate in their communities is 25 percent or higher such that referral problems are encountered routinely. Compared to office-based physicians, community health centers have significantly more difficulty obtaining specialist care for their uninsured and Medicaid patients, in part because office-based physicians tend to treat only an occasional uninsured patient. Securing referrals to care for Medicare and privately insured patients are the same for community health center patients and patients at private physician offices.[353] Even when community health centers have referral arrangements, upfront payments can be a major barrier to receiving care.[354]

In a recent study, over 90 percent of community health centers reported that it was difficult to obtain off-site specialty care for their uninsured patients, confirming the decades long problem.[355] About 25 percent of patients at community health centers require a medically necessary referral, and this percentage is the same for uninsured patients.[356] In a recent study that looked at how community health centers *do* obtain

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[352] Gusmano, Fairbrother, and Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured."

[353] Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities." 7.

[354] Nakela L. Cook et al., "Access to Specialty Care and Medical Services in Community Health Centers," *Health Affairs* 26, no. 5 (2007).

[355] Michelle M. Doty et al., "Enhancing the Capacity of Community Health Centers to Achieve High Performance," no. May (2010), http://www.commonwealthfund.org/Publications/Fund-Reports/2010/May/Enhancing-the-Capacity-of-Community-Health-Centers-to-Achieve-High-Performance.aspx?page=all (accessed March 14, 2013).

[356] Cook et al., "Access to Specialty Care and Medical Services in Community Health Centers."

referrals for uninsured patients, the most common method was the “tin cup.”[357] The method was originally described by the physician Fitzhugh Mullan when he was working at a community health center. As he describes it, the tin cup is “the perpetual, frustrating, quixotic, creative, and demeaning process of begging for services from others for our patients.”[358] Needless to say, the predominant tin cup method was the least satisfying for community health center directors. Other methods were to hire subspecialists, use telehealth referrals, contract with a community hospital, collaborate with a teaching community, or to become fully integrated with a local safety net hospital or local government health system.[359] One point is that even though community health centers are sometimes equated with free clinics in the (most often mistaken) sense that they provide free care, the clinics may often resort to “begging” for specialty services which is closely associated with charity. Mullan says as much when he also states the tin cup “means resorting to charity services, give-away programs, personal connections, system loopholes, solicited forbearance, and persuasion.”[360]

As described earlier, the inability to obtain an accepted standard of care for uninsured patients has been associated with moral distress in health care providers. In the case of community health centers, recent emphasis has been on the ability to achieve characteristics of a patient-centered medical home. While the definition of a medical home varies widely, some of the features are a “patient-centered orientation toward the

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[357] Katherine Neuhausen et al., "Integrating Community Health Centers into Organized Delivery Systems Can Improve Access to Subspecialty Care," *Health Affairs* 31, no. 8 (2012).

[358] Fitzhugh Mullan, "Tin-Cup Medicine," *Health Affairs* 20, no. 6 (2001).

[359] Neuhausen et al., "Integrating Community Health Centers into Organized Delivery Systems Can Improve Access to Subspecialty Care."

[360] Mullan, "Tin-Cup Medicine."

whole person" and "care that is coordinated across all elements of the health care system and the patient's community."[361] Coordination of care extends to care beyond the health center and includes specialty referrals. In one study, patients' experiences of care were better and physicians' reports of burnout were less when a medical home model of care was implemented.[362] In another study, when health care providers and staff perceived more patient-centered medical home characteristics in their community health centers, they had higher morale, though burnout was greater. The postulated reason was that implementing the medical home places extra burdens on providers and staff. [363] In general, physicians' perception of quality problems in their practice has been associated with dissatisfaction, professional isolation, and work-life stress. These factors are linked significantly to the quality of care provided to patients.[364]

Community Health Centers and Free Clinics after the Implementation of the Affordable Care Act

Problems obtaining specialty care at community health centers and at free clinics are one of the reasons that better integration into health systems has been recommended as necessary after 2014 when most of the Affordable Care Act's provisions will be

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[361] George L. Jackson et al., "The Patient-Centered Medical Home: A Systematic Review," *Annals of Internal Medicine* 158, no. 3 (2012).

[362] Robert J. Reid et al., "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, before and after Evaluation," *American Journal of Managed Care* 15, no. 9 (2009).

[363] Sarah E. Lewis et al., "Patient-Centered Medical Home Characteristics and Staff Morale in Safety Net Clinics," *Archives of Internal Medicine* 172, no. 1 (2012).

[364] Mariah A. Quinn et al., "The Relationship between Perceived Practice Quality and Quality Improvement Activities and Physician Practice Dissatisfaction, Professional Isolation, and Work-Life Stress," *Medical Care* 47, no. 8 (2009).

implemented.[365] The Congressional Budget Office estimated after the Supreme Court ruling essentially making the Medicaid expansion to people with an income below 133 percent of the federal poverty level optional for states, that there will be an estimated 27 million people remaining uninsured in 2022.[366] Community health centers are expected to provide 22 percent of their services to uninsured patients in 2019 when 8 percent of people in the nation will be uninsured.[367] The number of people remaining uninsured is the primary reason that free clinics are expected to be necessary after the Affordable Care Act is implemented.[368]

In the case of community health centers and free clinics it is not necessarily apparent why a community would need to have both types of clinics. One reason is the observation that community health centers only reach one-fifth of the people residing in medically underserved communities.[369] While the relationship between any set of safety net providers in a community is often not well integrated, in some cases there is a particularly strained relationship between community health centers and free clinics. For example, some free clinic leaders have said that community health centers’ focus on Medicaid patients and payment collections has increased the number of patients seen at free clinics. Even among some community health center employees, there are some who believe that fees are a barrier to receiving care. Free clinic volunteers may believe that

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[365] Jacobson et al., "Examining the Structure and Sustainability of Health Care Safety Net Services."

[366] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision."

[367] Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities." 11.

[368] Jacobson et al., "Examining the Structure and Sustainability of Health Care Safety Net Services."

[369] Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities." 3.

community health centers should lower the cost barrier to care for their low income uninsured patients.[370] In Little Rock, the community fully supported a free clinic but that was believed to result in little impetus to expand the community health centers' capacity. An observer said: "The free clinics are embraced more by the community at large… providing the charity out of the goodness of their heart."[371]

When researchers recently examined the structure and sustainability of free clinics and community health centers, one conclusion was that regional partnerships will be needed to facilitate specialty referrals and also to guide patients to the most appropriate site for care. The researchers interviewed leaders of primary care safety net organizations in Michigan. The term "hybrid" clinic was applied to free clinics that are targeted toward the uninsured but also do take insurance and are not community health centers.[372] This model is one that the researchers see as more sustainable than the clinics that do not have any insured patients.[373] In a national study of free clinics, almost 8 percent would have fallen under the hybrid designation.[374]

Perhaps adding to the terms that Deborah Stone has used to describe altruism in American life, as discussed in the introduction, is the term "altruistic opportunism."[375] A free clinic leader used the phrase to describe the ability to take advantage of relationships,

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[370] Aaron Katz et al., "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects under Reform," (2011), http://www.hschange.com/CONTENT/1257/ (accessed March 14, 2013).

[371] Ibid., 4.

[372] Jacobson et al., "Examining the Structure and Sustainability of Health Care Safety Net Services," 127.

[373] Ibid.

[374] Darnell, "Free Clinics in the United States: A Nationwide Survey."

[375] Jacobson et al., "Examining the Structure and Sustainability of Health Care Safety Net Services," 141.

networks, and fundraising to support the altruistic goals of a free clinic. For some free clinic leaders, taking insured patients would mean decreasing the capacity to treat uninsured people, their primary mission. The researchers conducting the interviews also commented that “free clinics would need to overcome the fierce independence that they have demonstrated to date” if they were to form regional networks.[376] Other commentators believe that free clinics have adapted in a number of ways over time and have always “served as gap-fillers, targeting patients who are underserved by mainstream medicine.”[377]

There is a taken-for-granted quality to much of what is written about the continued presence of free clinics after implementation of the Affordable Care Act’s main provisions. In the recent analysis in Michigan, the authors state that “free clinics will remain an important part of the health care safety net. It is unrealistic to expect that FQHCs will have the capacity to serve all of the newly insured people.”[378] It is not reassuring to think that a decades-long stopgap measure is accepted so readily for the future. If free clinics do remain an essential part of the health care safety net in the future, given the often hostile political rhetoric against undocumented immigrants, it is uncertain whether communities would continue to support free clinics. Of the estimated 27 million people remaining uninsured, one third will be undocumented immigrants.[379]

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[376] Ibid., 145.

[377] Darnell, "Free Clinics in the United States: A Nationwide Survey," 951.

[378] Jacobson et al., "Examining the Structure and Sustainability of Health Care Safety Net Services," 144.

[379] Taylor, "Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market."

For community health centers, with the combination of the Medicaid expansion already mentioned and federal funding increases, the service capacity is expected to reach 44 million in 2015 and 50 million by 2019.[380] The Affordable Care Act also increases funding for the National Health Service Corps which currently accounts for more than half of the physicians employed by community health centers.[381] The National Health Service Corps supports scholarships and loan assistance for physicians practicing in a medically underserved area. Foreign medical graduates who complete a U.S. residency can also have the requirement to return to their home countries waived if they have a contract to serve as a full time primary care provider in a medically underserved area.[382] Community health centers have had significant challenges in recruiting adequate health care professionals.[383] The Affordable Care Act also funds the Teaching Health Center Graduate Medical Education Program which, it is hoped, will increase the number of primary care professionals at health centers.[384]

Local Access to Care Programs

For many stakeholders in health care, the failure of the Clinton Health Security Act in 1994 was an impetus to look to the community for efforts to address health care

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[380] Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities."

[381] Ibid., 6.

[382] Taylor, "The Fundamentals of Community Health Centers." 10-11.

[383] Roger A. Rosenblatt et al., "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *Journal of the American Medical Association* 295, no. 9 (2006).

[384] Candice Chen, Frederick Chen, and Fitzhugh Mullan, "Teaching Health Centers: A New Paradigm in Graduate Medical Education," *Academic Medicine* 87, no. 12 (2012).

and the health of the nation more broadly.[385] One commentator said that the behavior of communities occurred "as though some oddly flexible national health care reform policy actually was being implemented."[386] One of the initiatives, the Community Care Network, began in 1995 with funding from the Kellogg Foundation and several hospital associations. The aim of the demonstrations in twenty-five communities across the nation was to restructure local health delivery systems into networks that would improve access to health care and efficiency.[387] The hope was that the public-private partnerships formed would be a new model of coordinating voluntary efforts to improve care for underserved people in a comprehensive way and that otherwise competing organizations would be brought together to effectively collaborate. A broad range of activities were undertaken and some of the initiatives were focused specifically on improving access to care for uninsured people directly, others were more focused on coordination of care or developing an infrastructure.[388] The term "local access to care program" encompasses the variety of approaches taken by the communities and it is defined as a "community initiative designed to facilitate access to needed health care services to the uninsured

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[385] Jane S. Durch, Linda A. Bailey, and Michael A. Stoto, eds., *Improving Health in the Community: A Role for Performance Monitoring* (Washington, DC: National Academies Press, 1997), v.

[386] Richard J. Bogue et al., "Community Experiments in Action: Developing Community-Defined Models for Reconfiguring Health Care Delivery," *Journal of Health Politics, Policy & Law* 22, no. 4 (1997): 1051.

[387] Romana Hasnain-Wynia, "Overview of the Community Care Network Demonstration Program and Its Evaluation," *Medical Care Research and Review* 60, no. 4 Suppl (2003). Bogue et al., "Community Experiments in Action: Developing Community-Defined Models for Reconfiguring Health Care Delivery."

[388] Hasnain-Wynia, "Overview of the Community Care Network Demonstration Program and Its Evaluation." See also Gloria J. Bazzoli et al., "Collaborative Initiatives: Where the Rubber Meets the Road in Community Partnerships," *Medical Care Research and Review* 60, no. 4 Suppl (2003).

through a local organizing entity."[389] When the Community Care Networks were evaluated in 2003, the overall findings were an improvement in community health needs assessment, a modest improvement in health care for some sites, and no improvements in community cost of care.[390] Despite the largely unremarkable findings, some communities benefitted and, for the most part, expectations remained high for community collaboration.

The Robert Wood Johnson Foundation supported the Communities in Charge program beginning in 2000, which sought to provide initial funds for community coalitions to improve access to care for the uninsured. All of the communities that implemented initiatives through this support subsequently received further funding from either the Kellogg Foundation's Community Voices program or the federal Health Resources and Services Administration Community Access Program.[391] There were a great variety of projects undertaken by communities. Some projects focused on community infrastructure and others included the creation of managed care-like programs for uninsured people and donated care programs, discussed below.[392] In a publication

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[389] Lynn A. Blewett, Jeanette Ziegenfuss, and Michael E. Davern, "Local Access to Care Programs (LACPs): New Developments in the Access to Care for the Uninsured," *Milbank Quarterly* 86, no. 3 (2008): 463.

[390] Matthew Calhoun, "Evaluation Finds Local Community Care Networks Do Not Reduce Costs, Show Some Improvement in Health Status," (2003), http://pweb1.rwjf.org/reports/grr/029519.htm. See also Douglas A. Conrad et al., "Community Care Networks: Linking Vision to Outcomes for Community Health Improvement," *Medical Care Research and Review* 60, no. 4 Suppl (2003).

[391] Robert Wood Johnson Foundation, "Communities in Charge: Financing and Delivering Health Care to the Uninsured," April 4, (2007), http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2007/rwjf69549 (accessed March 14, 2013).

[392] Isabel Friedenzohn and Terry Stoller, "State and Community Collaboration: Lessons from the Communities in Charge Program and Other Local Initiatives," *State Coverage Initiatives* VI, no. 1 (2005), http://www.statecoverage.org/files/State%20and%20Community%20Collaboration%20-

from evaluators of the programs, however, the achievements were less than hoped for: "Notwithstanding a couple of medium-wattage points of light, [Communities in Charge] offers little hope that communities can or will make major breakthroughs in expanding coverage or care for the uninsured."[393]

By far the largest program to be undertaken in the hope of building community responses for the care of the uninsured was the federal government's Community Access Program which began towards the end of Bill Clinton's presidency in 2000 with an initial $22 million in grants.[394] The program was continued under President George W. Bush with $40 million in grants dispersed in 2001 to new grantees and a continuation of funding for the already obtained grantees.[395] In total, under the renamed Healthy Community Access Program, more than $400 million was invested in community coalitions to improve access and coordination of health care services for the uninsured.[396] The program ended in 2006 with some successes noted, particularly among local safety nets that were already the strongest.[397] However, "the program ultimately, was judged

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%20Lessons%20from%20the%20Communities%20in%20Charge%20Program%20and%20Other%20Local%20Initiatives.pdf (accessed March 14, 2013).

[393] Lawrence D. Brown and Beth Stevens, "Charge of the Right Brigade? Communities, Coverage, and Care for the Uninsured," *Health Affairs* 25, no. 3 (2006): W160.

[394] U.S. Department of Health and Human Services, "HHS Announces $22 Million in New Grants to Improve Services to Uninsured Americans," *HHS News* (2000), http://archive.hhs.gov/news/press/2000pres/20000907.html (accessed March 14, 2013).

[395] Health Resources and Services Administration, "HRSA Announces $40 Million in CAP Grants," (2001), http://archive.hrsa.gov/newsroom/releases/2001%20Releases/CAP.htm (accessed March 14, 2013).

[396] Marion E. Lewin and Raymond J. Baxter, "America's Health Care Safety Net: Revisiting the 2000 IOM Report," *Health Affairs* 26, no. 5 (2007).

[397] John F. Hoadley, Laurie E. Felland, and Andrea B. Staiti, "Federal Aid Strengthens Health Care Safety Net: The Strong Get Stronger," *Issue Brief Center for Studying Health System Change*, no. 80 (2004), http://hschange.org/CONTENT/669/669.pdf (accessed March 14, 2013). See also Denise A. Davis, Amy M. Tiedemann, and Joel C. Cantor, "HRSA Community Access Program: Local Achievements and Lessons Learned," (2003), http://www.cshp.rutgers.edu/Downloads/270.pdf (accessed March 14, 2013).

‘ineffective,’ largely because of its unclear purpose, poor design, and lack of accountability.”[398]

Often with funding from the above mentioned foundations or with federal support, communities have also utilized volunteer referral networks to coordinate care for uninsured patients. Information is limited about these programs because there is no central repository or registry. An estimate is that there are fifty communities in the nation with such programs. Project Access in Buncombe County, North Carolina was the first volunteer physician referral network and it was created with help from the Robert Wood Johnson’s Reach Out program in 1994.[399] Project Access and other volunteer referral networks usually have a central coordinator who receives requests for a referral. The applicants are screened for eligibility according to the community’s criteria. Some volunteer referral networks require citizenship and have encountered resistance from providers who object to caring for noncitizens.[400] Visits with participating physicians are scheduled and sometimes assistance with pharmaceuticals is provided by the coordinating office. The Buncombe County Project Access is supported financially by the county for administrative staff and for the purchase of medicines. Most of the specialty referrals

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[398] Darnell, "Free Clinics in the United States: A Nationwide Survey," 952. See also: ExpectMore.gov, "Detailed Information on the Healthy Community Access Program Assessment," (2005), http://georgewbush-whitehouse.archives.gov/omb/expectmore/detail/10003515.2005.html (accessed March 14, 2013).

[399] Stephen L. Isaacs and Paul Jellinek, "Volunteer Health Care Programs: A Report to the W.K. Kellogg Foundation," (2006), http://www.wkkf.org/knowledge-center/resources/2007/05/Volunteer-Health-Care-Programs.aspx (accessed March 14, 2013).

[400] Karen Minyard et al., "Lessons from Local Access Initiatives: Contributions and Challenges," (2007), http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Aug/Lessons-from-Local-Access-Initiatives--Contributions-and-Challenges.aspx (accessed March 14, 2013).

come from the county's health department.[401] The community primary care providers who participate in the program agree to accept ten to twelve uninsured patients a year and specialty physicians agree to accept twenty to twenty-four patients a year.[402]

Operation Access is a San Francisco based organization that coordinates care for uninsured people with a low income who need low-risk specialty care or surgery. It was founded in 1993 and received support from the Robert Wood Johnson Foundation. The program combines volunteer surgeons, nurses, anesthetists, and administrative staff together during "Super Surgery Days" where several outpatient surgeries are performed. Supplies are donated and hospitals are encouraged to claim the programs as a community benefit. Several other communities in California have initiated similar programs.[403] Some commentators have worried that partnerships at the community level may not be able to overcome differences in power and may be more of "an exercise in hospital noblesse oblige or simply a hospital marketing ploy" than a real effort to engage in a concerted activity with the community to improve health care.[404]

Researchers with the Center for Studying Health System Change have been tracking health care in several communities across a number of years. Part of their work has been to assess the presence and impact of local access to care programs. In some of

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[401] Isaacs and Jellinek, "Volunteer Health Care Programs: A Report to the W.K. Kellogg Foundation."

[402] Gillian K. Baker, Alan T. McKenzie, and Paul B. Harrison, "Local Physicians Caring for Their Communities: An Innovative Model to Meeting the Needs of the Uninsured," *North Carolina Medical Journal* 66, no. 2 (2005).

[403] Kaiser Permanente, "Kaiser Permanente & Operation Access: Restoring Health & Dignity through Skilled Volunteerism," (2009), http://www.pointsoflight.org/sites/default/files/site-content/files/skillsbasedvolunteeringkaiser_fv.pdf (accessed March 14, 2013). See also Operation Access, "Annual Report 2008," (San Francisco, CA2008). Isaacs and Jellinek, "Volunteer Health Care Programs: A Report to the W.K. Kellogg Foundation."

[404] Bruce Spitz and Grant Ritter, "Evaluating Community Partnerships: A Response," *Journal of Health Politics, Policy & Law* 27, no. 1 (2002): 97.

the communities there has been difficulty in recruiting and retaining physicians for referral networks. In some cases the reason seems to be "low Medicaid reimbursement rates, growing malpractice concerns, and report of 'donor fatigue.'"[405] Some physicians have not wanted to take on patients for whom the expense of medication puts treatment out of reach. Presumably this is a worry over the quality of care that can be provided in the referral networks that do not offer prescription assistance. Some of the programs are linked with community health centers and free clinics.

Among the programs that offer discounted care instead of free care, there is sometimes the community's preference to focus on working uninsured people coupled with a general sense that health care should not be free. On balance, the community tracking study showed that the care provided through local access to care programs was "invaluable" to those who receive care but that the programs "barely make a dent in the overall problem."[406] Once the Affordable Care Act is implemented there is also the concern that "safety-net coordination programs could face a loss of private funding and community interest if the perception is that they are no longer needed due to greater access to affordable health insurance coverage, or if the perception is that the remaining uninsured are undeserving of coverage, for example, undocumented immigrants who are ineligible for coverage expansions under the Affordable Care Act."[407]

Much like the situation with free clinics, local access to care program volunteers have had little involvement as a group on advocating for broader health care reform. The

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[405] Erin Fries Taylor, Peter Cunningham, and Kelly McKenzie, "Community Approaches to Providing Care for the Uninsured," *Health Affairs* 25, no. 3 (2006): W180.

[406] Ibid., W181.

[407] Cunningham, Felland, and Stark, "Safety-Net Providers in Some US Communities Have Increasingly Embraced Coordinated Care Models," 1705.

programs face the same challenges in needing to document that “money was spent wisely and made a difference” as well as real differences in ideology among the volunteers.[408] In one assessment of volunteer programs, researchers concluded that they did not believe that support for such programs “weakens the case for expanded or universal health insurance.” The researchers also say: “In fact, we believe that by systematically documenting the *limits* of even the most fully developed volunteer programs to meet all of the need in their communities, these programs *strengthen* the case for expanded or universal coverage.”[409] It is not at all clear that documenting the limits of volunteer programs has been undertaken or how such documentation would occur, however.

The researchers make the additional comment in favor of volunteer programs; they “shore up the core altruistic values of medicine.”[410] Most compelling, the researchers state that “from a moral perspective, we believe that it would be unethical to deny uninsured individuals access to volunteer care on the grounds that doing so might weaken the political momentum for broader reform.”[411] These are important points to make and likely state what many volunteers have come to believe. Yet, the underlying premise that uninsured people are denied access to medical care elsewhere is still left unaddressed. Most significantly, the assumption that altruism is enhanced by volunteer work leaves out other conceptions of altruism that lead to no one being denied care in the first place. This is part of the meaning of the statement that Karen Davis of the Commonwealth Fund made in response to a query about a local access to program: “All

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[408] Brook, "Health Policy and Public Trust," 213.

[409] Isaacs and Jellinek, "Volunteer Health Care Programs: A Report to the W.K. Kellogg Foundation." 27.

[410] Ibid.

[411] Ibid.

these local efforts are commendable, but they are like sticking a finger in the dikes," noting that the larger trend was to avoid the uninsured.[412]

Physicians' Provision of Charity Care in Their Offices

Professional medical societies encourage the provision of charity care in a number of ways. For example, the American Medical Association's Code of Ethics states: "Each physician has an obligation to share in providing care to the indigent."[413] The code specifically mentions volunteering at weekend clinics as a way to fulfill this obligation. The American College of Surgeons started a volunteerism initiative in 2004, Operation Giving Back, which serves as a source of information on volunteer opportunities in the United States and other countries.[414] The American College of Physicians considers volunteerism as a criterion for advancement to fellowship status.[415]

In terms of the number of low income uninsured people who sought primary care in private physicians' offices or a Health Maintenance Organization (HMO) office, a recent analysis showed that the majority of this group, 57 percent, received care at those sites. About 20 percent received care at a community health center or clinic and about the same percentage did not have a regular site for medical care. Three percent of primary care for uninsured people with a low income occurred at hospital outpatient

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[412] Erik Eckholm, "Hospitals Try Free Basic Care for Uninsured," *New York Times*, October 25, 2006.

[413] American Medical Association, "American Medical Association Code of Medical Ethics: Opinion 9.065 Caring for the Poor," (1994), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9065.shtml (accessed March 14, 2013).

[414] Howard B. Shapiro and Andrew L. Warshaw, "Surgeon Volunteers: Charitable Immunity Statutes Shield," *Bulletin of the American College of Surgeons* 87, no. 10 (2002). See also American College of Surgeons, "Operation Giving Back," http://www.operationgivingback.facs.org/about/ (accessed March 14, 2013).

[415] Walker, "Want to Help Improve Access? Become a Volunteer."

departments.[416] The study, however, did not measure the number of patients who needed medical care but did not seek it. A study from the mid-1990s showed that over 80 percent of the care that uninsured people received occurred in private physician's offices but this percentage was not limited to low income patients. In that study about 9 percent of physician's office visits on average were comprised of uninsured patients.[417]

The proportion of physicians providing charity care in their offices, however, has been steadily declining. The Center for Studying Health System Change has been tracking physician charity care for a number of years. The proportion of physicians providing any charity care fell from about 76 percent in 1997 to about 59 percent in 2008.[418] In the month preceding the most recent survey, on average among the physicians providing any charity care, somewhat less than ten hours was spent on charity care. Surgeons provided the most charity care and pediatricians the least. Presumably this is because of surgical specialists' on-call responsibilities at hospital emergency departments and because of the relatively fewer children who are uninsured as compared to adults. The highest level of charity care was provided by solo or two-physician groups and among the physicians with the highest earnings as well as those physicians in practice for longer than ten years. Lower charity care by physicians in group practice and institutional

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[416] Ellie Grossman, Anna T. Legedza, and Christina C. Wee, "Primary Care for Low-Income Populations: Comparing Health Care Delivery Systems," *Journal of Health Care for the Poor and Underserved* 19, no. 3 (2008).

[417] Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices."

[418] Ellyn Boukus, Alwyn Cassil, and Ann S. O'Malley, "A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey," *Data Bulletin: Center for Studying Health System Change*, no. 35 (2009), http://www.hschange.com/CONTENT/1078/1078.pdf (accessed March 14, 2013). See also Peter J. Cunningham, "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001," *Tracking Report: Center for Studying Health System Change*, no. 6 (2002), http://www.hschange.com/CONTENT/505/505.pdf (accessed March 14, 2013).

or managed care practices are attributed to policies that are set by the organization.[419] There are also geographic differences in charity care provision with physicians located in metropolitan areas providing less charity care than physicians in nonmetropolitan areas and physicians in the south offer more charity care than in other regions.[420]

There are a number of limitations to the data on charity care at physicians' offices. In the survey, the question asked regarding charity care defines it as "charging no fee or a reduced fee to patients with financial need. Charity care does not include services you provided expecting to be paid but were not."[421] It is unclear whether the estimates by self-reports result in greater or lesser amounts of charity care being reported. On the one hand, it is socially desirable to report charity care and, on the other hand, accurate accounting of charity may be difficult within the practice setting. In the surveys, physicians are instructed to disregard bad debt, which occurs when payment was expected but not received. This means that, in part, it is the perception of physicians regarding expectation of payment that may determine whether a patient is regarded as a charity patient. It is also not clear whether physicians have the accounting measures in place to tabulate charity care.[422]

Adding to the uncertainty about physician charity care for the uninsured is a comprehensive analysis by economists that showed a best estimate that physicians actually provide a *negative* amount of uncompensated care. The researchers defined

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[419] Boukus, Cassil, and O'Malley, "A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey."

[420] Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net."

[421] Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices," 218.

[422] Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net."

uncompensated care as the difference between what insured patients pay for care versus uninsured patients. The database used contained the billing information of over 4,000 physicians and over 4 million patient visits in practice sites across the nation. This is how their analysis was done: “[I]f an uninsured patient receives a procedure with a list price of $200, but insurance companies would only pay that doctor $90 on average, we say that patient received $90 worth of care. If the patient paid nothing, we call that $90 of uncompensated care.”[423] The researchers found that while about a quarter of the care provided to uninsured patients does not result in a payment at a physician’s office, almost two-thirds of uninsured patients pay more than insured patients for their care. On net, the amount of uncompensated care is negative for all uninsured patients, though their conservative estimate is that uncompensated care comprises 0.8 percent of practice revenue (if no revenue from collection agencies are counted and no accounting for practice differences are done).[424] Anecdotally, this seems to be the case. For example a gynecologist told the New York Times that he gets twenty-five dollars for a routine exam by one insurer but charges $175 for a woman without insurance.[425]

The researchers found that only 7 percent of uninsured patients were not charged for services and only 8 percent were billed less than half of what an insured person was billed, while 87 percent of the uninsured were billed more than the average paid by an insurer. In the economists analysis, uninsured patients paid $7.8 million to practices and another $8.7 million was sent to collection agencies. An estimate is that 10 percent of the

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[423] Jonathan Gruber and David Rodriguez, "How Much Uncompensated Care Do Doctors Provide?" *Journal of Health Economics* 26, no. 6 (2007): 1152.

[424] Ibid.

[425] Gina Kolata, "Medical Fees Are Often Higher for Patients without Insurance," *New York Times*, April 2, 2001.

amount sent to collection agencies is recovered. The researchers note that their findings are strikingly different than the findings from the Center for Studying Health System Change but they believe that physicians are estimating charity care relative to list prices and not the discounted prices that insurers pay.[426] Their findings are also consistent with an earlier study showing that only about half of uncompensated care is generated by uninsured patients and the other half is generated by insured patients.[427] In other words, physicians are probably reporting on the survey what is occurring from their point of view.[428]

The findings from the economists' study are also consistent with one study in which over two hundred primary care practice sites were asked about their policies regarding uninsured patients. More than two-thirds of the sites that were accepting uninsured patients required full payment at the time of service. However, 40 percent of sites stated they offered some free care and about the same offered a sliding scale payment. The survey did not assess written policies or the actual experiences of patients.[429] Other informal findings have been similar with primary care physicians reporting that uninsured patients are billed the list price while insurers receive discounts.[430]

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[426] Gruber and Rodriguez, "How Much Uncompensated Care Do Doctors Provide?."

[427] Kerry E. Kilpatrick et al., "Uncompensated Care Provided by Private Practice Physicians in Florida," *Health Services Research* 26, no. 3 (1991).

[428] Gruber and Rodriguez, "How Much Uncompensated Care Do Doctors Provide?" 1165.

[429] Thomas P. O'Toole, Peter M. Simms, and Bruce W. Dixon, "Primary Care Office Policies Regarding Care of Uninsured Adult Patients," *Journal of General Internal Medicine* 16, no. 10 (2001).

[430] Mark A. Hall and Carl E. Schneider, "Learning from the Legal History of Billing for Medical Fees," *Journal of General Internal Medicine* 23, no. 8 (2008).

In a national survey of general internists, more than two-thirds reported that they reduced the customary fee or did not charge for services for uninsured patients who had difficulty paying. At the same time, most uninsured patients were already established patients who lost health insurance. The researchers commented that this meant that physicians reporting charity care may not have in mind the “usual image” of the uninsured but rather patients who are temporarily uninsured or have the ability to pay.[431] In a study of rural physicians and patients, most of the care to uninsured people was simply billed at the full fee rate with only a rare visit unbilled. Physicians and their staff often made judgments about whether the patient “deserved” charity care and there were no clear standards for this.[432] Another survey of primary care physicians showed that a majority would withhold care from hypothetical patients who do not pay their bills and about 40 percent had actually done so.[433] Also confirming the findings in the economists' survey is information from patients. In a nationwide survey of uninsured people in 2010, more than half reported that they paid full price for their care and more than 80 percent paid some amount out-of-pocket for their care. Almost one-third of uninsured people in 2010 reported having problems paying a medical bill.[434] In one study of mostly uninsured patients who were currently receiving care at a public outpatient department, almost half

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[431] Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices," 220.

[432] Pat Taylor et al., "Small Town Health Care Safety Nets: Report on a Pilot Study," *Journal of Rural Health* 19, no. 2 (2003).

[433] Neil J. Farber et al., "When the Patient Does Not Pay: A Survey of Primary Care Physicians," *Medical Care* 48, no. 6 (2010).

[434] Emily R. Carrier, Tracy Yee, and Rachel Garfield, "The Uninsured and Their Health Care Needs: How Have They Changed since the Recession?" (2011), http://www.kff.org/uninsured/8246.cfm (accessed March 14, 2013).

had either delayed care or had an unmet need for health care. Almost one third had competing financial needs for paying for food, shelter, or clothing.[435]

The general internists who were surveyed did report doubts about their ability to provide the quality and continuity of care that they would like to provide to uninsured patients. The most difficult quality of care problems were the inability to obtain diagnostic procedures, lab tests, medications, or a referral to a specialist when necessary. About one third of responding internists believed they could maintain continuity of care for the uninsured, less than 10 percent believed they could be assured of obtaining laboratory tests, and only 5 percent thought they could be assured of obtaining diagnostic tests for uninsured patients. Less than one-fourth of the physicians reported that they could provide medications to their uninsured patients or usually refer them to specialists. Almost half of the time, patients of the general internists who were uninsured could not follow recommendations because of cost considerations.[436] One physician has commented that the refusal by some physicians to take a referral from a colleague because the patient is uninsured is a contributor to a lost sense of camaraderie.[437]

The most closely related studies on physicians' perspectives on limits to care occurred during the time when capitated managed care arrangements were at their height. For example, family physicians were significantly more "bothered" or distressed when incentives were in place to limit care under capitation.[438] Other critiques of limiting care

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[435] Allison L. Diamant et al., "Delays and Unmet Need for Health Care among Adult Primary Care Patients in a Restructured Urban Public Health System," *American Journal of Public Health* 94, no. 5 (2004).

[436] Fairbrother et al., "Care for the Uninsured in General Internists' Private Offices."

[437] Farrin A. Manian, "Physicians Vs Physicians," *Archives of Internal Medicine* 161, no. 6 (2001).

[438] Joannie Shen et al., "The Effects of Payment Method on Clinical Decision-Making: Physician Responses to Clinical Scenarios," *Medical Care* 42, no. 3 (2004).

have objections based on the moral concept of justice in which like cases should be treated similarly.[439] These studies were based on external pressures to limit care. There is much less written about situations in which care is limited because a patient cannot afford treatment or tests and referrals cannot be obtained due to lack of insurance.

One small study found that primary care physicians were most likely, about 40 percent of the time, to change their preferred management when a patient was uninsured.[440] Another study confirmed that insurance status is a factor in clinical decision making with physicians less likely to recommend services for uninsured patients.[441] In one essay, a physician describes the dilemmas faced by the patient and the physician when the patient does not have health insurance. One conclusion is that the "physician may be forced to provide a nonstandard approach to care."[442] One point is that physicians in their offices may believe there are moral consequences to providing care to uninsured patients related to knowing that the quality of care they can reasonably provide is lower than what they would prefer and that these consequences have largely been unexplored.[443] The physician in the essay urges colleagues to discuss limits in care due to cost with patients, to be informed about less costly sites of care, and to advocate more broadly within their own institutional practices or at a national level for policies to

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[439] Daniel P. Sulmasy, "Cancer Care, Money, and the Value of Life: Whose Justice? Which Rationality?" *Journal of Clinical Oncology* 25, no. 2 (2007). Daniel P. Sulmasy et al., "Physicians' Ethical Beliefs About Cost-Control Arrangements," *Archives of Internal Medicine* 160, no. 5 (2000).

[440] David S. Meyers et al., "Primary Care Physicians' Perceptions of the Effect of Insurance Status on Clinical Decision Making," *Annals of Family Medicine* 4, no. 5 (2006).

[441] Elizabeth A. Mort et al., "Physician Response to Patient Insurance Status in Ambulatory Care Clinical Decision-Making. Implications for Quality of Care," *Medical Care* 34, no. 8 (1996).

[442] Saul J. Weiner, ""I Can't Afford That!": Dilemmas in the Care of the Uninsured and Underinsured," *Journal of General Internal Medicine* 16, no. 6 (2001): 417.

[443] Sidney D. Watson, "In Search of the Story: Physicians and Charity Care," *St. Louis University Public Law Review* 15, no. 2 (1996).

provide better care for uninsured people. The concept that charity care is less than ideal is certainly not new. In 1946 an editorial stated that the charity tradition "provides a quality of medicine well below that which could readily be provided."[444]

The physician describing dilemmas in the care of uninsured office patients also discusses measures to reduce exposure to the risk of malpractice if nonstandard care is provided.[445] Physicians often believe inaccurately that patients with a low income are more litigious than other patients. In one study almost half of physicians reported that a fear of malpractice was a reason to limit care to uninsured people.[446] As already mentioned, efforts to increase liability protection for physicians has been the most visible advocacy effort among volunteer physicians and groups. Several states have enacted laws to address liability for volunteers, including capping the compensatory damages that can be awarded to injured persons and changing the negligence standard of care. In some cases, patients must be notified about these protections for volunteer physicians and some protections are limited to primary care or to a reasonable scope of practice for the particular physician.[447] None of these protections, of course, address the moral implications of providing care that is less than standard to uninsured patients.

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[444] Allan M. Butler, "Minority Views on Improving Medical Care," *New England Journal of Medicine* 234(1946).

[445] Weiner, ""I Can't Afford That!": Dilemmas in the Care of the Uninsured and Underinsured."

[446] Helen Burstin et al., "Do the Poor Sue More?: A Case-Control Study of Malpractice Claims and Socioeconomic Status," *Journal of the American Medical Association* 270, no. 14 (1993). See also Frand M. McClellan et al., "Do Poor People Sue Doctors More Frequently? Confronting Unconscious Bias and the Role of Cultural Competency," *Clinical Orthopedics and Related Research* 470, no. 5 (2012).

[447] Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net." Karen W. Geletko et al., "Reducing the Impact of the Health Care Access Crisis through Volunteerism: A Means, Not an End," *American Journal of Public Health* 99, no. 7 (2009).

Among the concepts related to physicians' provision of charity, three that are common are 1) physicians have a moral duty to provide charity care to people unable to pay; 2) physicians need to provide charity care in order to express altruism; 3) charity care is the preferred way to provide care to people who are uninsured and cannot afford care because it enhances physician autonomy and limits governmental interference in the practice of medicine. These concepts are expressed widely, though the last concept that charity is preferred is less often expressed outright. In 1986, the bioethicist H.Tristram Englehardt wrote that among the alternatives systems of medical care, a free market distribution "maximizes free choice" and that "charity can at least blunt severe losses at the natural and social lotteries."[448] Also according to Englehardt, the profit motive in medical care can lead to many solutions within the health care system and for those left out of the market, there is charity. Furthermore, if for-profit institutions skim well-paying patients, then this skimming can be a virtuous act because it leads to moral candor about the level of care provided to indigent patients.[449]

Another legal bioethicist, Richard Epstein, has argued strongly in favor of relying on free market mechanisms along with charity in the provision of medical care. In his view:

> [S]ystems of voluntary compassion are sustainable because the dimensions of the program are limited by the willingness of its supporters to give of their own resources, not those of others. No one should be against compassion. But everyone should be on guard against conscripting others into their compassionate causes.[450]

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[448] H. Tristram Engelhardt, *The Foundations of Bioethics* (New York, NY: Oxford University Press, 1986), 357.

[449] Ibid.

[450] Richard Allen Epstein, *Mortal Peril: Our Inalienable Right to Health Care?* (Reading, MA: Addison-Wesley Publishing Company, 1997), xiii.

Epstein believes that medical advances have far surpassed the hopes of a century ago but that on matters related to the political economy of medical care:

> [T]he legal arrangements prized by the reflective nineteenth-century theory of laissez-faire—strong autonomy rights, strong property rights, widespread contractual freedom, and powerful charitable institutions—have proved superior to the more complex legal and administrative edifice that have displaced them.[451]

Furthermore, charities "know how to exercise the discretion that they (should) enjoy under the law." What is needed, in Epstein's view is to "restore some of the older wisdom that allowed commercial and charitable operations to work side by side."[452]

More recently, a 2012 article by Ronald Hamowy relays concern about the Affordable Care Act stating that the concept that "we are part of some organic body and that we are interconnected so that we 'belong' to and are responsible for each other is basically antithetical to our notion of the sovereignty of the individual."[453] Hamowy's view is quite similar to Epstein's in that free markets have been a "spectacular engine of progress" in medical care and the freedom to compete and the freedom to express autonomy are preferred over a claim that government should be responsible for health care. In a compassionate society, according to Hamowy, when people are in need of medical care and cannot afford it, the answer is charity care. The reason to have a "fellow feeling for those less fortunate" resides in our knowledge of what it means to "fall short of some goal."[454] Citing the sizable charitable contributions made by Americans,

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[451] Ibid., 431.

[452] Ibid.

[453] Ronald Hamowy, "Medical Responsibility," *Journal of Law, Medicine & Ethics* 40, no. 3 (2012): 535.

[454] Ibid., 535-536.

Hamowy is certain that charity can be counted on: “Surely a nation so philanthropic would insure that no one who lacked the means to afford it went wanting for needed medical care.”[455]

Implicit in the concept that physicians have a moral duty to provide charity care is at least some sense that this provision will be adequate to meet the needs of people who cannot afford to pay for medical care, even if only temporarily. In 1989 George Lundberg, then-editor of *JAMA*, wrote with a lawyer colleague that both professions should devote fifty hours a year, or about one week providing care to the poor.[456] A group of bioethicists in 2003 calculated that physicians would need to provide care to about eighty-eight uninsured patients a year to meet the health care needs of half of uninsured people in the nation under a principle of fair beneficence.[457] When the AMA’s Council on Ethical and Judicial Affairs published their report on caring for the poor, they stated that there “should be no illusion that the voluntary charity of the medical profession can cure the problem of lack of access to health care…However, the need for charity care exists today, and probably always will.”[458] Even the tracking studies of physician charity care imply that physicians should provide charity; if not, why track it? There is no argument here that physicians should not provide charity, only that if physicians should provide charity it creates a diffusion of responsibility and shifts the

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[455] Ibid., 536.

[456] George D. Lundberg and Laurence Bodine, "Fifty Hours for the Poor," *Journal of the American Medical Association* 262, no. 21 (1989).

[457] Avhaham Astor, Marion Danis, and Gopal Sreenivasan, "Providing Free Care to the Uninsured: How Much Should Physicians Give?" *Annals of Internal Medicine* 139, no. 9 (2003).

[458] AMA Council on Ethical and Judicial Affairs, "Caring for the Poor," *Journal of the American Medical Association* 269, no. 19 (1993): 2537.

focus from governmental responsibility to individual practitioners. As the previous paragraphs show, this is intentional for some physicians and groups.

The moral duty of physicians to provide charity is also intertwined with the third concept commonly associated with physician charity care which is that physicians need charity to express altruism. This was the concept that Dr. Hilfiker put forth earlier in this chapter regarding the ability of “the poor” to instill in individuals and professionals an ideal of service.[459] The AMA’s Council on Ethical and Judicial Affairs quotes the following: “[W]ithout charity something essential goes out of medicine, something vital disappears from the life of its practitioners.”[460] According to the authors, if there were no charity it would mean:

> [A] loss not only for patients, but for physicians as well. By drawing on the physician’s mercy, compassion, and empathy, charity care strengthens the emotional bonds between patient and physician that are too often weakened by the commercialization of medicine. Charity care can also provide a strong counterweight to the growing disaffection that physicians are experiencing with the practice of medicine. Providing care without expectation of payment, to patients who may be most in need of care, reaffirms the primacy of medicine as a helping profession.[461]

These sentiments are similar to what many professionals have expressed throughout this chapter. One flaw in this concept of charity is that it does not take into account the people who are recipients of charity. The notion culturally that people do not want charity seems to have become buried in other cultural conceptions of poor people. Even under the best of circumstances where charity care is provided with dignity and compassion, from what little is known about patient’s views, there is still a sense of

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[459] Hilfiker, "Unconscious on a Corner."

[460] AMA Council on Ethical and Judicial Affairs, "Caring for the Poor," 2535.

[461] Ibid.

shame and humiliation at needing charity care. Discussed earlier was the concept from the political philosopher Michael Walzer that uninsured people with a low income may not be members in the political community.[462] When charity care is provided it may be out of an individual's or group's desire to ameliorate real suffering but it occurs because uninsured people are already morally excluded. Moral exclusion occurs "when individuals or groups are perceived as outside the boundary in which moral values, rules, and considerations of fairness apply."[463]

Another flaw in the notion of charity care as the locus of altruism is its focus on the good that charity accomplishes in demonstrating altruism and compassion in the physician and in the entire profession, which obscures a focus on the patient. While it is true that providing charity care is an altruistic act, and not disagreeing that charity care is necessary now, should charity care be what makes medicine a "helping profession?" Why would the medical profession want to end charity care if, without it, medicine cannot demonstrate mercy, compassion, and empathy? In 1981 Richard Reynolds, a former vice president of RWJF, wrote that to the extent that "poor people have been provided the mechanism to seek care as ordinary patients rather than supplicants is laudable."[464] He urges physicians to think differently about charity:

> But what about charity? Is it not part of a noble profession? Are physicians less if they are deprived of charity? Does the removal of opportunities by society to provide charity alter the character of the physician and character of his practice? Perhaps the gradual disappearance of the commonplace nature of charitable activities as a part of everyday practice has lessened the role of the physician in

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[462] Walzer, *Spheres of Justice: A Defense of Pluralism and Equality*.

[463] Dennis J. Moberg and Mark A. Seabright, "The Development of Moral Imagination," *Business Ethics Quarterly* 10, no. 4 (2000).

[464] Richard C. Reynolds, "The Loss of Charity in the Practice of Medicine," *American Journal of Medicine* 71, no. 2 (1981): 197.

> the society which he serves. The answer is not to repeal the social legislation that has made the practice of charity by physicians less ordinary, but to look for other opportunities that may enrich the profession and the members of the profession through the delivery of charitable practice…There is charity in taking more time with a frail elderly patient…There is charity in continuing to follow patients at home or in nursing homes…Perhaps an even more impressive and still individual response is for a physician to foster a charitable attitude in reviewing those changes in health care policy as they are promulgated by state or federal government…To maintain an attitude of charity may be more difficult and more important than performing an act of charity.

Written some decades ago, Reynold's ideas are just as relevant today but they still leave out the fact that the relationship between charity care and the "goodness" of physicians is deeply ambiguous. Volunteers may be moral heroes at times but they may also encounter moral distress, become emotionally exhausted or suffer burnout. There is also the irony that "there is inadequate respect for physicians who spend the majority of their efforts meeting the needs of the indigent."[465] Like Dr. Kilgore at the beginning of this chapter, physicians may become relatively powerless with their patients.

Conclusion

Thousands of physicians, other health care providers, community organizations and institutions have worked over more than a century to volunteer their time and services to people who need medical care but cannot afford it. Charity care as a symbol came to be seen by some as the very moral foundation of medicine even as other countries developed alternatives. With the implementation of many of the provisions of the Affordable Care Act at hand, few observers have expressed the belief that the need for charity care will end. Still, profound changes are sure to happen and in ways that are not yet anticipated.

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[465] AMA Council on Ethical and Judicial Affairs, "Caring for the Poor. Council on Ethical and Judicial Affairs, American Medical Association," *Journal of the American Medical Association* 269, no. 19 (1993): 2535.

Looking at charity care at the community level, which is arguably its simplest form, reveals a number of perplexing issues. One is the difficulty of making sense of what it is and what the boundaries are. More often than not, what is called charity is not free care provided to patients even at free clinics and community health centers. The same holds true for charity care at physicians' offices. While no one believes that it costs nothing to provide medical care, even when all health care providers are volunteers, the cost by some estimates is not less than in other settings. If charity care is not free and does not necessarily cost less to provide, then what is it? One incomplete answer is that charity at the community level is often an attribute of certain persons seeking care, primarily those who have a low income and no health insurance. Another incomplete answer is that charity care allows for broad discretion and provides no assurances for access.

Most volunteers are profoundly affected by their work and find it deeply meaningful. This seems to be as much the case for volunteers who believe strongly that the exclusion of people from conventional sites of care is unjust and intolerable as it is for people who believe that charity care is a preferred way to provide care to those left out of America's still largely market-based health care system. That charity in health care can accommodate these two views is one of its hallmarks. These ambivalent views are also a main reason that the people most able to provide an authentic account of the difficulties faced by those who get charity care have not become advocates as a group. Bringing the perspective of patients and providers in charity care settings to the political conversation is repeatedly thought to be a strong reason that charity care can buttress the claims for all-inclusive national health care coverage and therefore not impede these efforts. The problem is that charity care providers have not been this voice for change. With nowhere to turn for such a public conversation, charity care provision and volunteering largely remain the only game in town for those who do not want to turn their backs on people in need.

Since the 1920s free clinics were seen as a temporary measure soon to be unnecessary. Now observers express the opinion that providing charity care at the community level will continue even with dramatic changes in health care ahead. The present time may still provide the opportunity to reassess local charity care practices. That uninsured patients with a low income, like all of us, do not want charity may enter our conversations and challenge our reliance on charity to demonstrate personal and professional virtue.

Chapter 2: Medical Education and Charity Care

For the past few years, the Dallas Morning News has, depending on your point of view, either brought important questions and issues to light regarding medical trainees and the care they provide at a large public hospital, or unfairly targeted a beleaguered program. The Parkland Hospital is over one hundred years old and is now part of one of the nation's largest public teaching hospital and health systems. The hospital is staffed by faculty and residents from the University of Texas Southwestern Medical Center.[466] At the heart of the issues raised recently by the Dallas newspaper is the level of supervision, or lack thereof, provided to medical and, particularly, surgical residents.[467] The hospital is supported financially by several mechanisms but the parent organization, the Dallas County Hospital District, was established explicitly "to furnish medical aid and hospital care to the indigent and needy persons residing in the hospital district."[468]

Most of the issues raised by the newspaper in Dallas concerning medical education and the provision of care in the "charity" hospital are morally troubling yet

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[466] Ron J. Anderson, Sue Pickens, and Paul J. Boumbulian, "Toward a New Urban Health Model: Moving Beyond the Safety Net to Save the Safety Net--Resetting Priorities for Healthy Communities," *Journal of Urban Health* 75, no. 2 (1998).

[467] Reese Dunklin, Sue Goetinck Ambrose, and Brooks Egerton, "UT Southwestern Faculty Let Unsupervised Resident Doctors Operate at Parkland," *Dallas Morning News*, August 1, 2010.

[468] Anderson, Pickens, and Boumbulian, "Toward a New Urban Health Model: Moving Beyond the Safety Net to Save the Safety Net--Resetting Priorities for Healthy Communities," 368.

have received comparatively little attention.[469] Are patients informed about the role of medical students and residents in their care?[470] Is there a different standard of care regarding the role of trainees at the public hospital versus the role of trainees at private hospitals where faculty also see patients?[471] Is there grave and real harm to patients when medical students and residents receive little supervision?[472] When faculty express concerns over supervision, are the concerns addressed reasonably?[473] Does an inadequate level of supervision add up to fraud when patients are insured through Medicare?[474] Among the issues raised by the Dallas newspaper is whether there is a culture among medical educators and trainees in which all of the questionable practices have been tacitly endorsed.

In a 2004 report commissioned by the Dallas County Commissioners, both Parkland hospital and the outpatient clinics were described as operating on a model in which "teaching needs and academic interests drive the services, staffing, hours and operations," and that the "training model at Parkland is dated and does not absolutely

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[469] The Parkland Hospital is known as the charity hospital. Steve Thompson, "Long Wait Common in Parkland Hospital ER May Have Cost Ex-Restaurateur His Life. " (2009), http://www.wfaa.com/news/local/64514612.html (accessed March 14, 2013).

[470] Sue Goetinck Ambrose and Reese Dunklin, "Parkland Memorial Hospital Consent Form Was Full of Gray Areas," *Dallas Morning News*, August 4, 2010; Brooks Egerton, "Ethicists Fear Patients Don't Know Students May Be Behind Surgical Masks," *Dallas Morning News*, November 13, 2010.

[471] Reese Dunklin and Sue Goetinck Ambrose, "Doctors: Double Standard for Residents at Parkland, UT Southwestern," *Dallas Morning News*, August 2, 2010.

[472] Dunklin, Ambrose, and Egerton, "UT Southwestern Faculty Let Unsupervised Resident Doctors Operate at Parkland."; Dunklin and Ambrose, "Doctors: Double Standard for Residents at Parkland, UT Southwestern."; Brooks Egerton, "Level of Trainee Supervision at Parkland Memorial Hospital Has Long Been Debated," *Dallas Morning News*, November 13, 2010.

[473] UT Southwestern Medical Center at Dallas v. Larry M.Gentilello, No. 05-07-00845-CV, July 21, 2010. Dunklin, Ambrose, and Egerton, "UT Southwestern Faculty Let Unsupervised Resident Doctors Operate at Parkland."

[474] Reese Dunklin and Miles Moffeit, "Feds Probe Alleged Fraud at UT Southwestern, Parkland," *Dallas Morning News*, May 30, 2010.

need to persist."[475] The report recommended "mov[ing] away from the dominance of the teaching model shaping clinical care by looking intensively and critically at policies and procedures and lines of communication that have evolved over time that were developed to facilitate teaching rather than efficient patient care."[476] The model "has increasingly serious impacts on the ability of Parkland to…respond to the health care needs of its patients"[477] Faculty physicians have described a "culture clash" particularly between newer faculty and the "old guard." The culture that prioritized teaching over patient care has lasted longer at Parkland than in other hospitals because, according to one of the 2004 reviewers, it was such a "good dinosaur."[478] The CEO of Parkland has a perspective on what trainees should do based on his own training where he has said, as a "fourth-year medical student, I did seventeen amputations in a state hospital."[479] The Dallas newspaper asked an official with the Oklahoma Medical Board where Parkland's CEO went to medical school about the statements. The official said, "[I]t's not illegal for medical students to perform amputations." He went on to say that "The only time it would be shocking was if it was on me…That's how we always get: 'They've got to learn, they've got to practice…but just not on me.'"[480]

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[475] Health Management Associates, "Long Range Planning Isssues for the Dalllas County Hospital District," (Chicago, IL2004), 35,47.

[476] Ibid., 35.

[477] Ibid., 68.

[478] Dunklin, Ambrose, and Egerton, "UT Southwestern Faculty Let Unsupervised Resident Doctors Operate at Parkland."

[479] Brooks Egerton, "Parkland CEO: "I Did 17 Amputations" before Getting Medical Degree," *Dallas Morning News*, November 13, 2010.

[480] Ibid.

At the very least, the ongoing questions about medical education and care at the Dallas charity hospital serve to show that there are unresolved and sometimes troubling issues at stake. The relationship between medical education and care provided to people with a low income or who are uninsured and also more likely to be minority is most commonly viewed as beneficial to all. Underlying such care is the moral symbol of charity and, with it, ambiguity and ambivalence. Institutions such as safety net hospitals and especially public hospitals such as Parkland derive much of their moral significance from their association with charity. The complex relationship between charity care and medical education is, in many respects, embedded in ambiguity that has been obscured and often rendered opaque by the morally praiseworthy provision of charity. There are a number of reasons to attempt to fully recognize the relationship between charity care and medical education. The first is that the medical education system plays a foundational role in equipping physicians with the knowledge, skills, and attitudes they will ultimately bring forward to the people and communities they serve. The second is that many academic medical centers have a role nationally and locally as institutions whose mission includes provision of care to the poor and uninsured.[481] The third reason to explore the connection between medical education and charity care is that, through a variety of federal, state, and local sources, funding is tied to this relationship.

This chapter is a chronological survey of the historical role of charity care in medical education. The cultural and social assumptions and expectations of the care of patients who are considered to be charity patients are followed from the earliest days of the nation to the present time. The profound changes in the structure of medical education

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[481] Commonwealth Fund Task Force on Academic Health Centers, "A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured," (Washington, DC: Commonwealth Fund, 2001), 1.

from its haphazard beginning to the formalized and regulated form currently in place are traced. The relationship between sources of funding for medical education and the provision of charity care is reviewed. Finally, the role of medical education in the care of low income people is explored from the perspective of explicit and tacit knowledge conveyed during medical training.

Early History of Medical Education in Apprenticeships and Charity Care

Throughout our nation's history, medical education and charity care practices have been closely linked with the types of illnesses suffered by Americans, the range of therapies available, and the variety of practitioners and places available for providing care. While medical education was an integral part of the nation's provision of care to the sick poor from the earliest days, training future physicians was never the sole purpose of medical care provided to the poor. Broader economic and political forces along with social and cultural assumptions about the recipients of charity care were always operative. In particular, distinctions between the "worthy and unworthy poor, between the demoralized pauper and the hard-working but unfortunate ailing laborer" were seen as "real and categorical distinctions."[482]

Since there were no effective legal restrictions on the right to practice medicine until the late nineteenth century, an aspiring physician could choose to pursue a medical education in the seventeenth and eighteenth centuries by one of three ways: 1) travel to Europe to study; 2) become formally apprenticed; or 3) learn informally. A study of almost 1,600 medical practitioners in Massachusetts from 1630 to 1800 illustrates these paths to practice. Among those studied, a few physicians had trained in Europe, the

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[482] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York, NY: Basic Books, 1987), 324.

majority had no formal training, and about one-third had completed at least one year's apprenticeship.[483] Therefore, it is likely that the attitudes about providing medical care to the poor were a product of widely-held social and cultural assumptions, traditions conveyed through apprenticeships, as well as European traditions.

Prior to the opening of medical schools, private courses were offered in subjects such as anatomy beginning in the 1750s and 1760s in places such as New York, Philadelphia, and Boston. These private courses have been considered as the "true beginning" of formal medical education in the United States.[484] After the middle of the eighteenth century, some physicians, often after training in Europe, began approaching colleges about establishing medical schools. Medical schools could offer degrees to students, a stable physical presence, and enhancement of professional reputations for students and faculty. In 1767 a medical school was established in New York, at what would become Columbia University. In Philadelphia a medical school was established at the University of Pennsylvania in 1769, and the Harvard medical school was organized in 1783.[485]

The number of medical schools grew exponentially during the nineteenth century. There were four medical schools in 1800,[486] seventy-five medical schools in 1860,[487] and

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[483] William G. Rothstein, *American Medical Schools and the Practice of Medicine: A History* (New York, NY: Oxford University Press, 1987), 25.

[484] Ibid., 28.

[485] Ibid., 28-29.

[486] Ibid., 48.

[487] Ibid., 92.

by 1906 there were 162 medical schools.[488] As already mentioned, at the beginning of the nineteenth century, a physician may or may not have gone to a medical school. In fact, less than one third of practicing physicians had a medical degree in the opening decades of the century.[489] Apprenticeships provided the dominant method of medical education and these had no standard content. When the group that was to become the American Medical Association met for the first time in 1846, its primary goal was to raise and standardize the requirements for a medical degree.[490] The distinctions between proprietary medical schools and the schools affiliated with prominent universities remained loose until late in the nineteenth century.[491] For example, at Harvard before 1869 the connections between the university and medical school were weak. The medical school faculty collected fees directly from students, paid the school's expenses, and conducted their own affairs, including electing a dean.[492]

When the first medical schools were established, the emphasis was on the teaching of the scientific and theoretical aspects of medicine because the practical portion was largely left to the apprenticeship system.[493] Graduates of medical schools in the mid-nineteenth century could "graduate without having attended a delivery, without having

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[488] Ibid., 142.

[489] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (New York, NY: Oxford University Press, 1995), 20.

[490] Starr, *The Social Transformation of American Medicine*: 89, 90.

[491] William Frederick Norwood, "Medical Education in the United States before 1900," in *The History of Medical Education; an International Symposium Held February 5-9, 1968*, ed. Charles Donald O'Malley (Berkeley, CA: University of California Press, 1970), 483.

[492] Starr, *The Social Transformation of American Medicine*: 114.

[493] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 28.

witnessed an operation, and often without having examined a patient."[494] The apprenticeship system of medical education increased in influence after 1750 and remained as an important part of medical education even into the twentieth century.[495] Though the practices of preceptors shifted more to physicians at medical schools and institutions from physicians in private practice over the nineteenth century, by 1870 less than 3 percent of medical students at Harvard had no preceptor and in 1900 about 20 percent of medical students at the University of Maryland had no preceptor.[496] In any case, what apprentices learned about their future obligations to provide charity services was most likely a product of societal expectations, role-modeling by preceptors, and European influences.

Some historical scholars of medical education have emphasized the deficiencies of apprenticeships: the differences in educational quality due to the preceptors' inclinations, the lack of systematic instruction with textbooks, and the time spent in menial chores.[497] Other scholars have emphasized how apprentices learned to prepare drugs, act as a nurse, and learn about the doctor's relationship to the patient, the family and the community.[498] In the South, apprentices also learned that their first patients were most likely to be "either slaves, who had little or no choice, or Irish river boatmen and

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[494] Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York, NY: Basic Books, 1985), 12.

[495] Rothstein most clearly documents apprenticeships. Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 25.. Ludmerer also documents apprenticeships into the twentieth century. Ludmerer, *Learning to Heal: The Development of American Medical Education*: 283.

[496] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 97.

[497] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 16.

[498] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 25-27.

local ne'er-do-wells who either did not know or did not care who they were getting as a doctor."[499]

Among the available sources of information about what apprentices may have learned is a book titled, *Book on the Physician Himself and Things That Concern His Reputation and Success,* by D.W. Cathell published in 1881.[500] In the book, the practically "right," the professionally "right," and the morally "right" actions are tightly interwoven. Cathell may or may not represent the average physician serving as a preceptor, however, he was a professor of pathology at the College of Physicians and Surgeons of Baltimore, served on the Examining Board of the State of Maryland's Medical and Churigical Faculty, and wrote a book that was so popular it had ten editions.[501] He published at least one series of case studies about rectal medications including the indications for their use and the range of doses of medicines, primarily morphine and belladonna.[502]

Cathell's views on professional obligations of charity care for the poor are complex. As a practical matter,

> You will find it comparatively easy to get practice in the slums and among the moneyless poor, and relatively hard to do so among the wealthier classes…but, no matter whether in mansion, cottage, or hovel, every man, woman, or child you

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[499] Steven M. Stowe, *Doctoring the South : Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century*, Studies in Social Medicine (Chapel Hill, NC: The University of North Carolina Press, 2004), 29-30.

[500] The tenth edition is cited here: Daniel Webster Cathell, *Book on the Physician Himself and Things That Concern His Reputation and Success*, 10th ed. (Philadelphia, PA: F. A. Davis Company, 1892).

[501] Duncan Neuhauser, "Public Opinion Is Our Supreme Court: D W Cathell MD, the Physician Himself," *Quality and Safety in Health Care* 14, no. 5 (2005); Medical and Chirugical Faculty of the State of Maryland, *Transactions of the Medical and Chirugical Faculty of the State of Maryland* (Baltimore, MD: Press of Thomas and Evans, 1885).

[502] ———, *Transactions of the Medical and Chirugical Faculty of the State of Maryland*: 195-206.

> attend, white and black, rich and poor, will aid in enriching your experience and in shaping public opinion by giving you either a good or a bad name.[503]

Paul Starr describes Cathell's book as falling under the general sort of manual of personal advice that is an "amoral guideboo[k] to getting on in the world" and as a testament to anxieties about authority and status among a weak profession.[504] Cathell may have been overly concerned with public opinion of physicians, yet this is another way of saying that societal expectations played an important role in establishing the basis for providing charity care. [505]

It is not so easy to dismiss this book since many of its precepts remained embedded in future statements about the profession. In a prescient declaration that is surprisingly similar to a portion of the 1957 Principles of Medical Ethics of the American Medical Society,[506] Cathell advises:

> You are not obliged to assume charge of any case, or to engage to attend a woman in confinement, or to involve yourself in any way against your wish; but, after doing so, you are morally, if not legally, bound to attend, and to attend properly, even though it may be a charity or "never pay" patient. At the same time you have a right, should necessity arise, to withdraw from any case by giving proper notice. Bear in mind that ethical duties and legal restraints are as binding in pauper and charity cases as in any other, for both ethics and law rest upon abstract principles, and govern all cases alike.[507]

Cathell offers a lengthier paragraph on the charitable duties of physicians in emergencies:

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[503] Cathell, *Book on the Physician Himself and Things That Concern His Reputation and Success*: 58-59.

[504] Starr, *The Social Transformation of American Medicine*: 86.

[505] Starr emphasizes how Cathell was concerned above all with public opinion: ibid., 85-88.

[506] The 1957 Principles of Medical Ethics states in Section 5: "A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his service only after giving adequate notice." American Medical Association, "Principles of Medical Ethics," American Medical Association, http://www.ama-assn.org/ama1/pub/upload/mm/369/1957_principles.pdf (accessed March 14, 2013).

[507] Cathell, *Book on the Physician Himself and Things That Concern His Reputation and Success*: 60.

> Humanity requires you (as God's instrument) to go promptly to all cases of sudden emergency, accidents, and the like, in which the life or limb of a fellow-creature is in jeopardy, without regard to the prospect or otherwise of a fee. You should do various things for the sake of charity; among these is to give relief to any one injured, or in great pain or suffering, regardless of fees. At such times regard only Man in distress; show no distinction between rich and poor, high and low, but consider only your simple duty to suffering humanity. The good Samaritan succored the wounded man, took him to an inn, and provided for his immediate necessities. You, as a physician, should be equally humane and prompt to go and bind up wounds, and relieve suffering in all cases of emergency. After this is done further attendance is, of course, optional, and depends upon whether you choose to render it, or feel that you can afford it; but you are really no more bound to continue to attend such a one gratuitously than the baker is to give away his bread to the hungry, or the tailor to give away his clothes to the ragged.[508]

There is a certain amount of Cathell's advice in which he clearly assumes that physicians are taking care of the poor without pay. In one section, he calculates the amount of charity services: "Allowing that there are in the United States fifty thousand regular practicing physicians, and that each does one hundred dollars' worth of labor to charity practice a year,--which is far below the average,--we have the enormous sum of five millions of dollars of charitable labor given by its medical profession every year."[509] Later, Cathell estimates that "A moderately successful practitioner has about two thousand persons who call him *their* 'doctor' (Fully three hundred of whom are moneyless or bad pay)."[510]

At the same time, Cathell clearly does believe that there are distinct and distinguishable categories of the poor. He cautions:

> But even in dispensing charity, careful discrimination is essential. There would seem to be three classes of the poor,--the Lord's poor, the devil's poor, and the poor devils. The first and last are worthy objects of every physician's attention,

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[508] Ibid., 309.

[509] Ibid., 310.

[510] Ibid., 315.

> and you would do well to lose no opportunity to give relief to their ailments. The less, however, you have to do with the other class (*the devil's poor*), and the less health and strength you waste on them, the better for you; nevertheless, you will be more or less compelled to attend more than you would otherwise care to do of the lowest and vilest victims of vice, intemperance, and sensual indulgence,--who are perhaps a curse to their families and a nuisance to the neighborhood,--and watch over them as faithfully as if they were noblemen; some for God's sake, and others, it may be, on account of their relationship to better and more provident patients; you will generally find, however, that, "though this citizen and that fellow may be brothers, their pocket-books are not sisters."[511]

In a sense, Cathell's book offers a written account of advice a preceptor could have given to an apprentice. Throughout his book, there is a seamless, even if conflicting, set of values regarding the provision of charity care. Christian charity is a duty of everyone, and especially of the physician as it relates to God-given talents. This duty is strict in some circumstances, such as when the care of the patient is acutely in progress or in emergencies. The duty is, however, limited to the prerogatives of the physician and his circumstances. There is a self-interested aspect to any duties undertaken for charity, as these will contribute to the physician's knowledge and experience. Public opinion matters because the physician's reputation will be affected by the way charity cases are handled. Finally, the poor can be distinguished based on their deservingness and judgments of just this sort are integral to charity cases.

Medical Schools and Hospitals Gain Importance in Medical Education and Charity Care

Though apprenticeships remained integral to medical education, by the middle of the nineteenth century medical schools provided the dominant source of medical

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[511] Ibid., 310.

education.[512] The role of the hospital was important to both models of medical education. For example, prior to the opening of a medical school in Philadelphia, apprentices of attending physicians and surgeons were allowed on the wards of the almshouse.[513] The influence of hospitals on the trajectory of medical education was greater, in the historical view, than its numbers would suggest, in part because of the ability to look back from the current vantage point to how modern hospitals and academic health care centers began. When the first hospital survey in America was done in 1873, there were fewer than 20,000 hospital beds whereas there were 10,000 medical students.[514] At the time of this survey, only 1 or 2 percent of American physicians had hospital privileges.[515] Hospitals in America in the eighteenth and much of the nineteenth centuries played almost no role in the training or practice of rural physicians and little more in the case of urban physicians, yet for a relatively small elite group, the hospital served as a primary locus of clinical training, prestige, and influence.[516]

Modeled in large part after British practices, the American colonies established almshouses as early as 1612.[517] Though one of the functions of the almshouses was providing care for the physically and mentally ill poor, not all of the almshouses

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[512] William G. Rothstein, *American Physicians in the Nineteenth Century : From Sects to Science* (Baltimore, MD: Johns Hopkins University Press, 1992), 85.

[513] Harry F. Dowling, *City Hospitals: The Undercare of the Underprivileged* (Cambridge, MA: Harvard University Press, 1982), 19.

[514] Edward C. Atwater, "Internal Medicine," in *The Education of American Physicians: Historical Essays*, ed. Ronald L. Numbers (Berkeley, CA: University of California Press, 1980), 153.

[515] Starr, *The Social Transformation of American Medicine*: 162.

[516] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 59.

[517] According to Bonner, America's early colonies sense of "isolation, independence, and new conditions and needs" were among the reasons that medical education took on variations of British practices. Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945*: 15.

developed into hospitals. The earliest public almshouse, opened in about 1731, that evolved into a hospital, would become the Philadelphia General Hospital.[518] What is now recognized as a “familiar symbiosis” between hospitals’ caring and curing functions, and medical education developed gradually.[519] However, support for the first hospitals often included appeals to the potential educational function of the wards. Such was the case when Benjamin Franklin appealed to the Pennsylvania Provincial Assembly in 1751 to support a hospital.[520] In an eloquent commencement speech to New York medical school graduates in 1819, Samuel Bard summed up how important hospital wards were for providing medical education:

> [I]n the study of diseases, and in the practice of medicine, no histories, however accurate—no reasoning, however just—can convey the knowledge necessary for their treatment and cure. The student must see, and hear, and feel for himself. The hue of the complexion the feel of the skin, the luster or languor of the eye, the throbbing of the pulse and the palpitations of the heart, the quickness and ease of respiration, and the tone and tremor of the voice, the confidence of hope, and the despondence of fear, as they are expressed in the countenance, baffle all description; and yet all and each of these convey important and necessary information. Where can these be learned but at the bedside of the sick? And where shall a young man, who cannot be admitted into the privacies of families, or the chambers of women, acquire this necessary information, but in a public hospital, which is not only intended as an asylum to relieve the complicated misery of poverty and sickness, but as a school of medicine, to contribute to the public welfare…[521]

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[518] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 10.

[519] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 190.

[520] Ibid; Rosemary Stevens, "'A Poor Sort of Memory': Voluntary Hospitals and Government before the Depression," *Milbank Memorial Fund Quarterly/ Health and Society* 60, no. 4 (1982): 552-553.

[521] Samuel Bard, *Two Discourses Dealing with Medical Education in Early New York* (New York, NY: Columbia University Press, 1921), 19-20.

Thus, the teaching function of hospitals was almost invariably a reason that physicians promoted hospitals.[522] The physician founders of the Massachusetts General Hospital began their first letter to fellow Bostonians on the need for a hospital with the claim that the hospital would not be merely an almshouse but would embrace "a two-fold object--the relief of the sick, and the instruction of medical students."[523] The need to improve the education of physicians was undoubtedly real. The educational function of hospitals, at a time when most Americans, and particularly the most influential Americans, would not have considered entering a hospital, served to align the motives of the physicians and community leaders and portray the hospital as a place that benefited the community beyond the direct functions of providing care for the poor. Each community, especially if the call to providing a proper medical education were unheeded, would suffer the consequences. In Boston in 1810, the founding of a hospital which included the education of physicians was portrayed as essential to everyone in the region:

> Those who are educated in New-England have so few opportunities of attending to the practice of physic,[sic] that they find it impossible to learn some of the most important elements of the science of medicine, until after they have undertaken for themselves the care of the health and lives of their fellow citizens…With such deficiencies in medical education, it is needless to show to what evils the community is exposed.[524]

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[522] Atwater, "Internal Medicine," 151.

[523] Harvey Cushing, "The Personality of a Hospital," in *Massachusetts General Hospital: Memorial and Historical Volume Together with the Proceedings of the Centennial of the Opening of the Hospital* (Boston, MA: Griffith-Stillings Press, 1921), 22.

[524] Massachusetts General Hospital, "Journeys 2010: Massachusetts General Hospital Annual Report " Massachusetts General Hospital, http://www.mgh.harvard.edu/assets/pdf/AR2009lr.pdf (accessed March 14, 2013).

It was not until the period of time between roughly 1870 and 1917 that the "American hospital was transformed from an asylum for the indigent into a modern scientific institution."[525]

Another way in which hospitals had a greater influence in medical education than their numbers would suggest was in the hospital amphitheater. Operating rooms were not a feature of hospitals until late in the nineteenth century, so that surgery was often performed in hospital amphitheaters.[526] The patients operated on in the surgical amphitheaters were invariably poor. Throughout most of the nineteenth century, dependence and social class were as much a part of hospital services as illness and disease.[527] Major surgical operations at the hospital required the "conjunction of poverty with a handful of then-operable surgical conditions."[528] Even in the case of accidents, the severity of injuries did not distinguish those who were hospitalized from those who were brought home for care; only an inadequate or nonexistent home brought the truly unfortunate to the hospital.[529]

When American physicians traveled to Europe for medical education, they encountered hospital educational facilities that generally relied upon teaching in large

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[525] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 17.

[526] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 45.

[527] This point is a major theme or Charles Rosenberg's book. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 5, 19, 337.

[528] Ibid., 28.

[529] Morris J. Vogel, "Patrons, Practitioners, and Patients: The Voluntary Hospital in Mid-Victorian Boston," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: University of Wisconsin Press, 1997), 325.

amphitheaters in Great Britain, France, and Germany.[530] In the Paris hospitals as many as two thousand students would fill a large amphitheater.[531] As in Europe, hospitals in America built amphitheaters that served a variety of educational functions, not only teaching surgical techniques, but also performing autopsies and providing clinical or didactic lectures. Pennsylvania Hospital had an amphitheater which was used for clinical lectures beginning in 1804. The Philadelphia General Hospital had an amphitheater seating 800 people at about this time.[532] Charity Hospital in New Orleans built an amphitheater in 1848 that would seat 600.[533] The role of the amphitheater in medical education increased throughout the nineteenth century. One medical student in 1890 at the University of Pennsylvania described "what were called clinical lectures in the pit of a huge amphitheater. The patient would be brought in and the several hundred students on the benches could see him, but they learned very little in a practical way from that kind of exercise."[534] Yet, the same student was able to recall the alternative of ward rounds resulting in the examination of no more than two or three patients during his entire course of medical school. The value of amphitheater teaching had some staunch supporters and some physicians, such as one founder of the Mayo Clinic, is reported to have learned and later described detailed accounts of surgeries viewed in an

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[530] Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945*: 109, 124, 129.

[531] Ibid., 321.

[532] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 48.

[533] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 63.

[534] David Riesman, "Clinical Teaching in America, with Some Remarks on Early Medical Schools," *Transactions and Studies of the College of Physicians of Philadelphia* 4th, no. 7 (1939-1940): 100, quoted in Atwater, "Internal Medicine," 158.

amphitheater.[535] William Osler held an amphitheater clinic weekly at Johns Hopkins at the turn of the nineteenth century.[536] In the year 1901, the Philadelphia General Hospital reported that 13,547 medical students had been in attendance for at least some clinical lectures at the amphitheater.[537]

Whether used for demonstrations on the clinical findings of medical patients, teaching surgical techniques, or displaying the methods and findings at autopsies, these hospital amphitheaters relied upon poor patients as a source of "clinical material." In contrast, paying patients were rarely subjected to being used in teaching. At the turn of the nineteenth century when hospitals were beginning to house some private paying patients both pecuniary considerations and deeply ingrained social assumptions meant that these patients would not be used in teaching.[538] Even after death, social position mattered. It was a "grim reality" that autopsies were customarily only performed on the poor.[539] Once anesthesia was routinely in use, the "dignities of class" continued, and private patients were not subjects of teaching while unconscious.[540] People more likely to be poor, such as immigrants and free or slave African Americans, were

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[535] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 64; Gert H. Brieger, "Surgery," in *The Education of American Physicians: Historical Essays*, ed. Ronald L. Numbers (Berkeley, CA: University of California Press, 1980), 185.

[536] Michael Bliss, *William Osler: A Life in Medicine* (New York, NY: Oxford University Press, 1999), 224; Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 109.

[537] Charles Rosenberg, "From Almshouse to Hospital: The Shaping of Philadelphia General Hospital," *Milbank Memorial Fund Quarterly/ Health and Society* 60, no. 1 (1982): 142.

[538] ———, *The Care of Strangers: The Rise of America's Hospital System*: 259.

[539] Ibid., 275.

[540] Ibid., 294.

disproportionately represented in hospital wards, amphitheaters, and postmortem examinations.[541]

Dr. Benjamin Cotting recounted in the pages of the predecessor journal to the *New England Journal of Medicine* at the end of the nineteenth century, that one of his first private patients had a cancerous ulcer of the breast for which she sought the opinions of several well-regarded Boston physicians. The woman chose to have Dr. Cotting perform the necessary operation but the advice of many of his professional friends was "not to attempt so serious a matter, suggesting that, leaving out the possible return of the disease with ultimate fatal result, there was the possibility imperfect performance, the risk of loss of self-possession in case of unexpected emergencies, and other like chances."[542] On the urging of one physician mentor, Dr. Cotting agreed to perform the surgery with the assistance of five physicians, largely because he had "while a student, performed quite a number of severe surgical operations in almshouse practice, some of magnitude, severity and danger, quite equal to that proposed; and therefore hesitated less than if it were a first trial."[543] In a sense, Cotting's ability to perform the operation meant that the educational function of the almshouse hospital was fulfilling the purpose of allowing the charity patient to provide the clinical experience which would then be utilized for the private patient.

There is little reason to believe that European practices related to medical education and charity care differed significantly from American practices during most of

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[541] The poor who may require hospitalization included anyone who whose lost income due to illness would tip the balance toward indigence. Ibid., 102.

[542] Benjamin Cotting, "A Bit of Professional Reminiscence, Etherwise and Otherwise," *Boston Medical and Surgical Journal* 136 (1897): 1.

[543] Ibid.

the nineteenth century. As in the United States, advocates of providing charity medical services relied on a variety of reasons: moral, economic, public health-related, and reasons primarily related to maintenance of social order. In 1842 a British surgeon declared: “[M]orally speaking; it must be a wicked act in any person, or body of persons, to withhold or improperly provide that medical advice and assistance to the poor which it is in their power and their duty to give.” Both private individuals and public entities must provide for the general good “where it is coupled with power, with humanity, charity, and a due and faithful consideration for the real wants and feelings of our inferiors.”[544] Also in Great Britain, it was acknowledged that hospital admission might rest on whether “the nature of their diseases was a subject of interest to the medical or surgical officers.”[545] The Paris hospitals were envied for their enormous number of cases and the unfettered ability to autopsy indigent patients, yet the harshness of the clinicians was often criticized by Americans. On his return to Boston, one young man described a leading French clinician: “For brutality I do not think his equal can be found. If his orders are not immediately obeyed, he makes nothing of striking his patient and abusing him harshly. A favorite practice of his is to make a handle of a man’s nose, seizing him by it and pulling

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[544] J. D. Jeffery, "Thoughts on the Poor-Law, with Reference to the Medical Care of the Poor," *Provincial Medical and Surgical Journal (1840-1842)* 3, no. 27 (1842).

[545] Bennett Lucas, "Clinical Lectures Delivered at the Metropolitan Free Hospital, Lecture I," *Provincial Medical and Surgical Journal (1840-1842)* 5, no. 115 (1842): 217.

him down on his knees."[546] While there were reports of abuses in American hospitals, there has been no ability to quantify these.[547]

In central Europe during the second half of the nineteenth century thousands of American physicians received specialty training. The establishment of these clinical specialties was a result of "work in urban public hospitals that provided free care for the poor."[548] Between 1870 and 1914 about 10,000 Americans studied in Vienna and about 3,000 in Berlin. At Vienna's General Hospital, all of the postmortem cases were routinely autopsied. As the medical historian Charles Rosenberg has noted: "The demands of clinical investigation could be as absolute and all-encompassing as those of traditional benevolence, and the authority of science could be as transcendent as that of a more conventional piety."[549] The large number of patients available for study in these cities provided the opportunity for specialty training at a time when most medical school professors in America were generalists.[550] In the 1870s and 1880s it was uncommon for specialists to be allowed privileges at hospital teaching wards in America since "[c]ontrol of wards meant control of informal, but often lucrative, teaching opportunities, of clinical decision making, of the raw material for articles and books."[551] By the first decades of the

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[546] Howard Payson Arnold, *Memoir of Jonathan Mason Warren, M.D* (Boston,MA: Privately Printed, 1886), 85, quoted in Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 41; Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945*: 139.

[547] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 365.

[548] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 100.

[549] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 276.

[550] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 101.

[551] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 173.

twentieth century, however, specialization gradually became integrated into hospital structure, serving to exemplify the image of the hospital as a scientific institution.[552]

Attitudes by and about Charity Patients in the Late Nineteenth Century

On the wards in America, the expectations of what would be learned about the relationship between the ward or charity patients and the fledgling physicians were sometimes acknowledged openly and often conflicted, though unacknowledged or tacit learning was undoubtedly at least as important as what was openly stated for medical students. A professor of surgery at Massachusetts General Hospital remarked in an 1849 address: "Clinical study is bed study. Here the student closes and grapples with the malady of whose Protean forms he has as yet only read. Here he learns at once the language of disease and the language of suffering humanity; and if his scientific sense is educated, his kindlier feelings are also developed."[553] Though these professor's words encompass care not just for poor patients, the idea that contact with human suffering will cultivate kindliness is explicit.

The realities of the ward meant that students observed suffering of many kinds and it became "familiar very quickly."[554] Yet the process of objectifying the poor began before students came to the wards. In advertisements and brochures for medical schools, the abundance of "clinical material" was stressed. In New Orleans, for example, the Charity Hospital admitted over 18,000 patients annually in 1849, most of whom were

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[552] Ibid., 174-175.

[553] Henry J. Bigelow, *An Introductory Lecture, Delivered at Massachusetts Medical College, November 6, 1849* (Boston, MA: David Clapp, 1850), 5.

[554] Stowe, *Doctoring the South : Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century*: 57.

poor and "outsiders" because the city was a major seaport. Notices from the New Orleans medical school stressed both the clinical material available at the hospital as well as the bodies available for dissection.[555] Harvard Medical School assured prospective students that at Massachusetts General Hospital "indigent patients from any part of the continent, requiring surgical operations, are received, supported, and attended gratuitously at the Hospital."[556] That some medical school advertisements also wildly exaggerated their facilities and their affiliations with hospitals was also often remarked upon.[557] When Abraham Flexner surveyed American medical schools in 1909 he scathingly attacked advertisements: "The school catalogues abound in exaggeration, misstatement, and half-truths. The deans of these institutions occasionally know more about modern advertising than about modern medical teaching."[558] Specifically noting that private hospital beds were not available for teaching, Flexner challenged the University of Illinois' brochure citing that the University of Illinois Hospital "contains one hundred beds, and its clinical advantages are used exclusively for the students of this college," when over half of the beds were actually private and therefore not available for teaching purposes.[559]

The attending physicians and preceptors in the early years of the nineteenth century had made it clear that "their service at the hospital implied the right to use the

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[555] John Duffy, *From Humors to Medical Science : A History of American Medicine*, 2nd ed. (Urbana, IL: University of Illinois Press, 1993), 133.

[556] J.C. Warren, "Administration: Care of Patients General Statements Concerning," in *Some Account of the Medical School in Boston, and of the Massachusetts General Hospital*, ed. Massachusetts General Hospital (Boston, MA: Phelps and Farnham, 1824), 9, quoted in Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 196.

[557] Martin Kaufman, "American Medical Education," in *The Education of American Physicians: Historical Essays*, ed. Ronald L. Numbers (Berkely, CA: University of California Press, 1980), 13.

[558] Abraham Flexner, *Medical Education in the United States and Canada* (New York, NY: Carnegie Foundation for the Advancement of Teaching, 1910), 19.

[559] Ibid.

wards for instructing their apprentices."[560] This sense of *quid pro quo* whereby the "objects of charity who filled a hospital's bed could hardly refuse to cooperate in clinical teaching; it was the principle way in which they could repay society for the gratuitous care they received," coexisted with strong notions of Christian charity and benevolence and professional obligations to provide charity.[561] A physician who was to practice at Harvard for forty years wrote to his parents in 1869 that a hospital position would provide him with immediate professional stature and contacts, but also such a position would provide "access to the pool of charity patients that provided indispensable raw material for scholarly work and publications."[562] By the beginning of the twentieth century, according to a New York Commissioner of Health, the prospect of the limitless knowledge that science offered meant that hospitals should not stand in the way of such progress by clinging to outdated sentimentality over patients:

> In wet-blanketing the ardor of scientific enthusiasm, in shutting their doors in the face of the research worker and its medical students, hospitals have abandoned their claims to distinction and have stunted their own growth. Sentimentality has commanded them to lock up their priceless storehouses of knowledge, and medical science in America has been half starved in consequence.[563]

Most accounts of what patients may have experienced in nineteenth century hospitals related to medical education are from secondary sources. A particularly riveting account of how a journalist felt and what he perceived a patient and others in the

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[560] Rosenberg, "From Almshouse to Hospital: The Shaping of Philadelphia General Hospital," 141.

[561] ———, *The Care of Strangers: The Rise of America's Hospital System*: 190.

[562] Ibid., 168.

[563] Sigismund S. Goldwater, "The Unfinished Business of General Hospitals," *Medical Record* 73 (1908): 982, quoted in Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 332-333.

audience to be feeling while watching an operation in the amphitheater of the New Orleans Charity Hospital was written in 1859:

> One of the most exciting spectacles to be witnessed in the institution [Charity] is seen when fifty or a hundred students crowd the couch of some patient who is about to undergo an important surgical operation. The trembling expectancy of the terrified subject, the nervous pallor of the medical tyros, who are about to see a man's leg or arm whipped off for the first time; the careless nonchalance of the hospital habitués; the giant form of that veteran man of the knife, Dr. Stone, as with cuffs thrown back, eyes all ablaze, his lips firmly clenched, he prepares to make the adroit thrust; the quick prefatory whirl of the well-grasped blade; the sudden flash of polished steel; the dull, muffled sound of the yielding flesh, the spirt [sic] of blood, the scrape of the keen edge upon the solid bone, the sharp cry of the patient, followed by the heavy moan of pain—these are the outlines of a picture that thrills and terrifies the uninitiated beholder.[564]

However sparse the accounts by patients are, one eminent historian has stated that there is "abundant evidence that patients did in fact fear the invasion of their bodies and privacy by student hands and eyes."[565] Not only fear, but shame played a role as well when alms were required in the form of charity medical care. It is not easy to say whether the humiliation of charity was alone the cause of stigma that many people tried to avoid if at all possible by paying a fee for the "part-pay wards" or whether there was a combined effect of loss of dignity from multiple sources, including the added indignity of being used in teaching. However, when a person had any means to provide payment there was a strong incentive to do so.[566] This is one reason, in addition to a desire for a religious bond, that Catholic hospitals, which charged their patients small fees, were popular.[567]

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[564] Duffy, *From Humors to Medical Science : A History of American Medicine*: 99.

[565] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 207.

[566] Though see later in this chapter how payment for medical services did not necessarily change a patient's status to not-a-charity patient.

[567] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 111.

There were a range of complex attitudes and emotions expressed by medical students and physicians filling house officer assignments at hospitals about their patients. A house officer position existed as early as 1788 at the Philadelphia almshouse in the form of a resident apothecary. The Baltimore almshouse had a resident physician in 1818.[568] By the middle of the nineteenth century full-time positions as house officer were highly sought after and were filled with graduates from medical school. By 1914 more than three-fourths of medical school graduates went on to an internship.[569] There seems to be no doubt that hospitals were, at least initially, strange and frightening to these aspiring practitioners. Social and cultural assumptions as well as stereotypes and bias were often expressed about the patients students and residents encountered. Attending physicians tended to reinforce cultural assumptions as well. Both poor patients and patients of racial or ethnic minority groups were sometimes viewed not only in terms of quid quo pro for teaching, but also as having different sensibilities (than "us") when used in teaching. Thus one physician commented that: "the negro [sic] is more docile and does not object to being used in clinic for teaching purposes and is one of the most prolific sources in the study of medicine."[570] At Massachusetts General Hospital in 1851, a trustee was alarmed at the number of Irish laborers requiring care and suggested that a cheaper structure house these patients because: "They cannot appreciate and do not really

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[568] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 16.

[569] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 63, 68, 210.

[570] Wayne Smith, "Scientific Economic and Humane Conduct of Municipal General Hospitals in the Southern States," *Transactions of the American Hospital Association* 16 (1914): 280, quoted in Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 302.

want, some of those conveniences which would be deemed essential by most of our native citizens."[571]

One historian has interpreted how students felt about patients as a stance of charity:

> The closest approach most students seem to have made to fellow feeling with patients was not in terms of sympathy but in terms of charity—a very different calculus of caregiving. By adopting charity as a posture toward the sick, students gave a distinct texture to the tangled matter of class, emotion, and caregiving that they were learning along with techniques in amputations and childbirths. Thinking of oneself as acting charitably in the patient's best interests was a cleanly functional and self-protective image of doctoring. It acknowledged—indeed, expanded—the distance between doctor and patient, allowing the former to disengage emotionally while also giving him a welcome opportunity to smooth out disturbing issues of power, work, and his authority.[572]

The gulf between medical students, house officers, attending physicians, and the patients who were treated at hospitals reflected and, indeed, mirrored, the social distance and difference between these two groups in society. "Charity" in this sense embodied both a real and ideological hierarchy. These experiences on hospital wards could leave compassion essentially unaddressed. It is not entirely clear if, or how, trainees transitioned from hospitals where compassion was difficult, and condescension and contempt common, to cultivating this most important aspect of community practice.[573] Clearly the hospital remained "a microcosm of the social relationships and values that prevailed outside the institution."[574]

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[571] N. I. Bowditch and George Edward Ellis, *A History of the Massachusetts General Hospital*, 2d ed. (Boston, MA: Printed by the Trustees from the Bowditch fund, 1872), 366, quoted in Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 42.

[572] Stowe, *Doctoring the South : Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century*: 58.

[573] Ibid., 58-59.

[574] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 297-298.

There was often a struggle, not only with power, over the management of hospitals, but also with different ideologies over the purpose of hospitals. In 1887 a New York Hospital executive warned that physicians and medical staff members may be more concerned with professional interests than patient care and dignity, and that unless cases were "interesting" patients would be discharged "often half-cured, and sometimes without any benefit at all."[575] One young doctor recognized that hospital physicians were sometimes less understanding than the lay board members of the hospital when both examined applicants for hospital admission, concluding that: "It must be confessed that the young medical man was often too disposed to be sarcastic, cynical, suspicious, and anxious to drive away every applicant who did not bear in his or her body the symptoms of being an interesting medical or surgical case."[576] Hospitals could and did change admission criteria, establish particular services, provide payments or housing expenses, or advertise for free treatments to make patients available for teaching purposes.[577]

Concerning how patients ought to feel about the care they receive, there tended to be a convergence between lay hospital board members and the physicians in that both groups expected patients receiving care to be grateful. Thus a committee member enthusiastically described a woman who had a prolonged hospital course as having the appropriate deference and grateful character: "Such an instance of patience under suffering, and of gratitude to all around her; connected with such abject indigence, will, I think, stimulate every member of this board to double their exertions to promote the

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[575] Board of Governors New York Hospital, "Minority Report to Special Committee Report on Training School and Outpatient Department," (New York, NY: New York Hospital, 1887), quoted in Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 275.

[576] ———, "From Almshouse to Hospital: The Shaping of Philadelphia General Hospital," 133.

[577] ———, *The Care of Strangers: The Rise of America's Hospital System*: 207.

interests of the institution."[578] An appropriate display of gratitude was one means of ensuring continued support from trustees and benefactors.

Gratitude was not just a preferred attitude; it was enforced by law through charitable immunity for hospitals. In 1875 a man sued the Massachusetts General Hospital for negligence and incompetence when, after receiving free treatment, he claimed his broken leg had been set improperly. The court held that a charitable institution was not liable even if negligence and incompetence had occurred. In a similar case, a letter to the newspaper complained that "there are some patients so wholly devoid of ordinary gratitude for favors to which they had not a shadow of a claim, as to make their benefactors suffer by reason of their very kindness."[579] This type of charitable immunity was actively used to protect nonprofit hospitals until the mid-1970s.[580]

Thus, a person whose status was "charity patient," received medical care on the basis of a legal standard which differed from the legal standard of care of people who were not charity patients.[581] Institutions were able to maintain the differences between charity and paying patients also by clearly limiting educational activities to charity patients. For example, at the University of Michigan near the turn of the nineteenth

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[578] Ibid., 50.

[579] Vogel, "Patrons, Practitioners, and Patients: The Voluntary Hospital in Mid-Victorian Boston," 331.

[580] Bradford H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals* (Cambridge, MA: Harvard University Press, 1991), 65. Charitable immunity doctrines are still present in some states, for instance Massachusetts limits the liability of nonprofit hospitals to $20,000. See Kenneth R. Kohlberg, "Modern Reflections on Charitable Immunity," *Massachusetts Law Review* 89, no. 4 (2006).

[581] For the current legal standards for volunteer physicians, see, for example: Salinsky, "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net."; American Medical Association, "State Listing of Licensing Provisions and Liability Laws," American Medical Association, http://www.ama-assn.org/ama1/pub/upload/mm/22/state-licensing.pdf (accessed March 14, 2013).; and Lisa Benrud, Jacqueline Darrah, and Alison Johnson, "Liability Considerations for Physician Volunteers in the U.S.," American Medical Association, http://virtualmentor.ama-assn.org/2010/03/hlaw1-1003.html (accessed March 14, 2013).

century, there was a policy of not charging patients when students were allowed to observe an operation. In Charleston, a surgical bill was protested on the grounds that students had observed the operation.[582]

Dispensaries at the Turn of the Nineteenth Century Were Important for Medical Education

Hospital wards and amphitheaters were not the only places that poor patients became subjects of teaching. As noted in Chapter 1, Charles Rosenberg attributes the growth of outpatient clinics for the poor, known as "dispensaries," in late nineteenth century America to the fundamental relationship between the dispensary and the world of medical education and status. Throughout their existence, the dispensaries were supported explicitly for a complex set of reasons. Often there was a deeply felt sentiment of empathy and benevolence for the sick poor seeking relief from disease at the dispensary. At the other extreme, the dispensary, almost always supported by private contributions, could save taxpayer dollars by keeping the sick poor out of the public almshouse and able to continue to work. Any chance that a contagious disease might spread from the tenements to the wealthier parts of town would also be curtailed.[583] This mixture of motives from the standpoint of communities—benevolence, social control, and public health interests—was not unlike the mixture of reasons that drove the relationship between charity care at the dispensary and medical education.

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[582] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 414.

[583] ———, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," 311-312; ———, *The Care of Strangers: The Rise of America's Hospital System*: 199, 207.

Physicians also expressed altruistic motives for working at the dispensaries, which were most often free for patients.[584] At the same time, physicians had several self-interested reasons to seek a dispensary position. Ambitious young physicians who formed the core of the medical elite almost always had hospital and dispensary appointments. In this way, these physicians became connected to city leaders, philanthropists, and seasoned physicians who were on the boards of managers. It was well-recognized that dispensaries filled a "pedagogical void."[585] This void had consequences affecting patients which were explained in 1894 as follows:

> The "poor man's doctor" is too often either inexperienced or incompetent or worse, a scheming quack from whom the poor should be protected…Through the dispensaries, with their carefully selected physicians, the poor classes have the benefit of the best service. This is true economy for the saving of health and wealth. It is this knowledge that nerves the more fastidious among the poor to submit themselves to the ordeal of the free clinic."[586]

This quotation presents a mixed picture. Clearly the benefits to poor people included protection from incompetent, or worse, physicians. At the same time, there was also an understanding that dispensaries were "ordeals" for these patients. The dispensaries were sometimes referred to as "medical soup kitchens," where the needs of doctors-in-training for exposure to patients superseded the health needs of patients. In fact, in a door-to-door survey of people living in New York in 1913, over half of the people who were sick were

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[584] Though see Chapter 1 for the historical evidence that dispensaries were not necessarily free.

[585] Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," 312.

[586] Charles Savage, "Dispensaries Historically and Localy Considered," in *Hospital, Dispensaries, and Nursing: Papers and Discussions in the International Congress of Charities, Correction and Philanthropy, Section III, Chicago, June 12th to 17th 1893*, ed. John S. Billings and Henry M. Hurd (Baltimore, MD: Johns Hopkins Press, 1894), 647.

not getting any treatment in part because of the fear of going to a dispensary.[587] The surveyors reported that, of those people who went to a dispensary, less than a third returned because of the "unbearable conditions,"[588] which included overcrowding, long waits, and lack of relief of symptoms. A summary of these complaints included "abusive language, lack of examination, and inefficient treatment."

As in the hospital setting, the social distance between patients and physicians was almost "unbridgeable" in the dispensaries.[589] Even sympathetic physicians who understood well the connections between poverty and disease and the influence of squalid conditions tended to share the "ambivalence and even hostility" of peers toward the patients.[590] Differences in social class, religious customs, racial and ethnic origins, language, and the pervasive effects of poverty, combined with a belief in the distinction between the worthy and unworthy among the poor led to the decline of dispensaries once the professional and educational benefits to physicians lessened.

The Twentieth Century Development of Medical Schools Led to Struggles for Control of Hospitals

At the beginning of the twentieth century, obtaining control of hospitals was a top priority for medical schools.[591] Throughout the nineteenth century, hospitals were

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[587] Starr, *The Social Transformation of American Medicine*: 182-184.

[588] George McAneny and Henry Wright, eds., *Report of the Committee on Inquiry into the Departments of Health, Charities, and Bellevue and Allied Hospitals in the City of New York* (New York, NY: J.J. Little and Ives Company, 1913).

[589] Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary," 315.

[590] Ibid., 316.

[591] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 155-165.

established and operated primarily as responses by the local community to health care needs among residents with lower socioeconomic status. Hospitals were most often run by lay boards of trustees who hired a supervisor. Among these hospital administrators, there were several reasons to resist an educational role for their institutions. At some hospitals, educational functions were seen as competing or conflicting with placing the care of sick patients as the highest priority or as incompatible with the charitable purposes of hospitals. Thus, the board of trustees of Roosevelt Hospital in New York stated in a letter to Columbia Medical School in 1910 that they "have no power to divert the funds under their care from charitable to educational purposes."[592] At Blockley Hospital in Philadelphia, the trustees were concerned about "whether it is consistent with our duty toward these unfortunate inmates of the Hospital to place them in [the] charge of mere novices who never had a case before entering its wards."[593]

In the case of Roosevelt Hospital, the objections to becoming a teaching hospital for Columbia were led by an eminent physician and former dean of the very same medical school.[594] The trustees at Massachusetts General Hospital firmly resisted complete control of the hospital by Harvard Medical School. In a 1937 history of the hospital, a trustee was quoted as offering the following advice:

> The Trustees have always maintained their independence, not forgetting that the functions of the hospital are the kindly care of the patient, research into the cause of disease, and the advancement of the public health, as well as medical education. It has not been lost upon them that in some hospitals dominated by medical schools, zeal for medical education outweighs the well-being of the

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[592] Ibid., 163-164.

[593] William S. Middleton, "Clinical Teaching in Philadelphia Almshouse and Hospital," *Medical Life* 40 (1933): 215, quoted in Atwater, "Internal Medicine," 152.

[594] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 160-165.

> patients… may Trustees always remember that there should be co-operation with, not domination by the Medical school"[595]

When the officials at Massachusetts General Hospital sought tax funds from the state legislature in the early nineteenth century, the legislature was assured that the hospital had no intention of allowing "students in medicine an opportunity to experiment, at the expense of the feelings, health, and lives of the poor patients."[596]

That the hospitals' charitable purpose differed from the aims of medical schools was understood by Abraham Flexner. In his 1910 publication on medical education, Flexner stated: "It is commonly represented that medical schools are benevolent enterprises, to which selfish financial considerations are nowadays quite alien. Such is not even generally the case."[597] Flexner repeatedly sought, not to change the charitable purpose of hospitals, but to align medical education with its social function: "The medical profession is a social organ, created not for the purpose of gratifying the inclinations or preferences of certain individuals, but as a means of promoting health, physical vigor, happiness—and the economic independence and efficiency immediately connected with these factors."[598] Flexner envisioned a future for medical education which would uphold university-based medical schools, end proprietary medical schools, and place medical education within the domain of public and state interest and regulation: "Practically the medical school is a public service corporation. It is chartered by the state; it utilizes

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[595] Frederic A. Washburn, *The Massachusetts General Hospital; Its Development, 1900-1935* (Boston, MA: Houghton Mifflin Company, 1939), 99, quoted in Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 112-113.

[596] Atwater, "Internal Medicine," 152.

[597] Flexner, *Medical Education in the United States and Canada*: 126.

[598] Ibid., 42.

public hospitals on the ground of the social nature of its service. The medical school cannot then escape social criticism and regulation."[599]

While Flexner believed that hospital and dispensary work were essential to medical schools, he recognized that both of these practices had additional purposes so that there should be a delineation of the responsibility for financing these separate but parallel tasks. As a practical matter, funding for hospitals, in his view, would continue as it had for patient care. Thus, "the hospital discharging simultaneously a philanthropic office may…be provided for independently of school funds and yet be as intimately a part of the educational organization as if teaching were its main purpose."[600] Henry Pritchard, in the introduction to Flexner's report, is quite emphatic about the role of hospitals in medical education:

> A hospital under complete educational control is as necessary to a medical school as is a laboratory of chemistry or pathology. High grade teaching within a hospital introduces a most wholesome and beneficial influence into its routine. Trustees of hospitals, public and private, should therefore go to the limit of their authority in opening hospital wards to teaching, provided only that the universities secure sufficient funds on their side to employ as teachers men who are devoted to clinical science.[601]

Funds for teaching clearly, according to Flexner, devolves to medical schools: "However the hospital and dispensary are supported, the teaching budget of the clinical years is necessarily a charge upon the funds of the medical school."[602]

Other reasons that hospital trustees resisted affiliating with medical schools included doubts about the abilities and sentiments of medical students. After Charles

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[599] Ibid., 154.

[600] Ibid., 130-131.

[601] Ibid., xi.

[602] Ibid., 132.

Eliot become President of Harvard University, he stated in his first report in 1870: “The ignorance and general incompetency of the average graduate of American Medical Schools, at the time when he receives the degree which turns him loose upon the community, is something horrible to contemplate.”[603] This was a reflection of both minimal entrance requirements and poor education in medical schools. In 1900 only 15 to 20 percent of medical schools required a high school diploma for admission.[604] Medical students had a reputation of being uncouth and unruly.[605] Trustees had broad clinical authority and were “reluctant to relinquish patient control to practitioners and their students, whom they considered unregulated and unpracticed.”[606] Administrators observed, for example, at Sloane Maternity Hospital in 1901 that the wards were barren when school was in session, because: “The women dread nothing so much as the knowledge that students are to be present.”[607] In San Francisco in 1889, the hospital officials warned its house physicians that patients were to be “treated with the dignity that befits sick people.”[608] The poor quality of medical students was highlighted in 1902 when

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[603] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 48.

[604] Ibid., 113.

[605] Albert R. Jonsen, *A Short History of Medical Ethics* (New York, NY: Oxford University Press, 2000), 67.

[606] Elizabeth Robilotti and David Rosner, "The Trustee's Dilemma: Hospitals as Benevolence or Business--Looking Back a Century," in *The Ethics of Hospital Trustees*, ed. Bruce Jennings (Washington, DC: Georgetown University Press, 2004), 25.

[607] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 415.

[608] ———, "And Heal the Sick: The Hospital and the Patient in the 19th Century America," *Journal of Social History* 10, no. 4 (1977): 438.

only eighteen out of eighty-seven candidates, all graduates of medical schools, were deemed fit for military medical service.[609]

As long as medical schools operated independently of universities, and for the profit of their professors, it was unlikely that philanthropists could be encouraged to create endowments for medical schools. Educational reform was, therefore, tied to the goal of expanding opportunities for clinical instruction in hospitals. At the same time, hospital administrators came to understand that, at least in some instances and particularly with large donations, benefactors no longer wished to support the traditional charitable functions of hospitals, instead preferring to fund medical schools. This change in where philanthropic medical funding was targeted served to better align the incentives for hospitals and medical schools to become affiliated. In 1891, medical schools received $500,000 in endowment funds. By 1934, medical schools received a total of $150 million in endowment funds from just nine prominent foundations.[610] As the editor of *JAMA* stated in 1940: “From 1914 to 1929, medicine became the pet of the philanthropies.”[611] President Eliot of Harvard remarked in 1907: “Gentlemen, the way to get endowment for medicine is to improve medical education.”[612] He was referring to the addition of four

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[609] Robert F. Weir, "Society Report: New York Academy of Medicine," *Medical Record* 62, no. 26 (1902): 1030.

[610] Rosemary Stevens, *American Medicine and the Public Interest*, Updated ed. (Berkeley, CA: University of California Press, 1998), 56.The medical historian, Richard Shryock, notes that between 1900 and 1930 the United States had become the richest nation of all time. Possession and control of this vast American wealth became increasingly concentrated; the number of millionaires in 1914 was about 4,500 and, in 1926, this number was 11,000. Richard Harrison Shryock, *American Medical Research, Past and Present*, Three Centuries of Science in America (New York, NY: Arno Press, 1980), 80-81.

[611] Morris Fishbein, "Medical Education - 1905 to 1940," *Journal of the American Medical Association* 114, no. 13 (1940): 1148.

[612] Charles W. Eliot, *American Medical Association Bulletin* 3 (1907): 263, quoted in Stevens, *American Medicine and the Public Interest*: 60.

million dollars in endowment funds received by Harvard Medical School once the admission criteria included a college degree.

It is too simplistic to say that support for care of the sick poor was in direct competition with support for medical schools since schools were also seeking to align with hospitals so that their charity wards could more thoroughly be used in clinical teaching, yet there is an element of competition for these philanthropic funds. Hospitals, however, tended to direct their fund raising requests to local wealthy men and women whereas medical education and medical research were objects of a national wealthy class.[613] John D. Rockefeller, for example, was unlikely to have contributed to a hospital for the sole purpose of providing funds to care for the sick poor. According to Rockefeller, "The best philanthropy, the help that does the most good and the least harm, the help that nourishes civilization at its very root, that most widely disseminates health, righteousness, and happiness, is not what is usually called charity."[614] In terms of resisting the education of physicians at their hospitals because resources were viewed as properly directed at their hospital patients, trustees overcame their reluctance, in part, because of philanthropic gifts. By the mid-1920s income from endowments was the second largest source of income for medical schools.[615] It tended to be the case that the wealthiest medical philanthropists wished to support scientific medical schools and, like Rockefeller, this was viewed as "scientific philanthropy" and not charity.[616] It should be

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[613] E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley, CA: University of California Press, 1979), 100-101.

[614] Ibid., 18.

[615] Ibid., 175.

[616] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 148.

noted, though, that the role of philanthropy in medical education was not uniformly lauded. Suspicions about the Rockefeller Foundation were expressed succinctly in 1912 by a Los Angeles newspaper article: “monopoly-ridden masses don’t want charity under any guise, but justice.”[617]

Reform of medical education, the rise of hospital care, and the achievements in medicine resulting from the identification and cure of infectious disease, advances in surgical treatment, the development of technologies such as x-rays, all combined to make the ideal image of the hospital one that was affiliated with a university medical school.[618] The first American hospital survey had found 178 hospitals in 1873, in 1923 there were 4,978 hospitals.[619] Hospitals had become a pervasive feature of American communities. Thus, it was easier, as one dean commented, to “educate the trustees of existing hospitals to an appreciation of the value to their institutions of the use of patients as clinical material.”[620] The rise of teaching hospitals proceeded with great rapidity in the early twentieth century. In 1906, of the 162 medical schools in existence, only 92 had any hospital affiliation.[621] By 1921, every medical school in the country had established control of a hospital by ownership or affiliation.[622] In 1930 there were seventy-six

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[617] Editorial, *Los Angeles Record*, May 14, 1912, quoted in Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America*: 169.

[618] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 64.

[619] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 341.

[620] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 220.

[621] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 58.

[622] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 226.

medical schools, all rated acceptable and partly premised on the availability of a hospital affiliation.[623]

There was no single cause for this rapid shift. Although philanthropy served to align these interests, other economic interests were important. In one view, it had become "economically mandatory" for hospitals and medical schools to become affiliated in order for both to carry out their work.[624] State legislatures were lobbied to provide state university hospitals in conjunction with medical schools. With the publication and wide dissemination of the Flexner Report, it was seen as imperative to have medical schools and hospitals closely aligned.[625] Research carried on in their hospitals could bring the institutions world-wide fame. Indeed, clinical studies as well as observations were being published. For example, beginning in 1904, the Philadelphia General Hospital began listing a bibliography of the articles published based on the "clinical materials" at the hospital.[626] Medical school faculty in Ohio declared: "Every hospital should learn the fact -- that efficient teaching of medicine and surgery in its wards is promotive of the best interests and reputation of the hospital."[627] Medical school faculty had to succeed in their efforts to align with hospitals or risk, as many did, closure due to a low rating by the American Medical Association. Hospital trustees came to believe that a medical school alliance could ensure better patient care. According to the medical historian Kenneth Ludmerer, "[w]hether a teaching hospital would actually provide the best care was never

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[623] Ibid., 245.

[624] Ibid., 224.

[625] Ibid., 219-230.

[626] Rosenberg, "From Almshouse to Hospital: The Shaping of Philadelphia General Hospital," 141.

[627] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 227.

proved, only assumed, but it was an assumption that hospital and medical school officials made with ease."[628] In St. Louis a hospital official voiced the sentiment "that the best hospitals of today and those which accomplished the highest service are intimately connected with great medical schools."[629] Educational reforms played a significant role:

> Fears engendered by the presence of medical students in the wards, so common a generation earlier, had virtually disappeared. With the adoption of higher entrance requirements, the average student displayed far more intelligence and better manners than at any time previously. Medical students, given white coats and referred to as "young doctors," came to be accepted in the hospital as a matter of course.[630]

Exactly where patients needs and desires fit into this picture was, for the most part, not considered. In 1902, Professor Burwell of Harvard summarized a plan which required the close affiliation of a hospital and medical school where he outlined the participants:

> To make this plan effective it would be necessary that the three parties concerned, the student, the hospital, and the school, should each find it advantageous. It would be of advantage to the student, for he would gain that practical experience that he so keenly desired. It would be of advantage to the board of government of a hospital, for assistants would come to them from a responsible body, with regularity, having been trained for their duties. From the school's standpoint, the advantages were manifest. It would in an organized manner provide opportunity for students to acquire practical knowledge.[631]

Among the "three parties," there was no mention of the patient. By 1926, The Association of American Medical Colleges announced that every medical school had ward clerkships.[632] The clerkships were hailed by medical educators. Yet, the patient's

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[628] Ibid., 222.

[629] Ibid.

[630] Ibid., 230.

[631] Weir, "Society Report: New York Academy of Medicine," 1031.

[632] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 230.

role was also clear to medical faculty: “Patients must clearly understand from the beginning that they are admitted for teaching purposes and that they are to be willing to submit to this when pronounced physically fit.”[633] There was, then, a remarkable transformation in how hospital superintendents and trustees regarded their role in medical education. The idea that the priority of care for the sick in hospitals could come into conflict with educational purposes almost completely faded.

The Role of and Definition for Charity Care in the Early Twentieth Century

The question: “What is charity care?” did not often present itself in the nineteenth century. The two most common forms of charity were hospital charity care and charity care by physicians in the community, with the third most common form being dispensary care. These forms of charity care seemed relatively straightforward, charity care was care given to the poor for which the payments were foregone or made by philanthropists and taxes generated locally or sometimes statewide, but generally not by the poor and sick themselves, and, often the provision of this care was defined by or entailed no fees paid to practitioners.

Yet even in the nineteenth century, the exact definitions and boundaries of charity care were not uniform. The boundary between a charity patient and not-a-charity patient was not clear and it could change imperceptibly, at least in part because it was a term full of assumptions and lacking any fixed definition. Some patients who paid a portion of the cost of their own care at hospitals, dispensaries, and to community physicians were still

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[633] Ibid., 233.

considered charity patients.[634] At the same time, some of these patients intentionally paid whatever they could to avoid the designation of charity.

One view of the meaning of charity care at the beginning of the twentieth century is available in a classic legal case. The case, *Schloendorff v. Society of the New York Hospital,* is often cited as important in the history of informed consent and the right to self-determination in medical ethics and as an important, though now superseded, legal precedent for hospital charitable immunity.[635] *Schloendorff* was decided in 1914, although the events occurred in 1908.[636] Mary Schloendorff had lived most of her life in San Francisco where she was a "teacher of physical training, voice, and culture, of reduction and development" and she was in "perfect" physical condition prior to the 1906 earthquake.[637] After surviving the earthquake Mary Schloendorff fled to New York where her son lived. The ordeal left her "greatly frightened and nervous."[638] She sought medical care for "dyspepsia or indigestion" and eventually went to New York Hospital on the advice of her physician.[639]

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[634] This fact is discussed again in Chapter 4 on hospital charity care.

[635] The most often cited quote from Judge Cardova is: "Every human being of adult years and sound mind has the right to determine what shall be done with his own body." Tom L. Beauchamp, "Informed Consent," in *Medical Ethics*, ed. Robert M. Veatch (Sudbury, MA: Jones and Bartlett Publishers, 1997). See also Paul A. Lombardo, "Phantom Tumors and Hysterical Women: Revising Our View of the Schloendorff Case," *Journal of Law Medicine and Ethics* 33, no. 4 (2005).

[636] *Schloendorff v. Society of the New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).

[637] ———, "Phantom Tumors and Hysterical Women: Revising Our View of the Schloendorff Case," 795.

[638] Ibid.

[639] Ibid.

Mary Schloendorff was treated by Dr. Frederick Bartlett, a resident physician.[640] At this time New York Hospital had over a dozen interns living at the hospital in highly sought after positions.[641] Just prior to being discharged after a month of inpatient care, Mary. Schloendorff was told she had a “lump” in her abdomen. An attending surgeon, Dr. Lewis Stimson, was consulted but he could not confirm the lump and an “ether examination” was recommended. Mary Schloendorff testified that she repeatedly told Dr. Bartlett, Dr. Stimson, the anesthetist and the nurses that she did not want an operation, only an examination. She awoke from the ether to find that she had undergone a hysterectomy because of uterine fibroids, which are benign tumors, found at the time of the ether examination. After a prolonged hospitalization at New York Hospital, Bellevue, and a convalescent hospital, Mrs. Stimson had several permanent injuries.[642] One leg and her left hand had injuries which a doctor testifying on her behalf ascribed to embolism. The judge summarized: “[G]angrene developed in her left arm; some of her fingers had to be amputated; and her sufferings were intense.”[643]

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[640] At this time, the term “resident” was used interchangeably with “intern.” See, for example: Robert P. Hudson, "Abraham Flexner in Perspective: American Medical Education, 1865-1910," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: University of Wisconsin Press, 1997), 209-210. See also *Schloendorff v. Society of the New York Hospital*.

[641] Sandra Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900* (New York: Oxford University Press, 1999), 38.

[642] Lombardo, "Phantom Tumors and Hysterical Women: Revising Our View of the Schloendorff Case," 795-798.

[643] *Schloendorff v. Society of the New York Hospital*.

Mary Schloendorff lost her case.[644] She was suing the New York Hospital, not the doctors, for "violat[ing] its contract by operating upon the plaintiff without her consent."[645] The judge in this case, Benjamin Cardozo, was a novice at the time of the trial, serving temporarily on the New York Court of Appeals when the trial was initiated. He would, years later, sit on the U.S. Supreme Court.[646] The consulting surgeon, Dr. Lewis Stimpson, was a Professor of Surgery at Cornell Medical School whose son became the Secretary of War during both World War I and II.[647] So, in many respects, the people involved in this case were not ordinary. However, the views on charity expressed by Judge Cardozo were likely to have been prevalent for the time.

According to Cardozo:

> A hospital, maintained as a charitable institution for the care and healing of the sick, is not liable for the negligence of its physicians and nurses in the treatment of patients. It remains exempt though the patient makes some payment to help defray the cost of board, and such a payment is regarded as a contribution to the income of the hospital, to be devoted, like its other funds, to the maintenance of the charity.

It is clear from court testimony that Mary Schloendorff did pay for her care at New York Hospital. The sum was seven dollars a week. In Judge Cardozo's view, paying the hospital does not negate the fact that it is a charity: "The purpose is not profit, but charity, and the incidental revenue does not change the [hospital]'s standing as a charitable

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[644] The liability of hospitals for the negligence of their staff, including physicians is now well-established. See, for instance, Dieter Giesen, *International Medical Malpractice Law : A Comparative Law Study of Civil Liability Arising from Medical Care* (Norwell, MA: Kluwer Academic Publishers, 1988), 50-53.

[645] Ibid.

[646] Lombardo, "Phantom Tumors and Hysterical Women: Revising Our View of the Schloendorff Case."

[647] New York Times. "Dr. Lewis A. Stimson, Noted Surgeon, Dies," *New York Times*, September 18, 1917. New York Times. "Henry L. Stimson Dies at 83 in His Home on Long Island," *New York Times*, October 21, 1950.

institution."[648] The judge explains his reasoning concerning the hospital: "It has no capital stock; it does not distribute profits; and its physicians and surgeons, both the visiting and the resident staff, serve it without pay. Those who seek it in search of health are charged nothing, if they are needy, either for board or for treatment."[649] Recent scholars have noted the "extraordinary deference to charitable immunity of hospitals" that is apparent in Judge Cardozo's decision.[650] Yet the judge's decision captures the symbolic power that the charitable hospital and its professionals represented:

> A hospital opens its doors without discrimination to all who seek its aid. It gathers in its wards a company of skilled physicians and trained nurses, and places their services at the call of the afflicted, without scrutiny of the character or the worth of those who appeal to it, looking at nothing and caring for nothing beyond the fact of their affliction.[651]

Judge Cardozo apparently did not know that his image of the hospital was already partly a myth and that, within a few years, many aspects of his image of the hospital as a charity would change. In some respects, nineteenth century hospitals did provide charity care as Judge Cardozo envisioned. In 1874 at Roosevelt Hospital, another private charitable hospital in New York, 1,177 patients received free care, 177 patients paid full or partial costs, which included forty-three patients receiving care in private rooms.[652] Paying patients, however, came to dominate hospital beds. At New York Hospital where Mary Schloendorff received care, between 1910 and 1930, the proportion of patients whose care was entirely subsidized by the hospital declined from seventy-four to

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[648] *Schloendorff v. Society of the New York Hospital*.

[649] Ibid.

[650] Lombardo, "Phantom Tumors and Hysterical Women: Revising Our View of the Schloendorff Case," 792.

[651] *Schloendorff v. Society of the New York Hospital*.

[652] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 402.

thirteen.[653] During the 1930's despite the overwhelming needs of people in the community following the Great Depression, New York Hospital's proportion of free patients declined to 5 percent.[654] These trends were occurring nationally, though the degree of heterogeneity was high. Even early in the twentieth century, the proportion of patients receiving free care was diminishing in many hospitals. Among the nongovernmental hospitals in Illinois in 1917, only 15 percent of the patients were true charity cases, receiving treatment for free, while 77 percent paid full rates and 9 percent paid for part of their care.[655]

Judge Cardozo's image of the hospital admitting all who came to its doors was not quite true even when he made the decision. Private hospitals, like New York Hospital, were quite similar to their public hospital counterparts in the nineteenth century in that, for the most part, patients were poor and unable to afford medical treatment.[656] At the same time, decisions by hospital trustees of the private institutions differed from decisions made by officials at the municipal or public institutions. Patients with stigmatizing conditions such as venereal disease, alcoholism, and even cancer or those clearly dying could be sent to the public hospital though private hospitals could elect not to take these patients in.[657] Patients applied for admission and trustees could personally review the application or require a letter of reference. The desired patients were "clean,

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[653] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 56.

[654] Ibid., 76.

[655] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 32.

[656] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 35.

[657] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 306. See also Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 36.

sober, and industrious."[658] In some hospitals, there was never an encompassing vision of charity for their institutions. Boston City Hospital, for example, in a statement in 1878 by a trustee, proclaimed the institution is "not a free hospital, but a place where it is right and proper to pay, and where all must pay what they can for the good they get."[659]

In the early twentieth century New York Hospital was pulled in two opposite directions. On the one hand, the hospital developed a more formal procedure for excluding charity patients when, in 1919, a new policy was codified whereby all "free cases" would have their admission determined by an executive committee of the board."[660] A pull in the other direction, of accepting more free patients, occurred because of the larger role of the hospital in medical education. Ward patients were needed more than ever as "clinical material" and "[s]elected poor patients would always be accepted for their teaching potential."[661]

When Mary Schloendorff was admitted to the hospital in 1908, there were no medical students allowed on the wards, although interns had been present for many years.[662] Cornell Medical College and New York Hospital made an initial agreement to affiliate in 1912. This affiliation was precipitated by a $250,000 gift from Dr. Lewis Stimson, Mary Schloendorff's surgeon. New York Hospital and Cornell Medical College made a formal alliance in 1927, which included the building of a new medical center.[663]

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[658] ———, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 21.

[659] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 82.

[660] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 56.

[661] Ibid., 56-57.

[662] Ibid., 34.

[663] Ibid., 61.

In 1899 New York Hospital had only six private rooms among its 200 or so beds, the rest of the beds were in large wards with twenty-five to thirty people.[664] After the new medical center was built, about 1,000 beds eventually were available at the new hospital.[665] There were 100 semiprivate beds in use by the late 1930s.[666]

The need for "clinical material" in teaching had its limits. There was often no guarantee of receiving care even in a teaching hospital or clinic. For example, at the Washington University dispensary in St. Louis from 1929-1930, "Negro patients were being admitted in too large numbers for the type of work the institution wished to carry on."[667] To reduce the number of patients, a charge of fifty cents was approved. The charge was "not allowed to interfere with the admission of negro obstetrical patients who were desired because they offered a high percentage of pathological clinical material."[668] The 1931 book on the medical administration of teaching hospitals from which this quote is taken goes on to inform the reader that: "In hospitals connected with medical schools most of the patients used by the staff for teaching purposes are those who occupy a free bed. Pay patients whether in wards or private rooms are used only occasionally."[669] In some respects, not much had changed over the previous one hundred years. Contrary to the image Judge Cardozo's words create, "looking at nothing and caring for nothing

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[664] Ibid., 21.

[665] Ibid., 76.

[666] Ibid., 88.

[667] Emmet Blackburn Bay, *Medical Administration of Teaching Hospitals* (Chicago, IL: University of Chicago Press, 1931), 24.

[668] Ibid.

[669] Ibid., 36.

beyond the fact of their affliction," there were clearly factors beyond affliction that determined whether medical care would be provided.[670]

In a few places, primarily at public hospitals, patients were rarely, if ever, turned away. An intern in the 1950s at Bellevue later wrote that other hospitals could reject a patient by writing "No beds" on the admission slip but that Bellevue continued to take in everyone.[671] Particularly, however, during the years of the Great Depression, patients without the ability to pay were shunned. In a national survey in the 1930s, only about 10 percent of the beds in private hospitals were "free care" beds. Whereas sometimes a clear policy limiting admission or charging fees was undertaken, often *how* charity patients were excluded was not known. This prompted one exasperated official from the Cleveland Welfare Federation to remark: "The thing which cannot be measured statistically is the extent to which persons needing hospital care are having it refused."[672] There was, in New York at least, a clear answer to this question asked in a 1938 survey: "Taken all in all, what are your chances of getting into a hospital if you cannot afford to pay? Not very good."[673] Some of the methods for keeping poor patients out of the hospital were documented. At Philadelphia General Hospital in 1935, a policy to limit admissions was implemented and it included stricter checks on eligibility for free care and tighter screening for cases that could be treated at home. Other unsubtle ways to deter

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[670] *Schloendorff v. Society of the New York Hospital*.

[671] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 106.

[672] Editorial, "Hospital Work up Funds Down," *The Survey*, September 1933, 323, quoted in Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 145. See also: Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*.

[673] Ryllis Alexander Goslin and Omar Pancoast Goslin, *You and Your Hospitals: A Digest of the Hospital Survey for New York* (New York, NY: United Hospital Fund, 1938), 14, quoted in Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 74.

hospital care included announcements in newspapers. For example, in Paterson, New Jersey, one hospital published, in three languages, the state law making “charity abuse” a misdemeanor resulting in large fines or hard labor.[674]

According to Judge Cardozo, one of the factors contributing to the hospital’s status as a charity was the fact that, although Mary Schloendorff paid for her care, the doctors gave their services gratis. With the mergers and affiliations developing between hospitals and medical schools across the nation in the early twentieth century, paying the physician-professors was a contentious issue. Judge Cardozo’s decision was on the cusp of this issue. In the mid-nineteenth century, physicians associated with medical schools were anxious to fill unpaid positions in hospitals. Some physicians undoubtedly believed this care was an expression of professional beneficence, at the same time there were many benefits including prestige, a greater likelihood of referrals, medical student fees, and powerful connections with local influential merchants.[675] According to one source, in 1880 no American hospital permitted fees to be charged by their doctors. This changed over the next few decades, so that, by 1905, out of fifty-two hospitals in New England, only five did not allow fees to be charged to private patients.[676] The expectation that physicians would provide free care to all hospital patients had faded by 1910, but it remained for poor patients treated on the wards.[677]

During the early twentieth century and particularly after the publication of the Flexner Report, the standard held out for medical schools and hospitals was Johns

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[674] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 144-145.

[675] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 253.

[676] Starr, *The Social Transformation of American Medicine*: 164.

[677] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 21.

Hopkins Medical School. Johns Hopkins was a wealthy merchant who left his fortune to the development of a university, hospital, and medical school. The school opened in 1893 and it was the first school where all applicants were required to have a bachelor's degree.[678] Modeled after the German schools, the clinical and basic science professors were full time faculty members paid by salary. If a strict plan were followed in other medical schools becoming affiliated with hospitals, the clinician-professors would have all their fees go to a departmental fund instead of directly to the physicians. A so-called "geographical" system allowed clinician-professors to retain their consulting fees. Support for full time clinical professors came from several sources but especially from the Rockefeller Foundation's General Education Board.[679] Abraham Flexner called the General Education Board "the leading influence in remodeling American medical schools on the Hopkins plan."[680] The Board had contributed over $82 million to medical education reform.[681] By 1954, full time clinical professors were on the faculty of all but fifteen medical schools and, by 1985, all the schools had full time clinical faculty.[682] Medical school clinical faculty were becoming salaried professors during this period of time. Of course, whether Judge Cardozo would still view Mary Schloendorff as a patient at a charitable hospital if her care was provided by a salaried clinician is not known.

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[678] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 57-60.

[679] Ibid., 210-211.

[680] Abraham Flexner, *Abraham Flexner: An Autobiography* (New York, NY: Simon and Schuster, 1960), 37, quoted in Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America*: 193.

[681] ———, *Rockefeller Medicine Men: Medicine and Capitalism in America*: 193.

[682] Ludmerer, *Learning to Heal: The Development of American Medical Education*: 210.

The Influence of the “House” Doctor, or Interns and Residents, on Care for Charity or Poor Patients

The doctor Mary Schloendorff saw daily was a resident, also known at this time as an “intern,” who would have been a “resident,” that is, a physician in the first year after medical school living and working at the hospital. By 1900, especially in urban areas, the “real staff of every hospital in the city” were the house staff.[683] At the turn of the nineteenth century, the hospital intern often competed fiercely for the opportunity which might presage a prestigious career as a consulting physician. Though a hospital position was initially an opportunity for a select few, by 1919, the number of internships available exceeded the number of medical school graduates.[684] Throughout the nineteenth century few interns received payment other than room and board.[685] From the beginning of the internships, care was unsupervised and learning occurred on the job. A Philadelphia resident physician in 1886 described the common occurrence of these men: “Now nine out of ten have never prescribed for a patient, and they are not only greatly embarrassed, but truly do not know what to do.”[686] Busy city hospitals in particular “allowed interns to assume extensive responsibilities without admitting the consequences; too much responsibility too soon means too little supervision, which increases the chance of harm to patients.”[687] To be a charity patient was to be subject to use for educational purposes. As one young surgeon commented in the mid-1960s: “They

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[683] Thomas J. Hillis, "The Hospital Governor and His Staff," *Medical News* 77 (1900): 4, quoted in Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 65.

[684] There were less than 2,700 graduates and over 3,500 internships available. See John Milton Dodson, "The Fifth, or Intern, Year," *Journal of the American Medical Association* 73, no. 7 (1919).

[685] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 184.

[686] Ibid., 181-182.

[687] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 54.

are ignorant and unquestioning, and have come from pretty backward places; they have a profound faith in the medical profession…We can turn their minds and their bodies inside out because they come to us as charity patients."[688]

Even when there were not enough interns for hospitals to hire, the pay remained quite low. A national survey in 1950 found that some large teaching hospitals did not pay any stipends, some offered minimal payments, but these stipends varied widely. In those hospitals having difficulty obtaining interns, payments were much higher.[689] In a 1960 committee report on university hospital internships, it was recommended that teaching hospitals offer a stipend which met the cost of living conditions of the community. The consensus in the report was that "the greater part of the intern's compensation should come in the form of education."[690] The stipends for interns dramatically increased between 1967 and 1969.[691] Beginning in 1965, both Medicare and private payers were reimbursing hospitals on a "reasonable cost" basis which included the costs of graduate medical education.[692]

Throughout these years, the charity patient and the education of future doctors remained tightly interwoven. The terms "charity," "ward," and "service" patient, all were

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[688] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 146-147.

[689] In large teaching hospitals, interns rarely received more than $25-50 a month, in hospitals having difficulty filling internships the payments rose to $100-200 a month. John E. Deitrick and Robert C. Berson, *Medical Schools in the United States at Mid-Century* (New York, NY: McGraw-Hill, 1953), 269.

[690] Richard H. Saunders, "The University Hospital Internship in 1960: A Study of the Programs of 27 Major Teaching Hospitals," *Journal of Medical Education* 36 (1961): 658.

[691] American Medical Association, "Medical Education in the United States. Section 3. Graduate Medical Education. Annual Report on Graduate Education in the United States," *Journal of the American Medical Association* 206, no. 9 (1968): 2029.

[692] Prior to this, insurers were charged for these costs. Eugene C. Rich et al., "Medicare Financing of Graduate Medical Education," *Journal of General Internal Medicine* 17, no. 4 (2002).

used to refer to essentially the same group of people.[693] When medical schools were studied in a 1950 report, the increase in the number of people with health insurance was viewed as a definite problem from the standpoint of education.[694] During the decade from 1940 to 1949, the number of people with health insurance rose dramatically. For the most part, the health insurance covered surgical and hospital-based care.[695] Over 60 percent of Americans had some type of voluntary health insurance by 1953.[696] Concerning the hospital internships at teaching hospitals, the 1950 survey found that "a definite difference existed between work with charity or ward patients and work with private patients, whose professional care was the responsibility of their private physicians."[697] When interns were assigned to private patients as well as ward patients "they immediately detracted from the quality of the educational experience of the internship."[698] The conundrum was even greater for the residents than for the interns. The number of residents at the teaching hospitals had increased from 1,000 to over 2,500 in the decade before 1950.[699] The problem was a matter of "responsibility" and "authority:"

> When a second-year or third-year resident was placed on a teaching ward under a consultant appointed by the professor of a department, the resident was held strictly responsible for the over-all professional care of the patients and for the quality of the work of the resident and interns who worked under him…In dealing

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[693] William E. Sedlacek, "Research in Medical Education. Attitudes of Residents toward Their Complex Role in Medical Education," *Journal of Medical Education* 43, no. 3 (1968).

[694] Deitrick and Berson, *Medical Schools in the United States at Mid-Century*: 281.

[695] Margaret C. Klem, "Voluntary Health Insurance on the National Scene: The Present Status of Voluntary Health Insurance," *American Journal of Public Health* 40, no. 3 (1950).

[696] Starr, *The Social Transformation of American Medicine*: 328.

[697] Deitrick and Berson, *Medical Schools in the United States at Mid-Century*: 273.

[698] Ibid.

[699] Ibid., 277.

> with the private patients of individual physicians it has been almost impossible to give a resident the degree of authority and responsibility that could be assigned to him on teaching wards.[700]

The report recommended that the care of the private patients by residents be "redefined" if "responsibility for patient care is to be maintained as a basic principle of residency training."[701] The reason was clear: "The method of residency training developed by teaching hospitals utilizing wards designed for teaching is jeopardized by the increase in the number of private and insured patients. This problem has not been adequately solved by teaching hospitals, and it is becoming increasingly acute."[702]

"Free Beds" are not for a Charitable Purpose but for Teaching Value

Returning to Mary Schloendorff once again, the topic of payment was one which Judge Cardozo directed his attention to squarely. In the judge's view, paying for care did not negate the fact that she was receiving charitable aid from the hospital. The practice of charging "charity" patients was widespread but also uneven. In 1911, one New York charitable hospital sent a bill for twenty-one dollars to every charity patient even when it had already been determined that the patients could not pay.[703] In 1927, one editorial claimed that "the so-called free bed is practically nonexistent," and this was as true of the university teaching hospital as it was of the religiously affiliated hospital.[704] Even the patient who pays little for care may "feel disinclined" to participate in repeated exams by

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[700] Ibid., 281.

[701] Ibid., 287.

[702] Ibid., 286.

[703] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 36.

[704] Editorial, "Free Beds for Medical Teaching," *Journal of the American Medical Association* 90, no. 3 (1927).

students. The answer, according to the editorial, was to provide endowments for free beds to be maintained for the purpose of providing clinical material for teaching. The admission must be determined based on the "desirability of the patient from the point of view of teaching."[705]

The dean of Stanford University School of Medicine described the increasing "ward rate" at their affiliated Lane Hospital in response to the editorial. Throughout his letter, the patients who are paying the ward rates are referred to as occupying "free beds" even after providing a detailed description of the amounts charged to the patients. Furthermore, the patients may be charged a fee but their use for teaching purposes was not endangered: "It is assumed that for the privilege of getting free medical attention of the best order patients are willing to be used as clinical material, and so far as I know we have no difficulty in having our medical students have full access to these patients for purposes of examination and observation."[706] The dean does point out that the ward rates do not cover the full cost of care and that:

> The money available for free beds is allotted to the different departments of the medical school, and the heads of the various services can admit patients to the hospital so long as there is still a balance left in their free bed accounts. It is understood that this money is not for charitable purposes but that the cases should be selected for their teaching value.[707]

The dean may not realize that the fears of the late nineteenth century hospital trustees were being lived out in his words and processes. Hospital "free beds" were not for the purpose of charity. The purpose was to obtain "clinical material" and only if such

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[705] Ibid.

[706] William Ophuls, "Correspondence: Free Beds for Medical Teaching," *Journal of the American Medical Association* 90, no. 3 (1927).

[707] Ibid.

material clearly had “teaching value.” In addition, not unlike Judge Cardovo’s explanation, hospital “free beds” were not free in any ordinary sense. The director of Mount Sinai Hospital also responded to the editorial, claiming that hospitals are “doing as much free work today as they ever did, and doing it more scientifically, more humanely, and at greater cost.”[708] The author also details the payments required of ward patients, though these are “voluntary” and in “twenty-five years, no patient has been denied admission on account of inability to pay.”[709] At the very least, these articles demonstrate that, like Mary Schloendorff, payment did not mean escaping the designation as “free,” “charity,” or “ward” patient.

To summarize these points, Judge Cardozo insisted that Mary Schloendorff was a “charity” patient, or at least a beneficiary of a charitable hospital, even though she did pay for her care. The Stanford Medical School Dean repeatedly writes of the “free” patients utilized for teaching purposes after he has explained that each of these patients does pay for his or her care. In his case, additional funds are provided to each department director, though the purpose of these funds are educational and, specifically, *not charity*. Again, the ordinary, everyday meaning of “free” and “charity” does not appear to be what these words denote.

“Service” or “Charity” Patients’ Views Are Rarely Considered

The question of whether patients wanted to escape these designations was rarely directly posed. In a 1941 article, however, the author reports on “100 unselected patients in the medical service of the Peter Bent Brigham Hospital before, during, and after

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[708] Sigismund S. Goldwater, "Correspondence: Free Beds for Medical Teaching," *Journal of the American Medical Association* 90, no. 3 (1928): 224.

[709] Ibid.

Saturday morning teaching rounds."[710] The purpose was to further the basis for understanding the patient-physician relationship, the "need for interpretation of personality structure, and the expression of sympathy and tact at the bedside."[711] The article begins with the established role of bedside teaching in medical education and the lack of knowledge about the patient's reaction to this role. Consecutive patients who were going to be presented at formal bedside rounds were interviewed before and after the presentations. The patients were told that they would be presented before a large group, from fifty to seventy people, including hospital staff members, visiting physicians, students and nurses. There was no mention of asking the patient whether he or she agreed to the presentation, though the process of formal rounds was explained beforehand and the author interviewed each patient after the teaching rounds.

Among the findings were that: "No severe emotional trauma was observed," although one fourth of the patients had "anticipatory anxiety," thirteen were distressed by factors mentioned in their medical history, and ten were distressed by the physical examination.[712] When information was included in the presentation which conveyed "personality difficulties," this led to "resentment, anger, and humiliation."[713] Sometimes the patients expressed a mixed response, as when a young Greek-American housewife both "enjoyed the presentation" and also resented it and felt humiliated when her history included a suicide attempt nine years earlier. She said: "I felt as if my soul was exposed,

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[710] John Romano, "Patients' Attitudes and Behavior in Ward Round Teaching," *Journal of the American Medical Association* 117, no. 7 (1941): 664.

[711] Ibid.

[712] Ibid.

[713] Ibid., 665.

and the fact that I did try to commit suicide I wish he hadn't said before all those people."[714] The author cautions that, at times, "emotional factors are equated with moral values," and that this equating of moral attributes to emotional states occurs among the physicians and nurses and not only among lay people. Patients are well aware of this. Thus, according to the author: "An anxious person is apt to be considered morally weak as often as he is accepted as a sick person."[715] Therefore, it is better for some information to be discussed without the patient present. In some of the cases, the mention of factors related to social class caused humiliation or embarrassment. A former businessman hospitalized for nutritional deficiencies due to alcoholism was upset that the pain in his feet was attributed to second-hand shoes: "The only thing that bothered me at all was the mention of the secondhand shoes. That sort of wounded my dignity. Why couldn't they have said an old pair of shoes?"[716]

Unsurprisingly, disrobing the patients in front of the group caused embarrassment, though only in seven of the patients interviewed. The author's conclusion is heavily weighted toward the positive aspects of the use of patients in this type of ward rounds, though it clearly goes a long way in attempting to understand the process from the patient's point of view. In any case, the purpose of the study was not to determine *whether* ward rounds should be conducted in this manner. In this respect, at least the author could, and did, offer ways to improve the process for the patient: "All patients were pleased by the personal interest of the staff. The presence of the nurse at the

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[714] Ibid.

[715] Ibid., 667.

[716] Ibid., 665.

bedside, a reassuring word and the calling of the patient by name did considerable to allay tension and anxiety."[717]

This glimpse of how patients viewed their circumstances as "charity" patients and "clinical material" remains inadequate for a full understanding. At the same time, the stigma and shame of charity is a familiar concept. Even the impoverished poor during the Great Depression were part of American culture in which, as FDR himself expressed, to be on the "dole" was to be exposed to a corrupting influence that weakened moral fiber. It was not only that the public could blame the poor for their predicament, but also the poor blamed themselves. Years after the Depression, one businessman related: "I didn't want to go on relief. Believe me, when I was forced to go to the office of relief, the tears were running out of my eyes. I couldn't bear myself to take money from anybody for nothing."[718]

As early as 1915, an Assistant Surgeon General provided a detailed estimate of "sickness insurance" for the nation, specifically as "a preventive of charity practice."[719] After detailing the income and expenditures for the average wage earner, he concludes: "No reasonable thrift can save from this small margin a sum sufficient to pay for a death, an additional birth, or unusual sickness," and further, sickness insurance leaves no "taint of charity" while allowing prompt and proper treatment for any illnesses.[720] Even though patients may get health services free at hospitals and clinics, "many more, too proud to

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[717] Ibid., 666.

[718] David J. Rothman, "Our Brothers' Keepers," *American Heritage Magazine* 24, no. 1 (1972).

[719] Benjamin S. Warren, "Sickness Insurance: A Preventive of Charity Practice," *Journal of the American Medical Association* 65, no. 24 (1915).

[720] Ibid., 2057.

ask for charity treatment, either get no treatment at all, treatment too long delayed, or treatment of dubious value."[721] This sentiment was reflected in New York City's Associated Hospital Service plan, a Blue Cross health insurance program which explained in a 1935 advertisement: "The average man, with the average income has pride. He is not looking for charity; he is not looking for ward care. He wants the best attention for himself and his family."[722] If social insurance of the kind proposed in 1915 was not forthcoming, private insurers would step in. Reaping the benefits of medical care was becoming more important. It has been suggested that it was not until about 1915 that the average person had more than a fifty-fifty chance of benefiting from the care provided by a physician.[723]

Meanwhile, New York Hospital where Mary Schloendorff received care as a "charity" patient was now a "free hospital," as the board president wrote in 1947, not in the sense of treating patients for free, but "in the sense of being free to avoid bureaucracy or politics, free to investigate in the whole field of medicine, free to experiment in the better organization of medical care, free to innovate, to initiate new plans, to progress, perhaps to lead the way."[724] At New York Hospital by the early 1950's, redefining "free" may have been in order since only 1 percent of the ward patients were actually treated free of charge.[725]

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[721] Ibid., 2059.

[722] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 88.

[723] Stevens, *American Medicine and the Public Interest*: 135.

[724] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 86.

[725] Ibid., 108.

There was a growing belief, more so in some regions than others, that the public systems of care were responsible for people viewed as indigent. In New York, this was the sentiment expressed by the president of the United Hospital Fund in 1948. Private hospitals came to view their social role in a way that would have shocked nineteenth century trustees. Private hospitals would continue to admit poor patients for educational purposes. Beyond that, this care would be limited.[726] Moreover, the price of ward care per day was, in a 1947 United Hospital Fund report, higher than in semiprivate rooms, leading one author to conclude that the care was so expensive perhaps because of the salaries of the house staff.[727]

Just as in the nineteenth century, charity patients were subject to different rules in twentieth century hospitals. A hospital superintendent and physician at a teaching hospital in New York in 1930 described how charity patients as well as part-pay patients were, in most hospitals, not allowed to have visitors except during rigidly enforced hours, perhaps every other day. Pay patients were allowed visitors at all times every day. There were also unwritten "rules," as when the hospital personnel "restrain their resentment with difficulty, or not at all, when the patient making an unreasonable demand is a public charge. In a private room the same fancied affront would pass unnoticed."[728] The superintendent reminds the readers to refrain from "coldness and indifference" and, instead, "maintain an inexhaustible supply of kindness, consideration and

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[726] Ibid., 86.

[727] Daniel M. Fox and Daniel C. Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," *Journal of Health Politics Policy and Law* 16, no. 2 (1991): 730.

[728] Walter S. Goodale, "The Patient: Some of His Reactions to Hospital Administration," *Journal of the American Medical Association* 94, no. 13 (1930): 908.

forbearance."[729] After reading this article, questions remain about how frequently the author observed instances of "incivility and inattention" in the teaching hospital. Further differences in the care of charity patients included that some floors were entirely segregated by charity status. Segregation by race was the standard for most hospitals. Segregation by race or ethnicity and by charity status was a complex, ill-defined mixture. African-American people, even those paying for care, were housed in segregated wards. In some hospitals, only the wards with black patients were used for teaching.[730]

An important factor in the provision of hospital care to people of limited financial means is the role of perceived cues concerning a particular institutions' commitment to such patients. For example, in New York hospitals, the knowledge that some hospitals were unwilling to take charity patients did seem to lessen the number of potential charity patients seeking care. Racial preferences in care were also widely known in the city. One physician said that poor patients may have felt that a certain hospital "wasn't a hospital for people like them."[731] This sort of social knowledge did have quite real manifestations, especially in the case of discrimination by race. In Washington, D.C. in 1944, a pregnant black woman and her sister were walking to Gallinger Hospital, which admitted black patients, but the woman collapsed and gave birth on the sidewalk. Her sister, Pearl Miles, ran half a block to Sibley Hospital, a white-only hospital, where a nurse refused to summon a doctor and grudgingly offered care in a basement. According to one author:

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[729] Ibid., 909.

[730] Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York, NY: Oxford University Press, 1999), 120.

[731] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 109.

"Insulted and rejected by the hospital, the sisters waited outside in subfreezing weather for twenty minutes, until an ambulance came and took them to Gallinger Hospital."[732]

From the little that is known about patients' views of charity care in teaching hospitals, it is difficult to say more than that there were a variety of responses but at least some patients did experience profound humiliation, shame, and resentment. Also, there is no reason to believe that charity care would have been freely chosen if any reasonable alternatives were available. In contrast, the presence of ward patients was so integral and so necessary to medical education that, as already mentioned, there was almost no way for medical educators to imagine how teaching could occur without these patients. In one mid-1950's article, the author refers to the "most pressing problem today…the threat to ward service."[733] In a thorough article by a physician in charge of a predominantly private bed teaching hospital in Chicago in 1953, the author concludes that "the success of the public ward system in teaching performance will not be matched by all private services in the near future," and "some public ward beds are essential."[734] This is from an author *encouraging* teaching at private hospitals with private patients. Private patients, according to the author, will not allow the many visits by students and housestaff whereas the "ward patient often does so through lack of an alternative."[735] Greater courtesies are necessary with private patients, such as that both the patient and the attending physician must be asked permission for the usual teaching practices, including bedside rounds.

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[732] Susan Lynn Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950* (Philadelphia, PA: University of Pennsylvania Press, 1995), 76.

[733] Carl A. Moyer, "The Residency Program in a University-Affiliated Hospital; Organization and Administration," *Journal of the American Medical Association* 161, no. 1 (1956): 29.

[734] S. Howard Armstrong, "Private Beds in Medical Teaching," *Journal of the American Medical Association* 153, no. 2 (1953).

[735] Ibid., 83.

Private patients must be told of the role of the resident on the surgical services and the resident cannot expect the clinical responsibility to equal the ward service. The author also notes that it is the housestaff applicants who express a strong preference for public ward service. [736]

"Ward" or "Service" Patients are Important Factors in Graduate Medical Education

The general importance of ward patients in education was reflected in the choice of internship and residency location. In a 1960 study of the internship year, over one thousand interns rated "number of ward patients admitted" as fourth in the reasons a particular internship program was selected. When these interns rated their responsibility for patients, there was a dramatic difference between the ward patients and private patients. For example, on the internal medicine service, 85 percent of the interns felt that they had a "great deal" of responsibility for ward patients and only 17 percent felt they had this much responsibility for private patients.[737] A physician who trained at Bellevue Hospital in the 1950's described the difference between the city hospital and the private hospital as "night and day," and not only for the patients, but also for the housestaff. Primarily, this was because at Bellevue "every patient that came into the hospital 'belonged' to the house staff...We ran the place."[738] A similar sentiment occurred at Johns Hopkins where senior surgical residents "hid" cases from the attending physicians so that they could operate on the patients. This system had its rewards. Often, these

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[736] Ibid.

[737] Number one was: "Medical reputation of the hospital;" number two was: "Recommendations of others who interned there;" number three was: "Section of the country in which hospital is located."Saunders, "The University Hospital Internship in 1960: A Study of the Programs of 27 Major Teaching Hospitals," 576.

[738] William A. Nolen, *The Making of a Surgeon* (New York, NY: Random House, 1970), 180.

factors meant that training at a hospital with a large ward service led to achieving a reputation as a more capable physician.[739] In the late 1950s a chairman of surgery at Cornell University Medical Center expressed this view: “Teaching medical centers which emphasize primarily private patient care in an attempt to be self-supporting soon lose their academic atmosphere, and their capacity for teaching and research.”[740] Even more simply put by the dean of a Pennsylvania medical school: “You cannot maintain the highest type of teaching without adequate ward facilities in a University Hospital.”[741] Another dean in New York in the 1950s worried that if residents relied solely on private patients, the programs would “deteriorate into a kind of second-rate apprenticeship.”[742]

The question of how much supervision was occurring at teaching hospitals and whether there was a gap between what was necessary to maintain quality of patient care and what was actually occurring was “never openly admitted by hospital authorities.”[743] Occasionally the issue of supervision and quality of care did come up. In a 1932 survey of medical schools by the American College of Surgeons, Cook County Hospital in Chicago was criticized for the lack of supervision of house staff, excessive responsibility placed on interns, lack of rules and policies regarding house staff, and the lack of any measures of quality or outcomes.[744] At times this lack of supervision may have inadvertently been expressed. In a 1949 publication from Cook County Hospital, the

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[739] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 92.

[740] Ibid., 174.

[741] Ibid.

[742] Ibid., 175.

[743] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 219.

[744] Ibid., 121.

authors describe over 300 cases of patients with obstruction of the small intestine, a potentially fatal condition. According to the article, in these cases, “members of the House Staff are responsible for almost all the care of these patients, guiding pre-and postoperative management and performing the major part of the surgery, assisted by the Cook County Hospital Night Surgeon, who is usually an associate or younger staff member.”[745] It is not, however, clear from this article whether the fact that the care of these patients was almost entirely managed by the house staff was inadvertently, or intentionally, mentioned.

By 1967, concern about the loss of ward patients was greater: “Now the drying up of the great river of indigent patients is accelerating.”[746] The number of people with hospitalization insurance increased from fewer than 8 million to over 170 million in the thirty years from 1939 to 1969.[747] One solution, similar to that put forth in the 1950’s, but with less forbearance, was to utilize private patients. There was a call to recognize that the days of “the old distinction between ward and private patient has become obsolete.”[748] This was a remarkable change; in a 1934 report from the Council on Medical Education, the private paying patients “may be shown as a rare jewel, a flower, or a curiosity; but medical students will never be allowed to follow through a disease and

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[745] Samuel J. Fogelson and Chester Moen, "Management of Mechanical Obstruction of the Small Intestine at Cook County Hospital," *Quarterly Bulletin of the Northwestern University Medical School* 23, no. Fall (1949), quoted in Dowling, *City Hospitals: The Undercare of the Underprivileged*: 220.

[746] Editorial, "Medical Teaching and the Private Patient," *Journal of the American Medical Association* 202, no. 8 (1967): 837.

[747] The percent of Americans with hospitalization insurance increased from 6 to 85 in these years. Dowling, *City Hospitals: The Undercare of the Underprivileged*: 151.

[748] Editorial, "Medical Teaching and the Private Patient," 837.

learn its course on such patients."[749] By the mid-1960s a different sentiment was expressed: The patient must acknowledge that, at an educational institution, he "enters treatment by the unit only on specific consent to accept treatment by such member of the team as may be designated."[750] The old system whereby teaching "could depend on indigent patients for the development of the young doctor's judgment as the decision-maker" seemed to be giving way to a new "team" concept so that it "no longer matters who pays whom for the service."[751]

Another approach at one hospital was to use the university's endowment to support ward care. This was very much like their nineteenth century counterparts except that the costs of subsidizing care directly were much higher.[752] At New York Hospital in the early 1950's, this concept of utilizing paying patients more generally was put into action in a way that was limited to patients whose care was paid for by public third party sources. Many of the semiprivate rooms were opened for teaching and research, though most of these patients were receiving subsidized care from the city.[753] By 1965 there was a belief that "the education of the medical student and house officer increasingly will need to take place with patients entitled to care as a matter of right, not charity."[754]

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[749] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 112.

[750] Editorial, "Medical Teaching and the Private Patient," 837.

[751] Ibid.

[752] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 175.

[753] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 79, 109.

[754] Cecil G. Sheps, "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part II. A Perspentive for Today's Realities," *Journal of Medical Education* 40, no. 11 (1965).

According to another author in 1965, teaching hospitals should recognize the change in expectations by patients:

> The time has come to do away with two kinds of accommodations—at least two as divergent as are found in many of our teaching hospitals. Sick people, whether rich or poor, deserve a decent modicum of comfort and privacy. Most of us have never spent a night in a ward with 16 or 20 seriously ill of our fellows; anyone who has knows that it is not a pleasant experience. Further, if one doesn't support the one-class principle on philosophical or, if you will, humanitarian grounds, he will have to support it on practical ones, for when patients are insured their attitudes toward the physical aspects of hospitalization change, and if their insurance calls for private or semiprivate rooms, they expect to receive them.

Also, by the mid-1960s virtually all large hospitals were teaching hospitals in that they had house staff training programs.[755] Some of these hospitals negotiated with private third party insurers to receive payments for care given in semiprivate rooms to certain patients. In the 1950s and 1960s, for example, some teaching hospitals negotiated with Blue Cross and other private insurers so that patients who did not already have a private physician could be housed in semiprivate rooms and be used in teaching.[756] Just as New York Hospital had redefined "free" such that free care to patients was no longer a part of the definition, some hospitals simply redefined who was considered a ward patient.[757] Arrangements were also sometimes made specifically with teaching hospitals to provide services for certain publicly funded patients. For example, in Massachusetts, federal vendor payments for poor patients were only allowed for teaching hospitals and not for

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[755] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 238-239.

[756] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 175.

[757] Ibid.

local physicians, if the patient lived within fifteen miles of a teaching hospital.[758] As hospitals evolved to house more private and semiprivate rooms, instead of the terms “free,” “charity,” or “ward” patient, the term “service” patient was often used to describe patients whose care was paid by public third-party payers. This term, “service” patient, became a common one with reference to patients whose care was paid by Medicaid, and sometimes Medicare, after these were enacted in 1965.[759]

Another way in which government actions encouraged the use of patients for teaching purposes was through the Veterans Administration Hospitals. Though not exactly considered charity patients, veterans utilizing Veterans Administration health facilities today are more likely to be members of disadvantaged groups.[760] When the United States entered World War I in 1917, Congress established a new system of veterans’ benefits which was administered by three agencies. In 1930 the three agencies were consolidated into the Veterans Administration (VA). At that time, there were fifty-four hospitals in the system. By 2005 there were 173 VA hospitals in 171 VA medical centers. At the present time, 107 of America’s 126 medical schools are affiliated with VA medical centers and more than half of U.S. trained physicians received some of their training at VA facilities.[761]

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[758] John H. Knowles, "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part III. Chapter 8. Medical School, Teaching Hospital, and Social Responsibility," *Journal of Medical Education* 40, no. 11 (1965).

[759] Bernard Siegel, "Medical Service Plans in Academic Medical Centers," *Journal of Medical Education* 53, no. 10 (1978).

[760] Karin M. Nelson, Gordon A. Starkebaum, and Gayle E. Reiber, "Veterans Using and Uninsured Veterans Not Using Veterans Affairs (VA) Health Care," *Public Health Report* 122, no. 1 (2007).

[761] Walter E. Longo et al., "The Role of the Veterans Affairs Medical Centers in Patient Care, Surgical Education, Research and Faculty Development," *American Journal of Surgery* 190, no. 5 (2005).

After World War II the VA leaders recognized that the medical staff was woefully inadequate to meet the needs of returning veterans. Prior to this time a "perception, rightly or wrongly, existed that medical school affiliation might encourage lack of supervised care and even 'experimentation' on veterans."[762] In 1946 Congress passed Public Law 293, and it was followed by Policy Memorandum No. 2, which detailed the sharing of responsibilities for patient care and education through medical school affiliations. The architect of this policy reasoned that these affiliations were needed in order to "gain the services of hundreds of interns and residents who could treat veterans under supervision of the teaching staffs."[763] Though measures of the quality of patient care at VA facilities have been excellent in the past decade, such was not always the case.[764] The tension between educational and patient care activities was expressed in congressional testimony in 1980 by the Executive Director of the National Association of VA Physicians. The director stated that medical school faculty members "admit veteran patients not on the basis of need but according to their value as 'teaching material.'"[765] The affiliations between VA hospitals and medical schools did, to some extent, relieve the medical schools of the fear that the rise in health insurance would mean that private patients would become the only available patients for medical education.[766]

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[762] Ibid., 665.

[763] Ibid., 666.

[764] Ibid.

[765] Vernon A. Guidry, "Probe Questions Propriety of VA Doctors' Outside Incomes," *Baltimore Sunday Sun*, September 19, 1982, quoted in Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 280.

[766] Vernon W. Lippard, *A Half-Century of American Medical Education, 1920-1970*, Josiah Macy, Jr., Foundation (Baltimore, MD: Port City Press, 1974), 71.

The premise that patients were clinical or teaching material was pervasive. Thus, one medical school dean could say sincerely that ward patients and private patients contributed to education in their respective ways: “The lower social and economic classes are far less communicative but far more available to physical examinations. The reverse is true for the upper social and economic groups.”[767] Throughout these years, and not unlike Dr. Cathell in the 1900’s, there were conflicting notions of charity care spoken of in a seamless manner. The religious appeals of the nineteenth century physician were gone. The zeal for charity was now more often contained in the rhetoric of awe for scientific medicine and in scientific medicine’s necessary pursuit of, and heightened requirements for, education.

Accounting for Charity Care Funds is Poor at Best and Funds are Often “Redeployed”

One of the difficulties in accurately following the level of charity care provided by hospitals during this time period is that there was, overall, a lack of standardized accounting or reporting systems for hospitals. The push to create guidelines for hospital payments began in earnest as hospital insurance became more common and as federal cost sharing for vendor payments through state welfare programs increased in 1950.[768] In order to receive payments, hospitals had to be able to differentiate the costs associated with care for the poor from the costs associated with the private paying patients. To this end, the American Hospital Association in 1953 published the first book on hospital

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[767] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 174.

[768] Robert Bocking Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New Brunswick, NJ: Transaction Publishers, 2003), 23.

payments.[769] Even into the early 1960s, cost accounting was "amateur and idiosyncratic."[770] At some city hospitals, the admittance of patients who could pay for services lagged behind the ability to collect. Gallinger Hospital in Washington, D.C. only asked half of its patients about their ability to pay in 1947, and even those who could pay were often not billed.[771] Gallinger Hospital was, by the 1930s, an integral part of clinical services and training at both Georgetown and George Washington University Medical Schools.[772] By 1961 the hospital had installed a new billing system and it more than doubled the percentage of its costs which were collected.[773]

The lack of standardized accounting procedures and how this could lead to manipulation of teaching hospital finances was occasionally acknowledged by hospital officials. The Board President of New York University Hospital was concerned that showing that the hospital had prospered during World War II would discourage philanthropy. The President chose to transfer capital expenses to the operating budget in order to stay in the red and "avoid the evidence of too much prosperity."[774] According to one historian and speaking not only for teaching hospitals, but for all nonprofit hospitals: "Exactly how many patients were arriving at voluntary hospitals without funds and being treated free, with no government reimbursement, was unknown."[775] When hospitals on a

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[769] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 270-271.

[770] Ibid., 271.

[771] Dowling, *City Hospitals: The Undercare of the Underprivileged*: 153.

[772] Ibid., 117-120.

[773] Ibid., 153.

[774] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 83.

[775] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 269.

national level in the 1950s reported that $140 million in expenses were uncompensated, it was not necessarily a reflection of charity care since it could have meant undercharges to payers, or inefficient operations, or poorly organized billings to those either insured or able to pay their costs.[776] At Massachusetts General Hospital in 1964, the hospital director reported that ten dollars extra per day was charged to patients and insurers because of their losses from free care. However, when the losses were itemized, only one third was due to free service.[777] The hospital director also explained that the costs are higher in a teaching hospital because of educational expenses. These additional expenses included house staff stipends and additional diagnostic testing by trainees. The additional testing occurred because: "Medical faculties have not taught restraint and thoughtfulness in the use of tests."[778] There were other ways in which funds were shifted. In New York in the late 1940s, an increase in the subway tax was promoted as a way to raise desperately needed funds for public hospitals but once the tax was passed only a fraction went to the hospitals and the rest was absorbed by the city.[779]

Another complicating factor in the finances of medical schools and their affiliated hospitals is that loose accounting standards combined with cross-subsidization obscured the accuracy and accountability of the funds. After the Flexner Report, when it became essential for medical schools to affiliate with hospitals and maintain strong university ties, and much of this was funded by philanthropy, the collaboration often meant a

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[776] Ibid., 269-270.

[777] Knowles, "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part III. Chapter 8. Medical School, Teaching Hospital, and Social Responsibility," 189.

[778] Ibid., 191.

[779] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 85.

coalescing of the budget. In the 1920s one medical school dean deliberately tried "to so intermix the budgets of the medical school and hospital that the university would never be able to separate them."[780] In 1932 one report stated that no medical school had a comprehensive system of cost accounting.[781]

Once medical research became a priority for medical schools, funding was further complicated. By far the most important factor in the growth and financing of medical schools after World War II was medical research. Between 1940 and 1950, expenditures devoted to research in public medical schools increased 900 percent, while overall expenditures increased 200 percent. At private medical schools funds devoted to research increased by 700 percent, while overall expense increased by 100 percent.[782] Expenditures on medical research in 1947 totaled $87 million. In 1966 the total was over $2 billion.[783] In some schools the priority of research clearly displaced the educational and social imperative of maintaining ward beds. Thus in one medical school in Pennsylvania, ward beds were converted to semiprivate beds explicitly to help generate revenue for research. In other schools research funds flowed toward educational purposes, "bootlegged" as one faculty member described these funding flows.[784] By the early 1970s, one author described the $1.3 billion in funding from the National Institutes for Health for research provided to medical schools as subsidizing general institutional

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[780] Deitrick and Berson, *Medical Schools in the United States at Mid-Century*: 54.

[781] Ibid., 16.

[782] Ibid., 38-39.

[783] This number includes all sources of funding for research: federal, state, and local governments; private entities; and industry. James A. Shannon, "The Advancement of Medical Research: A Twenty-Year View of the Role of the National Institutes of Health," *Journal of Medical Education* 42, no. 2 (1967).

[784] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 217.

functions: “about $800 million was ‘redeployed’ into institutional and departmental support…The distinction between research and education became as fluid as the imagination of the individual grantees wished it to be.”[785]

One reason to point out the fluidity of these funds is that it helps to explain the historical context of how academic medical centers are currently financed Yet, no matter how much fluidity in funds there were, charity care was singled out as having three simultaneous features: it was a financial burden; it was necessary for medical education; and it was proof of adherence to a moral standard. Claims that charity care has dire financial consequences seemed to perpetually exist alongside vast expansions of medical schools and their associated hospitals.

The source of payments to hospitals and physicians changed throughout the twentieth century. In 1963 at a national level, 60 percent of hospital care was funded by patients through hospital insurance or other private consumer expenditures, 38 percent by tax funds, and 2 percent by philanthropy.[786] Twenty years later, in 1982, more than half, 53 percent, of hospital care was funded by government payments including Medicare and Medicaid and one third by private health insurance.[787] Physician services in 1963 were paid directly by patients or through health insurance in 93 percent of the cases, and the remainder came from public sources through vendor payments by the federal government and philanthropic sources.[788] When payments were made on behalf of poor patients, the

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[785] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 282-283.

[786] Louis S. Reed, "Private Consumer Expenditures for Medical Care and Voluntary Health Insurance, 1948-63," *Social Security Bulletin* December (1964): 22.

[787] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 209.

[788] Reed, "Private Consumer Expenditures for Medical Care and Voluntary Health Insurance, 1948-63," 22.

amount tended to be less that the full cost of care.[789] At Massachusetts General Hospital in 1964, the amount paid per day for a welfare patient was about forty dollars and the usual charge was fifty dollars.[790]

The Impact of Medicare and Medicaid on Education and Care of the Poor

Despite the creation and implementation of Medicare and Medicaid in 1965, education still took place primarily while caring for the poor. From the perspective of the American public in 1965, why didn't the passage of Title XVIII (Medicare) and Title XIX (Medicaid) as amendments to the Social Security Act, intended to provide health insurance for the elderly and poor people in certain categories, change medical education such that teaching would be distributed equitably among all patients within and among training programs? According to Rosemary Stevens, the simplest view is that Medicare and Medicaid did not fundamentally change how medicine was practiced. With a few exceptions, such as the expansion of nursing homes for the care of some of the elderly, physicians still saw patients in the same practice environments and hospitals still admitted patients much like they had before the legislation.[791] In fact, Medicare in its initial enactment did not intend to change the organizational structure of medical care. Section 1801 of the law directed that "Nothing in this title should be construed to

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[789] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 260.

[790] Knowles, "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part III. Chapter 8. Medical School, Teaching Hospital, and Social Responsibility," 189.

[791] Stevens, *American Medicine and the Public Interest*: 445.

authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical serves are provided."[792]

At the same time, the significance of Medicare and Medicaid cannot be overstated, particularly in regard to the impact of Medicare and Medicaid combined with the 1964 Civil Rights Act, which prohibited federal funding to organizations that engage in racial segregation or other forms of discrimination. These programs played a central role in desegregating and eliminating gross disparities in care by race. In less than four months, more than 1,000 hospitals quietly integrated their medical staffs, waiting rooms, and hospital floors. Although the VA hospitals had been integrated since 1948 under President Truman's Executive Orders and some medical schools had integrated in order to receive federal research funding beginning in 1961, the bulk of overt discrimination did not end until Medicare was implemented in 1966.[793]

The enactment of Medicare and Medicaid was often viewed with concern. Some authors worried on moral grounds that programs like Medicaid and Medicare could displace charity and altruism as professional and ethical attributes.[794] In a 1966 survey of over 1,000 medical students at four schools, over half believed that Medicare would cause physician charity care to decrease.[795] According to Kenneth Ludmerer, "the arrival

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[792] Ward Darley and Anne R. Somers, "Medicine, Money and Manpower--the Challenge to Professional Education. II. Opportunity for New Excellence," *New England Journal of Medicine* 276, no. 23 (1967): 1296.

[793] David Barton Smith, "Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda," *Health Affairs* 24, no. 2 (2005).

[794] Ronald M. Green, "Altruism in Health Care," in *Beneficence and Health Care*, ed. Earl E. Shelp (Hingham, MA: Kluwer Boston, Inc., 1982).

[795] James R. Scholten, Ronald Rubin, and Charles E. Lewis, "Medicare and Medical Students," *Journal of the American Medical Association* 197, no. 5 (1966).

of Medicare and Medicaid hastened the erosion of the charitable mission of academic medical centers."[796]

Some physicians at teaching hospitals echoed the earlier fears expressed about the increase in private health insurance. At Massachusetts General Hospital, governmental insurance for the elderly might "wipe out the medical ward teaching service with a stroke of the pen."[797] And yet, according to Ludmerer: "If medical education escaped relatively unscathed, that was because a truly one-class system of care was never fully achieved. Major steps had been taken in that direction, but full egalitarianism in medical care did not occur, any more than it did elsewhere in American society."[798] The following is a summary of how educational processes managed to remain "unscathed" by Medicare and Medicaid, as written by Kenneth Ludmerer who is the author of a book on the history of medical education:

> Ultimately, an accommodation was reached satisfying Medicare and Medicaid authorities that beneficiaries were receiving private medical care and yet leaving the graduate training system essentially intact. This was accomplished by allowing house officers to be delegated major responsibilities for patient management as the representatives of the attending physician, who was now the private physician of legal record. Attending physicians, as before, would round regularly with their house staff. It was expected that the resident would immediately contact the attending physician if help were needed. Attending physicians would document their participation in the patients' charts, typically by writing a brief admitting note within 48 or 72 hours of admission or, alternatively by countersigning the resident's admitting note.

This accommodation was far from settled from the point of view of the federal government as later investigations into the Medicare program's payments would show.

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[796] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 227.

[797] Ibid., 229.

[798] Ibid., 230.

There is no question, however, that even though medical education continued on its trajectory much like before the implementation of Medicare and Medicaid, dramatic changes were occurring. There is also no doubt that Medicare and Medicaid provided a:

> massive infusion of money into the health care system. Whatever the initial concerns of the medical profession, these programs proved a bonanza for physicians and for most hospitals. Suddenly, there was public money to pay for the millions who had previously been medically indigent. Elderly persons, once forced to seek care in public hospitals or in the charity wards and outpatient departments of voluntary hospital, now could pay for their care.[799]

Medical schools and teaching hospitals grew at an incredible pace immediately after the passage of these two programs. In 1963 there were 87 medical schools and, by 1979, there were 126 medical schools. The number of hospitals affiliated with medical schools grew from 517 in 1966 to 1,168 in 1975.[800] From 1965 to 1990, the total revenue of American medical schools grew from $882 million to almost $21 billion.[801] The full time faculty at medical schools increased from just over 17,000 in 1965 to almost 75,000 in 1990.[802] The expansion of clinical services led to changes in the structure of hospitals, including the decline of the large charity wards. As the large wards were replaced by private and semiprivate rooms, "it appeared that the two-tiered system of medical care, one for the affluent and one for the poor, soon would be eliminated."[803]

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[799] Robert H. Ebert and Eli Ginzberg, "The Reform of Medical Education," *Health Affairs* 7, no. 2 Suppl (1988): 10.

[800] Peter W. Butler, James D. Bentley, and Richard M. Knapp, "Today's Teaching Hospitals: Old Stereotypes and New Realities," *Annals of Internal Medicine* 93, no. 4 (1980).

[801] In 2009 dollars, for 1965 the amount is $6 billion as compared to $34.5 billion for 1990. See: Samuel H. Williamson, "Seven Ways to Compute the Relative Value of a U.S. Dollar Amount - 1774 to Present," www.measuringworth.com/uscompare/ (accessed March 14, 2013). The source of the revenue is Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 327.

[802] ———, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 327.

[803] Ebert and Ginzberg, "The Reform of Medical Education," 10.

During this time of growth, private philanthropy was not a primary source of revenue for teaching hospitals. After the implementation of Medicare and Medicaid the contribution of private philanthropy declined further from 6 percent of national health expenditures in 1966 to about 3 percent in 1975.[804] Put another way, in 1929 philanthropic spending in health care was nearly as much as the federal government but, by 1973, philanthropic spending was only 16 percent of the amount expended by the federal government.[805]

The Medicaid and Medicare programs were to become vital to teaching hospitals and medical schools. In 1966 this funding was zero and all clinical income was only 6 percent of the total medical school revenue. By 1999, it was half of all sources of funding.[806] While perhaps somewhat of an exaggeration, the medical historian William Rothstein concluded that: “Medicare and Medicaid converted the medical school’s major existing source of patients—the indigent—from subsidized to full-pay patients with all payments made directly by the federal or state government.”[807] There is no doubt that medical schools and teaching hospitals began to rely on patient care income, however. In the 1950s some medical schools implemented precursors to faculty practice plans but

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[804] In 1978, about 82 percent of the operating revenue for the 65 university-owned teaching hospitals was derived from third party payers and self pay patients. In the 43 public university hospitals, about 75 percent of operating revenue came from these sources. Among all of the university owned teaching hospitals, state and local government appropriations were about 32 percent of total operating revenue in 1971 declining to about 11 percent in 1978. Butler, Bentley, and Knapp, "Today's Teaching Hospitals: Old Stereotypes and New Realities."

[805] Robert J. Blendon, "The Changing Role of Private Philanthropy in Health Affairs," *New England Journal of Medicine* 292, no. 18 (1975).

[806] Ralph W. Muller, "What Matters: Making the Case for Public Support of Teaching Hospitals and Medical Schools," *Academic Medicine* 76, no. 2 (2001). See also Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 327-328.

[807] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 260.

these were “administered with astonishing casualness.”[808] In a survey of medical school deans as late as 1970, 20 percent did not know the amount of income derived from their entire faculty. Most of the income generated by the growth in clinical services was used to increase the salaries of the clinical faculty. By 1975, the faculty at medical schools achieved income parity with their private practice counterparts.[809] Most scholars agree that clinical revenue was used to subsidize many of the education and research programs at what was becoming an entity called “academic health center,” or “academic medical center.”[810]

“Charity” Patient Experiences are Astonishing and Humiliating

Like earlier times, the experiences of patients are difficult to find in the mid-1960s. There are, however, some scattered sources of information regarding the conditions at teaching hospitals which also take the patients’ account seriously. In 1964, Jan de Hartog published *The Hospital*. A Dutch Quaker playwright and author who came to Houston in the early 1960’s, de Hartog and his wife began volunteering as orderlies at Houston’s charity hospital. He wrote a series of editorials describing what they found: “a dog pound,” “a death house.”[811] Underfunded and understaffed, the hospital was a

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[808] Ibid., 259.

[809] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 221-225.See also Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 262-263.

[810] Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*: 226. The Commonwealth Fund defines “academic health center” as “allopathic U.S. medical schools and their closely affiliated or owned educational and clinical institutions.” Commonwealth Fund Task Force on Academic Health Centers, "Envisioning the Future of Academic Health Centers," (Washington, DC: Commonwealth Fund, 2003). The term “academic medical center” is usually interchangeable with “academic health center.”

[811] Joe Adcock and Cynthia Adcock, "Houston's Hospitals: The Smell of Charity," *The Nation* (1965): 5-6.

"'chilling dehumanized world of a novel by Kafka,'" where "thoughtless humiliation of the patient was part of the routine."[812] The hospital had been a site for teaching through Baylor College of Medicine since the 1950s.[813] The de Hartog's and their brigade of volunteers could not sustain a workforce adequate for the hospital's neglected patients. At the time 70 percent of the patients were black and the community tended to voice the sentiment that: "Patients at Ben Taub are all freeloading."[814] Yet, this is not what de Hartog chronicled. In one of many instances of incomprehensible neglect:

> In the emergency room he saw a Negro girl in a wheel chair, head in hands, a pool of blood spreading below her on the floor. Nothing was done for her because she had not registered, she could not register because she could not push her chair the last 3 yards to the registration desk.[815]

Newborns died from bacterial epidemics, women were left exposed, and intermittent breathing machines went from "instruments of mercy into tools of torture" because there was no staff to run them properly.[816] It was reported that one nurse was, at times, responsible for over 400 patients. The doctors and nurses were slow to speak out, "muzzled by professional 'ethics' and economic pressure."[817] One physician on staff, however, remarked: "In Ben Taub we are forced to treat the poor Negroes [sic] as another species, test animals, relics of the Stone Age not as sensitive as we to pain. In Ben Taub

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[812] Ibid., 6.

[813] Harris County Hospital District, "Harris County Hospital District: History," http://www.hchdonline.com/about/history.htm (accessed March 17, 2012).

[814] Adcock and Adcock, "Houston's Hospitals: The Smell of Charity," 8.

[815] Ibid., 6.

[816] Ibid.

[817] Ibid.

you are either a saint or a sadist." [818] At this charity hospital no one was treated free and an audit recommended the hospital improve its billing practices. The audit and the local furor, despite repeated denials of the hospital's conditions by the board and administrators, led to the creation of a tax supported hospital system late in 1965.[819]

Another book, *Sickness and Society*, published in 1968, was a combined effort of a pediatrician and a sociologist.[820] The authors use a pseudonym for the hospital, though it was at Yale-New Haven Hospital.[821] Over 200 patients were studied if they and their physicians agreed. Like de Hartog's book, the study is on the cusp of the enactment of Medicaid and Medicare. The hospital is a large teaching hospital with over 800 beds in 1962, staffed by the medical school and by private practitioners. The book is a comprehensive account of the lives of patients and their families, as well as all of the people working in the hospital including administrators, attending faculty, private practitioners, nurses, interns, residents, and medical students. The authors documented the pervasive and profound ways in which socioeconomic status affected every aspect of patient care. Ward patients were subjected to much more scrutiny regarding whether their medical condition warranted admittance, consequently the ward patients' illnesses were more severe and advanced and they were more often admitted on an urgent basis.[822] The private patients were not carefully screened for their ability to pay and were not asked for

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[818] Ibid., 8.

[819] Ibid. See also Harris County Hospital District, "Harris County Hospital District: History."

[820] Raymond S. Duff and August B. Hollingshead, *Sickness and Society* (New York, NY: Harper & Row, 1968).

[821] Robert Zussman, "A Forgotten Classic?" *Sociological Forum* 20, no. 2 (2005).

[822] Duff and Hollingshead, *Sickness and Society*: 177-178.

cash in advance, whereas ward patients were required to pay in advance unless admitted urgently and were subject to providing thorough details about their finances.[823]

On the wards, the house staff provided almost all of the medical services. On the semiprivate and private areas, the house staff still provided much of the medical services because they were always present at the hospital. The students, also, were "doctors" on the wards.[824] The differences in the services provided on the wards as compared to the private areas were profound, however.

> [The school of medicine] provides the physicians and student physicians to examine and treat the sick poor who come to them. Faculty and students are able to realize their research and teaching goals by caring for these 'service patients'. The medical students learn how to practice scientific medicine, and the faculty physicians test new drugs and procedures on this 'clinical material.'[825]

The authors make the point that the medical school faculty are rewarded for research and teaching but not for providing excellent care to the community's sick poor. The priorities as well as inefficiencies of the hospital were expressed by one member of the house staff:

> This is why we are in an academic center—to learn, although sometimes the patients don't benefit from this. Sometimes the patients have extensive procedures carried out on them that wouldn't be done elsewhere. Sometimes a man suffering with a terminal illness will be kept alive for months on various procedures which completely deplete the family fortune and keep this poor person alive for a long period of time. All of us learn something from this. Maybe a day will come when alterations can be made in this approach and the patient won't be kept alive just to suffer, but in our keeping some patients alive only to suffer and die in pain, we learn something more about keeping patients alive to live.[826]

The book is full of such ambiguous statements by various members of the hospital staff. In the patients studied, the mortality was much higher on the wards, 37 percent as

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[823] Ibid., 36-43.

[824] Ibid., 47, 372.

[825] Ibid., 46.

[826] Ibid., 48.

compared to 15 percent among the semiprivate patients and 26 percent among the private patients. This was attributed primarily to the severity of illness.[827] Among the patients who died, the house staff were often conflicted about asking about an autopsy. The pressure to secure an autopsy was vastly different for the ward patients. The intern with the most autopsies in a year was rewarded by the school of medicine with time off and paid expenses to attend a medical meeting.[828]

There was no doubt that ward patients did feel shame, humiliation, and stigmatized because they could not afford the private or semiprivate rooms. The authors' state:

> The wards carried an aura of dishonor among self-respecting people…[T]hey realized if they were admitted they would have no choice of who cared for them…Admission to the wards was not easy and it was not accepted willingly by those who could avoid it. The vast majority of poor people resented the stigma they had to assume in order to be admitted to the hospital as a ward patient, but when they were desperately ill they had no other choice but to accept what was available to them.[829]

Although all of the hospitalized patients were fearful, anxious, and apprehensive on admission to the hospital, the fears of the ward patients increased during the hospitalization to a much greater degree than patients on the semiprivate or private areas, even after accounting for the severity of illness.[830] The ward patients often "harbored terrifying memories and suspicions which were then added to their long list of life's adversities."[831] The increase in fear may not be surprising since, for example, one patient

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[827] Ibid., 307.

[828] Ibid., 320-330.

[829] Ibid., 117-118.

[830] Ibid., 278.

[831] Ibid., 286.

interviewed related the following about the several procedures that were undertaken after she was admitted: First, “the pelvic examination was ‘quite a production.’ The doctors talked to one another but not to her.”[832] The medical student, intern, and resident were all involved while “Three thoracenteses were done in just this way—one doctor teaching another.”[833] A medical student described the following concerning the use of patients in teaching: “So there I was standing in line with a dozen other students. I had a glove on my hand like the rest, waiting to stick my finger in and feel that cancer on her rectal shelf. That’s the way you learn.”[834]

As a part of the authors’ analysis in *Sickness and Society*, the hospital charges and the impact of the cost of their illnesses were followed for a period of two years on 161 patients. The ward patients, though shunned by administrators and the subjects of teaching and research, did not receive free care. In fact the mean charges billed to the ward patients were higher than those of the patients in the private or semiprivate areas. None of the patients had their entire bill paid by the public welfare agency. Among the ward patients, 55 percent paid their bill within thirty days. After two years, six of the ward patients had not paid all of their bills. Patients or their families who suffered severe or very severe economic hardships were clustered among the ward patients. The families classified as suffering very severe hardship were either impoverished by their illness or

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[832] Ibid., 129.

[833] Ibid.

[834] Ibid., 48.

the economic burden was such that it was unlikely that the families would ever return to their previous standard of living.[835]

Perhaps among the most important conclusions by the authors, in regard to this chapter, was their explication of the relationship between “inadequate care and ineffective learning.”[836] The authors conclude that practices on the wards are not “suitable as a patient-care model for students of the health professions.”[837] While emphasis is placed on the problems as society-wide, the authors do believe that teaching hospitals have a necessary role to play. In their view:

> The training of practitioners, especially early training, took place primarily in the ward accommodation where patients were not assertive; for the most part, students could and did continuously ignore the patients. Given the environment of the School of Medicine with its focus on disease, it is understandable that the medical student looked upon the patient only incidentally as a social and human being. Because of limited support from the community for the care of the sick poor and the simultaneous requirement that the hospital must care for these persons at least at a minimal level, medical and nursing students often became unwilling participants in what they considered to be inadequate care of the poor.[838]

The authors were aware that the medical school and teaching hospital studied in their work had a particularly academic emphasis as well as a particular history and local circumstances, yet the comprehensiveness of their study is impressive and difficult to ignore.

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[835] Ibid., 347-362.

[836] Ibid., 380.

[837] Ibid., 381.

[838] Ibid., 380.

The Process of Medical Education Can Enhance Resentment and Patronization of Indigent, Poor, or Charity Patients

The findings of the study by Duff and Hollingshead are also reinforced by other sources. In a 1966 article in the *New England Journal of Medicine*, an intern provides a window into some of the attitudes and experiences that may have been prevalent. The author states that house staff are subject to caring for hordes of indigent patients through university teaching hospitals. Overworked in underfunded facilities, resentment and frustration develop and as a result “an affection that is less than respect for the clinic patients” is fostered.[839] Further, “this resentment is readily displaced downward on the patients, who are easy objects for it after all.”[840] The sense of rage at patients who come to the emergency room in an ambulance but who are really “crocks” is palpable. The house officer, after all, “wants to treat only ‘real’ disease.”[841] The relationship to indigent charity patients is time and role limited, according to the author:

> Yet the clinic patients are involved in a crueler irony than being the disadvantaged concern of the future. They have, theoretically, consented to be used for training and research in exchange for the satisfaction of their needs. Yet many physicians, who have learned their profession in the wards and outpatient departments of the city hospital, go on to practice medicine without ever seeing the indigent again. The indigent, on the other hand, receive a steady supply of young doctors, changing every year, who will treat their acute problems but who are unwilling to become involved—as private physicians become involved—in the chronic diseases and psychic aggravations that may bother them even more. In essence, they are still “the needy.”[842]

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[839] Michael L. Glenn, "Challenge to the City Hospitals. An Intern's View," *New England Journal of Medicine* 274, no. 26 (1966): 1477.

[840] Ibid., 1478.

[841] Ibid., 1479.

[842] Ibid.

This paragraph provides a portrait of the role of medical education and charity care that serves as an indictment of the system.

There are several reasons to believe that, once Medicaid and Medicare were fully implemented, the problems as described by Duff and Hollingshead, and the intern cited above, did not disappear. In some cases, such as the New York system of municipal hospitals, the funds from Medicare and Medicaid meant merely that the city reduced its subsidies for hospital care of the poor and the hospitals' funding remained essentially unchanged.[843] These public sources of insurance, in the case of urban public hospitals, allowed some patients access to other facilities in the private sector and left the public hospitals with a concentrated number of people with no third party payment.[844] Public hospitals were besieged with criticism. At a 1973 conference on hospitals, a summary of the status of public hospital was provided:

> The poor who get care do not like the public hospitals; the boards of supervisors or city councils who have to raise taxes to support them do not like them; the people in general do not like them because they are stigmatized as providers of second class medicine; taxpayers resent their taxes going into facilities for the poor; and health planners want them to go away.[845]

In another view that is quite unique, the chairman of the department of medicine at State University of New York, Downstate Medical Center, Ludwig Eichna, went to medical school for the second time from 1975 to 1979 in order to discover the source of problems in the system of medical education. Eichna detailed how, in practice, the focus and first priority of medical education was not the patient. In fact, according to Eichna:

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[843] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 143.

[844] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 314.

[845] Alice Tetelman, "Public Hospitals--Critical or Recovering?" *Health Services Reports* 88, no. 4 (1973): 296.

“Patients are looked on not as ill people but almost as impersonal beings that exist for the students’ own development.”[846] Patients are treated as “teaching material” or “teaching adjuncts.” Medical students are “foisted” on patients often without their being asked and for the purpose of “[t]itillation” and it is “questionable whether these students learn anything of value.”[847] When it comes to the care of patients with little financial means: “Daily, students witness different treatment of patients with the same health needs, depending on what the dollar dictates rather than what medicine dictates.”[848]

Some of the most publicized aspects of the inadequacy of care for low income people came from house staff activists in the early 1970s. One intern in 1975, on strike for better hospital equipment stated: “We’re not doctors-in-training. We are the primary care physicians for poor people in ghettos.”[849] In the tumult of the times, house staff associations used collective bargaining techniques, including strikes, for self-interested reasons such as better wages and hours, but they also sought to improve facilities, equipment and staffing for city hospitals in Los Angeles, Boston, New York, and San Francisco.[850]

One activist and pediatrician, Fitzhugh Mullan, has written about his awareness of the estrangement of the city hospitals from their local communities, the lack of attention to cultural particularities, and the assumptions about intellect or worth of the patients

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[846] Ludwig W. Eichna, "Medical-School Education, 1975-1979: A Student's Perspective," *New England Journal of Medicine* 303, no. 13 (1980): 734.

[847] Ibid.

[848] Ibid.

[849] Lily M. Hoffman, *The Politics of Knowledge : Activist Movements in Medicine and Planning*, Suny Series in the Sociology of Work (Albany, NY: State University of New York Press, 1989), 2.

[850] Lilly Hoffman, "Housestaff Activism: The Emergence of Patient Care Demands," *Journal of Health Politics, Policy & Law* 7, no. 2 (1982).

seeking care. To Mullan's eyes in the early 1970s: "It [was], simply, a separate and unequal second-class system."[851] To him, and unlike the house staff interviewed at Yale-New Haven, there was hypocrisy in how medical schools use the teaching hospitals where care is "impersonal, unpredictable, marked by long waits, [and] rarely administered by the same physician on successive visits." [852] In keeping with the title of his book, *White Coat, Clenched Fist*, Mullan rails: "Can't you understand that our practice of medicine under these circumstances insults and oppresses communities of people we purport to serve and who need our respect and support badly?"[853]

To others who had worked happily within the system, the turbulent 60s and 70s raised the consciousness of problems which had long been accepted without hesitation. One physician in this category describes the hard work for little pay during house staff years. The work was virtually all provided by the house staff on the charity patients at a large teaching hospital which served primarily poor black patients, patients upon whom generations of house staff had acquired clinical skills. The house staff was surprised when the community's residents wanted to become more active in their own health care and hospital: "The hospital and medical school which had trained us and, in the process, provided care to these people as patients was referred to by them as 'the plantation,' a poignant reference to the almost inevitable patronization that creeps into some relationships between doctor and patients and offsets the charitable intentions."[854]

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[851] Fitzhugh Mullan, *White Coat, Clenched Fist : The Political Education of an American Physician* (Ann Arbor, MI: University of Michigan Press, 2006), 94.

[852] Ibid., 93.

[853] Ibid., 96.

[854] Reynolds, "The Loss of Charity in the Practice of Medicine," 197.

Funding for Charity Care Becomes Further Enmeshed in Funding for Graduate Medical Education

So, despite the tremendous infusion of funds through Medicare and Medicaid and the exponential growth in medical schools and academic medical centers, charity care remained a burden. Teaching hospitals were experiencing difficulties with charity care primarily because of their association with public hospitals. In a 1982 study of teaching hospitals, the public teaching hospitals provided 11 percent of the volume of care and 31 percent of the total uncompensated care.[855] The private teaching hospitals provided 32 percent of the volume of care but only 2 percent of the uncompensated care.[856]

Public hospitals were more likely than their private counterparts to affiliate with medical schools since the early 1900s. Understaffed and underfunded, the institutions were more likely to welcome faculty to their staff, though this was not universally the case. In a 1940 follow-up to the Flexner Report, usually called the Weiskotten Report, the author found that some medical schools paid hospitals for the privilege of teaching, some hospitals reimbursed medical schools for the patient care services of the faculty, but most shared the salaries of the faculty involved in teaching. When the Weiskotten Report was published in 1940, forty-nine of sixty-seven medical schools were associated with either a city hospital or other government hospital.[857] In 1982 at least two-thirds of all medical schools were affiliated with public hospitals.[858] University hospitals were either public or private. In a 1976 study, the university hospitals which were publicly owned had *no*

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[855] The term “uncompensated care” has as many problems with its assumed meaning, legal definition, and everyday usage as does the other terms used in describing charity care. This is one of the topics discussed in Chapter 4.

[856] Rothstein, *American Medical Schools and the Practice of Medicine: A History*: 272.

[857] Ibid., 175.

[858] Ibid., 214.

private patients. The privately owned university hospitals had almost all private patients (95 percent).[859] One point, then, is that the provision of uncompensated care was more a reflection of the hospital than of the medical school as such. Another point is that, when it comes to a morally praiseworthy task, the "credit" tends to be extended to the maximum number of entities. Among the people and organizations claiming credit for charity care, the list is long: physicians on the staff of medical schools who receive a salary, physicians on the staff of community hospitals who may or may not receive a salary or compensation for teaching, house staff, medical schools, university hospitals, public hospitals, private hospitals, local governments, state governments, and the federal government.

When Judge Cardozo, in 1914, explained his reasoning in the Mary Schloendorff's case, he cited a previous Rhode Island Supreme Court case as setting a precedent for the relationship between the charity giver, the sick neighbor, and the physician. This case, and others, helped to solidify the doctrine of charitable immunity from tort liability at nonprofit hospitals, at least until the 1970s, as already mentioned.[860] The purpose of bringing up this case here is to emphasize the change in the number of potential charity givers. In the Rhode Island case cited by Cardozo:

> If A. out of charity employs a physician to attend B., his sick neighbor, the physician does not become A.'s servant, and A., if he has been duly careful in selecting him will not be answerable to B. for his malpractice. The reason is, that A. does not undertake to treat B. through the agency of the physician, but only to procure for B. the services of the physician.[861]

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[859] Ibid., 273.

[860] Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 63.

[861] *Schloendorff v. Society of the New York Hospital*.

In this case, there are three parties: the charity giver (A.), the physician, and the recipient of charity medical care (B). Judge Cordoza assigns the hospital the status of charity giver, and he also assigns this status to the physicians. By the mid-twentieth century, the recipient of charity medical care remained essentially unchanged, and may or may not have paid for his or her care, just as Mary Schloendorff paid for her care. However, the hospital, the physician, the local, state, and federal governments could all consider themselves the morally praiseworthy charity giver. Moreover, each of these people or organizations could also claim the burden of charity care, something that was much less likely to happen in 1914 when the locus was the hospital.

The founders of Medicare and Medicaid did not want to challenge the structure of medical care and medical education. This was an explicit policy decision, as already mentioned, in order to gain the cooperation of hospitals and physicians.[862] There was a fear that hospitals could refuse to treat patients who were insured under public health insurance or provide these patients with “second class” care.[863] An amalgamation of prior and new programs and with the primary purpose of sheltering the elderly and the deserving poor from the financial devastation of illness, Medicare and Medicaid were characterized as a “three-layer-cake. The first layer, Medicare Part A, is hospital insurance for the elderly, in essence for those who are receiving social security benefits. Medicare Part B is a voluntary program of insurance for physician’s services, whether in the hospital or in an outpatient setting. Medicaid was originally a program that provided

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[862] Starr, *The Social Transformation of American Medicine*: 375.

[863] Judith Feder and Bruce Spitz, "The Politics of Hospital Payment," *Journal of Health Politics Policy and Law* 4, no. 3 (1979): 440.

medical services for people already receiving public assistance or “welfare.”[864] Funding for house staff, known increasingly by the term “resident,” and referred to as graduate medical education, was explicitly mentioned in the 1965 law concerning Medicare: "Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net costs of such activities, (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program."[865]

Medicare Provides Payments for Residents and for Faculty Teaching and Supervision and Medicaid Provides Payments for Higher Costs at Teaching Hospitals

To the extent that house staff, or residents, provided charity care, Medicare did provide payments for these services. Under Part A, Medicare provided a prorated payment for the cost of stipends to interns and residents and compensation paid by the hospital to physicians for their teaching and supervisory services.[866] Prior to the enactment of Medicare and Medicaid, teaching hospitals were widely considered to have

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[864] The Medicaid program was never based on financial criteria alone, though it will come much closer to this in 2014. The basis was financial but only for certain categories of low income people. Jonathan Oberlander, *The Political Life of Medicare*, American Politics and Political Economy (Chicago: University of Chicago Press, 2003), 30. See also Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 60-61,66.

[865] U.S. Congress, "Social Security Amendments of 1965. Report of the Committee on Ways and Means of H.R. 6675, 89th Congress, 1st Session, Report No. 213," (Washington, DC: U.S. Government Printing Office, 1965) , quoted in Michael Weinrich, "Federal Funding for Graduate Medical Education," *Neurology* 53, no. 6 (1999): 1176.

[866] Institute of Medicine, "Medicare--Medicaid Reimbusement Policies: Effects on Teaching Hospitals, Physician Distribution, and Foreign Medical Graduates," in *Social Security Studies, Interim Report* (Washington, DC: Institute of Medicine, 1975), 6.

increased costs relative to their non-teaching hospital counterparts.[867] Since the hospital payments were cost based, the funds for teaching and resident and intern stipends were paid according to their specified cost, which meant that higher costs were paid relative to non-teaching hospitals. Until 1972 Medicaid hospital payments were modeled after Medicare's cost based reimbursement.[868] Overall, cost became a significant issue. Between 1966 and 1976, the average cost per day in the hospital more than doubled. Two-thirds of the increase in cost was attributed to expansions in the hospital payroll and in "profits," whereas less than 10 percent was due to increased utilization.[869] Payroll increases were evident in the salaries of interns and residents, for example, in 1968, the average stipend for an intern was $6,200 and, in 1978, it was $13,904.[870] The federal government paid about half of all the total salary and fringe benefits of residents in 1976. The average cost of these salaries and benefits was 3 to 7 percent of the budget, or over $2 million dollars, for surveyed teaching hospitals in 1978.[871]

Medicare Part B payments were provided for "personal and identifiable" services to patients by their physician. The original legislation on Medicare was structured for the payment of physicians in non-teaching settings. Questions arose regarding payments to teaching physicians under Part B. Policymakers were concerned that reimbursement to

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[867] Knowles, "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part III. Chapter 8. Medical School, Teaching Hospital, and Social Responsibility," 191.

[868] Institute of Medicine, "Medicare--Medicaid Reimbusement Policies: Effects on Teaching Hospitals, Physician Distribution, and Foreign Medical Graduates," 7.

[869] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 287.

[870] Richard M. Knapp and Peter W. Butler, "Financing Graduate Medical Education," *New England Journal of Medicine* 301, no. 14 (1979).

[871] Medicare and Medicid accounted for 35 percent of the total amount and almost 18 percent was paid through VA hospitals' residency programs. A small amount was paid through federal research or other funds. Mary A. Fruen and Samuel P. Korper, "Issues in Graduate Medical Education Financing," *Journal of Health Politics Policy and Law* 6, no. 1 (1981).

teaching physicians might duplicate other payments under Part A which already provided payment for teaching physician supervision and salaries of interns and residents.[872] To clarify, the discussion on the role of Medicare and Medicaid at teaching hospitals is relevant because of the longstanding involvement of both the hospitals where charity care was occurring and the professionals who were providing this care. There is not a direct alignment between this discussion and charity care for two reasons. The first has to do with how charity care is defined, which has already been shown to be highly variable and not directly related to payments. For the most part, historically, the “charity,” “ward,” and “service” patients were poor and that was the reason for their inclusion in teaching services. It is not possible to completely disentangle a “charity” patient from a “poor” patient, or from the group of patients utilized in teaching. In a sense, this inability to completely disentangle these groups of people is precisely the point. Currently, the language commonly used to describe patients involved in teaching is “service” patient, or “indigent” patient, and it is much less common to refer to a “charity” patient, perhaps related to the stigma of that designation.

The second reason that the discussion on teaching hospitals and Medicare and Medicaid is not in direct alignment is that a strong case can be made that having these public forms of insurance, by definition, means that a patient covered under these programs is not a charity patient.[873] When Congress asked for information on payments through Medicare for teaching, at least initially, they were not concerned with those left out of these programs who may be receiving charity care. On the other hand, because of

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[872] Institute of Medicine, "Medicare--Medicaid Reimbusement Policies: Effects on Teaching Hospitals, Physician Distribution, and Foreign Medical Graduates," 1-11.

[873] See Chapter 5 for a more complete discussion of the relationship between Medicaid and charity.

the significant overlap between those who were providing charity care, particularly the interns and residents, and the places where charity care was occurring, in large part at teaching hospitals, there is good reason to follow these trends. In 1982, the Association of American Medical Colleges reported that teaching hospitals provided close to half of all "free" care, though these hospitals only accounted for less than 10 percent of hospital beds.[874] Also, there is simply little other information on what was actually happening at teaching hospitals regarding supervision of residents in the case of patients with or without public insurance. Later, Congress and others began to specify a more direct connection between payments directed at teaching hospitals and the provision of charity care.

A considerable amount of controversy and even stalemate was created over the definition of a "private" patient.[875] In the initial legislation, both Medicare and Medicaid were to allow the provision of needed health care for the elderly and certain low income people on the same basis as people with other sources of health insurance. Congress did recognize that in some areas and, in particular in some teaching and public hospitals, "a segment of the population continues to receive care as 'service' patients."[876]

Congress Begins to Question the Billing for Supervision under the Medicare Program

Concern by Congress over the cost of care at teaching hospitals and whether there was "double billing" led to an investigation in 1969 in Chicago. There were two ways

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[874] David E. Rogers and Robert J. Blendon, "The Academic Medical Center Today," *Annals of Internal Medicine* 100, no. 5 (1984).

[875] Knapp and Butler, "Financing Graduate Medical Education."

[876] Institute of Medicine, "Medicare--Medicaid Reimbursement Policies: Effects on Teaching Hospitals, Physician Distribution, and Foreign Medical Graduates," 15.

that Medicare could be paying excessive reimbursement. The first was that supervisory costs, under Part A, might be provided when little or no supervision occurred. Second, services billed under Part B fee-for-service could have been provided by a resident and, therefore, the patient was not a "private" patient for billing purposes.[877] The 1969 investigation found that, at one hospital, almost all of the services were provided by a resident with only limited involvement of the attending physician, though services were billed under the attending physician's name. At other hospitals, the problem was called "widespread and significant."[878] Several teaching hospitals were suspended from Medicare payments. The hospitals argued that the policies were unclear and payments were reinstituted to reflect newly published rules.[879] In another study of six teaching hospitals in 1971, residents had provided 67 percent of the services billed under Medicare. In 1984 a study of ten teaching hospitals found inadequate documentation in almost half of the patient care services regarding the requirement that "the physician renders sufficient personal and identifiable services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought."[880]

Rules had been issued requiring comparability of care for Medicare and other patients because of concerns about "perceived differences in doctor-patient relationships between teaching physicians and their private patients, and those physicians and their

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[877] Knapp and Butler, "Financing Graduate Medical Education."

[878] Institute of Medicine, "Medicare--Medicaid Reimbusement Policies: Effects on Teaching Hospitals, Physician Distribution, and Foreign Medical Graduates," 11.

[879] Ibid., 11-12.

[880] General Accounting Office, "Medicare: Documenting Teaching Physician Services Still a Problem," (Washington, DC: U.S. General Accounting Office, 1986), 11.

institutional patients.”[881] However, compliance with this rule was not part of the study. None of these findings address what the proper supervisory role of teaching physicians should be, only whether compliance is provided for required documentation for billing purposes. The findings of these studies do not address the level of resident supervision in the care of “charity” patients. Given the history of care for “charity” patients, it does seem unlikely that supervision would be greater for these patients and quite likely that supervision would be less.

During the period of time between the enactment of Medicare and Medicaid and the mid-1980s, the connection between charity care and the funding of medical education was most often viewed in terms of the positive influence of these funds. Generous and open-ended funding of graduate medical education coupled with the patient care payments of Medicare and Medicaid for former charity patients tended to be the focus of comments.[882] For several reasons, the link between medical education and the provision of charity care, at the institutional level, not at an individual patient level, became more common. In part, this was due to the rising costs of health care and changes in financing of hospital care and medical education.

Medicare’s Prospective Payment System Creates New Direct and Indirect (IME) Graduate Medical Education (GME) Payments Which are Linked to Indigent Care

Cost containment efforts of the Reagan era resulted in a change from hospital payments made on a cost basis to a prospective payment system. Under this system, a specific predetermined amount is paid for each hospital stay according to a diagnosis-

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[881] Ibid., 28.

[882] Ebert and Ginzberg, "The Reform of Medical Education."

related group (DRG).[883] Recognizing the higher costs at teaching hospitals and the original acknowledgment that Medicare should bear some of the burden of graduate medical education (GME), the prospective payment system included two designated payments, direct graduate medical education payments and indirect medical education (IME) payments.[884] In contrast to funds allocated on a cost basis prior to the prospective payment system, the direct graduate medical education payments were, and are, made on a per resident basis. The IME payments are a percentage add-on to Medicare payments for teaching hospitals.[885] The role of private insurers in the funding of graduate medical education is difficult to assess since this funding is implicit and occurs as a consequence of higher negotiated rates with private insurers covering patients at academic medical centers. Currently private insurers do not separately identify or negotiate payments for graduate medical education. Estimates in 2006, however, included over $7 billion in funds from private insurers in support of graduate medical education.[886]

When the Congressional Budget Office studied Medicare's role in graduate medical education in 1995, providing care to people who are poor and uninsured was viewed as a reason to support the continued funding of graduate medical education by Medicare. According to the study:

> Access to care for uninsured, indigent people may be affected by the level of GME subsidies for two reasons. First, since GME subsidies are a significant source of revenue for a number of teaching hospitals, changing the level of the

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[883] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 322-324.

[884] Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs* 20, no. 2 (2001).

[885] Linda E. Fishman and James D. Bentley, "The Evolution of Support for Safety-Net Hospitals," *Health Affairs* 16, no. 4 (1997).

[886] John K. Iglehart, "Medicare, Graduate Medical Education, and New Policy Directions," *New England Journal of Medicine* 359, no. 6 (2008).

> subsidies would probably affect the amount of various services that teaching hospitals provide, including care for uninsured people. Second, to the extent that care for indigent people is provided by hospital residents, changes in subsidies could affect access for that group by influencing the number of residents available to provide such care.[887]

These sources of funds are significant. In 2009, payments by Medicare for direct costs of GME were about $3 billion and payments for the IME costs were about $6.5 billion.[888] The GME funds from Medicare have been shown to have a significant effect in supporting teaching hospitals. This support, however, is not directly aligned with teaching hospitals in which a large amount of uncompensated care for people who are poor and uninsured takes place. In a 1994 study, a small number of teaching hospitals were among the top providers of uncompensated care and almost all of these were owned by state, county, or city government.[889]

The amount of GME funding provided by Medicare has been a contentious issue for many years, particularly for the IME payments. The Medicare Payment Advisory Commission (MedPAC) has determined that the IME payments are more than twice the amount that can be empirically justified. The Commission pointed out that this $3 billion consists of extra payments with no restrictions on the use of the payments.[890]

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[887] Congressional Budget Office, "Medicare and Graduate Medical Education," (Washington, DC: Congressional Budget Office, 1995), 30.

[888] MedPAC, "Report to the Congress: Aligning Incentives in Medicare," (Washington, DC: Medicare Payment Advisory Commission, 2010), 103.

[889] Linda E. Fishman, "What Types of Hospitals Form the Safety Net?" *Health Affairs* 16, no. 4 (1997).

[890] John K. Iglehart, "Health Reform, Primary Care, and Graduate Medical Education," *New England Journal of Medicine* 363, no. 6 (2010).

Spokespersons for academic medical centers have explained that some or all of the extra payments are used to finance other missions, especially indigent care.[891]

Medicare Disproportionate Share Hospital (DSH) Payments are Linked to Low Income Hospital Patients

Medicare also supports hospitals that provide care to low income patients through the Medicare Disproportionate Share Hospital (DSH) program. The Medicare DSH program was created in 1982 and funded in 1986.[892] In 2009, the Medicare DSH program costs were about $9.8 billion.[893] The Medicare program operates on the principle that it may only pay for its own beneficiaries.[894] When Medicare established the DSH program, the rationale was that hospitals serving a greater proportion of low income patients incurred greater expenses. Additional studies over time failed to show this connection between low income Medicare beneficiaries and increased costs. However, in large hospitals that served a proportionately higher number of Medicaid patients, costs were also higher for Medicare beneficiaries. When this data did not persist concerning higher costs for Medicare beneficiaries in hospitals serving greater numbers of Medicaid patients, another rationale for these funds was put forth; certain hospitals providing care

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[891] Adepeju L. Gbadebo and Uwe E. Reinhardt, "Economists on Academic Medicine: Elephants in a Porcelain Shop?" *Health Affairs* 20, no. 2 (2001).

[892] Association of American Medical Colleges, "AAMC: Medicare Disproportionate Share (DSH) Payments," https://www.aamc.org/advocacy/teachhosp/97342/teachhosp_hosp0003.html (accessed March 14, 2013).

[893] American Hospital Association et al., "America's Hospitals and Health Systems," http://www.aha.org/aha/content/2009/pdf/090610-aa-house-senate-dsh-let.pdf (accessed March 14, 2013). See also Christie Provost Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program," (Washington, DC: George Washington University, 2009).

[894] Bruce C. Vladeck, "Paying for Hospitals' Community Service," *Health Affairs* 25, no. 1 (2006).

to larger numbers of low income patients could be in danger of closing, which would limit access to care for low income Medicare beneficiaries.[895]

Funding for the Medicare DSH program is linked to both medical education expenses and to the provision of charity care, though not directly. When the Medicare DSH program began, in order to obtain budget neutrality, the funds were redirected from a portion of the IME payments.[896] Teaching hospitals receive two-thirds of the Medicare DSH payments, even though these are not specifically directed toward medical education expenses.[897] In addition, discussions of Medicare graduate medical education funding are often undertaken together with Medicare DSH funding.[898]

Medicare's DSH funding formula uses two proxy measures to estimate the number of low income patients served by a hospital: the proportion of low income Medicare beneficiaries receiving supplemental security income (SSI) payments and the number of Medicaid patients receiving care at the hospital.[899] Beginning in the late 1990s, Medicare's administrators began to recognize that hospitals with the largest share of uncompensated care often do not have the largest share of either Medicaid or low

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[895] Association of American Medical Colleges, "AAMC: Medicare Disproportionate Share (DSH) Payments." Barbara Wynn et al., "Analysis of the Joint Distribution of Disproportionate Share Hospital Payments," (Santa Monica, CA: RAND Corporation, 2002), 3, 5-6.

[896] Association of American Medical Colleges, "AAMC: Medicare Disproportionate Share (DSH) Payments."

[897] Weinrich, "Federal Funding for Graduate Medical Education."

[898] Sean Nicholson, *Medicare Hospital Subsidies: Money in Search of a Purpose* (Washington, DC: American Enterprise Institute Press, 2002). See also: Fishman and Bentley, "The Evolution of Support for Safety-Net Hospitals."

[899] There is also a separate provision, called the "Pickle" provision named after the Texas congressman who sponsored it, for certain urban hospitals with at least 100 beds that can demonstrate that more than 30 percent of net inpatient care revenue was provided by state or local government for the inpatient care of low income patients not reimbursed by Medicare or Medicaid. Wynn et al., "Analysis of the Joint Distribution of Disproportionate Share Hospital Payments."

income Medicare patients. According to the 1999 Medicare Payment Advisory Commission: "The measure of low-income costs should reflect: Medicare patients eligible for Supplemental Security Income, Medicaid patients, patients sponsored by other indigent care programs, and uninsured and underinsured patients as represented by uncompensated care (both charity care and bad debts)."[900] Currently, the Medicare DSH payments do not factor in uninsured patients.[901] However, the Affordable Care Act will make changes to the Medicare DSH payments beginning in 2014 by reducing the amount of funding by 75 percent and subsequently increasing the payments based on the percent of the population remaining uninsured and the amount of uncompensated care provided by hospitals.[902]

For a variety of reasons, there are critics of the Medicare DSH program. A criticism that is particularly relevant in this chapter is that the Medicare DSH program encourages hospitals to admit publicly insured low income patients through both the Medicare and Medicaid programs but creates disincentives to admit uninsured or charity patients. One analysis of the impact of the Medicare DSH program estimated that the effect on hospital behavior was to increase the number of Medicaid admissions by about 3 percent and to reduce charity care by less than 1 percent.[903] The Medicare DSH formula

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[900] MedPAC, "Report to the Congress: Medicare Payment Policy: Chapter 3: Updating and Reforming Prospective Payment for Hospital Inpatient Care," (Washington, DC: Medicare Payment Advisory Commission, 1999), 62.

[901] ———, "Payment Basics: Hospital Acute Inpatient Services Payment System," Medicare Payment Advisory Commission, http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_hospital.pdf (accessed March 14, 2013).

[902] Kaiser Family Foundation, "Medicare: A Primer," (2010), http://www.kff.org/medicare/upload/7615-03.pdf (accessed March 14, 2013).

[903] Nicholson, *Medicare Hospital Subsidies: Money in Search of a Purpose*: 5.

essentially subsidizes the institution rather than the practice of providing charity care, and financially penalizes hospitals for admitting uninsured patients.[904]

The Medicaid Program is the Second Largest Source of Funds for GME and the Funds are Linked to Charity Care

The Medicaid program, which is a public health insurance program for certain categories of low income people, also provides funding for graduate medical education and for hospitals that provide a disproportionate amount of services for uninsured low income people. Medicaid is administered by the states, which creates over fifty distinct programs, but it is financed jointly by the states and the federal government. The states must follow broad federal guidelines in benefits and coverage. Currently, the federal government funds 57 percent of the Medicaid program. Medicaid, in 2009, provided health insurance coverage to 45 percent of low income Americans.[905] In 2009, forty-one states and the District of Columbia provided payments for direct and/or indirect graduate medical education costs under their Medicaid program and the total amount is estimated to be about $3.78 billion. Medicaid is the second largest payer, behind Medicare, of graduate medical education. Unlike Medicare, the federal government has no explicit guidelines for states on whether and how their Medicaid programs should or could make direct and indirect graduate medical education payments.[906]

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[904] Ibid.

[905] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation’s Health Coverage Program for Low-Income People."

[906] Tim M. Henderson, "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey," American Association of Medical Colleges, https://services.aamc.org/publications/showfile.cfm?file=version161.pdf&prd_id=299&prv_id=371&pdf_id=161 (accessed March 14, 2013).

The connection between Medicaid graduate medical education funding and the provision of charity care or care to low income people or to underserved communities has been made explicitly. In a survey of states regarding their Medicaid funding of graduate medical education, several included in their rationale for providing this funding that graduate medical education is a public good. States surveyed also included in their rationale that education of future physicians who will treat Medicaid beneficiaries and who will train in settings where care for the underserved is provided are important goals.[907] In a 2007 letter to Centers for Medicare & Medicaid Services regarding a proposed rule that would eliminate federal matching funds for Medicaid graduate medical education, the Association of American Medical Colleges provided the following reasons to continue this funding:

> [M]any major teaching hospitals share a special mission in treating large numbers of Medicaid and uninsured patients. Representing only six percent of all hospitals, major teaching hospitals are the sites for approximately a quarter of all Medicaid discharges. Indeed, our nation’s teaching hospitals provide large amounts of ambulatory care in poor communities, often acting as the “family doctor” in areas where few individual practitioners exist, accept Medicaid as a form of payment, or provide charity care. Major teaching hospitals also provide nearly one-half (45 percent) of all hospital charity care.[908]

The proposed rule that would eliminate federal funding for Medicaid graduate medical education was not implemented.[909]

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[907] Ibid.

[908] Robert M Dickler, "Letter to Leslie Norwalk, Acting Adminstrator, Centers for Medicare and Medicaid Services," Association of American Medical Colleges, https://www.aamc.org/download/55992/data/062207.pdf (accessed March 14, 2013).

[909] Beginning in 2007, President Bush introduced several regulations that would have reduced federal Medicaid spending by nearly $20 billion over 5 years, including a rule that would end federal funding for graduate medical education. In 2008, Congress placed a moratorium on finalizing the proposed regulations, and President Obama blocked their implementation in 2009. Henderson, "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey."

The Medicaid Disproportionate Share Hospital (DSH) Program and Tax Appropriations Link Funds for Many Teaching Hospitals to Charity Care

Medicaid also supports hospitals that provide services to low income patients through the Medicaid disproportionate share hospital program (DSH).[910] The Medicaid DSH payments for 2009 include approximately $11.3 billion in federal funds.[911] Congress enacted changes to the Medicaid program in 1981 which were directed at containing the costs of the program. Prior to this time, state Medicaid programs were required to follow Medicare cost-based reimbursement principles. Concerned that these efforts would have a greater negative effect on hospitals that treat “a large volume of Medicaid patients and patients who are not covered by other third party payers,” the law included the provision that states “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs” by raising the payment rates.[912] States generally did not implement the Medicaid DSH payments because the requirements were vague and broad. In 1987, Congress enacted more stringent and specific requirements for states to report on their DSH payments and the law defined the minimum requirements for determining which hospitals would receive these payments. Unlike the Medicare DSH payments, the Medicaid DSH payments were tied to charity care charges along with Medicaid utilization.[913] Medicaid DSH payments

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[910] The Medicaid DSH Program is discussed in more detail in Chapter 4 and particularly in Chapter 5.

[911] Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[912] *Omnibus Reconciliation Act of 1981*, Public Law 97-35. Codified, as amended, at 42 U.S.C. § 1396a(a)(13).

[913] Lynne Fagnani and Jennifer Tolbert, "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs," (The Commonwealth Fund, 1999).

grew exponentially from under $1 billion before 1990 to $17.4 billion two years later.[914] More than half of these funds were federal matching payments.[915]

When the Commonwealth Fund studied the role of academic health centers in providing care to the poor and uninsured in 2001, Medicaid DSH payments were described as a "critical source of revenues."[916] The study noted that academic health centers are often considered to be a vital component of the health care safety net for low income people for two reasons, "institutional traditions" and the frequent close affiliation with public hospitals. Forty-three percent of academic health centers were closely affiliated with public hospitals in 1999.[917] The Association of American Medical Colleges reported that, in 2008, teaching hospital members accounted for 6 percent of all acute care hospitals and 22 percent of all hospital discharges but they provided 41 percent of all charity care, and 28 percent of Medicaid inpatient care.[918]

Another source of funds that ties charity care to medical education is tax appropriations. State and county governments provide tax appropriations in support of both public and private hospitals. However, about 85 percent of the tax appropriations are

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[914] Jean Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," (Washington, DC: Congressional Reseach Service, 2005), 4.

[915] Commonwealth Fund Task Force on Academic Health Centers, "A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured," 16.

[916] Ibid., 16-17.

[917] Ibid., 11.

[918] Association of American Medical Colleges, "Policy Priorities to Improve the Nation's Health from America's Medical Schools and Teaching Hospitals," https://www.aamc.org/download/97686/data/obamatransition.pdf.pdf (accessed March 14, 2013).

provided to public hospitals. In 1996, academic health centers used about 37 percent of their tax appropriations for indigent care and about 34 percent for general operations.[919]

To summarize, the sources of funding that link charity care to medical education include: Medicare direct GME payments and IME payments, Medicare DSH payments, Medicaid direct and indirect medical education payments, Medicaid DSH payments, and tax appropriations. One of the difficulties in examining the extent to which these sources of funding achieve their purpose or purposes is the fluidity of funds. In 2006, a former director of the Centers for Medicare and Medicaid Services described the situation:

> Hospitals in the United States have engaged in internal cross-subsidization throughout their history, using surpluses obtained from more prosperous patients, philanthropy, or government to defray the costs of services for which they were not paid. Rarely has that process been conducted with the degree of formality or neatness that would make life simpler for policymakers or policy analysts; from the viewpoint of most hospital executives, money is after all, fungible, and revenue is revenue. If all revenue exceeds all expenses, most are willing to stop there.[920]

In a 2009 article, leaders of academic health centers described the complexity of these organizations, making the point that cross-subsidization clearly occurs and that the "[Academic Health Center] AHC is not a 'three-legged stool' of patient care, research, and teaching—a metaphor implying greater similarity of purpose, functioning, and financing than is the case."[921] As this article explains, the fact of cross-subsidization,

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[919] Commonwealth Fund Task Force on Academic Health Centers, "A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured," 19.

[920] Vladeck, "Paying for Hospitals' Community Service," 34.

[921] Mark Wietecha, Steven H. Lipstein, and Mitchell T. Rabkin, "Governance of the Academic Health Center: Striking the Balance between Service and Scholarship," *Academic Medicine* 84, no. 2 (2009): 174.

discretionary revenue, commingling of funds or fluidity in financing academic health centers is not questioned in the literature.[922]

Faculty at Medical Schools and Teaching Hospitals Likely Do Not Know about the Sources of Funds and Fluidity of Funds That Tie Medical Education to Charity Care

For several reasons, including the fact that funds are fluid and discretionary, it is doubtful that faculty at medical schools and teaching hospitals recognize the sources of funding that tie medical education to charity care. The payments for Medicare direct GME expenses are paid to teaching hospitals. According to one analysis, medical schools may not receive these funds explicitly: “[I]n most cases, little GME funding flows to the school. Even in university-based teaching hospitals, the transfer of GME dollars to the programs and faculty are individualized, often idiosyncratic, arrangements varying from school to school.”[923] In 2009, there were about 90,000 residents in the United States and the average amount of Medicare direct GME and IME was $100,000 per resident.[924]

While the teaching hospital receives payments for Medicare direct GME, both IME payments and the payments for Medicare DSH are add-ons to reimbursements for patient care. Medicare payments for IME and DSH are highly concentrated. Almost half of these payments go to 200 hospitals, averaging $30 million per hospital. Since 90

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[922] There are numerous references to this phenomenon. See, for example, Robert F. Jones and Susan C. Sanderson, "Clinical Revenues Used to Support the Academic Mission of Medical Schools, 1992-93," *Academic Medicine* 71, no. 3 (1996).; Vladeck, "Paying for Hospitals' Community Service."; Fishman and Bentley, "The Evolution of Support for Safety-Net Hospitals."; John K. Iglehart, "Forum on the Future of Academic Medicine: Session II--Finances and Culture," *Academic Medicine* 72, no. 9 (1997).

[923] Rich et al., "Medicare Financing of Graduate Medical Education," 286.

[924] On average, hospitals received more than $70,000 in indirect medical education payments (though this was through add-ons to reimbursements) and $30,000 in direct medical education payments. MedPAC, "Report to the Congress: Improving Incentives in the Medicare Program: Chapter 1: Medical Education in the United States: Supporting Long-Term Delivery System Reforms," (Washington, DC: Medicare Payment Advisory Commission, 2009).

percent of major teaching hospitals receive both of these payments, these hospitals have the highest Medicare margin among all hospitals.[925] The Medicare IME payments and the Medicare DSH payments show up as clinical revenue. To the extent that teaching hospital faculty are compensated through clinical revenue and not explicitly compensated for teaching and supervision, faculty may believe that their teaching and supervision time is unreimbursed.[926]

When faculty practice plans at medical schools have been studied, out of several academic missions, the academic mission of research has received the most funding.[927] For example, for one year in the early 1990s, it was estimated that clinical revenue derived from faculty practice plans supported research at all of the nation's medical schools in the amount of approximately $816 million.[928] In 1996, almost three quarters of all medical school faculty reported unsponsored research, that is, research for which there was no external funding. A major source of funding for unsponsored research is presumed to be excess clinical revenue.[929] That research funds derived from surplus

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[925] Medicare profit margins are defined as Medicare payments minus the allowable costs of treating Medicare patients, all divided by Medicare payments. The overall Medicare margin for major teaching hospitals fell below zero (–1.5 percent) for the first time in 2008. The overall Medicare margin for all hospitals was substantially lower than the margin for teaching hospitals (–7.2 percent) in 2008. ———, "Report to the Congress: Medicare Payment Policy," (Washingon, DC: Medicare Payment Advisory Commission, 2010).

[926] Steven Shea et al., "Compensation to a Department of Medicine and Its Faculty Members for the Teaching of Medical Students and House Staff," *New England Journal of Medicine* 334, no. 3 (1996).

[927] The total amount of practice plan funds used to support academic programs in all medical schools for the years 1992 to 1993 was an estimated $2.4 billion. Of this amount, $816 million was directed to research. Jones and Sanderson, "Clinical Revenues Used to Support the Academic Mission of Medical Schools, 1992-93."

[928] Ibid.

[929] Joel S. Weissman et al., "Market Forces and Unsponsored Research in Academic Health Centers," *Journal of the American Medical Association* 281, no. 12 (1999).

clinical revenue might compete with funds in support of charity care is generally not recognized by medical educators. Going further, a case can be made that using surplus clinical revenue from Medicare funds for IME and DSH is not just a matter of competition between research and education but actually a matter of diverting funds from charity care to research. This radical view comes from evidence that, historically and currently, the justification for these funds has been primarily due to the provision of care to low income patients and, more recently, uncompensated or charity care and not because of an identified directive for the Medicare program to provide funds for research.[930] To be clear, funding of unsponsored research cannot be traced to its source. "[P]recise accounting" measures are not available, though survey information and projections are available.[931] Funding from Medicare DSH and IME payments also cannot be traced from their origin to a specific purpose, either research, charity care, or any other purpose.[932] The Medicare program, however, does consider research costs as a non-allowable expense for the purpose of calculating Medicare costs.[933] To the extent that any of the sources of funding that are primarily justified as providing reimbursement for charity care result in excess clinical revenue, this could be considered a diversion of funds.

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[930] Total funding for biomedical research from federal, state, and local governments; private entities; and industry was $1.01trillion in 2007. Federal funds from the NIH provided $27.8 billion in research funding and other federal sources accounted for another $5.2 billion in 2007 for biomedical research. E. Ray Dorsey et al., "Funding of US Biomedical Research, 2003-2008," *Journal of the American Medical Association* 303, no. 2 (2010).

[931] Jones and Sanderson, "Clinical Revenues Used to Support the Academic Mission of Medical Schools, 1992-93."

[932] Lane Koenig et al., "Estimating the Mission-Related Costs of Teaching Hospitals," *Health Affairs* 22, no. 6 (2003).

[933] MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," (Washington, DC: Medicare Payment Advisory Commission, 2007), 76-77.

The Association of American Medical Colleges (AAMC) Claims Financial and Arguably Moral “Credit” for the Provision of Charity Care, though Accountability is Lacking

The organization that represents American medical schools and teaching hospitals is the Association of American Medical Colleges (AAMC). The Association, in communication with the President, Congress, and the Medicare Payment Advisory Commission (MedPAC), virtually always refers to the important role of organizational members in providing charity care, uncompensated care, and care to the uninsured.[934] MedPAC is aware that some policymakers assert that the Medicare IME and DSH payments are “appropriately used to help fund social missions,” even though “it is difficult to account for hospitals’ use of the funds.”[935] The primary social mission referred to in this context is the provision of uncompensated care. On the other hand:

> [S]ome have suggested that spending large sums of money through Medicare to support vaguely defined social benefits all too often does not result in the social benefits being provided. In this vein, it is unclear how much of the IME and DSH monies have gone to supporting social benefits rather than to improving the competitive position of the hospitals receiving them.[936]

When MedPAC studied the relationship between the provision of uncompensated care and receipt of Medicare IME and DSH payments, the summary statement was: “[I]t appears that the hospitals most involved in teaching and in treating Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to

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[934] See, for example: Association of American Medical Colleges, "Policy Priorities to Improve the Nation’s Health from America's Medical Schools and Teaching Hospitals;" Atul Grover, "Comments of the Association of American Medical Colleges to the Senate Finance Committee: Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options," Association of American Medical Colleges, https://www.aamc.org/download/73388/data/052809.pdf (accessed March 14, 2013).

[935] MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," 80.

[936] Ibid.

treating patients who are unable to pay their bills."[937] In other words, the way that the Medicare IME and DSH payments are targeted does not result in the distribution matching the level of uncompensated care provided.

MedPAC has worked with the Centers for Medicare and Medicaid Services (CMS) to improve the reporting of charity care because the "information will be critical for evaluating policies that consider linking Medicare disproportionate share (DSH) payments to hospitals' uncompensated care costs, as well as analyses of the distribution of uncompensated care costs among hospitals."[938] MedPAC noted that the reporting of uncompensated care as required by Medicare beginning in 2003 had not been accurate or consistently done on the hospital cost reports.[939] Several suggestions for improving the targeting of Medicare DSH funds were proposed to direct the funds more narrowly to charity care instead of bad debt and to require that hospitals have a charity care policy with eligibility criteria.[940] As already mentioned the Affordable Care Act will reduce Medicare DSH payments and, presumably, use the newer and better methods as implemented by CMS in determining actual charity care provided.[941] The IME payments

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[937] Ibid., 79.

[938] Glenn Hackbarth, "Letter to CMS: Proposed Revisions to the Medicare Cost Report," August 27, (2009), http://www.medpac.gov/documents/Cost_report_comment_MedPAC_final%2010-27-09.pdf (accessed March 14, 2013).

[939] MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," 85.

[940] Ibid., 86-87.

[941] The Affordable Care Act contains provisions that will reduce Medicare DSH funding by $22 billion over 10 years. Beginning in FY 2014 the reductions will reduce each hospital's current Medicare DSH payments by 75 percent. However, additional payments will be made to hospitals based on the savings from the 75 percent reduction, with this amount being reduced over time as the uninsured rates fall. The specific amounts that a hospital will receive will be based on its uncompensated care costs as a share of aggregate national uncompensated care costs. *Patient Protection and Affordable Care Act*, Public Law 111–148, 111th Congress (March 23rd, 2010), § 3133. See also Corey Davis, "Q & A: Disproportionate

are relatively unaffected by the Affordable Care Act, even though MedPAC recognizes that there is “no accountability” for these funds by teaching hospitals.[942]

Faculty at Medical Schools and Teaching Hospitals Also Likely Do Not Know about the Medicaid GME Funds That Tie Medical Education to Charity Care

In the same way that Medicare funds may not be recognized as tying medical education to charity care by teaching hospital faculty, Medicaid funds may not be readily identified as linking charity care to medical education. Medicaid direct and indirect medical education payments are sometimes add-ons to reimbursement for patient care but are also sometimes made in lump sums to medical schools or teaching hospitals. In 2009 as already mentioned, forty-one states made Medicaid direct and indirect graduate medical education payments. More than half of these states make payments on a per case or per diem basis and the other states used a variety of methods, including direct payments to institutions.[943] The federal government does not have reporting requirements for states to document their Medicaid graduate medical education payments, though federal matching funds are provided to those states that choose to have these programs.[944] In the states that do use add-ons to payments for direct and indirect Medicaid medical education, additional payments are likely seen as general clinical revenue.

Share Hospital Payments and the Medicaid Expansion," (2012), http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf (accessed March 14, 2013). The Medicaid DSH program funding will also be reduced as a result of the Affordable Care Act. This reduction is discussed in Chapters 4 and 5.

[942] MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," 85.

[943] Henderson, "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey."

[944] Elicia J. Herz and Sibyl Tilson, "CRS Report for Congress: Medicaid and Graduate Medical Education," (Washington, DC: Congressional Research Service, 2008).

Medicaid DSH Funds Are the Largest Source of Federal Funds for Uncompensated Care and Are Vital to Many Teaching Hospitals: Are Medicaid DSH Funds Sometimes Diverted to Educational Purposes?

Medicaid DSH funds are not only a source of funds that contribute a critical source of revenue to academic medical centers, as already discussed, the funds are also commonly viewed as the "largest source of federal funding for uncompensated hospital care."[945] According to the AAMC, the Medicaid DSH program "provides critical financial assistance to our teaching hospitals and academic clinical faculty, which serve as 'safety net' providers for much of the nation's population."[946] Another organization, the National Association of Public Hospitals and Health Systems (NAPH), has members that overlap but are not entirely the same as members of the AAMC. For example, 23 percent of residents trained at NAPH hospitals in 2009 and more than three-quarters of NAPH members are teaching hospitals.[947] NAPH reported that the Medicaid DSH payments financed 22 percent of "unreimbursed" costs in 2009.[948] In comparison, the Medicare DSH payments financed 5 percent of these costs.[949] The vital importance of the Medicaid DSH payments for many public and teaching hospitals is a recurrent theme. At

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[945] Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program," 1.

[946] Jordan J. Cohen, "Centers for Medicare and Medicaid Services, Letter," Association of American Medical Colleges, https://www.aamc.org/download/79166/data/102405.pdf (accessed March 14, 2013).

[947] Obaid S. Zaman, Linda C. Cummings, and Sari Siegel Spieler, "America's Public Hospitals and Health Systems, 2009," National Association of Public Hospitals, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Public-Hospital-Financial-Characteristics-.aspx?FT=.pdf (accessed March 14, 2013).

[948] "Unreimbursed" is another term, like "charity" or "uncompensated," where definitions may differ from intuitive meanings and definitions may vary according to how or by whom the term is used. In this case, NAPH defines "unreimbursed" as losses on patient care, including losses on self-pay patients and losses on Medicare and Medicaid. Funding such as DSH payments, indirect medical education payments, and state and local government payments are not included as covering these costs but are generally recorded separately by NAPH. Ibid., 21.

[949] Ibid., 16.

the same time, the Medicaid DSH program is plagued with a number of problems. Among the problems with the program is the "lack of transparency and accountability for documenting the direct impact of federal spending on care for vulnerable populations."[950] The Affordable Care Act, predicted to expand insurance coverage by about 30 million people, also reduces spending on the Medicaid DSH program by $14 billion over ten years, beginning in 2014.[951] The methodology for the reduction will be determined in future regulations.[952]

One of the questions that arises because of the lack of accountability in the Medicaid DSH program is the extent to which funding that is intended to bolster the provision of care to those hospitals committed to providing care for the uninsured, or charity patients, is, instead, used for other purposes. For this section of this chapter, which relates the provision of charity care to medical education, one question is whether there is any evidence that the costs related to medical education prevents or impedes the provision of charity care. The possibility was raised earlier that the Medicare IME payments, to the extent that they produce surpluses, might divert funds from the provision of charity care to research at teaching hospitals.

In Louisiana, following Hurricane Katrina, the Public Affairs Research Council viewed the Medicaid DSH payments to the ten-hospital charity system as diverting funds

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[950] The history and the problems related to the Medicaid DSH program will be discussed further in Chapter 5. Aaron McKethan et al., "Reforming the Medicaid Disproportionate-Share Hospital Program," *Health Affairs* 28, no. 5 (2009).

[951] Matthew Buettgens and Mark A. Hall, "Who Will Be Uninsured after Health Insurance Reform?" Urban Institute, http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf (accessed March 14, 2013).

[952] Deborah Bachrach, Laura Braslow, and Anne Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net," (2012), http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Vulnerable-Populations.aspx (accessed March 14, 2013).

from providing charity care to providing funds for graduate medical education. The Public Affairs Research Council found that "[c]harity health care and medical education are physically and fiscally intertwined in Louisiana's state-run charity hospital system."[953] The report views Louisiana's charity hospitals as "potent symbols of the authority of the state of Louisiana," where "good health and quality of life depended on generosity of the government in Baton Rouge."[954] In 2003, Louisiana's charity hospitals were highly dependent on Medicaid DSH funds, relying on these funds for 88 percent of total revenues.[955] The total amount of DSH payments at the time of the report was over $1 billion annually with little ability for policymakers and the public to be informed about how the funds were spent. The Public Affairs Research Council Report concurred with a report from the consulting firm PricewaterhouseCoopers that Louisiana should "separate the safety-net mission for the under and uninsured from the educational mission of the LSU medical professional teaching system."[956] Reliance on Medicaid DSH funds helped to ensure a "two-tier" system whereby most patients with private insurance coverage chose to go to other hospitals and the state financed charity hospitals served mostly the uninsured. Since Medicare patients could choose among available hospitals,

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[953] Public Affairs Research Council of Louisiana, "Realigning Charity Health Care and Medical Education in Louisiana," May (2007), http://www.parlouisiana.com/s3web/1002087/docs/Publications/Realigning_Charity_May_2007.pdf. (accessed March 14, 2013).

[954] Ibid., 3.

[955] Robin Rudowitz, Diane Rowland, and Adele Shartzer, "Health Care in New Orleans before and after Hurricane Katrina," *Health Affairs* 25, no. 5 (2006).

[956] PricewaterhouseCoopers for the Louisiana Recovery Authority Support Foundation, "Report on Louisiana Healthcare Delivery and Financing System," April (2006), http://lra.louisiana.gov/assets/docs/searchable/reports/PwChealthcarereport42706l.pdf (accessed March 14, 2013).

there were few, about 11 percent, of Medicare patients at the charity hospitals.[957] As a result of having few Medicare patients, funding for graduate medical education through Medicare direct GME and IME payments was minimal, while at the same time funding through Medicaid DSH was greater than average. [958] For example, the charity hospitals in two cities received nearly 70 percent of the Medicaid DSH funding but provided care to 35 percent of the uninsured cases.[959]

When the Office of the Inspector General audited Louisiana's Medicaid DSH program for the years 2003 to 2007, the findings were that state-owned public hospitals received payments for almost all of their reported uncompensated care, 94 percent, whereas private hospitals received funds covering one-fifth of their reported uncompensated care costs.[960] The conclusion of the Public Affairs Research Council was that, because the Medicaid DSH funds were primarily going to the hospitals with large roles in medical education and little other sources of funds were available for educational purposes; in effect the Medicaid DSH funds were being diverted to cover the cost of medical education.[961] Much like the case in Louisiana, the Texas Higher Education Coordinating Board in 2004 found that DSH payments were not designated as

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[957] Rudowitz, Rowland, and Shartzer, "Health Care in New Orleans before and after Hurricane Katrina."

[958] Medicare GME funding per resident in 2003 was $16,000 for charity hospitals and over $100,000 at other community hospitals in Louisiana.Public Affairs Research Council of Louisiana, "Realigning Charity Health Care and Medical Education in Louisiana."

[959] Ibid., 19.

[960] Office of Inspector General, "Review of Medicaid Disproportionate Share Hospital Payment Distribution," (Washington, DC: Department of Health and Human Services, 2010).

[961] Public Affairs Research Council of Louisiana, "Realigning Charity Health Care and Medical Education in Louisiana."

educational funds but they were used through cost shifting to cover the costs of providing graduate medical education.[962]

In the aftermath of Hurricane Katrina, medical education programs have reported that they “have benefited from the development of new affiliations that provide higher patient and procedure volumes in more supervised settings than the traditional programs.”[963] As already discussed in the context of the implementation of Medicaid and Medicare, the issue of supervision of residents has been raised frequently in regard to the Medicare program. Since Medicare patients, by definition, are not charity patients, the implication for charity patients can only be inferred from such results. At the same time, it is quite apparent that medical students and residents are often involved in the care of charity patients. Two measures of this relationship have already been provided. The first is the AAMC statement that, in 2008, 41 percent of all charity care and 28 percent of Medicaid inpatient care was provided by member hospitals.[964] The second is that NAPH hospitals provided training sites for almost a quarter of all residents in 2009 and more than three-quarters of NAPH members are teaching hospitals.[965] Stated succinctly by the 2003 Texas Higher Education Coordinating Board: “Uninsured Texans play an important role in graduate medical education; they are one of the groups of patients that residents

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[962] Texas Higher Education Coordinating Board, "Funding Graduate Medical Education in Texas," Texas Higher Education Coordinating Board. (2004), http://www.thecb.state.tx.us/reports/PDF/0778.PDF?CFID=21164330&CFTOKEN=35990020 (accessed March 14, 2013).

[963] N. Kevin Krane, Richard P. DiCarlo, and Marc J. Kahn, "Medical Education in Post-Katrina New Orleans: A Story of Survival and Renewal," *Journal of the American Medical Association* 298, no. 9 (2007): 1054.

[964] Association of American Medical Colleges, "Policy Priorities to Improve the Nation’s Health from America's Medical Schools and Teaching Hospitals."

[965] Zaman, Cummings, and Spieler, "America’s Public Hospitals and Health Systems, 2009."

care for and treat, while honing their medical skills and expertise."[966] In California, a 1998 review reported that the county hospital systems with 10 percent of all the states' hospital beds provided 84 percent of all indigent care for the state. These hospitals were training sites for one-third of the residents in the University of California system, where the residents are "given a great deal of responsibility for direct patient care, ensuring that they are fully prepared for the medical workforce when they graduate from their residency programs."[967] When charity care is provided by public hospitals that are involved in teaching, it is: "Less clear…whether additional care to the uninsured in cities with public hospitals is a result of altruistic behavior, viewing the poor as clinical material, or both."[968]

Supervision of Residents is Again a Focus of Congressional Reports: Physicians at Teaching Hospitals (PATH) audits

One publication on the health care system in post-Katrina Louisiana described the fact that supervision of trainees had improved as compared to what took place before the hurricane.[969] Prior to the hurricane more than half of the New Orleans Charity Hospital's inpatient care was provided to uninsured people.[970] While supervision of charity or uninsured patients in teaching hospital settings has not been a specific concern for

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[966] Texas Higher Education Coordinating Board, "Funding Graduate Medical Education in Texas."

[967] Wendy J. Jameson, Katherine Pierce, and Denise K. Martin, "California's County Hospitals and the University of California Graduate Medical Education System. Current Issues and Future Directions," *Western Journal of Medicine* 168, no. 5 (1998): 306.

[968] Kenneth E. Thorpe and Charles Brecher, "Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?" *Journal of Health Politics Policy and Law* 12, no. 2 (1987): 322.

[969] Krane, DiCarlo, and Kahn, "Medical Education in Post-Katrina New Orleans: A Story of Survival and Renewal."

[970] Rudowitz, Rowland, and Shartzer, "Health Care in New Orleans before and after Hurricane Katrina."

policymakers, Congress has remained interested in the level of supervision for Medicare patients since the program began. Congress in the 1980s again directed the Government Accounting Office to assess mainly whether teaching physicians who were billing Medicare Part B were actually providing “sufficient personal and identifiable services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought.”[971] The resulting 1986 report included the finding that, in about half of the cases reviewed, there was inadequate documentation.

In the mid-1990s, the Office of the Inspector General initiated the “Physicians at Teaching Hospitals” (PATH) audits, which created considerable controversy. In 1995, the University of Pennsylvania settled a claim with the Department of Justice for $30 million in disputed Medicare billings for teaching physicians. PATH audit settlements totaled close to $70 million by 1998.[972] Needless to say, complying with Medicare rules and adequate documentation gained attention.[973] Teaching physicians had a mixed view of enforcement of the Medicare requirements. Even before the PATH audits, one teaching physician welcomed the requirements because “abuses occur not infrequently.”[974] Citing the special responsibilities of teaching physicians in a letter, this physician stated:

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[971] General Accounting Office, "Medicare: Documenting Teaching Physician Services Still a Problem," 11.

[972] ———, "Medicare: Concerns with Physicians at Teaching Hospitals (Path) Audits," (Washington, DC: U.S. General Accounting Office, 1998).

[973] Jordan J. Cohen and Robert M. Dickler, "Auditing the Medicare-Billing Practices of Teaching Physicians--Welcome Accountability, Unfair Approach," *New England Journal of Medicine* 336, no. 18 (1997). ; Ruth SoRelle, "Tracking a Tangled Path. Physicians at Teaching Hospitals," *Circulation* 97, no. 22 (1998).

[974] Pascal James Imperato, "Letter to the Editor: Accountability and House Staff," *Annals of Internal Medicine* 100, no. 3 (1984): 456.

> The worst abuses occur when supervising physicians fail to meet both the minimum Medicare requirements for reimbursement as patients' attending physicians and yet are reimbursed. By abdicating responsibility for patients' care to house staff, while simultaneously generating income elsewhere, these physicians have simultaneously defrauded Medicare while providing house staff with the undesirable model of an entrepreneurial physician more interested in financial gain than patient care.[975]

Further, the "regulations insure greater legal, moral, and ethical compliance on the part of attending physicians."[976] On the other hand, some physicians viewed the requirements as marking the passing of a better era. For example, in a 2004 editorial, the following was expressed:

> [I]t is no longer possible for clinical faculty to "trade" time spent directly caring for patients in exchange for teaching time. In the past, residents or fellows would perform physical examinations, perform certain procedures, and write notes in patients' records and, in turn, the faculty member would use the time she or he would have spent performing these tasks for teaching. In the United States, recent government and insurance requirements for the attending physician to personally perform patient care services have essentially eliminated such traditional practices.[977]

In fact, one research study published in 1998 defined "traditionally" supervised residents as "cases in which the resident cares for a patient with input from an attending physician, but the attending physician does not leave a separate note in the record."[978]

The issue of adequate supervision and resident work hours became a subject of intense scrutiny in 1984 because of the death of Libby Zion, an eighteen year old college student. Libby Zion died at New York Hospital within hours of being admitted through

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[975] Ibid.

[976] Ibid.

[977] Catherine D. DeAngelis, "Professors Not Professing," *Journal of the American Medical Association* 292, no. 9 (2004): 1060.

[978] Colin M. Sox et al., "The Effect of Supervision of Residents on Quality of Care in Five University-Affiliated Emergency Departments," *Academic Medicine* 73, no. 7 (1998): 779.

the emergency department where she had been evaluated solely by a junior resident. The resident in the emergency department believed Libby Zion had a simple viral illness causing a high fever and agitation when she consulted by telephone with the attending physician. On the hospital floor she was assigned to an intern and she was seen by a resident, both of whom had been on duty for eighteen hours. Medication to reduce the fever and anxiety were given. The nurse reported a few hours later to the intern that Libby Zion had become more agitated and her fever had increased to 107. Restraints and a cooling blanket were ordered by the intern, though no physician assessed her condition in person. After her condition improved, her restraints were removed. Shortly thereafter, Libby Zion's condition worsened and she went into respiratory arrest and could not be resuscitated.[979]

Her father, a former federal prosecutor and New York City newspaper columnist, was not only distraught but sought answers to the completely unexpected death of his daughter.[980] The resulting grand jury investigation did not pursue criminal indictments but did indict the system of graduate medical education:

> Under the present system, it is acceptable for seriously ill patients to be evaluated and cared for in a level one hospital emergency room by a doctor who is still in a post graduate training program and may have little or no experience dealing with patients on an emergency basis. Moreover, those patients who are admitted into these hospitals for treatment are often cared for by interns and residents who are not required to have contemporaneous, in person consultations with senior physicians before they initiate a course of treatment. As a consequence, the most seriously ill patients may be cared for by the most inexperienced physicians… A hospital is not

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[979] See the following for more on the Libby Zion case. David A. Asch and Ruth M. Parker, "The Libby Zion Case," *New England Journal of Medicine* 318, no. 12 (1988). Marc K. Wallack and Lynn Chao, "Resident Work Hours: The Evolution of a Revolution," *Archives of Surgery* 136, no. 12 (2001).

[980] ———, "Resident Work Hours: The Evolution of a Revolution."; Bertrand M. Bell, "Reconsideration of the New York State Laws Rationalizing the Supervision and the Working Conditions of Residents," *Einstein Journal of Biology and Medicine* 20 (2003).

> the place for recently graduated doctors to grow and develop in isolation; rather it is a place where the learning process should continue under strict supervision.[981]

Following the grand jury investigation a commission, the “Bell Committee,” was formed under the direction of New York’s governor to study the recommendations made by the grand jury. For the next few decades the issue became much more focused on resident work hours than on supervision.[982] The issue of resident work hours has been fueled by reports of medical errors in hospitals and the patient safety movement. Work hours of residents remain a contentious subject. In regard to supervision, there continues to be a question of the degree to which interns and residents are supervised and taught.[983] In a review of a book about the Libby Zion case published ten years later, a third-year medical student wrote that she was “surprised and sometimes alarmed by the lack of involvement of attending physicians in teaching and patient care.”[984] The most recent standards by the Accreditation Council of Graduate Medical Education, effective in July 2011, do specify both limitations in work hours and more explicit supervision requirements.[985]

Neither the Medicare PATH audits nor the Bell Committee was focused on the provision of care to charity or “service” patients. However, the chairman of the Bell Commission reported that their research often showed “resident-run residencies” and that

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[981] ———, "Reconsideration of the New York State Laws Rationalizing the Supervision and the Working Conditions of Residents," 36.

[982] ———, "Supervision, Not Regulation of Hours, Is the Key to Improving the Quality of Patient Care," *Journal of the American Medical Association* 269, no. 3 (1993).

[983] Robert. Steinbrook, "The Debate over Residents' Work Hours," *New England Journal of Medicine* 347, no. 16 (2002).

[984] Lara Goitein, "The Girl Who Died Twice: Every Patient's Nightmare: The Libby Zion Case and the Hidden Hazards of Hospitals," *New England Journal of Medicine* 334, no. 3 (1996): 201.

[985] Thomas J. Nasca, Susan H. Day, and E. Stephen Amis, Jr., "The New Recommendations on Duty Hours from the Acgme Task Force," *New England Journal of Medicine* 363, no. 2 (2010).

involvement of educators in the care of patients was “too infrequently honored in the breech in some academic medical centers and was not honored at all in regard to service patients in voluntary hospitals and to patients in large urban public hospitals in New York State.”[986] Some of these findings by the Bell Commission strongly echo the recent controversy at Parkland Hospital in Dallas.

As a result of the PATH audits and further clarification of regulations on resident supervision effective in 1996, a study was conducted to assess the effects of the requirements. [987] Among the findings was that the percentage of patients seen by both a resident and an attending physician did not change at government hospitals after the clarification of the regulations, although overall the percentage of patients seen both by a resident and an attending physician did increase. There were increases in the percentage of non-white and Medicaid patients seen by both a resident physician and by an attending but the averages for these groups remained lower than for whites and people not insured by Medicaid.[988] A physician who published a book in 2008 after completing a residency at New York Hospital in the early twenty first century describes being told about the difference between Bellevue and New York Hospital, that “everything was different” including the “culture” of the hospital and the patient population. In a nutshell: “The

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[986] Bell, "Supervision, Not Regulation of Hours, Is the Key to Improving the Quality of Patient Care," 404.

[987] Cohen and Dickler, "Auditing the Medicare-Billing Practices of Teaching Physicians--Welcome Accountability, Unfair Approach."

[988] The major findings of the study were that the percentage of Medicare patients seen by both a resident and an attending physician were no different before versus after the clarification of requirements. Robert S. Stern, "Medicare Reimbursement Policy and Teaching Physicians' Behavior in Hospital Clinics: The Changes of 1996," *Academic Medicine* 77, no. 1 (2002).

patients are indigent. Residents perform most of the procedures. You know how it is: high autonomy, low liability."[989]

What is Actually Learned by Students and Trainees at Academic Medical Centers About the Provision of Charity Care?

While academic medical centers have a mission to provide medical education and often have a mission to provide care to the uninsured or charity patients, the focus has primarily been on the benefits of the relationship between these two missions. The purpose of this section is not to make the case that academic medical centers should be responsible for the care of all uninsured people or those people who may be in need of charity care. In a general sense it is important to acknowledge that discussions of academic medicine are rife with concerns about the "hidden cross-subsidies for charity care" and "how the problem of the uninsured distorts virtually any discussion on costs and subsidies in the U.S. health care system."[990] The purpose in the following section is to explore how the policies of academic medical centers in regard to the provision of charity care are intertwined with what is learned by students and residents about that care.

As an example of this focus, a teaching physician has remarked that students and residents are "being shown and taught how to turn away from sick people without money."[991] In this 1992 article, the author describes his role as an attending physician on a university hospital medicine service when a young woman with no health insurance and a history of intravenous drug use was admitted for a suicide attempt and a fracture of her

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[989] Sandeep Jauhar, *Intern: A Doctor's Initiation* (New York, NY: Farrar, Straus and Giroux, 2008), 282.

[990] Gbadebo and Reinhardt, "Economists on Academic Medicine: Elephants in a Porcelain Shop?" 148-149.

[991] Steven H. Miles, "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 268, no. 18 (1992): 2562.

forearm. The consulting orthopedic surgeon at the nonprofit university hospital recommended an operation to repair the fracture but he would not perform the operation because the woman did not have health insurance and even though she lived in a state where she was eligible for Medicaid, the surgeon did not believe the amount of Medicaid reimbursement would be sufficient. The attending physician appealed to the Chairman of Medicine who took the issue to the Chairman of Orthopedic Surgery. Citing that "compassionate" admission by the Internal Medicine service did not obligate the surgical staff to provide care, the surgeons stood firm in denying care. The attending physician next called the admitting physician at the county hospital to arrange a transfer. The response was that a transfer would not be accepted since care was available at the nonprofit hospital but, if the woman were released and sent to their emergency department, she would receive appropriate care. Discharge would require removal of her difficult-to-place central venous catheter. After explaining to the patient that there were ongoing negotiations, she secretly left the university nonprofit hospital and went to the county hospital where she received appropriate care of the fracture of her arm. The author of the article goes beyond illustrating the "saddening and, to some, infuriating," care and the "officious interpersonal encounter and disrupted medical care for such a clear and simple medical need," to highlight the effect on the educational experience.[992]

The medical service team of the teaching hospital where the patient was admitted included a resident, two interns, and two medical students. Though these trainees were aware of the practice of turning away indigent patients from the hospital and clinic, "they were jarred by the abrupt interruption of the woman's treatment. Surprise quickly turned

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[992] Ibid., 2561.

to accommodation as she became yesterday's news."[993] The author lists four adverse consequences to the education of physicians and, as a result, to the future health care of the public. The first is that "it disrupts the transmission of a professional tradition that recognized the claim of indigent ill persons on the medical profession."[994] The second is that "teaching young physicians and their patients that physicians may properly put their own advantaged financial interests ahead of their patients' immediate needs fuels cynicism on both sides of the doctor-patient relationship."[995] Also, it "may reinforce the stigmatizing, fatalistic attitudes that many house staff have toward poor patients…"[996] Third, teaching students to turn away from indigent patients undermines the broader, ancient message that a physician is bound by 'professing' humane kindness (*humanitas*) and compassion (*misericordia*) to those in need…Fourth, it diminishes physicians' credibility in the debate about the essential purpose of health care."[997]

It is probably worth noting that among the letters to the editor in response to this article, one put forth that it was "perfectly proper" for a surgeon not "to assume the care of someone whom he or she really does not like" and the "patient was obviously not someone whom any of us would want to assume responsibility for."[998] Another letter

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[993] Ibid.

[994] Ibid.

[995] Ibid.

[996] Ibid., 2562.

[997] Ibid.

[998] Frank E. Jones, "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789.

stated: “Charity is giving care because you want to—not because you have to.”[999] In one letter, the author is accused of promoting socialism and in another he is accused of “not [practicing] what he preaches” because of funding he received in support of the essay.[1000] However, one letter stated that the author was too “charitable in his comments.”[1001] Additional information on what is known or theorized about the possible effects of turning away poor or uninsured or charity patients from teaching hospitals, in relationship to the educational purpose of medical schools and teaching hospitals, will be addressed after first outlining some of these practices.

Reports that academic medical centers were, after an initial staggering growth phase following implementation of Medicare and Medicaid, reducing access to care for low income patients, began in the 1980s. In a study of academic health centers covering the years 1963 to 1981 the following was reported: “One of the most distressing findings of this study is the identification of the trend toward limiting access to some hospitals for the poor and near-poor.”[1002] An example of this trend was seen in Kentucky where there are two university medical school affiliated hospitals. In July of 1981, the University of Kentucky Hospital began restricting admissions according to a “Financial Allowance and Patient Payment Policy.” The policy restricted admission of indigent patients to those

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[999] Gilbert G. Eade, "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789.

[1000] David L. Hartsuch, "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993). Joseph P. Keenan, "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1790.

[1001] Jeffrey L. Kaufman, "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789.

[1002] Ruth S. Hanft, "The Impact of Changes in Federal Policy on Academic Health Centers," *Health Affairs* 1, no. 4 (1982): 80.

requiring immediate treatment and to those in which payment was assured.[1003] In 1982, a Nebraska public university hospital instituted policy restricting nonemergency hospital admissions unless an upfront payment of 20 percent of the estimated bill was paid. A survey of public hospitals included as a part of the report on the Nebraska public university hospital found that almost half of these hospitals had some formal policy to deny admission in some circumstances. The authors also predicted that “the limitation of care to indigents must be expected to have adverse impact on the values faculty strive to establish in their students.”[1004]

In an analysis of hospital provision of uncompensated care from the years 1980 to 1982, in which a little more than one quarter of the hospitals were teaching hospitals, the need for free care increased dramatically while delivery of free care was relatively unchanged.[1005] This analysis was undertaken prior to the implementation of the Medicare and Medicaid DSH payments. Part of the analysis included interviews with hospital administrators to determine how the rationing of free care was done. Two strategies were dominant. One was “directly prohibiting or discouraging hospital use by people unable to pay.”[1006] This was primarily achieved by requiring upfront payments for nonemergency services. The second was “reducing the availability of services heavily used by the

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[1003] Diana McClure et al., "Report of the Commission on Financing Health Care for the Medically Indigent," (Frankfort, KY: Legislative Research Commission, 1987), 51-52.

[1004] David J. Fine et al., "Indigent Care Limitation in University-Owned Hospitals," *Health Care Management Review* 8, no. 3 (1983): 23.

[1005] Judith Feder, Jack Hadley, and Ross Mullner, "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982," *Milbank Memorial Fund Quarterly/Health and Society* 62, no. 4 (1984).

[1006] Ibid., 559.

uninsured poor."[1007] Such services included outpatient care, psychiatric care, hospice care and social services. Other, less common, approaches to ration free care included maintaining a fixed budget where cases were selected by a committee based on informal or formal criteria. For example, one hospital determined that people with self-inflicted injuries or illnesses were to receive last priority. Some hospitals transferred responsibility for decisions on free care to physicians in order to reduce the hospital's liability to both trustees and their communities. Interviews at teaching hospitals established that, on occasion, policies were overridden "for teaching purposes."[1008] Among the conclusions to the article is: "Paying hospitals rather than insuring individuals is clearly a second-best approach to financing care to the currently uninsured" but that "the uninsured may be better off with second-class care than with no care at all."[1009] The conclusion of this article from the 1980s has been made by researchers using data from the late 1990s.[1010]

There has been a sporadic mention of teaching hospitals in which policies limiting care to poor and uninsured people have been overridden by "teaching waivers." Presumably, if the patient is an "interesting case," then he or she will be accepted as a charity patient. In one case from the 1970s, "teaching cases" were considered problematic because they were chosen without adhering to financial criteria and, therefore, some of these patients were viewed as having the ability to pay for their own care.[1011] The

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[1007] Ibid.

[1008] Ibid.

[1009] Ibid., 563, 565.

[1010] Jack Hadley and Peter Cunningham, "Availability of Safety Net Providers and Access to Care of Uninsured Persons," *Health Services Research* 39, no. 5 (2004).

[1011] Anonymous, "Indigent Care: A New Approach for Delivery and Funding," *Case Studies in Health Administration* 3 (1983).

Nebraska report on limiting care to the uninsured at a university teaching hospital also mentioned that exceptions were made if a patient had “special teaching value.”[1012] In 2003, a university public hospital in Texas that had implemented a rationing program for poor uninsured patients also mentioned teaching waivers.[1013] In an ethnographic study of a publicly funded teaching hospital published in 2002, the author found that the graduate medical education program was popular because of the number of interesting patients, in part because of seeing the “natural course of disease untreated.”[1014] In sorting through applicants for residency, the faculty actively looked for applicants who had worked in a third world country because “those applicants were more likely to understand and support the work that goes into providing indigent care” at a county hospital.[1015] Reframing patients as interesting allowed for “procedures that might not be justified on strictly biomedical grounds could [instead] be justified as an opportunity for graduate medical instruction.”[1016] The author of the study found that the practice of medicine at the county hospital proceeded “according to a cultural logic” which revolved around graduate medical education and posed a question for future research that would address how graduate medical education “occurs without a supply of indigent patients.”[1017]

[1012] Fine et al., "Indigent Care Limitation in University-Owned Hospitals," 22.

[1013] Bernard Wysocki, "The Rules: At One Hospital, a Stark Solution for Allocating Care," *Wall Street Journal*, September 23, 2003.

[1014] Daniel Dohan, "Managing Indigent Care: A Case Study of a Safety-Net Emergency Department," *Health Services Research* 37, no. 2 (2002): 369.

[1015] Ibid., 373.

[1016] Ibid., 368.

[1017] Ibid., 375.

According to a 2008 article, the University of Chicago's medical center, the flagship hospital of one of the highest ranking medical schools in the nation, does not accept uninsured patients. This policy even includes patients with a cancer diagnosis who are known to be eligible for either Medicaid or Medicare because of their diagnosis.[1018] Also in Chicago, in 1995, the public hospital, which is also a large teaching hospital, had a queue of 10,000 adult patients with waits of over two years for appointments.[1019] A survey that was undertaken specifically to ask faculty who were providing direct patient care at academic health centers from 2000 to 2001 included questions about their experiences with providing care to uninsured people.[1020] According to the survey; "Nearly one in five clinical faculty felt that they were discouraged by their group practice or hospital from seeing too many indigent patients, and more than one in ten reported that their group practice placed formal limits on the number of patients or the amount of care they could provide."[1021] In contrast to bland statements about the amount of charity care provided by academic health centers, this paper concludes with a statement that the findings "illustrate the limits of charity care in our health care system."[1022] Importantly, the authors also discuss how their findings impact education:

> Our findings also have implications for medical education. Medical schools and their affiliated hospitals have a centuries-old tradition of caring for the poor and

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[1018] Mishka Terplan et al., "Does Equal Treatment Yield Equal Outcomes? The Impact of Race on Survival in Epithelial Ovarian Cancer," *Gynecologic Oncology* 111, no. 2 (2008).

[1019] David U. Himmelstein and Steffie Woolhandler, "Care Denied: US Residents Who Are Unable to Obtain Needed Medical Services," *American Journal of Public Health* 85, no. 3 (1995).

[1020] This citation is also mentioned in chapter 1. Weissman et al., "Limits to the Safety Net: Teaching Hospital Faculty Report on Their Patients' Access to Care."

[1021] Ibid., 163.

[1022] Ibid., 165.

> training the next generation of physicians to undertake this vital social task Students might be taught to treat all patients equitably, but they are likely also to be influenced by a "hidden curriculum." Because medical school faculty function as role models, their behavior is constantly monitored by students and residents. Despite what is taught in classes, the hidden curriculum could be sending the message that limiting services for uninsured patients is acceptable.[1023]

Many reports of the care of uninsured patients or charity care practices do not specifically discuss the relationship between these practices and medical education.

Probably the most recent analysis of the actual practices regarding uncompensated care at academic medical centers was published in 2008. It included an analysis of practices at three urban academic medical centers in Illinois with differing ownership models; public, nonprofit, and for-profit. At all three sites even when there were written policies regarding charity care or the management of self-pay patients, these policies were often not adhered to and there was considerable variability within the institutions. Most of the self-pay patients at all three institutions had a low income and were from racial or ethnic minority populations. The public institution did not have a charity care policy and all of the uncompensated care was reported as bad debt. The public institution provided care to more self-pay patients but also had the most aggressive collection practices and did collect two-thirds of the charges incurred. Up to one-third of outpatients were turned away if they were unable to pay. The nonprofit institution also had aggressive prepayment and collection practices and a lower volume of self-pay patients. Half of the uncompensated care at the nonprofit hospital was reported as charity care. Forty percent to half of the outpatients were turned away. The for-profit institution had a much lower volume of self-pay patients with most of these patients seen in the emergency department where federal law requires that stabilizing treatment be provided.

[1023] Ibid., 164.

Perhaps because of this limited exposure to outpatients and because outpatients were virtually all seen in emergency department, no one was turned away at the for-profit institution. All of the uncompensated care at the for-profit hospital was reported as bad debt. In addition to financial data and interviews with hospital personnel, the researchers interviewed self-pay patients. Close to half of the patients at the public hospital and nonprofit hospital had been contacted by a collection agency as a result of previous visits and a little more than half of the patients at the for-profit hospital had been contacted by a collection agency as a result of previous visits.[1024]

At the same time, many academic medical centers have maintained, when asked, that their mission to provide indigent care has been sustained.[1025] Furthermore, academic medical centers are quite diverse.[1026] Even in teaching hospitals that report maintaining a commitment to caring for people regardless of their ability to pay for care, faculty have reported limited access to some services. Faculty members at one such teaching hospital in Washington have the opinion that "training in an environment oriented toward egalitarian patient care sets a strong example for trainees who might not otherwise have significant opportunities to witness the many health disparities created by our current health care system."[1027] Accurate, comprehensive, and timely research on the practices

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[1024] Saul J. Weiner et al., "Managing the Unmanaged: A Case Study of Intra-Institutional Determinants of Uncompensated Care at Healthcare Institutions with Differing Ownership Models," *Medical Care* 46, no. 8 (2008).

[1025] David Blumenthal, Joel S. Weissman, and Paul F. Griner, "Academic Health Centers on the Front Lines: Survival Strategies in Highly Competitive Markets," *Academic Medicine* 74, no. 9 (1999).

[1026] David Blumenthal and Gregg S. Meyer, "Academic Health Centers in a Changing Environment," *Health Affairs* 15, no. 2 (1996).

[1027] John V. Sheffield et al., "The Public Hospital Mission at Seattle's Harborview Medical Center: High-Quality Care for the Underserved and Excellence in Medical Education," *Academic Medicine* 81, no. 10 (2006): 890.

and policies of academic medical centers in regard to the provision of care to uninsured or charity patients and the effects of those practices on what is learned by students and residents is largely unknown.[1028] Much of the research that is done about hospitals generally or hospitals that serve as safety net institutions is not specifically about teaching hospitals or academic medical centers. Concerning hospitals and their provision of charity care generally, even those "whose mission includes treating indigent patients are reluctant to make the process too easy or too public for fear of becoming magnets for uninsured patients."[1029] Along these lines, a university hospital in Colorado discontinued its primary care program, in part because of the fear that "it might attract new indigent patients."[1030] In other research, hospitals identified as safety net hospitals, and including many teaching hospitals, reported a variety of measures that reflected either a changing mission to provide care to the uninsured or the adoption of new strategies. For example, in Arkansas a university hospital began putting privately insured patients ahead of uninsured patients in scheduling appointments. In other communities, patients were not treated in the emergency department for conditions considered nonemergencies, eligibility for charity care was applied more rigorously, and cost sharing amounts were

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[1028] The reasons that research is lacking are many. Kanak Gautam, Barbara Arrington, and Claudia Campbell, "Inner-City Hospitals: A Call for Research," *Journal of Health Care for the Poor and Underserved* 6, no. 4 (1995).

[1029] Joel S. Weissman, "The Trouble with Uncompensated Hospital Care," *New England Journal of Medicine* 352, no. 12 (2005).

[1030] John F. Steiner et al., "Managed Care for Uninsured Adults: The Rise and Fall of a University-Based Program," *American Journal of Managed Care* 8, no. 7 (2002): 660.

increased.[1031] Some organizations were attempting to change their image as a safety net provider to an image that appeals to a broader population.[1032]

The information available does show that many teaching hospitals and academic medical centers, though diverse institutions where generalities may not be supported, do take measures to avoid care of uninsured or charity patients. At the same time, scattered sources also show that poor or charity patients continue to be the participants in medical education to a greater extent than private patients. In a small 2003 qualitative study, medical students reported that patients at public hospitals often had little choice in whether to participate in medical education because, in many cases, the public hospital was the only option available for medical care and, therefore, choosing to be a part of medical education was not relevant. Medical student involvement in patient care was often felt to be necessary in the public hospital system because of the high volume of patients. One student described the following metaphor: "[I]f you're a thirteen year old in a car with your dad. And your dad has a heart attack. It's unethical to drive that car but something's going to happen unless somebody takes the wheel to do something."[1033] The students preferred rotations at the public teaching hospital versus the private teaching hospital because there were more opportunities for hands-on experiences.

[1031] Chapter 3 discusses care in the emergency department in much more detail.

[1032] Cunningham, Bazzoli, and Katz, "Caught in the Competitive Crossfire: Safety-Net Providers Balance Margin and Mission in a Profit-Driven Health Care Market."; Bruce Siegel, Marsha Regenstein, and Peter Shin, "Health Reform and the Safety Net: Big Opportunities; Major Risks," *Journal of Law Medicine and Ethics* 32, no. 3 (2004).;and Barbara Martinez, "Safety Net Frays as Hospitals Shift Resources from Poor," *Wall Street Journal* (2008), http://blogs.wsj.com/health/2008/08/12/safety-net-frays-as-hospitals-shift-resources-from-poor/ (accessed March 14, 2013).

[1033] Maa and McCullough, "Medical Education in the Public Versus the Private Setting: A Qualitative Study of Medical Students' Attitudes," 353.

Students also reported that, in many cases, the patients at public hospitals seemed to have more confidence in the students' status and abilities. At the public hospital, "'a lot of those patients, the medical student is their doctor, they know no different.' Even when the medical student status is emphasized, patients failed to understand….In contrast, in the private clinics, the students noted, 'I've never had anybody assume I was a doctor.'"[1034] These findings are quite similar to statements made in a 1998 book, *Surviving Medical School*. In the book, for example:

> Indigent patients are often less perceptive than private patients of the subtler distinctions in the medical hierarchy and just assume "Everybody's a doctor, some doctors are just younger than others." By contrast, private patients, expecting to be attended by their personal physicians, can be more difficult. They resent interrogation or being "practiced on" by students and want "only professional people around them." Fortunately, some attending physicians explain to them that the teaching role is an important function in any medical center. Others leave it to the students to work it out with patients as best they can.[1035]

The authors of the qualitative study address moral questions related to patients attended to by medical students in a public versus a private hospital. Somewhat similar to the conclusion of the young intern in 1966, the conclusion to their study is that: "This patient population should not be understood to have an ethical obligation to accept increased risk to themselves to educate future physicians, especially when these physicians go on to serve mostly the private sector."[1036]

[1034] Ibid.

[1035] Robert H. Coombs and Bernard Virshup, *Surviving Medical School* (Thousand Oaks, CA: Sage Publication, 1998), 112.

[1036] Maa and McCullough, "Medical Education in the Public Versus the Private Setting: A Qualitative Study of Medical Students' Attitudes," 354.

Policies on Billing for Services Have a Direct Impact on Medical Education and the Provision of Care to Poor People

Medical student involvement in patient care may differ between public hospitals and private hospitals for reasons related to billing, as discussed in Chapter 1 related to medical student-run clinics. In part as a result of the Medicare PATH audits at teaching hospitals and more explicit guidelines by the Centers for Medicare and Medicaid Services, medical students' notes may only be used for billing purposes for the review of systems and the past, family, and social history and not for documenting any part of the physical exam. While medical educators may believe that medical students should actively participate in examination of patients and in documentation, differing standards when participating in the care of uninsured or charity patients as compared to insured patients may be reinforced by the need to adhere to billing standards.[1037]

Among the many ironies concerning medical education and the care of poor people is that, especially in the 1990s, competition for patients insured through Medicaid was sometimes fierce.[1038] Academic medical centers were particularly vulnerable, on several grounds, when competitor hospitals began vying for Medicaid patients. Especially in the case of obstetrical care, patients covered by Medicaid began to leave academic health centers to go to other local hospitals.[1039]

In one of the most rapid changes to academic health centers regarding patients covered by Medicaid, in 1994 Tennessee implemented Tenncare as a new managed care

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[1037] Gliatto, Masters, and Karani, "Medical Student Documentation in the Medical Record: Is It a Liability?"

[1038] The connection between Medicaid and charity care is explored in Chapter 5.

[1039] Mark W. Tomlinson et al., "Changes in Health Care Delivery: A Threat to Academic Obstetrics," *American Journal of Obstetrics and Gynecology* 173, no. 5 (1995).

program for all Medicaid beneficiaries and most of the state's uninsured people.[1040] As a result, the volume of Medicaid patients at academic health centers declined significantly. The formerly uninsured patients who gained Tenncare coverage were able to choose to go to hospitals that were not teaching hospitals. Tenncare transformed some of the state's academic medical centers because it proceeded to: "deeply affect their revenues, their case mix, the educational experience of residents and students, and the research opportunities of clinical faculty."[1041] The revenue that was lost was not only the revenue from clinical services but also the funding of graduate medical education through Medicaid and Medicaid DSH payments. In a later 2003 article on the subject of the loss of Medicaid patients at academic health centers because of competition, there is concern about the "network of urban medical centers serving primarily indigent patients in an unspoken contract of medical services in exchange for student and resident education."[1042] The worry is caused by the decline in Medicaid patients: "By far, the most damaging blow to Oslerian education, however, has been the erosion of the traditional patient population of the urban medical center—the Medicaid patient."[1043] The relationship between academic medical centers and poor patients, some of whom may be charity patients, is not simply that there may be a mission to provide this care, or even that, alternatively, care should be avoided because of the financial burden. Rather, often

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[1040] Tenncare is also discussed in Chapter 5 as an example of a Medicaid 1115 Waiver program.

[1041] Gregg S. Meyer and David Blumenthal, "Tenncare and Academic Medical Centers: The Lessons from Tennessee," *Journal of the American Medical Association* 276, no. 9 (1996): 676.

[1042] Deborah S. Lyon, "Medical Education and Indigent Patient Care," *Current Women's Health Report* 3 (2003): 501.

[1043] Ibid.

all of the special missions of academic medical centers, including education and research, are interwoven with care of poor patients.

Differences between Care of Poor People and Care for the Privately Insured in Medical Education

The attitudes of attending physicians, residents and medical students toward poor patients are particularly important since so much care is provided to this group of patients through academic medical centers. Two of the practices that are repeatedly mentioned as differing between the care of poor patients, whether Medicaid or charity patients, as compared to care of patients with Medicare or private health insurance, are 1) the level of supervision or degree of student or resident responsibility, and 2) measures taken to avoid the provision of hospital or outpatient care to poor, or uninsured, or charity patients. It seems reasonable to believe that these practices or policies which either discourage or deny care may have an influence on the attitudes of health care providers, though a direct causal link is unlikely to be possible. Policies that are considered administrative are not often appreciated as influencing education. Yet: “A policy formulated is a lesson taught. It is a lesson about what really counts, for it involves real effects on resources and people. It is a lesson in what is valued and what is not. It is a statement that contains an ethical choice.”[1044] Policies that limit care to poor people have the potential to serve an educational function even if the policies are not directly addressed in educational settings: “Put in pedagogical terms, which gives the more powerful lesson: what the instructor in

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[1044] Stanley J. Reiser, "The Ethics of Learning and Teaching Medicine," *Academic Medicine* 69, no. 11 (1994): 875.

the classroom says about ethical priorities concerning resource use and vulnerable populations, or what the school actually does about them?”[1045]

A third difference between the care of patients who are poor and patients who are not poor is the attitude of the physicians, students, and residents toward such patients. Citing the AAMC documents that describe the disproportionate share of uninsured patients seen at teaching hospitals and hospitals affiliated with academic medical centers, the authors of an insightful review, Delese Wear and Mark Kuczewski, remark: “It is no secret that many teaching hospitals are located in economically disadvantaged areas and that students often learn medicine disproportionately on poor populations.”[1046] Specifically, there is no getting around the fact that “teaching hospitals bring medical students and residents face-to-face with poor and uninsured patients on a regular basis.”[1047] The authors note that in some cases the education of medical students in public hospital settings or settings in which students are heavily involved in the care of poor patients appears to have led to an increase in biases, stereotyping and cynicism. The authors urge a variety of approaches to the education of medical students that recognizes the complexity of the attitudes of medical students toward poor patients.[1048]

Attitudes toward the Poor in Medical Education Likely Mirror Attitudes in Society

When the medical historian Charles Rosenberg researched nineteenth century hospitals, he repeatedly found that hospitals were at once insulated from their

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[1045] Ibid., 876.

[1046] Delese Wear and Mark G. Kuczewski, "Perspective: Medical Students' Perceptions of the Poor: What Impact Can Medical Education Have? " *Academic Medicine* 83, no. 7 (2008): 639.

[1047] Ibid., 640.

[1048] Ibid.

communities because of their internal culture, while they also mirrored society and societal attitudes.[1049] Attitudes of Americans toward the poor include that people generally believe the causes of poverty are multiple, “although the majority of Americans believe that individualistic causes, such as lack of effort or laziness, drug use, or low intelligence are more important factors than societal or structural ones, such as discrimination, low wages, or poor education.”[1050] Even when Americans recognize that there are multiple causes of poverty including structural causes, there is commonly also a belief that individuals can overcome these obstacles if they work hard enough. Once the locus of control becomes the individual, poverty becomes a personal failure. Surveyors have found that political affiliation is consistently associated with stereotypes and attributions of poverty. Almost half of all Republicans in a somewhat older 2000 survey agreed that lack of effort was the most significant cause of poverty whereas about one quarter of Democrats believed the statement.[1051]

Medical students’ attitudes toward providing care for the poor have been studied and the data have shown that there is a decline in attitude during the course of medical school.[1052] Decline in the attitudes of medical students toward caring for the poor have

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[1049] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*.

[1050] Wear and Kuczewski, "Perspective: Medical Students' Perceptions of the Poor: What Impact Can Medical Education Have?" 640.

[1051] Ibid., 641.

[1052] Sonia J. Crandall, Robert J. Volk, and Vicki Loemker, "Medical Students' Attitudes toward Providing Care for the Underserved. Are We Training Socially Responsible Physicians?" *Journal of the American Medical Association* 269, no. 19 (1993).

been resistant to changes in the medical school curriculum.[1053] This decline is part of a larger phenomenon in which medical students may suffer ethical erosion, a decline in empathy, greater detachment and self interested actions.[1054] The attitudes of medical students and physicians toward their patients may have a profound effect on the patient – physician relationship.[1055] The connection between the attitudes of medical students toward caring for the poor and their career choice has not been simple. In a study of medical students at one school, those who had strong feelings of responsibility toward underserved patients in recent years were not more likely to choose a primary care residency.[1056] Despite these findings, there continues to be a significant number of articles that propose the idea that medical "student involvement in indigent care potentially benefits both patients and students."[1057]

Residents who complete their training in a public hospital or who have high exposure to vulnerable groups of patients were, in one study, no more likely to want to

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[1053] Sonia J. Crandall et al., "Medical Students' Attitudes toward Underserved Patients: A Longitudinal Comparison of Problem-Based and Traditional Medical Curricula," *Advances in Health Sciences Education Theory and Practice* 12, no. 1 (2007).

[1054] See generally the following. Chris Feudtner, Dimitri A. Christakis, and Nicholas A. Christakis, "Do Clinical Clerks Suffer Ethical Erosion? Students' Perceptions of Their Ethical Environment and Personal Development," *Academic Medicine* 69, no. 8 (1994). Bruce W. Newton et al., "Is There Hardening of the Heart During Medical School?" *Academic Medicine* 83, no. 3 (2008); Jack Coulehan and Peter C. Williams, "Vanquishing Virtue: The Impact of Medical Education," *Academic Medicine* 76, no. 6 (2001).

[1055] Judith A. Hall et al., "Physicians' Liking for Their Patients: More Evidence for the Role of Affect in Medical Care," *Health Psychology* 12, no. 2 (1993).

[1056] Sharon Wayne et al., "Medical Students' Attitudes toward Underserved Populations: Changing Associations with Choice of Primary Care Versus Non-Primary Care Residency," *Journal of Health Care for the Poor and Underserved* 21, no. 2 (2010).

[1057] John A. Dodson and Allen S. Keller, "Studentjama. Medical Student Care of Indigent Populations," *Journal of the American Medical Association* 291, no. 1 (2004). Edward J. Eckenfels, "Contemporary Medical Students' Quest for Self-Fulfillment through Community Service," *Academic Medicine* 72, no. 12 (1997).

practice in underserved areas than other residents.[1058] Attitudes by family practice residents surveyed in Ohio about poor patients in the late 1980s were largely negative regardless of the number of patients with low socioeconomic status cared for by the resident. The majority of residents believed that welfare benefits cause the poor to be dependent and about half believed that poor women have children in order to receive welfare benefits. A quarter of the residents believed that lack of effort was the cause of being poor. More than half of the residents believed that poor patients were more likely to miss appointments without canceling, be late for appointments, have less knowledge about their illness and be unlikely to practice preventive health measure.[1059] Although this study is older now, there are some indicators that these attitudes have not improved. In a study of pediatric residents, the authors found it "striking to note how many residents expressed negative responses toward caring for underserved families."[1060] Over the course of their residency training, a third of the residents who expressed an interest in working with the underserved lost this interest. The residents who did plan to continue to care for the underserved felt more effective in outpatient clinic, less worried about

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[1058] Joel S. Weissman et al., "Residents' Preferences and Preparation for Caring for Underserved Populations," *Journal of Urban Health* 78, no. 3 (2001).

[1059] James H. Price et al., "Perceptions of Family Practice Residents Regarding Health Care and Poor Patients," *Journal of Family Practice* 27, no. 6 (1988). There is a fair amount of evidence that nonadherence to medication, low health literacy, and poor health behaviors are associated with low socioeconomic status. See, for example, P. Michael Ho, Chris L. Bryson, and John S. Rumsfeld, "Medication Adherence: Its Importance in Cardiovascular Outcomes," *Circulation* 119, no. 23 (2009). James R. Dunn, "Health Behavior Vs the Stress of Low Socioeconomic Status and Health Outcomes," *Journal of the American Medical Association* 303, no. 12 (2010). On the other hand, the issue of whether stereotyping is "accurate" is a more complex one. For example, stereotypes tend to exaggerate and reinforce negative attributes. Stereotypes can be self-fulfilling by evoking negative responses as well. Brian D. Smedley et al., *Unequal Treatment : Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academy Press, 2003), 172-174.

[1060] Carol Cohen Weitzman et al., "Care to Underserved Children: Residents' Attitudes and Experiences," *Pediatrics* 106, no. 5 (2000): 1026.

becoming numb to psychosocial problems, and had greater empathy with their underserved patients.[1061] Recent scholarship is more likely to focus on ascertaining or improving knowledge rather than attitudes.[1062]

Practicing Physicians' Attitudes about the Poor are Nuanced though Likely also Mirror Society's Views

In a large study of practicing cardiologists, there was significant evidence that physician perceptions of patients are affected by patient race and socioeconomic status. Physicians tended to perceive African-Americans and people with lower socioeconomic status more negatively in several dimensions than they did whites or patients with higher socioeconomic status. Patients with low socioeconomic status were rated as less likely to be compliant, less likely to desire a physically active lifestyle, less likely to have significant career demands, and to be at risk for inadequate social support. The physicians rated patients with lower socioeconomic status more negatively on traits such as self-control, rationality, and intelligence. Physicians rated black patients as at risk of being noncompliant, abusing substances, and lacking social support. Black patients were rated as less intelligent by their physicians and physicians reported lower feelings of affiliation toward African-Americans. The authors summarize the importance of their findings beyond the possibility that treatment decisions may vary:

> Even assuming that physicians' treatment decisions are unaffected by their perceptions of patients, physician attitudes towards patents are of concern because of their potential impact on patients' satisfaction and behavior. When patients perceive that physicians like them, care about them and are interested in them as a

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[1061] Ibid.

[1062] See, for example, Mark L. Wieland et al., "Resident Physicians' Knowledge of Underserved Patients: A Multi-Institutional Survey," *Mayo Clinic Proceedings* 85, no. 8 (2009).; Jennifer Furin et al., "A Novel Training Model to Address Health Problems in Poor and Underserved Populations," *Jounal of Health Care for the Poor and Underserved* 17, no. 1 (2006).

> person, they are likely to volunteer more information and be more active in the encounter, more satisfied, and more compliant with medical regimens.[1063]

In another national survey, physicians were three times more likely to make negative comments than positive comments about their perceptions of indigent patients. Negative comments related to three categories: "spending habits, poor health choices, and abuse of the 'the system.'"[1064] The physicians who commented about the material possessions of indigent patients often did so by framing the possessions as personal choices. An example of this sentiment is seen in the comments of one emergency medicine doctor whose practice is half caring for indigent patients: "It is difficult to feel that someone is 'needy' who has cable TV, a cell phone, and can't afford the prescription I gave them until they get paid, as they pull a cigarette out of the box. How can we determine who is truly needy?"[1065] Poor health choices of the indigent were mentioned in a third of the responses expressing negative views of the indigent. An ophthalmologist commented: "I have observed that the 'medically needy' are usually young persons without insurance, whose medical problems increasingly result directly from their bad health practices – including, increasingly, use of drugs, smoking, malnutrition, lack of exercise, etc. My sympathy for them is decreasing."[1066] Physicians' perception of abuses by indigent patients included not complying with recommendations, unnecessarily using ambulance services, and manipulation of physicians in order to get narcotics. One

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[1063] Michelle van Ryn and Janet Burke, "The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients," *Social Science and Medicine* 50, no. 6 (2000): 823.

[1064] Heidi T. Chirayath, "Difficult, Dysfunctional, and Drug-Dependent: Sturcture and Agency in Physician Perceptions of Indigent Patients," *Social Theory & Health* 5 (2007): 36.

[1065] Ibid., 37.

[1066] Ibid., 38.

physician related his views of the indigent to his experiences in medical school and residency:

> I have worked as a volunteer in medical school and I do not see the need to help medically needy people. My ideals have been affected by seeing patients on welfare and Medicaid abusing the system (ie [sic] Using an ambulance or 911 to get a free trip to the hospital ER) during residency. This has made me much more critical on who really needs help.[1067]

A remarkable finding from this survey was that while physicians generally held their indigent patients responsible for their spending habits, poor health habits, and abuses; in contrast, physicians often reported feeling constrained by structural factors which inhibited their own agency over actions. Among the structural or system factors that physicians reported impinging on their care for indigent patients were poor reimbursement rates through Medicaid, bureaucratic hassles, Medicare regulations which make charity care "fraud," pressures of managed care, and fears of litigation. Many of these factors reported by physicians may not be "factual," however, the confusion is no doubt genuine and the effects are quite real in serving to discourage providing care to indigent patients. For example, a physician commented: "The spread of managed care has destroyed the ability, and desire, to provide charitable care. This is due both to pressures to be productive and the restrictive regulations limiting how we can practice."[1068] Another physician wrote: "I used to do more charity work but due to the new laws passed, it makes it out of the question for me to provide care to the needy without me [sic] committing Medicare fraud."[1069] Regarding the fear of litigation, a physician

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[1067] Ibid., 39.

[1068] Ibid., 41.

[1069] Ibid. Chapter 4 discusses the CMS clarification that Medicare rules do not prohibit charity care. Tommy G. Thompson, "Letter from Tommy G. Thompson Secretary of Health and Human Services to commented: “Yes—it’s called the unhappy habit of the ‘have nots’ to sue physicians—I’ve not had the experience but also avoid occasions for it.”[1070]

Other remarkable findings from the survey comments include the complexity and nuances of the responses and the contradictions in physicians’ attitudes and actions. More than half of the comments provided specific examples of ways to provide care to indigent patients. Some physicians cited the Golden Rule; some stated they treated all of their patients the same regardless of ability to pay; others spent extra time with indigent patients. While over half of the comments on physicians’ perceptions of indigent patients “showed universal disdain,”[1071] a fifth expressed differences in perceptions based on the deservingness of the patients. One physician stated:

> I find that there is a difference between families who can’t pay for services (and I usually serve them at reduced or gratis fees) and those who could but have more pressing priorities (designer clothes, upscale cars and homes, tobacco and alcohol, etc.) and claim they can’t afford care. I choose not to serve them. Also, many uninsured are by no means medically indigent, they just choose not to buy insurance because of its high cost—they save money by paying directly.[1072]

A pediatrician remarked: “Adversely, I’d say the Medicaid… program in [New York] is open to abuse. I see [Medicaid] patients dressed better than most and driving expensive autos. And they always seem to have the gall to ask for samples. On the other hand, some

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Richard J. Davidson, President, American Hospital Association," February 19, (2004), http://archive.hhs.gov/news/press/2004pres/20040219.html (accessed March 14, 2013).

[1070] Chirayath, "Difficult, Dysfunctional, and Drug-Dependent: Sturcture and Agency in Physician Perceptions of Indigent Patients," 42. Chapter 1 discusses the evidence that poor people are not more litigious. See, for example, Burstin et al., "Do the Poor Sue More?: A Case-Control Study of Malpractice Claims and Socioeconomic Status."

[1071] Chirayath, "Difficult, Dysfunctional, and Drug-Dependent: Sturcture and Agency in Physician Perceptions of Indigent Patients," 44.

[1072] Ibid., 45-46.

of the nicest, most appreciative families in my practice of 30+ years have been those on [Medicaid]."[1073] Another physician stated:

> Working in Philadelphia and Chester, PA taught me that there is very little I could do to help the needy. Vast majority either did not care or had ulterior motives other than getting healthy. Made me become a 'selective' caregiver—help only those whom I perceived wanted and deserved it. I despise this, so I will never work in the inner city again.[1074]

Framing the willingness to provide care to indigent people in terms of their deservingness mirrors the provision of charity in the nineteenth century. The basis for determining who deserves care is, however, much less of a society-wide agreed upon notion. The author of the study points out that the ability to categorize indigent patients as deserving or undeserving is a way in which physicians are active agents despite perceiving themselves as lacking agency because of structural and systemic factors. Physicians report acting in heroic ways for at least some of their indigent patients. This also means that:

> [I]t is impossible to simply label physicians as either uncaring or humanitarian, for their attitudes and behaviours are nuanced, subtle, and complex. While physicians are quick to 'blame the victim' instead of acknowledging more structural reasons for patient noncompliance, many doctors also go to great lengths to serve those in their care. In most cases, even physicians who acknowledge that service to indigent patients is something they neither value nor choose to provide take great pride in their commitment to their patients, despite often feeling increasingly at odds with both the medical and legal systems, and even some patients themselves.[1075]

The author's analysis contributes significantly to appreciating the complexities and contradictions in physicians' perceptions and practices regarding care of poor patients.

In another irony, most of the scholars whose work addresses the role of medical education in the provision of care to poor people recognize the systemic nature of

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[1073] Ibid., 45.

[1074] Ibid.

[1075] Ibid., 47.

problems and yet propose mainly educational remedies focused on the individual student or resident. For example, the use of reflective experiences, service learning programs, and other programs that encourage students' to understand the social causes and effects of poverty are oriented toward the individual students.[1076] Many of the suggested programs focus on increasing knowledge related to topics of particular concern in the care of underserved people.[1077] Other authors advocate a broader approach to improving health care provided to poor or underserved people.[1078] Yet, many of these approaches do not address the disproportionate use of poor patients in medical education, the practices of institutions that limit care to the uninsured, or the negative attitudes pervasive in society and among practicing physicians concerning poor people.

Patients' Recent Views of Their Experiences with Medical Education

There remains a paucity of information on the perceptions of poor, uninsured, or underserved patients regarding their health care needs and desires, and especially on their perceptions of care provided by trainees. In one study utilizing focus groups, which included patient focus groups, attempting to understand what community and academic faculty preceptors should appreciate when providing care to the underserved, several themes emerged. Patients emphasized issues of communication and respect: "Patients expressed an almost universal wish for physicians to listen to them and to attempt to

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[1076] Wear and Kuczewski, "Perspective: Medical Students' Perceptions of the Poor: What Impact Can Medical Education Have?"

[1077] Wieland et al., "Resident Physicians' Knowledge of Underserved Patients: A Multi-Institutional Survey."; Weissman et al., "Residents' Preferences and Preparation for Caring for Underserved Populations."

[1078] David Muller et al., "The Role of Social and Community Service in Medical Education: The Next 100 Years," *Academic Medicine* 85, no. 2 (2010).; Christine Loignon et al., "Physicians' Social Competence in the Provision of Care to Persons Living in Poverty: Research Protocol," *BMC Health Services Research* 10 (2010).

‘understand my life.’”[1079] Patients recognized that physicians needed to understand cultural differences based on income and that: “Poor people want to be treated just like any other human being.”[1080] Patients expressed frustration with issues related to the health care system such as the cost of care, lack of transportation, the inconvenience of long waits, and the lack of continuity in their providers.[1081]

In a study comparing patient satisfaction in resident versus attending faculty clinics, patients were less satisfied with residents especially in regard to their personal manner including interpersonal characteristics such as courtesy, respect, sensitivity, and friendliness, and in a key measure of respect toward the patient. This dissatisfaction was especially apparent at the university outpatient clinic site where resident clinics were involved in the care of patients who were more likely to be African-American, have lower socioeconomic status, and to be in poorer health when compared to attending clinics. Availability of ancillary staff and rooms was also less for resident than attending clinics.[1082] The study raised several questions about whether resident clinics were ensuring that benefits to the patients were “commensurate with [the] burdens.”[1083]

In another study of bedside teaching, patients were more comfortable when their teams demonstrated caring by concern, understanding, and warmth. Thirteen percent of

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[1079] Wendy L. Hobson et al., "Caring for the Underserved: Using Patient and Physician Focus Groups to Inform Curriculum Development," *Ambulatory Pediatrics* 5, no. 2 (2005): 92.

[1080] Ibid.

[1081] Ibid.

[1082] William S. Yancy, Jr. et al., "Patient Satisfaction in Resident and Attending Ambulatory Care Clinics," *Journal of General Internal Medicine* 16, no. 11 (2001).

[1083] Nicholas H. Fiebach and Jeffrey G. Wong, "Taking Care of Patients in Resident Clinics: Where Do We Stand?" *Journal of General Internal Medicine* 16, no. 11 (2001): 788.

the patients felt uncomfortable when several people examined them at once.[1084] Patients have recommended that physicians ask their permission to conduct bedside presentations, that their privacy should be respected, that all the physicians should introduce themselves, and that fewer physicians should be present.[1085] Several sources have noted that patients may not be asked whether they would like to participate in bedside teaching rounds or in outpatient clinics.[1086] In a recent study of medical student participation in a family practice outpatient clinic, more than half of the preceptors did not obtain permission for the medical student to participate while the student was not in the exam room and about half of the preceptors relied on the student to inform the patient about their participation in the exam.[1087]

Except for the one publication on the perceptions of medical students about education in the public versus the private setting, little direct attention has been placed on how the majority of educational experiences occur while caring for poor people.[1088] Scholars have likened the process of medical training to the process of medical research in that the benefits of education do not necessarily accrue to the patient but to future

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[1084] Kathlyn E. Fletcher, David S. Rankey, and David T. Stern, "Bedside Interactions from the Other Side of the Bedrail," *Journal of General Internal Medicine* 20, no. 1 (2005).

[1085] Lisa S. Lehmann et al., "The Effect of Bedside Case Presentations on Patients' Perceptions of Their Medical Care," *New England Journal of Medicine* 336, no. 16 (1997).

[1086] Katherine C. Chretien et al., "A Qualitative Study of the Meaning of Physical Examination Teaching for Patients," *Journal of General Internal Medicine* 25, no. 8 (2010).

[1087] Tricia S. Tang and Eric P. Skye, "When Patients Decline Medical Student Participation: The Preceptors' Perspective," *Advances in Health Sciences Education Theory and Practice* 14, no. 5 (2009).

[1088] Maa and McCullough, "Medical Education in the Public Versus the Private Setting: A Qualitative Study of Medical Students' Attitudes."

patients.[1089] Unlike research, educators appear to haphazardly inform patients or request permission for participation in education. Trainees and educators "may disguise their status or the nature of their involvement in patients' care, --in part because of fear that patients will not consent to their participation but perhaps also because of private worries that practicing their still-unrefined skills on patients is not justified."[1090] In July of 2011, the Accreditation Council for Graduate Medical Education implemented new requirements pertaining to resident duty hours and supervision. One of the requirements is: "Residents and attendings should inform patients of their role in the care of each patient."[1091] Despite the conflicts inherent in medical education, training has occurred by tradition rather than through a deliberative process which includes the perspective of patients.[1092] This tradition has included a heavy reliance on "charity" or poor patients.[1093]

Conclusion

The role of charity in medical education is a continuous one from the earliest colonial days. Relying on charity patients for training was an accepted practice from the point of view of physicians and considered *quid pro quo* for services and treatment. Physicians also relied on charity patients because non-charity patients would not allow themselves to be the objects of instruction. The distinction between a charity and non-

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[1089] Janicemarie K. Vinicky et al., "Patients as "Subjects" or "Objects" in Residency Education?" *Journal of Clinical Ethics* 2, no. 1 (1991).

[1090] Chiong, "Justifying Patient Risks Associated with Medical Education."

[1091] Nasca, Day, and Amis, "The New Recommendations on Duty Hours from the Acgme Task Force."

[1092] Tara J. Kennedy et al., "Progressive Independence in Clinical Training: A Tradition Worth Defending?" *Academic Medicine* 80, no. 10 Suppl (2005).

[1093] O'Shea, "Individual and Social Concerns in American Surgical Education: Paying Patients, Prepaid Health Insurance, Medicare and Medicaid."

charity patient was not necessarily based on whether a payment was received for medical care. Despite such payments by patients or by local, state, and federal funds or public insurance, charity patients were used almost exclusively for medical education. Over time, charity patients used for medical training came to be called “ward,” and then “service” patients. Whatever charity patients came to be called, the people behind the designation were poor and more likely to be racial or ethnic minorities. This is as much the case today as it was more than 100 years ago.

Several of the narrative accounts available that describe the patient’s point of view about their experiences with medical education are disturbing and sometimes astonishing. Throughout the latter half of the twentieth century, the level of supervision of trainees was questioned by reports from the federal government concerning Medicare patients. While there are currently recommendations to inform patients and request permission for participation in medical training, the evidence does not support that this is actually occurring. Supervision of medical trainees as a concern has been largely superseded by concern about trainee work hours.

Attitudes of society, medical students, residents, medical school faculty, and practicing physicians are often negative with regard to poor and minority patients. There is reason to question what trainees may learn from their experiences with this population of people who are most likely to be seen during training. In some cases, training experiences have clearly resulted in increased resentment toward poor patients and their humiliation. Trainees also learn powerful lessons from the policies and practices that are in place at teaching hospitals regarding the care of uninsured and vulnerable patients. Three historical and current differences in the care of charity, ward, or service patients as compared to private patients or patients with higher socioeconomic status include less faculty supervision; institutional and hospital policies that serve to delay, deny, or financially burden these patients; and negative perceptions and attitudes.

. The financing of charity care and medical education is intertwined and fluid. It occurs largely on the basis of the morally praiseworthy task of the provision of charity by teaching hospitals. Moral praise translates into societal credibility and endorsement of medical education and serves to almost completely dissipate scrutiny or accountability for practices that should be questioned.

The nation stands on the eve of substantial changes to the provision of care and especially in regard to poor patients. Nevertheless, the passage of Medicare and Medicaid perhaps represented even more profound changes and, yet, much of the way in which care was provided to poor patients remained largely a matter of long-held traditions. The controversy at Parkland attests to the current conflicts which are a product of these traditions. Seeing these conflicts concerning medical education and charity care through an historical lens, as this chapter attempts to do, may contribute to a fuller discussion and a more just approach to the provision of care to poor people.

Chapter 3: Emergency Departments and Charity Care

In February of 2009, the Chicago Tribune reported that twelve-year-old Dantae Adams went to the University of Chicago Medical Center's Emergency Department after part of his upper lip was torn off in an attack by a stray pit bull. According to his mother and hospital records, he was sent home after minimal treatment and told to "follow up with Cook County" in one week. Dantae's mother expressed how she felt: "I am so hurt that the university rejected my son."[1094] She was also so concerned that she later took her son on an hour long bus ride to the public county hospital. The plastic surgeon who reconstructed Dantae's lip stated that treatment was urgently needed.[1095]

The incident fueled a controversy in Chicago and Washington. In part, the controversy was about the University of Chicago's announcement earlier that week of a new program aimed at reducing emergency department care for people considered to have nonurgent injuries and illnesses. Criticisms of the announced changes were serious. While generally people agree with the common sense idea that those with minor illnesses may benefit from having an established physician practice to go to instead of the emergency department, the details of the announced changes were primarily about limiting emergency department care. In an unprecedented step, two national emergency medicine physician groups condemned both the care of Dantae and the new initiative that involved decreasing staff and the number of beds available to emergency department patients requiring admission. Physicians critical of the changes who were employed by

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[1094] Jason Grotto, "Mauled by Dog, Kid Sent Home by ER," *Chicago Tribune*, February 13, 2009.

[1095] Ibid.

the University of Chicago told the American Academy of Emergency Medicine (AAEM) that the new initiatives “drastically changed” the way patients were treated. They explained that emergency physicians were directed by the new hospital policy to discharge patients as soon as they are stable rather than complete an evaluation and either admit them or arrange for follow up care.[1096] The president of the American College of Emergency Physicians (ACEP) said that the new policy was dangerously close to “patient dumping,” which has been prohibited by law since 1986.[1097]

A medical center spokesperson said that the cost of a visit to the emergency room for a nonurgent condition was $1,200.[1098] Also according to the medical center, the hospital is an advanced teaching facility where costs are much higher than at other community hospitals, so it makes sense to refer patients elsewhere when possible.[1099] The question is for whom does it make sense? When the changes in the emergency department were announced, one reason was clearly to reduce costs for the medical center.[1100] The president of ACEP expressed concern about access to care for the patients turned away who are primarily either uninsured or insured through Medicaid: “There

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[1096] Kathleen Louden, "Chicago Hospital to Halt New Emergency Department Policies after Criticism," *Medscape Medical News* (2009), http://www.medscape.com/viewarticle/589704?sssdmh=dm1.445141 (accessed March 14, 2013).

[1097] Laura Gore, "University of Chicago Medical Center Is Failing Emergency Patients, Nations Emergency Physicians Say; Urge Congress to Hold Hearings on the State of Emergency Care," (2009), http://www.acep.org/content.aspx?id=44294. The law referred to here is the Emergency Medical Treatment and Labor Act, 42 USC § 1395dd (2002), also known as EMTALA or the anti-dumping law.

[1098] Joe Stephens, "Obama Camp Has Many Ties to Wife's Employer," *Washington Post*, August 22, 2008.

[1099] Bruce Japsen, "ER Doctors Condemn University of Chicago Plan to Divert Patients," *Chicago Tribune*, February 20, 2009.

[1100] Louden, "Chicago Hospital to Halt New Emergency Department Policies after Criticism."

simply are no other health care providers willing to care for most of these patients."[1101] The University of Chicago Medical Center appears to be in good shape financially, despite the costs associated with the emergency department. In 2008, the hospital's revenues exceeded expenses by $87 million and, in 2007, by $85 million.[1102] In a letter to the Wall Street Journal, the hospital's chief executive stated: "The University of Chicago's expensive, high-technology facilities are ideal for patients with advanced problems, but we often aren't the best venue for primary care. For example, a center like ours can provide about 2,100 routine outpatient visits at a cost of $1 million—and our Medicaid reimbursements fall well short of that. The same $1 million could fully support more than 6,200 routine visits at a more streamlined local clinic focused on primary care."[1103] The executive did not offer an explanation for the high cost of care at the medical center but implies that the cost is related to its facilities.

For several years the hospital had been working on a larger initiative, called the Urban Health Initiative, which the University says is designed to help patients with nonemergency conditions establish a medical home with a primary care provider.[1104] The Initiative was also designed to allow the medical center to focus on the role of advancing research and medical education, instead of contending with an emergency department

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[1101] Gore, "University of Chicago Medical Center Is Failing Emergency Patients, Nations Emergency Physicians Say; Urge Congress to Hold Hearings on the State of Emergency Care."

[1102] Thomas N. Burton, "Chicago Hospital Doctors Protest Planned Bed Cuts," *Wall Street Journal*, March 12, 2009.

[1103] James L. Madera, "Costly ERs Are a Poor Tool for Community Health Care," *Wall Street Journal*, March 13, 2009. The average payment by Medicare for an intermediate level of care in a hospital outpatient department is $124.40. Medicare beneficiaries are responsible for a 20 percent copayment. MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System: Chapter 6: Federally Qualified Health Centers," (Washington, DC: Medicare Payment Advisory Commission, 2011), 154. Based on the information on costs by the University of Chicago's CEO, the average cost at the Medical Center is $476 as compared to $161 at other institutions.

[1104] Stephens, "Obama Camp Has Many Ties to Wife's Employer."

crowded with patients who could be better served elsewhere.[1105] The hospital's CEO said that the aim of the hospital is to admit more privately insured patients.[1106] At least some of the furor from the announced changes was likely related to one of the Urban Health Initiative's creators, Michelle Obama.[1107] Earlier versions of the Urban Health Initiative had received both praise and criticism. A spokesperson with the Illinois Hospital Association endorsed the initiative, stating: "Patients need a source of ongoing care, and this initiative is trying to make that care available in a more appropriate setting and in a more timely way."[1108] Improving access to primary care is laudable from everyone's point of view; however, when tied to limiting access to care through the emergency department, the consensus falls apart. The chairman of emergency medicine at Chicago's public hospital pointed out that many low income workers have difficulty getting to clinics because of their limited hours. He also said: "Often, the patients think it's something serious when it's happening to them. And a lot of the time, the patients are right."[1109] Obama had left the University of Chicago prior to the implementation of the controversial "triage out" emergency department policy.[1110]

Almost 200 fellows and residents at the University of Chicago Medical Center protested the changes in emergency department policy in a letter to hospital trustees,

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[1105] Grotto, "Mauled by Dog, Kid Sent Home by ER."

[1106] Burton, "Chicago Hospital Doctors Protest Planned Bed Cuts."

[1107] Stephens, "Obama Camp Has Many Ties to Wife's Employer."

[1108] Ibid.

[1109] Ibid.

[1110] Louden, "Chicago Hospital to Halt New Emergency Department Policies after Criticism."

stating: "[T]hese changes directly violate our oath as physicians to do no harm."[1111] There are similar programs in other areas, though the details of the program can make a significant difference in the outcomes for patients. Advocates say triage out programs prevent misuse of the emergency department and increase efficiency.[1112] A physician with the University of Colorado supports their hospital's triage out system. Still, the University of Colorado physician also said that most emergency physicians are uncomfortable with the process and: "Selecting out patients we're not going to see goes against what our specialty is about."[1113]

Within a month of the report about Dantae and the public announcement of the new initiative, the University stated that a committee would "review, refine, and modify" the plan.[1114] Partially in response to the new policy, the chairman of the department of medicine stepped down and, within a few months, the medical center's director had resigned.[1115] Critics of the emergency department policy, such as the president of the American College of Emergency Physicians, were concerned about the precedent it would set for other hospitals: "If other community, non-profit hospitals follow this

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[1111] Ibid.

[1112] Triage out has also been called "deferral out." Marc J. Shapiro and Gail M. O'Brien, "Deferral out of the Emergency Department: The Wrong Solution?" *Annals of Emergency Medicine* 36, no. 1 (2000). Another term used is "redirected." See: Laurie E. Felland, Robert E. Hurley, and Nicole M. Kemper, "Safety Net Hospital Emergency Departments: Creating Safety Valves for Non-Urgent Care," Center for Studying Health System Change, http://www.hschange.com/CONTENT/983/ (accessed March 14, 2013). "Referral of care" is also used to describe the programs. Timothy Seay, Angela Straface, and John Myers, "Counterpoint: Don Your White Hat! " *Emergency Medicine News* XXIX, no. 12 (2007).

[1113] Louden, "Chicago Hospital to Halt New Emergency Department Policies after Criticism."

[1114] Editorial, "University of Chicago Reconsiders Plan to Redirect ER Patients " (2009), http://blogs.wsj.com/health/2009/03/16/university-of-chicago-reconsiders-plan-to-redirect-er-patients/ (accessed March 14, 2013).

[1115] Mike Colias, "Embattled U of C Med Center CEO Madara to Resign," *Crain's Chicago Business*, August 14, 2009.

example and shift the lion’s share of resources to its high-revenue elective patients and procedures, it will leave many emergency patients virtually out in the cold.”[1116] There already is evidence that nonprofit hospitals in the Chicago area provide much less charity care than the value of their tax breaks. Charity care in Chicago and in Illinois generally has been the subject of reports, lawsuits, and legislation.[1117]

Dantae, however, was not a charity patient, he was insured through Medicaid. The hospital reports that Medicaid does not cover the cost of caring for its beneficiaries.[1118] Whether these shortfalls in Medicaid count towards maintaining tax exempt status is uncertain.[1119] Illinois Attorney General Lisa Madigan has invested considerable effort in requiring stricter standards and accountability from nonprofit hospitals, like the University of Chicago Medical Center.[1120] In 2007, the hospital reported to the state that 63 outpatients and 312 inpatients received free care.[1121] The number of hospital

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[1116] Japsen, "ER Doctors Condemn University of Chicago Plan to Divert Patients."

[1117] Center for Tax and Budget Accountability, "An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return," (Chicago, IL: Center for Tax and Budget Accountability, 2009).

[1118] Grotto, "Mauled by Dog, Kid Sent Home by ER."

[1119] The Center for Tax and Budget Accountability cites case law in Illinois which does not count Medicaid shortfalls towards property tax exemption: Center for Tax and Budget Accountability, "An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return." The Illinois Hospital Association cites the Internal Revenue Service community benefit reporting, which includes Medicaid shortfalls: Illinois Hospital Association, "Response of the Illinois Hospital Association and the Metropolitan Chicago Healthcare Council to CTBA Charity Care Report," (2009), http://www.ihatoday.org/uploadDocs/1/ctbareportresponse.pdf (accessed March 14, 2013).

[1120] Mike Colias, "Hospitals Slip Madigan's Net: Panel's Watered-Down Charity Care Decision Another Setback for AG," *Crain's Chicago Business*, February 2, 2009.

[1121] Grotto, "Mauled by Dog, Kid Sent Home by ER."

admissions for 2007 was 26,377.[1122] At the time of the University of Medical Center controversy, the Illinois Supreme Court was close to ruling that another nonprofit hospital in Illinois, Provena Covenant, should continue to have its property tax exemption revoked because it was not a charitable institution. The case, which began in 2004, cited Provena's miniscule charity care. In 2002 Provena provided charity care to 302 patients, about as much as the University of Chicago, though revoking nonprofit status has not been pursued in the case of the university's hospitals.[1123] Charity care as a percent of hospital expenses was slightly greater than 1 percent in 2007 for the University of Chicago Medical Center, almost half of the average for nonprofit hospitals in Cook County.[1124]

The situation for poor patients seeking emergency department care in Chicago seems to have worsened. In a subsequent article by the Chicago Tribune, patients were arriving at the public hospital after initially being seen at local nonprofit hospitals. Many of the patients had been given maps to the public hospital and discharge instructions to go to the public hospital. Some of the discharge instructions included statements such as "Go to Cook County Hospitals immediately," in the case of a man with a broken jaw; "Follow up at Cook County Hospital for uterine tumor surgery" was written on another discharge slip. The county hospital does not turn patients away but it does have many of the same financial pressures as area nonprofit hospitals. The county hospital receives about half of

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[1122] University of Chicago Medical Center, "2007 Annual Report: Evolution of Science and Medicine," (2008), http://www.ihatoday.org/uploadDocs/1/ctbareportresponse.pdf (accessed March 14, 2013).

[1123] Bruce Japsen and Jason Grotto, "Burden Higher for Nonprofit Hospitals, Illinois Supreme Court Says," *Chicago Tribune*, March 19, 2010.

[1124] Stephens, "Obama Camp Has Many Ties to Wife's Employer." See also: Center for Tax and Budget Accountability, "An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return."

its operating revenue from tax appropriations, yet nonprofit hospitals receive taxpayer support through forgone taxes.[1125]

Nonprofit hospitals defend the triage out procedures as reasonable and "about getting people to the appropriate level of care."[1126] At the same time, Chicago Tribune journalists reported that most nonprofit hospitals deny that their emergency departments send patients to the public hospital even when shown discharge slips from their hospital which clearly does just that. In other words, triage out is defended and denied. As already mentioned, the practice is also criticized. One emergency room physician severely criticized the practices as "legalized patient dumping."[1127] Another physician pragmatically pointed out that once care has been undertaken to rule out an emergency condition, "why not close the loop? At that point, it's not a labor intensive issue."[1128] Dr. Kellermann, a physician who has been involved in the Institute of Medicine's Committee on the Future of Emergency Care, described the triage out program: "We've looked you over. You're not that sick. Now go away." The problem, according to Kellermann is: "If we don't see them in the emergency room, they will not get the care they need, and some of them will come back much sicker."[1129]

The events at the University of Chicago illustrate a particular case of a phenomenon that has been occurring more frequently throughout America: turning away people who come to the emergency department and are deemed to have a nonemergency

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[1125] Jason Grotto and Bruce Japsen, "Are Hospitals Passing Off Their Low-Profit Patients?" *Chicago Tribune*, April 10, 2009.

[1126] Ibid.

[1127] Ibid.

[1128] Ibid.

[1129] Louden, "Chicago Hospital to Halt New Emergency Department Policies after Criticism."

condition.[1130] In order to justify turning people away from the emergency department, a number of assumptions or assertions are commonly made. Often framed as a necessity on the basis of costs or crowding, turning people away from the emergency department cannot shed its moral implications.[1131] In a larger context, the essential struggle is about more than the role of financial and economic considerations in access to health care. The emergency department has already been the place where Congress and the American public have drawn the line for a civilized society. A civilized society does not allow hospitals to turn away people with emergency conditions. However, refusing health care, even for a minor injury, to a patient by a health care provider goes against the image of a professional who is committed to the well being of others. Not attending to minor injuries by health care professionals goes against neighborliness and common decency. Withholding care, particularly when it benefited physicians or organizations, was a subject of intense controversy, especially in the 1990s during the heyday of managed care.[1132] In recent debates about health care reform, health care costs seem to overshadow all else, yet, at the same time, even these debates are also about values and assumptions.[1133]

[1130] Felland, Hurley, and Kemper, "Safety Net Hospital Emergency Departments: Creating Safety Valves for Non-Urgent Care."

[1131] Kenneth V. Iserson, "Assessing Values: Rationing Emergency Department Care," *American Journal of Emergency Medicine* 10, no. 3 (1992).

[1132] See, for example, Gail J. Povar et al., "Ethics in Practice: Managed Care and the Changing Health Care Environment: Medicine as a Profession Managed Care Ethics Working Group Statement," *Annals of Internal Medicine* 141, no. 2 (2004). Jerome P. Kassirer, "Managed Care and the Morality of the Marketplace," *New England Journal of Medicine* 333, no. 1 (1995).

[1133] See, for example, Michael E. Chernew, Katherine Baicker, and John Hsu, "The Specter of Financial Armageddon--Health Care and Federal Debt in the United States," *New England Journal of Medicine* 362, no. 13 (2010). Jonathan Gruber, "The Cost Implications of Health Care Reform," *New England Journal of Medicine* 362, no. 22 (2010).

The emergency department has come to symbolize the last hope and a safe haven in health care. Emergency department care has been cited as proof that no one in America goes without health care. In 2007, President Bush echoed a popular belief: "[P]eople have access to health care in America. After all, you just go to an emergency room."[1134] President Bush was at least partly correct, the Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, does provide for a limited right to health care for people with emergency medical conditions and for women in labor, in most hospitals, and regardless of ability to pay.[1135] Twelve-year-old Dantae Adams' case seems to straddle the space of uncertainty between an emergency medical condition and a condition that is "merely" nonurgent. This uncertainty is a built-in part of emergency care and, for that matter, all medical care. Is it a heart attack or indigestion? Is this problem a symptom of a sexually transmitted infection from a wayward spouse or the mere worry of the possibility? Behind each of these questions lies a problem applying to a person.

The limited right to emergency stabilization and treatment in the emergency department, the uncertainty concerning which conditions are "real" emergencies and, according to some, the professional and ethical standards of emergency physicians has, for the most part, meant that people arriving in the emergency department are treated for whatever acute conditions are present.[1136] These factors have also contributed to the

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[1134] Paul Krugman, "The Waiting Game," *New York Times* 2007. Renee Semonin-Holleran, "I Wanted to Come in Early, before It Got Busy.," *Journal of Emergency Nursing* 35, no. 2 (2009).

[1135] *Emergency Medical Treatment and Labor Act*. 42 U.S. Code § 1395dd (2002).

[1136] Lynne D. Richardson and Ula Hwang, "America's Health Care Safety Net: Intact or Unraveling?" *Academic Emergency Medicine* 8, no. 11 (2001). Anne-Claire C. Durand et al., "ED Patients: How Nonurgent Are They? Systematic Review of the Emergency Medicine Literature," *American Journal of Emergency Medicine* 29, no. 3 (2011). Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point* (Washington, DC: National Academies Press, 2007), 48-49.

designation of the emergency department as the “safety net of the safety net.”[1137] As discussed in the introduction, the safety net is a broad term that has not been well defined. The safety net’s moral meaning is arguably tied to its association with charity care and this is especially so in the emergency department. The Institute of Medicine has described the safety net as a “patchwork of institutions, financing, and programs that vary dramatically across the country as a result of a broad range of economic, political, and structural factors.”[1138] Despite the lack of a clear definition of the safety net, the role of the emergency department in this patchwork is accepted. The reason for this recognition of the emergency department as a vital component of the safety net is apparent:

> Historically, the [emergency department] has served as the only available point of access to the health care system for many vulnerable and disenfranchised individuals. The [emergency department] is sometimes the sole provider of care to those who, because of financial, cultural, medical, environmental, or organizational barriers, are unable to obtain adequate health care from other providers.[1139]

The safety net role of the emergency department is also often linked to a “crisis” in emergency departments.[1140] A crisis in emergency departments is commonly perceived by health care professionals, the public and policymakers. Emergency departments are overcrowded, waiting times are often long, and much of the care provided is unreimbursed.[1141]

[1137] ———, *Hospital-Based Emergency Care: At the Breaking Point*: 42-43.

[1138] Lewin and Altman, *America's Health Care Safety Net: Intact but Endangered*, 4.

[1139] Richardson and Hwang, "America's Health Care Safety Net: Intact or Unraveling?" 1056.

[1140] Bruce Siegel, "The Emergency Department: Rethinking the Safety Net for the Safety Net," *Health Affairs* Suppl Web Exclusives (2004).

[1141] Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*. Uncompensated care in the emergency

It is common for the bulk of these problems to be blamed on the poor and uninsured. In a 2008 *New York Times* editorial, the author states: “The nation’s failure to provide health insurance for all Americans seems to be harming even many of those who do have good health coverage. That is one very plausible interpretation of a disturbing increase in waiting times at emergency rooms that are often clogged with uninsured patients seeking routine charity care.”[1142] The editorial helps to create an image of masses of uninsured people who are expecting charity for minor problems while jeopardizing the care of people who do have health insurance. The health law scholar Laura Hermer has suggested that the federal law that requires most hospitals to provide stabilizing emergency care, EMTALA, “unintentionally invites scapegoating of the poor and uninsured.”[1143] Just as the administrator from the University of Chicago implied, it is the uninsured and people publicly insured through Medicaid, who remain the “undesirables.”[1144]

Emergency department crowding, however, is not primarily caused by the use of the emergency department by uninsured people. Emergency department crowding has multiple causes both within the emergency departments, within hospitals, within regions,

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department will be discussed later in this chapter. Broader issues in uncompensated care will be discussed in Chapter 4.

[1142] Editorial, "Emergency Room Delays," *New York Times*, January 19, 2008.

[1143] Laura D. Hermer, "The Scapegoat: EMTALA and Emergency Department Overcrowding," *Journal of Law and Policy* 14, no. 2 (2006): 723.

[1144] Ibid., 732. The word “undesirable” occurs in other reports of patient dumping, see for example, David A. Ansell and Robert L. Schiff, "Patient Dumping. Status, Implications, and Policy Recommendations," *Journal of the American Medical Association* 257, no. 11 (1987).

and through broad-based financial incentives.[1145] At the same time, the one factor most commonly associated with emergency department crowding is the inability to admit patients to an inpatient bed once a decision is made to do so.[1146] A study of the University of Chicago's emergency department by three national leaders of emergency medicine recommended changes, including adding beds, which would improve waiting times. Instead, the changes at University of Chicago included cutting almost half of the inpatient beds available to the emergency department for general medicine and more than 10 percent of the intensive care beds available to the emergency department. The cuts to beds within the emergency department were curtailed after the intense criticism.[1147]

The events at the University of Chicago, importantly for this chapter, do not seem to have interfered with its claim that it is a charitable institution. Furthermore, practices such as triage out do not seem to have changed the presumption that no one is denied medical care in America. The Boston Globe reported in April of this year that Mississippi Governor Haley Barbour stated: "There's nobody in Mississippi who does not have access to health care."[1148] The emergency department has had a primary role from the latter part of the twentieth century until the present time in creating the belief that Americans receive health care when they need it. Since the enactment of EMTALA, this

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[1145] Daniel A. Handel et al., "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals," *Academic Emergency Medicine* 17, no. 8 (2010). The origin of the belief that emergency department crowding is primarily caused by the uninsured poor will be discussed later in this chapter.

[1146] General Accounting Office, "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities," (Washington, DC: U.S. General Accounting Office, 2003), 22.

[1147] Burton, "Chicago Hospital Doctors Protest Planned Bed Cuts."

[1148] Christopher Rowland, "Amid Strained Clinics, Foe Assails 'Obamacare,'" *Boston Globe*, April 20, 2011.

belief that all Americans can get health care through the emergency department has been tied to assumptions about charity care.

This chapter begins with a history of emergency medical care and the ethical and legal duties of physicians and hospitals in providing emergency care. Included in this history is the practice of patient dumping. EMTALA is placed in historical context and the law is explained.[1149] The reason that the law is called an unfunded mandate is explored and the question of whether EMTALA requires charity care is addressed. Next, the origin of attributing emergency department crowding to nonurgent care and uninsured people is described. Triage out programs are introduced in historical context and summarized. The evolution of research on nonurgent care in the emergency department is clarified. Two federal efforts, rules issued by the Centers for Medicare and Medicaid Services (CMS) and the Deficit Reduction Act of 2005, both bearing on triage out programs, are explained. The publications in medical journals on triage out programs are analyzed through the lens of research, quality improvement, and as a policy change. Costs and resource use in the care of patients with nonurgent conditions are detailed. The final two sections include an analysis of the potential for triage out programs to worsen health care disparities and an analysis of the ethical concerns raised by the programs. The conclusion summarizes the relationship between emergency department care and charity care.

History of Emergency Care: The Duty to Treat and Patient Dumping

The moral duty of physicians to provide medical care in times of catastrophic emergencies was recognized in 1347, when the Black Death, a pandemic of bubonic

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[1149] *Emergency Medical Treatment and Labor Act*.

plague, arrived in Europe. While histories often demonstrate that physicians left the cities to escape the disease, many physicians stayed to provide care. The reasons for this fidelity to patients often derived from Christian or Jewish concepts of charity, or civil duties to the state, as well as a desire for profit.[1150] The tradition that recognized fidelity to patients came to America with its founders. When yellow fever broke out in Philadelphia in the summer of 1793, Benjamin Rush described his obligations to his patients in a letter to his wife: "[I]t would be as much your duty not to desert me in that situation, as it is mine not to desert my patients."[1151]

The first Code of Medical Ethics of the American Medical Association (AMA), written in 1847, outlined how physicians should interact with each other when more than one physician had arrived to provide emergency care to a patient. Indirectly it is an affirmation of a duty, or at least the likelihood, of providing care in an emergency. The Code referred to limits on eleemosynary services but declared that poverty "should always be recognized as presenting valid claims for gratuitous service."[1152] Some services should be provided with a "pecuniary acknowledgment," yet, "to individuals in indigent circumstances, such professional services should always be cheerfully and freely accorded."[1153]

[1150] Jonsen, *A Short History of Medical Ethics*: 45.

[1151] Lyman H. Butterfield, ed. *Letters of Benjamin Rush Volume II* (Princeton, NJ: Princeton University Press, 1951), 664, quoted in Abigail Zuger and Steven H. Miles, "Physicians, AIDS, and Occupational Risk. Historic Traditions and Ethical Obligations," *Journal of the American Medical Association* 258, no. 14 (1987): 1926.

[1152] American Medical Association, "Code of Medical Ethics of the American Medical Association," (1847), http://www.ama-assn.org/resources/doc/ethics/1847code.pdf (accessed March 14, 2013).

[1153] Ibid., 106.

By 1957, the AMA Code of Medical Ethics clarified the role of the physician in an emergency: “A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his service only after giving adequate notice.”[1154] In regard to payment, the Principles state: “His fee should be commensurate with the services rendered and the patient’s ability to pay.”[1155] An explicit obligation to provide gratuitous care was no longer a part of the Principles. The 2001 Principles of Medical Ethics were revised but retained a special obligation in emergencies: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”[1156]

Despite the heightened duties expressed in the AMA Principles of Medical Ethics for physicians during emergencies, in America, there is essentially no legal right to health care. In most cases, physicians do not have a legal duty to treat individuals even in medical emergencies.[1157] The Indiana Supreme Court set the standard for no legal duty to treat in an 1899 case of wrongful death, *Hurley v Eddingfield*. In the case, a physician refused to render aid to a woman during childbirth. The physician had been the family physician for some time. The woman’s husband made three requests for assistance, one of which offered advance payment to the physician. “Without any reason whatever,” the

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[1154] In Chapter 2, D.W. Cathell’s book written in the nineteenth century similarly referred to the duty to provide care in an emergency. ———, "Principles of Medical Ethics."

[1155] Ibid., 3.

[1156] ———, "Principles of Medical Ethics," (2001), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page? (accessed March 14, 2013).

[1157] Though see the discussion of physicians’ obligation to treat related to EMTALA.

physician persisted in his refusal while the woman lay dying..[1158] The Indiana Supreme Court did not accept the argument that the physician’s recently obtained medical license conferred a compulsory duty to treat upon the physician.[1159] The court affirmed the physician's right to decide whether he will practice at all and on what terms. This is a classic case that continues to be cited and remains part of the common law regarding no duty to treat.[1160]

By the middle of the nineteenth century, hospitals were beginning to hire physicians whose duties would include attending to emergency cases.[1161] Most hospitals, however, did not accept all patients who came to their doors. Voluntary hospitals routinely limited care in the nineteenth century by perceived social worth and by related notions of the stigma of certain illnesses.[1162] Thus, at one private hospital in Connecticut, the trustees would provide care free to “persons of temperate and industrious habits, who, from sickness or accident required care or attention, for which they are unable to pay.”[1163] African American patients were refused admittance in segregated hospitals.[1164] In nonsegregated hospitals, African Americans were housed in the least desirable locations and subject to limits on the number admitted. For example, at the turn of the nineteenth

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[1158] Sara Rosenbaum, "The Impact of United States Law on Medicine as a Profession," *Journal of the American Medical Association* 289, no. 12 (2003): 1548.

[1159] Ibid.

[1160] Lois Shepherd and Mark A. Hall, "Patient-Centered Health Law and Ethics," *Wake Forest Law Review* 45, no. 5 (2010).

[1161] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 67.

[1162] This point is made in Chapter 2 and in Chapter 4.

[1163] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 108.

[1164] P. Preston Reynolds, "The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 through 1967," *American Journal of Public Health* 87, no. 11 (1997).

century at Grady Hospital in Atlanta, there were excess beds for whites and a waiting list for “colored” beds.[1165]

In the nineteenth century, however, it was much more common for accident and injury victims to go to their own homes rather than the hospital.[1166] This began to change in the early twentieth century as hospitals became more abundant and medical care offered significant advancements. There were nearly 5,000 hospitals in America in 1923 whereas, in 1873, there were less than 200.[1167] Hospitals most often continued to limit who received care. For example, during the first few decades of the twentieth century, voluntary hospitals regularly sent dying patients to public hospitals. Patients were also rejected by voluntary hospitals “under the rules,” which often meant patients with mental illness, venereal disease, epilepsy, alcoholism and even measles and scarlet fever.[1168]

To the extent that patient dumping involves refusing to care for certain patients as well as transferring patients from private to public hospitals, there is evidence that these practices were occurring throughout the history of American hospitals. Transfers to public hospitals seem to have been common practice, particularly in urban areas where there were both public and private hospitals. In New York in 1938, the commissioner of hospitals defended the transfer of an accident victim from New York Hospital to City Hospital for economic reasons by explaining that it was a process undertaken daily and that it prevented the voluntary hospitals from encountering the overcrowding and lack of

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[1165] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 301-302.

[1166] Beatrix Hoffman, "Emergency Rooms: The Reluctant Safety Net," in *History and Health Policy in the United States: Putting the Past Back In*, ed. Rosemary Stevens, Charles Rosenberg, and Lawton R. Burns (New Brunswick, NJ: Rutgers University Press, 2006), 251.

[1167] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 341.

[1168] Opdycke, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*: 57.

funding that the city hospitals endured.[1169] Voluntary hospitals in New York were given subsidies for providing care to poor patients but they could also turn away selected patients. According to the New York commissioner of health, public hospitals were to maintain an open door under any and all circumstances: "Treatment cannot be refused cases in public city hospitals because of limitations of time or space."[1170] Later, in the 1950s, most voluntary hospitals in New York could reject a patient by writing "No beds" on an admission slip. At Bellevue, a public hospital, that was not allowed.[1171] It is worth noting the similarities between the mid-century note, "No beds," to what is happening today in Chicago where a discharge slip states "Go to Cook County Hospitals." Social worth considerations, stigmatizing illnesses, and economic reasons for not taking or for transferring patients did not entirely explain what was happening. At New York Hospital during the 1950s, for instance, the number of patients receiving full charity was less than 1 percent so that, presumably, any financial burden would be minimal. Since hospitals could use their own criteria for admission, the basis for turning patients away could vary according to perceived needs of the hospital. At New York Hospital patients might still be rejected but it was more likely to be because the case was not "interesting" than because of financial considerations. As a teaching hospital, educational needs could drive the decision to accept or reject a patient.[1172]

Hospitals began to build dedicated emergency rooms in the middle of the twentieth century. In the 1930s, only a few hospitals had such rooms but, by 1960, over

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[1169] Ibid., 71.

[1170] Ibid., 78.

[1171] Ibid., 106.

[1172] Ibid., 108. The role of medical education and training needs is discussed fully in Chapter 2.

90 percent had emergency wards.[1173] The growth in emergency rooms paralleled the postwar expansion of hospitals as a result of the Hill-Burton Hospital Survey and Construction Act of 1946. Hill-Burton funds provided the opportunity for hospitals to build new emergency departments as part of new hospital construction beginning in the 1940s, or to build or revamp existing ones through amendments to the program in 1970.[1174] The expansion in emergency rooms also occurred concurrently with advancements in postwar trauma care, medical technology, and in municipal emergency services such as police, fire, and ambulance services.[1175] Hospitals marketed emergency departments aggressively because admissions originating in the emergency department boosted income and community status. Hospitals were simultaneously rewarded and cursed with dramatic growth in the number of visits.[1176] About 9.4 million patients were seen in emergency rooms in 1954 and, by 1965, the number of patients had increased to 28.7 million each year.[1177]

Problems in the emergency department were recognized long before Congress stepped in to make legislative changes. In the 1950s, a survey in New England

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[1173] Hoffman, "Emergency Rooms: The Reluctant Safety Net," 252.

[1174] Hill-Burton is discussed in more detail in Chapter 4. Kenneth R. Wing, "The Community Service Obligation of Hill-Burton Health Facilities," *Boston College Law Review* 23, no. 3 (1982): 588.

[1175] Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*: 353-354.

[1176] Hoffman, "Emergency Rooms: The Reluctant Safety Net," 252.

[1177] Brian J. Zink, *Anyone, Anything, Anytime : A History of Emergency Medicine* (Philadelphia, PA: Mosby Elsevier, 2006), 13. In 2007, the total number of ED visits was about 117 million. Ning Tang et al., "Trends and Characteristics of US Emergency Department Visits, 1997-2007," *Journal of the American Medical Association* 304, no. 6 (2010).

documented the exponential rise in emergency department visits.[1178] In 1963, prior to the enactment of Medicare and Medicaid, one academic physician commented: “The emergency ward of the urban hospital has become the doctor for the aged and medically indigent, particularly on weekends and at night.”[1179] In a 1964 study of patients at one emergency department who were deemed to have nonemergency medical conditions, the authors concluded that “much of the increment of nonurgent usage is due to dependence on the hospital for general medical needs by the indigent ‘core city’ population, and to recourse to the emergency service by self-supporting members of the community who cannot get or do not seek prompt attention from private physicians.”[1180] Another observation by the authors was that the primary problem was not the emergency department but the lack of available, affordable, and prompt medical care in the community. All of the patients in the study were billed for their medical care, so the question of charity was not an issue.[1181] Emergency medicine did not become a specialty until the 1970s, so there was little consensus on what constituted an emergency. Sorting out the basis for categorizing patients as having a condition that requires emergency care would end up taking many years and it is still being refined. Practice patterns were also

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[1178] Ernest C. Shortliffe, T. Stewart Hamilton, and Esward H. Noroian, "The Emergency Room and the Changing Pattern of Medical Care," *New England Journal of Medicine* 258, no. 1 (1958).

[1179] John H. Knowles, "Medical Care: Its Social and Organizational Aspects. The Balanced Biology of the Teaching Hospital," *New England Journal of Medicine* 269, no. 24 (1963): 402.

[1180] E.Richard Weinermann et al., "Yale Studies in Ambulatory Medical Care. V. Determinants of Use of Hospital Emergency Services," *American Journal of Public Health* 56, no. 7 (1966): 1054.

[1181] Ibid.

changing. Urgent complaints that would have been treated in a physician's office evolved to become conditions more suitably treated in the emergency department.[1182]

Throughout much of the twentieth century, hospitals were protected from liability for decisions made in their hospitals and emergency departments because of both the doctrine of charitable immunity for nonprofit hospitals and governmental immunity for public hospitals.[1183] Charitable immunity was part of the reason that the court in a 1934 case, *Birmingham Baptist Hospital v. Crews,* ruled that individuals have no right to be admitted to a hospital and a hospital has no duty to accept any admission. The court also declared that there was no exception to the rule for emergency department treatment and that the rule applied to public and private hospitals unless a statutory duty became law. The case involved a two-year-old girl with diphtheria who died after admission was refused.[1184] Case law was sometimes buttressed by professional guidelines. For example, the American Hospital Association's *Manual on Admitting Practices and Procedures* in the early 1950s stated that admissions departments should transfer patients "for financial reasons or because they are warranted by the patient's medical condition."[1185]

African Americans continued to have additional difficulty in getting needed medical care and emergency care. In a 1956 study, about one third of Southern hospitals did not admit African Americans under any conditions, even in emergencies. Only 6

[1182] Hoffman, "Emergency Rooms: The Reluctant Safety Net," 255.

[1183] William J. Curran, "Legal History of Emergency Medicine from Medieval Common Law to the AIDS Epidemic," *American Journal of Emergency Medicine* 15, no. 7 (1997): 663.

[1184] The following publications discuss the history of establishing a legal duty for hospitals to treat in a medical emergency. Lisa M. Enfield and David P. Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," *American Journal of Law and Medicine* 13, no. 4 (1988): 567. Curran, "Legal History of Emergency Medicine from Medieval Common Law to the AIDS Epidemic," 663. Hoffman, "Emergency Rooms: The Reluctant Safety Net," 261.

[1185] ———, "Emergency Rooms: The Reluctant Safety Net," 262.

percent of hospitals offered African Americans services without any restrictions.[1186] Under the original Hill-Burton law, separate but equal health care facilities were allowed and eighty nine hospitals were built as either all-white or all-black. Dying after being refused medical care was a familiar cultural story, particularly in the South, for African Americans at mid-century. In December of 1950 a young African American male college student was denied admission to Duke University Hospital after being injured in an automobile accident. The hospital had no “Negro” beds available because its quota had been reached. He was transported to a black hospital where he died.[1187] In 1964, largely as a result of a class action lawsuit, the Supreme Court upheld a lower court’s ruling declaring the separate but equal provisions in Hill-Burton unconstitutional. The court ruled that the nonprofit hospitals were an “arm of the state” because of the acceptance of Hill-Burton funds and thus could not violate the Fourteenth Amendment equal protection provisions. Application of these civil rights provisions in Hill-Burton were not retroactive. However, the decision helped to support the passage of Title VI of the Civil Rights Act later in 1964 which prohibits discrimination in the provision of federally funded programs.[1188]

In case law divergent views on a duty of hospitals to provide emergency medical care were developing. A case that would set a strong precedent was *Wilmington General Hospital v. Manlove* in 1961. Darien Manlove, a four-month-old child, died of

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[1186] Paul B. Cornely, "Segregation and Discrimination in Medical Care in the United States," *Amercian Journal of Public Health* 46, no. 9 (1956).

[1187] Karla F. Holloway, "Accidental Communities: Race, Emergency Medicine, and the Problem of Polyheme," *American Journal of Bioethics* 6, no. 3 (2006).

[1188] Smith, "Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda." Reynolds, "The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 through 1967."

pneumonia after a nurse in the emergency department refused to examine or treat the child, although she did try to reach the child's treating physicians. The lower court determined that the receipt of public funds and nonprofit status obligated the hospital to render emergency medical treatment. The Supreme Court of Delaware rejected the duty to treat from the public funds perspective, but held that an obligation to treat arose from the public's reliance on the hospital's custom of providing emergency care. The court held that "liability on the part of a hospital may be predicated on the refusal of services to a patient in the case of an unmistakable emergency, if the patient has relied upon well-established custom of the hospital to render aid in such cases."[1189] Also called the reliance theory, the court reasoned that when a hospital has an emergency department, it had invited patients to seek emergency care there.[1190]

Manlove was one of the cases cited by the court in *New Biloxi v. Frazier* in 1962. The case is shocking in its utter disregard for the health and life of the patient. Mr. Frazier was an African American man who was carried into the emergency department by ambulance attendants after being shot in the arm, severing an artery. Hospital personnel did not attempt to stop the bleeding and even walked away from him although his arm was bleeding profusely. The ambulance attendants insisted that Mr. Frazier be put on an emergency table. When cardiovascular shock became apparent, no attempt was made to stop the bleeding. Mr. Frazier was transferred to a Veteran's Administration Hospital after two hours where he died from shock due to hemorrhage within fifteen minutes of his arrival. The Supreme Court of Mississippi affirmed the lower court's

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[1189] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 569.

[1190] Mitchell F. Rice, "Medical Indigency and Inner City Hospital Care: Patient Dumping, Emergency Care and Public Policy," *Journal of Health and Social Policy* 1, no. 2 (1989).

decision, finding for the plaintiff. The court stated that once the hospital undertook to render aid, it had a "duty to use reasonable care in protecting his life and well being."[1191]

The first specific federal requirement to provide emergency care was contained in the language of regulations enacted in 1979 regarding the 1946 Hill-Burton Act. The Act, as already mentioned, provided funds for hospital construction and renovation. Receipt of Hill-Burton funds required an assurance that hospitals receiving the funds would provide uncompensated care and community service. Originally, each hospital receiving Hill-Burton funds agreed to provide a "reasonable volume of free or reduced cost care" to "individuals unable to pay" and to make their service "available to all" people in the service area of the hospital.[1192] Hospitals, however, had wide discretion in choosing how to provide their free care obligation. Furthermore, there was no individual entitlement to free care even for the people who met the hospital's eligibility requirements. In *Stanturf v. Sipes* in 1969, the plaintiff was denied treatment for his frost-bitten feet at a nonprofit Missouri hospital emergency department when he could not afford a twenty-five dollar advance admittance fee. The hospital refused to allow the payment of this fee by a relative or a local pastor. Mr. Stanturf subsequently required amputation of both feet. The court found that the receipt of Hill-Burton funds by the hospital did not provide a clear entitlement to medical care.[1193] The Missouri Supreme Court reversed the lower court's

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[1191] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 577-578.

[1192] Michael A. Dowell, "Hill-Burton: The Unfulfilled Promise," *Journal of Health Politics Policy and Law* 12, no. 1 (1987): 155-156.

[1193] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 571-572.

decision and invoked the theory of reliance expressed in *Manlove*: “There was an unmistakable emergency and the hospital had an [emergency department].”[1194]

The principle of no duty to treat was applied in other case law to hospitals just as it had to physicians. In a 1975 case, *Campbell v Mincey*, a federal judge in Mississippi ruled that there was no legal duty to admit and treat emergency patients based on common law. In the case, a county hospital had refused admission to an African American woman who arrived in labor. The hospital’s practice of not admitting a patient unless he or she had a personal physician on the hospital staff was a rule that perpetuated segregated hospital facilities after the passage of Medicare and the Civil Rights Act. The court ruled that the woman, who delivered her baby in a parking lot, could not be considered to have a medical emergency because the delivery and postpartum recovery occurred uneventfully.[1195] This federal case and other state court decisions show that a hospital’s obligation to treat medical emergencies was gaining ground in some cases and not others but that clear and explicit duties, especially to people unable to pay for their care and to minority patients, was far from realized.[1196]

After a series of case law and class action lawsuits which sought to enforce hospitals’ obligation under the Hill-Burton Act to provide charity care in a nondiscriminatory manor, new regulations were enacted in 1979.[1197] Included in these new Hill-Burton community service obligations were several related to the provision of

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[1194] Lawrence A. Cross, "Pressure on the Emergency Department: The Expanding Right to Medical Care," *Annals of Emergency Medicine* 21, no. 10 (1992): 1267.

[1195] Rosenbaum, "The Impact of United States Law on Medicine as a Profession," 1548.

[1196] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 578.

[1197] Dowell, "Hill-Burton: The Unfulfilled Promise," 160.

emergency care. Some of the obligations were: (1) A hospital may not deny emergency services to any person who resides in the hospital's service area on the ground that the person is unable to pay for those services. (2) A hospital may discharge a person that has received emergency services, or may transfer the person to another hospital able to provide necessary services, when the appropriate medical personnel determine that discharge or transfer will not subject the person to a substantial risk of deterioration in medical condition. (3) The prohibition of exclusionary admission policies if they have the effect of excluding people who need available services. Examples of exclusionary policies listed in the regulations included requiring that patients have a private family doctor with staff privileges and delaying or denying admission to patients solely because they do not have the necessary cash on hand.[1198]

In some respects, the 1979 Hill-Burton regulations regarding community service obligations as they relate to emergency services were even more far reaching than EMTALA and, at the very least, they were a legislative precursor. In addition to the three requirements implemented in 1979 related to emergency care, there were specified levels of charity care based on hospital revenue or a percentage of the funds provided through Hill-Burton; if the specified amount of charity care was not provided, then additional years of obligation were added; individuals must be notified of the Hill-Burton obligations; people eligible under Hill-Burton but who were denied charity must receive an explanation in writing and be able to appeal the decision; the hospital must undertake an affirmative action plan if not enough eligible people seek services at the hospital.[1199]

[1198] *Hospital Survey and Construction Act of 1946*, Public Law 79-725. U.S. Code 42 § 124.603.

[1199] Ibid., § 124.501-512. See also James F. Blumstein, "Court Action, Agency Reaction: The Hill-Burton Act as a Case Study," *Iowa Law Review* 69, no. 5 (1984).

Yet, the regulations were rarely enforced. One author summarized this based on federal and state reports: “A substantial number of Hill-Burton hospitals have provided little or no free care, fraudulently credited ineligible accounts or bad debts, or completely ignored their uncompensated care obligations.”[1200] Thus, Hill-Burton did not create a right to health care as many advocates wished. It was not only that clear Hill-Burton obligations were not being enforced. Denials of care could occur if a hospital had no Hill-Burton obligation, for reasons other than ability to pay, and when a hospital had met its yearly obligation.[1201]

Even more upsetting to the general public were the stories in the news about the failure of Hill-Burton hospitals to comply with the emergency care requirements. In December of 1984 a twenty-one year old man who was severely burned over 45 percent of his body in an automobile accident was denied emergency care at Vanderbilt University Hospital. The reason given by the hospital for the denial was the man’s lack of insurance. He was transferred to an Army hospital about 1,000 miles away where his leg was amputated. In another Hill-Burton hospital in South Carolina in the same year, a three year old girl with spinal meningitis was denied emergency care because she was uninsured and unable to pay. She died after admission to a hospital 125 miles away. Her physicians blamed the delay for her death.[1202]

Throughout the 1980s the issue of refusing medical care at emergency rooms and patient dumping was gaining public attention. Not all of the news reports included

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[1200] Dowell, "Hill-Burton: The Unfulfilled Promise," 163.

[1201] George J. Agich, "Access to Health Care: Charity and Rights," in *Rights to Health Care*, ed. Thomas J. Bole and William B. Bondeson (Norwell, MA: Kluwer Academic Publishers, 1991), 189.

[1202] Dowell, "Hill-Burton: The Unfulfilled Promise," 165.

information on Hill-Burton obligations. In St. Louis in 1980, a man with a steak knife in his back was transferred from an emergency department because he could not produce $1,000 cash in advance.[1203] In Congressional hearings in 1985, a *60 Minutes* segment on the problem and a Washington Post article about a Dallas man who was badly burned but refused care at several private hospitals were cited as contributing to public outrage.[1204] An economist described the problem as a change in focus at hospitals from merely shifting costs to shifting patients: [T]he uninsured poor themselves [have] become the hot potatoes one hospital seeks to dump into the lap of another."[1205]

There was a public perception that patient dumping was not only occurring but rapidly increasing. After President Reagan was elected in 1980, spending reductions were announced and considered essential for a nation that was struggling with a $200 billion deficit.[1206] Medicare and Medicaid had not solved the problem of the uninsured, though these programs did change the financial status of the average hospital from a net loss to unprecedented levels of net gain.[1207] According to Bradford Gray, a health care analyst and scholar: "The reimbursement environment from the late 1960s until the early 1980s made it difficult not to make money operating hospitals, so long as they were located

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[1203] George J. Annas, "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards," *American Journal of Public Health* 76, no. 1 (1986).

[1204] Tiana Mayere Lee, "An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement " *Annals of Health Law* 13, no. 1 (2004).

[1205] Annas, "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards."

[1206] Kenneth R. Wing, "Medicare and President Reagan's Second Term," *American Journal of Public Health* 75, no. 7 (1985).The federal deficit in 2009 was $1.4 trillion. Chernew, Baicker, and Hsu, "The Specter of Financial Armageddon--Health Care and Federal Debt in the United States."

[1207] Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 32-37.

away from concentrations of low-income populations."[1208] By the 1990s, however, the outspoken Governor of Colorado, Richard Lamm, would declare that "the halcyon days of blank check medicine are definitely over."[1209]

In the mid-1980s, the perceived increase in patient dumping and measures put in place to reduce health care costs were linked in the public's and policymakers' view. A prospective payment system in the Medicare program was described as the "most important change in Medicare's history," when it was enacted in 1983.[1210] Instead of a "blank check," otherwise known as payment based on whatever was spent, the prospective system grouped payments into Diagnostic Related Groups (DRGs) designed to encourage hospitals to become efficient through placing them at financial risk if their costs exceeded allowable payments.[1211] The prospective payment system initially contributed to large margins in hospital care of Medicare patients, with revenues exceeding costs by up to 20 percent. Rate adjustments in the program brought the margin on Medicare down dramatically by 1987.[1212]

Also, as a result of Medicaid cutbacks, less than half of low income Americans were covered by the program in 1983 whereas almost two thirds of the nation's poor had been covered when Medicaid was first implemented in 1965. During the same period of

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[1208] Ibid., 33.

[1209] Subcommittee on Health of the Committee on Ways and Means, House of Representatives, *Testimony of Richard Lamm: New Health Professions and Graduate Medical Education Recommendations*, 104th Congress, 2nd sess., April 16, 1996, 6.

[1210] John K. Iglehart, "Medicare Begins Prospective Payment of Hospitals," *New England Journal of Medicine* 308, no. 23 (1983): 1428.

[1211] Ibid.

[1212] Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 39-40.

time, the number of people living at or below 125 percent of the federal poverty level increased by more than a quarter.[1213] Further, because of lower Medicaid reimbursement begun in the 1980s, Medicaid patients were often as a group "lumped in with the uninsured; to hospitals, both represented financial losses."[1214] The number of uninsured people at the time that Congressional hearings were occurring on problems with emergency care, which was after passage of the EMTALA, was about thirty-seven million, around 15 percent of the population.[1215]

There were twenty-one states with laws responding to the problem of patient dumping by the mid-1980s.[1216] Texas passed a law in 1983 requiring treatment in emergency departments regardless of socioeconomic status and, in 1986, an addition to the law provided guidelines on preventing patient dumping in hospital transfers.[1217] The law was passed in part because of appalling cases. For example, an uninsured laborer in Texas with third-degree grease burns went to the closest for-profit hospital and two other for-profit hospitals for care. He was refused emergency care at each hospital because he could not pay a deposit ranging from $500 to $1500. He finally drove to the public hospital in Dallas where he was admitted. Later he received a bill from one of the for-

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[1213] Robert J. Blendon et al., "Uncompensated Care by Hospitals or Public Insurance for the Poor. Does It Make a Difference?" *New England Journal of Medicine* 314, no. 18 (1986); Daniel N. Rosenstein, "Emergency Stabilization for a Wounded Cobra," *Issues in Law and Medicine* 9, no. 3 (1993).

[1214] Hoffman, "Emergency Rooms: The Reluctant Safety Net," 260.

[1215] Rice, "Medical Indigency and Inner City Hospital Care: Patient Dumping, Emergency Care and Public Policy," 7.

[1216] Judith L. Dobbertin, "Eliminating Patient Dumping: A Proposal for Model Legislation," *Valparaiso University Law Review* 28, no. 291 (1993).

[1217] D. Kent Norman, "Managing Interhospital Patient Transfers," *Hospitals* 59, no. 6 (1985). William G. Reed, Karen A. Cawley, and Ron J. Anderson, "The Effect of a Public Hospital's Transfer Policy on Patient Care," *New England Journal of Medicine* 315, no. 22 (1986).

profit hospitals for the minimal care that had been provided.[1218] The patient dumping crisis in Texas may have been worsened by the small percentage of poor people eligible for Medicaid, the oil industry bust of the 1980s, and the large number of for-profit hospitals.[1219]

Florida was another state with a law designed to prevent patient dumping. The law required hospitals with emergency departments to admit any patient needing admission regardless of ability to pay. The obligation of a private hospital to continue the hospitalization of a patient who remains unable to pay once they have been stabilized was the subject of a Florida lawsuit. Florida's Supreme Court overturned a lower court's ruling that Miami's public hospital was required to take transfers from private hospitals when the patient was stabilized. The court found that the United States Constitution did not impose an obligation for states to pay for indigent care; that Florida law did not require county hospitals to accept indigent patients who were hospitalized elsewhere; and that "[p]ost-emergency indigent health care is a problem for legislative solution."[1220] Generally, state laws enacted to prevent patient dumping were not effective.[1221] Some of the state laws, however, were used in developing the federal antidumping statute.[1222]

[1218] Geraldine Dallek, "Hospital Care for Profit," *Society* July/August (1986). This is one of the cases that received attention at the 1985 Congressional hearings.

[1219] Robert Reinhold, "Treating an Outbreak of Patient Dumping in Texas," *New York Times*, May 25, 1986. See also Arnold S. Relman, "Texas Eliminates Dumping. A Start toward Equity in Hospital Care," *New England Journal of Medicine* 314, no. 9 (1986).

[1220] Jur Strobos, "Tightening the Screw: Statutory and Legal Supervision of Interhospital Patient Transfers," *Annals of Emergency Medicine* 20, no. 3 (1991): 308.

[1221] Karen Treiger, "Preventing Patient Dumping: Sharpening the Cobra's Fangs," *New York University Law Review* 61, no. 6 (1986): 1187.

[1222] Ibid., 1202.

There is no doubt that patient dumping was a problem in which opinions differed about its existence, its causes, and, therefore, approaches to solutions. One scholar, David Hyman, has painstakingly questioned whether patient dumping was a "true" problem. Since Congress and the public were aghast at anecdotal news reports and the empirical rigor of each study on the problem of patient dumping had what could be considered some methodological flaws, a large degree of skepticism is warranted, according to Hyman. Arguing that certain cases are "legends," Hyman finds that some of the important "facts" were left out of patient dumping cases.[1223] He proceeds to detail many of these facts. For example, one patient in a dumping case that had been written about in academic journals had a "troubled youth," "a distinct pattern of lying," and he would use money for medication "to purchase alcohol and drugs, including cocaine."[1224] Furthermore, the patient had a large medical debt to the hospital accused of patient dumping. Hyman reported that the patient would likely have qualified for charity care but "he had repeatedly refused to provide the necessary information" for a charity determination.[1225] People testifying on behalf of the patient had "problematic" credibility, according to Hyman.[1226] One of these witnesses had both "received free care seven or eight times," and "had not paid her bill."[1227] The witness wrote a letter to the hospital characterized as "an attempt at blackmail" by Hyman, though the witness did not agree

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[1223] David A. Hyman, "Lies, Damned Lies, and Narrative," *Indiana Law Journal* 73 (1998): 814.

[1224] Ibid., 815-816.

[1225] Ibid., 816.

[1226] Ibid., 821.

[1227] Ibid.

with this.[1228] Another witness also "repeatedly received free care" at the hospital.[1229] The hospital did ordinarily turn over bad debts to a collection agency.[1230] These witnesses were not considered credible in part because they had received free care, yet they each had medical debts at the hospital, therefore it is not clear what was free about their care. Hyman does not address the question of how these "facts" should have been accounted for or why they matter. The implication from Hyman's account of the facts, which were left out of other accounts in academic journals, is that people who cannot pay for their care lack a degree of credibility and that noncompliance with medical treatment may make a person suspect on grounds of criminality and willfully engaging in harmful behavior. Generally, Hyman's account is one which brings up the issue of whether a patient is deserving of care.[1231] The question of whether a patient deserves care is, of course, precisely the issue that determined care in the nineteenth and early twentieth century.

While some questioned the existence of a patient dumping problem, others found it deeply morally troubling. In February 1985, a little more than a year before Congress would pass EMTALA, three articles were published in the *New England Journal of Medicine* which would highlight the sense that the issue of patient dumping was putting the moral foundation of medicine, and of hospitals, on an edge from which a descent

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[1228] Ibid.

[1229] Ibid., 822.

[1230] Ibid., 821.

[1231] Richard Epstein is a like-minded proponent of taking into account whether a patient deserves care and he uses the same example that Hyman exhaustively discusses: Epstein, *Mortal Peril: Our Inalienable Right to Health Care?*: 94.

could be bottomless.[1232] While physicians were clearly blameworthy in some of the articles, there was also the impression that physicians were not able to control larger forces.

A case reported on in the February journal, *Thompson v. Sun City Community Hospital,* illustrates these points. A thirteen-year-old boy was injured in an accident. The boy, Michael Thompson, had been pinned against a wall when a car had fallen off of a jack. Among his various injuries, the left femoral artery in his leg was severed. The bone was visible at the knee and there was no pulse in the left leg.[1233] The emergency room physician at a private hospital called an orthopedic surgeon and a vascular surgeon who agreed that emergency surgery was indicated. The decision, not specifically determined at trial by whom, was made to transfer the boy to the county hospital. The hospital agreed that the reason for the transfer was financial and that it was the hospital's policy to transfer patients based on indigence and it was common practice in the region. A hospital administrator testified specifically that emergency charity patients were routinely transferred to the county hospital when a physician determined that a transfer could occur.[1234] While the physicians agreed that the transfer "could" occur, a witness said the emergency room doctor told the boy's father, "I have the shitty detail of telling you that

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[1232] Arnold S. Relman, "Economic Considerations in Emergency Care. What Are Hospitals For?" *New England Journal of Medicine* 312, no. 6 (1985). Keith Wrenn, "No Insurance, No Admission," *New England Journal of Medicine* 312, no. 6 (1985); William J. Curran, "Economic and Legal Considerations in Emergency Care," *New England Journal of Medicine* 312, no. 6 (1985).

[1233] George J. Annas, *The Rights of Patients : The Authoritative Aclu Guide to the Rights of Patients*, 3rd ed., An American Civil Liberties Union Handbook (Carbondale, IL: Southern Illinois University Press, 2004), 100-101.

[1234] Ibid., 101.

Mike [the patient] will be transferred to County."[1235] The child had surgery at the county hospital but was left with a permanent injury. The court determined that the physicians were not liable because they could not require that the hospital admit the patient nor could they have prevented the transfer. The court followed the recommendations of the Joint Commission on the Accreditation of Hospitals (JCAH) concerning emergency services: "No patient should arbitrarily be transferred if the hospital where he was initially seen has means for adequate care of his problem."[1236] The Joint Commission, in its standards on patients' rights, included the financial resources of the patient as an inappropriate consideration in patient care and, therefore, the court found it "arbitrary." The court determined as well that the county's reimbursement system for indigent care would have covered reasonable costs at the private hospital.[1237] At the end of the appeal, the court found the hospital was liable; the physicians were not liable; and the court remanded the case.[1238]

Another article in the February *New England Journal of Medicine* was published "virtually unedited, because it so vividly describes the author's distress as he vainly tries to persuade a staff neurosurgeon at a regional hospital to accept the patient in transfer, only to be told that the hospital administration will not allow it for economic reasons."[1239]

[1235] Curran, "Economic and Legal Considerations in Emergency Care," 374.

[1236] Ibid., 375. Now called the Joint Commission, it has been known as first, JCAH and then the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The federal government recognizes Joint Commission accreditation of hospitals as evidence of compliance with the Medicare program. States also may require Joint Commission accreditation for hospital licensure. Strobos, "Tightening the Screw: Statutory and Legal Supervision of Interhospital Patient Transfers."

[1237] Curran, "Economic and Legal Considerations in Emergency Care."

[1238] *Thompson v. Sun City Community Hospital*, 141 Ariz. 597, 688 P.2d 605 (1984).

[1239] Relman, "Economic Considerations in Emergency Care. What Are Hospitals For?" 372.

In the essay referred to, Keith Wrenn, an internist at a small rural hospital recounts two harrowing cases of patients with neurologic injuries who were transferred to larger tertiary hospitals for urgently needed care and procedures that were unavailable at the small hospital. In both cases the first question asked was whether the patient had health insurance. In the first case, "[a]fter much pleading," the patient was transferred and later died.[1240] Although the patient had health insurance, that information was not known at the time of the transfer. In the second case, the same hospital refused the transfer because the patient was uninsured. According to Dr. Wrenn, the reason given was: "ostensibly because the neurosurgeon to whom I talked had gotten into trouble with the administration for accepting a similar patient in the recent past."[1241] The patient was transferred to a different hospital but the refusal was particularly distressing because it spoke to the "trend of letting economic matters take precedence over matters of humanity."[1242] The distress mentioned by the editor of the journal is expressed most intensely in the following:

> I am disappointed and angry at an institution in which I trained and feel degraded by my association with a profession that seems to be losing sight of its primary purpose –providing the service of health care. I also feel betrayed because the ethical principles that were imparted during training (and for that matter in growing up) seem to be just words blithely uttered in lip service to the Hippocratic oath.[1243]

Dr. Wrenn's sentiments do not appear to be merely anecdote, his worries are substantiated. In a 1984 survey, the percentage of physicians who were discouraged by

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[1240] Wrenn, "No Insurance, No Admission," 373.

[1241] Ibid.

[1242] Ibid.

[1243] Ibid.

their hospital from admitting uninsured patients was as much as 52 percent at for-profit hospitals, 20 percent at nonprofit hospitals, and 14 percent at public hospitals.[1244] Just prior to the enactment of EMTALA, George Annas, a bioethicist commented:

> Whatever 'minimum' we owe all members of our community regarding medical treatment, it must include emergency treatment or the transformation of medicine from a profession dedicated to the alleviation of illness and suffering to a business unconcerned with suffering, disability, or even death will be complete in the institutional setting.[1245]

Emergency Medical Treatment and Labor Act

EMTALA was proposed by Representative Pete Stark, a Democrat from California, in 1986.[1246] In the Senate, Ted Kennedy, who chaired the committee considering the law, expressed the view that health care system changes were affecting the problem of patient dumping:

> [T]he environment of medical practice is changing dramatically. Hospitals are insecure about their futures. They are more reluctant than before to offer care for which they may not be compensated. At the same time, there are more people who have no health insurance and cannot pay for their healthcare. These larger problems demand solutions. But we must not wait for complete solutions. It is imperative that all emergencies be treated appropriately today.[1247]

[1244] Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 106.

[1245] Annas, "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards," 76.

[1246] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem."

[1247] U.S. Congress, "Congressional Record. Statement of Senator Kennedy," October 23, (Washington, DC, 1985), quoted in Hermer, "The Scapegoat: EMTALA and Emergency Department Overcrowding," 716.

Most scholars agree with Senator Kennedy that EMTALA was necessary but that it did not fully address the fundamental problem of limited access to care and how to fund care received by uninsured and socially vulnerable people.[1248]

Despite assertions that patient dumping was not a “real” problem, there was, as already mentioned, evidence that some members of the public, the medical profession, and policymakers believed otherwise: “It took an Act of Congress to determine that refusal to provide examination and treatment of individuals presenting to emergency departments was simply unconscionable.”[1249] Whether patient dumping was a new or old problem, whether it was increasing or merely prompted by misinformed anecdote, it was taken seriously by Congress in 1986. Patient dumping seemed to reach a point where public and professional values were threatened. The authors of an early study of patient dumping clearly expressed this sentiment:

> Patient dumping is a dramatic and foreseeable by-product of a market approach to health care. It became an embarrassment which the federal government addressed when the cut-throat climate of medicine, coupled with significant documentation of the serious consequences of patient dumping in the press and medical literature, began to erode public confidence in the medical profession.[1250]

EMTALA was enacted in 1986, as a part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).[1251] There was little opposition to the law, only the provision of criminal penalties for violators was contested and this was dropped from the

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[1248] Howard S. Berliner, "Patient Dumping--No One Wins and We All Lose," *American Journal of Public Health* 78, no. 10 (1988). Rice, "Medical Indigency and Inner City Hospital Care: Patient Dumping, Emergency Care and Public Policy."; Cross, "Pressure on the Emergency Department: The Expanding Right to Medical Care."

[1249] Robert A. Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services," *Emergency Medcial Clinics of North America* 24, no. 3 (2006): 559.

[1250] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 592.

[1251] *Emergency Medical Treatment and Labor Act*.

final law.[1252] It seems, once EMTALA was passed, it became easier to articulate the problem it addressed. For example, patient dumping was characterized by the Committee on Government Operations in 1988 as follows:

> Patient dumping can take many forms. The most common is the transfer of a patient from one hospital emergency room to another for economic reasons, that is, lack of insurance and inability to pay. Dumping may occur from any part of a hospital, but the majority of these incidents take place from emergency rooms. It can mean turning patients away who may be actually ill, seriously injured, or in active labor, and it can be accomplished by transferring patients to other hospitals, refusing to treat them, or subjecting them to long delays before providing care. These transfers may involve discrimination on the basis of poverty, race, ethnicity, or appearance.[1253]

Since EMTALA was enacted, it has often been remarked that the idea behind the law is simple: "[N]o one who goes to a hospital emergency room seeking emergency medical care should be turned away or sent to another medical facility in an unstable condition because he cannot pay for care, or because he is otherwise considered an 'undesirable' patient."[1254] Yet, EMTALA is often perceived as complex and confusing. Some of the complexity results from its interpretation through case law over the past more than twenty years. Another part of the complexity of EMTALA derives from administrative interpretation, rulemaking, and enforcement. EMTALA exists within a "web of rules."[1255] The web includes the statute, the regulations issued by the

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[1252] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 579.

[1253] Office of Inspector General, "Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act by the Health Care Financing Administration," ed. U.S. Department of Health and Human Services (Washington, DC: U.S. Government Printing Office, 1995), 2.

[1254] Lauren A. Dame, "The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care," *Journal of Law and Medicine* 8, no. 1 (1998): 3.

[1255] Ann M. Bittinger, "Changes to EMTALA Rules Affect Pediatric Emergency Departments," *Pediatric Emergency Care* 20, no. 5 (2004): 348.

Department of Health and Human Services, and the interpretive guidelines issued by the agencies charged with enforcing EMTALA.[1256]

EMTALA requires that all hospitals that participate in Medicare comply with the statute. The requirements of the statute apply to any and all individuals who come to the hospital's emergency department requesting examination or treatment. The hospital must provide an appropriate medical screening examination, the purpose of which is to determine whether or not an emergency medical condition exists. If an emergency medical condition or labor, in the case of a pregnant woman, exists, the hospital must either provide treatment to stabilize the medical condition or transfer the patient to another medical facility according to the statute's guidelines. Hospitals are not allowed to delay provision of an appropriate medical screening examination in order to inquire about the individual's method of payment or insurance status. Hospitals with specialized capabilities must accept an appropriate transfer of a patient. Furthermore, both hospitals and physicians responsible for the care of emergency department patients are subject to severe monetary penalties, up to $50,000 for each violation. Hospitals can be terminated from the Medicare program for violations. Individuals who suffer harm as a direct result of a participating hospital's violation of EMTALA obligations have a private right of action, including equitable relief and damages. The law provides whistleblower protections for medical personnel who refuse to authorize a transfer when a patient is not stabilized or for any employee who reports a violation of EMTALA.[1257]

In the first few years after EMTALA was enacted, it was feared by some that its provisions would be skirted on many of the same grounds that Hill-Burton obligations

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[1256] Ibid.

[1257] *Emergency Medical Treatment and Labor Act*.

had been avoided. The weak enforcement of so many of the Hill-Burton requirements was among the reasons for skepticism.[1258] Some scholars were concerned that ambiguous language in the law would prohibit effective enforcement. Courts began interpreting the law with differing standards which increased uncertainty about the requirements of the law. A host of amendments and regulations were suggested as remedies to the problems envisioned with the law.[1259] Between 1987 and 1988, the House Committee on Government Operations studied patient dumping and warned that "[n]o matter how strong the statute, it is useless without enforcement…A law sitting quietly on the books will not serve as an obstacle to violations."[1260]

By the time the congressional report from the House Committee on patient dumping was completed in 1988, there was much more evidence of the scope of the patient dumping problem. When EMTALA was enacted, two studies of patient dumping were available. A study published in 1984 analyzed transfers from private hospitals to the major public hospital in Alameda County, California, Highland General Hospital. The study concluded that "transfer of patients from private to public hospital emergency rooms is common, involves primarily uninsured or government insured patients, disproportionately affects minority group members, and sometimes places patients in

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[1258] Treiger, "Preventing Patient Dumping: Sharpening the Cobra's Fangs," 1209-1223.

[1259] See the following for discussions of court interpretations and suggested improvements. Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem." Maria O'Brien Hylton, "The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma," *Brigham Young University Law Review* 1992, no. 4 (1992). Thomas L. Stricker, "The Emergency Medical Treatment and Active Labor Act: Denial of Emergency Medical Care Because of Improper Motives," *Notre Dame Law Review* 67 (1991). Lee, "An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement ."

[1260] Enfield and Sklar, "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem," 589.

jeopardy."[1261] A prospective study for the years 1980-1985 of Chicago's only public general hospital, Cook County General Hospital, demonstrated a five-fold increase in the number of patients transferred from regional hospitals. Almost all of the transfers were because patients lacked health insurance and almost all patients were among minority groups. In both studies, patients were harmed by the transfers. In the Cook County study, the authors concluded that "the private health sector's ability to consider the condition and well-being of patients objectively, given the strong economic incentives to transfer the uninsured" could be seriously questioned.[1262] Both studies also reported that current hospital standards, such as those by the Joint Commission and other authorities, were not being followed.

Subsequent studies continued to show that patient dumping did not cease with the enactment of EMTALA.[1263] At the same time, there were reports that the patient dumping problem had lessened, or as one author commented, "tolerance for indigent patient transfers [was] declining."[1264] An estimate of the occurrence of patient dumping nationally by extrapolating from regional studies was that about 250,000 patients were

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[1261] David U. Himmelstein et al., "Patient Transfers: Medical Practice as Social Triage," *American Journal of Public Health* 74, no. 5 (1984): 496.

[1262] Robert L. Schiff et al., "Transfers to a Public Hospital. A Prospective Study of 467 Patients," *New England Journal of Medicine* 314, no. 9 (1986): 556.

[1263] Athur L. Kellermann and Bela B. Hackman, "Patient 'Dumping' Post-Cobra," *American Journal of Public Health* 80, no. 7 (1990). Harry D. Kerr and James C. Byrd, "Community Hospital Transfers to a VA Medical Center," *Journal of the American Medical Association* 262, no. 1 (1989). Dennis R. Durbin et al., "The Effect of Insurance Status on Likelihood of Neonatal Interhospital Transfer," *Pediatrics* 100, no. 3 (1997). Mark Schlesinger et al., "The Determinants of Dumping: A National Study of Economically Motivated Transfers Involving Mental Health Care," *Health Services Research* 32, no. 5 (1997).

[1264] Strobos, "Tightening the Screw: Statutory and Legal Supervision of Interhospital Patient Transfers," 308. See also: Anne Belli, "Suit Alleges 'Patient Dumping':Two Hospitals Deny Accusations by State," *Dallas Morning News*, March 10, 1993.

affected annually at the time that EMTALA was implemented.[1265] Within the first two years of EMTALA’s enactment, however, the federal government attempted to assess the extent of patient dumping only to find that it was extremely rare that emergency departments had a record of transfers into or out of their departments.[1266] When EMTALA implementation and enforcement were assessed again in 2001, one conclusion was that there was little data both before and after implementation of EMTALA on the incidence of patient dumping. The number of EMTALA violations was far too imprecise to be used as measure of occurrences. Furthermore, assessing the occurrence of patient dumping was not a focus because, for the most part, enforcement of EMTALA did not have a punitive purpose. Most of the decisions related to penalties were imposed with the main purpose of encouraging future compliance.[1267]

Is EMTALA an Unfunded Mandate? Does EMTALA Require Charity Care?

In the decades since EMTALA was enacted, it has so often been called an “unfunded mandate” that the designation is unlikely to change.[1268] Some commentators have called care provided under EMTALA “mandatory uncompensated care,” and

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[1265] Ansell and Schiff, "Patient Dumping. Status, Implications, and Policy Recommendations."

[1266] Richard P. Kusserow, "Patient Dumping after Cobra: Assessing the Incidence and the Perspectives of Health Care Professionals," (Washington, DC: U.S. Department of Health and Human Services Response to Complaints, 1988).

[1267] General Accounting Office, "Emergency Care: EMTALA Implementation and Enforcement Issues," (Washington, DC: U.S. General Accounting Office, 2001).

[1268] American College of Emergency Physicians, "EMTALA," (2011), http://www.acep.org/content.aspx?id=25936 (accessed March 14, 2013). Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services."; Arthur L. Kellermann, "Crisis in the Emergency Department," *New England Journal of Medicine* 355, no. 13 (2006).

distinguish this from “charity care, which implies a voluntary provision of care.”[1269] There are reasons to think of EMTALA as an unfunded mandate and there are also reasons to think of EMTALA in other ways. First, strictly speaking under the law, EMTALA is not a mandate. Compliance with EMTALA is voluntary since hospitals can choose not to participate in Medicare and only Medicare participating hospitals have obligations under EMTALA. Since EMTALA requires the provision of services regardless of ability to pay, the statute would be considered a violation of the thirteenth amendment’s prohibition against slavery or indentured servitude and the fifth amendment’s injunction against the taking of private property “without just compensation,” if it were not voluntary, according to Robert Bitterman, an EMTALA expert.[1270] The distinction between what is and is not a mandate, and on what constitutional basis, was a defining issue in the June 2010 ruling by the Supreme Court to uphold the Affordable Care Act’s individual mandate to purchase health insurance. That the Supreme Court upheld the individual mandate, which some have called “misleading” as a mandate because not everyone is subject to it; and that it did so in a “long and complex” decision, speaks to the thorniness of the concept of a mandate.[1271] On the other hand, Medicare was the health insurer of forty-seven million people in 2010 and accounted for 29 percent of all hospital spending in 2008, so hospitals may not view

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[1269] Gregory L. Larkin, Catherine A. Marco, and Wesley Fields, "Managed Care, Charity Care, and the Common Good," *Journal of the American Medical Association* 282, no. 17 (1999): 1620.

[1270] Robert A. Bitterman, "Explaining the EMTALA Paradox," *Annals of Emergency Medicine* 40, no. 5 (2002): 474.

[1271] Balkin points out that: “The mandate would not apply to dependents, persons receiving Medicare or Medicaid, military families, persons living overseas, persons with religious objections, or persons who already get health insurance from their employers under a qualified plan.” Jack M. Balkin, "The Constitutionality of the Individual Mandate for Health Insurance," *New England Journal of Medicine* 362, no. 6 (2010). Timothy Stoltzfus Jost, "The Affordable Care Act Largely Survives the Supreme Court’s Scrutiny—but Barely," *Health Affairs* 31, no. 8 (2012).

Medicare participation as optional.[1272] Few hospitals do not participate in Medicare. In 2009, there were 6,100 hospitals participating in Medicare.[1273]

The Medicare program has a number of functions in addition to providing health insurance to its beneficiaries.[1274] Medicare spending in 2009 was $509 billion, making it a program that can significantly affect a wide range of practices.[1275] As already mentioned, one of EMTALA's goals can primarily be described as antidiscrimination. Medicare's history is strongly tied with antidiscrimination efforts. In 1965, President Johnson insisted that implementation of the Medicare program focus on making sure that hospitals were compliant with Title VI of the Civil Rights Act in order to participate in the program. In this sense, the Medicare Title VI certification effort was similar to EMTALA.[1276] Both Title VI and EMTALA are antidiscrimination laws and both must be adhered to regardless of cost. The cost of desegregation and nondiscriminatory treatment was never a real issue in the 1960s, perhaps because of the "carrot" of Medicare and Medicaid funds for former charity patients.

Although EMTALA requires the provision of emergency medical screening and stabilization, and directs that delays are not allowed in order to inquire about health

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[1272] Kaiser Family Foundation, "Medicare: A Primer."

[1273] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System: Chapter 1: Context for Medicare Payment Policy," (Washington, DC: Medicare Payment Advisory Commission, 2011), 5.

[1274] Michael Gusmano and Mark Schlesinger, "The Social Roles of Medicare: Assessing Medicare's Collateral Benefits," *Journal of Health Politics, Policy & Law* 26, no. 1 (2001).

[1275] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System: Chapter 1: Context for Medicare Payment Policy," 13.

[1276] Smith, "Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda."

insurance, the law is silent on the matter of billing.[1277] There are several ways to understand the relationship between EMTALA and funding. One view is that: “EMTALA is nothing but a giant unfunded government mandate and its uncompensated care burden decimates hospitals…”[1278] Another view is that EMTALA is “one more victim of a broken health care delivery system and a scapegoat for the nation’s health care woes.”[1279] In fact, EMTALA neither provides funds for emergency care nor prohibits billing of patients who are provided care. EMTALA does create a legal right to medical screening and stabilizing treatment for emergency medical conditions regardless of ability to pay.[1280]

Has EMTALA increased the burden of uncompensated care for hospitals? A New York Times editorial declared recently that “hospitals lose so much money dispensing charity care through emergency rooms that many collapse into bankruptcy or give up emergency care.”[1281] One reason that the question of uncompensated care does not have a simple answer is that it is not known how much of a burden of uncompensated care is attributable to EMTALA and how much is attributable to “the business of hospital [emergency departments]. [S]ome of the bad debt attributable to EMTALA would have been incurred even in the absence of this legislation—providing screening and

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[1277] Gerard F. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs* 26, no. 3 (2007).

[1278] Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services," 563.

[1279] Edward Monico, "Is EMTALA That Bad?" *Virtual Mentor* 12, no. 6 (2010), http://virtualmentor.ama-assn.org/2010/06/hlaw1-1006.html (accessed March 14, 2013).

[1280] *Emergency Medical Treatment and Labor Act*.

[1281] Editorial, "Emergency Room Delays."

stabilization is, after all, the business of hospital [emergency departments].”[1282] In other words, attributing uncompensated care to EMTALA begs the question of whether its provisions would have been encountered without the law.

There are also a number of complexities regarding the reporting of uncompensated care, which is usually defined as a combination of bad debt and charity care.[1283] Uncompensated care tends to be tracked by national data whereas the reporting of charity care alone is uncommon in databases. So the question, does EMTALA require charity care is enmeshed with uncompensated care. At the hospital-wide level, uncompensated care has remained surprisingly stable from prior to the enactment of EMTALA to the present. In 1985, the percent of total hospital services reported as uncompensated was 5.8, and in 2008 the percent of total hospital services reported as uncompensated was exactly equivalent.[1284] When EMTALA was enacted, Congress may have had mixed messages about uncompensated care. In 1984, Hospital Corporation of America (HCA), the largest for-profit hospital chain, reported $297 million in profits, which leaves the question of a burden of uncompensated care open.[1285]After the

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[1282] Carol K. Kane, "Physician Marketplace Report: The Impact of EMTALA on Physician Practices," (2003), http://www.ama-assn.org/resources/doc/health-policy/pmr2003-02.pdf (accessed March 14, 2013).

[1283] Joyce M. Mann et al., "A Profile of Uncompensated Hospital Care, 1983-1995," *Health Affairs* 16, no. 4 (1997). One of the complexities of uncompensated care is how it is defined. Terrell W. Zollinger et al., "A Determination of Institutional and Patient Factors Affecting Uncompensated Hospital Care," *Hospital and Health Services Administration* 36, no. 2 (1991). See Chapter 4 for a detailed discussion on uncompensated hospital care.

[1284] The percent of hospital services reported as uncompensated has fluctuated relatively very little, while the dollar amount has increased substantially. In 2009, the percent of total services reported as uncompensated was 6.0 percent. American Hospital Association, "American Hospital Association Uncompensated Hospital Care Cost Fact Sheet," (2012), http://www.aha.org/content/12/11-uncompensated-care-fact-sheet.pdf (accessed March 14, 2013).

[1285] Scott Kraft, "Chains' Role Debated: Hospitals for Profit: What Price Care?" *Los Angeles Times*, March 31, 1985.

enactment of EMTALA, according to some analysts, there was a relative shift in uncompensated care costs from government hospitals to other hospitals.[1286]

In a 2003 national study of the impact of EMTALA on physician practices, emergency physicians reported an average of over $138,000 of EMTALA-related bad debt per physician each year. However, this reported amount of bad debt was for nonpayment when payment was expected. In other words, this amount of bad debt specifically *excluded* "charity care for which either no payment is expected, or only payment at a reduced rate."[1287] This is consistent with a nationwide analysis of unpaid emergency department charges in 1998 in which the total amount of unpaid charges was $14.4 billion, yet only $2.6 billion, or 18 percent, was attributable to uninsured patients. The authors of this study conclude: "These findings question the common misperception that the uninsured are solely responsible for the financial crisis facing many [emergency departments]."[1288] In another study of national pediatric emergency department visits from 1996-2003, there were similar findings. In this study and in two other national emergency department studies, the ratio of payments to charges among uninsured people was higher than the ratio among people insured through Medicaid.[1289] In California, the

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[1286] John L. Ashby, Jr., "The Burden of Uncompensated Care Grows," *Healthcare Financial Management* 46, no. 4 (1992).

[1287] Kane, "Physician Marketplace Report: The Impact of EMTALA on Physician Practices," 2.

[1288] Alexander C. Tsai et al., "Declining Payments for Emergency Department Care, 1996-1998," *Annals of Emergency Medicine* 41, no. 3 (2003).

[1289] Renee Y. Hsia et al., "Trends in Charges and Payments for Nonhospitalized Emergency Department Pedicatric Visits, 1996-2003," *Academic Emergency Medicine* 15, no. 4 (2008). Tsai et al., "Declining Payments for Emergency Department Care, 1996-1998." Renee Y. Hsia, Donna MacIsaac, and Laurence C. Baker, "Decreasing Reimbursements for Outpatient Emergency Department Visits Acrosss Payer Groups from 1996 to 2004," *Annals of Emergency Medicine* 51, no. 3 (2008).

ratio of payments to charges for uninsured people was higher than the ratio from Medicaid and Medicare.[1290]

This information highlights two common problems that complicate understanding the provision of charity care in emergency departments. First, when using uncompensated care, which is comprised of charity care and bad debt, to describe the burden of charity, a great majority of this amount may be due to unpaid charges incurred by people with health insurance. These unpaid charges may occur as a result of patient nonpayment of uncovered services, and denials or downcoding of claims. While these are a problem, they are not the same as the provision of charity care. Charity care is generally defined as services for which no payment is expected.[1291] Second, none of this data answers the question of whether the cost of providing care is met by payments made to hospitals since charges do not necessarily reflect costs.[1292] Hospital accounting standards specify that charity care should be reported based on cost, not charges.[1293] There is also some evidence to suggest that the overall declining ratio of payments to charges in the emergency department across all payer groups may be partially explained by unjustified emergency department charge inflation.[1294] This charge inflation, moreover, tends to

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[1290] Glenn A. Melnick and Katya Fonkych, "Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?" *Health Affairs* 27, no. 2 (2008).

[1291] Kane, "Physician Marketplace Report: The Impact of EMTALA on Physician Practices."

[1292] Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs* 25, no. 1 (2006).

[1293] Healthcare Financial Management Association, "Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers," *Healthcare Financial Management* 2007, January (2006).

[1294] Tsai et al., "Declining Payments for Emergency Department Care, 1996-1998."

disproportionately disadvantage uninsured people.[1295] The disadvantage comes about because uninsured people, unlike public and private health insurers, rarely have enough information to negotiate hospital prices, particularly during emergencies.[1296] If the cost of services is not known, then it is difficult to justify the negotiation of a payment rate for uninsured patients that is lower than the "sticker price." Also, if hospitals report charity care at the full charge level, this would dramatically inflate the value of charity care, as was seen in the case of Hill-Burton charity care reporting.[1297]

According to the most recent national data, the average charge for an emergency department visit in 2008 for uninsured people was $1,203, of which about half is paid out-of-pocket.[1298] Again, if uninsured people pay, on average, half of their emergency department charges, this is more than the 33 percent payment rate by Medicaid, the 38 percent payment rate by Medicare, and it falls somewhat below the 56 percent payment rate of private insurers.[1299] Contrary to public perception, uninsured people as a whole pay for a substantial portion of their care. The perspective of the hospital, which usually emphasizes the burden of uncompensated care, can obscure the burden of higher charges

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[1295] Hsia, MacIsaac, and Baker, "Decreasing Reimbursements for Outpatient Emergency Department Visits Acrosss Payer Groups from 1996 to 2004."

[1296] Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing."

[1297] Ibid.

[1298] Agency for Healthcare Research and Quality, "Emergency Room Services-Mean and Median Expenses Per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2008," (2011), http://www.meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2008&Table=HCFY2008%5FPLEXP%5FE&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT08&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug= (accessed March 14, 2013). This charge includes all levels of acuity.

[1299] Hsia, MacIsaac, and Baker, "Decreasing Reimbursements for Outpatient Emergency Department Visits Acrosss Payer Groups from 1996 to 2004."

and unrealized charity for low income uninsured patients. A recent analysis has shown that people with the lowest incomes pay a larger share of their income in expenditures on health care than people in higher income groups.[1300] Other studies have determined that uninsured people receive less than half as much care but pay a larger share out of pocket than people with private health insurance. Furthermore, the cost of uncompensated care for hospitals is largely covered by government sources.[1301] Estimates for 2008 demonstrate that about 82 percent of hospitals' uncompensated care costs are covered by current government subsidies after taking into account the amount that uninsured people pay out of pocket.[1302] There is another important caveat about cost analyses. Cost from the patient's point of view and from the physician's point of view has not been only concerned with monetary cost but also with the traditionally defined costs of pain, suffering, death, or lost productivity. These costs, obviously, are not captured with economic analyses.[1303]

When EMTALA was enacted, one of the problems identified was how the agencies responsible for oversight and enforcement would interact with the agencies

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[1300] Patricia Ketsche et al., "Lower-Income Families Pay a Higher Share of Income toward National Health Care Spending Than Higher-Income Families Do," *Health Affairs* 30, no. 9 (2011).

[1301] Payments to hospitals for uncompensated care are discussed in detail in Chapter 4.

[1302] Jack Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* 27, no. 5 (2008). ———, "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage," August (2008), http://www.kff.org/uninsured/7809.cfm (accessed March 14, 2013). Derek DeLia and Joel Cantor, "Emergency Department Utilization and Capacity," *The Synthesis Project*, no. 17 (2009), http://www.rwjf.org/pr/product.jsp?id=45929 (accessed March 14, 2013).

[1303] Rebecca R. Roberts et al., "Distribution of Variable Vs Fixed Costs of Hospital Care," *Journal of the American Medical Association* 281, no. 7 (1999): 645.

responsible for the Hill-Burton requirements, which did include charity care.[1304] From the point of view of patients, charity care can be extremely difficult to find. Patients in the emergency department may be less likely to be informed about the availability of charity care and financial assistance and even safety-net providers do not automatically offer free care to the uninsured.[1305] The conclusion of one study on the issue of the cost and availability of health care for the uninsured directly "contradicts a common belief that the uninsured can always get care when they need it—and do so for free."[1306] In addition, as already mentioned, the charges incurred by uninsured patients can be substantially higher than charges to public and private health insurers.[1307] Quite recently, a random survey of hospitals found that fewer than half of nonprofit hospitals provided an application for charity care and only about a quarter provided information on who was eligible for charity care.[1308] For nonprofit hospitals, the Affordable Care Act will prohibit some of the most egregious hospital billing practices and require greater transparency in charity care and financial assistance policies.[1309]

[1304] Kusserow, "Patient Dumping after Cobra: Assessing the Incidence and the Perspectives of Health Care Professionals."

[1305] Dennis Andrulis et al., "Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?" January (2003), http://www.accessproject.org/paying_for_healthcare_when_youre_uninsured.pdf (accessed March 14, 2013).

[1306] Ibid., 2.

[1307] Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing."

[1308] Carol Pryor et al., "Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?" May (2010), http://www.communitycatalyst.org/press_room/press_releases?id=0138 (accessed March 14, 2013).

[1309] *Patient Protection and Affordable Care Act*, § 9007. See also Community Catalyst, "Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-Profit Hospitals," (2010), In a 1996 publication assessing emergency department costs, the authors provided some of the scarce information on free care. Like the 2008 reports, this study of national data showed that uninsured people paid about half of the charges in emergency departments and that substantially more of the payment was out-of-pocket for uninsured people as compared to people with health insurance. Free care accounted for only 10 percent of the expenditures on uninsured patients. Among the conclusions was that their findings “contradict the widespread impression that hospitals provide large amounts of uncompensated [emergency department] care to the uninsured.”[1310] Other evidence of the amount of charity care provided by emergency departments comes from the National Hospital Ambulatory Medical Care Survey. This survey began in 1992 to gather, analyze, and disseminate information about the health care provided by hospital emergency departments. Currently, the National Ambulatory Medical Care Survey defines “no insurance” as including the categories of self-pay and no charge or charity but prior to the 2005 data, these were separate categories. Table 1 shows that, over the years that this information has been collected, the percentage of emergency department visits for people with no health insurance has been between about 14 and 17 percent. The percentage of emergency department visits that were no charge or charity has remained at about 1 percent of visits since this information was collected.

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http://www.communitycatalyst.org/doc_store/publications/Hospital_Accountability_Summary_ACA.pdf (accessed March 14, 2013).

[1310] Patrick H. Tyrance, Jr., David U. Himmelstein, and Steffie Woolhandler, "US Emergency Department Costs: No Emergency," *American Journal of Public Health* 86, no. 11 (1996): 1529.

Table 1: Percentage of Emergency Department Visits Categorized As “No Health Insurance:” 1992-2008 [1311]

	Self-pay	No Charge/ Charity
1992	13.8	0.9
1996	16.8	1.2
2000	17.4	*
2004	16.0	0.8
2008	14.4	1.2

Data from the National Hospital Ambulatory Medical Care Survey.
*Figure does not meet standard of reliability or precision.

Even the most ardent critics of EMTALA concede that Congress has recognized the burden of uncompensated care and responded in a variety of ways.[1312] Medicare supports hospitals that provide care to low income patients through the Medicare Disproportionate Share Hospital (DSH) program, as discussed in Chapter 2.[1313] As a reminder here, the Medicare DSH program was created in 1982 and funded in 1986.[1314]

[1311] Susan M. Schappert, "National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary," *Vital and Health Statistics* Series 13, no. 125 (1997): 59. Linda F. McCaig and Barbara J. Stussman, "National Hospital Ambulatory Medical Care Survey: 1996 Emergency Department Summary," *Advance Data from Vital and Health Statistics*, no. 293 (1997): 5. Linda F. McCaig and Nghi Ly, "National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary," *Advance Data from Vital and Health Statistics* Number 326 (2002): 11. Linda F. McCaig and Eric W. Nawar, "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary," *Advance Data from Vital and Health Statistics*, no. 372 (2006): 13. Centers for Disease Control National Center for Health Statistics, "National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables," (2011), http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2008_ed_web_tables.pdf (accessed March 14, 2013).

[1312] Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services."

[1313] Chapter 4 also includes a discussion of Medicare DSH payments to hospitals.

[1314] Association of American Medical Colleges, "AAMC: Medicare Disproportionate Share (DSH) Payments."

In 2009, the Medicare DSH program costs were about $9.8 billion.[1315] Medicaid also supports hospitals that provide services to low income patients through the Medicaid disproportionate share hospital program (DSH), which was also discussed in Chapter 2.[1316] The Medicaid DSH payments for 2009 include approximately $11.3 billion in federal funds.[1317] The Medicaid DSH program began in 1981 but states generally did not implement the Medicaid DSH payments because the requirements were vague and broad. In 1987, Congress enacted more stringent and specific requirements for states to report on their DSH payments and the law defined the minimum requirements for determining which hospitals would receive these payments. Medicaid DSH payments were tied to charity care charges along with Medicaid utilization.[1318] In 2003, section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act included payments explicitly to cover the costs of EMTALA related care to some categories of undocumented immigrants for the years 2005 to 2008.[1319] Though this provision has expired, some states have allocated funds to cover the cost of emergency care for undocumented immigrants.[1320] How the issue of cost is framed, then, reflects the perspective of the organization or person doing the framing. For example, the point of

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[1315] American Hospital Association et al., "America's Hospitals and Health Systems." See also Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[1316] Chapters 4 and 5 include a discussion of the Medicaid DSH payments.

[1317] Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[1318] Fagnani and Tolbert, "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs."

[1319] *Medicare Prescription Drug Improvement and Modernization Act of 2003*, Public Law 108-173, 108th Cong., 2nd sess. (December 8, 2003).

[1320] C. Annette DuBard and Mark W. Massing, "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants," *Journal of the American Medical Association* 297, no. 10 (2007).

view of the patient, the federal or state government, private health insurers, the hospital, and the emergency department vary.[1321]

From the point of view of hospitals and providers, EMTALA has been praised and cursed since its inception. In January of 2001, the Office of the Inspector General surveyed emergency department directors and staff, and found that 44 percent of emergency department directors believed that EMTALA had led to improved quality of patient care, primarily through patient protections. At the same time, over 25 percent of emergency department directors believed that EMTALA had a negative effect on emergency departments for a variety of reasons, including increased bureaucracy, financial problems related to unfunded but mandated services, and frustrations in providing screening exams for nonemergency medical conditions when patients are uninsured.[1322] Some critics have suggested that as the statute has been interpreted and enforced, it has had the paradoxical effect of undermining the public policy objectives it intended to promote. That is, according to critics, the intent of EMTALA to improve access to emergency care has been crippled by regulatory requirements and uncompensated care burdens that have contributed to emergency department closures.[1323]

Emergency department crowding is often attributed to EMTALA. However there are several reasons to question whether it was the law that led to crowding.[1324] As already mentioned, rates of emergency department use were increasing prior to EMTALA's

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[1321] American College of Emergency Physicians, "Quality of Care and the Outcomes Management Movement," (2005), http://www.acep.org/content.aspx?id=30166 (accessed March 14, 2013).

[1322] Office of Inspector General, "The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments," (Washington, DC: Department of Health and Human Services, 2001).

[1323] Robert Wanerman, "The EMTALA Paradox. Emergency Medical Treatment and Labor Act," *Annals of Emergency Medicine* 40, no. 5 (2002).; Bitterman, "Explaining the EMTALA Paradox."

[1324] Hermer, "The Scapegoat: EMTALA and Emergency Department Overcrowding," 716-723.

enactment for a variety of reasons.[1325] In the years from 1955 to 1980, emergency department visits increased 550 percent whereas hospital admissions rose by 30 percent.[1326] Yet, the causal link to EMTALA for crowding is common and persistent. When the Institute of Medicine studied hospital emergency departments in 2007, the report stated:

> Hospital [emergency departments] and trauma centers are the only providers required by federal law to accept, evaluate, and stabilize all who present for care, regardless of their ability to pay. An unintended but predictable consequence of this legal duty is a system that is overloaded and underfunded to carry out its mission.[1327]

Between 1995 and 2005, the annual rate of emergency department visits increased by 20 percent but the number of hospital emergency departments decreased by close to 400.[1328] The consequences of crowding have been estimated to include increased risks of medical errors leading to higher rates of complications and mortality, as well increases in ambulance diversion, longer waiting times, and patient's leaving without being seen, and interference with disaster preparedness.[1329]

[1325] Hoffman, "Emergency Rooms: The Reluctant Safety Net." Arthur L. Kellermann and Ricardo Martinez, "The ER, 50 Years On," *New England Journal of Medicine* 364, no. 24 (2011).

[1326] Kevin F. O'Grady et al., "The Impact of Cost Sharing on Emergency Department Use," *New England Journal of Medicine* 313, no. 8 (1985).

[1327] Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*: xv.

[1328] Eric W. Nawar, Richard W. Niska, and Jiamnin Xu, "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary," *Advance Data from Vital and Health Statistics*, no. 386 (2007).

[1329] Handel et al., "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals." Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*.

Origin of Emergency Department Crowding Attributed to Nonurgent Care and Care of Uninsured People

Crowding is persistently linked as well to the care of patients who are not found to have an emergency medical condition and to uninsured people. For example, one recent author claimed that emergency departments are "[j]ammed with increasing numbers of uninsured Americans and enrollees in public programs," and that increases in emergency department use is primarily "driven by patients seeking care for non-urgent problems."[1330] It seems clear from this and other comments that what is at stake is more than data. The role of values and worldviews has been called the "two moralities" in America and it is reflected, for example, in two different views on health care reform.[1331] In the case of care in the emergency department, the desire to reduce emergency department care is of justifiable importance from multiple viewpoints including patients, providers, hospitals, and policymakers. While interventions to reduce emergency department care are often formulated by hospitals and providers in order to reduce cost, or to decrease crowding, patients would undoubtedly benefit from a reduction in illnesses and barriers to care that bring them to emergency departments.[1332]

It is difficult, however, to align goals between patients and providers and hospitals when care in the emergency department carries with it a variety of stigmas. An example is the portrayal of patients with frequent emergency department visits as "unscrupulous, uninsured, and unnecessarily clogging [emergency departments] by presenting with

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[1330] John S. O'Shea, "The Crisis in America's Emergency Rooms and What Can Be Done," *Backgrounder* 2092 (2007), http://www.heritage.org/Research/Reports/2007/12/The-Crisis-in-Americas-Emergency-Rooms-and-What-Can-Be-Done (accessed March 14, 2013).

[1331] Paul Krugman, "A Tale of Two Moralities," *New York Times*, January 13, 2011.

[1332] Roger K. Resar and Frances A. Griffin, "Rethinking Emergency Department Visits," *Journal of Ambulatory Care Management* 33, no. 4 (2010).

primary care complaints better treated elsewhere."[1333] One physician described his attitude about caring for uninsured patients in the emergency department: "I used to get angry every time the emergency room admitted an uninsured patient. I would try to spend less time with them—20 minutes instead of 30—and try to get them out of the hospital quickly and hope they would not come to my clinic."[1334] A nurse stated that a patient "made me mad" when he came to the emergency department for treatment for a sexually transmitted disease because: "We're not here for his convenience. We're here to treat emergency medical problems."[1335]

There are a variety of reasons for the perception that uninsured people and people seeking care for nonurgent conditions are responsible for emergency department crowding. In 1993, a report by the federal government stated: "The most commonly cited factors contributing to the increase in visits, were the number of people without health insurance, especially those seeking nonurgent care."[1336] This conclusion in this report was derived from surveys and the report is clear that these factors were primarily opinions. In other words, it is accurate to say that the majority of hospital officials had the opinion that uninsured people and people seeking care for nonurgent conditions were some of the main reasons for emergency department crowding.[1337] Since then, a number of studies have demonstrated that the increase in emergency department visits is not

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[1333] Eduardo LaCalle and Elaine Rabin, "Frequent Users of Emergency Departments: The Myths, the Data, and the Policy Implications," *Annals of Emergency Medicine* 56, no. 1 (2010): 42.

[1334] Manoj Jain, "Equal Treatment for the Uninsured? Don't Count on It," *Washington Post*, October 14, 2008.

[1335] Ceci Connolly, "Some Finding No Room at the ER," *Washington Post*, April 26, 2004.

[1336] General Accounting Office, "Hospital Emergency Departments: Unevenly Affected by Growth and Change in Patient Use," (Washington, DC: U.S. General Accounting Office, 1993), 21.

[1337] Ibid., 3, 16-17.

primarily due to uninsured patients and uninsured patients are not more likely to visit an emergency department for nonurgent care.[1338]

In a remarkable qualitative study, researchers examined the assumptions made in the medical literature about uninsured patients presenting for emergency care throughout more than fifty years. Assumptions were defined as “statements presented as fact or taken for granted.”[1339] The most common assumption was that uninsured patients “realize no matter what may be their complaint, even if it is not an emergency, they can receive care at any local [emergency department] for free.”[1340] The authors reviewed the data on assumptions and concluded that some of the assumptions in the medical literature were supported, such as that uninsured patients lack access to primary care, delay getting care, and receive less care. Other assumptions were not clearly supported, such as that uninsured patients present with nonurgent conditions, cause crowding in emergency departments, and visit the emergency department more frequently than insured patients.[1341] What is most remarkable about the study is that the authors clearly show how these assumptions infuse discussions of American hospitals:

[1338] Peter Cunningham and Jessica May, "Insured Americans Drive Surge in Emergency Department Visits," *Center for Studying Health System Change Issue Brief*, no. 70 (2003), http://www.hschange.com/CONTENT/613/?words=emergencydepartment (accessed March 14, 2013). S. Trzeciak and E. P. Rivers, "Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health," *Emergency Medicine Journal* 20, no. 5 (2003). Elen J. Weber et al., "Are the Uninsured Responsible for the Increase in Emergency Department Visits in the United States?" *Annals of Emergency Medicine* 52, no. 2 (2008). Tang et al., "Trends and Characteristics of US Emergency Department Visits, 1997-2007."; Tamyra C. Garcia, Amy B. Bernstein, and Mary Ann Bush, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" *National Center for Health Statistics Data Brief*, no. 38 (2010), http://www.cdc.gov/nchs/data/databriefs/db38.pdf (accessed March 14, 2013).

[1339] Manya F. Newton et al., "Uninsured Adults Presenting to US Emergency Departments: Assumptions Vs Data," *Journal of the American Medical Association* 300, no. 16 (2008): 1916.

[1340] Ibid., 1918.

[1341] Ibid.

> Through repetition, however, these assumptions have become part of both common knowledge and political debates. Suddenly, “everybody knows” that uninsured patients presenting for minor illnesses are a major contributor to crowding in EDs, endangering other patients who are actually sick.[1342]

Going further, the authors recognize the potential for widespread harms based on these assumptions because they “run the risk of further stigmatizing vulnerable populations, thereby worsening health disparities.”[1343]

Origin of Emergency Department “Triage Out” Programs

It is not at all clear how emergency departments historically have dealt with patients who do not have emergency conditions. Yet, reports of the number of patients seeking care in the emergency department who have nonemergency conditions are not new. The number of emergency department patients who required hospital admission is, surprisingly, similar today to the rate reported for one study published in 1958.[1344] In an article in 1965, the author states:

> The disproportionate increase in total visits to hospital emergency facilities is largely due to their use for general health problems by those who remain outside the private medical-care system on the one hand and those who find it too inflexible on the other. The emergency room, with the only always-open door and the only policy of immediate service without prior financial screening, has become the last (and now, increasingly, the first) resort for those for whom even the hospital clinic is too limited a resource.[1345]

One of the first “triage out” processes, similar in many ways to the process at the University of Chicago, was described in 1965. At that time, both nonurgent visits to the

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[1342] Ibid., 1921.

[1343] Ibid.

[1344] The rate of hospital admission was 17 percent in 1958 and 13 percent in 2007. Shortliffe, Hamilton, and Noroian, "The Emergency Room and the Changing Pattern of Medical Care."; Kellermann and Martinez, "The ER, 50 Years On."

[1345] Weinermann et al., "Yale Studies in Ambulatory Medical Care. V. Determinants of Use of Hospital Emergency Services," 948.

emergency department and the use of the emergency department by people with low incomes and the “urban core” were cited as reasons to implement the triage out process: “The objectives are to assist patients with nonurgent conditions to make proper use of regularly available community resources and to protect the ‘readiness to serve’ capacity of the emergency station.”[1346] Researchers who interviewed hospital administrators in 1982 and 1983 concluded: “Probably the easiest way to discourage use is to require nonemergency patients without insurance to pay all or part of their bills in advance.”[1347]

National data is lacking about triage out processes in both the past and currently. Essentially all of the information available is from single institutions or areas. Even in these early years, the triage out process was controversial. At this time and until the late 1980s, emergency departments were often staffed by interns and residents.[1348] In the 1965 study, housestaff were sometimes reluctant to defer treatment. This reluctance, in some instances, continues today. For example, in 2009, the authors of one study reported: “Clinicians derive satisfaction from providing care, and rationing health care does not provide that same type of satisfaction. Redirecting patients is emotionally charged at times for the clinician and patient.”[1349] Even proponents of triage out programs state that

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[1346] E. Richard Weinerman, S. Robert Rutzen, and David A. Pearson, "Effects of Medical "Triage" in Hospital Emergency Service," *Public Health Report* 80 (1965): 390.

[1347] Feder, Hadley, and Mullner, "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982," 559.

[1348] Zink, *Anyone, Anything, Anytime : A History of Emergency Medicine*: 226-231.

[1349] Kathleen Nash, Hoang Nguyen, and Melinda Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding," *Journal of Emergency Nursing* 35, no. 2 (2009): 112.

most emergency physicians are uncomfortable with the process: “It’s very hard for us as physicians to not want to help people.”[1350]

The only “evidence” that triage out processes are unusual is that they remain controversial and counter to the self-identified “safety net for the safety net” concept.[1351] Commonly, care in the emergency department is described as “the only unrestricted site of universal health care in America.”[1352] Emergency physicians also generally see themselves and their profession as providing care to all. Thus, the authors of one article describe themselves: “We treat all persons who come to us seeking care, regardless of their income, race, ethnicity, insurance status, or special needs. We are the ultimate safety net for those whom other providers turn away.”[1353] For a great many emergency physicians, the description seems to be an expression of moral identity. At the same time, triage out programs and reports of emergency departments continuing to fail to provide care to people with dire emergency conditions even after EMTALA seem to threaten this identity.[1354] The National Hospital Ambulatory Medical Care Survey does not collect data on triage out programs and the survey also has just under 20 percent of visits where

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[1350] Jan Greene, "Sending Low-Acuity Patients Away from the ED: Closing the Door or Stemming the Tide?" *Annals of Emergency Medicine* 49, no. 3 (2007): 319.

[1351] Siegel, "The Emergency Department: Rethinking the Safety Net for the Safety Net."

[1352] James A. Gordon, "Emergency Care as Safety Net," *Health Affairs* 19, no. 2 (2000).

[1353] Lynne D. Richardson and Ula Hwang, "Access to Care: A Review of the Emergency Medicine Literature," *Academic Emergency Medicine* 8, no. 11 (2001): 1030.

[1354] Elizabeth L. Higginbotham, "Patient-Dumping Cases Still Pose a Problem," *RN* 62, no. 6 (1999). Kaija Blalock and Sidney M. Wolfe, "Questionable Hospitals: 527 Hospitals That Violated the Emergency Medical Treatment and Labor Act: A Detailed Look at “Patient Dumping”," (2001), http://www.citizen.org/documents/qhcompletereport.pdf. (accessed March 14, 2013) . Jeffrey Kahntroff and Rochelle Watson, "Refusal of Emergency Care and Patient Dumping," *Virtual Mentor* 11, no. January (2009), http://virtualmentor.ama-assn.org/2009/01/hlaw1-0901.html (accessed March 14, 2013).

the triage status or immediacy is not known.[1355] Therefore, a great deal of information is unavailable about the number of triage out programs and the people affected by them.

There is one study of a triage out program in 1983 which was published at about the time of EMTALA's enactment. It took place at an urban pediatric teaching hospital and it began at a time when much less was known about the science of triage. Although the study concluded that referring pediatric patients outside of the hospital was safe and effective, about 7 percent of the diagnoses were more serious than the initial triage diagnosis when the patient was seen by a physician after the triage out process and about 3 percent were hospitalized.[1356] Another triage out program began in 1988 soon after EMTALA was enacted and the authors specifically mention that they sought the opinion of legal counsel before implementing the process. The authors believed that "most [emergency departments] provide care to all persons who present," but that many patients have "minor complaints. Use of the [emergency departments] by these patients may result from the convenience of receiving care on demand."[1357] The report is one of the first about a triage out program after the enactment of EMTALA. The triage out process described in the report occurred at the University of California, Davis, nonprofit hospital which is part of a large urban academic medical center. After a medical screening exam, if the patient's condition was nonurgent based on a predetermined list of fifty medical conditions, then the patient was told that he or she would not be seen in the emergency department. A receptionist at an assistance desk was available to provide a list of regional

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[1355] Tang et al., "Trends and Characteristics of US Emergency Department Visits, 1997-2007."

[1356] Frederick P. Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care," *American Journal of Diseases of Children* 140, no. 3 (1986).

[1357] Robert W. Derlet and Denyse A. Nishio, "Refusing Care to Patients Who Present to an Emergency Department," *Annals of Emergency Medicine* 19, no. 3 (1990): 262.

clinics. Close to 20 percent of patients, over 4,000, were refused care. Unlike the 1965 study or the study which began just prior to EMTALA, this study design did not include any attempt to contact patients who were refused care, instead area clinics were asked in phone calls whether there were any adverse consequences.[1358]

The report "sparked a major controversy" on several grounds.[1359] Yet, in the next few years, the same authors published updates to the report in which the "essence of the study was the denial of care to a selected subset of patients who were determined to have nonemergency medical problems."[1360] Over 31,000 patients in a five year span were defined as having a nonemergency condition and were denied treatment. About half of the denied patients did not go to the receptionist's desk in the emergency department to obtain information on clinics. Perhaps responding to criticism about the previous report's lack of patient follow up, the later study attempted to contact patients directly. Only about a third of the patients could be contacted by telephone about their subsequent care. Of the people who could be contacted, the majority of patients sought care elsewhere at other sites, although over a fourth of those patients did not seek further care. The authors acknowledged that among the goals of the study, one was to improve the use of the resources of the emergency department. The authors hypothesized that the risks to patients would be outweighed by the benefits in terms of lower cost to the hospital and improved use of resources. At the same time, the impact of the process on the emergency department "could not be accurately measured" in terms of whether the process improved

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[1358] Ibid.

[1359] Richardson and Hwang, "Access to Care: A Review of the Emergency Medicine Literature."

[1360] Robert W. Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study," *Annals of Emergency Medicine* 25, no. 2 (1995): 216. Robert W. Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience," *American Journal of Emergency Medicine* 10, no. 3 (1992).

crowding or costs.[1361] Patient safety was difficult to assess since most patients were not contacted, though the authors believed that the wide availability of alternative sites of care was a factor in patient safety.[1362]

Perhaps unsurprisingly, the idea of reducing costs by decreasing utilization of the emergency department was taken up by managed care organizations at around the same time that these reports were published.[1363] In the 1990s, under managed care preadmission authorization programs, managed care insurers used gatekeepers to decide whether the costs of nonemergency visits would be covered.[1364] Research about the effects of these preauthorization requirements often showed that patient safety was compromised.[1365] People covered through Medicaid, and less often, Medicare were also subject to preauthorization procedures.[1366] Especially for children enrolled in Medicaid, the preauthorization process led to significant harms.[1367] Although the preauthorization process, strictly speaking, denied payment and not care, the effect was that patients often

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[1361] Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study," 220.

[1362] Ibid.

[1363] The Medicaid program in Maryland diverted patients from emergency departments to clinics in 1988. Mary T. Koska, "States, Hospitals Aim to Cut Costly ED Visits," *Hospitals* 62, no. 23 (1988).

[1364] Robert W. Derlet and Gary P. Young, "Managed Care and Emergency Medicine: Conflicts, Federal Law, and California Legislation," *Annals of Emergency Medicine* 30, no. 3 (1997).

[1365] John L. Zautcke et al., "Denial of Emergency Department Authorization of Potentially High-Risk Patients by Managed Care," *Journal of Emergency Medicine* 15, no. 5 (1997). Kimberly M. Viner et al., "Managed Care Organization Authorization Denials: Lack of Patient Knowledge and Timely Alternative Ambulatory Care," *Annals of Emergency Medicine* 35, no. 3 (2000).

[1366] ———, "Managed Care Organization Authorization Denials: Lack of Patient Knowledge and Timely Alternative Ambulatory Care."

[1367] Kathy N. Shaw, Steven M. Selbst, and Frances M. Gill, "Indigent Children Who Are Denied Care in the Emergency Department," *Annals of Emergency Medicine* 19, no. 1 (1990). Anne M. Gadomski et al., "Diverting Managed Care Medicaid Patients from Pediatric Emergency Department Use," *Pediatrics* 95, no. 2 (1995).

left the emergency department once payment would be denied. There would sometimes be a further delay if patients were seen by their primary care physician. These primary care physicians were also the gatekeepers who had made an over-the-phone assessment. Once the patient was in front of them, these gatekeepers did not always agree with their own telephone assessments.[1368] Hospitals and emergency physicians were concerned that denial of payments by public and private insurers was increasing uncompensated care because patients who did not leave were not always paying their bills and the insurer often denied payment.[1369]

According to some authors, the backlash against managed care was driven in large part by the restrictions placed on emergency services. States began to enact “prudent layperson” standards with forty one states eventually adopting such standards. Though these standards differed, in general they required managed care organizations to reimburse hospitals for emergency department care when a patient with symptoms that a prudent layperson would consider as warranting emergency care received treatment, even if their condition was ultimately determined to be nonurgent.[1370] In 1997, Congress included prudent layperson standards for reimbursement in the Medicaid and Medicare programs in the Balanced Budget Act.[1371] Tightly controlled managed care restrictions

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[1368] Mark A. Hall, "The Impact and Enforcement of Prudent Layperson Laws," *Annals of Emergency Medicine* 43, no. 5 (2004).

[1369] David Segal, "For Hospitals, Charity Often Begins in the ER; Managed Care Cost Cutting Leaves Record Unpaid Bills," *Washington Post*, March 13, 1996.

[1370] Renee Y. Hsia, Jia Chan, and Laurence C. Baker, "Do Mandates Requiring Insurers to Pay for Emergency Care Influence the Use of the Emergency Department?" *Health Affairs* 25, no. 4 (2006).

[1371] James Li, Hannah K. Galvin, and Sandra C. Johnson, "The "Prudent Layperson" Definition of an Emergency Medical Condition," *American Journal of Emergency Medicine* 20, no. 1 (2002).

began a retreat and, by the early twenty first century, many of the measures used to control cost were softened or abandoned.[1372]

Summary of Published Data on Triage Out Programs

Table 2 provides a summary of the publications on triage out programs. There are nine publications in medical journals that describe hospital implementation of triage out programs from the years 1983 to the present in the United States.[1373] These publications were obtained through searching the references to each publication and the citing articles to each publication, and all publications that included hospital implementation of triage out processes were included. Publications which involved only managed care authorization denials were not included and publications assessing triage reliability and safety that did not also include the implementation of triage out programs were not included. All of the publications reported that the problem addressed was emergency department overcrowding, except the first publication, which addressed inappropriate utilization. All of the publications are from academic medical centers with either a public hospital or a nonprofit hospital. Although the first publication by Rivara was a

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[1372] Cara S. Lesser, Paul B. Ginsburg, and Kelly J. Devers, "The End of an Era: What Became of the "Managed Care Revolution" in 2001?" *Health Services Research* 38, no. 1 Pt 2 (2003).

[1373] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Derlet and Nishio, "Refusing Care to Patients Who Present to an Emergency Department." Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience." Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study." Donna L. Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial," *Annals of Internal Medicine* 137, no. 9 (2002). Donna L. Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service," *Annals of Emergency Medicine* 36, no. 1 (2000). Donna L. Washington, Paul G. Shekelle, and Carl D. Stevens, "Deferred Care for Adults with Musculoskeletal Complaints," *Effective Clinical Practice* 4, no. 2 (2001). Amy Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services," *Journal of Emergency Nursing* 30, no. 4 (2004). Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

description of a triage out program in a large urban academic medical center children's hospital and the first University of California, Davis, publication included triage out of pediatric patients, the other publications describe only programs involving adult patients.[1374] Two publications did not include information on whether the triage out process included pediatric patients.[1375] When children were excluded from the triage out programs, the authors cited safety concerns.[1376]

Three publications included data on health insurance. In these reports, the majority of patients triaged out were uninsured or insured by the Medicaid program.[1377] Three publications included data on the income of patients triaged out. In these reports, the great majority of patients had a low income.[1378] Four publications included data on race or ethnicity and the majority of patients were racial or ethnic minorities.[1379]

[1374] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Derlet and Nishio, "Refusing Care to Patients Who Present to an Emergency Department."

[1375] Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services." Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

[1376] Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience."

[1377] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial." Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services."

[1378] Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial." Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service." Washington, Shekelle, and Stevens, "Deferred Care for Adults with Musculoskeletal Complaints."

[1379] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial."; Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service." Washington, Shekelle, and Stevens, "Deferred Care for Adults with Musculoskeletal Complaints."

In three of the publications, patients were given a choice to receive deferred care or usual care. The authors noted that patients were self-selected to some degree in these reports.[1380] Six publications were undertaken after an emergency department policy change which included the implementation of a triage out program.[1381] In one publication, a policy decision was made to "stop guaranteeing same-day care to all patients presenting for unscheduled care," which was independent of the study itself.[1382] An appointment was made at the time of the emergency department visit for patients in four of the publications. More than half up to greater than 95 percent of patients did return for appointments when these were made for the patients at the time of the visit.[1383] In the remaining five publications, patients were given a list of clinics that might be available for health care needs.[1384]

[1380] Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial." Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service."; Washington, Shekelle, and Stevens, "Deferred Care for Adults with Musculoskeletal Complaints."

[1381] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Derlet and Nishio, "Refusing Care to Patients Who Present to an Emergency Department." Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience." Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study." Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services." Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

[1382] Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service," 17.

[1383] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial."; Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service."; Washington, Shekelle, and Stevens, "Deferred Care for Adults with Musculoskeletal Complaints."

[1384] Derlet and Nishio, "Refusing Care to Patients Who Present to an Emergency Department." Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience."; Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study." Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of

One of the deficiencies of most of the publications was that the ability to track and determine the outcomes of patients triaged out was extremely low or tracking the outcomes of patients triaged out was not a part of the study. This is particularly so for the programs that did not make appointments for patients. Of the patients who were able to be contacted when contact was attempted, the additional problem is one of "'follow-up bias.' In a study design in which patients who are denied [emergency department] care are subsequently contacted to ascertain health outcomes, patients with adverse outcomes such as hospitalization, significant illness, or death may be unavailable for follow-up contact."[1385] The highest rate of adverse events was reported in the latest publication where about 8 percent of patients who were triaged out returned and were hospitalized.[1386]

Follow-up Services."; Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

[1385] Robert A. Lowe and Stephanie B. Abbuhl, "Referral out from the ED-Appropriate? Author Reply," *Academic Emergency Medicine* 3, no. 11 (1996): 1072.

[1386] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

Table 2. Summary of Triage Out Publications

										Characteristics of Patients Triaged Out			Triage Out Process			Follow-up of Patients Triaged Out		
Author	Type of hospital	State	Year	Problem Addressed	Design	IRB	QI*	Reported Outcomes	Number of patients	Income	Race/ Ethnicity	Health Insurance	Patient Choice	Appointment made	Payment	Number deferred who Received care	Patients contacted	Adverse events
Rivara, et.al. (1986)	Nonprofit Pediatric AMC **	TN	1983 Oct.-Nov. 6-weeks	Inappropriate utilization	Retrospective evaluation of triage system and telephone survey ED Policy Change	Informed consent for medical record review and telephone follow-up	--	Health status of patients 2 weeks after triage included 11% with minimal symptoms and 6% with severe symptoms. Most patients kept their appointment, though the best rate of keeping appointment was for same day care. Physician's diagnosis was more clinically serious than the triage nurse's diagnosis in 6.7% of cases.	748 children eligible for triage (not urgent on entering ED).	--	White-5.4% Black-94.7%	Self-pay-19.7% Medicaid-55.5% Commercial-24.7%	No	Nurse makes appointment before patient leaves.	No charge for triage assessment.	74% of 651 appointments made by triage nurse were kept	569/748 contacted by phone (76%)	23 patients hospitalized who were in the triage group. Of these, 15 (2%) had been triaged out of the ED.
Derlet, et.al. (1990)	Nonprofit AMC**	CA	1988 6 mo	ED Over-crowding	ED Policy Change Retrospective chart review	--	--	Compared to before the policy change, decrease in number of patients who left without being seen and decrease in number of "minor" ED visits. 42 (1%) patients returned to ED within 48 hours. 1% refused to leave ED.	4,186 patients categorized as nonemergencies out of 22,390 presenting to ambulatory triage area (19%)	--	--	--	No	Assistance desk personnel provided information on clinics and considered financial information in recommending clinics.	No charge for triage evaluation.	--	--	--
Derlet, et.al. (1992)	Nonprofit AMC**	CA	1988-1991 3 yr	ED Over-crowding	ED Policy Change Retrospective chart review	--	--	Compared to before the policy change, decrease in the number of patients who left without being seen. 112 (less than 1%) of patients returned to same ED. Effect on "decompression" could not be assessed.	21,069 patients categorized as nonemergencies out of 136,794 presenting to ambulatory triage area (15.4%)	--	--	--	No	Assistance desk personnel were available to provide information on clinics. Most (59%) patients triaged out did not go to the desk.	No charge for triage evaluation.	--	3,740/21,069 contacted by phone (18%)	14 patients had documented adverse outcomes
Derlet, et.al. (1995)	Nonprofit AMC**	CA	1988-1993 5 yr	ED Over-crowding	ED Policy Change Retrospective chart review	--	Y	Impact on ED could not be measured. Chart reviews identified 128 patients (0.4%) triaged out with high risk conditions. 1.8% returned to the same ED. 1% went to other ED.	31,165 patients categorized as nonemergency out of 176,074 (18%)	--	--	--	No	In the final year, patients were given a list of clinics.	No charge for triage evaluation.	--	5,065/31,165 contacted by phone (16%)	11 patients had documented adverse outcomes since the previous publication.

Table 2. (cont'd) Summary of Triage Out Publications

										Characteristics of Patients Triaged Out			Triage Out Process			Follow-up of Patients Triaged Out		
Author	Type of hospital	State	Year	Problem Addressed	Design	IRB	QI*	Reported Outcomes	Number of patients	Income	Race/ Ethnicity	Health Insurance	Patient Choice	Appointment made	Payment	Number deferred who Received care	Patients contacted	Adverse events
Washington, et. al. (2002)	Public Urban AMC**	CA	March 1997 -May 1998	ED Over-crowding	Randomized, controlled trial to assess equivalence of health outcome between deferred care and usual care.	Approved	--	Self-reported health status. Deferred care group had slightly less improvement in health status and slightly worse function than usual care group	1,176 patients 421 met screening criteria 48% declined to participate 156 enrolled 75 assigned to deferred care	77% with annual income <$10,000	White and other-25% Black-16% Hispanic-59%	77% of deferred care group were uninsured	Yes	Next day appointments were made at the hospital's primary care clinic.	--	71/74 96% All given next-day appointments at primary care clinic	91% in deferred care group interviewed 7 days after ED visit	No hospitalizations or deaths. Could not exclude clinically meaningful disadvantage of deferred care.
Washington, et. al. (2000)	VA Tertiary care medical center	CA	2000 (Publication date) 4 months	ED Over-crowding	Development and validation of criteria for safety of deferred care.	Approved	Y	Hospitalization rates and 30-day mortality rates were higher in group not eligible for deferred care.	1,187 patients 226 met screening criteria 154 (68%) Agreed to deferred care	95% met VA low income guidelines	White-27% Black-38% Hispanic-5% Asian-2% Unknown/other-28%	--	Yes	Patients were given same day appointments or appointments within 1 week	--	139/154 68%	--	3 "unrelated" to presenting complaint hospitalizations in those classified as safe for deferred care
Washington, et. al. (2001)	VA Tertiary care medical center	CA	2001** 4 months	ED Over-crowding	Consensus process of development of deferred-care guidelines for adults with musculoskeletal complaints. Field testing of guidelines in a prospective observational study.	Approved	--	Reliability of guideline was high between two nurses. 24% of patients met guidelines for deferred care, most agreed to deferred care and most kept their appointments.	448 patients 107 met guidelines 76 (71%) agreed to deferred care	95% met VA low income guidelines	White-28% Black-36% Hispanic-4% Asian-1% Unknown/other-32%	--	Yes	Patients were given appointments at the primary care clinic, most often within 1 day, though the median time to appointment was 3 days.		67/76 87%	--	--
Diesburg-Stanwood, et. al. (2004)	Public Urban AMC**	CO	2002 Oct.-Nov. 30 days	ED Over-crowding	Exploratory Descriptive ED Policy Change	Approved for medical record review and telephone survey	Y	Most patients who were contacted did not get health care after being triaged out. 45% of contacted patients reported condition unchanged or worse	225 patients deemed nonemergent	--	--	Self-pay-69% State plan-9% Private-9% Medicare or Medicaid-7%	No	Patients were given a packet with a list of clinics by financial counseling office.	--	--	82/225 37% contacted	--
Nash, et. al. (2009)	Public State-owned AMC**	TX	3 month inter-vals 1) Nov. 2004-Jan. 2005 2) April 2005-June 2005 3) August 2005-Oct. 2005	ED Over-crowding	ED Policy Change	--	Y	Time in the room and time in the department were lower after the triage out program started. The number of patients who left without being seen declined from 11% to 4%. Unscheduled ED return visits also declined from 5% to 3%.	--	--	--	--	No	Patients are accompanied to the discharge planner's desk. Patients with health insurance have different options from patients without any form of "sponsorship."	Patients are charged for screening exam. Patients pay a deposit if they stay to get care.	--	--	7.8% patients screened out returned and were hospitalized in a selection of audited charts.

*QI = Quality Improvement
**AMC = Academic Medical Center

Research on Nonurgent Care and Care for Poor or Uninsured Patients in the Emergency Department

During this time, a wide range of unanswered empirical questions were explored: How much of the problem of crowding in emergency departments was a result of uninsured patients or poor patients on Medicaid? How many people were coming to emergency departments with nonurgent conditions? Are patients seeking care for nonemergency conditions responsible for crowding in emergency departments? Is patient safety compromised when care deemed nonurgent is deferred or denied? These empirical questions were pursued with urgency when the focus was payment for insured managed care patients' care, though there generally was, and still is, less urgency when the focus is primarily on uninsured patients. Remarkably, some of the answers to the empirical questions were answered through research that overturned much of the rhetoric and even evidence of the time.

As already mentioned, the question of whether uninsured patients are responsible for emergency department crowding, though there are some complexities, is mainly no. That is, uninsured patients rely on emergency departments for care because uninsured people receive much less care than insured patients, therefore, the proportion of care received in the emergency department for uninsured patients is higher than insured patients.[1387] Yet, the share of emergency department visits classified as self-pay or no charge, which mostly consists of uninsured patients, decreased from 1995 to 2008,

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[1387] Newton et al., "Uninsured Adults Presenting to US Emergency Departments: Assumptions Vs Data."

despite the fact that the number of uninsured people increased during this period.[1388] Rates of emergency department use by patients insured by Medicaid are higher than patients in all other payer groups and this trend has increased.[1389] Table 3 shows the rates of emergency department visits per 1000 persons or enrollees. At the same time, when synthesis of the research was recently done, it confirmed that the growth in volume of emergency department visits is driven by people who have a higher income, private health insurance, and private physicians as their usual source of care. This is primarily because there are a larger number of privately insured patients in the general population.[1390] Figure 1 shows that most, over 40 percent, of emergency department visits are by people with private health insurance.

Table 3: Adult Emergency Department Visit Rate by Insurance Status per 1,000 Persons (Enrollees) 2007 [1391]

Private insurance	189
Medicare	403
Medicaid	947
Uninsured	423

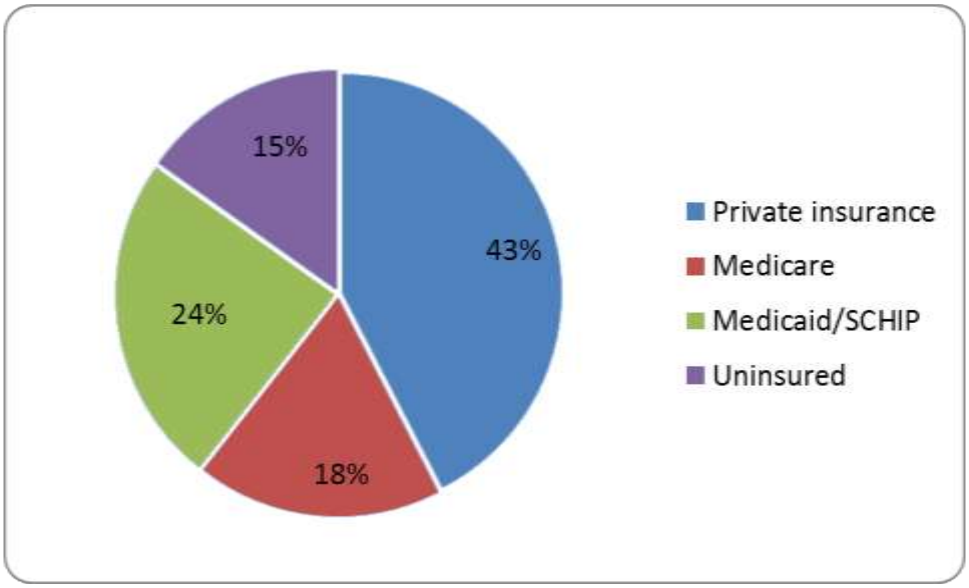
[1388] The decrease was from 17 to 15 percent of visits. The number of uninsured increased by 23 percent during this period. Peter Cunningham, "Nonurgent Use of Hospital Emergency Departments: Senate Testimony, " (2011), http://hschange.org/CONTENT/1204/?words=au07 (accessed March 14, 2013).

[1389] Tang et al., "Trends and Characteristics of US Emergency Department Visits, 1997-2007."

[1390] DeLia and Cantor, "Emergency Department Utilization and Capacity." 4.

[1391] Tang et al., "Trends and Characteristics of US Emergency Department Visits, 1997-2007."

Figure 1: Payer Distribution of Total ED Visits, 2008 [1392]



When the first report on refusing care in the emergency department for nonurgent conditions was published by the University of California, Davis, national estimates of the number of people with nonurgent conditions were “distinguished by a remarkable lack of precision and widespread confusion.”[1393] Estimates were as high as more than half of emergency department visits were for nonurgent conditions.[1394] For example, in the first National Hospital Ambulatory Medical Care Survey of emergency departments in 1992, 55 percent of all visits were categorized as nonurgent. The authors of the national survey were well aware that the definitions of emergency and urgency varied and their definition did not take into account the prudent layperson standard. They cautioned:

[1392] Centers for Disease Control National Center for Health Statistics, "National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables."

[1393] Newton et al., "Uninsured Adults Presenting to US Emergency Departments: Assumptions Vs Data," 1031.

[1394] Linda F. McCaig, "National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary," *Advance Data from Vital and Health Statistics*, no. 245 (1994).

> There are many other factors influencing one’s decision to seek treatment at an [emergency department]. These include the lack of a regular source of medical care, lack of health insurance, lack of transportation, need for after-hours care, exposure to violence, lack of education, dependency on others, lack of a telephone, and other barriers to care. It is important to acknowledge this continuing debate concerning the relationship between urgency of visit and appropriateness of [emergency department] utilization, and to avoid equating urgent visits as defined in the [National Hospital Ambulatory Medical Care Survey] with appropriate visits to hospital [emergency departments]. A comprehensive picture of urgency and appropriateness must take into account other factors such as the patient’s subjective reasons for visiting the [emergency department], nature and severity of the patient’s symptoms, and issues of access to and availability of alternate source of outpatient care.[1395]

In 2008, only 8 percent of visits were classified as nonurgent. Trends in the number of nonurgent visits have actually decreased slightly since 2000, when a little more than 10 percent of visits were classified as nonurgent.[1396] What accounts for this wide discrepancy in the percentage of emergency department visits categorized as nonurgent? One factor was that a considerable amount of research was undertaken to reliably categorize the urgency of emergency department visits, to distinguish triage from “appropriateness,” and to standardize the collection of data.[1397] Though by no means is there an uncriticized consensus on many of the issues, at the very least the complexities of the data are more likely to be recognized.[1398]

One of the complexities that came to be recognized is that the determination of the urgency of a visit based solely on a physician’s diagnosis after examination of a patient may be quite different from the patient’s perception of symptoms when deciding to seek

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[1395] Schappert, "National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary," 13.

[1396] Cunningham, "Nonurgent Use of Hospital Emergency Departments: Senate Testimony." 6.

[1397] Richardson and Hwang, "Access to Care: A Review of the Emergency Medicine Literature."

[1398] For example, a limited number of studies have classified more than half of emergency department visits as “ambulatory care sensitive.” DeLia and Cantor, "Emergency Department Utilization and Capacity." 6.

emergency care. This was the basis for the prudent layperson standard.[1399] The lack of agreement even among physicians about what constitutes the need for emergency care was one of the reasons that national data now collected on the National Hospital Ambulatory Medical Care Survey categorizes the urgency of a hospital emergency department visit by the level of immediacy (in minutes) assigned upon arrival at the emergency department by triage staff.[1400] There are five categories of urgency: (1) immediate; (2) emergent (within 15 minutes upon arrival); (3) urgent (between 15-60 minutes); (4) semiurgent (1-2 hours); and (5) nonurgent (2-24 hours). Emergency department visits were triaged as nonurgent at similar rates among the uninsured, persons with Medicaid coverage, and those with private insurance in 2007.[1401] In testimony to Congress, Peter Cunningham, a health care analyst, described nonurgent care in the following way:

> The majority of visits that are considered urgent or semi-urgent reside in a gray area as to whether they could potentially be shifted to other primary care settings, such as freestanding urgent care centers or through same-day appointments with private practice physicians. While many conditions associated with these visits could likely be treated in other outpatient settings, it is not necessarily inappropriate for the patient to use the emergency department depending on the circumstances, such as the availability of other health care providers in the area, the time of day and day of the week when services are needed, and the affordability of these other providers based on a patient’s insurance status and ability to pay.[1402]

Research on crowding in the emergency department also intensified and began to consider multiple factors, not only the emergency department in isolation. At the hospital level, the image of the open door of the emergency department while the back door, that

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[1399] Li, Galvin, and Johnson, "The "Prudent Layperson" Definition of an Emergency Medical Condition."

[1400] Cunningham, "Nonurgent Use of Hospital Emergency Departments: Senate Testimony. "

[1401] Garcia, Bernstein, and Bush, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?"

[1402] Cunningham, "Nonurgent Use of Hospital Emergency Departments: Senate Testimony." 6.

is, the ability to admit patients to inpatient beds, remains closed, is sometimes used.[1403] Waiting times in the emergency department and time spent on ambulance diversion are consistently found to correlate with hospital occupancy and the scarcity of staffed inpatient beds, particularly those in the intensive care and critical care units.[1404] A large Canadian study found that the volume of nonurgent patients did not appreciably affect the waiting time, time to first physician contact, or length of stay for seriously ill patients. The results of this study suggest that diverting nonurgent patients away from emergency departments would not reduce crowding or improve care for seriously ill patients.[1405] One recent smaller study emphatically confirmed the finding that the volume of patients with nonurgent conditions was not associated with crowding in a pediatric emergency department.[1406]

Other research has determined that the financial incentives of hospitals may not deter crowded emergency departments and may favor inefficiencies.[1407] In 2004, following an earlier alert that tied emergency department treatment delays to more than fifty hospital deaths, the Joint Commission instituted new guidelines that would have required accredited hospitals to take serious steps to reduce crowding, boarding, and diversion. According to an Institute of Medicine Study: “Under industry pressure,

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[1403] Brent R. Asplin, "Ignoring the Front Door: U.S. Hospital Operations Circa 2009," *Academic Emergency Medicine* 16, no. 7 (2009).

[1404] DeLia and Cantor, "Emergency Department Utilization and Capacity." 11.

[1405] Michael J. Schull, Alex Kiss, and John Paul Szalai, "The Effect of Low-Complexity Patients on Emergency Department Waiting Times," *Annals of Emergency Medicine* 49, no. 3 (2007).

[1406] James Graham, Mary E. Aitken, and Steve Shirm, "Correlation of Measures of Patient Acuity with Measures of Crowding in a Pediatric Emergency Department," *Pediatric Emergency Care* 27, no. 8 (2011).

[1407] Handel et al., "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals."; Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*.

however, these requirements were withdrawn and replaced with a weaker standard."[1408] Reinstating the strong standard by the Joint Commission was recommended by the Institute of Medicine study. Another example of the financial disincentives to reducing crowding cited in the Institute of Medicine study was the fact that in many private hospitals, the only way an uninsured patient can be admitted is through the emergency department. Crowding may have the effect of reducing the admissions that would come about because of EMTALA, while preserving the capacity to admit elective patients.[1409] Researchers have found that financial incentives to maintain elective admissions and scheduled surgeries combine with political power structures within hospitals. For example, reducing the variability in elective admissions through surgical schedule smoothing or operating room schedule smoothing reduces emergency department crowding and increases operating room utilization rates: "However, the barrier to smoothing of elective admissions has been one of political power within hospitals."[1410] Surgical subspecialty services that increase profitable demand may not be amenable to scheduling changes that affect the entire hospital's operations.[1411]

After the publication of the reports in the 1990s from the University of California, Davis, teaching hospital which denied care to patients with nonurgent conditions, two studies were undertaken to test the safety and validity of the criteria used to refuse care. In both studies, patient safety was compromised and the use of the published criteria to

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[1408] ———, *Hospital-Based Emergency Care: At the Breaking Point*: 6.

[1409] Ibid., 156-159.

[1410] Handel et al., "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals," 844.

[1411] Ibid.

refuse care was questioned on medical, ethical, financial, and legal grounds.[1412] Additional small studies were done at a VA hospital and a public hospital which involved triage out processes.[1413] In both of these studies the patients had the option to receive care on the same day whereas in the University of California, Davis reports, patients were not given that option.

Another large urban academic medical hospital at the University of Colorado reported on a triage out program that primarily affected uninsured patients. Only a little more than a third of the patients who were triaged out could be contacted and, of those patients about half had improved and about half had not improved or had worsened. Of the patients who had no follow up appointment, about half said that lack of health insurance, lack of financial resources, and inability to get an appointment were the reasons.[1414] These studies are detailed in Table 2. A large study on access to care for patients insured through Medicaid used the medical conditions selected from the list of about fifty that are not considered serious enough to warrant treatment in the hospital emergency department of the University of California, Davis, in Sacramento. Only about one fifth of the clinics studied in Sacramento were able or willing to treat a Medicaid enrollee within two days after a call from a person claiming to be insured by Medicaid. These authors cautioned: “If financial and administrative barriers to outpatient care in the

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[1412] Robert A. Lowe et al., "Refusing Care to Emergency Department of Patients: Evaluation of Published Triage Guidelines," *Annals of Emergency Medicine* 23, no. 2 (1994). Adrienne Birnbaum et al., "Failure to Validate a Predictive Model for Refusal of Care to Emergency-Department Patients," *Academic Emergency Medicine* 1, no. 3 (1994).

[1413] Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service." Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial."

[1414] Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services."

emergency department are imposed before workable alternatives are in place, many of the poor will have nowhere to go."[1415] In another large study, the safety of a triage out process was questioned because "a small, but disturbing" number, just over 5 percent, of patients were hospitalized after their initial assessment was nonurgent.[1416]

CMS Final Rules Clarify Limited Obligations under EMTALA for Nonurgent Care

While there remains little information on the use of triage out processes because there does not appear to be any data collection on a wide level, there are occasional reports of the programs in the media and good reason to think they have increased substantially. One of the reasons for the increase in turning away nonurgent patients is likely the clarification of the limits of obligations to patients under EMTALA. The Centers for Medicare and Medicaid Services (CMS), in 2003, issued final rules concerning EMTALA.[1417] The bulk of the lengthy final rules cover topics unrelated to nonemergency conditions, focusing on four issues that have sometimes had contradictory interpretations: obligations of hospitals in providing on-call physician coverage; answering whether EMTALA applies to inpatients; determining the physical location where EMTALA is triggered, and clarifying whether preauthorization is allowed.[1418] Yet, the final rules did also clarify the limits of a hospital's obligations under EMTALA to a

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[1415] Medicaid Access Study Group, "Access of Medicaid Recipients to Outpatient Care," *New England Journal of Medicine* 330, no. 20 (1994).

[1416] Gary P. Young et al., "Ambulatory Visits to Hospital Emergency Departments. Patterns and Reasons for Use. 24 Hours in the ED Study Group," *Journal of the American Medical Association* 276, no. 6 (1996).

[1417] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions," *Federal Register* 68, no. 174 (September 9, 2003).

[1418] Bittinger, "Changes to EMTALA Rules Affect Pediatric Emergency Departments."

person deemed to have a nonemergency medical condition. It does appear that some hospitals that have implemented triage out policies for nonurgent patients are well aware of the greater legal clarity with which the triage out policies can be undertaken. For example, Hospital Corporation of America's (HCA) chief executive said, regarding their announced new policy in early 2004 to screen out nonemergency patients: "We are obviously very, very sensitive to (patient-dumping) regulations and don't want to—in any way, shape, or form—run afoul of those."[1419]

Prior to issuing the EMTALA final rule, CMS published proposed regulations and asked for public comment. The case of a patient with a nonemergency medical condition that CMS provided for clarifying purposes reveals several assumptions that were made. The example is as follows:

> A woman walks up to the front desk of a hospital's emergency room…and tells the hospital employee attending the front desk that she had a wound sutured several days earlier and was directed by her doctor to have the sutures removed that day. The front desk attendant registers the woman…and directs the woman to the waiting area. An emergency nurse, who has been designated by the hospital as a 'qualified medical person'…calls the woman into the examination area of the emergency room. The nurse asks the woman if she has experienced any discomfort or noticed any problems in the area sutured. The woman explains that she is feeling fine, and the wound is not causing her any discomfort, but that her doctor had directed her a week ago to have the sutures removed that day. The nurse physically inspects the sutures and determines that the wound is healing appropriately. The nurse explains to the woman that she does not have an emergency medical condition and may direct the woman to an outpatient clinic where nonemergency personnel will provide the services the woman has requested.[1420]

[1419] Vince Galloro, "Screen Test: HCA Tries to Move Nonemergency Patient out of ER," *Modern Healthcare* 34 (2004).

[1420] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates," *Federal Register* 67, no. 90 (May 9, 2002): 31473.

As the case is told it is shaped by the narrator, in this case staff from CMS.[1421] The case reads more like an interaction between two strangers meeting on the street, one needing directions, and the other giving them, than someone seeking treatment in the emergency department. Although there appears to be an attempt to use language devoid of emotion, the straightforward sentence structure implies a woman walking confidently up to the desk. She has already received appropriate care a week ago and the use of “her doctor” sounds as if she has a personal physician, not only a regular source of care. The woman is able to articulate quite succinctly exactly why she is in the emergency department, and furthermore, she is a compliant patient, doing exactly as she was told. The waiting time is not mentioned but after the wait the woman is feeling fine. There is no mention of the possibility that the woman could be feeble, exhausted, or desperate after a long wait, unable to pay for care at a clinic, not have transportation to a clinic, unable to leave her job to go to a clinic during their hours, or not be able to get an appointment for weeks. The importance of this narrative style is that it creates a world which may be far from representative of the actual lives of people seeking care for nonurgent conditions in the emergency room.

EMTALA was not intended to address medical conditions that were nonurgent, so the importance of the narrative is the image it portrays and not really that, had officials considered other factors, the law would have been changed to cover nonemergency conditions. In contrast to the narrative by CMS, interviewers of uninsured people seeking care for nonurgent conditions have been “struck by the distress in patients’ lives that brought on a visit to the emergency department. However, this distress—contrary to the

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[1421] Tod Chambers and Kathleen Montgomery, "Plot: Framing Contingency and Choice in Bioethics," in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. Rita Charon and Martha Montello (New York, NY: Routledge, 2002).

medical model—was not solely physiologic; it was not just about the body."[1422] In summarizing the interviews, the authors stated:

> The distress experienced by the person contrasted starkly with his or her discharge diagnosis. Indeed, the patients' discharge diagnoses seemed almost trivial when juxtaposed to their stories. Their medical diagnoses were estranged from their life experiences. The distress they experienced touched the totality of the patients' lives and was far from simple. This situation is contradictory to the understanding of [emergency department] visits from the medical perspective, which is based exclusively on an objectifying, reductionistic, physiologic model.[1423]

The final rules do make it clear that "a hospital must be seen as having an EMTALA obligation with respect to any individual who comes to the dedicated emergency department …whether or not the treatment requested is explicitly for an emergency condition."[1424] The final rules incorporate the prudent layperson standard: "A request on behalf of the individual would be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition."[1425] The rules go on to say that the screening only needs to be as extensive as necessary to determine whether a medical emergency exists and could include only brief questioning if the individual states he or she is not seeking emergency care.[1426]

In the final rules there was one comment about the example given in the proposed rules concerning the woman with the sutures and whether there was a requirement that

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[1422] Jane Koziol-McLain et al., "Seeking Care for Nonurgent Medical Conditions in the Emergency Department: Through the Eyes of the Patient," *Journal of Emergency Nursing* 26, no. 6 (2000): 560.

[1423] Ibid.

[1424] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions," 53235.

[1425] Ibid., 53234.

[1426] Ibid.

the woman have a “same-day on-campus” referral.[1427] CMS responded that the referral to an outpatient clinic was not an EMTALA obligation, but that:

> [I]t would appear to us that good standards of practice would dictate that any qualified medical personnel screening the patient would refer the patient elsewhere for treatment of her obvious medical condition, rather than simply sending her out of the emergency department upon finding that she did not have an emergency medical condition.[1428]

In other responses, the recommendation by CMS is to refer someone with a nonemergency medical condition to “his or her physician’s office” and “it is worthwhile to encourage patients to seek more appropriate sources of nonemergency care.”[1429] To summarize the case and the responses by CMS, they do not directly confront the situation that most uninsured people face when seeking care in the emergency department or in finding care if they are turned away because their condition is considered nonurgent. In some respects, CMS neither stepped away from the intent of EMTALA to require care in emergencies, nor did they allow hospitals and providers to scale down their obligations to all people until there was reasonable assurance through the screening examination about whether an emergency condition is present. On the other hand, the detail provided by CMS of the limits of obligation to people with nonurgent conditions and the clear endorsement of alternative sites of care likely contributed to an increase in triage out programs. At the same time, the CMS responses implied the expectation that medical professionals would follow professional and ethical standards when caring for patients with nonurgent conditions.

[1427] Ibid., 53237.

[1428] Ibid., 53237-53238.

[1429] Ibid., 53235.

Triage Out Programs Expand

It was several months after CMS issued final rules concerning EMTALA that HCA announced the beginning of its triage out program.[1430] As already mentioned, HCA is the largest for profit hospital chain in the United States.[1431] In 2011, HCA facilities included 162 hospitals and 112 freestanding surgery centers in twenty states and England.[1432] Initially, HCA introduced its triage out process as a pilot program in the Gulf Coast region. Then, in mid-2009, the program became system wide. Under the program, patients in the emergency department receive a medical screening examination and, if they are classified as "non-emergent or non-urgent" patients are directed to the registration department, where they can decide to stay for treatment, but only if they pay. Insured patients must pay their insurance co-payment or deductible. Uninsured patients must pay a $150 facility fee up front. Patients who decline to pay then leave without further treatment.[1433]

HCAs triage out program had a ripple effect in the Gulf Coast region. In Texas and in Florida hospital officials have remarked that, when their competitors begin the triage out program, they are getting some of the patients who are screened out so it has pressured them to start their own triage out programs.[1434] In the Gulf Coast region, soon after HCA began its triage out program, a state owned public teaching hospital

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[1430] Galloro, "Screen Test: HCA Tries to Move Nonemergency Patient out of ER."

[1431] Editorial, "Largest for-Profit Hospital Chains," *Modern Healthcare* 37, no. 10 (2007).

[1432] Hospital Corporation of America, "HCA Facts," (2012), http://hcahealthcare.com/util/documents/HCAFactSheet2012.pdf (accessed March 14, 2013).

[1433] David Burda, "HCA Rolling out Emergency-Room Screening Program," *Modern Healthcare* (2009), http://www.modernhealthcare.com/article/20090614/REG/306119942# (accessed March 14, 2013).

[1434] Editorial, "Ambulatory Care Quarterly: ED Screening Changes Put Pressure on Competitors," *Hospital Case Management*, June 1, (2005).

announced a similar program in 2005, as did a large nonprofit teaching hospital in Houston.[1435] In 2006, a county owned Houston hospital announced its program.[1436] Most of these programs followed the precedent set by HCA in requiring a $150 payment upfront for patients with no health insurance when their condition was considered nonurgent. The reason given for instituting the programs usually was to decrease crowding and to keep services available for "true" emergencies.

The availability of care at other locations after a patient is not treated is often severely limited. For example, in Houston, the waiting time for a community clinic appointment was eight weeks when their triage out program was implemented.[1437] Officials in Houston have also determined that public and private primary care clinics have the capacity to care for just over one third of patients who need care.[1438] This lack of capacity in the clinics makes getting care for people who are screened out difficult or impossible, if care is needed soon.[1439] In areas other than the Gulf Coast, triage out programs have been getting some attention from journalists and have been the subject of a few publications. At the University of Colorado, for instance, their triage out program

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[1435] Brian Zachariah, "The Right Medical Care at the Right Place," *Galveston County Daily News*, February 1, 2005. Alexis Grant and Todd Ackerman, "New Fees Discourage Noncritical Patients from Using ER," *Houston Chronicle*, August 2, 2006.

[1436] Bill Murphy, "Harris County to Limit Emergency Room Access," *Houston Chronicle*, July 31, 2006.

[1437] Ibid. Carter Thompson, "UTMB Weighs First Month of ER Screening," *Galveston County Daily News*, April 14, 2005.

[1438] Greene, "Sending Low-Acuity Patients Away from the ED: Closing the Door or Stemming the Tide?"

[1439] Ibid.

required an upfront fee of $260 in 2004 for an uninsured patient to receive medical care for a nonurgent condition.[1440]

Some of the triage out programs have not only gotten attention in the media, but they have been criticized, as was the case for the University of Chicago.[1441] An editorial in a Denver newspaper criticized the University of Colorado Hospital for implementing a policy that required payment before care for nonemergency conditions would be given.[1442] There was criticism in the Sacramento area about the University of California Davis triage out program.[1443] In one article concerning the triage out program in Sacramento, a physician said: “It’s an incredibly mean, nasty time to be in medicine.”[1444] Most of the media coverage has been relatively neutral, as in Milwaukee and Alaska.[1445] St. Joseph Regional Medical Center, a Catholic nonprofit hospital in Milwaukee, sent letters to uninsured patients with outstanding bills for emergency care stating that future visits for anyone with nonemergency conditions would entail a minimum fee of $150. Other hospitals in the area were adopting similar policies.[1446] There seemed to be little criticism in the media of these practices.

[1440] Amy Diesburg-Stanwood and Kathleen Oman, "Redirect Nonurgent Patients and Comply with EMTALA," *ED Nursing* 7, no. 12 (2004).

[1441] Grotto, "Mauled by Dog, Kid Sent Home by ER."

[1442] Editorial, "ER Screening Plan at CU Very Troubling," *Rocky Mountain News*, June 14, 2003.

[1443] ———, "Turning Away Patients: Hospitals, County Need Stronger Safety Net," *Sacramento Bee*, February 10, 2005.

[1444] Connolly, "Some Finding No Room at the ER."

[1445] Joe Manning, "State Tackles Emergency Room Misuse," *Milwaukee Journal Sentinel*, January 31, 2004. Editorial, "Debts Have Hospitals Seeking Payments up Front," *Associated Press*, June 5, 2004.

[1446] Joe Manning, "St. Joseph Hopes Fee Will Reduce Minor ER Visits," *Milwaukee Journal Sentinel*, October 24, 2003.

Not all nonurgent patients are shunned by hospitals. At the same time that triage out programs seem to be increasing, hospitals are taking measures to ensure that potential patients are aware of short waiting times in some emergency departments by making those times available online or by texting.[1447] Other emergency departments are advertising that patients can register online or by phone for an appointment. These advertisements offer paying a fee, from $4.99 to $24.99, for making an emergency department appointment, so that you can "relax at home while you wait."[1448] Obviously, these advertisements target people who could receive care in offices or at urgent care centers, not people with life threatening emergencies.[1449]

The triage out policies do make it clear that, if care is provided, it is not free. What is not at all clear is how the triage out policies are unified with hospital charity care policies since none of the reports have mentioned that patients who have been screened and have nonurgent conditions might be eligible for charitable care. The reports suggest that nonurgent care in the emergency department is excluded from consideration of eligibility for charity care. This seems to be the case for HCA. The hospital chain's former chief executive described their charity care policy in 2007:

> You need to think about the uninsured in three categories: charity care, the uninsured discount and those who don't pay even after the uninsured discount and you have a bad debt. For us, we define charity care as 200 percent or below of the federal poverty guidelines. … If a person who comes into the emergency room and gets admitted into the hospital does not have insurance and falls within those guidelines, we will first try to get them qualified for Medicaid. The issue is not just the hospital care, but essentially the ongoing care of the family. Getting them

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[1447] Pamela Lewis Dolan, "Emergency Departments Turn to Texting Wait Times," *American Medical News* (2011), http://www.ama-assn.org/amednews/2011/08/22/bisb0822.htm (accessed March 14, 2013).

[1448] Carol Levine, "But Wait, Call Now and Get Two ER Appointments for Only $24.99," *Bioethics Forum Blog* (2011), http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=5488&blogid=140 (accessed March 14, 2013).

[1449] Ibid.

> qualified for Medicaid means that they will have access to physician offices and other modes of care even after their hospitalization. If they don't qualify for Medicaid or a state program and there's no other way for their care to be paid for, then we would write that off as charity care and never send them the bill.[1450]

In other words, HCA's policy applies to patients admitted to the hospital from the emergency department. In the case of nonprofit hospitals and academic medical centers, the relationship between charity care and requiring upfront payment for nonurgent care is in question. When it comes to public hospitals, how the policies accord with their mission is a reasonable question to ask. Even though surveys show that most hospitals do not share their eligibility criteria for charity care, there are strong standards in the hospital industry to do just that.[1451] The American Hospital Association (AHA) issued voluntary guidelines for hospitals on billing and collection in 2004 in order to prevent Congress from creating mandatory rules on charity care.[1452] In 2005, AHA claimed that almost all of its members had agreed to follow the guidelines by signing a confirmation of commitment.[1453] Included in the AHA guidelines, and of concern to low income patients, are the following:[1454]

[1450] Sharon H. Fitzgerald, "Hca's Bovender on Going Private, the Uninsured and Why He Goes to Work," *Medical News*, no. July (2007), http://www.medicalnewsinc.com/hca-s-bovender-on-going-private-the-uninsured-and-why-he-goes-to-work-cms-61 (accessed March 14, 2013).

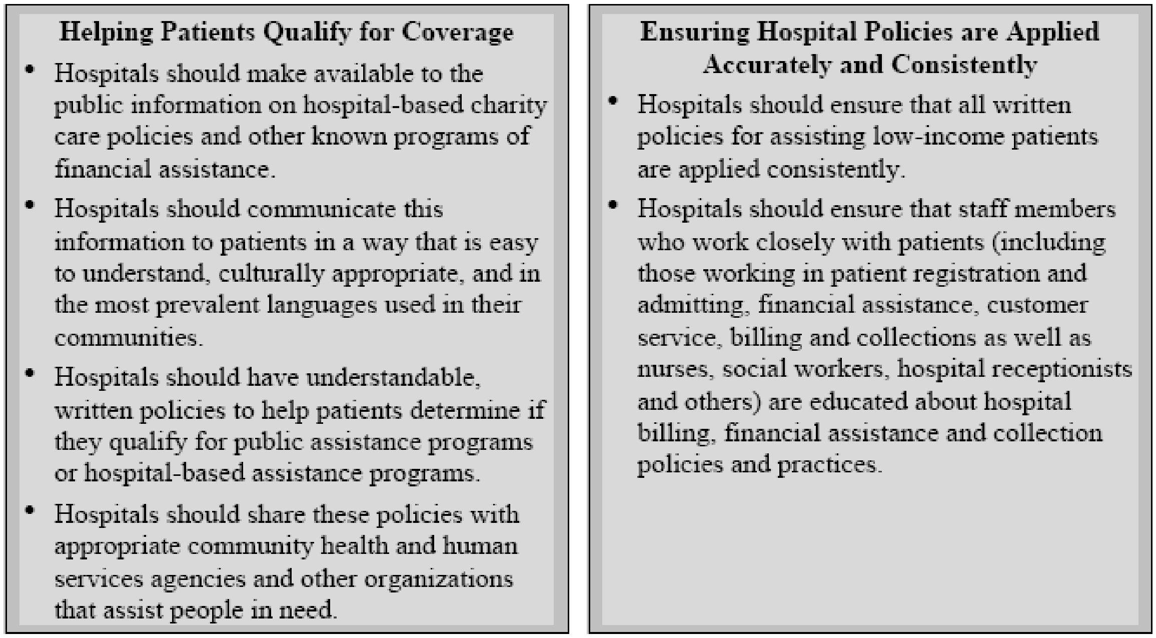
[1451] Pryor et al., "Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?" Joe Carlson, "Charity Disparity. Report on Hospital Policy Disclosures Ill-Timed: AHA," *Modern Healthcare* 40, no. 19 (2010).

[1452] The AHA Guidelines are discussed again in Chapter 4 related to the hospital billing and collection lawsuits and controversy.

[1453] American Hospital Association, "AHA Confirmation of Commitment," http://www.aha.org/aha/content/2004/pdf/cocweblist.pdf (accessed March 14, 2013).

[1454] ———, "Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association " http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf (accessed March 14, 2013). Reproduced from Lenihan, "Clearing the Fog," 19.

Figure 2: Excerpts from the American Hospital Association 2004 Guidelines



Helping Patients Qualify for Coverage

- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.
- Hospitals should share these policies with appropriate community health and human services agencies and other organizations that assist people in need.

Ensuring Hospital Policies are Applied Accurately and Consistently

- Hospitals should ensure that all written policies for assisting low-income patients are applied consistently.
- Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

A variety of authors have noted that improvements in hospital charity care policies and practices could have a significant beneficial effect for patients in the emergency department.[1455] The Healthcare Financial Management Association has also issued principles on charity care and bad debt policies and valuation. The key portions of the principles rely on financial criteria, such as patient income, not location of services or severity of illness.[1456] The Affordable Care Act will require nonprofit hospitals to have charity care and financial assistance policies in place that include eligibility criteria.[1457]

[1455] Jessamy Taylor, "Don't Bring Me Your Tired, Your Poor: The Crowded State of America's Emergency Departments," *National Health Policy Forum Issue Brief No. 811*, July 7, (2006), http://www.nhpf.org/library/issue-briefs/IB811_EDCrowding_07-07-06.pdf (accessed March 14, 2013). Handel et al., "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals."

[1456] Healthcare Financial Management Association, "Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers."

[1457] *Patient Protection and Affordable Care Act*, § 9007. See also Community Catalyst, "Protecting Consumers, Encouraging Community Dialogue: Reform’s New Requirements for Non-Profit Hospitals." There have been delays in the requirements for nonprofit hospitals. Stephanie Strom, "Congress Questions the IRS About Delays in Its Oversight of Nonprofit Hospitals," *New York Times*, October 31, 2011.

Yet, it is not clear how hospitals will respond to these requirements or whether these requirements will be enforced. Further, the fact that hospitals provide some charity care often makes the public unable or unwilling to scrutinize the details of practices and policies.

The American College of Emergency Physicians (ACEP) has taken a strong stand against triage out programs in their policy statement, “Medical Screening of Emergency Department Patients:

> ACEP strongly opposes deferral of care for patients presenting to the ED. ACEP believes that deferring medical care for patients presenting to the emergency department reflects a void in the healthcare system. In situations in which it is required that patients be deferred, very specific and concrete standards must be adopted by the hospital to ensure patient access to an alternative setting and timely, appropriate treatment. Deferral of care from the ED can have significant risks. Emergency departments participating in deferral of care processes should have active emergency physician involvement in the development of the processes. Emergency physicians should always have the opportunity to further evaluate and treat any patient presenting to the ED and should not be compelled to participate in deferral of care strategies.[1458]

This statement is a more recent update to a 1995 position statement by the Ethics Committee of the Society for Academic Emergency Medicine.[1459] Among emergency physicians, triage out programs are a divisive issue.[1460] It is not known whether or to what extent this strong stance by ACEP has had an effect on emergency medicine physicians or on the future standards under which the profession is practiced. The fact that all of the published reports on triage out programs are from large teaching hospitals

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[1458] American College of Emergency Physicians, "Medical Screening of Emergency Department Patients," (2007), http://www.acep.org/Content.aspx?id=29572 (accessed March 14, 2013).

[1459] Society for Academic Emergency Medicine Ethics Committee, "Ethics of Emergency Department Triage: SAEM Position Statement. ," *Academic Emergency Medicine* 2, no. 11 (1995).

[1460] Greene, "Sending Low-Acuity Patients Away from the ED: Closing the Door or Stemming the Tide?." John C. Moskop, "Nonurgent Care in the Emergency Department--Bane or Boon?" *Virtual Mentor* 12, no. 6 (2010), http://virtualmentor.ama-assn.org/2010/06/pfor1-1006.html (accessed March 14, 2013).

means at least that many future emergency medicine physicians are training where these triage out programs exist. In some reports, the triage out programs are taken largely as a given, as if they are a natural answer to problems in the emergency department.[1461]

As already mentioned there is an amazing paucity of information about triage out programs. The outcomes assessed are usually only in terms of the function of the emergency department in waiting times or other measures with little, if any, reliable measurement of the outcome for patients triaged out.[1462] The most recent publication on a triage out program described it as a quality improvement process.[1463] In a letter to the editor by an emergency nurse practitioner responding to the recent publication, which described a triage out program at a public hospital, the author criticizes the practice: “Diverting patients away from the [emergency department] safety net is a potentially dangerous practice and one that I cannot endorse as a caring professional.”[1464] Again there seem to be two opposing views within the emergency medicine profession. In one view, emergency medicine is about caring for people with emergency conditions and, in another view, emergency medicine is about caring for all people who come to the emergency department. These opposing views are certainly not new. In the 1966 article mentioned in Chapter 2, an intern working in the emergency department stated: “Certain

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[1461] Felland, Hurley, and Kemper, "Safety Net Hospital Emergency Departments: Creating Safety Valves for Non-Urgent Care."

[1462] Derlet and Nishio, "Refusing Care to Patients Who Present to an Emergency Department." Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study." Kevin S. Merigian, Lynda J. Park, and Kari Blaho, "Referral out from the ED--Appropriate?" *Academic Emergency Medicine* 3, no. 11 (1996).

[1463] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

[1464] Denise Dunford, "Screening out Does Little to Address ED Overcrowding," *Journal of Emergency Nursing* 35, no. 4 (2009).

repetitive scenes go on day after day in the emergency room. A patient on public assistance, rushed to the hospital in a city ambulance, is discovered to have a cold or gastroenteritis."[1465] In the intern's view, the problems in the emergency department are caused in large part by nonurgent patients and the task at hand is to learn to treat "real" disease.[1466]

A 1972 study of six emergency departments found that hospital staff "make judgments about the worthiness of the person and the appropriateness of his demands and take these judgments into account when performing the service."[1467] In this study, at all of the hospital emergency departments, "abuse" was most often ascribed to patients with nonurgent conditions.[1468] In 2004, an emergency physician stated that in "the past six months, ambulances have delivered three hangnail cases to the [emergency room]."[1469] This physician also linked denying care for patients with nonurgent conditions to the emergency department's mission of treating life-threatening illnesses.[1470] The 1972 study reported similar observations at all of the hospitals: "[W]e repeatedly heard the same kinds of 'atrocity stories': a patient with a sore throat of two-weeks' duration comes in at

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[1465] Glenn, "Challenge to the City Hospitals. An Intern's View," 1477.

[1466] Ibid.

[1467] Julius A. Roth, "Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of the Hospital Emergency Service," *American Journal of Sociology* 77, no. 5 (1972): 855.

[1468] Ibid.

[1469] Connolly, "Some Finding No Room at the ER."

[1470] Ibid.

3:00 AM on Sunday and expects immediate treatment.”[1471] The author attributes some of these negative appraisals of nonurgent patients to the notion of work role boundaries.

Triage Out Programs: Research, Quality Improvement, or “Merely” a Policy Change?

Are publications on triage out programs research or quality improvement processes or something else? There is a remarkable lack of rigor in the underlying premise of many of the triage out studies. Four of the triage out reports in Table 2 mention quality improvement initiatives or personnel.[1472] While some of the issues regarding the differences between research and quality improvement are not settled, if triage out programs are implemented as quality improvement efforts there are some general criteria that should be met. A group convened by the Hastings Center defined quality improvement as “systematic, data-guided activities designed to bring about immediate improvements in health care delivery in particular settings.”[1473] According to Tom Beauchamp, a noted bioethicist, the distinction between research and practice, where practice is aligned with quality improvement, was elucidated in the 1970s by the Belmont report and he summarized this recently:

> The Commission’s view can be bluntly stated: To qualify as [medical] practice, two conditions must be satisfied: (i) an intervention aimed at benefiting a patient and(ii) the intervention has a reasonable probability of success. By contrast, to qualify as research, the two conditions that must be satisfied are (i) protocol-controlled design to test a hypothesis and (ii) an organized aim at generalizable

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[1471] Roth, "Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of the Hospital Emergency Service," 846.

[1472] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding." Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study."; Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service."

[1473] Joanne Lynn et al., "The Ethics of Using Quality Improvement Methods in Health Care," *Annals of Internal Medicine* 146, no. 9 (2007).

> scientific knowledge. This elegantly simple schema has had enormous influence in biomedical ethics and regulatory policy internationally, and it appears still today to be the received view.[1474]

For both conditions concerning practice, the triage out interventions do not seem to satisfy the criteria. It is often not clear what would count as success in reports on triage out programs or whether any patients have benefited. As Table 2 shows, there are harms to patients who are triaged out and the "benefits" to emergency departments such as decreased waiting times have not been causally linked to the implementation of the programs. As the University of Chicago debate showed, there is a theory that triage out programs will induce better care in a medical home, yet the lack of any data to prove this, the dismal ability to track patients once they are triaged out in the few cases where this is attempted, and the proven significant adverse events among some of the reports leads to the conclusion that these programs do not properly fall into the realm of quality improvement. Certainly the case that patients who are triaged out have benefited has not been demonstrated and the idea that patients who remain in the emergency department have benefited is not proven and has, in fact, been disproven in the large Canadian study.[1475] Methodological soundness and a lower risk to patients than usual care are some of the hallmarks of ethical quality improvement projects.[1476]

Rie and Kofke have extensively reviewed the moral conflicts in cost containment activities that are labeled as quality improvement initiatives. They assert: "The a priori prediction that the diminution in quality in any given money-saving situation will be

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[1474] Thomas L. Beauchamp, "Viewpoint: Why Our Conceptions of Research and Practice May Not Serve the Best Interest of Patients and Subjects," *Journal of Internal Medicine* 269, no. 4 (2011): 384.

[1475] Schull, Kiss, and Szalai, "The Effect of Low-Complexity Patients on Emergency Department Waiting Times."

[1476] Lynn et al., "The Ethics of Using Quality Improvement Methods in Health Care."

acceptable must necessarily be best labeled as an untested hypothesis and imposition of an operational moral value to patient care without disclosure."[1477] In their view, cost containment quality improvement initiatives often violate the Nuremberg Code and, when participants are subjected to risks beyond usual clinical practice, they should properly be understood as research.[1478] While the publications on triage out programs state that the purpose of the programs was to reduce crowding or inappropriate utilization, often the reports make some attempt to quantify theoretical cost savings.[1479]

The research on triage out programs in Table 2 shows that five publications received Institutional Review Board approval. In two of the publications, the approval was for the review of medical records and the telephone surveys or interviews.[1480] In the three other studies that received approval, the patients were given an option to participate. These studies clearly fall under the designation of research.[1481] One of these publications was a randomized controlled trial undertaken to assess the equivalence of health outcomes between patients who agreed to deferred care and patients who received usual care. Even in this study, the authors "could not exclude a potential clinically meaningful

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[1477] W. Andrew Kofke and Michael A. Rie, "Research Ethics and Law of Healthcare System Quality Improvement: The Conflict of Cost Containment and Quality," *Critical Care Medicine* 31, no. 3 Suppl (2003): S146.

[1478] Ibid.

[1479] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study."

[1480] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services."

[1481] Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial." Washington et al., "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service." Washington, Shekelle, and Stevens, "Deferred Care for Adults with Musculoskeletal Complaints."

disadvantage of deferred care" in some measures that are difficult to validate, though the general findings were that their detailed standardized screening criteria can safely identify patients at public hospital emergency departments for referral to next-day care.[1482] This study was criticized on several grounds. One author simply asked, in reference to this publication:

> How did we arrive at a situation in which emergency departments are forced to develop triage systems that incorporate deferred care? I suspect almost no patients would prefer such a system. After leaving home, work, or play and traveling to an emergency department, most patients would probably be disappointed by receiving 'treatment' of triage to an appointment the following day. Some of my colleagues in emergency medicine…feel that deferred care conflicts with the professionalism and service ethic of their specialty.[1483]

Other criticisms included that the study was based on "false premises," since emergency department crowding is not the result of patients seeking care for nonurgent conditions.[1484] Further, this critic points out that the results of the study show that one additional day of symptoms and disability were suggested for the patients who received deferred care. Also, the fact that the patients were primarily "ethnically diverse, poor, and uninsured" is problematic since this group already faces "formidable barriers to care and suffer worse health outcomes as a result."[1485] Another group of critics points out that patients in the deferred care group had" less improvement in health status, worse health at follow-up, and more days in bed and disability days" and that these patients were allowed

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[1482] Washington et al., "Next-Day Care for Emergency Department Users with Nonacute Conditions. A Randomized, Controlled Trial," 712.

[1483] Eric B. Larson, "Deferred Care for Patients in the Emergency Department," *Annals of Internal Medicine* 137, no. 9 (2002): 764.

[1484] A. L. Kellermann, "Deferred Care for Emergency Department Users with Nonacute Conditions; Letters," *Annals of Internal Medicine* 139, no. 6 (2003): 526.

[1485] Ibid., 527.

to self-select deferral since they were given the option of usual care.[1486] These criticisms are directed at probably the most well done study available.

Since six of the publications in Table 2 have their basis in an emergency department policy change, it is important to recognize that standards regarding research and quality improvement are not necessarily held to in policy changes. Also relevant is that it is not entirely clear how the authors of the publications conceived of the triage out process as it might be related to the concept of research or quality improvement.[1487] J. Frank Wharam and Norman Daniels have pointed out that health policy changes may be based on “political sentiment rather than evidence of benefits or harms.”[1488] These authors describe the current approaches to assessing health policies, which happens to be a good description of the publications in Table 2:

> Assessment of new health policies is rarely systematic and typically is undertaken by a haphazard collection of the curious, concerned, or adequately funded. The objectivity of these investigators may be difficult to assess. Studies are usually retrospective and often include populations convenient from a sampling perspective rather than relevant to broader policy making. Determining if intervention and comparison have representative health care access or outcomes may be impossible. In addition, results are often not published for years after policy implementation and tend to describe use of health services rather than clinical outcomes.[1489]

[1486] Robert A. Lowe, K. John McConnell, and Stephanie B. Abbuhl, "Deferred Care for Emergency Department Users with Nonacute Conditions, Letter," *Annals of Internal Medicine* 139, no. 6 (2003).

[1487] Rivara et al., "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." Derlet and Nishio, "Refusing Care to Patients Who Present to an Emergency Department."; Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience." Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study." Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services." Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

[1488] J. Frank Wharam and Norman Daniels, "Toward Evidence-Based Policy Making and Standardized Assessment of Health Policy Reform," *Journal of the American Medical Association* 298, no. 6 (2007): 677.

[1489] Ibid.

Further, despite suggestions that a policy may be inherently unethical, the lack of accountability and assessment of new health policies means that adverse outcomes or unintended consequences may not be known for many years. The framework by Wharam and Daniels makes any health policy change accountable for health outcomes.[1490] In general, the publications in Table 2 that are premised on emergency department policy changes do not adequately address health outcomes. Furthermore, triage out programs have been implemented in a wide range of hospitals for which no information is available.

There is some suggestion as well that triage out programs do involve a conflict of interest. For example, after the implementation of the process in a large public hospital in Tennessee, the stated effect of the process was to allow the expansion of research and educational programs because of cost savings.[1491] A response to this assertion criticized the approach: "[R]efusing [emergency department] care to medically indigent patients while using limited fiscal resources for research and education programs—cry out for discussion."[1492] Similar remarks about the relationship between the hospital's funding and priorities and triage out programs have been made in Colorado and at the University of Chicago. At the University of Colorado Hospital, physicians stated "in order to execute the hospital's mission, such as research, they must control costs by eliminating 'free care' in the emergency room."[1493] The University of Chicago's chief executive said

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[1490] Ibid.

[1491] Merigian, Park, and Blaho, "Referral out from the ED--Appropriate?"

[1492] Lowe and Abbuhl, "Referral out from the ED-Appropriate? Author Reply."

[1493] Editorial, "ER Screening Plan at CU Very Troubling."

that the hospital was seeking to get more privately insured patients by admitting more patients to its "programs of distinction" while treating fewer patients in the emergency department.[1494]

Other conflicts of interest may directly affect physicians involved in triage out programs. Incentive pay has been used by emergency physician groups contracted to provide care at HCA hospitals. The physicians are given an override option when a patient is initially triaged by a nurse as nonurgent. If a physician exceeds a 30 percent ceiling on the override option because they want to "do a test to see if an emergency exists, or if they do not think the patient should see a finance counselor before the completed [emergency department] visit, then they override the triage RN's assessment of nonurgent."[1495] The physicians commonly override 20 percent of the triage nurse's assessment. When the ceiling is reached, physicians risk "a few thousand dollars" in incentive pay.[1496]

Triage Out Programs May Have Been Boosted by the Deficit Reduction Act of 2005

Some triage out programs define payments required for nonemergency care as "copayments." For example, in Cleveland, a large safety net hospital implemented a $150 copayment for nonemergency care for uninsured patients living outside of the hospital's county.[1497] As already mentioned, at the University of Colorado, the copayment is $260

[1494] Burton, "Chicago Hospital Doctors Protest Planned Bed Cuts."

[1495] Editorial, "Ambulatory Care Quarterly: ED Screening Changes Put Pressure on Competitors."

[1496] Ibid.

[1497] Aaron Katz et al., "Cleveland Hospital Systems Expand Despite Weak Economy," in *Community Report* (Center for Studying Health System Change, 2010).

for an uninsured person.[1498] In the Houston area, the copayment is $150 for uninsured people.[1499] Cost sharing in the form of copayments is not only an attempt to shift the ever growing expenditures on health care to patients, it is part of a theory about what drives health care's costs and who is responsible for illness. Often, cost sharing is linked to a general sense that people should bear some personal responsibility for their health and health care costs. Though this seems "intuitively attractive," there is a possibility of negative health effects when implementing cost sharing measures.[1500] Low income people are the most likely to be harmed by cost sharing measures.[1501] Prior to the Deficit Reduction Act of 2005, states could implement emergency department copayments for certain Medicaid enrollees but providers could not deny care to an individual unable to afford the copayment.[1502]

While Medicaid enrollees are not the primary subject of this chapter, Medicaid is the public health insurance program for certain categories of low income people. Medicaid covers 45 percent of poor people. Changes in eligibility at the state level, individual variations in income, and barriers to enrollment, often mean that people cycle

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[1498] Diesburg-Stanwood and Oman, "Redirect Nonurgent Patients and Comply with EMTALA."

[1499] Murphy, "Harris County to Limit Emergency Room Access." Thompson, "UTMB Weighs First Month of ER Screening."

[1500] Robert. Steinbrook, "Imposing Personal Responsibility for Health," *New England Journal of Medicine* 355, no. 8 (2006): 756. See also Laura. D. Hermer, "Personal Responsibility: A Plausible Social Goal, but Not for Medicaid Reform," *Hastings Center Report* 38, no. 3 (2008).

[1501] Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," (Washington, DC: Center on Budget and Policy Priorities, 2003).

[1502] Karoline Mortensen, "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments," *Health Affairs* 29, no. 9 (2010).

through periods of Medicaid enrollment and periods of being uninsured.[1503] The main point for this section is that the Deficit Reduction Act of 2005 endorsed the idea that an appropriate method of reducing nonurgent care in the emergency department is to implement cost sharing for such care.[1504] Implicitly, the Act endorses the idea that nonurgent care is inappropriate in the emergency department, that health care providers can adequately distinguish people whose care is nonurgent from those whose care constitutes an emergency, and that requiring copayments from mostly extremely poor Americans is acceptable.

When CMS published final rules on cost sharing in the Medicaid program for nonemergency care in the emergency department in the Federal Register, a summary of comments was provided. Several comments are conceptually related to triage out programs. For example, on resource use, one comment was: “[B]y the time the emergency physician and the emergency department team have completed the EMTALA-required medical screening examination, 90 percent of the resources are expended and most of the work is complete.”[1505] Another comment, which is similar to the response of several physicians who maintain that refusing care in the emergency department for nonurgent conditions is contrary to the professional’s role is: “[I]t would be unpalatable to many doctors to inform the patient that his or her condition is not emergent and he or she has to make a payment before receiving a prescription or some minor additional

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[1503] Medicaid’s complex relationship with charity care is discussed in Chapter 5. Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation’s Health Coverage Program for Low-Income People."

[1504] *Deficit Reduction Act of 2005*, Public Law 109-171, 109th Cong., 2nd sess. (January 3, 2006).

[1505] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Premiums and Cost Sharing," *Federal Register* 73, no. 228 (2008): 71838.

treatment."[1506] Finally, like many statements that triage out programs are unethical, one comment in the final rules was: "[I]t is unethical to withhold treatment while the patient is in front of [the health care provider] and even harder to justify when the potential financial gains are so small."[1507] CMS responded that providers have an option to reduce or waive cost sharing on a case-by-case basis.

Unlike many triage out programs, however, the requirements of the Deficit Reduction Act of 2005 make certain obligations a necessary part of cost sharing in the Medicaid program for nonemergency care in the emergency department. Specifically, a hospital that has determined through a medical screening examination that an emergency medical condition is not present, before imposing cost sharing on an individual in the Medicaid program, must provide the name and location of an available and accessible alternate nonemergency service provider that can provide the service with the imposition of a lesser cost sharing amount or no cost sharing, and a referral to coordinate scheduling of treatment by this provider.[1508] These provisions in the final rules expand upon the Deficit Reduction Act's requirement that in order for a hospital to impose cost sharing for Medicaid enrollees: "The individual must actually have available and accessible an alternate non-emergency services provider with respect to the necessary services."[1509]

The requirements for available and accessible alternatives and the coordination of care in the Deficit Reduction Act are in stark contrast to what has been reported in the

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[1506] Ibid.

[1507] Ibid.

[1508] Ibid., 71854.

[1509] Dennis G. Smith, "State Medicaid Director Letter," August 15, (2007), https://www.cms.gov/SMDL/downloads/SMD081507.pdf (accessed March 14, 2013).

publications on triage out programs. For example, in the three studies from the University of California, Davis, patients most often, in the two earlier studies, did not receive any referral information because they were not seen at the assistance desk.[1510] In the last publication from this hospital, patients were given a list of clinics, though there was no mention of the copayments required at these alternative sites or of any effort to coordinate appointments.[1511] In the latest publication about a triage out program at a public hospital in Texas, the authors clarify in a letter that: "When patients are discharged from the emergency department or the hospital, they are responsible for follow-up care."[1512] Though discharge planners provide "information about available community resources," it is unknown what happens once patients are discharged.[1513] Similarly, in the triage out publication from Colorado, the patients were given a packet with a list of providers, though follow up appointments were "the responsibility of the person seeking treatment."[1514] A health care consumer advocate has made the point that "a piece of paper listing local clinics is not access to care."[1515]

[1510] Robert W. Derlet, "Refusal of Care: The Ethical Dilemma; Author Reply," *Annals of Emergency Medicine* 19, no. 10 (1990); Derlet et al., "Triage of Patients out of the Emergency Department: Three-Year Experience."

[1511] Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study."

[1512] Kathleen Nash and Melinda Tillman, "Screening out Does Little to Address ED Overcrowding: Author Response," *Journal of Emergency Nursing* 35, no. 4 (2009).

[1513] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding," 110.

[1514] Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services," 314.

[1515] Connolly, "Some Finding No Room at the ER."

The Cost of Nonurgent Care in the Emergency Department

As already mentioned, the authors of the University of California, Davis, triage out program hypothesized that the risks to patients would be outweighed by the benefits in terms of lower cost to the hospital and improved use of resources. Yet, in their three reports, the authors were unable to demonstrate cost reductions.[1516] The nation had heard from its president, Bill Clinton, in a 1993 speech outlining health care reform, about the expense of emergency department care:

> Because when people don't have any health insurance, they still get health care, but they get it when it's too late, when it's too expensive, often from the most expensive place of all, the emergency room. Usually by the time they show up, their illnesses are more severe, and their mortality rates are much higher in our hospitals than those who have insurance. So they cost us more. And what else happens? Since they get the care but they don't pay, who does pay? All the rest of us. We pay in higher hospital bills and higher insurance premiums. This cost shifting is a major problem.[1517]

It turns out that, like many assumptions about emergency department care, intuitively these assumptions make sense, yet often evidence does not support the assumptions. Uwe Reinhardt, a health care economist has declared that: “Hospital emergency departments have long been decried as one of the most ‘expensive’ places to deliver routine health care, even by policy analysts who ought to know better.”[1518]

Does nonurgent care in emergency departments cost more than care for similar conditions provided in other settings? This is a question that seems simple, yet, the wide range of estimates of the number of emergency department visits that could potentially be

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[1516] The authors also did not show a reduction in crowding. Derlet et al., "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study."

[1517] William J. Clinton, "Address on Health Care Reform," (1993), http://millercenter.org/president/speeches/detail/3926 (accessed March 14, 2013).

[1518] Uwe E. Reinhardt, "Spending More through 'Cost Control:' Our Obsessive Quest to Gut the Hospital," *Health Affairs* 15, no. 2 (1996): 153.

shifted to primary care settings makes the question difficult to answer.[1519] In a synthesis study by the Robert Wood Johnson Foundation, the authors summarize the cost of nonurgent care in the emergency department: “The true costs associated with care in the [emergency department], particularly non-urgent care, are not well understood.”[1520]

Publications whose purpose has been to assess the cost of nonurgent care in the emergency department have varied widely in their findings. In a 1994 study, the authors compared charges for care in the emergency department for nonurgent conditions to charges at physician offices for similar care. Their conclusion was that charges were two to three times greater in the emergency department and that up to $7 billion in health care savings could be achieved through diverting nonurgent care to other sites. However, this data was based on charges, not costs.[1521] In a 1996 study, the marginal cost of nonurgent visits was “far less than generally assumed.”[1522] The marginal cost of nonurgent care was about $25 and the average cost was similar to the cost of nonurgent care in a physician’s office.[1523] In a 2005 study, the marginal costs were much higher than what was predicted in the earlier study, yet the methodology was also much different and could not account for only the conditions that were possibly reasonably treated in settings such as physician

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[1519] Cunningham, "Nonurgent Use of Hospital Emergency Departments: Senate Testimony." 11.

[1520] DeLia and Cantor, "Emergency Department Utilization and Capacity."

[1521] Laurence C. Baker and Linda S. Baker, "Excess Cost of Emergency Department Visits for Nonurgent Care," *Health Affairs* 13, no. 5 (1994).

[1522] Robert M. Williams, "The Costs of Visits to Emergency Departments," *New England Journal of Medicine* 334, no. 10 (1996): 645.

[1523] ———, "Costs of Visits to Emergency Departments, Author Reply," *New England Journal of Medicine* 335, no. 3 (1996).

offices.[1524] Other complexities include that, in the case of salaried physicians at public hospitals or academic medical centers where the fixed costs, including salaries, are high, reducing emergency department services alone may not substantially reduce cost.[1525] All of these reasons and the conflicting data have led to the aforementioned conclusion that the costs of nonurgent care are not well understood and that "it is unclear whether the diversion of non-urgent [emergency department] patients to other settings would produce significant cost savings."[1526] Even the most recent data on shifting nonurgent care to other sites relies on estimations that are not yet proven.[1527]

The Use of Resources in Providing Nonurgent Care in the Emergency Department

A related concept to cost is the concept of resource use. Several authors have referred to the fact that the bulk of resource use for nonurgent care in the emergency department has already occurred when people are refused further care in triage out programs. The Agency for Healthcare Research and Quality publishes a manual for determining the severity of emergency department care. One of the factors that the manual recommends using in determinations of severity, which is unique to this instrument, is "resource use", which is defined as "hospital services, tests, procedures, consults or interventions that are above and beyond the physician history and physical, or

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[1524] Anli Bamezai, Glenn Melnick, and Amar Nawathe, "The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume," *Annals of Emergency Medicine* 45, no. 5 (2005). Arthur L. Kellermann, "Calculating the Cost of Emergency Care," *Annals of Emergency Medicine* 45, no. 5 (2005). Jonathon Showstack, "The Costs of Providing Nonurgent Care in Emergency Departments," *Annals of Emergency Medicine* 45, no. 5 (2005).

[1525] Roberts et al., "Distribution of Variable Vs Fixed Costs of Hospital Care."

[1526] DeLia and Cantor, "Emergency Department Utilization and Capacity."

[1527] Robin M. Weinick, Rachel M. Burns, and Ateev Mehrotra, "Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics," *Health Affairs* 29, no. 9 (2010).

very simple emergency department interventions such as applying a bandage."[1528] The Emergency Severity Index uses a five-level acuity rating, with levels four and five representing the lowest acuity levels. Level four patients are predicted to require one resource and level five patients are predicted to require no resources. Counting the number of resources is not part of the instrument for high acuity patients but is used in the three lower acuity levels in this instrument. The physical examination and history are not included in the counting of resources needed to determine the disposition of the patient.[1529] The major point here is that, in at least one triage instrument in use, there are often no, or few, additional resources required to appropriately care for nonurgent patients. Again, triage is not the same as a medical screening examination because it is generally somewhat more extensive, so most of the time involved in caring for the patient has occurred when a triage out decision is implemented after the medical screening exam.

The time it takes to comply with a hospital's procedure for a triage out program including informing patients of the details can be significant. In the latest publication on a triage out program at a public hospital in Texas, the authors note: "Health care providers often spend more time explaining the [medical screening examination] process and how to find a medical home than it takes to determine that no emergency exists."[1530] In terms of the efficiency of triage out programs, several authors have questioned the "true efficiency of any referral-out program. After the [emergency department] staff have completed the evaluation mandated by [EMTALA], how much more time and resources

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[1528] Nicki Gilboy et al., "Emergency Severity Index, Version 4: Implementation," (Rockville, MD: Agency for Healthcare Research and Quality, 2005).

[1529] Ibid.

[1530] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding," 112.

are required to treat the patient?”[1531] Arthur Kellermann, an emergency department policy expert, has asked a similar question related to the efficiency of triage out programs: “Is it wise? After conducting a detailed history and directed examination, and even obtaining selected laboratory tests, wouldn’t it be more prudent to simply treat the patient and arrange follow-up rather than start the process all over again the following day?”[1532] One leader of an emergency physician group agrees: “[I] takes 95 percent effort to medically screen a low-acuity patient so why not go the additional five percent and provide definitive care?”[1533] In the case that CMS used to illustrate when a patient with a nonemergency condition could be referred away from the emergency department after a medical screening exam, the patient had sutures that were healing well. It would likely take as much time to remove the sutures as it would to explain that the sutures would not be removed in the emergency department and that the patient should go to her doctor to have them removed.

There is an exceedingly small amount of information on how patients perceive triage out programs. At one public hospital in Texas, patients triaged out do not receive a patient satisfaction survey.[1534] Therefore, patients’ views on the process are often unknown. In a publication describing a triage out program in Colorado, however, “many” patients reached in a follow up phone survey “believed we were discriminating against

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[1531] Lowe and Abbuhl, "Referral out from the ED-Appropriate? Author Reply," 1072.

[1532] Kellermann, "Deferred Care for Emergency Department Users with Nonacute Conditions; Letters," 527.

[1533] Shari Welch et al., "The Medical Screening Exam: Hold onto Your (White) Hat! " *Emergency Medicine News* XXIX, no. 10 (2007).

[1534] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

them because of lack of insurance."[1535] Refusing to provide needed medical care when there is minimal additional time or resources required raises moral questions that differ from refusing to provide care in medical emergencies. Lack of information on patient perceptions inhibits the ability to fully account for these differences.

Triage Out Programs and Their Potential to Worsen Health Care Disparities

Triage out programs, when they are described in the medical literature, are often unclear about the relationship between the problem addressed, which is usually overcrowding, and the outcomes reported, which may not show valid data on reducing crowding and may report only limited data on patient outcomes.[1536] While it is problematic to assign motives to processes, such as triage out programs, if the motives are not explicit, the lack of data that support improvement in crowding leaves the motives in question. Robert Bitterman, an expert on EMTALA, has described one implicit reason for triage out programs: "The 'screen and street' hospital's real goal is [to] discourage future use of its emergency department by the uninsured in its community."[1537] Although it is difficult to know how much triage out programs contribute to decreased access to emergency departments, there is evidence that access is worse for uninsured people. In a national survey on access to emergency care in 2004, adults who were younger, had a

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[1535] Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services," 315.

[1536] See Table 2.

[1537] Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services," 565.

lower income, and were uninsured had significantly worse access to emergency care.[1538] As already mentioned, there are reasons to link worse access to attitudes about uninsured people as well as people with nonurgent conditions. For example, the idea that there are "inappropriate" visits to the emergency department is often applied to patients with nonurgent conditions. One author, Steven Bernstein, has described this: "In its more malignant form, inappropriate [emergency department] use has been characterized as visits by people of lower socioeconomic status who are 'gaming' the system by claiming benefits and services to which they are not entitled."[1539] Bernstein notes that language matters and that the use of the term "inappropriate" further stigmatizes patients by "blaming the victim" and that "the notion of the 'inappropriate' [emergency department] user is largely apocryphal."[1540]

If triage out programs do have the goal of discouraging future use of emergency departments by uninsured people in a community, or even if this effect is not a goal, but a consequence, then serious questions are raised. From the perspective of patients, the conundrum "can be viewed as inadvertently training people to delay seeking care: if they seek care 'too soon,' they are viewed as not sick enough, but if they overly delay, they are scolded for taking dangerous chances."[1541] A group of emergency physicians have asked:

[1538] Jae Kennedy et al., "Access to Emergency Care: Restricted by Long Waiting Times and Cost and Coverage Concerns," *Annals of Emergency Medicine* 43, no. 5 (2004).

[1539] Steven L. Bernstein, "Frequent Emergency Department Visitors: The End of Inappropriateness," *Annals of Emergency Medicine* 48, no. 1 (2006): 18.

[1540] Ibid.

[1541] Gay Becker, "Deadly Inequality in the Health Care "Safety Net": Uninsured Ethnic Minorities' Struggle to Live with Life-Threatening Illnesses," *Medical Anthropology Quarterly* 18, no. 2 (2004): 270.

> What are we really teaching patients when they are turned away? Will a mother learn not to bring her child for an earache or for a fever or for any sickness, regardless of severity? Patients, regardless of educational status, can be poor judges of whether their complaints are emergent. When is a sore throat an emergency? …P]atients overestimate and underestimate the urgency of their complaints.[1542]

In a recent study on people who delay care for acute myocardial infarction, uninsured people and those with financial concerns were much more likely to delay seeking care.[1543] This delay in seeking care for a potentially fatal but treatable medical condition raises the specific concerns that could, or even have already, come about because of discouraging care. The authors of the study theorize that it is likely that uninsured patients not only delay seeking care for myocardial infarction, but also delay care for other common medical conditions, such as stroke, pneumonia, and appendicitis, which are all time sensitive and treatable serious illnesses.[1544] Lack of health insurance is associated with about 45,000 deaths each year and while the factors involved may be multiple, discouraging care could be one of these factors.[1545]

Research has shown that the experience of previously negative interactions in getting health care does jeopardize future care. In one study, perceptions of disrespect or of receiving unfair treatment within the patient-physician relationship were relatively common, especially among people from racial or ethnic minority groups. These negative perceptions influenced the utilization of health care and could contribute to existing

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[1542] Welch et al., "The Medical Screening Exam: Hold onto Your (White) Hat! " 3.

[1543] Kim G. Smolderen et al., "Health Care Insurance, Financial Concerns in Accessing Care, and Delays to Hospital Presentation in Acute Myocardial Infarction," *Journal of the American Medical Association* 303, no. 14 (2010).

[1544] Paula Braveman et al., "Insurance-Related Differences in the Risk of Ruptured Appendix," *New England Journal of Medicine* 331, no. 7 (1994).

[1545] Andrew P. Wilper et al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99, no. 12 (2009).

health care disparities.[1546] One publication on triage out programs, as already mentioned, reported that some patients believed that discrimination on the basis of not having health insurance was a factor.[1547] Attitudes among physicians about the "appropriateness" of the emergency room visit may negatively affect care that is given, as already mentioned.[1548]

Attitudes about appropriateness can combine with bias related to race or ethnicity and socioeconomic status. In a study of managed care plans that required preauthorization, African Americans were more likely than whites to be denied authorization for emergency department visits. The association persisted despite adjustment for triage score, age, gender, day and time of arrival at the emergency department, and the type of managed care organization. The authors of the study state: "For [emergency department] gatekeeping to be ethical, the process should not be influenced by nonmedical factors."[1549] While denials of preauthorization are not the same as denials of care in triage out programs, there are substantial similarities since in both cases the end result is not receiving care in the emergency department that is requested. When the Office of the Inspector General surveyed hospital emergency departments, 8 percent of respondents, and in hospitals with a large proportion of Medicaid patients, almost 18 percent, reported that decisions about medical screening examinations were at

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[1546] Janice Blanchard and Nicole Lurie, "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice* 53, no. 9 (2004).

[1547] Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services."

[1548] Lynne D. Richardson, Charlene Babcock Irvin, and Joshua H. Tamayo-Sarver, "Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine," *Academic Emergency Medicine* 10, no. 11 (2003).

[1549] Robert A. Lowe et al., "Effect of Ethnicity on Denial of Authorization for Emergency Department Care by Managed Care Gatekeepers," *Academic Emergency Medicine* 8, no. 3 (2001).

least sometimes influenced by a patient's ability to pay.[1550] This is precisely what EMTALA was designed to prevent, making it unlikely that socioeconomic status has disappeared as a basis for decisions on whether to treat emergency or nonurgent patients.

Studies of disparities in health care show that there is a complex interplay between socioeconomic status, health insurance, and race/ethnicity.[1551] One question is whether triage out policies institutionalize bias. Table 2 shows that when information on race and ethnicity and income are reported, the patients who are triaged out are primarily poor and from minority populations. In terms of bias based on socioeconomic status, when only uninsured patients who are unable to provide a copayment are refused care, as in some of the reports on triage out programs, institutional bias seems self evident.[1552] Even though increases in emergency department utilization are not primarily due to uninsured patients, uninsured people rely more on emergency departments for access to care than insured people. Among the privately insured, 7 percent of ambulatory care visits occur in emergency departments and among Medicaid enrollees 17 percent of ambulatory care visits occur in emergency departments whereas more than one-fourth of all ambulatory care visits by the uninsured are in emergency departments. Dependence on emergency departments has grown significantly among uninsured people since 1995 when 16 percent of ambulatory care visits occurred in hospital emergency

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[1550] Office of Inspector General, "The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments."

[1551] Julio Frenk, "Medical Care and Health Improvement: The Critical Link," *Annals of Internal Medicine* 129, no. 5 (1998). Kevin Fiscella and David R. Williams, "Health Disparities Based on Socioeconomic Inequities: Implications for Urban Health Care," *Academic Medicine* 79, no. 12 (2004).

[1552] Lowe and Abbuhl, "Referral out from the ED-Appropriate? Author Reply." Kellermann, "Deferred Care for Emergency Department Users with Nonacute Conditions; Letters."

departments.[1553] Minority populations are much more likely to be uninsured than whites. Whites have an uninsured rate of 14 percent, African Americans 23 percent, and Hispanics about one third.[1554] Therefore, uninsured patients are more likely to be minority and more likely to be the most affected by triage out policies.

Several studies have documented that disparities in providing health care occur specifically in the emergency department. Some examples of disparate care for racial and ethnic minority patients include care for mild traumatic brain injury, management of pediatric appendicitis, pain management, treatment for childhood asthma, and diagnoses of schizophrenia.[1555] Studies also show that the effects of racial and ethnic disparities in emergency department care are often the result of the combined effects of being uninsured and from a racial or ethnic minority population.[1556] The causes of health care disparities, in the emergency department and elsewhere, are multiple. However, the emergency department may be a setting in which the role of bias and stereotyping are

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[1553] Cunningham, "Nonurgent Use of Hospital Emergency Departments: Senate Testimony. "

[1554] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer," (2010), http://www.kff.org/uninsured/7451.cfm (accessed March 14, 2013).

[1555] Jeffrey J. Bazarian et al., "Ethnic and Racial Disparities in Emergency Department Care for Mild Traumatic Brain Injury," *Academic Emergency Medicine* 10, no. 11 (2003). Mark F. Guagliardo et al., "Racial and Ethnic Disparities in Pediatric Appendicitis Rupture Rate," *Academic Emergency Medicine* 10, no. 11 (2003). Joshua H. Tamayo-Sarver et al., "Racial and Ethnic Disparities in Emergency Department Analgesic Prescription," *American Journal of Public Health* 93, no. 12 (2003). Richardson, Irvin, and Tamayo-Sarver, "Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine." David C. Cone et al., "Health Care Disparities in Emergency Medicine," *Academic Emergency Medicine* 10, no. 11 (2003).

[1556] Anbesaw W. Selassie et al., "The Effect of Insurance Status, Race, and Gender on ED Disposition of Persons with Traumatic Brain Injury," *American Journal of Emergency Medicine* 22, no. 6 (2004). N. Ewen Wang et al., "Socioeconomic Disparities Are Negatively Associated with Pediatric Emergency Department Aftercare Compliance," *Academic Emergency Medicine* 10, no. 11 (2003).

particularly influential.[1557] Emergency departments are inherently fast-paced, complex, and demanding places to receive care, often in the context of considerable clinical uncertainty. A 2002 Institute of Medicine report noted the relationship between these factors and the potential for bias and stereotyping in the following passage:

> Even highly educated and socially conscious individuals, such as doctors, are susceptible to these biases. Moreover, the types of situations that promote these biases –time pressure, incomplete information, high demand on attention and cognitive resources- are those that frequently occur in the context of doctor-patient interactions.[1558]

While stereotyping functions largely unconsciously and it is deeply embedded in human cognition, it can have a powerful effect even among well meaning people. An article describing medical educators' efforts to reduce health care disparities provides the following example of how stereotyping may affect care in the emergency department:

> When Althea Alexander broke her arm, the attending resident at Los Angeles County—USC Medical Center told her to "hold your arm like you usually hold your can of beer on Saturday night." Alexander, who is black, exploded. "What are you talking about? She demanded. "Do you think I'm a welfare mother?" The white resident shrugged: "Well aren't you?" Wrong. Alexander was a top official at the USC School of Medicine where the resident was studying.[1559]

As already detailed, emergency department care of nonurgent patients is associated with anger, stigma, negative assumptions, and judgments of appropriateness. In a 1979 article, hostility to people with nonurgent conditions was evident throughout the emergency department: "Like old war buddies trading stories, everyone from billing

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[1557] Jordan J. Cohen, "Disparities in Health Care: An Overview," *Academic Emergency Medicine* 10, no. 11 (2003). Richardson, Irvin, and Tamayo-Sarver, "Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine."

[1558] Smedley et al., *Unequal Treatment : Confronting Racial and Ethnic Disparities in Health Care*: 10.

[1559] Sonia Nazario, "Treating Doctors for Prejudice: Medical Schools Are Trying to Sensitize Students to 'Bedside Bias.' " *Los Angeles Times*, December 20, 1993.

clerks to department chairmen relate a litany of abuses they have observed."[1560] This hostility had profound effects, according to the author, altering the entire process of care, and producing anger from patients.[1561] More recently, a man with a broken jaw and ribs went to two public hospitals in Denver where he was turned away through triage out programs. His description of the process was: "I didn't see how these days, in the United States, anyone could be denied care…I felt like Neanderthal man."[1562] Instead of anger, the man seemed to express a sense of fatalism.[1563]

The man with the broken jaw and ribs did get care at another hospital that does not have a triage out program. The physician who treated him used the term "barbaric," another physician called the process "unconscionable," and a third physician said, "it may be legal, but it's highly unethical."[1564] There seems to be no doubt that the man was in "excruciating pain." During the triage out process the man was told that his jaw was fractured and three ribs were broken.[1565] The emergency department refused to treat him unless he had health insurance or cash. At the hospital that does not turn patients away through triage out programs, physicians described several people with serious but not life-threatening conditions who have been triaged out from public hospitals and then have come to their emergency department.

[1560] B. W. Wolcott, "What Is an Emergency? Depends on Whom You Ask," *Journal of the American College of Emergency Physicians* 8, no. 6 (1979): 241.

[1561] Ibid.

[1562] Marsha Austin, "Hospitals Turn Away Ill, Injured," *Denver Post*, June 29, 2003.

[1563] J. Wardle and A. Steptoe, "Socioeconomic Differences in Attitudes and Beliefs About Healthy Lifestyles," *Journal of Epidemiology and Community Health* 57, no. 6 (2003).

[1564] Austin, "Hospitals Turn Away Ill, Injured."

[1565] Ibid.

Physicians who are part of triage out programs defend them, saying they are doing the best they can in the face of budget shortfalls. Admittedly, even for these physicians defending their triage out programs, care in other settings in the Denver area is not timely. Appointments at community clinics were not available for six to eight weeks at the time the man with the broken jaw and ribs was turned away.[1566] In a large study in several communities, researchers found that the timing and availability of an appointment for urgent follow-up care after being discharged from the emergency department was particularly difficult for uninsured patients even when they reported serious conditions that warrant timely care.[1567]

A senior policy advisor at CMS was aware of the Denver hospital's triage out programs in 2003, just prior to when the EMTALA final rules were implemented. He stated: "You are walking a very fine line, and you had better make sure you stay on the right side of the fence."[1568] He seemed to believe at that time that the final rules would clearly indicate which medical conditions could not be treated, such as suture removal or prescription refills. Instead, the final rules used those examples but mainly relied on professional standards to set guidelines on ensuring care after a patient undergoes a medical screening exam and has a nonurgent diagnosis.[1569] In 1999, CMS published a Special Advisory Bulletin to clarify concerns related to managed care plans requiring prior authorization for services at the emergency department. CMS recognized that

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[1566] Ibid.

[1567] Brent R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments," *Journal of the American Medical Association* 294, no. 10 (2005).

[1568] Austin, "Hospitals Turn Away Ill, Injured."

[1569] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions," 53234-53238.

managed care plans had a “legitimate interest in deterring their enrollees from over-utilizing emergency services,” just as hospitals may now believe they have a legitimate interest in deterring visits for nonurgent care.[1570] CMS emphasized that hospitals are not allowed to require patients to sign financial responsibility forms or make copayments prior to a medical screening exam.[1571] Under EMTALA there is a strong right to medical screening and treatment for a health emergency and protections against discrimination especially in regard to ability to pay. These rights are utterly stripped away if medical screening fails to uncover a medical emergency.

Since the diagnosis of an emergency condition determines whether there is a right to treatment, the question is raised about how accurate the determinations are. A great deal of research, some referred to earlier in this chapter, over decades indicates that the triage process in emergency departments is fallible. Although triage is not equivalent to the medical screening exam required by EMTALA, the similarities between these processes are useful in understanding the possibilities for errors.[1572] One study looked at the accuracy and reliability of triage decisions by physicians, nurses, and a computer program to determine both the need for emergency department care and the ordering of that care. The authors found significant variability in the triage decisions, indicating the limitations of using triage methods that are not standardized or validated to determine the

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[1570] Department of Health and Human Services Office of Inspector General, "OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute," *Federal Register* 64 no. 217 (November 10, 1999): 61356.

[1571] Ibid., 61358.

[1572] Shelley Cohen and Stephen A. Frew, "No. 1 EMTALA Mistake: Confusing Triage and MSE," *ED Nursing*, November (2004).

need and priority for care among patients seen in the emergency department.[1573] Another study tested the published guidelines for refusing care to patients in the emergency department who were considered to have nonurgent conditions. Of the patients who would have been denied treatment, one-third of the patients were considered appropriate to receive care in the emergency department and four patients were hospitalized. In addition, disagreement in rating appropriateness occurred in 12 percent of cases.[1574] A second study based on the triage out criteria in use at the University of California, Davis, did not refuse care but determined the outcomes for patients who would have met the criteria for refusal. There were just over 1 percent of patients who met the criteria but were hospitalized. The authors cautioned that the triage out process should not be implemented unless alternative sites of care are "geographically and financially accessible."[1575] While there are new methods for evaluating the severity of medical conditions for the purpose of triage which seem to provide greater reliability, these methods are not in use consistently in emergency departments and are not designed with triage out programs as part of their use.[1576] In one recent publication, the authors state that "evaluations of [emergency department] care appropriateness need to consider not

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[1573] Judith C. Brillman et al., "Triage: Limitations in Predicting Need for Emergent Care and Hospital Admission," *Annals of Emergency Medicine* 27, no. 4 (1996).

[1574] Lowe et al., "Refusing Care to Emergency Department of Patients: Evaluation of Published Triage Guidelines."

[1575] Birnbaum et al., "Failure to Validate a Predictive Model for Refusal of Care to Emergency-Department Patients," 217.

[1576] Gilboy et al., "Emergency Severity Index, Version 4: Implementation." Dustin W. Ballard et al., "Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits," *Medical Care* 48, no. 1 (2010).

only the severity of a patient's condition, but also access to alternative sources of care."[1577]

The fallibility of triage raises additional questions about whether triage out policies might institutionalize bias. A recent study has shown that emergency department wait times, which are influenced by triage determinations, are greater for minority patients who had a stroke.[1578] Another study found minority children had considerably longer wait times in emergency departments. The authors concluded that "to the extent that triage status assignments reflect how clinicians' views of patients' immediacy may be influenced by subjective factors, this study is useful in understanding the potential differential treatment based on perceived immediacy."[1579] Further, in settings where the care of certain patients is denied based on a determination of a nonurgent medical condition, does this fundamentally alter the culture of the emergency department and the relationship between the patient and the health care provider? One group of emergency medicine physicians asked this question: "And how are a physician's diagnostic skills affected when his eyes and heart are focused on pushing away as many patients as possible, rather than searching for the terribly significant event hiding beneath the benign clinical presentation?"[1580]

[1577] ———, "Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits."

[1578] Sudeep J. Karve et al., "Racial/Ethnic Disparities in Emergency Department Waiting Time for Stroke Patients in the United States," *Journal of Stroke and Cerebrovascular Diseases* 20, no. 1 (2011).

[1579] Christine Y. Park, Mary Alice Lee, and Andrew J. Epstein, "Variation in Emergency Department Wait Times for Children by Race/Ethnicity and Payment Source," *Health Services Research* 44, no. 6 (2009): 2034.

[1580] Welch et al., "The Medical Screening Exam: Hold onto Your (White) Hat! " 35.

This is not a simple question to answer. However, a recent national study did assess whether there are sociodemographic differences in triage assignment and whether these differences affected diagnostic testing for patients who came to emergency departments for chest pain. The study found that African Americans, Hispanics, patients insured by Medicaid, and uninsured patients were less likely to be triaged into the emergent category. There were no differences in the symptoms at presentation between these groups of patients and other groups. Racial and ethnic minority patients, patients insured by Medicaid, and uninsured patients were then less likely to receive basic diagnostic testing consistent with guidelines by the American College of Cardiology and the American Heart Association.[1581] While this study does not establish causality, it does add to a body of research suggesting that triage decisions may be influenced by unconscious bias.[1582] In one study of the triage decisions by nurses of cardiac patients, the emergency department nurses relied, in part, on their own personal beliefs and attitudes. In their narratives, the nurses had "preconceived and often negative attitudes, perceptions, and beliefs."[1583] The author summarized the problems that may arise as a result:

> Perceptions of this sort, based on negative attitudes and beliefs, may interfere with [emergency department] nurses' ability to consider an acute cardiac condition in ethnically or culturally diverse patients. Stereotypes and biases can disproportionately influence judgment, causing the construction of erroneous correlations, despite the absence of confirming evidence. Moreover, the activation

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[1581] Lenny Lopez et al., "Racial and Sex Differences in Emergency Department Triage Assessment and Test Ordering for Chest Pain, 1997-2006," *Academic Emergency Medicine* 17, no. 8 (2010). Alan Mozes, "Not All Chest Pain Treated Equally in U.S. Hospitals," *HealthDay News*, September 24, 2010.

[1582] Cynthia Arslanian-Engoren, "Gender and Age Bias in Triage Decisions," *Journal of Emergency Nursing* 26, no. 2 (2000); Alexander R. Green et al., "Implicit Bias among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients," *Journal of General Internal Medicine* 22, no. 9 (2007).

[1583] Cynthia Arslanian-Engoren, "Explicating Nurses' Cardiac Triage Decisions," *Journal of Cardiovascular Nursing* 24, no. 1 (2009): 55.

> of attitudes is associated with biased information processing, which can lead to judgment errors.[1584]

While the possibility that triage out programs are subject to implicit bias, prejudices, and stereotyping is a moral problem, it is not as commonly the grounds for moral objections to the programs in publications and in the media as are ethical principles and professionalism.[1585] The author of one letter, however, recognizes that uncertainty and biases may influence triage out programs and he suggests that "great care must always be taken when designing any program that allows for turning people away. While full of the best of intentions, an individual having a bad day, exercising poor judgment, making a human error, or 'getting even' with a patient can ruin those good intentions."[1586] In other correspondence, one author suggests that triage out programs are targeting a group that is already stigmatized: "[T]he American medical profession as a whole is always looking for reasons to avoid caring for 'undesirables,' and…this attitude is becoming more of a factor in the setting of the [emergency department], traditionally a place where the challenge of immediate access is always present."[1587] Arthur Kellermann has suggested that triage out programs may not be fair in comments about a study in which the patients who were triaged out were "of all adult age groups, ethnically diverse,

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[1584] Ibid., 56.

[1585] Madison Powers and Ruth Faden, "Racial and Ethnic Disparities in Healthcare: An Ethical Analysis of When and How They Matter," in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, ed. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson (Washington, DC: National Academies Press, 2003).

[1586] Howard Henze, "Refusal of Care: The Ethical Dilemma," *Annals of Emergency Medicine* 19, no. 10 (1990): 1198.

[1587] Richard Lieberman, "Refusal of Care: The Ethical Dilemma," *Annals of Emergency Medicine* 19, no. 10 (1990): 1197.

poor, and uninsured," the groups that already have less access to care.[1588] None of the data on disparities in health care due to inability to pay, insurance status, or racial and ethnic minority status prove that such disparities are created or sustained by policies that deny care for nonemergencies in emergency departments. Yet, the research on health care disparities in the emergency department, the history of negative attitudes toward nonurgent patients, and statements made by critics of triage out programs suggest the morally troubling possibility that such programs may amplify prejudice and bias, even if unwittingly.

The Ethics of Triage Out Programs

Throughout this chapter, the ethics of triage out programs have been questioned. Triage out programs have been called "highly unethical," "unconscionable,"[1589] and a "travesty."[1590] The threat to a long tradition of professional ethics was the basis for the protest letter from resident physicians at the University of Chicago and it is similar to the threat that patient dumping was seen to embody in the pre-EMTALA era.[1591] The pre-EMTALA denials were sometimes cast as events in which professionals were relatively powerless on a matter of hospital policy.[1592] Triage out programs, on the other hand, do

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[1588] Kellermann, "Deferred Care for Emergency Department Users with Nonacute Conditions; Letters," 527.

[1589] Austin, "Hospitals Turn Away Ill, Injured." Editorial, "ER Screening Plan at CU Very Troubling."

[1590] Kenneth V. Iserson, "Refusal of Care: The Ethical Dilemma," *Annals of Emergency Medicine* 19, no. 10 (1990): 1197.

[1591] Louden, "Chicago Hospital to Halt New Emergency Department Policies after Criticism." Wrenn, "No Insurance, No Admission."

[1592] Relman, "Economic Considerations in Emergency Care. What Are Hospitals For?." Wrenn, "No Insurance, No Admission." Curran, "Economic and Legal Considerations in Emergency Care."

have some prominent physician champions.[1593] Kenneth Iserson, an ethicist and emergency physician, is a strong opponent of triage out programs. He has commented that the triage out process "devalues justice, autonomy, nonmaleficence, and beneficence."[1594] Further commenting on the nature of the threat, Iserson states: "Routinely refusing emergency department care to selected patients…is just such a challenge to the values upon which American medicine and emergency medicine rest."[1595] In particular, Iserson writes of the harms of triage out programs that undermine the principle of nonmaleficence:

> William Osler, Oliver Wendell Holmes, and others wrote that the duty of a physician was to cure rarely, relieve often, comfort always. This is the expectation of the public presenting themselves for medical care. Patients with no recourse to other care seek relief of pain and fear in the [emergency department]. If physicians fail to provide the requested comfort or to alleviate pain and fear, they do harm as clearly as if they cause bodily injury. Patients with diminished concept of self worth have this feeling reinforced by being turned away when they seek help. Intentional harm to patients comes in many forms. The emergency physician participates in a system that first humiliates and fails to provide care only at risk to their basic values.[1596]

Robert Bitterman believes that triage out programs that do not make arrangements for patients to receive care may violate the American College of Emergency Physicians Code of Ethics which states: "Emergency physicians have an ethical duty to act as advocates for the health needs of indigent patients and to assist them in finding appropriate care"

[1593] Derlet, "Refusal of Care: The Ethical Dilemma; Author Reply." Donna Washington and Paul G. Shekelle, "Deferred Care for Emergency Department Users with Nonacute Conditions; Author Reply," *Annals of Internal Medicine* 139, no. 6 (2003).

[1594] Iserson, "Assessing Values: Rationing Emergency Department Care," 263.

[1595] Ibid.

[1596] Ibid., 264.

and “[e]mergency physicians shall embrace patient welfare as their primary professional responsibility.”[1597]

Not only are ethical codes from emergency medicine relevant, since triage out programs involve hospitals and medical professionals, moral traditions from medicine, nursing, and hospitals are also significant. While each of these moral traditions has a specific history and focus, in general, these traditions share the primary duty to ensure the welfare of the patient. For example, in 2002, several medical societies created a Charter on Medical Professionalism. There are three principles and the following is the first principle:

> *Principle of primacy of patient welfare.* This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.[1598]

The American Nurses Association Code of Ethics includes many references to patient welfare. Provision 1 of the Code states :

> The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.[1599]

[1597] Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services," 565. American College of Emergency Physicians, "Code of Ethics for Emergency Physicians," *Annals of Emergency Medicine* 52, no. 5 (2008).

[1598] American Board of Internal Medicine Foundation, American College of Physicians-American Society of Internal Medicine, and European Federation of Internal Medicine, "Medical Professionalism in the New Millennium: A Physician Charter," *Annals of Internal Medicine* 136, no. 3 (2002): 243.

[1599] American Nurses' Association, "American Nurses Association: Code of Ethics for Nurses with Interpretive Statements," (2001), http://www.nursingworld.org/codeofethics (accessed March 14, 2013).

Provision 2 of the Code states: “The nurses’ primary commitment is to the patient, whether an individual, family, group, or community.”[1600] In 2007, the American Hospital Association published updated policies and guidelines in order to “strengthen community hospital relationships and to reassure patients, regardless of their ability to pay, of hospitals’ commitment to caring.”[1601] The three principles outlined by the American Hospital Association include: 1) “Treat all patients equitably and with dignity, respect, and compassion.” 2) “Serve the emergency health care needs of everyone, regardless of ability to pay.” 3) “Assist patients who cannot pay for part or all of the care they receive.”[1602]

Despite the congruence between the professionalism charter of physicians, the code of ethics of the American Nurses Association, and the American Hospital Association’s principles, triage out programs are implemented through these organizations and professionals. An important difference between triage out programs and many other measures that may limit care primarily to uninsured people, such as locating a hospital in an affluent area or limiting care to uninsured people who call a physician’s office, is that the patient requesting medical care is at the hospital and in front of a health care professional. How can the primacy of patient welfare be consistent with refusing care? This is one of the essential ways in which the triage out process challenges moral, professional, and organizational norms: Saying no to a request for help. In the words of ethicists Edmund Pellegrino and David Thomasma: “When a health care

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[1600] Ibid.

[1601] American Hospital Association, "Community Accountability and Transparency: Helping Hospitals Better Serve Their Communities," (2007), http://www.aha.org/content/00-10/07accountability.pdf (accessed March 14, 2013).

[1602] Ibid.

professional says, ‘Can I help you?’ that caregiver raises the expectation that he or she will help. The professional is morally obliged to meet that expectation.”[1603] This view has been expressed as well by John McArthur and Francis Moore: “The fundamental act of professional medical care is the assumption of responsibility for the patient's welfare—an unwritten contract assured by a few words, a handshake, eye contact denoting mutual understanding, or acknowledgment by the physician that 'We will take care of you.’"[1604] Triage out involves refusing care to a person who is present, is requesting care, and is located where care is readily obtainable and involves minimal further time or resources.

It turns out that there are many similarities, and some differences, between patient dumping in the pre-EMTALA era and the era of triage out programs. Table 4 summarizes these similarities and differences. This chapter has highlighted the instances in which commentators have expressed how patient dumping in the pre-EMTALA era and refusing care through triage out programs threatens the moral identity of health care professionals. Despite criticisms of EMTALA, however, it would be reasonable to assert that the law served to align legal and professional ethical norms. There are exceptions to this view, notably from Richard Epstein, a legal scholar who believes that “any hospital should be able to ‘just say no’ to any patient, without giving reasons for its decisions.”[1605] Epstein further states: “To the question, ‘you cannot let them die, can you?’ we have to avoid the reflexive answer, no.”[1606] In Epstein’s view, EMTALA “limits the freedom of a

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[1603] Pellegrino and Thomasma, *The Virtues in Medical Practice*: 38.

[1604] John H. McArthur and Francis D. Moore, "The Two Cultures and the Health Care Revolution. Commerce and Professionalism in Medical Care," *Journal of the American Medical Association* 277, no. 12 (1997).

[1605] Epstein, *Mortal Peril: Our Inalienable Right to Health Care?*: 103.

[1606] Ibid.

hospital to ration care inside its ER,"[1607] and it promotes "excessive risks" by those who know the costs of care for conditions related to illegal drugs, firearms, alcohol, and other self-inflicted harms will be "borne by others."[1608] Epstein warns against an "excess of sentimentalism."[1609] While it is not known whether Epstein's views are relevant to hospital policy, he is a Professor Emeritus of Law at the University of Chicago where he also is a Senior Fellow of the Center for Clinical Medical Ethics at the University of Chicago Medical School.[1610] This is the place, of course, where this chapter began.

[1607] Ibid., 95.

[1608] Ibid., 102.

[1609] Ibid., 99. Several authors have cautioned that making comparisons to Nazi era atrocities risks trivializing them by comparing them to current relatively mild transgressions. At the same time, there are risks to ignoring parallels to such profound acts of cruelty. The point I would like to make is that Epstein's view that letting some people die by refusing care in emergency departments if they have certain conditions and of avoiding sentimentalism does have parallels to the distortion of what it meant to care in Nazi Germany. Warren T. Reich, "The Care-Based Ethic of Nazi Medicine and the Moral Importance of What We Care About," *American Journal of Bioethics* 1, no. 1 (2001). Parallels have been drawn as well specifically to emergency department care where patients may be labeled as drug seekers or "frequent fliers," which can contribute to stigma and exclusion. Joel Martin Geiderman, "Ethics Seminars: Physician Complicity in the Holocaust: Historical Review and Reflections on Emergency Medicine in the 21st Century, Part II," *Academic Emergency Medicine* 9, no. 3 (2002).

[1610] University of Chicago, "The University of Chicago Law School: Faculty: Richard A. Epstein," University of Chicago Law School, http://www.law.uchicago.edu/faculty/epstein.

Table 4: Patient Dumping Similarities and Differences in the Pre-EMTALA Era and in Triage Out Programs

	Pre-EMTALA	Triage Out
Emergency conditions not treated	+	–
Nonurgent conditions not treated	?	+
Case law sets precedent for treatment	+	–
Uninsured disproportionately affected	+	+
Racial/ethnic minorities disproportionately affected	+	+
Implemented by hospitals, physicians, and nurses	+	+
Research provides evidence that questions practice	+	+
Criticized on moral grounds/threatens moral identity of profession	+	+
Patients sent away from private to public hospitals	+	–
Patients sent away from for profit, public, nonprofit, and teaching hospitals	–	+
Reasons asserted - financial	+	+
Reasons asserted - crowding	–	+
Reasons asserted – patients are better off	–	+

There are at least two circumstances in which a process that is similar to aspects of triage out programs would be morally justified. One instance is when care is provided in an emergency department fast track, which is a dedicated area in or next to the emergency department that is specifically designed and designated for patients with minor illnesses or injuries.[1611] The second is during a catastrophic public health emergency. Currently, the United States is not well prepared for disaster events. In order to improve preparedness for naturally occurring or manmade disasters, the Institute of Medicine has published guidance for the development of crisis standards of care. When crisis standards of care are necessary, an equitable process which is characterized by: "*Consistency*—in application across populations and among individuals regardless of their human condition (e.g., race, age, disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources)," is recommended.[1612] Furthermore, "ethical norms do not change during disasters—professionals remain obligated to providing the best care reasonable in these circumstances. The covenant between physician and patient gains rather than loses value in a crisis."[1613] Even under extreme circumstances, or perhaps especially under extreme circumstances, professional ethical norms are essential.

This leads to the question, when, if ever, may professional ethical norms be suspended? Do triage out programs fulfill the criterion of the best care reasonable under the circumstances? While the specifics of the triage out programs have already been described, the following reviews the process. Several authors have described triage out programs, which are sometimes named euphemistically, "referral of care" programs:

> Referral-of-care programs work something like this: A patient comes to the ED with a complaint deemed nonurgent after a normal triage evaluation. The patient goes to an exam room, where a provider either confirms his low-acuity status or

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[1611] Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*: 149.

[1612] Bruce M. Altevogt et al., eds., *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report* (Washington, DC: National Academies Press, 2009), 3.

[1613] Lawrence O. Gostin and Dan Hanfling, "National Preparedness for a Catastrophic Emergency," *Journal of the American Medical Association* 302, no. 21 (2009): 2365.

> re-triages him to the regular ED. Patients confirmed as nonurgent then see a financial counselor, who allows the patient to review the cost of care for the visit (generally around $150, the average hospital cost for a Level I ED visit). The patient may pay this amount or receive a referral for lower cost, more appropriate care.[1614]

At the public hospital in Texas, if a patient needed a prescription, this was not provided unless the patient paid an additional copayment. All patients were charged for the medical screening exam.[1615] Patients with health insurance must pay their insurance-required copayment, Medicaid patients do not have a copayment, and uninsured patients were required to pay $150.[1616] While the precise details of triage out programs may vary, in Houston, the process results in most patients with health insurance staying for further care and most uninsured patients not staying for further care. One physician who is the medical director of a group of emergency physicians, described what happens: "For every 10 people we have in the waiting room, our statistics show that seven will have insurance, and six of the seven will stay."[1617] In a large New Mexico hospital, a triage out program involves different alternatives for care once a nonurgent condition is diagnosed: "Cases that are non-emergent or non-urgent are sent to customer service representatives, called navigators, who then schedule an appointment for the patient to see a primary care physician within 12 to 24 hours; uninsured patients are connected to other care resources

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[1614] Seay, Straface, and Myers, "Counterpoint: Don Your White Hat! "

[1615] Nash, Nguyen, and Tillman, "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding."

[1616] Thompson, "UTMB Weighs First Month of ER Screening."

[1617] Editorial, "Ambulatory Care Quarterly: ED Screening Changes Put Pressure on Competitors."

within the community."[1618] Similarly, when HCA announced that its triage out process in the Gulf Coast region would be extended nationwide, the process was described:

> Non-emergent and non-urgent patients are shunted off to the registration department, where they can decide to stay for treatment but only if they pay. Patients with insurance must pay their insurance co-payment or deductible. Patients without insurance must pay a $150 facility fee up front. Non-emergent and non-urgent who decline to pay then leave without further treatment. [A chief executive] said some 40% of ER visits at HCA's Gulf Coast hospitals were classified as non-emergent or non-urgent, and only 1% of those decided to stay and pay for treatment.[1619]

What, if anything, is morally problematic about this process? In order to attempt to sort out this question, it may be helpful to understand that there are aspects of the process that differ from care in most other settings and there are aspects of the process that differentially affect patients based on ability to pay and insurance status. First, there are few, if any, settings in which a health care provider discontinues the process of a patient visit in order to send the patient to a financial counselor. For any patient, whether insured or uninsured, this process could compromise some essential aspects of the patient physician relationship. So, the question becomes: Is there anything morally problematic about discontinuing a health care visit prior to a final and agreed upon point in order to require payment? A visit has begun and a relationship has been established, a history and physical exam has occurred and a diagnosis has been established, but no treatment has been provided. Even among patients with the full expectation of paying for their visit, discontinuing care in the middle of a visit in order to require payment can be viewed as morally problematic. The interruption alters the priority from care of the patient to financial return for the health care provider. While there is general agreement that health

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[1618] ———, "Reducing Emergency Department Volume—and Costs," *Healthcare Financial Management Association* (2010), http://www.hfma.org/Content.aspx?id=3825 (accessed March 14, 2013).

[1619] Burda, "HCA Rolling out Emergency-Room Screening Program."

care providers and hospitals should be adequately compensated, it could be disconcerting, offensive, or upsetting to hold the prescription or other needed treatment hostage until the payment is made. There is some uncertainty as to how this actually occurs in triage out programs. For example, does the health care provider say: “All you need is a prescription but I will not give that to you until you pay?” In the hypothetical case that CMS described in order to explain that EMTALA does not require further treatment when a condition is not deemed an emergency, where a woman with sutures does not have them removed, CMS did not specifically address a situation in which treatment was withheld unless a payment was made.

There is little known about how patients perceive triage out programs, yet a process that could be viewed as disconcerting, offensive, or upsetting is concerning. What is more concerning is that the process could be viewed as intimidating because it does hold the final treatment hostage. All that stands between the simple and easily resolvable health problem is immediate payment. Requiring a payment upfront or at the end of a visit is less likely to convey the same propensity for intimidation. Intimidating behavior is not rare and is well documented in health care settings.[1620] Related to the propensity for intimidation, the triage out process seems highly paternalistic when the patient is left out of sharing in the decision of when to receive the recommended treatment, such as a prescription. The triage out process is counter to patient centered

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[1620] Institute for Safe Medication Practices, "Intimidation: Practitioners Speak up About This Unresolved Problem: Part 1," March 11, (2004), https://ismp.org/Newsletters/acutecare/articles/20040311_2.asp (accessed March 14, 2013). Theresa Zimmerman and Geri Amori, "The Silent Organizational Pathology of Insidious Intimidation," *Journal of Healthcare Risk Management* 30, no. 3 (2011).

care, which is responsive to patients' preferences, needs, and values, and encourages shared decision making.[1621]

The few comments by patients that have been expressed about triage out programs are about feelings and emotions. Dantae's mother was "hurt," the man in Denver "felt like Neanderthal man," and the patients interviewed there were frustrated and felt they were discriminated against because of insurance status.[1622] Patients generally are much more likely to judge physicians based on interpersonal skills reflected in behaviors that convey a commitment to "genuinely being of service," rather than technical skills.[1623] The triage out process may or may not foster technically competent care but the process does not seem to foster compassion. Compassion is widely considered to be an essential professional virtue. It can be defined as "a trait that combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness, and discomfort at another's misfortune."[1624] Compassion "combines a response to the distress of others and a desire to alleviate that distress."[1625] It is morally problematic to have a process in which a health care provider does not act to alleviate distress, particularly when the provider has actively

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[1621] Institute of Medicine Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).

[1622] Grotto, "Mauled by Dog, Kid Sent Home by ER." Austin, "Hospitals Turn Away Ill, Injured." Diesburg-Stanwood et al., "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services."

[1623] Neeli M. Bendapudi et al., "Patients' Perspectives on Ideal Physician Behaviors," *Mayo Clinic Proceedings* 81, no. 3 (2006).

[1624] Beauchamp and Childress, *Principles of Biomedical Ethics*: 32.

[1625] Beth A. Lown, Julie Rosen, and John Marttila, "An Agenda for Improving Compassionate Care: A Survey Shows About Half of Patients Say Such Care Is Missing," *Health Affairs* 30, no. 9 (2011).

sought the necessary information and performed a physician examination and determined what the appropriate action is and that it requires minimal further effort.

The triage out process is also morally problematic because it undermines trust. Trust pertains to people as when a person is said to be trustworthy and trust also pertains to institutions, such as hospitals. A patient may distrust health care providers and institutions but some degree of trust is necessary in order to seek medical care. Broadly, this trust can be defined as “the belief that some entity will act in one’s interest in the future, trust then requires the perception that the entity is capable of doing what is needed (technical competence) and the perception that the entity wants to do what is needed (value congruence).”[1626] While there may be some question of a betrayal of trust insofar as judgments about whether a condition is an emergency are known to be fallible and subject to bias, primarily the betrayal of trust is the failure to want to do what is needed. Withholding the final prescription or removal of sutures, both of which require little time and little in other resources is a betrayal of trust in this sense.

There is another sense in which the triage out process is a betrayal of trust. As already mentioned, the motive of the process has been described as discouraging future use of the emergency department by the uninsured in a community.[1627] Other comments have clearly indicated that the process is partly about teaching people a lesson. For example, in Houston, an administrator stated: “Accessing the emergency room for the sniffles is not appropriate. We will be teaching people to navigate our system and use our

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[1626] Judy A. Shea et al., "Development of a Revised Health Care System Distrust Scale," *Journal of General Internal Medicine* 23, no. 6 (2008): 727.

[1627] Bitterman, "EMTALA and the Ethical Delivery of Hospital Emergency Services."

clinics."[1628] Several emergency physicians have stated: "On leaving an [emergency department] with a referral-of-care program, the patient has no sense of finality, no discharge papers to make her feel she has resolved her situation. Sending her out to obtain care from an appropriate source encourages her to address her medical condition responsibly."[1629] Annette Baier, in her analysis of trust, carefully delineates *what* is entrusted. In the emergency department, such trust involves technically competent care and compassionate care. When a patient reveals information about the medical condition for which care is sought and undergoes a screening examination, what is entrusted is care for that condition. If a trusted health care professional instead takes an action that is directed at changing future behavior, this fails to address what was entrusted. On Baier's analysis, specifying "what good was in question" helps us to see why "intrusive, presumptuous, and paternalistic [actions] disappoint rather than meet the trust one has in such circumstances."[1630] While health care providers often have a legitimate role in affecting future behavior, this should come about through a caring provider patient relationship which attends to the condition for which care is sought.

In a seminal article elucidating the ideal physician patient relationship, the authors condemn an "instrumental model. In this model, the patient's values are irrelevant; the physician aims for some goal independent of the patient, such as the good of society or furtherance of scientific knowledge…[T]his model is not an ideal but an aberration."[1631]

[1628] Murphy, "Harris County to Limit Emergency Room Access."

[1629] Seay, Straface, and Myers, "Counterpoint: Don Your White Hat! "

[1630] Annette Baier, "Trust and Antitrust," *Ethics* 96 (1986): 238.

[1631] Ezekiel J. Emanuel and Linda L. Emanuel, "Four Models of the Physician-Patient Relationship," *Journal of the American Medical Association* 267, no. 16 (1992): 2222.

Teaching a lesson is a goal independent of the patient when the patient's medical condition is not addressed. Other goals independent of the patient are reducing crowding, improving quality for other patients, and decreasing health system costs in instances where the patient's medical condition is not addressed. [1632]

Emergency department crowding has been associated with a greater risk of medical errors and reduced access and quality of care, particularly for patients with life-threatening emergencies.[1633] As detailed in this chapter, however, emergency department crowding is not primarily caused by patients with nonurgent conditions. Care of patients in critical condition is often claimed to have been harmed by patients with nonurgent conditions when care of nonurgent patients is linked to crowding. Recent authors have pointed out that these nonurgent visits were the "whipping boy" of crowding since at least the 1980s even though the evidence then and now does not support this view.[1634] One of the problems with scapegoating patients with nonurgent conditions and implementing triage out programs is that it deflects attention and effort away from the proven measures that prevent crowding, such as decreasing the time for an admitted patient to be transferred to the inpatient bed.[1635] While triage out programs may claim to be concerned about health care quality, quality measures often do not include information on the patients who are triaged out. Steven Woolf has proposed that lapses in caring are a quality issue affecting more people than individual medical errors or system flaws. He

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[1632] Seay, Straface, and Myers, "Counterpoint: Don Your White Hat! "

[1633] Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*.

[1634] John C. Moskop et al., "Emergency Department Crowding, Part 1--Concept, Causes, and Moral Consequences," *Annals of Emergency Medicine* 53, no. 5 (2009): 606.

[1635] Jonathon S. Olshaker, "Managing Emergency Department Overcrowding," *Emergency Medicine Clinics of North America* 27, no. 4 (2009).

proposes that the current interest in quality improvement as it relates to patient safety should be expanded to include lapses in caring in order to have a much greater impact on the health of Americans. Lapses in caring are defined as:

> [U]nsatisfactory care resulting not only from failure to meet normative benchmarks for quality…but also from experiences that leave patients feeling uncared for, affecting them in domains that are less easily measured (for example, feeling unheard, rushed, inconvenienced, or humiliated; or being unable to access desired information, instruction, or reassurance).[1636]

Furthermore, the triage out process described in many publications in the media is not internally consistent with the goal of reducing crowding. Since any patient who has the ability to pay, and especially those with health insurance and, therefore, a significantly lower copayment, may remain in the emergency department for treatment, the result is that patients who are uninsured and cannot pay the fee are repelled.[1637] The triage out process combines the paternalism of acting to change future behavior with the notion of autonomy conceived of as the "choice" that patients make when they cannot pay a large copayment. According to several emergency physicians: "The patient is *never* turned away: The patient *chooses* to seek other medical care or to stay and pay for the treatment of his non-emergency complaint."[1638] As Uwe Reinhardt, a health economist, has noted: "[T]o tell an uninsured single mother of several sickly children that she is henceforth empowered to exercise free choice in health care with her meager budget is not necessarily a form of liberation, nor is it efficient in any meaningful sense of that

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[1636] Steven H. Woolf, "Patient Safety Is Not Enough: Targeting Quality Improvements to Optimize the Health of the Population," *Annals of Internal Medicine* 140, no. 1 (2004).

[1637] Connolly, "Some Finding No Room at the ER." Manning, "St. Joseph Hopes Fee Will Reduce Minor ER Visits." Murphy, "Harris County to Limit Emergency Room Access."; Editorial, "Ambulatory Care Quarterly: ED Screening Changes Put Pressure on Competitors."

[1638] Seay, Straface, and Myers, "Counterpoint: Don Your White Hat!"

term. It is rationing by income class."[1639] Regarding patients "as autonomous informed decision makers who are well equipped to negotiate their own care," is common and is associated with failures to receive treatment that physicians and patients agree upon.[1640]

While there is widespread agreement that health care costs are too high and that costs matter morally, publications on triage out programs have not satisfied the initial criteria that, if a cost containment measure is undertaken, it should reduce cost. There are multiple conjectures that triage out programs will, or do, reduce cost. A publication on the American College of Emergency Physicians website goes as far as to say: "It is, however, a legitimate right of the institution to limit non-emergency care if it affects the solvency of the hospital (no margin, no mission) in the name of the ethical principle of Justice (sic)."[1641] There is no consensus on the costs of care for nonurgent visits.[1642] Even more relevant, none of the studies that have been done have tried to assess the cost of a visit after the medical screening exam. This cost, for instance, would be the specific cost of writing a prescription or removing sutures, when these are the actions that are withheld in triage out programs. The moral dimensions of cost containment include that the institutions or providers implementing them should be accountable for health outcomes.[1643] There are few data on the health outcomes of patients who have been

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[1639] Uwe E. Reinhardt, "Economics," *Journal of the American Medical Association* 275, no. 23 (1996): 1804.

[1640] Nina A. Bickell et al., "Missed Opportunities: Racial Disparities in Adjuvant Breast Cancer Treatment," *Journal of Clinical Oncology* 24, no. 9 (2006): 2520.

[1641] American College of Emergency Physicians, "Medical Screening of Emergency Department Patients."

[1642] DeLia and Cantor, "Emergency Department Utilization and Capacity."

[1643] Larry R. Churchill, "What Ethics Can Contribute to Health Policy," in *Ethical Dimensions of Health Policy*, ed. Marion Danis, Carolyn M. Clancy, and Larry R. Churchill (New York, NY: Oxford University Press, 2002).

triaged out, but the data that is available shows that there are clearly health risks.[1644] Notably, proponents of triage out programs often assert that benefits of these programs accrue to the patients who remain in the emergency department. The problem is not only that this assertion is countered by the data available, but also that a benefit-cost analysis is “highly suspect if the benefits and costs in question do not accrue to the same persons.”[1645]

As already detailed, triage out programs in the published literature shown in Table 2 demonstrate that the people affected are primarily low income and racial or ethnic minorities. Disparities in health care are morally problematic and, as already discussed, these may arise from the same historical trends that led to the implementation of EMTALA, from the fallibility of triage decisions, from the fast-paced environment of the emergency department, from cost sharing strategies, from negative attributions about patients with nonurgent conditions, and from unconscious bias and stereotyping. Triage out programs raise the question of whether such programs institutionalize bias. At the institutional level, “inaction in the face of need” has been suggested as constitutive of institutionalized racism.[1646] Because compassion encompasses the desire to alleviate distress and trust involves the belief that a person or institution wants to do what is needed, the failure to respond in terms that patients agree upon in triage out processes is morally problematic. Beyond institutionalizing bias, there is a question of whether the triage out process could actually amplify, or enliven bias and stereotyping of patients on

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[1644] See Table 2.

[1645] Reinhardt, "Economics," 1803.

[1646] Camara Phyllis Jones, "Levels of Racism: A Theoretic Framework and a Gardener's Tale," *American Journal of Public Health* 90, no. 8 (2000): 1212.

the basis of socioeconomic status, health insurance status, nonurgent status, or by race or ethnicity. In a 2007 Washington Post article, a physician who was vehemently opposed to the implementation process “came around,” as did a nurse. The nurse now gets “mad” at patients with nonurgent conditions.[1647] Initial reluctance at implementing triage out programs by the providers who will be putting the process into practice is common.[1648] How do these professionals overcome their sense that the process is wrong and what does this mean for anyone presenting for care in the emergency department? To the extent that virtues such as compassion and trustworthiness are habits or dispositions, there is the concern that providers may not be able to simply turn these traits off and on.[1649]

In the case of the nurse who now is angry at nonurgent patients, one concern is that anger is known to increase stereotypical responses. Attitudes of health care providers toward poor patients, minority patients, and nonurgent patients are known to be subject to negative appraisals. Despite the emphasis on nonjudgmental egalitarianism in health care settings, moral appraisals by health care providers are pervasive and often center on deserving or undeserving groups.[1650] Patients are exquisitely sensitive to whether physicians like them and demonstrate empathy or compassion. These affective components of visits are complex and mediated reciprocally. While the effects of conveying positive regard may be difficult to assess in many dimensions, appropriate expressions of caring concern do affect health outcomes and even health costs in a

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[1647] Connolly, "Some Finding No Room at the ER."

[1648] Nash and Tillman, "Screening out Does Little to Address ED Overcrowding: Author Response." Connolly, "Some Finding No Room at the ER."

[1649] Pellegrino and Thomasma, *The Virtues in Medical Practice*.

[1650] Terry E. Hill, "How Clinicians Make (or Avoid) Moral Judgments of Patients: Implications of the Evidence for Relationships and Research," *Philosophy, Ethics, and Humanities in Medicine* 5 (2010).

positive manner and in measurable ways.[1651] Conversely, when poverty or minority status leads to stigmatized views of particular patients, there are negative health consequences.[1652] People living in poverty have reported that the stigma they perceive defines their "moral worth as a human being" and that both stigma and lack of resources harm health.[1653] This information suggests that what is morally at stake with triage out programs for patients and providers can be subtle, yet powerful.

Defenders of the triage out process have sometimes used the notion of distributive justice in terms of allocation of funds as a moral framework but have not accounted for justice in broader terms of fairness.[1654] Disparities in health care access and quality in the United States based on socioeconomic status and minority status have not improved since national tracking of this information began in 2002.[1655] There is often a question of whom or what is accountable for disparities in health care.[1656] These facts should mean that implementing programs that raise the possibility of worsening disparities in care ought to be scrutinized. Considerations of fairness in the provision of health care across low income and racial and ethnic minority groups "matters not only

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[1651] Debra Roter and Judith A. Hall, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, 2nd ed. (Westport, CT: Praeger, 2006). Lown, Rosen, and Marttila, "An Agenda for Improving Compassionate Care: A Survey Shows About Half of Patients Say Such Care Is Missing."

[1652] Hill, "How Clinicians Make (or Avoid) Moral Judgments of Patients: Implications of the Evidence for Relationships and Research."

[1653] Linda I. Reutter et al., ""Who Do They Think We Are, Anyway?": Perceptions of and Responses to Poverty Stigma," *Qualitative Health Research* 19, no. 3 (2009): 308.

[1654] American College of Emergency Physicians, "Medical Screening of Emergency Department Patients."

[1655] Peter A. Clark, "Prejudice and the Medical Profession: A Five-Year Update," *Journal of Law, Medicine & Ethics* 37, no. 1 (2009).

[1656] Jan Blustein, "Who Is Accountable for Racial Equity in Health Care?" *Journal of the American Medical Association* 299, no. 7 (2008).

because medical care influences people's health and well-being, thereby expanding their life possibilities; it matters because provision of medical care affirms people's belonging to a society—and their humanity and dignity as community members and citizens."[1657] All Americans will rely on fairness during a public health emergency, making the question of whether an emergency department process is fair relevant for everyone.

There are other important moral implications of triage out programs that pertain to the organizational level and the ways in which organizational culture affects interactions at the individual level. The physicians and nurses who express reluctance to implement the programs, at least initially, are subject to a variety of organizational constraints in maintaining opposition to such programs. Organizational silence is a term that has been used to describe a variety of settings where factors such as the tendency toward conformity and devaluing dissenting views contributes to maintaining practices that are harmful to patients. Two authors have described what can happen in a hospital setting that is relevant to triage out programs: "The irony is that out of deference to existing authority gradients and a desire to maintain harmonious working relationships with colleagues, providers suppress their concerns about doing the right thing."[1658] Other factors that may be relevant to triage out programs are the tendency to oversimplify and to homogenize issues into acceptable terms.[1659] Researchers have proposed that the fundamental importance of caring relationships in health care is profoundly affected by organizational structures. These structures can inhibit interpersonal care: "Any social,

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[1657] Ana I. Balsa et al., "Clinical Uncertainty and Healthcare Disparities," *American Journal of Law & Medicine* 29, no. 2-3 (2003): 217.

[1658] Kerm Henriksen and Elizabeth Dayton, "Organizational Silence and Hidden Threats to Patient Safety," *Health Services Research* 41, no. 4, Part 2 (2006): 1540.

[1659] Ibid.

organizational, administrative, and financial arrangements within practice settings that contribute to distancing physicians from their patients will result in tendencies to dehumanize them and will ultimately diminish the physicians' competence to heal."[1660] On the other hand, changing organizational structure in ways that promote caring and compassion may have a more positive impact than changing individual physician behaviors.[1661] Put simply, "if an organization's systems are not what they should be, then *even* good people may be hindered from doing their best—and may sometimes be led to do much *worse* than they could do."[1662]

In the case of triage out programs, oversimplification of the problems to be addressed and carelessness in the assessment of outcomes combine in pernicious ways. Nonurgent patients come to be viewed as threats to patients with emergency conditions, threats to individual physician's financial well-being, and threats to the financial solvency of the hospital. That the patients not treated also happen to be members of disadvantaged groups hardly seems relevant. Moreover, once a policy or practice is in place, and as more organizations engage in the practice, "its legitimacy increases and it becomes an industry norm."[1663] Concerning triage out programs, some emergency physicians have described that:

> [T]he approach may be setting in across emergency medicine, and if so, it threatens to alter the specialty…This happens where there is general acceptance

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[1660] Robert A. Scott et al., "Organizational Aspects of Caring," *Milbank Quarterly* 73, no. 1 (1995): 81.

[1661] Ibid.

[1662] David T. Ozar, "Finding a Voice. Like Individuals, Organizations Are Moral Speakers and Actors," *Health Progress* 87, no. 6 (2006).

[1663] E. Jose Proenca, Michael D. Rosko, and Jacqueline S. Zinn, "Community Orientation in Hospitals: An Institutional and Resource Dependence Perspective," *Health Services Research* 35, no. 5, Part 1 (2000): 1027.

> of approaches and procedures once considered risky or unworkable 'so that you become immune over time to things that once would have alarmed you.'[1664]

Confusion about the goals of the triage out programs makes it difficult to offer alternatives, to recognize if the programs are achieving their purpose, or to revise them.

Unlike the pre-EMTALA era when public hospitals seemed to champion the cause of safe and nondiscriminatory care of poor and minority patients for emergency conditions, triage out programs have been undertaken by all types of hospitals and, as shown in Table 2, publications in the medical literature are from public or nonprofit teaching hospitals. The triage out process is surprisingly similar among for-profit, public and nonprofit hospitals: Care for nonurgent conditions is available but only if payment occurs prior to treatment. The fact that safety net providers, such as public and large teaching hospitals, engage in practices that rival their market oriented counterparts is well documented.[1665] Considerable changes as a result of the Affordable Care Act are expected with safety net advocates expressing the opinion that "a robust safety net system may offer the best chance of providing quality care to those excluded from health reform and those who newly acquire health insurance."[1666] On the other hand, triage out programs in public and large nonprofit teaching hospitals provide further evidence that

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[1664] Anne Scheck, "U of C Backs Off ED Cuts, but Still Plans to Redirect Patients," *Emergency Medicine News* XXXI, no. 6 (2009): 24.

[1665] See the following for examples. Weissman, "The Trouble with Uncompensated Hospital Care."; Gloria J. Bazzoli et al., "The Influence of Health Policy and Market Factors on the Hospital Safety Net," *Health Services Research* 41, no. 4, Part 1 (2006). J. D. Kleinke, "Deconstructing the Columbia/HCA Investigation," *Health Affairs* 17, no. 2 (1998). Steiner et al., "Managed Care for Uninsured Adults: The Rise and Fall of a University-Based Program." Martinez, "Safety Net Frays as Hospitals Shift Resources from Poor." Bruce Siegel, Marsha Regenstein, and Peter Shin, "Health Reform and the Safety Net: Big Opportunities; Major Risks," *Jounal of Law Medicine and Ethics* 32, no. 3 (2004).

[1666] Mitchell H. Katz, "Future of the Safety Net under Health Reform," *Journal of the American Medical Association* 304, no. 6 (2010): 680.

these safety net institutions are not necessarily serving as advocates or as a voice for the poor and disadvantaged.[1667]

Another issue that becomes shrouded by the confusion in the goals and purposes of triage out programs has to do with their legal implications. It seems to be a relatively settled matter that EMTALA does not prohibit triage out programs. As already detailed in this chapter's section on the 2003 Final Rules issued by CMS, "hospitals' EMTALA obligations end at the point at which no emergency is found to exist, using non-discriminatory examination procedures."[1668] At the same time, legal scholar Sara Rosenbaum makes the point that "EMTALA effectively leads to the establishment of a provider/patient relationship, which then gives rise to a legal duty of professionally reasonable care…where none might have existed in the absence of a provider/patient relationship."[1669] For patients with nonurgent conditions, EMTALA opens the door to the emergency department in creating the provider/patient relationship, which, particularly for uninsured patients, might not have happened without the law. A second misconception is that although it is also relatively settled that the mere fact that something is legal or illegal does not make it moral or immoral, proponents of triage out programs rarely go beyond the merely legal.[1670] For example, health care providers are not legally barred from yelling at coworkers, making condescending remarks, or using abusive language. It is, however, unprofessional as well as unethical to behave in these

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[1667] Colleen M. Grogan and Michael K. Gusmano, "Political Strategies of Safety-Net Providers in Response to Medicaid Managed Care Reforms," *Journal of Health Politics, Policy & Law* 34, no. 1 (2009).

[1668] Sara Rosenbaum and Brian Kamoie, "Finding a Way through the Hospital Door: The Role of EMTALA in Public Health Emergencies," *Journal of Law, Medicine & Ethics* 31, no. 4 (2003): 592.

[1669] Ibid.

[1670] Jeremy Sugarman and Daniel P. Sulmasy, *Methods in Medical Ethics* (Washington, DC: Georgetown University Press, 2001), 8.

ways in the health care setting and the Joint Commission now requires hospitals to have policies to address disruptive behavior.[1671] In other words, in the case of triage out programs, there is more at stake than whether the processes are legal under EMTALA.

Conclusion

The relationship between emergency department care and charity care has several dimensions. The symbolic power of reassuring images of care in emergency departments and charity care serves in profound ways to bolster the belief that all Americans can get the health care they need and that transactions and interactions in health care occur as a result of moral commitments. Emergency department care and charity care are also linked historically through the Hill-Burton amendments and through a long struggle to clarify a duty to treat. When EMTALA was enacted, it was seen by many observers as saving the moral foundations of medicine. At the same time, the law fueled a backlash because direct funding was not part of EMTALA. The rhetoric of an unfunded mandate and coerced charity completely overshadows the fact that hospital uncompensated care has remained remarkably stable at about 6 percent of revenue since prior to EMTALA's enactment; only about 1 percent of emergency patients receive charity care each year since this data has been collected beginning in 1992; uncompensated care is attributable primarily to people with health insurance in multiple studies; there are several sources of funds for uncompensated care; and uninsured people on the whole pay for emergency care at a rate that is similar to people with private health insurance. EMTALA does not require charity; the law only provides for the *possibility* of charity care.

[1671] Joint Commission, "Behaviors That Undermine a Culture of Safety," no. 40 (2008), http://www.jointcommission.org/assets/1/18/SEA_40.PDF (accessed March 14, 2013). Alan H. Rosenstein and Bruce Naylor, "Incidence and Impact of Physician and Nurse Disruptive Behaviors in the Emergency Department," *Journal of Emergency Medicine* (2011).

Triage out programs are at least in part a result of a backlash from EMTALA. Triage out programs and the care of emergency patients in the pre-EMTALA era share a degree of unconcern for patient welfare and they also share the groups of patients who are affected: low income, uninsured, disproportionately racial and ethnic minority patients. Triage out programs and care of emergency patients in the pre-EMTALA era differ in the level of acuity of the patient and the type of hospital implementing the programs. In implementing triage out programs, the utterly real and complex problems of emergency department crowding, unreimbursed costs, and lack of affordable and accessible primary care somehow all boil down to one set of culprits and one solution. To the extent that triage out programs are viewed as problematic on moral and professional grounds by those institutions and professionals implementing the programs, there is some suggestion that, if only there was enough money, ethical standards could be adhered to.

What can be done to call attention to the many questions that should be asked about triage out programs? There are at least three ways that questions about triage out programs could be addressed. The first is by obtaining more information. If the National Hospital Ambulatory Medical Care Survey included questions on the number of triage out programs and the demographic information on the patients who are triaged out, then a great deal more would be known about the process. If large studies were done on the health outcomes of patients who are triaged out, then knowledge of the safety or harms could be based on much better data. Second, the need to increase the accountability and transparency of charity care provided by hospitals has been recognized for many years. While some of the transparency and accountability of hospitals in regard to charity care will improve as the Affordable Care Act is implemented, there are still steps to be taken in the enforcement process. Also, the Affordable Care Act only addresses nonprofit hospitals' charity care and community benefit, leaving public hospitals and for-profit hospitals less accountable even after its implementation.[1672] Increasing the transparency and accountability of all hospitals with clear methods of enforcement are needed. Third, ethical analysis of triage out programs has received comparatively little attention. Thus far, even strongly worded disapproval in emergency medicine ethics statements seems to have had little effect on the programs. This chapter may add to an understanding of the moral implications of triage out programs, primarily through considering the moral harms to patients and providers of the loss of compassion and trust, and by the ways in which the programs can amplify and act in synergistic ways, to magnify bias and stereotyping of poor and minority patients. More interest in elucidating the ethical significance of triage out programs is needed, however. Once the number of people enrolled in Medicaid increases, as it is expected to do in 2014, there will likely be even greater pressure to implement triage out programs.[1673] A related concern to that of calling attention to questions about triage out programs is that proven measures to improve crowding should be put into operation and enforced by regulatory means.[1674]

From a larger perspective, the relationship between emergency department care and charity care demonstrates that patients, providers, and the public can be blinded to

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[1672] *Patient Protection and Affordable Care Act*, § 9007. Community Catalyst, "Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-Profit Hospitals." There have been delays in the requirements for nonprofit hospitals. Strom, "Congress Questions the IRS About Delays in Its Oversight of Nonprofit Hospitals."

[1673] Weinick, Burns, and Mehrotra, "Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics."

[1674] Handel et al., "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals." Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, *Hospital-Based Emergency Care: At the Breaking Point*.

details because of the powerful images associated with charity. The safety valve effect of charity and emergency department care may let off enough steam to dampen enthusiasm for changes. Triage out programs seem to also demonstrate, in a concrete way, the limits of what can be expected from charity. Simply put, charity as a symbol or as a practice is unable to create the kind of solidarity that is needed in health care.

Chapter 4: Hospital Charity Care

Carlos Ferlini worked in his own business near Los Angeles installing and repairing gutters. He made a decent living and paid all his bills until a tragic accident occurred. In February 2006, Ferlini fell off a roof and was rushed to Providence St. Joseph's Medical Center. St. Joseph's is a Catholic nonprofit hospital where he stayed for eighteen days, fourteen in intensive care, for a fractured skull and ribs and a punctured lung.

Unfortunately, Mr. Ferlini was uninsured.[1675] Like many self-employed workers, individually-purchased insurance was unaffordable.[1676] The hospital bill, however, was not just unaffordable; it was shocking, almost a quarter of a million dollars. The story of Carlos Ferlini's tragic accident was reported on by the television news show, *60 Minutes*. A community activist in Los Angeles helped Ferlini to determine that an average insurance company would have paid $50,000 for the same care that Ferlini received. When *60 Minutes* contacted St. Joseph's Medical Center after the story of Carlos Ferlini aired, the hospital said that Ferlini qualified for their charity care program.[1677]

Marijon Binder, a sixty-two year old woman, was rushed in 2001 from a convention center trade show for people who work with the disabled to Resurrection Medical Center, a Catholic nonprofit hospital in Chicago, because chest pain and shortness of breath had incapacitated her. The story was detailed in a book by Jonathon

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[1675] Daniel Schorn, "Hospitals: Is the Price Right?" April 20, (2006), http://www.cbsnews.com/stories/2006/03/02/60minutes/main1362808.shtml (accessed March 14, 2013).

[1676] In 2006, 6.6 percent of Americans purchased individual health insurance. Elizabeth A. November et al., "Individual Insurance: Health Insurers Try to Tap Potential Market Growth," *Center for Studying Health System Change Research Briefs*, no. 14 (2009). Potential purchasers of individual policies are predominantly low income. In 2003, a healthy person with an income at 200 percent of the federal poverty level would have to pay almost 15 percent of their income in premiums. Melinda B. Buntin, M. Susab Marquis, and Jill M. Yeglan, "The Role of the Individual Health Insurance Market and Prospects for Change," *Health Affairs* 23, no. 6 (2004).

[1677] Schorn, "Hospitals: Is the Price Right?"

Cohn.[1678] Binder stayed for two days at the hospital and received a bill for $11,000. Although she said she had clearly written on her admission form that she was uninsured and filled out a financial assistance application, the hospital disputed this. When the hospital bill arrived, she called the billing department and she was told that the financial assistance process was slow and would eventually be worked out. The hospital also disputed this and said there was no record of her call. A year later, Marijon Binder was served with a court summons; she was being sued by Resurrection Medical Center.

What attracted some attention was that Marijon Binder had spent most of her life as a Catholic nun. She had taught school in San Francisco and was sent to Chicago by her religious order because of her professional textbook writing. In Chicago she eventually became involved with helping elderly people keep their pets and she founded a nonprofit organization dedicated to that cause. When one of the organizations' volunteers developed health problems, Binder became her caretaker, which resulted in severing her ties to the Catholic order. After receiving the subpoena, Binder went to Resurrection asking if her status as a former nun would make her eligible for charity or, with the documentation of her limited income, if this would make her eligible. The answer was no on both accounts. The answer was no despite the detailed documentation that Marijon Binder provided on her finances, which showed that she and her elderly friend were both living in subsidized housing on her friend's social security and pension and that their bank account had about forty dollars remaining at the month's end. Binder then contacted Resurrection's attorneys who told her that unless she could make payments of at least $100 a month, she was going to court. Many months and court appearances later, in 2003, after filing her own brief with the court, Marijon Binder's debt was ruled absolved by the judge at her hearing.[1679]

[1678] Jonathan Cohn, *Sick : The Untold Story of America's Health Care Crisis--and the People Who Pay the Price* (New York, NY: HarperCollins Publishers, 2007).

[1679] Ibid., 141-165.

Resurrection Medical Center maintained that it made financial assistance available to people who applied and “that many of the people who wanted assistance didn’t really need it—and that even those who did need it often refused to cooperate when the hospital tried to help.”[1680] Yet, the attention directed nationwide on nonprofit hospitals’ lack of available charity care, inflated charges directed at uninsured people, and aggressive collection practices were the subject of several lawsuits and Congressional hearings.[1681] In 2009, Resurrection Medical Center reached a settlement agreement in a multimillion dollar class-action lawsuit that had been filed in 2004 on behalf of uninsured patients. Without admitting wrongdoing, Resurrection sent notices to over 220,000 patients treated from 2001 informing them that, if their income is less than the federal poverty level, they are eligible for free care; for people with income up to twice the federal poverty level, the discount is 80 percent of the bill. No uninsured person will be charged more than 10 percent of their annual income, if their income is up to 400 percent of the federal poverty level.[1682] Sister Carol Keehan, president of the Catholic Health Association of the United States in 2006 said that a small number of Catholic hospitals have been accused of overly aggressive collection practices. These practices, she said, "resulted more from inattention than from a deliberate decision to hound poor people."[1683]

[1680] Ibid., 158.

[1681] House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *A Review of Hospital Billing and Collections Practices*, 108th Congress, 2nd sess., June 24, 2004. Ellen Moskowitz, "Recent Developments in Health Law: Class Action Suits Allege Improper Charitable Care Practices," *Journal of Law, Medicine & Ethics* 33, no. 1 (2005). Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing." Beverly Cohen, "The Controversy over Hospital Charges to the Uninsured--No Villains, No Heroes," *Villanova Law Review* 51 (2006).

[1682] Claire Bushey, "Resurrection Settles Multimillion-Dollar Lawsuit," *Chi Town Daily News*, January 14, 2009. Judith Graham, "Hospital Lawsuit Settlement May Help Tens of Thousands of Uninsured Patients," *Chicago Tribune*, January 14, 2009.

[1683] Robert Pear, "Nonprofit Hospitals Face Scrutiny over Practices " *New York Times*, March 19, 2006.

Despite the attention of federal and state lawmakers, the people who might reasonably be considered among those eligible for hospital charity care seem to continue to face a multitude of problems getting such care and the situation is increasingly complex. Recently, for example, the antipoverty group Community Service Society of New York released a report detailing lack of compliance with state law regarding financial assistance programs among over two hundred hospitals.[1684] The New York Times interviewed several people who were not offered a chance to complete a financial aid application before their bills were handed over to a collection agency. For example, Myrlene Stimphil, a nurse and mother of an adult disabled son, and her husband, are trying to delay foreclosure after a New York hospital placed a lien on their home for over $40,000. She has tried to seek a reduced payment but was told that the hospital would "get back to her." Meanwhile, her son, who is brain damaged from a premature birth, has been receiving phone calls from a collection agency. The hospital where her son was treated received over ten million dollars from the state charity care pool in 2010. As a condition of receiving funds through the pool, hospitals are required by state law to have publicly available written financial assistance policies and procedures and hospitals are not permitted to foreclose on a patient's home while the financial assistance application is pending. The report by the Community Service Society shows that two-thirds of the hospitals did not comply with aspects of the law, yet the hospitals still received funds through New York's Indigent Care Pool.[1685]

Carlos Ferlini, Marijon Binder, and Myrlene Stimphil, are a few of the many people who have struggled with hospital charity care. Though these stories may briefly

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[1684] Elisabeth R. Benjamin, Arianne Slagel, and Carrie Tracy, "Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program," (2012), http://www.cssny.org/userimages/downloads/IncentivizingPatientFinancialAssistanceFeb2012.pdf (accessed March 14, 2013).

[1685] Nina Bernstein, "Hospitals Flout Charity Aid Law," *New York Times*, February 12, 2012. See also *Hospital Financial Assistance Law*, New York Public Health Law (2006), §2807-k.

raise eyebrows, in general it is concern about the welfare of hospitals that has driven policy decisions and the flow of government funds to support charity care. There are several recent developments that have already been implemented, or will be soon, that will likely have an impact on the provision of charity care by hospitals. Health care reform through the Affordable Care Act (ACA) is the biggest factor impacting hospital charity care. The law includes provisions which are projected to substantially decrease hospital charity care. The Affordable Care Act also includes protections for patients at nonprofit hospitals who are financially unable to pay for all or part of their care.[1686]

Prior to the passage of the Affordable Care Act, changes in how hospitals report charity care changed significantly in three federal agencies. The Internal Revenue Service (IRS) increased the financial reporting requirements of nonprofit hospitals regarding charity care and other community benefits beginning with 2009 filings and further revisions to the reporting requirements to the IRS were made by the Affordable Care Act.[1687] Also beginning in 2009, the Centers for Medicare and Medicaid Services (CMS) implemented new audit rules concerning the Medicaid Disproportionate Share Hospital (DSH) program which standardize reporting of costs for uninsured patients.[1688] Only hospitals that participate in the Medicaid DSH program are subject to the new audits. All hospitals that participate in Medicare and Medicaid, however, must file a Medicare Cost Report each year. CMS completely redesigned the part of the Medicare Cost Report that provides details on charity care.[1689] In combination these changes have the potential to

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[1686] *Patient Protection and Affordable Care Act*, §9007. See also John Holahan and Bowen Garrett, "The Cost of Uncompensated Care with and without Health Care Reform," March (2010), http://www.urban.org/publications/412045.html (accessed March 14, 2013).

[1687] Kristine Principe et al., "The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals," *American Journal of Public Health* 102, no. 2 (2012).

[1688] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule " *Federal Register* 73, no. 245 (December 19, 2008).

[1689] Hackbarth, "Letter to CMS: Proposed Revisions to the Medicare Cost Report."

dramatically improve transparency and accountability in charity care processes and funding at individual hospitals.

The Meaning of Hospital Charity Care

In earlier chapters, the ways in which historical or contextual references to charity care varied and could, sometimes subtly and almost imperceptibly, alter the meaning of charity was described. For example, in the sphere of medical education "charity" patients often paid for their care and "charity" patients became known as "ward" patients and "service" patients as the twentieth century progressed. In the emergency department, references to "uncompensated care" as interchangeable with charity care have occurred more often in recent years and sometimes this means that some, most, or all of such care consists of bad debt, not charity. Also, it turns out that among "free" clinics, only about half do not charge fees.[1690] In addition to the use of "uncompensated care" as synonymous with charity, there are other terms such as "indigent care," which may be used interchangeably with charity but which have their own set of meanings that are similar but not identical to charity.

One purpose of this dissertation has been to examine the implications of the moral and symbolic meaning of charity in health care. Hospitals are the most visible symbol of charity in health care. Hospitals are simultaneously a powerful symbol of the morality of medical care and of the scientific and technological basis of medicine. Hospitals as symbols of morality have been resilient to vast changes in the hospital industry. According to the historian Rosemary Stevens:

> American ideals of community, voluntary organization, and charity in its widest sense infuse the history of American hospitals, providing an ethos for social welfare which is largely independent of political division into "market" or

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[1690] Chapters 1, 2, and 3 included information on the complexities of the term "uncompensated care" as it relates to the subject of each chapter, whereas this chapter explicitly addresses the topic.

> “government” organization. But these ideals are as difficult to interpret in practical terms today as they were in the 1950s or 1920s.[1691]

Hospitals as a source of charity care are at the center of tensions between hospitals as businesses and charities in the case of nonprofit and public hospitals. For-profit hospitals must also reassure the public that benevolence, especially in the form of kindness and compassion, is among their traits.[1692] These tensions between hospitals as profit making businesses and altruistic healing institutions are perhaps now more apparent than ever. Stevens argues that the history of hospitals over more than a century confirms that hospitals have always been “chameleon-like, income-maximizing, yet idealized institutions.”[1693] The ambiguity of the purposes and essential qualities of hospitals, then, is a central feature of American hospitals throughout their history. Despite significant changes in hospital organization that have encouraged competition and market based solutions, “it has proved impossible…to lay the ghosts [to rest] of social obligation and moral virtue that cling to the powerful American ideals of voluntarism, charity, and community.”[1694] Ambiguity, as we saw in the introduction, is the “most important feature of all symbols.”[1695] Stevens concludes in her book on the history of hospitals that nonprofit hospitals, in particular, are important *because* they carry the burden of unresolved, perhaps unresolvable contradictions—and because they make these contradictions visible.”[1696] Stevens’ view is important and her expansive and insightful work is unparalleled. Yet, when it comes to hospital charity care, there is still

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[1691] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 354.

[1692] *“[B]enevolence* refers to the morally valuable character trait—or virtue—of being disposed to act for the benefit of others. Thomas L. Beauchamp, "The Principle of Beneficence in Applied Ethics," *Stanford Encyclopedia of Philosophy* (2009), http://plato.stanford.edu/entries/principle-beneficence/ (accessed March 14, 2013).

[1693] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 355.

[1694] Ibid., 361.

[1695] Stone, *Policy Paradox : The Art of Political Decision Making*: 157.

[1696] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 361.

much that remains opaque and therefore not visible in our nation's views about hospital charity care, our financing of that care, and our understanding of our reliance on hospital charity to signal moral goodness.

A reasonable first question to ask is: What is charity in the hospital setting? After recognizing the cultural and symbolic significance of charity and the moral connotations of service, altruism, and benevolence, there is still the issue that charity is presumed also to be a quantifiable service in monetary terms. Like the broader notion of "charity" in a variety of its manifestations, hospital charity care has ambivalent, not only ambiguous, meanings.[1697] While we rely on the existence of charity care to affirm moral goodness, at the same time we abhor much of what charity represents: the financial burden of charity on hospitals, the question of whether people receiving charity deserve it or should be blamed for needing it, and the casting of charity care as having a potential to harm the rest of us who don't need charity. These conflicting ideas concerning hospital charity care in some respects enrich its symbolic power, yet also make less visible what is at stake in policy decisions.[1698]

This chapter explores what charity is in the hospital setting including the symbolic and moral meaning of hospital charity and the language that has been used to describe hospital charity. The chapter includes the history and current status of laws relating to hospitals as charities and as tax exempt organizations with at least vague obligations to provide charity. There is an almost equally long history of regulation of the tax exempt hospital sector that continues up to the present time. The ways in which hospitals report charity care to the public and to governmental agencies is another area of inquiry that is continuously changing and is probed in this chapter. Also included are the views of

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[1697] Jonathan Engel states about "ambivalence" that "no other word better describes efforts at charity medical care in the United States over the past half-century. Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965*.

[1698] Stone, *Policy Paradox : The Art of Political Decision Making*: 160-161.

patients who may need charity care because they do not have the financial means to cover the cost of their care. The complex and mostly implicit ways in which hospital charity care is funded are investigated as well. In the conclusion to this chapter, the question of whether hospital charity care promotes or impedes the qualities we cherish as morally fundamental and defining in our most visible symbol of American health care is considered.

The Language of Hospital Charity Care: Origin of the Use of "Uncompensated Care"

Much of the recent attention to charity care provision by hospitals has been directed at nonprofit hospitals which make up about half of America's hospitals.[1699] Among the approximately 5,700 acute care hospitals in the United States today, there are three types based on ownership status. Nonprofit hospitals, the most common type of hospital, include more than 2,900 hospitals, and, especially historically, are referred to as "voluntary" hospitals. For-profit or proprietary hospitals number just over 1,000 hospitals. Public hospitals owned by state or local governments also total just over 1,000. Public hospitals owned by the federal government number just over 200.[1700] The teaching status of a hospital is a separate category. For example, about 10 percent of the approximately 1,000 hospitals that are members of the Council of Teaching Hospitals are for-profit, about 13 percent are public hospitals, and about 76 percent are nonprofit.[1701]

[1699] Sara Rosenbaum and Ross Margulies, "Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice," *Public Health Report* 126, no. 2 (2011).

[1700] American Hospital Association, "Fast Facts on US Hospitals," (2012), http://www.aha.org/research/rc/stat-studies/101207fastfacts.pdf (accessed March 14, 2013).

[1701] Association of American Medical Colleges, "Key Facts About Teaching Hospitals," February (2009), https://www.aamc.org/download/82452/data/keyfactsaboutth.pdf (accessed March 14, 2013).

A recurring question over the past several decades is: Does hospital ownership matter in the provision of charity care? Furthermore, beyond the federal law requiring all hospitals to provide emergency care and other legal requirements for certain hospitals to provide charity care because of tax exemption or state and county mandates, why should hospitals provide charity care? The expectation to provide charity care from within the hospital industry and from observers differs somewhat based on the type of hospital. Public hospitals are generally those owned and operated by cities, counties, or states with a common "safety net mission" of providing health care to all, regardless of ability to pay.[1702] Nonprofit hospitals identify as mission-driven and community oriented with unique values, governance, and accountability which align their activities to the public good. Treating patients regardless of their ability to pay remains a common declaration.[1703] For-profit hospitals, it is sometimes argued, have obligations to their communities in the same manner that any corporation has such obligations.[1704] Finally, all hospitals can be viewed as having "social obligations that flow from the needs of the communities that they serve and the ethical traditions of health care."[1705]

Next is the question of whether and to what extent hospitals provide charity care. Some of the reasons that the question is not simple are that there has not been a uniform definition of hospital charity; the reliability and validity of information on charity can be questioned; many terms with unclear meanings can be used synonymously with charity;

[1702] Obaid S. Zaman, Linda C. Cummings, and Sari Siegel Spieler, "America's Public Hospitals and Health Systems, 2009: Results of the Annual NAPH Hospital Characteristics Survey," (Washington, DC: National Public Health and Hospital Institute, 2010). Ron J. Anderson, Paul J. Boumbulian, and S. Sue Pickens, "The Role of U.S. Public Hospitals in Urban Health," *Academic Medicine* 79, no. 12 (2004).

[1703] J. David Seay, "Beyond Charity: Mission Matters for Tax-Exempt Health Care," (Washington, DC: The Catholic Health Association of the United States, 2007).

[1704] Steven D. Pearson, James E. Sabin, and Ezekiel J. Emanuel, *No Margin, No Mission : Health-Care Organizations and the Quest for Ethical Excellence* (Oxford ; New York: Oxford University Press, 2003), 119-123.

[1705] Bradford H. Gray, ed. *For-Profit Enterprise in Health Care* (Washington, DC: National Academy Press, 1986), 115.

and most data on charity care is not reported separately from "uncompensated care" which is a term with its own multiple meanings, definitions, and ambiguities. The term "uncompensated care" was not in common usage as a term that referred to charity care until the 1980s. The Hospital Survey and Construction Act of 1946, usually known as the Hill-Burton Act, is the first law that brought the term "uncompensated care" into the realm of public policy, though not definitively until 1972.[1706] The Hill-Burton Act has its origin in the post-World War II era. Just a few months after World War II, President Truman urged Congress to pass a national health program based on compulsory health insurance. The only portion of his national health program that survived the vigorous opposition to what was cast as "socialized medicine" was the Hill-Burton Act.[1707] There was "virtually unanimous" support for more hospitals among the public, Congress, and stakeholders such as the American Hospital Association (AHA) and the American Medical Association.[1708]

The Hill-Burton Act required nonprofit and public hospitals receiving construction funds to provide the following:

> [A] reasonable volume of free patient care. As used in this section, 'free patient care' means hospital service offered below cost or free to persons unable to pay therefor[sic], including under 'persons unable to pay therefor,' both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed hospital care.[1709]

It seems that these free and reduced cost care obligations were meant to include people in the "class" of patients considered indigent and among people, like Carlos Ferlini mentioned at the beginning of this chapter, who were otherwise self-supporting and not

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[1706] Hill-Burton requirements for the provision of emergency care were discussed in Chapter 3.

[1707] Starr, *The Social Transformation of American Medicine*: 280-283.

[1708] Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 592-599. Starr, *The Social Transformation of American Medicine*: 283.

[1709] The original law is quoted in Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 611.

considered indigent but could not afford hospital care. In subsequent commentaries and legal decisions, Hill-Burton's requirements were commonly referred to as both "uncompensated" and "charity care" obligations. In 1972, regulations issued by the predecessor to the Department of Health and Human Services (DHHS), the Department of Health, Education, and Welfare (HEW), defined "services to persons unable to pay therefor'" as "uncompensated services."[1710]

The term "indigent," as mentioned in the Hill-Burton Act, has continued to be a term used in close relationship to charity and sometimes used interchangeably with a "charity" patient and with uncompensated care provision or funding. "Indigent" often meant means-tested program eligibility, for example, eligibility for cash assistance.[1711] The Hill-Burton use of "indigent" included what is now commonly known as a "medically indigent" person, that is, someone who is indigent only because of medical costs or bills. The determination of financial eligibility for medical care on the basis of indigency was an exceedingly uneven practice throughout the mid-twentieth century.[1712] The decisions were often left to "untutored staff" who were essentially rationing care or subjecting patients to financial insolvency. In 1964 just prior to the enactment of Medicare, the National Council on Aging outlined a set of principles and criteria for determining indigency which placed priority on clear policies with objective standards that could be applied flexibly and fairly.[1713]

[1710] Rand E. Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," *Yale Law Journal* 88, no. 2 (1978): 270.

[1711] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 36.

[1712] In the early twentieth century, as discussed in Chapter 2, attempts to categorize patients who should be eligible for free dispensary care was an uneven and difficult practice.

[1713] National Council on the Aging, "Principles and Criteria for Determining Medical Indigency: Report of the Committee for the Project of the National Council on the Aging," *American Journal of Public Health* 54, no. 10 (1964).

Obviously, the creators of the Hill-Burton Act did not anticipate the specific legislation that would create Medicare and Medicaid. Because the Hill-Burton Act required charity care provision to the "legally indigent" and Medicaid eligibility was initially tied to eligibility for cash assistance based partly on indigent status, some hospitals reasoned that full payment by Medicaid could be claimed as fulfillment of the Hill-Burton charity care obligation.[1714] Hospitals also claimed that because Hill-Burton free care could be paid for "wholly or partly" out of public funds that the cost of care of people insured through government programs such as Medicare and Medicaid could count towards fulfillment of their charity care obligation.[1715] This line of reasoning served to underscore the difficulty of maintaining a clear boundary between what counted as charity and everything else.

In addition to the requirement to provide free and reduced cost care, the Act required making hospital services available to all within the hospital's service area, also known as the "community service" requirement.[1716] The uncompensated care and community service requirements were both commonly referred to as the "charity care obligations."[1717] The 1946 Act specified that the hospital was expected to cover the cost

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[1714] The current statute does not use the term "indigent" or "legally indigent" but does include the standards by which "a person unable to pay" is determined which include, for example, state standards for the medically needy and the federal poverty guidelines. See HHS Public Health Service, "Grants, Loans and Loan Guarantees for Construction and Modernization of Hospitals and Medical Facilities," *Code of Federal Regulations* Title 42 (2006): §53.111(g).

[1715] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 269-270.

[1716] The community service requirement has an important role in the history of civil rights enforcement in American hospitals. Hill-Burton required hospitals to make "available to all persons residing…in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility."Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 581. Regulations published in 1947 provided for an exception "in cases where separate hospital facilities are provided for separate population groups." The "separate-but-equal clause" was declared unconstitutional in *Simpkins v. Moses Cone Hospital* in 1963 and the Act was amended to remove all references allowing racial discrimination. Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 266.

[1717] Wing, "The Community Service Obligation of Hill-Burton Health Facilities." Sharon Kearney Coleman, "The Hill-Burton Uncompensated Services Program," (2005), http://www.policyarchive.org/handle/10207/bitstreams/719.pdf (accessed March 14, 2013).

of care for people unable to pay through the usual sources of charitable hospital services; local or other public funds, donated contributions, and hospital profits.[1718] Within the postwar context of the Act, Congress perceived the charity care obligations as an “affirmation of the common expectation that nonprofit hospitals would continue to provide charity care consistent with their historic mission of community service.”[1719] In fact, Senator Taft, a Republican from Ohio, believed that 20 percent of the patients in every general hospital were indigent. He is credited with authoring the charity care provisions of Hill-Burton.[1720] The Surgeon General at the time, Dr. Parran, estimated that 33 percent of hospital care was provided to indigent patients.[1721] The president of the AHA reassured Congress in hearings prior to passage of Hill-Burton: “We feel these nonprofit hospitals are public property, except that they are not controlled by a branch of the government.”[1722] In other words, the requirements were not seen as newly created obligations, merely the affirmation of existing ones. At the same time, the requirements acknowledged the fact that “without the notion that a recipient health facility was to

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[1718] The text of Section 53.63 states: “Hospital services for persons unable to pay therefor. [sic] Before a construction application is recommended by a State Agency for approval, the State Agency shall obtain assurance that the applicant will furnish a reasonable volume of free patient care. As used in this section, "free patient care" means hospital service offered below cost or free to persons unable to pay therefor, including under "persons unable to pay therefor," both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed hospital care. Such care may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as community chests or may be contributed at the expense of the hospital itself. In determining what constitutes a reasonable volume of free patient care, there shall be considered conditions in the area to be served by the applicant, including the amount of free care that may be available otherwise than through the applicant. The requirement of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the State Agency, subject to subsequent approval by the Surgeon General, that furnishing such free patient care is not feasible financially.” Quoted in Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 611.

[1719] James F. Blumstein, "Providing Hospital Care to Indigent Patients: Hill-Burton as a Case Study and Paradigm," in *Uncompensated Hospital Care: Rights and Responsibilities*, ed. Frank A. Sloan, James F. Blumstein, and James M. Perrin (Baltimore, MD: Johns Hopkins University Press, 1986), 99.

[1720] Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 595, 598.

[1721] Editorial, "The Propriety of Reimbursement by Medicare for Hill-Burton Free Care," *University of Pennsylvania Law Review* 130, no. 4 (1982): 912.

[1722] Dowell, "Hill-Burton: The Unfulfilled Promise," 161.

provide certain services to the public, the program becomes almost ludicrous: a major spending program to finance health facility construction solely to benefit the facility, but not the people in its community."[1723] In pointed questioning about whether hospitals receiving funds under Hill-Burton would restrict services to those who could pay, the president of the AHA again reassured Congress that low income people "will be taken care of."[1724]

Senator Taft's beliefs about the provision of charity by general hospitals were not confirmed by the limited information available. Rosemary Stevens has noted:

> Even in the 1950s relatively little care was actually given away, deliberately, by private nonprofit hospitals. Charity by voluntary hospitals, where it did exist, was often inadvertent. Hospital administrators talked of the percentage of charges to patients that were "uncollectible" or, matching income from patient fees against total hospital expenses, would claim a posted "deficit"—sometimes conveniently ignoring other income, from endowments, donations, or any local tax subventions. Uncollectibles represented 3.5 percent of the total charges of voluntary hospitals in 1953; 5.9 percent for proprietary hospitals, and 6.2 percent for government hospitals.[1725]

With the Hill-Burton Act, reliance on hospital charity as an alternative to a national health program was supported despite little evidence of its reality or reliability.

The Hill-Burton Act, by the 1980s, had funded approximately 40 percent of all the nation's hospital beds.[1726] Whether because of the growth of hospitals or for other reasons, the public's view of the role of hospitals included some skepticism, as described eloquently, though in a romanticized fashion, by a dissenting Pennsylvania judge in a 1961 ruling to reaffirm charitable immunity:

> It is historically true, and it is a tribute to the soundness of the human heart that it is true, that there was a time when good men and women, liberal in purse and

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[1723] Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 599.

[1724] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 268.

[1725] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 269.

[1726] Wing, "The Community Service Obligation of Hill-Burton Health Facilities," 578.

> generous in soul, set up houses to heal the poor and homeless victims of disease and injury. They made no charge for this care. They felt themselves richly rewarded in the knowledge that they were befriending humanity.
>
> Hospitals then were little better than hovels in which the indigent were gathered for the primitive cures available. The wealthy and the well-to-do were cared for in their homes. The hospital or infirmary was more often than not part of the village parish. Charity in the biblical sense prevailed. And if it happened that some poor mortal was scalded by a sister of mercy, who exhausted from long hours of vigil and toil, accidentally spilled a ladle of hot soup on a hand extended for nourishment, there was no thought of lawsuits against the philanthropists who made the meager refuge possible. But if, following such a mishap, litigation should have been initiated in the courts, it is not difficult to understand why judges would be reluctant to honor such a complaint, convinced on the basis of humanity, that an enterprise utterly devoid of worldly gain should be exempt from liability. A successful lawsuit against such a feeble structure might well have demolished it and have thus paralyzed the only helping hand in the world of unconcern for the rag-clothed sick and the crutchless disabled.
>
> The situation today is quite different. Charitable enterprises are not housed in ramshackly wooden structures. They are not mere storm shelters to succor the traveler and temporarily refuge those stricken in a common disaster. Hospitals today, to a large extent, are mighty edifices, in stone, glass and marble. They maintain large staffs, they use the best equipment that science can devise, they utilize the most modern methods of helping themselves to the noblest purpose of man, that of helping one's stricken brother. But they do all this on a business basis, and properly so… And if the hospital is a business for the purpose of collecting money, it must be a business for the purpose of meeting its obligations.[1727]

The discussion of the charitable role of hospitals was, perhaps, temporarily silenced by the passage of amendments to the Social Security Act in 1965 which included Medicare and Medicaid. As Stevens describes it, "Medicare tax funds flowed into hospitals in a golden stream, more than doubling between 1970 and 1975, and doubling again by 1980. Medicaid, though smaller, was equally expansive."[1728] Hospitals of the different ownership types, in the decades following passage of Medicare and Medicaid, became "oddly, both more alike and more sharply delineated….Profit-making hospitals had to demonstrate that they were benevolent, voluntary hospitals that they were efficient

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[1727] The judge was Michael A. Musmanno in *Michael v. Hahnemann Medical College and Hospital*, quoted in Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 64-65.

[1728] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 284.

and local-government hospitals that they were necessary."[1729] Moreover, with the implementation of reimbursement on the basis of provider-determined cost, "giving services free to patients through 'hospital charity' seemed dead."[1730] The resulting financial success of hospitals tended to fuel the perception of hospitals as businesses.

There is no doubt that both Medicare and Medicaid improved access and increased funds for people who could not pay for their care. In extensive interviews before and after the implementation of Medicare, the proportion of hospital stays where the patient incurred no charges dropped from 17 percent to 3 percent during the first few years of the program. Not all of these charges had been unpaid hospital charges, however, as many of the charges prior to Medicare's implementation were paid by local welfare programs.[1731] According to the researcher responsible for the early survey showing improved access, the benefits were not only tangible ones: "Perhaps more important than the rise in hospital use is the fact that the Medicare program has enhanced the dignity of the Nation's elderly by providing coverage for their needed hospital care and allowing them to be cared for in hospitals without regard to their personal resources."[1732]

In contrast to the dignity-enhancing creation of Medicare for the nation's elderly, reliance on the charity provisions of Hill-Burton would prove to be elusive and inadequate. Many of the problems encountered with the Hill-Burton charity care obligations during the 1970s are typical of the obstacles that currently exist regarding the provision of hospital charity care. These characteristic features include that the obligations incurred are voluntary and vague; hospitals have wide discretion in meeting the obligations; hospitals often include rendering care to people enrolled in public

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[1729] Ibid., 285.

[1730] Ibid., 310.

[1731] Regina Lowenstein, "Early Effects of Medicare on the Health Care of the Aged," *Social Security Bulletin*, no. April (1971).

[1732] Ibid., 3.

programs as fulfillment of their obligations; and, the ability to quantify charity at the hospital level is difficult and dependent upon self-reports and changing financial standards.

Measurement and enforcement of hospital charity care obligations derived from the Hill-Burton Act were dormant for twenty-five years. From 1946 until 1972, the hospital construction program acted under elaborate and detailed regulations concerning state planning and building by state agencies coordinating with HEW while the charity care obligations were ignored. HEW had not developed any criteria for determining who was "unable to pay" or how to measure a "reasonable volume of free care" and no state agencies were required to gather any information from hospitals on Hill-Burton charity care.[1733] According to Rand Rosenblatt, a health law scholar, the lack of regulations and enforcement meant that "the nondiscrimination and free care 'assurances' were reduced to a set incantation filed with an application for funds and thereafter apparently ignored."[1734]

Hill-Burton Charity Care Obligations in the War on Poverty Years

Health lawyers in the war on poverty years of the late 1960s, originally part of a team of lawyers housed in the Office of Economic Opportunity, became convinced that the Hill-Burton program created legal obligations not to deny hospital services to people who could not afford to pay.[1735] A series of class action lawsuits moved "a lethargic bureaucracy into action."[1736] Interim regulations pertaining to uncompensated care and

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[1733] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 268-270.

[1734] Ibid., 270.

[1735] The Office of Economic Opportunity was discussed in Chapter 1 as the organization responsible for the first community health center grants. Pamela Paul-Shaheen and Harry Perlstadt, "Class Action Suits and Social Change: The Organization and Impact of the Hill-Burton Cases," *Indiana Law Journal* 57, no. 3 (1982).

[1736] Ibid., 398.

community service were issued by HEW in 1972 and were amended in the following years. The initial regulations permitted hospitals to select one of three "presumptive compliance" guidelines for their free care obligation: 1) uncompensated care services valued at 3 percent of operating costs, 2) uncompensated services valued at 10 percent of federal assistance received, or 3) certification that the hospital would admit and serve any person seeking admission "without charge or at a charge…which does not exceed…such person's ability to pay" as determined by state-defined criteria, known as the "open door" policy. The uncompensated care obligation was to last for twenty years after Hill-Burton projects were completed.[1737] As to how the quantitative measure was determined, a government spokesperson admitted at a 1972 press conference on the new rules: "There is no well documented body of information on the national level as to the amount of services which are being provided to people unable to pay. It is interesting that there simply is not a national reservoir of this kind of information."[1738]

Yet HEW at first maintained that it had no duty to enforce its own regulations:

> The result was that hospitals generally continued their pre-1972 practices: exclusion of Medicaid patients, failure to give effective notice of the program's existence, failure to make advance written determinations of eligibility, and writing-off of various types of losses (e.g., refusal of third-party payors to reimburse for unnecessary care) as 'community service' to the poor.[1739]

A 1974 report by the General Accounting Office found that there was no active monitoring or compliance program within the responsible state agencies. A Senate Committee concluded that compliance efforts by federal and state agencies amounted to a "sorry performance" and that while the Act was over twenty years old, compliance was

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[1737] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 277.

[1738] Ibid., 270.

[1739] Ibid., 278.

"in its infancy."[1740] Hospitals generally did not inform state agencies about how they planned to meet their obligations and, even when they did, the evidence was sometimes meager. In one state with 136 hospitals that chose the "open door" presumptive compliance option, the average value of Hill-Burton uncompensated care per hospital was $190.[1741] Under continuous pressure from litigation, the open-door option was eliminated in 1979 regulations.

Virtually all of the amendments to the Act were a result of litigation. When, in 1972, the regulations defining "services to persons unable to pay" were changed to define such services as "uncompensated services" the reason was primarily to clarify that the obligation was to *persons* and not a blanket accounting measure of uncollectible accounts and government insurance claims. The 1972 interpretation was more aligned with the patient's perspective but it was aimed at preventing hospitals from claiming that services to patients covered by public health insurance programs fulfilled Hill-Burton obligations. Prior to this change, hospitals might claim the full amount of any services paid for by Medicare and Medicaid as fulfillment of Hill-Burton charity care obligations.[1742]

One of the first provisions in the 1972 regulations to be challenged successfully had to do with the distinction between bad debt and "services provided to people unable to pay." In *Corum v. Beth Israel Medical Center*, a federal district court declared a section of HEW's regulations invalid concerning unpaid bills.[1743] The 1972 regulations allowed hospitals to bill low income patients then claim the bills as uncompensated care under Hill-Burton if they remained unpaid. The court reasoned that, unless individuals unable to pay knew ahead of time that their care would be provided free or at a reduced

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[1740] Blumstein, "Court Action, Agency Reaction: The Hill-Burton Act as a Case Study."

[1741] Dowell, "Hill-Burton: The Unfulfilled Promise," 157.

[1742] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 269-270.

[1743] *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550 (1974). Dowell, "Hill-Burton: The Unfulfilled Promise."

rate, the effect would be that “many such persons will be discouraged by the uncertainty of their status from seeking any medical assistance at all.”[1744] In distinguishing between bad debt and services provided to people unable to pay, the court stated:

> It is fully understandable that hospitals wish to count towards their Hill-Burton requirement all services for which collection proves difficult. The statute, however, does not contemplate this convenient result. Rather, the only services for which the statutory assurance is received are those provided to persons who are *"unable",* not merely unwilling to pay.[1745]

Bad debt is an operating expense that falls to the hospital to cover, just as any business expense, the court reasoned.

In 1974, the original Hill-Burton program was folded into the National Health Planning and Resources Development Act and its oversight became a responsibility of the federal government, though state agencies continued to play a role in compliance monitoring.[1746] The 1979 regulations have remained relatively unchanged since they were enacted. In addition to not allowing the cost of an individual covered under a third party insurance or governmental program to count toward the hospital’s uncompensated services quota, several other changes were specified. The 1979 regulations established for the first time national eligibility criteria, based on income: Individuals whose annual income was at or below the poverty level were automatically eligible for uncompensated services; individuals whose annual income was at or below two times the poverty level were also eligible for uncompensated services, although the hospital could decide to limit its services to individuals below the poverty level only. Hospitals could follow the eligibility guidelines or allocate their uncompensated services on a first-request, first-served basis. Hospitals were required to notify the public of the existence of their uncompensated services programs through public notice and provision of personal notice

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[1744] *Corum v. Beth Israel Medical Center*, 558.

[1745] Ibid.

[1746] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 285.

to individuals served by the hospitals and hospitals were required to keep records documenting compliance and to periodically report on their compliance.[1747]

When the provisions of the Hill-Burton regulations were challenged in court, in general the courts were reluctant to interfere with day-to-day hospital practices. At the same time, the failure of the agencies responsible for creating substantive regulations to implement and enforce them meant that the court did review hospital practices. In one of the most important class action lawsuits filed under Hill-Burton, *Newsom v. Vanderbilt University*, judicial review of daily practices provided a rare window into hospital decision making and led to virtually all of the significant changes in the 1979 regulations.[1748] The case began in 1971 when Callie Mae Newsom was admitted to Vanderbilt University Hospital with pregnancy complications. Ms. Newsom was insured by Medicaid but the number of hospital days covered by the program was limited and she remained hospitalized after the Medicaid coverage ended. The hospital sued her when she could not pay the bill. When she returned to work, the hospital's collection agency pressed her into a wage garnishing arrangement. Ms. Newsom asked Nashville Legal Services to help her. The lawyer, Gordon Bonnyman, attempted to negotiate a settlement but the hospital did not respond.[1749]

In 1978 a district court heard the Newsom case as a class action suit on behalf of persons in the hospital's area who had been or would be in need of medical services for which they were unable to pay. The suit claimed that the hospital had failed to provide a reasonable volume of services to people unable to pay in violation of its duties under the Hill-Burton Act. HEW had ruled that the hospital was in compliance with Hill-Burton

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[1747] Department of Health and Human Services Public Health Service, "Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable to Pay," *Federal Register* 60, no. 62 (March 31, 1995).

[1748] Blumstein, "Court Action, Agency Reaction: The Hill-Burton Act as a Case Study."

[1749] Paul-Shaheen and Perlstadt, "Class Action Suits and Social Change: The Organization and Impact of the Hill-Burton Cases," 406-407.

before the case began but when the court reviewed the evidence, Judge Morton found that "until very recently Vanderbilt at best regarded its Hill-Burton obligation as a final write-off for bad debts and at worst ignored it completely."[1750] The court did not require retrospective compliance primarily because the meaning of compliance had been undefined for so long that is was "impossible to prove noncompliance" and the early 1970s regulations were so vague that it was hard to imagine how a hospital could have failed to comply.[1751]

The court did review in detail the processes through which the hospital declared its Hill-Burton obligations were satisfied. From testimony by Vanderbilt hospital's Director of Admissions, it was clear that the policy was to "say as little as possible to patients about Hill-Burton free care." The director tried to explain that, if the possibility of free care was mentioned, the "average" person's desire to pay would be greatly diminished. The court pointed out:

> Any concern that applicants for admission might be tempted to provide false information if armed with foreknowledge of potential Hill-Burton eligibility can certainly be countered with concern that Vanderbilt's current admissions procedures might encourage them to present an overly optimistic financial picture. The record is replete with evidence that applicants for admission are led to believe, and realistically so, that they will be turned away if they are perceived to be unable to pay. Moreover, of the many people who have been denied admission for financial reasons, a significant number have had nowhere else to turn for the needed treatment.[1752]

The court did not allow the hospital to claim Hill-Burton credit for bills sent to patients without notice of the possible availability of free care. The court also required the hospital to meet the regulatory guidelines in effect at the time of the ruling, including two requirements that were clearly not being met: Public health insurance costs of Medicaid and Medicare were not allowed to be included as fulfillment of Hill-Burton obligations

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[1750] *Newsom v. Vanderbilt University*, 453 F. Supp. 401 (1978).

[1751] Ibid., 412.

[1752] Ibid., 418.

and the basis of reporting had to be the cost and not the charges for services. The hospital admitted that the difference in charges over costs paid by Medicare, Medicaid, and other third parties was counted toward Hill-Burton uncompensated service obligations and that all of the reporting had been on the basis of charges. The result was that the State agency and HEW both received greatly inflated figures. The court noted that the inflated figures were not placing the hospital in financial jeopardy. The amount of Vanderbilt hospital's Hill-Burton obligation was $400,000 annually and an executive had stated in his deposition: "You know, $400,000 on a $30,000,000 operation is a modest amount of money."[1753]

One of the trial briefs described the hospital's "Weekly Summary of Patients Denied Admission for Financial Reasons," with entries such as: "Insufficient finances, sent out;" and "No money, or insurance, sent out."[1754] During the five months surrounding the trial, over one hundred people were denied admission to the hospital.[1755] The court was especially concerned with the failure of the hospital to inform patients that they might be eligible for free or reduced cost services. Not only were patients not told during the admission process about Hill-Burton obligations, the effectiveness of the requirement to post notice in prominent areas of the hospital was exhaustively questioned by the court because the admissions department had almost never had a request for care under Hill-Burton as a result of the posted notices.[1756]

[1753] Ibid., 420. The total amount of free care reported by Vanderbilt for 1975-76 was $458,885, though the record showed that the amount was based on charges and included the difference between charges and costs for patients insured through Medicare, Medicaid, and other third party payors. In a much-citted article, the amount of uncompensated care reported by Vanderbilt in 1982 was $16 million. Frank A. Sloan, Joseph Valvona, and Ross Mullner, "Identifying the Issues: A Statistical Profile," in *Uncompensated Hospital Care: Rights and Responsibilities*, ed. Frank A. Sloan, James F. Blumstein, and James M. Perrin (Baltimore, MD: Johns Hopkins University Press, 1986), 16.

[1754] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 271.

[1755] *Newsom v. Vanderbilt University*, 429.

[1756] Ibid., 428.

The court was also faced with the question of whether there was an entitlement to free care under Hill-Burton obligations. The court stated:

> [I]t is evident that plaintiff and the class of indigent persons she represents have a constitutionally protected right to needed uncompensated services under the Hill-Burton Act…This is not to say that plaintiff or other members of the class of indigent persons have an absolute right to Hill-Burton uncompensated services from defendant Vanderbilt Hospital or from any other Hill-Burton facility. This right is limited by the extent of the free care obligation of Hill-Burton facilities in relation to the need for uncompensated care in their service areas….[L]imited fiscal resources implies the denial of Hill-Burton benefits to some members of the class of persons unable to pay…[T]he denial of a right once recognized by statute and regulation can only be effected through procedures conforming with due process requirements to insure that available resources are not allocated arbitrarily…In the present case, plaintiff's interest in the fair and consistent allocation of necessary hospital services must be weighed against the defendant hospital's interests in determining eligibility for such services on an ad hoc basis, which the record demonstrates has been the case…The need for procedural regularity in the allocation of Vanderbilt's limited Hill-Burton services is particularly important in light of the unique role played by the hospital in the delivery of care within a large geographic area.[1757]

The court clearly reasoned that due process was even more important in the case of a limited right because of the potential for arbitrary decisions: "Without written, published standards, the personal biases and predilections of individual hospital staff could serve as the bases for denial of needed uncompensated services under the Act."[1758] The 1979 regulations incorporated the procedural due process requirements articulated by the *Newsom* court including the requirement of individual notice.

Though the 1979 regulations stood relatively unchanged after their creation, two court decisions affected further efforts at legal advocacy. First, the AHA challenged the regulations in *American Hospital Association v. Schweiker.* The regulations were upheld on appeal in the Seventh Circuit. The court stated: "The premise, assumed in 1945, that hospitals would voluntarily provide services to all residents, including the indigent, out of

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[1757] Ibid., 424-425.

[1758] Ibid., 425.

their history of charitable service, proved to be unjustified."[1759] Further, the court noted that "the hospitals receiving aid displayed a marked reluctance to give even the most token charitable care."[1760] In the meantime, on an appeal of *Newsom* in the Sixth Circuit, the court reversed the finding of entitlement for members of the class of patients needing medical care but who were unable to pay and reversed the due process measures, including individual notification. The sixth circuit had a different vision of the class of patients Hill-Burton obligations recognized. According to health law scholar James Blumstein: "In perhaps the most hard-boiled characterization, members of the beneficiary class under Hill-Burton were indistinguishable, even fungible."[1761] To advocates for those unable to pay for medical care, what was at stake was more than funding. Rand Rosenblatt explains this by quoting another law scholar:

> What Professor Tribe has termed "the right to be heard from, and the right to be told why…express the elementary idea that to be a *person*, rather than a *thing*, is at least to be *consulted* about what is done with one." Expressed in political terms, this root concept of human dignity highlights the need for a reconstruction of the democratic process, in which consultation over fundamental human needs is not made meaningless by a labyrinthine bureaucracy.[1762]

In 1978 Rosenblatt believed that the "long term significance of the Hill-Burton Program is thus not as a source of funds, but as a source of a principle—that government agencies and publicly funded hospitals are not islands of standardless discretion and autonomy, but rather institutions accountable to the beneficiaries of their operations."[1763] At the same time, when the Hill-Burton regulations strengthened the charity care and community service obligations in 1979, the historian Rosemary Stevens' interpretation

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[1759] *American Hospital Association v. Schweiker*, 721 F.2d 170, 178 (1983).

[1760] Ibid., 174.

[1761] Blumstein, "Court Action, Agency Reaction: The Hill-Burton Act as a Case Study."

[1762] Rosenblatt, "Health Care Reform and Administrative Law: A Structural Approach," 264.

[1763] Ibid., 286.

was that “hospitals would not give away services unless forced to do so.”[1764] So, while the 1979 regulations withstood the AHA challenge mostly because the court reasoned that the federal government had the authority to create the regulations, the *Newsom* court’s findings were overturned in large part on appeal.

Hill-Burton Charity Care Obligations Remain Unenforced, Allow for Wide Hospital Discretion, and Are Allotted to Medicare

The history of Hill-Burton demonstrates that the obligations were never rigorously enforced and unfettered discretion by hospitals was far from over. In a 1972 survey about 70 percent of Hill-Burton facilities had not complied with their Hill-Burton obligations.[1765] Twenty years later in a 1992 report, over half of Hill-Burton facilities were not providing sufficient uncompensated care to meet their annual obligations.[1766] The original Hill-Burton Act and the regulations limited the obligation of uncompensated care to an amount that was financially “feasible.” In the context of the beliefs of Congress in 1946 about the amount of charity care that was already being provided and the need for more hospitals, it seemed reasonable to not unduly burden hospitals with further charity obligations to the point of insolvency. Yet there is no doubt that this inaccurate reference point and the vagueness of the obligations under Hill-Burton even after the 1979 regulations were enacted contributed to the problems with enforcement. The agencies

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[1764] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 315.

[1765] Deborah K. Berk, "Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation," *American Journal of Law & Medicine* 9, no. 2 (1983).

[1766] Many of the obligated facilities were nursing homes. Department of Health and Human Services Office of Inspector General, "Public Health Service's Oversight of the Hill-Burton Program," (Washington, DC: Department of Health and Human Services, 1992).

responsible for enforcement were unable to "pierce the bookkeeping veil."[1767] They continued to rely on self-reported hospital data, unlike the information that was available in the *Newsom* case. Hospitals maintained wide discretion in implementing Hill-Burton programs and could do so based on "institutional priorities—for example, a hospital's teaching program—rather than patient's needs."[1768] The regulations required individual notification but also allowed hospitals to post a notice that their Hill-Burton obligation had been met for the year.[1769] Also, of course, Hill-Burton obligations were expiring. There were about 5,000 Hill-Burton uncompensated care obligated facilities in 1979 and, by the year 2000, there were only 650.[1770]

Although the Hill-Burton obligations were often referred to as charity care obligations in the lay and academic journals, the courts and the regulations maintained the language of the law with related terms such as "persons unable to pay," "free or below cost care," "indigent," and "uncompensated services." References to "charity" remained as historical context and as the public's understanding of Hill-Burton. While the regulations defining uncompensated services seemed relatively clear in not allowing bad debt expense or the cost of care for people insured through Medicaid and Medicare to count toward Hill-Burton obligations, these issues were far from settled. In fact, the current rhetoric concerning uncompensated care is as unsettled concerning bad debt and shortfalls from public programs as it was in the 1970s.

[1767] Norman L. Cantor, "The Law and Poor People's Access to Health Care," *Law and Contemporary Problems* 35, no. 4 (1970): 920.

[1768] Blumstein, "Court Action, Agency Reaction: The Hill-Burton Act as a Case Study."

[1769] Malcolm S. Dorris, "Hill-Burton Notice Provisions: Informing the Indigent," *Washington and Lee Law Review* 36, no. 4 (1979).

[1770] Department of Health and Human Services Public Health Service, "Compliance Alternatives for Provision of Uncompensated Services," *Federal Register* 66, no. 187 (September 26, 2001).

Another twist on the role of public health insurance programs was that, in addition to claiming the costs of care for people insured through Medicaid and Medicare, and the difference between the charges and contractually allowed costs as fulfillment of Hill-Burton obligations, Medicare also reimbursed hospitals for their Hill-Burton uncompensated care costs in many states in the early years of the program.[1771] One author in 1982 urged hospitals to "protect their rights to Medicare reimbursement for Hill-Burton costs by including such costs in their cost reports."[1772] In September of 1982, however, reimbursement by Medicare of Hill-Burton uncompensated care costs was eliminated in the Tax Equity and Fiscal Responsibility Act.[1773] Payment by Medicare of Hill-Burton uncompensated care costs was primarily a result of judicial review and the reasons for and against this reimbursement were contentious.[1774] One of the interesting arguments by providers was that Hill-Burton obligations were not "voluntary."[1775] Medicare regulations stipulated that charity was not an allowable cost in the Medicare program where charity allowances were defined as "reductions in charges made by the provider of services because of the indigence or medical indigence of the patient."[1776] The providers argued that, since the Hill-Burton free and reduced cost care obligations were legally required, they were not voluntary and could not be considered charity.

[1771] Berk, "Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation." Editorial, "The Propriety of Reimbursement by Medicare for Hill-Burton Free Care."

[1772] P. S. Hofstra, "Medicare Reimbursement for Hill-Burton Uncompensated Care Still Controversial," *Health Law Vigil* 5, no. 3 (1982): 5.

[1773] *Tax Equity and Fiscal Responsibility Act of 1982*, Public Law 97-248, § 106.

[1774] Hofstra, "Medicare Reimbursement for Hill-Burton Uncompensated Care Still Controversial."

[1775] Editorial, "The Propriety of Reimbursement by Medicare for Hill-Burton Free Care," 899.

[1776] Ibid.

Courts were not generally convinced by this argument since a variety of state and local funds directed to hospitals might require the provision of “charity” care. This line of reasoning does again raise the question of the boundary between charity and something else. If the hospital is paid by the government to provide charity, is the hospital providing charity? If the hospital contractually agreed to provide charity care in exchange for funds to build or remodel, is the hospital then providing charity or is it fulfilling its contract?

Some courts were swayed, however, by the argument that Medicare beneficiaries benefited indirectly from Hill-Burton construction funds so that a portion of the Hill-Burton costs was similar to other allowable indirect costs such as interest expense. Some of the Medicare administrators were perplexed, however. As they saw it, Medicare had already reduced the amount of charity:

> Since Congress was, in effect, removing from local communities and voluntary hospitals the burden of caring for most of the medically indigent, it rightfully expected that those communities and voluntary hospitals would continue to provide a certain amount of charity care to those indigents who would not be covered by either the Medicare or Medicaid Acts.[1777]

Just as the original Hill-Burton Act rested on the notion that charity care was an integral part of the hospital’s services, continued reliance seemed reasonable. Medicare officials argued that payment by the program for Hill-Burton obligations would be “double-dipping:” “The government provided public funds in the first place to a hospital for capital improvements. A condition of that grant was that the recipient offer free or below cost care to indigent persons. It is not reasonable to expect the Government then to use more public funds to pay yet a second time under a different program—Medicare—the costs of fulfilling that obligation.”[1778] On the other hand, the New Jersey prospective

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[1777] Ibid., 906.

[1778] Berk, "Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation," 221.

payment system that served as a model for Medicare's change in payments from a cost based to a prospective payment system included allowances for uncompensated care.[1779] It is conceivable that Medicare reimbursement of Hill-Burton obligations could have survived except for the fact that the nation had "discovered" there was a "crisis" in escalating health care costs.[1780]

Skyrocketing Hospital Costs Become the Overwhelming Concern Nationwide

This was an era when there was broad agreement that soaring hospitals costs under entitlement programs had to be addressed.[1781] Prior to the enactment of Medicare and Medicaid, $13.9 billion was spent on hospital care annually and, by 1980, this amount had reached $99.6 billion. Hospital care had risen to 40 percent of all health care expenditures from about 25 percent in 1940.[1782] The Tax Equity and Fiscal Responsibility Act, in addition to ending Medicare reimbursement for Hill-Burton obligations, also required the development of the prospective payment system which began in 1983.[1783] The Tax Equity and Fiscal Responsibility Act disallowed payment for Hill-Burton uncompensated care but, at the same time, created the Medicare Disproportionate Share (DSH) program.[1784] The Medicare DSH program began to add payments to hospitals serving a disproportionate number of low income patients by the time prospective

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[1779] John K. Iglehart, "New Jersey's Experiment with DRG-Based Hospital Reimbursement," *New England Journal of Medicine* 307, no. 26 (1982).

[1780] Starr, *The Social Transformation of American Medicine*: 381.

[1781] John K. Iglehart, "Federal Directions in Health Care Policy," *Journal of Health Politics Policy and Law* 5, no. 4 (1981).

[1782] Berk, "Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation." Editorial, "Data Watch: The Cost of Health Care," *Health Affairs* 1, no. 1 (1981).

[1783] Iglehart, "Medicare Begins Prospective Payment of Hospitals."

[1784] The Medicare DSH program was discussed in Chapter 2 related to medical education and the provision of charity care and it was discussed in Chapter 3 related to payments to hospitals' emergency departments for uncompensated care.

payment was fully implemented in 1986.[1785] Prospective payment was a significant change in Medicare reimbursement. The uncertainty related to this new payment method and several measures that simultaneously reduced the number of Medicaid enrollees and Medicaid reimbursements led to a "white-knuckle" year in 1986 for hospitals.[1786]

One of the most important sources of funds in future years for hospitals treating a disproportionate share of uninsured people and Medicaid beneficiaries, the Medicaid Disproportionate Share Hospital (DSH) program, as discussed in Chapters 2 and 3, was established by Congress in 1981. Changes in the Omnibus Reconciliation Act (OBRA) of 1981 were directed at containing the costs of the Medicaid program. Prior to this time, state Medicaid programs were required to follow Medicare cost-based reimbursement principles. Concerned that these efforts would have a greater negative effect on hospitals that treat "a large volume of Medicaid patients and patients who are not covered by other third party payers,"[1787] the law included the provision that states "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" by raising the payment rates.[1788] As discussed in previous chapters, states generally did not implement the Medicaid DSH payments because the requirements were vague and broad.[1789] In 1987, Congress enacted more stringent and specific requirements for states to report on their DSH payments and the law defined the minimum requirements for determining which hospitals would receive these payments. Unlike the Medicare DSH payments, the Medicaid DSH payments were tied to charity care charges

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[1785] Shadi S. Saleh and Mark Callan, "Trends in Medicare Disproportionate Share (DSH) Distribution in US Hospitals: 1996-2003," *Journal of Health Care Finance* 33, no. 2 (2006).

[1786] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 337.

[1787] See Fagnani and Tolbert, "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs," 7.

[1788] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," 2.

[1789] The Medicaid DSH program is discussed in detail in Chapter 5.

along with Medicaid utilization.[1790] Medicaid DSH payments grew exponentially from under $1 billion before 1990 to $17.4 billion two years later.[1791] More than half of these funds were federal matching payments.[1792]

It was the combination of reductions in public health insurance, an economic recession with high unemployment rates resulting in tight state budgets, rapid changes of consolidation and the rise of for-profits in the hospital industry, and the increasingly strong belief that competition and market mechanisms could control health care costs which served as the backdrop for a proliferation of studies and analyses on hospital uncompensated care. By 1984 uncompensated care had become a "hot" policy issue.[1793] It is worth noting, however, that at this point in time the decline in revenue from Medicare due to prospective payment was anticipated but not realized.[1794] The *average* margin on Medicare hospital payments was greater than 10 percent in the first few years of prospective payment, three times higher than a decade earlier, and much higher than the negative 5 percent in 2011.[1795] Total hospital margins, not just the margin from Medicare, were at an all time high at over 7 percent in 1984, though margins did decline in the latter 1980s.[1796] On the whole, in the early years of prospective payment, results

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[1790] Fagnani and Tolbert, "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs."

[1791] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," 4.

[1792] Commonwealth Fund Task Force on Academic Health Centers, "A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured," 16.

[1793] Sloan, "Uncompensated Hospital Care: A "Hot" Policy Issue."

[1794] Gail R. Wilensky, "Solving Uncompensated Hospital Care: Targeting the Indigent and the Uninsured," *Health Affairs* 3, no. 4 (1984).

[1795] Allen Dobson and Elizabeth W. Hoy, "Hospital PPS Profits: Past and Prospective," *Health Affairs* 7, no. 1 (1988). Carl J. Schramm and Jon Gabel, "Prospective Payment. Some Retrospective Observations," *New England Journal of Medicine* 318, no. 25 (1988). MedPAC, "Report to the Congress: Medicare Payment Policy: Chapter 3. Hospital Inpatient and Outpatient Services," (Washington, DC: Medicare Payment Advisory Commission, 2012), 58.

[1796] Karen Matherlee, "Margins as Measures: Gauging Hospitals' Financial Health," (Washington, DC: National Health Policy Forum, 1999).

were viewed as mixed. Under this system, a specific predetermined amount is paid for each hospital stay according to a diagnosis-related group (DRG).[1797] In 1986 John Iglehart noted that the early experience with DRGs showed some hospitals clearly profiting.[1798] To some extent, the focus on uncompensated care in the 1980s was a reaction to the perception that hospitals were being overcompensated. Some members of Congress and administrators of Medicare expressed "a belief that hospitals were cynically making exorbitant profits from slurping at the public trough while crying to legislators about the severity of the uncompensated care problem."[1799]

"Uncompensated" Care Overshadows Charity: Definitions, Reporting and Research Standards Are Variable and Careless

In the early studies, one of the first problems encountered was the variability in the definition of uncompensated care. The broadest definition included all hospital charges that were not fully reimbursed: charity, bad debt, contractual allowances by third-party payers, and professional courtesy allowances. The inclusion of these categories rested on the notion that hospitals "should" be paid full charges.[1800] Another problem concerned the reliability and validity of the data. Many studies used the AHA nationwide surveys which are voluntary, self-reported, and not independently verified. Not all

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[1797] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 322-324.

[1798] John K. Iglehart, "Early Experience with Prospective Payment of Hospitals," *New England Journal of Medicine* 314, no. 22 (1986).

[1799] R. Paul Duncan, "Uncompensated Hospital Care," *Medical Care Review* 49, no. 3 (1992): 300.

[1800] Thomas G. Rundall, Shoshanna Sofaer, and Wendy Lambert, "Uncompensated Hospital Care in California: Prvate and Public Hospital Responses to Competitive Market Forces," in *Advances in Health Economics and Research*, ed. Richard M. Scheffler and Louis F. Rossiter (Greenwich, CT: JAI Press, 1988).

hospitals complete the surveys, though the response rate is high.[1801] In addition, accounting standards for reporting charity care and bad debt have changed over the past few decades.

When the first reports of uncompensated care were done, hospitals were reporting charity care according to 1972 audit guidelines by the American Institute of Certified Public Accountants (AICPA). Medicare and Medicaid contractual adjustments, contractual discounts to commercial payers, charity care, bad debt, and other discounts such as courtesy discounts for employees, medical staff, and clergy, were aggregated and reported as deductions from revenue. This aggregation formed a line item that, when subtracted from the gross patient revenue, resulted in net patient revenue. In 1990, AICPA issued a revised guide to auditing and accounting for healthcare entities that superseded its 1972 guide.[1802] One of the main reasons for revising the audit guide was the gap between hospital charges and the amount third parties were contractually obligated to pay. In 1980, hospital charges were on average 20 percent higher than costs and, by 1989, charges were 44 percent higher than costs.[1803] The 1990 audit guide changed patient service revenue reporting such that hospitals report under net service revenue only the amount that third-party payers are obligated to pay as a result of contractual agreements. Charity care and bad debt were removed from deductions to gross patient revenue. The guide placed the reporting of bad debt as an operating expense which is more consistent with accounting standards in other businesses. AICPA removed

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[1801] There was a 20 percent nonresponse rate for the years 1998-2000. Jill R. Horwitz, "Making Profits and Providing Care: Comparing Nonprofit, for-Profit, and Government Hospitals," *Health Affairs* 24, no. 3 (2005).

[1802] Michael E. Bitter and Judith H. Cassidy, "The New Healthcare Audit Guide. Its Impact on Hospitals and Hospital Reporting," *Hospital Topics* 71, no. 4 (1993). Leslie Eldenburg and Naomi Soderstrom, "Accounting System Management by Hospitals Operating in a Changing Regulatory Environment," *The Accounting Review* 71, no. 1 (1996).

[1803] Ashby, "The Burden of Uncompensated Care Grows," 81.

charity care from revenue recognition because, by definition, there is no expectation of revenue. However, charity care must be disclosed in the financial statement footnotes.[1804]

Despite the guidance by AICPA, in 2004 most hospitals were not reporting charity care in their publicly disclosed financial statements. When this information was disclosed, it was not clear whether charges or cost was reported.[1805] In other ways as well, there is a remarkable degree of carelessness in the language used to describe charity and its related terms such as uncompensated care. Even among highly respected researchers, the term "uncompensated care" may not be defined at all and may be used interchangeably with "charity."[1806] The term "free care" has been used as synonymous with charity care plus bad debt.[1807] Other terms, such as "unsponsored care," have sometimes been used as equivalent to charity care. The AHA defined "unsponsored care" as uncompensated care net of state and local tax appropriations.[1808] However, in Texas, "unsponsored care" continues to be used by some state hospitals where it includes an unclear mix of "indigent" and "medically indigent" patient costs along with shortfalls from Medicaid.[1809] Some researchers continued to define uncompensated care broadly even after the AICPA guidelines specified separate reporting of charity and bad debt and

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[1804] Bitter and Cassidy, "The New Healthcare Audit Guide. Its Impact on Hospitals and Hospital Reporting."

[1805] Sandra J. Wolfskill, *Charity Care: Tools to Manage the Uninsured Population* (Marblehead, MA: HCPro, 2005), 15.

[1806] Joyce M. Mann et al., "Uncompensated Care: Hospitals' Responses to Fiscal Pressures," *Health Affairs* 14, no 1 (1995). J. Needleman, J. Lamphere, and D. Chollet, "Uncompensated Care and Hospital Conversions in Florida," *Health Affairs* 18, no. 4 (1999).

[1807] Feder, Hadley, and Mullner, "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982."

[1808] Ashby, "The Burden of Uncompensated Care Grows," 76. David Burda, "Charity Care: Are Hospitals Giving Their Fair Share?" *Modern Healthcare* 22, no. 24 (1992).

[1809] Texas State Auditor's Office, "An Audit Report on Charity Care at Health-Related Institutions," (2007), http://www.sao.state.tx.us/reports/main/07-034.pdf (accessed March 14, 2013).

the exclusion of contractual allowances and discounts.[1810] It has been recognized by some authors that there is "a fundamental lack of precision that constrains our ability to understand and respond to the uncompensated care problem."[1811] For the most part, researchers have over time simply accepted the constraints of lack of precision as constituting the accepted way to analyze charity and uncompensated care. For example, in 1997 researchers commented: "In principle, charity care better reflects the inability to pay that is a central policy concern. However, hospitals' classification of charity care and bad debt is inconsistent, and the two categories are regularly combined in analysis."[1812]

In other words, the main reason that uncompensated care became entrenched in the literature on charity care was that hospitals did not "make a rigorous distinction" between the two categories.[1813] This lack of distinction, now more than twenty-five years later, continues to be put forth as the reason that both charity and bad debt should be considered together. In its 2012 fact sheet on uncompensated care, the AHA explains:

> In terms of accounting, **bad debt** consists of services for which hospitals anticipated but did not receive payment. **Charity care**, in contrast, consists of services for which hospitals neither received, nor expected to receive, payment because they had determined, with the assistance of the patient, the patient's inability to pay. In practice, however, hospitals often have difficulty in distinguishing bad debt from charity care…Depending on a variety of factors, including whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt. Bad debt is often generated by medically indigent and/or uninsured patients, making the distinctions between the two categories arbitrary at best. Therefore, it is

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[1810] Zollinger et al., "A Determination of Institutional and Patient Factors Affecting Uncompensated Hospital Care." Kathleen Kilbane and Beth Blacksin, "The Demise of Free Care: The Visiting Nurse Association of Chicago," in *Readings in American Health Care: Current Issues in Socio-Historical Perspective*, ed. William G. Rothstein (Madison, WI: University of Wisconsin Press, 1995).

[1811] Duncan, "Uncompensated Hospital Care," 284.

[1812] Graham Atkinson, W. David Helms, and Jack Needleman, "State Trends in Hospital Uncompensated Care," *Health Affairs* 16, no. 4 (1997): 241.

[1813] Sloan, Valvona, and Mullner, "Identifying the Issues: A Statistical Profile."

> reasonable to consider bad debt as a component of hospitals' total cost of care to medically indigent and underinsured patients.[1814]

Researchers have pointed out that hospitals have differing motivations when reporting uncompensated care based on their ownership type.[1815] Reporting uncompensated care as bad debt reduces business revenue which lowers the taxable income of for-profit hospitals.[1816] Nonprofit hospitals have an incentive to report uncompensated care as charity since this conforms to public expectations and to some state laws which require charity care as a component of community benefit.[1817] Flexibility in hospital accounting practices reflects the bias of incentives based on ownership status in other ways as well. For example, for-profit hospital executives have an incentive to smooth earnings and to show continuous increases whereas nonprofit hospitals have an incentive to report excess revenue along with the constraint of not appearing too profitable.[1818]

Two publications on uncompensated care provided the first national information on such care for 1982.[1819] In the study published after a 1984 conference on uncompensated care the authors, led by economist Frank Sloan, defined uncompensated care as charity care and bad debt, citing the lack of a "rigorous distinction" between the two categories by hospitals. The results were widely cited and published in book

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[1814] Emphasis original. American Hospital Association, "American Hospital Association Uncompensated Hospital Care Cost Fact Sheet."

[1815] Atkinson, Helms, and Needleman, "State Trends in Hospital Uncompensated Care."

[1816] John K. Iglehart, "Medical Care of the Poor--a Growing Problem," *New England Journal of Medicine* 313, no. 1 (1985).

[1817] Atkinson, Helms, and Needleman, "State Trends in Hospital Uncompensated Care."

[1818] Andrew J. Leone and R. Lawrence Van Horn, "How Do Nonprofit Hospitals Manage Earnings?" *Journal of Health Economics* 24, no. 4 (2005).

[1819] Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Uncompensated Hospital Care: Rights and Responsibilities* (Baltimore, MD: Johns Hopkins University Press, 1986). Robert L. Ohsfeldt, "Uncompensated Medical Services Provided by Physicians and Hospitals," *Medical Care* 23, no. 12 (1985).

form.[1820] The authors used charges instead of costs and arrived at a total of $6.2 billion in uncompensated care for the year or about 5 percent of hospital charges. Choosing to aggregate bad debt and charity care into uncompensated care served to inflate the amount reported as compared to separating the amounts, as had been required in Hill-Burton reporting of uncompensated care. The authors did report that $1.7 billion was charity and the rest was bad debt and that 97 percent of the uncompensated care of for-profit hospitals was bad debt. However, the comparisons among hospitals were all aggregated charity care and bad debt.[1821] Choosing to report the aggregated amount in terms of charges also served to inflate the amount reported, though not the percentage as long as both were based on charges. These choices clearly reflected the perspective of health care providers.[1822] Hospitals received an average of 82 percent of all charges in 1981, including, on average, about 72 percent of all charges from self-pay patients. Even payments by commercial insurers were less than full charges, averaging 89 percent.[1823] Again, this was one of the main reasons that AICPA changed the guidelines for hospital financial reporting such that total revenue would reflect the amount that hospitals expected to receive from payers.[1824]

The amount of Hill-Burton charity care in 1984 was reported to be $3 billion, though how this fit within an understanding of reported uncompensated care was not clear, especially since the amount of charity care reported on the national level was only

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[1820] Sloan, Valvona, and Mullner, "Identifying the Issues: A Statistical Profile," 16.

[1821] Ibid.

[1822] Uwe E. Reinhardt, "Uncompensated Hospital Care," in *Uncompensated Hospital Care: Rights and Responsibilities*, ed. Frank A. Sloan, James F. Blumstein, and James M. Perrin (Baltimore, MD: Johns Hopkins University Press, 1986).

[1823] It is not entirely clear that self-pay and no charge patients were the same category, though in the Sloan study they were. Paul B. Ginsburg and Frank A. Sloan, "Hospital Cost Shifting," *New England Journal of Medicine* 310, no. 14 (1984): 895.

[1824] Bitter and Cassidy, "The New Healthcare Audit Guide. Its Impact on Hospitals and Hospital Reporting."

$1.7 billion in 1982.[1825] The amount of uncompensated care at the national level was "surprisingly small" to some health policy experts.[1826] Questions remained even when the data was analyzed. For example, how to account for tax appropriations at public hospitals when reporting uncompensated care was one area of uncertainty.[1827] State and local government funding of hospital care through tax appropriations and other non-Medicaid funding was $9.5 billion in 1982.[1828] Other questions arose such as how to address the uneven distribution of uncompensated care. The amount of uncompensated care was particularly large at public hospitals that were also teaching hospitals. Sloan and the other authors of the 1982 study of uncompensated care commented that, in general, the amount "does not seem to be sufficiently high to account for all of the recent interest among both public officials and the public at large."[1829] Some of the interest in uncompensated care derived from the belief that such care was responsible for hospitals' closings. Among the study's important and unexpected findings was that hospital closings were not a result of excessive uncompensated care.[1830] Yet even if specific findings did not turn out to be substantiated, there was a common perception that times were changing. The hospital industry felt threatened by cost containment measures. A researcher commented that

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[1825] Gloria J. Bazzoli, "Health Care for the Indigent: Overview of Critical Issues," *Health Services Research* 21, no. 3 (1986): 371.

[1826] Wilensky, "Solving Uncompensated Hospital Care: Targeting the Indigent and the Uninsured," 51.

[1827] Thomas J. Hoeger and Teresa M. waters, "Problems in Determining a Hospital's Level of Uncompensated Care," (Nashville, TN: Health Care Financing Administration, 1993), 48.

[1828] Feder, Hadley, and Mullner, "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982," 544. Lawrence S. Lewin, Timothy J. Eckels, and Linda B. Miller, "Setting the Record Straight. The Provision of Uncompensated Care by Not-for-Profit Hospitals," *New England Journal of Medicine* 318, no. 18 (1988).

[1829] Sloan, Valvona, and Mullner, "Identifying the Issues: A Statistical Profile," 41.

[1830] Ibid.

there had been “an erosion of the genteel arrangement of cross-subsidies (cost shifting) that historically allowed hospitals to provide charity care without serious financial penalty or competitive handicap.”[1831]

The set of information that has not been available at any time is about the people who need hospital care but do not receive it. This was fully recognized by the 1982 study’s authors: “An unfortunate characteristic of hospital-based data is that they do not describe those persons needing hospital care who are unable to obtain it.”[1832] The turning away of just over 100 patients in the five months surrounding the Newsom case in 1978 was one of the few sources of information and it was only available at trial.[1833] The measures that hospitals take to avoid uncompensated care were included in the 1982 study, though the information lacked details. On average, 15 percent of hospitals adopted “explicit limits” on charity care. Among the teaching hospitals that were providing the most uncompensated care, 26 percent adopted explicit limits on charity care.[1834] There is a gap in information on how these explicit limits were implemented and the gap remains today. On this issue, the bioethicist Charles Dougherty remarked: “For obvious reasons, hospitals do not report the numbers of individuals to whom they have denied care.”[1835] Survey results from 1982 did show that 15 percent of uninsured families did not obtain needed medical care and 4 percent were refused medical care because of financial

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[1831] Lawrence S. Lewin and Marion E. Lewin, "Financing Charity Care in an Era of Competition," *Health Affairs* 6, no. 1 (1987): 48.

[1832] Sloan, Valvona, and Mullner, "Identifying the Issues: A Statistical Profile," 40.

[1833] *Newsom v. Vanderbilt University*, 429.

[1834] ———, "Identifying the Issues: A Statistical Profile," 27-28.

[1835] Charles J. Dougherty, "Cost Containment, DRGs, and the Ethics of Health Care. Ethical Perspectives on Prospective Payment," *Hastings Center Report* 19, no. 1 (1989): 10.

reasons.[1836] About one million people tried to get medical care but could not in 1986, though the survey did not provide any other details.[1837] A full answer to the question of how many people could not get medical care would need to include people who did not believe they could obtain medical care and so did not try and those who sought care but were turned away.[1838]

As already mentioned, the most important data available on a national basis concerning uncompensated care is from the AHA surveys which are voluntary, self reported, and not independently verified. Nonresponse rates to the survey are higher from for-profit hospitals which may lead to some distortion of data.[1839] When the 1982 data from the AHA was examined, charity care and bad debt were available for analysis, albeit with the limitations of the information already mentioned. Robert Ohsfeldt, an economist in Indiana, used the same 1982 data available to Sloan but reported separately about charity care and bad debt. Overall, the percentage of charity care per hospital averaged 1.6 percent of gross revenue.[1840] Charity care as a percentage of total revenue was 4.2 percent for public hospitals, 1.1 percent for nonprofit hospitals, and 0.1 percent at for-profit hospitals.[1841] For bad debt, the percentage for hospitals at the national level in 1982

[1836] Gray, *For-Profit Enterprise in Health Care*, 98.

[1837] Howard E. Freeman et al., "Americans Report on Their Access to Health Care," *Health Affairs* 6, no. 1 (1987).

[1838] Gray, *For-Profit Enterprise in Health Care*, 98.

[1839] Horwitz, "Making Profits and Providing Care: Comparing Nonprofit, for-Profit, and Government Hospitals." Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 101.

[1840] Two studies were published on uncompensated care amounts in 1982 but the study in the journal *Medical Care* did not receive attention in the mainstream health policy literature. Ohsfeldt, "Uncompensated Medical Services Provided by Physicians and Hospitals."

[1841] Ibid., 1341.

was 3.6 percent. Public hospitals reported 6.6 percent of total revenue was bad debt, nonprofit hospitals reported 3.0 percent, and for-profit hospitals reported 2.9 percent.[1842] Would the public's and policymaker's understanding of charity care have been different if all of these early researchers had reported their findings as Ohsfeldt did, separating charity and bad debt?

The data from the AHA are not available to the public and few researchers are allowed access to it.[1843] One result is that the AHA can control, to some extent, the information the public sees. In 1992, David Burda, a journalist at *Modern Healthcare*, tried to get the AHA to release charity care and bed debt separately but the association refused, stating the figures were not reliable because charity care is mostly "guesswork." The AHA's general counsel acknowledged that there was no standard definition of uncompensated care and that there is an "infinite" number of ways to report it. Burda explained that the story the AHA was telling was not consistent with the information available: "The picture of charity care that the hospital industry wants everyone to see tells the story of an ever-rising wave of uninsured patients threatening financial ruin for hospitals too benevolent for their own good" but that internal documents demonstrated less charity care by hospitals in 1990 as compared to 1986.[1844] In 2005 the situation remained largely the same. That is, the AHA does not make charity care and bad debt

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[1842] Ibid., 1343.

[1843] Nancy M. Kane and Stephen A. Magnus, "The Medicare Cost Report and the Limits of Hospital Accountability: Improving Financial Accounting Data," *Journal of Health Politics, Policy & Law* 26, no. 1 (2001): 88. Amy J. Davidoff et al., "The Effect of Changing State Health Policy on Hospital Uncompensated Care," *Inquiry* 37, no. 3 (2000).

[1844] Burda, "Charity Care: Are Hospitals Giving Their Fair Share?"

information available for monitoring purposes and the distinction between the terms remained unclear.[1845]

A separate set of data on uncompensated care was presented at a 1984 conference by the United Hospital Fund of New York, though this information did not become widely included in the literature. This study used a national sample of data from all nonprofit hospitals for the year 1977 from the National Center for Health Services Research which linked to a comprehensive set of other databases, including the AHA's. Instead of aggregating bad debt and charity, the economist Joyce Kelley analyzed charity care admissions defined as inpatient services for which the payer source is either "no charge" or charity. The data showed that almost half of nonprofit hospitals did not have any charity admissions in 1977. The mean percentage of charity admissions was 2 percent of all admissions. The research also demonstrated that the nonprofit hospital's financial position was not related to the percentage of charity admissions.[1846] This information was not what nonprofit hospitals generally conveyed to the public.

When researchers chose to combine charity care and bad debt into the term "uncompensated care," it legitimized the hospitals' point of view that these infringements on profit or revenue were what mattered and simultaneously that the point of view of patients was not relevant. Acting in concert with the lack of data on how many patients were turned away from hospitals, the premise was that the problem was the lack of funding for hospitals on the care that they were obviously providing as evidenced by the

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[1845] Weissman, "The Trouble with Uncompensated Hospital Care."

[1846] Forty-eight percent of nonprofit hospitals did not have any charity admissions in 1977. Joyce V. Kelley, "Provision of Charity Care by Urban Voluntary Hospitals," in *Hospitals and the Uninsured Poor: Measuring and Paying for Uncompensated Care*, ed. Sally J. Rogers, Ann Marir Rousseau, and Susan W. Nesbitt (New York, NY: United Hospital Fund of New York, 1985).

amount of uncompensated care. The homogenization of bad debt and charity served also to assign moral significance to both categories. The use of the term “uncompensated care” as encompassing bad debt and charity care cast aside the findings of the *Corum* court in which it was understood that there was a practical and moral difference between billing all patients, even those who could not reasonably be expected to pay their bills because their income was too meager, then “writing off” those debts once they remained unpaid and determining ahead of time that the services would be charity. Using uncompensated care as encompassing bad debt and charity also cast aside the findings of the *Newsom* court. Ms. Callie Mae Newsom and the class of patients who had been or would be in need of medical services for which they were unable to pay were recognized by the court as subject not to the “writing off” of medical debt but to the potential of being turned away and, if services were received, of being sued by the hospital and having their wages garnished.

One of the most highly charged outcomes from the Sloan publication which combined bad debt and charity was that nonprofit and for-profit hospitals did not differ appreciably in the amount of uncompensated care provided.[1847] This information had at least two effects. First, it served to undermine the common assertion that the rise in for-profit hospitals would mean the provision of much less uncompensated care. Second, it led to further questions about whether there was any difference between nonprofit and for-profit hospitals. When a 1986 Institute of Medicine Committee studied the provision of uncompensated care, they found that all types of hospitals had undertaken measures to reduce such care and that differences between nonprofit and for-profit hospitals were

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[1847] Sloan, Valvona, and Mullner, "Identifying the Issues: A Statistical Profile," 24.

small. The committee also recognized that the combination of bad debt and charity care had serious shortcomings:

> “Uncompensated care” (deductions from gross revenues for bad debt and charity care) is a seriously flawed measure of either institutional performance or the extent to which the needs of those who are unable to pay are being met…To say that a hospital has a given percentage of bad debt does not reveal precisely whether it has been acting with generosity or whether it had been lax or ineffective in trying to collect payment. Furthermore, “uncompensated care” is not a measure of an institution’s real costs in providing such care, but only of what revenues would have been gained if payment had been received. Finally, expressed as a percentage of gross patient revenues, “uncompensated care” does not reflect any nonpatient care revenues that may be obtained to subsidize uncompensated care. Nevertheless, uncompensated care as a percentage of gross revenues is the most commonly used measure of institutions’ service to patients who are unable to pay. It is useful for comparisons across categories, but it should not be taken as a true measure of the extent to which human needs are being met. And, because not all persons seek needed care, uncompensated care (or number of uninsured patients served) is at best a partial proxy for the full unfinanced needs of the population.[1848]

The Institute of Medicine study was undertaken because the rise of for-profit hospitals had been of significant concern to a broad range of stakeholders. Although proprietary hospitals had been prevalent in the early twentieth century, making up half of all hospitals, these were small hospitals established by physicians and oriented toward their local communities. Most of these hospitals closed or became nonprofit hospitals throughout the following decades. In the late 1960s, however, investor owned companies came to dominate the for-profit hospital industry. In large part this was because of the increase in the number of hospitalized patients with health insurance and the reimbursement for a variety of costs under Medicare which lessened financial risks of investors. By 1983 about 13 percent of all hospitals were investor owned.[1849] Although for-profit hospitals were shown to provide significantly less uncompensated care in some

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[1848] Gray, *For-Profit Enterprise in Health Care*, 111.

[1849] ———, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 31-37.

states and, in a 1984 survey, physicians were two to four times more likely to report that their hospital discouraged admissions of uninsured patients at for-profit hospitals, these hospitals could still argue that differences in uncompensated care were small. Even if there was some small difference in uncompensated care, these hospitals could point out that they also paid taxes.[1850]

What is a Charity?

The small differences in uncompensated care did, as already mentioned, fuel an ongoing debate on the tax exempt status of nonprofit hospitals. The health policy analyst Bradford Gray noted in his 1991 book on for-profit health care: "Perhaps the greatest threat to the predominantly private, nonprofit nature of our hospitals comes not from the rise of an investor-owned sector but from changes among the nonprofits themselves."[1851] Challenges to tax exempt status which began with some furor in the 1980s were not new. The U.S. Treasury Department in 1942 required hospitals to submit a financial report in order to distinguish between the "bona fide voluntary hospital and the institution 'masquerading under the cloak of charity.'"[1852] However, in 1985 the Utah Supreme Court "shook the voluntary sector to its core" when it revoked the tax exempt status of two hospitals because of failure to provide a sufficient level of charity care.[1853] Spokespersons for investor-owned hospitals began to assert that the only difference between the types of hospitals was that for-profits paid taxes.[1854] In fact, generally for-

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[1850] Ibid., 105-106.

[1851] Ibid., 334.

[1852] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 223.

[1853] Mark A. Hall and John D. Colombo, "The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption," *Washington Law Reveiw* 66 (1991): 308.

[1854] Arnold S. Relman, "Are Voluntary Hospitals Caring for the Poor?" *New England Journal of Medicine* 318, no. 18 (1988).

profit hospitals would be found to provide more community benefit than nonprofit hospitals if the amount of taxes paid were included as a community benefit.[1855] An opinion survey in 1988 determined that 85 percent of the public believed that all hospitals should provide care to everyone regardless of ability to pay. Close to half of the public believed that nonprofit hospitals should not continue their tax exemption.[1856] The public and the nonprofit hospital industry seemed to have differing conceptions of what being a charitable hospital means.

Nonprofit scholars trace the history of charities to ancient times when Egyptians in about 1300 B.C. were buried with their record of “blessed giving,” which included all they had shared with the poor.[1857] The relationship between charities and tax exemption is also long-lasting. There are Biblical references to not allowing religious leaders to pay the equivalent of a tax.[1858] American scholars trace the existence of charities to the English Poor Laws and the Statute of Charitable Uses passed in 1601 as well as to the 1736 legal definition offered by England’s Lord McNaughten.[1859] Hospitals fit within the

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[1855] David Shactman and Stuart H. Altman, "The Impact of Hospital Conversions on the Healthcare Safety Net," in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* ed. Stuart Altman, Uwe E. Reinhardt, and Alexandra E. Shields (Chicago, IL: Health Administration Press, 1998), 199.

[1856] James B. Simpson and Sarah D. Strum, "How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered," *University of Puget Sound Law Review* 14 (1991): 636.

[1857] Thomas Kelley, "Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law," *Fordham Law Review* 73, no. 6 (2005): 2440.

[1858] David A. Hyman, "The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals," *American Journal of Law and Medicine* 16, no. 3 (1991): 334.

[1859] The Statute of Charitable Uses included the following: [S]ome for relief of aged, impotent and poor people, some for maintenance of sick and maimed soldiers and mariners, schools of learning, free schools, and scholars in universities, some for repair of bridges, ports, havens, causeways, churches, sea-banks, and highways, some for education and preferment of orphans, some for or towards relief, stock or maintenance for houses of correction, some for marriages of poor maids, some for supportation, aid and help of young tradesmen, handicraftsmen and persons decayed, and others for relief or redemption of prisoners or captives, and for aid or ease of any poor inhabitants concerning payments of fifteens, setting out of soldiers and other taxes;... Lord McNaughten summarized the legal aspects of charity as follows: “Charity" in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads. The Trusts last referred to are not the less charitable in the eye understanding that charities primarily were directed at the poor. As hospitals became distinguishable from almshouses in the nineteenth century, they still remained places primarily for the sick poor. In the years prior to the Civil War, "the hospital's patients were seen as genuinely needy almost by definition and less likely than recipients of free food or fuel to be impostors, for none but the ill and desperate would willingly seek the dubious comforts of a hospital ward."[1860]

Even then, hospitals had a limited number of free beds and paying patients were unlikely to be turned away despite their status as "undeserving" because of venereal disease or alcoholism.[1861] According to the historian Charles Rosenberg, patients who paid in part or in full were always a part of American hospitals. About half of the patients treated at the Pennsylvania Hospital from 1752 through 1854 paid all or part of their board.[1862] A variety of measures were undertaken to provide funding to hospitals. Hospitals lobbied their state and local governments for funds; local philanthropists could support a free bed in perpetuity with an endowment; businesses could prepay for their employees' hospital care; churches could take up collections in support of a hospital; and women's committees could sponsor fund raisers.[1863] Despite calling upon the benevolence of community members, in the first few decades of the twentieth century, paying patients and patients subsidized by government sources served to strengthen "[g]rudging if not punitive, attitudes toward the indigent."[1864] At Brooklyn Hospital in

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of the law, because incidentally they benefit the rich as well as the poor, as indeed, every charity that deserves the name must do either directly or indirectly.
Kelley, "Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law," 2448-2449. Hyman, "The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals," 354.

[1860] Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*: 22.

[1861] Ibid., 23.

[1862] Ibid., 32.

[1863] Ibid., 240-241.

[1864] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 47.

New York at the turn of the nineteenth century, trustees decided to limit the number of free patients such that, by 1913, over half of hospital days were provided to paying patients.[1865] The care of about 80 percent of the "free" patients was reimbursed, however, by municipal funds.[1866] Instead of increasing charity care, as already mentioned, the availability of government subsidy of low income patients paradoxically reduced the willingness of hospitals to take on patients who had no subsidy.[1867] By the first decade of the twentieth century, Paul Starr declared: "Hospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue."[1868] On a national level in 1922, hospitals received 65 percent of their income from paying patients, public appropriations comprised 17 percent of their income, endowments were almost 4 percent, donations less than 5 percent and other sources about 8 percent.[1869] At the same time, tax exemption was clearly seen as relieving the government of a burden and ensuring a continued quid pro quo. This was expressed clearly in the Congressional Record in 1917 by Senator Hollis: "For every dollar" of forgone taxes, "the public gets 100 percent" return in free hospital services.[1870]

One point that was mentioned at the beginning of this chapter is that nonprofit hospitals did not suddenly move away from their commitment to charity but that charity

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[1865] David Rosner, *A Once Charitable Enterprise : Hospitals and Health Care in Brooklyn and New York, 1885-1915*, Interdisciplinary Perspectives on Modern History (New York, NY: Cambridge University Press, 1982), 82-83.

[1866] Ibid., 144.

[1867] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 47.

[1868] Starr, *The Social Transformation of American Medicine*: 159.

[1869] Ibid., 161.

[1870] See Gabriel O. Aitsebaomo, "The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption," *Campbell Law Review* 26, no. 2 (2004): 76.

always stood in tension with the business of running hospitals. The tension also occurred between the symbolic ideal and the less-than-ideal reality. As Rosemary Stevens notes:

> [H]ospitals have simultaneously carried symbolic and social significance as embodiments of American hopes and ideals: not only of science, technology, and expertise, but of altruism, social solidarity, and community spirit. The ideal of "charity" has been at least as important as the "business of business."[1871]

Still, it is not hard to understand how state courts and local tax authorities could exempt hospitals from taxes even though hospitals were not specifically mentioned in the common law definition of a charity or in later federal tax revenue rulings. In the nineteenth and early twentieth century, the legal definition of charity has been described as ambiguous, amorphous, uncertain, and dependent upon the look and feel of the organization.[1872] In fact, the meaning of the concept of a charity has been deemed a "task that is about four hundred years overdue."[1873] Exemption of nonprofit hospitals from federal taxes after passage of the 16th Amendment allowing Congress to levy an income tax and the 1913 Revenue Act merely continued the practice of exempting organizations that were "organized solely for charitable…purposes" and in which the earnings did not inure to the benefit of any private stockholder or individual.[1874] Not all hospitals were allowed exemption from taxes, with courts sometimes deciding that, for example, a

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[1871] Stevens, *In Sickness and in Wealth : American Hospitals in the Twentieth Century*: 6.

[1872] Kelley, "Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law," 2469, 2472.

[1873] Hall and Colombo, "The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption."

[1874] Boris I. Bittker and George K. Rahdert, "The Exemption of Nonprofit Organizations from Federal Income Taxation," *Yale Law Journal* 85, no. 3 (1976): 301. Aitsebaomo, "The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption," 75-79.

physician-owned hospital was primarily formed for the purpose of raising revenue through charitable deductions.[1875]

Nonprofit hospitals qualify for federal tax exemption on the basis of the Internal Revenue Code section 501(c)(3) which was originally enacted in 1954 but followed its 1939 precursor.[1876] The tax code does not define "charitable," and according to the Joint Committee on Taxation, the definition has not been static when applied to hospitals.[1877] The tax code also does not provide for a per se exemption for hospitals, as already mentioned. Instead, a hospital must qualify for tax exemption by showing that it is organized and operated for a charitable purpose, that its earnings do not inure to any individual, and that it does not engage in political or lobbying activities.[1878]

There have been two standards for hospital federal tax exemption issued by the Internal Revenue Service. The first standard, Revenue Ruling 56-185 issued in 1956, stated that the term "charitable" in its legal sense "contemplates an implied public trust constituted for some public benefit."[1879] The ruling adopted the "financial ability standard," requiring that a charitable hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay." The ruling further stated that the tax exempt hospital must not "refuse to accept patients in need of hospital care who cannot pay for such services." The ruling addressed the issue of bad debt, stating that, if the hospital "operates

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[1875] A 1928 such case is mentioned in: Helena G. Rubinstein, "Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription," *Health Matrix* 7, no. 2 (1997). A 1961 case is briefly discussed in: Bittker and Rahdert, "The Exemption of Nonprofit Organizations from Federal Income Taxation," 337.

[1876] Terri L. Brooks, "Billions Saved in Taxes While Millions Underserved-What Has Happened to Charitable Hospitals?" *Houston Business and Tax Law Journal* 8 (2008): 395.

[1877] Joint Committee on Taxation, "Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals," (2006).

[1878] General Accounting Office, "Nonprofit Hospitals: Better Standards Needed for Tax Exemption," (Washington, DC: U.S. General Accounting Office, 1990).

[1879] Internal Revenue Service, "Revenue Ruling 56-185," (1956), http://www.irs.gov/pub/irs-tege/rr56-185.pdf (accessed March 14, 2013).

with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered." However, the ruling acknowledged that hospitals normally charge patients who are able to pay for services in order to meet the hospital's operating expenses and stated that the "fact that the hospital's charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability."[1880] At the same time, as a practical matter under the 1956 standard in the few cases where a tax exemption was challenged, a hospital that provided free care to fewer than 5 percent of its patients risked losing its tax exemption.[1881]

The 1956 standard effectively meant that a charitable hospital could not refuse to accept patients in need of hospital care who could not pay for such services and that bad debt alone would not qualify the hospital for tax exemption. In 1969, however, this standard was radically altered "to remove the requirements relating to caring for patients without charge or at rates below cost."[1882] The 1969 standard adopted the "promotion of health" standard which quickly became known as the "community benefit" standard and it remains the standard under which hospitals qualify as tax exempt today. The ruling states:

> The promotion of health…is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community…In considering whether a nonprofit hospital claiming such exemption is operated to serve a private benefit, the Service will weigh all of the relevant facts and

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[1880] Ibid.

[1881] T.J. Sullivan and V. Moore, "A Critical Look at Recent Developments in Tax-Exempt Hospitals," *Journal of Health and Hospital Law* 23 (1990).

[1882] Internal Revenue Service, "Revenue Ruling 69-545," (1969), http://www.irs.gov/pub/irs-tege/rr69-545.pdf (accessed March 14, 2013).

> circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessary [sic] be determinative.[1883]

The ruling indicated that some of the factors to be considered included the existence of a community board, an open medical staff, treatment of patients with "the aid of public programs such as Medicare," and the operation of "a full time emergency room and no one requiring emergency care is denied treatment." Specifically, the ruling allowed tax exemption if the nonprofit hospital "ordinarily limits admissions to those who can pay" themselves or through private or public health insurance, even when "[p]atients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients."[1884]

Health policy scholars have searched for an answer as to how the Internal Revenue Service could have abandoned the obligation of nonprofit hospitals to provide free care to the poor in exchange for tax exemption. During Congressional hearings in 1969, unsurprisingly, the AHA advocated tax exemption for any hospital "so long as its earnings do not inure to the benefit of any private individual—without regard to any test measuring the amount of free patient care."[1885] In an argument that has been called a "circular" redefinition of charity, Mark Hall and John Columbo note: "This view seems determined to reshape the concept of charity however necessary to fit the predominant pattern of what most nonprofit hospitals are currently doing."[1886] In issuing the 1969 ruling, the IRS accepted the point of view of hospital industry spokespeople. Ironically, three years after the implementation of Medicare and Medicaid and the additional health insurance coverage of millions of Americans, the hospital industry put forth the idea that

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[1883] Ibid.

[1884] Ibid.

[1885] M. Gregg Bloche, "Health Policy Below the Waterline: Medical Care and the Charitable Exemption," *Minnesota Law Review* 80 (1995): 306.

[1886] Hall and Colombo, "The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption," 323.

they were now “less, not more, responsible for those patients who lacked third-party coverage.”[1887] When the ruling was issued, moreover, there was no serious inquiry into whether the health needs of low income people were being adequately met. The IRS did not solicit input from advocates for the poor and certainly not from poor people themselves and the Department of HEW, responsible for both Medicare and Medicaid, was not consulted. The IRS officials who issued the ruling simply accepted the hospital industry’s contention that charity care had become an anachronism, a premise that has been called “pure fantasy.”[1888]

Although the ruling is considered a landmark, it is important to note as well that over the next two decades nonprofit hospitals that engaged in “patient dumping” in the emergency department were not threatened with loss of tax exemption despite the clear prohibition of this practice in the ruling.[1889] According to health policy historian Daniel Fox, if the IRS “had looked for hospitals which refused emergency care to patients unable to pay, it would have found no end of candidates for loss of tax exemption.”[1890] In 1971, on the wave of class action lawsuits under the Hill-Burton Act, a group of advocates brought suit against the secretary of the Treasury and the commissioner of the Internal Revenue Service seeking to revoke the 1969 ruling and reinstate the former standard for tax exemption. The twelve defendants in *Eastern Kentucky Welfare Rights*

[1887] Fox and Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," 260.

[1888] Bloche, "Health Policy Below the Waterline: Medical Care and the Charitable Exemption," 310.

[1889] See Chapter 3 on the emergency department and charity care. Fox and Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," 254. Also, the IRS issued Revenue Ruling 83-157 in 1983 which states that a hospital may still qualify for tax exemption if it does not operate an emergency department when, for instance, the community has sufficient emergency care and when a specialized hospital such as those limited to eye care or cancer care does not operate an emergency department. Internal Revenue Service, "Revenue Ruling 83-157," (1983), http://www.irs.gov/pub/irs-tege/rr83-157.pdf (accessed March 14, 2013).

[1890] Fox and Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts," 273.

Organization v. Simon, some of whom were insured through Medicaid, all claimed that nonprofit hospitals had denied medical care to them on the basis of inability to pay. Over the next five years the lawsuit made its way through the courts where eventually the Supreme Court ruled that the plaintiffs lacked standing to privately sue to enforce the Internal Revenue Code. The AHA argued in an amicus brief that there had been "a rapid disappearance of patients needing free care" and that the 1969 ruling required that hospitals not turn away Medicaid and Medicare patients.[1891] However, it was not until 1990 that the IRS stated it would henceforth require nonprofit hospitals to accept Medicaid patients. The appeal court's opinion mirrored the position of the AHA, finding that the "rationale upon which the [free care] definition of 'charitable' was predicated has largely disappeared."[1892]

The Tax Exempt Status of Hospitals is Challenged

Even though Revenue Ruling 69-545 changed the requirements for tax exemption to the vague notion of community benefit based on the broad "promotion of health" standard, courts at the federal, state, and local level as well as state officials and legislatures continued to include charity care as an important component of community benefit. John Columbo has described this process as the transformation of community benefit to "health care for the general benefit of the community plus something else like charity care."[1893] Yet many of the gains from the standpoint of returning to a requirement of some charity care have often been significantly watered down in political processes at the state and local level. For example, the Utah Supreme Court in the influential case,

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[1891] Ibid., 269.

[1892] Alice A. Noble, Andrew L. Hyams, and Nancy M. Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," *Journal of Law, Medicine & Ethics* 26 (1998): 118.

[1893] John Columbo, "The Failure of Community Benefit," *Health Matrix* 15, no. Winter (2005): 35.

Utah County v. Intermountain Health Care, took a dim view of the fact that the two nonprofit hospitals in question had aggressively pursued payment from all patients, offering only assistance with bank loans for those unable to pay. The court's six-part test for tax exempt status, however, was altered by Utah's Tax Commission which essentially adopted the hospital industry's proposal.[1894] As in Utah, several other states reenacted the basic principle that nonprofit tax exemption is a political process in which the judiciary is but one factor.[1895]

In 1990, the Attorney General of Texas was the first nontax authority to challenge the tax exempt status of a hospital.[1896] Houston's Methodist Hospital, at the time, was the nation's largest nonprofit hospital with over 1,000 beds and excess revenue over expenses of $22 million on total revenue of $462 million in 1989. The hospital claimed that it provided over $100 million in "free uncompensated care," while the Attorney General claimed that only $3.5 million was free care to the poor.[1897] The Attorney General was responding to complaints that uninsured patients were being denied access to the nonprofit hospital. A subpoena of financial information revealed that $600 million was being held in cash reserves by Methodist Hospital.[1898] Affidavits were filed from indigent patients stating they had been turned away from the hospital.[1899] In a deposition by the CEO of Methodist, it was revealed that the hospital's admission policy included

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[1894] Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," 120-121.

[1895] Ibid., 122.

[1896] Ibid., 123.

[1897] David Burda, "Houston's Methodist Hospital Given Charity-Care Ultimatum," *Modern Healthcare* 20, no. 28 (1990).

[1898] Kane and Magnus, "The Medicare Cost Report and the Limits of Hospital Accountability: Improving Financial Accounting Data," 86.

[1899] Daniel Rey-Bear, "Judicial Enforcement of Charitable Care Requirements for Nonprofit Hospitals' Tax-Exempt Status," *Texas Forum on Civil Liberties and Civil Rights* Fall (1993).

the denial of services to uninsured Houstonians who could not afford large cash deposits before receiving care. The CEO claimed: "It is a charitable purpose to serve a rich man or a poor man."[1900] Also according to the CEO, the hospital's educational and research activities fulfilled its charitable mission.[1901] The wide discrepancy between what the hospital reported and what external reviewers determined was actually the amount of charity care or uncompensated care has been revisited many times since the early 1990s in Texas and elsewhere.[1902]

When the Attorney General's lawsuit challenging the tax exemption of Methodist Hospital was dismissed because the attorney general lacked the authority to direct the allocation of the nonprofit hospital's resources, attention was directed toward legislation. In 1993, Texas became the first state to implement a law requiring a specific percentage of hospital revenue for charity and indigent health care and other community benefits.[1903] In the aftermath of the Texas Attorney General's difficulty in obtaining any financial information on the nonprofit hospital, the law also requires public disclosure of financial information collected by the state.[1904]

[1900] Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," 132.

[1901] Dana A. Forgione, "The Methodist Hospital System: Tax Exemption and Charitable Responsibilities of Not-for-Profit Hospitals," *Issues in Accounting Education* February 1, (2001).

[1902] See the following for examples. Deloitte Consulting, "Rider 61: Texas Hospitals' Uncompensated Care," (Austin, TX: Texas Health and Human Services Commission, 2006). Heather O'Donnell and Ralph Martire, "An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return," (2009), http://www.ctbaonline.org/All%20Links%20to%20Research%20Areas%20and%20Reports/Health%20Care/Executive%20Summary%20and%20Charts_Final.pdf (accessed March 14, 2013). Illinois Hospital Association, "Response of the Illinois Hospital Association and the Metropolitan Chicago Healthcare Council to CTBA Charity Care Report."

[1903] Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," 123.

[1904] Texas Health and Safety Code. *Powers and Duties of Hospitals*, §311.037.

The year 1993 was also remarkable for President Clinton's Health Security Act, which by 1994 turned out to be another twentieth century failure to achieve national universal health care coverage. This effort at reform was fueled by a general understanding by the early 1990s, that the growing cost of health care was an unsolved problem, that larger numbers of people were becoming uninsured, and that even middle class Americans could have difficulty obtaining and keeping adequate health insurance.[1905] The House Ways and Means Committee asked the attorneys on both sides of the Texas Methodist case to present their views while deliberating on the Health Security Act.[1906] The effect of the law on the hospital industry was not entirely clear. The AHA had initially endorsed the Act but withdrew its support on the basis of future Medicare cost control measures.[1907]

Adding fuel to the scrutiny of the charitable status of hospitals were the reports in the mid-1990s of record-setting levels of cash and profits at general acute care hospitals.[1908] In a 1998 review of nonprofit hospital accountability which detailed the efforts of several states, including Utah and Texas as already mentioned, the findings were generally that the judiciary was more likely to question the tax exemption of nonprofit hospitals when comparisons were made to for-profit hospitals because often nonprofits included in their community benefits the services that all hospitals provide. States had thus far been relatively unsuccessful in measuring community benefit and holding hospitals accountable. Much of the legislation that was enacted by states was

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[1905] Stuart Altman, "Health System Reform: Let's Not Miss Our Chance," *Health Affairs* 13, no. 1 (1994).

[1906] Forgione, "The Methodist Hospital System: Tax Exemption and Charitable Responsibilities of Not-for-Profit Hospitals."

[1907] Paul Starr, "What Happened to Health Care Reform?" *American Prospect* Winter, no. 20 (1995). Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives."

[1908] Sandy Lutz, "Indicators Point up for Hospitals' Cash Flow, Profits," *Modern Healthcare* June 10, (1996).

controlled by nonprofit hospitals or the industry received a great deal of deference. Once legislation was enacted, there was little critical evaluation or no meaningful sanctions for noncompliance. In Texas, the information obtained was “not reviewed, or even read” because of the lack of funding for such oversight.[1909] When the law in Texas was reviewed a few years after enactment, the summary was disappointing: “The initial results of Texas’ historic hospital charity-care law reveal that the law is more about creative arithmetic than taking care of the state’s poor.”[1910]

In Massachusetts, required reports were often not submitted; reporting guidelines were not uniform; and financial information was presented in ways that were difficult to understand. This led critics to suggest that the reports were deliberately misleading, obscuring how little benefits were being provided to the community. The reports also did not include the amount that hospitals receive from the state’s free care pool. In virtually all states, determining what counted as community benefit was interpreted variably and how benefits were measured were often based on their value, which might have no relationship to their cost to the hospital. In addition, all states were plagued with problems defining “charity care” and “community benefit.” Many community benefit reports amounted to little more than public relations efforts and there was sparse involvement of actual community members in the development of planned activities.[1911]

The 1998 review made several recommendations including the development of national standards for nonprofit hospitals’ community benefits which would be directly linked to the value of tax exemption. The standard, according to the review, should

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[1909] Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," 129.

[1910] Sandy Lutz, "Charity Care in Texas: Numbers Don't Tell the Story," *Modern Healthcare* 26, no. 19 (1996): 36.

[1911] Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives."

prioritize community benefits establishing the first priority as charity care defined as "care provided to income-eligible patients, who are determined (in advance of, during, or even after services are provided) to be *unable*, not *unwilling*, to pay for care provided."[1912] Only if a hospital is unable to provide charity care in an amount equal to its tax exemption, valued at cost and not charges, because of "*geographic factors alone* (for instance, not enough eligible charity patients reside within a reasonable distance to enable all hospitals in the service area to meet the standard through charity care), would a second-priority benefit be considered toward meeting the standard."[1913] Such a standard has yet to be developed. In 2008, the Government Accountability Office (GAO) stated: "At present, determination and measurement of activities as community benefit for federal purposes are still largely a matter of individual hospital discretion."[1914]

Hospital Charity Care from the Patient's Point of View

A significant change in the public's view of hospitals' policies toward uninsured people occurred as a result of a series of investigative reports in the *Wall Street Journal* beginning in 2003. Lucette Lagnado wrote of the routine hospital practice of billing uninsured people with little financial means many times the amount that a person with health insurance would be billed. Uncompensated care moved, at least temporarily, to a problem not just from the hospitals' perspective but to real people. Lagnado told the story of Rebecca Nix, a twenty-five year old college graduate from Texas who landed a dream job in New York but developed appendicitis at time when she had been laid off and did

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[1912] Ibid., 131.

[1913] Ibid. Emphasis original.

[1914] Government Accountability Office, "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," (Washington, DC: U.S. Government Accountability Office, 2008).

not have health insurance. She was billed over $19,000, more than three times the payment rate of someone insured through Medicaid and seven times the average payment rate of someone insured through a commercial managed care plan.[1915]

In 2004, the average markup of hospital charges was three times the cost, so that for a billed charge of $300, the cost would be $100. There are variations in this charge to cost ratio, however, with some hospital's charges approaching four times the cost in some areas.[1916] Insurers generally negotiate for discounts from billed charges so that the average payment was 38 percent of the charge in 2004.[1917] Hospital administrators admit that their method of assigning charges has "no rationality."[1918] The health economist Uwe Reinhardt has asked: "What prevailing distributive ethic in U.S. society, for example, would dictate that uninsured patients be billed the highest prices for hospital care and then be hounded, often mercilessly, by bill collectors?"[1919]

Lagnado also wrote about hospital debt that might never be paid off because of interest applied to an originally inflated bill. Such was the story of Mr. Quinton White whose wife died of cancer in 1993. Mrs. White's original bill in 1983 was for over $18,000 for cancer treatment. The nonprofit hospital that treated Mrs. White obtained a lien on their home and seized most of their savings but 10 percent interest added over $30,000 to the debt. Mr. White paid monthly installments but he missed several payments

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[1915] Lucette Lagnado, "Full Price: A Young Woman, an Appendectomy, and a $19,000 Debt " *Wall Street Journal*, March 17, 2003.

[1916] Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing."

[1917] Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy."

[1918] Allen Dobson et al., "A Study of Hospital Charge Setting Practices," (The Lewin Group, 2005).

[1919] Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy."

when, now seventy-seven years old and with his wife buried for ten years, he became ill himself.[1920]

Some patients even landed in jail when they were sued for nonpayment of their hospital bills and failed to comply with court orders, a practice called “body attachment.” One woman who was jailed briefly, Kara Atteberry a twenty-six year old mother of two, had an outstanding bill for over $1,600 for treatment of a miscarriage. A spokesperson for an agency in Illinois that tried to strip a nonprofit hospital of its tax exempt status because of the use of body attachments stated: “This concept of debtor’s prison, you read about it in Dickens, but it is still going on.”[1921] The series of articles by Lagnado was supplemented in the news media with other stories that made it clear that the problems with charging uninsured people more than private or public health insurers and aggressive tactics in collection efforts were occurring nationwide.[1922] The president of a New York think tank stated about the news coverage: “This is one of the classic cases where someone tells the story and lifts up the rock and what was underneath it was a lot of practices and a lot of suffering that were simply indefensible.”[1923] The people featured in the news reports were familiar to most Americans. They were usually hard working, determined to pay their debts, and just unlucky in life for a time.

Patients’ experiences with notification and provision of hospital charity care were extensively documented through surveys by community organizations across several

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[1920] Lucette Lagnado, "Twenty Years and Still Paying: Jeanette White Is Long Dead but Her Hospital Bill Lives On," *Wall Street Journal*, March 13, 2003.

[1921] ———, "Medical Seizures: Hospitals Try Extreme Measures to Collect Their Overdue Debts," *Wall Street Journal*, October 30, 2003.

[1922] Julie Appleby, "Hospitals Sock Uninsured with Much Bigger Bills " *USA Today*, February 24, 2004. Jonathan Cohn, "Uncharitable?" *New York Times*, December 19, 2004. Melissa B. Jacoby and Elizabeth Warren, "Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress," *Northwestern University Law Review* 100, no. 2 (2006).

[1923] Lucette Lagnado, "HHS Chief Scolds Hospitals for Treatment of Uninsured," *Wall Street Journal*, February 20, 2004.

states between 1999 and 2003. The surveys were developed by the health care advocacy organization Community Catalyst. In one survey, more than sixty nonprofit hospitals were questioned by trained uninsured and community monitors and most hospital staff told surveyors that no free care was available. When asked specifically about the hospital's charity care policy, front-line staff were almost universally unaware of the hospital's charity care policy.[1924] In another survey of over 6,800 uninsured people at safety net hospitals and clinics, almost half were never told about financial assistance. Nearly half of the uninsured respondents had unpaid medical bills where they were seeking medical care and about a quarter of these people said they would be deterred from seeking care because of their debt to the facility.[1925]

In a New York survey by trained uninsured people seeking care at nonprofit hospitals on Long Island, in about a quarter of phone calls questions about free care simply were not answered.[1926] From stories in the media and those gathered by community groups, the perspective of patients seeking financial assistance at hospitals is often bleak with multiple factors converging to make such care unattainable. For example, Margaret Loncar's husband was ill but died at home after refusing to go to the hospital when Margaret left for work because he already owed more than $40,000 in medical bills. Like most Americans, Mr. Loncar did not want to incur these debts and did feel obligated to pay his debts.[1927] As the health law scholar Kenneth Wing puts it:

[1924] Community Catalyst, "Not There When You Need It: The Search for Free Hospital Care," (Boston, MA: Community Catalyst, 2003).

[1925] Andrulis et al., "Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?"

[1926] Long Island Health Access Monitoring Project, "Hospital Community Benefits and Free Care Programs: An Initial Study of Seven Long Island Hospitals," (Hicksville, NY2001), 6.

[1927] Cohn, "Uncharitable?"

"For the services they received, they suffered financially, and in some cases catastrophically; for the service they could not afford, they suffered in other ways."[1928]

In 2009, as health care reform legislation made its way through Congress, a series of articles in California focused on the story of Tony Andrade, a forty-seven year old man whose surgery for bladder cancer was cancelled when the hospital became aware that he was uninsured. His job as a medical transport driver did not offer health insurance benefits. He describes the range of emotions he experienced, though only some of them were because of the fear and concern related to his diagnosis. Embarrassment at having no health insurance, feeling demeaned and despondent at having surgery cancelled, "the indignities, the blow to the pride," anger at himself for the mound of medical bills and losing his house, all of these feelings competed with the anxiety of his cancer diagnosis and added to the uncertainties of his future.[1929] His mother listed her son's problems in the following order after his surgery was paid for through county funds: the medical bills, the cancer coming back and his job. Mr. Andrade states simply: "If I could pay for any of it, I would."[1930] In other cases, when follow up care or procedures are delayed, patients may believe that their problem is not "real," otherwise surely they would receive care.[1931]

In a 2006 survey of how health insurance affects access to medical care, similar feelings were expressed by several respondents: "These families no longer call the clinic for fear of hearing the opening question: 'What is your insurance?' They feel intimidated and helpless because their infrequent interactions with the health care system have

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[1928] Kenneth R. Wing, "Health Care Reform in the Year 2000: The View from the Front of the Classroom," *American Journal of Law & Medicine* 26, no. 2-3 (2000): 287.

[1929] Bobby Caina Calvan, "Sacramento Man's Health Ordeal Puts Face on Uninsured," *Sacramento Bee*, November 29, 2009.

[1930] ———, "Behind the Health Debate: Cancer Patient Leaves Toughest Question Unasked," *Sacramento Bee*, November 30, 2009.

[1931] Jennifer D. Allen et al., "Follow-up of Abnormal Screening Mammograms among Low-Income Ethnically Diverse Women: Findings from a Qualitative Study," *Patient Education and Counseling* 72, no. 2 (2008).

resulted in denied care or unaffordable medical charges."[1932] To health care providers, people without health insurance are often invisible.[1933] Not having health insurance can cause fear of personal embarrassment and be experienced as stigmatizing.[1934] Mr. Duran, an uninsured man with cancer in Texas remarked recently, "When you don't have insurance, nobody listens to you. It's a powerless feeling. You feel like you're an outcast. You feel that you're homeless without insurance."[1935] Charity can often be deeply humiliating even when there is simply no other choice in obtaining health care. Lenny, a man who worked in a silver mine for thirty years but lost health insurance coverage when the mine closed, had bills over $140,000 after being hospitalized with a heart attack. When researchers with the Commonwealth Fund interviewed him, "tears came into his eyes" as he described asking for public assistance. He stated, "We have worked all of our lives, even went to work sick."[1936] An ethnographic study of uninsured people included interviews over a one year period where respondents described the difference between their experiences when they had health insurance and when they did not. One respondent stated, "When I had insurance, whenever I went to the doctor it felt great. They treat you with the utmost respect. You feel good, you feel like a decent person and the amount of time a person spends waiting is small." When the same respondent was uninsured, he stated, "They treat you different. They assume because you don't have insurance you

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[1932] Jennifer E. DeVoe et al., "Insurance + Access Not Equal to Health Care: Typology of Barriers to Health Care Access for Low-Income Families," *Annals of Family Medicine* 5, no. 6 (2007): 516.

[1933] Kevin Grumbach, "Insuring the Uninsured: Time to End the Aura of Invisibility," *Journal of the American Medical Association* 284, no. 16 (2000).

[1934] Roberta M. Orne et al., "Living on the Edge: A Phenomenological Study of Medically Uninsured Working Americans," *Research in Nursing and Health* 23, no. 3 (2000).

[1935] Manny Fernandez, "For Uninsured in Texas, Supreme Court Ruling Adds to Uncertainty," *New York Times*, June 29, 2012.

[1936] Susan Starr Sered and Rushika J. Fernandopulle, "Profiles of the Uninsured: Uninsured Americans Tell Their Stories," (2003), http://www.commonwealthfund.org/Resources/2005/Jan/Profiles-of-the-Uninsured.aspx (accessed March 14, 2013).

can't afford it, and if you can't afford it, it must mean you are not working, and if you are not working it must mean you are lazy…"[1937] Some uninsured respondents continued to work at obtaining health care and others were defeated and avoided further attempts until it was unavoidable.[1938]

The perspective of uninsured patients brings to the forefront broader issues related to a reliance on charity care, such as the relationship between economic security and health and the relationship between the emotional effects of being uninsured and health. Debt from any source has been shown to have a negative impact on mental health.[1939] Financial stress is associated with increases in blood pressure, disability, and mortality. Poor health is a contributing factor in nearly half of home foreclosures.[1940] The latest study on the relationship between bankruptcy and medical causes showed that illness or medical bills contributed to two-thirds of filings.[1941] Yet, the toll on patients of feeling stigmatized, humiliated, and powerless in their health care encounters, in addition to their financial tail-spin, is not a dominant policy issue. As health policy scholar Mark Schlesinger has remarked: "It is powerfully telling that anyone would feel the need to make the case that it is important to treat patients' emotions as a serious part of the health care experience."[1942] The emotional effects on health related to uninsured "status" and the

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[1937] Becker, "Deadly Inequality in the Health Care "Safety Net": Uninsured Ethnic Minorities' Struggle to Live with Life-Threatening Illnesses," 268.

[1938] Ibid.

[1939] Patricia Drentea and John R. Reynolds, "Neither a Borrower nor a Lender Be: The Relative Importance of Debt and SES for Mental Health among Older Adults," *Journal of Aging and Health* 24, no. 4 (2012).

[1940] Craig Evan Pollack et al., "A Case-Control Study of Home Foreclosure, Health Conditions, and Health Care Utilization," *Journal of Urban Health* 88, no. 3 (2011).

[1941] David U. Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* 122, no. 8 (2009).

[1942] Mark Schlesinger, "Editor's Note: In the Marketplace for Ideas Affecting Public Policy." *Journal of Health Politics Policy and Law* 28, no. 6 (2003).

financial ramifications of medical debt are, for the most part, not considered to be part of health care but somehow apart from hospital and medical care.

When asked why hospitals resort to collection efforts from patients who cannot reasonably be expected to be able to pay their full bill and taking into account that collection efforts are an expense, one response has been that “some hospitals might still view aggressive collection efforts as economically rational by discouraging uninsured patients from using the facility.”[1943] As already mentioned, hospitals sometimes portray their failure to inform patients about charity care and financial assistance and the subsequent aggressive collection efforts as merely careless or inattentive.[1944] The average collection rate on these inflated bills is 20 percent of their cost which suggests that the need for the hospital to recover the cost may not fully explain their behavior.[1945] In a report to Congress, an assertion was made that these collection attempts are for the benefit of patients: “Some facilities reportedly attempt to collect from nearly all patients to avoid them having the stigma of being labeled as eligible for charity.”[1946]

Hospital Charity Care Policies are Often Difficult to Find, Ambiguous, and Discretionary

Though virtually every hospital reports some charity care or at least some uncompensated care, the availability of charity care policies has repeatedly been shown

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[1943] Carol Pryor and Robert Seifert, "Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt," May (2003), http://www.commonwealthfund.org/Publications/Fund-Reports/2003/Jun/Unintended-Consequences--How-Federal-Regulations-and-Hospital-Policies-Can-Leave-Patients-in-Debt.aspx (accessed March 14, 2013). See also Weissman, "The Trouble with Uncompensated Hospital Care." Ricardo Guggenheim, "Uncompenated Care Is a $31 Billion Problem Waiting to Be Solved," *HealthLeaders News*, September 26, 2008.

[1944] Pear, "Nonprofit Hospitals Face Scrutiny over Practices."

[1945] Nancy M. Kane, "Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported? " *Saint Louis University Law Journal* 51 (2007).

[1946] MedPAC, "Report to the Congress: Medicare Payment Policy: Chapter 3: Updating and Reforming Prospective Payment for Hospital Inpatient Care," 63.

to be problematic. In addition to the several surveys conducted by uninsured and community members under the direction of Community Catalyst which showed that most often hospital staff were not aware of charity care policies, several other researchers have confirmed this finding. In 2005, the health care consultants PricewaterhouseCoopers surveyed hospital financial directors at 100 institutions and interviewed fifteen hospital leaders. The survey included mostly nonprofit hospitals, though 8 percent were for-profit. According to the financial directors, about half of the hospitals posted their charity care policy online and the majority said that patients are informed of the policy on admission. However, 7 percent of financial directors reported that federal poverty levels were not applicable to eligibility for full charity care at their hospital and 1 percent did not know the income level for eligibility.[1947]

In 2010, the Access Project and Community Catalyst surveyed ninety-nine nonprofit hospitals about their charity care policies by phone calls and internet searches. Although 57 percent of hospitals mentioned charity care on their website, only one quarter provided information about who qualifies for assistance based on income on their website. Only nine hospitals provided information on the specific discounts they offered based on income on their website. During phone interviews, all of the hospitals that could be contacted said that their hospital offered charity care. Only eight hospitals provided information by phone on their eligibility criteria. The AHA’s guidelines issued in 2004 state that hospitals should have understandable written policies that are applied consistently and that these should help patients determine if they qualify. The surveys indicated that hospitals do not always follow these guidelines in practice.[1948]

[1947] PricewaterhouseCoopers Health Research Institute, "Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape," (2005), http://www.pwc.com/us/en/healthcare/publications/acts-of-charity.jhtml (accessed March 14, 2013).

[1948] Pryor et al., "Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?"

In a 2004 publication about the discretion of front-line staff in rationing access to care for uninsured people at three hospitals in one metropolitan area, the results showed that charity care policies were ambiguous. The hospitals included a nonprofit, a for-profit, and a government hospital and their associated clinics. In some cases the policies were incomplete, did not address common situations, or were not distributed. When managers and administrators were interviewed, they acknowledged they "were eager to reduce the volume of self-pays" but that they had concerns about legal and public relations implications of their actions.[1949] At one hospital, the senior financial manager stated:

> Of course we cannot specify that patients should be turned away. Those decisions are handled in each clinic differently, depending on the supervisors, the physicians involved, even on how busy the practice is on that particular day. When faced with such situations, the front desk staff will talk with their supervisors about what to do. Patients are generally called aside to prevent an unpleasant scene. The supervisor will generally understand when to consult the doctors about difficult situations.[1950]

Because the policies were ambiguous, the front-line staff utilized considerable discretion in decisions about whether to provide access to care for uninsured people. Lower level clerical staff were much more likely to try to bend the rules to allow care at the hospital or their associated clinics than were upper level staff such as utilization managers. Even when clerical staff believed that people should not be turned away, they witnessed this happening. For example, one clerk said: "We used to hear, 'We are not about the money, we are about healthcare and saving lives.' Not this hospital in some cases. They have their own picks and chooses…'"[1951] Patients at times cried or tried to negotiate their upfront payment. One conclusion was that this process meant that people better able to

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[1949] Saul J. Weiner et al., "Rationing Access to Care to the Medically Uninsured: The Role of Bureaucratic Front-Line Discretion at Large Healthcare Institutions," *Medical Care* 42, no. 4 (2004): 309.

[1950] Ibid.

[1951] Ibid.

negotiate were more likely to gain access and this ability was not necessarily related to their medical need.

This research is a rare and important opportunity to understand what happens at hospitals that do not have clearly written policies and procedures. The findings suggest that “decisions about access are the product of a network of unwritten rules and understandings and the preferences of staff as they interface with a group of individuals who are attempting to become or remain clients of a reluctant bureaucracy.”[1952] In a commentary on the research, the commentators point out that the discretion and flexibility create the “illusion of benevolence; it functions as a tonic that further perpetuates the status quo.”[1953] These commentators provide further insight into why charity care polices may not be clear:

> Because it is ethically troubling to create clear policies that prohibit access to health care, local health care structures have evolved multilayered, often invisible means to sequentially filter out the uninsured while insulating the individual bureaucrat/caregiver from the cumulative moral consequences of such policies.[1954]

The vague and discretionary policies on charity care are consistent with much of the history in this chapter. At the same time, there have been some people and organizations who have worked to create standards for eligibility going back as long as a century ago when physicians tried to determine eligibility for free dispensary care and close to fifty years ago when the National Council on Aging devised principles and criteria which placed priority on clear policies with objective standards that could be applied flexibly and fairly.[1955]

[1952] Ibid., 311.

[1953] Nancy Walter and Dean Schillinger, "Front-Line Bureaucracies and the Moral Mechanics of US Health Care," *Medical Care* 42, no. 4 (2004): 304.

[1954] Ibid.

[1955] National Council on the Aging, "Principles and Criteria for Determining Medical Indigency: Report of the Committee for the Project of the National Council on the Aging."

Hospital Charity Care and Billing and Collection Practices are Scrutinized

Media attention to the fact that hospitals routinely charge uninsured patients much more than people with health insurance and then aggressively pursue these debts did strike a chord of unfairness to most Americans and it resulted in Congressional hearings beginning in 2004. In the opening statement to the hearings on hospital billing and collection practices, Representative Greenwood stated: "The situation is unfair and it is unjust."[1956] In describing body attachments and liens on homes, Representative DeGette stated: "The stories frankly are horrifying." [1957]Though health policy researchers could trace these practices to earlier decades, for the most part the general public's awareness was minimal.[1958] This was especially true for nonprofit hospitals. For example, in Bradford Gray's 1991 book on the profit motive in health care, he described nonprofit institutions as conforming "more closely than for-profit institutions to a service ethic that remains central. They tend to price less aggressively…"[1959] The public's expectation was that nonprofit hospitals would be "less likely to 'cheat' on quality, price gouge, or limit their services to those able and willing to pay."[1960] This faith in nonprofit hospitals' practices regarding pricing was a societal expectation that was violated by the media coverage.

[1956] *A Review of Hospital Billing and Collections Practices*, 5.

[1957] Ibid., 1.

[1958]See, for example, Irene Wielawski, "Gouging the Medically Uninsured: A Tale of Two Bills," *Health Affairs* 19, no. 5 (2000). Lucette Lagnado, "Hospitals Urged to End Harsh Tactics for Billing Uninsured," *Wall Street Journal*, July 7, 2003.

[1959] Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*: 332.

[1960] David A. Hyman and William M. Sage, "Subsidizing Health Care Providers through the Tax Code: Status or Conduct?" *Health Affairs* 25, no. 4 (2006).

Even prior to the Congressional hearings on billing and collection, the AHA sent an alert to its 4,800 member hospitals urging them to, in effect, audit their billing, charity care and debt collection processes.[1961] Two of the largest for-profit hospital corporations, Tenet and Hospital Corporation of American (HCA), announced pricing discounts for uninsured people.[1962] The AHA maintained, however, that Medicare rules require hospitals to bill uninsured patients the "full price" for their care.[1963] The director of Health and Human Services and the Office of the Inspector General responded to the AHA by publishing detailed guidelines explaining that federal rules did not in any way require hospitals to bill uninsured people at the full charge rate or require aggressive collection efforts. Though the basis for the AHA's assertion had some legitimacy in federal rules, the response clarified all of the questions that were raised.[1964] The AHA published a guideline on billing and collection practices and asked each member hospital to sign a commitment to those guidelines.[1965] The guidelines included that hospitals should have understandable written policies on charity care and financial assistance policies with clear eligibility criteria available to the public and that collection efforts should be fair. The AHA urged members to sign these voluntary commitments as a way to avoid mandatory requirements.[1966] In 2006, the AHA specified that hospitals should

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[1961] Lagnado, "Hospitals Urged to End Harsh Tactics for Billing Uninsured."

[1962] Pryor and Seifert, "Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt."

[1963] Thompson, "Letter from Tommy G. Thompson Secretary of Health and Human Services to Richard J. Davidson, President, American Hospital Association."

[1964] Cohen, "The Controversy over Hospital Charges to the Uninsured--No Villains, No Heroes."

[1965] Details of the guidelines from the AHA are included in Chapter 3.

[1966] Bill Lottoro and Carol Pryor, "Voluntary Commitments: Have Hospitals That Signed a Confirmation of Commitment to the American Hospital Association's Billing and Collections Guidelines Really Changed Their Ways?" (2005), http://www.accessproject.org/new/pages/item75.php (accessed March 14, 2013). American Hospital Association, "Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association ."

have policies to provide services to uninsured patients below 100 percent of the federal poverty level at no charge.[1967] Other hospital organizations responded with voluntary guidelines as well. For example, the Healthcare Association of New York issued guidelines in 2004 emphasizing the importance of treating patients with compassion "from the bedside to the billing office."[1968] The author of the New York guidelines described the general message as "don't try to get blood from a stone."[1969]

Beginning in 2004, also as a result of media attention, more than seventy class action lawsuits were filed in federal courts in more than forty states alleging that over 600 nonprofit hospitals were violating their obligations as tax exempt institutions by failing to provide adequate charity care, overcharging uninsured patients and using overly aggressive debt collection practices.[1970] The federal cases were uniformly dismissed on the basis that tax exempt status did not confer a private right of action and that the plaintiffs lacked standing, so the focus shifted to state courts.[1971] The state cases were more successful which resulted in several settlement agreements to provide clear charity care policies and discounts for uninsured patients. Resurrection Medical Center mentioned at the beginning of this chapter was one of the hospitals to reach a settlement agreement. Other hospitals responded to the legal threat or to perceived negative community reaction by raising the income level of their charity care policy or providing

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[1967] ———, "Billing, Collection, and Tax Exempt Status," (2006), http://www.aha.org/content/00-10/5_1_06_sb_billingcoll.pdf (accessed March 14, 2013).

[1968] Kelly A. Richmond and Pamela C. Smith, "Machiavellian Tendencies of Nonprofit Health Care Employees," *Journal of Health Care Finance* 32, no. 2 (2005): 28.

[1969] Cohen, "The Controversy over Hospital Charges to the Uninsured--No Villains, No Heroes," 276.

[1970] Corey Davis, "Nonprofit Hospitals and Community Benefit," (2011), http://healthjusticenetwork.files.wordpress.com/2011/07/nhelp_community_benefit.pdf (accessed March 14, 2013).

[1971] Cohen, "The Controversy over Hospital Charges to the Uninsured--No Villains, No Heroes."

discounts to uninsured patients.[1972] State legislatures also responded by enacting laws related to charity care and hospital billing. Twenty states now have laws requiring providers to notify patients and the public about their financial assistance policies and fifteen states enacted laws on hospital billing and debt collection.[1973]

In Congress, the House Ways and Means Committee held a hearing on the tax exempt health care sector in mid-2005.[1974] The GAO presented data from five states at the hearing. Among the findings were that nonprofit hospitals provided slightly more uncompensated care than for-profit hospitals. The GAO was unable to make distinctions among the hospital types based on community benefits. Government hospitals provided a greater percentage of uncompensated care in three of the states. Within each type of hospital, the data showed wide variation in uncompensated care.[1975] The commissioner of the IRS testified at these hearings that the decades old law pertaining to hospital tax exemption had not kept pace with the health care industry. The commissioner, however, also stated that the requirement that hospitals provide charity care according to their financial ability as in the pre-1969 ruling had not been repealed: “While a hospital is no longer required to operate to the extent of its financial ability for those not able to pay, doing so is a major factor indicating that the hospital is operated for the benefit of the

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[1972] Andrea Staiti, Robert Hurley, and Peter Cunningham, "Balancing Mission and Margin: Hospitals Alter Billing and Collection Practices for Uninsured Patients," (Center for Studying Health System Change, 2005).

[1973] Davis, "Nonprofit Hospitals and Community Benefit."

[1974] House Committee on Ways and Means, *A Review of the Tax-Exempt Health Care Sector*, 109th Congress, 1st sess., May 26, 2005.

[1975] David M. Walker, "Nonprofit, for-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits," (Washington, DC: Government Accountability Office, 2005).

community."[1976] Transparency in reporting in the tax exempt sector was described as the "lynchpin of compliance."[1977]

The Congressional Budget Office (CBO) used the data collected by the GAO from five states and provided additional analysis in a 2006 report. Notably, the report states that "charity care is a better measure of the community benefits provided by a hospital" but that uncompensated care defined as the sum of bad debt and charity was used because of data limitations.[1978] Nonprofit hospitals spent an average of 4.7 percent of operating expense on uncompensated care while for-profits spent 4.2 percent and government hospitals 13.0 percent, though there were wide variations among individual hospitals. Perhaps surprisingly, nonprofit hospitals had a somewhat lower share of Medicaid patients than for-profit hospitals. On two other measures of community benefit, emergency department care and labor and delivery services, nonprofit hospitals were more likely than for-profit hospitals to provide these services. The report also included information from the Joint Committee on Taxation about the value of tax exemption. Nationally, the estimated value of nonprofit hospitals' tax exemption for 2002 was $12.6 billion.[1979] The estimate included the value of federal income tax, tax exempt bond financing, charitable contributions, state income tax, state and local sales tax, and local property tax. Federal taxes accounted for about half of the total and state and local taxes accounted for the other half of the total.[1980] CBO did not compare the value of tax

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[1976] House Committee on Ways and Means, *Testimony of Mark Everson, IRS Commissioner: A Review of the Tax-Exempt Health Care Sector*, 109th Congress, 1st sess., May 26, 2005., 13.

[1977] Ibid., 16.

[1978] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," (Washington, DC: Congress of the United States Congressional Budget Office, 2006), 2.

[1979] The AHA reports that all of the nations hospitals' uncompensated care, both bad debt and charity, was $22.3 billion in 2002. American Hospital Association, "American Hospital Association Uncompensated Hospital Care Cost Fact Sheet."

[1980] Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits."

exemption to uncompensated care in the five states because bad debt is controversial as a component of community benefit and the data could not be separated into each component of uncompensated care. However, an earlier study had shown the value of hospital tax exemption exceeded the cost of charity care for three-fourths of nonprofit hospitals.[1981]

Charity Care and Uncompensated Care Reporting Will Be Significantly Improved

The IRS began its plan to increase transparency in the nonprofit hospital sector by sending comprehensive questionnaires to over 500 nonprofit hospitals in May 2006. The final report on the questionnaires was published in 2009 when the IRS had already formulated a redesigned IRS Form 990 for tax exempt hospitals.[1982] The redesigned form is a significant change from previous forms. The final report described how some hospitals on the questionnaire appeared to overstate reportable uncompensated care compared to what the redesigned Form 990 specifies. This happened because the uncompensated care amounts were often based on charges rather than on costs, or the amounts included bad debt, Medicare shortfalls, and commercial insurance discounts. Some hospitals appeared to have underreported amounts that the new form required details on.[1983] This kind of information likely impacted the questions asked on the new form but also highlighted the variability in reporting.

Detailed supporting documentation of community benefit and related financial information are now required in an additional supplement to the IRS Form 990 for tax exempt hospitals, Schedule H. In striking contrast to the inability of members of the

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[1981] Nancy M. Kane and William H. Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption," *Milbank Quarterly* 78, no. 2 (2000).

[1982] Internal Revenue Service, "IRS Exempt Organizations Hospital Compliance Project Final Report," (2009), http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html (accessed March 14, 2013).

[1983] Ibid.

CBO, GAO, and IRS to assess the amount of charity care and other community benefits in any of its previous reports, the new schedule requires separately reporting each component of community benefit. Instructions clarify definitions of each item. For example, the first question on Schedule H asks whether the organization had a financial assistance policy during the tax year. The instructions clarify this question:

> A financial assistance policy, sometimes referred to as a charity care policy, is a policy describing how the organization will provide financial assistance at its hospital(s) and other facilities, if any. Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services. Financial assistance does not include: bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to failure to pay by patients, or the cost of providing such care to such patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or contractual adjustments with any third-party payors.[1984]

The form does ask for the amount of bad debt separately and both amounts are reported as a cost and not on the basis of charge. Charity care and Medicaid shortfalls are components of community benefit, as are other means-tested government programs, community health improvements, health professions education, subsidized health services, community building activities, research, and cash or in-kind contributions to community groups. Medicare shortfalls are reported but are not included in calculating community benefit. In the case of unreimbursed Medicare payments and bad debt, the form asks for a written explanation as to why some or all these costs should be considered community benefit.[1985] The IRS does not require any certain amount or type of community benefit. In a press release about the new form, the director of the IRS

[1984] ———, "2011 Instructions for Schedule H (Form 990)," (2011), http://www.irs.gov/pub/irs-pdf/i990sh.pdf (accessed March 14, 2013).

[1985] Ibid.

stated the redesign "aims to give both the IRS and the public an improved window into the way tax-exempt organizations go about their vital mission."[1986]

The Catholic Hospital Association's guidelines on community benefit were largely adopted by the IRS in its new Schedule H. The AHA, however, has defined community benefit to include bad debt and Medicare shortfall.[1987] In the AHA's recent review of the 2009 Schedule H filings, Medicare shortfalls and bad debt attributable to people eligible for charity care are included among the review's findings. The review also does not report charity care separately from the cost of Medicaid shortfalls and other means-tested program unreimbursed care even though this information is clearly available.[1988] Authors at the journal *Modern Healthcare* have done their own analysis of the recently available data from Schedule H. On the basis of their analysis of more than 1,800 nonprofit hospitals, the median hospital expense for charity care in 2009 was 1.5 percent of total expense. More than one third of the hospitals spent less than 1 percent on charity care. When the value of the cost of all community benefits was tabulated, 5.9 percent of hospital expense was devoted to such activities.[1989] The authors recognize that the information made available through the IRS is "destined to be parsed and analyzed for years to come."[1990] Since the 1970s distinguishing between charity and bad debt has been advocated by patients and others working on behalf of patients. Auditing standards

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[1986] ———, "IRS Releases Discussion Draft of Redesigned Form 990 for Tax-Exempt Organizations," (2007), http://www.irs.gov/newsroom/article/0,,id=171329,00.html (accessed March 14, 2013).

[1987] Fred Joseph Hellinger, "Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements," *Journal of Health Politics, Policy & Law* 34, no. 1 (2009).

[1988] American Hospital Association, "Results of the 2009 Schedule H Project," (2012), http://www.aha.org/content/12/09-sche-h-benchmark.pdf (accessed March 14, 2013).

[1989] Melanie Evans and Joe Carlson, "Out in the Open. Not-for-Profit Hospitals' Charity Spending Revealed, but Finding a Standard Measure May Not Be So Simple," *Modern Healthcare* 41, no. 51 (2011).

[1990] Joe Carlson and Melanie Evans, "Short of the Mark. A Modern Healthcare Analysis of Form 990s Shows Some Very Profitable Hospitals Offering Little Subsidized Care," *Modern Healthcare* 41, no. 12 (2011). See also: Gloria J. Bazzoli, Jan P. Clement, and Hui-Min Hsieh, "Community Benefit Activities of Private, Nonprofit Hospitals," *Journal of Health Politics, Policy and Law* 35, no. 6 (2010).

for hospitals since 1990 have unequivocally stated that financial reports should classify charity and bad debt separately. Yet, reliable data that make a distinction between these two components of uncompensated care has not been available until this recent information from the IRS.

While the IRS redesign significantly improves the reporting of charity care and components related to community benefit for nonprofit hospitals, CMS has recently changed reporting for all hospitals. The Medicare Cost Report is filed by almost all of the nation's hospitals. Its primary purpose is to provide the basis for payments to health care institutions. The cost reports did not gather data on charity care, bad debt, or any measure of uncompensated care until 2003 but detailed information was not required after 2004 and the information was not considered meaningful.[1991] The new cost report changes are in effect beginning with 2010 reports. In a letter to CMS, the Medicare Payment Advisory Commission (MedPAC) fully endorsed the changes and commented that the definitions will prevent overstating the amount of charity care provided because full charges for charity care are converted to cost. Charity care is defined as follows: "Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria."[1992] Bad debt is reported separately at cost. Unreimbursed costs of means-tested programs such as Medicaid or state indigent health care programs are reported separately as well. The Affordable Care Act decreases additional Medicare payments to hospitals that provide a greater share of care to low income patients beginning in 2013 because of an expected decrease in the number of

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[1991] Kane and Magnus, "The Medicare Cost Report and the Limits of Hospital Accountability: Improving Financial Accounting Data." Thomas M. Schuhmann, "National Trends in Uncompensated Care and Profitability," *Healthcare Financial Management* September (2008).

[1992] Centers for Medicare and Medicaid Services, "Medicare: Provider Reimbursement Manual. Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS 2552-10," (Washington, DC: U.S. Department of Health and Human Services, 2010).

uninsured people. These Medicare DSH payments will be based on the information provided in the cost report. Medicare DSH payments were mentioned earlier in this chapter as the payments that were created by Congress at the same time that Hill-Burton payments by Medicare were disallowed. In Chapters 2 and 3, Medicare DSH payments were mentioned as a source of funds for uncompensated care. In addition, payments for the adoption of electronic health records will be made partially on the basis of the amount of charity care provided by the hospital and reported on the cost report.[1993]

It has been forty years since the 1972 *Corum* court explained why people who are unable to pay are appropriately considered charity patients as distinguished from people unwilling to pay. In the years since then, reliable information on hospital charity care has not been available. The changes to the IRS Form 990 for nonprofit hospitals and the Medicare Cost Report changes for all hospitals will likely provide a source of national information on charity care, bad debt, and uncompensated care that will be more meaningful and useful for policy purposes. Yet, accurate information on these components of uncompensated care is not assured by the changes in reporting.

Lack of Transparency and Accountability Currently Plague Hospital Charity Care Practices

The deeply rooted history of hospitals avoiding charity patients and the continued presence of extreme difficulties with uninsured patients receiving hospital care suggests that current health care patterns may be resistant to change. In some cases, hospitals have avoided providing care to uninsured patients eligible for charity even when funds are clearly available. Patients may not be told about the availability of specific funds at local hospitals or through state-wide programs that reimburse hospitals for charity care or

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[1993] Hackbarth, "Letter to CMS: Proposed Revisions to the Medicare Cost Report." Paul Clark, "Getting Compensated for Uncompensated Care," (2012), http://health.wolterskluwerlb.com/2012/06/getting-compensated-for-uncompensated-care/ (accessed March 14, 2013).

uncompensated care. In Massachusetts in 1999, prior to the 2006 implementation of the state's comprehensive health care reform efforts designed to provide almost universal health insurance coverage, the state had an uncompensated care pool. The pool reimbursed hospitals for a portion of their uncompensated care costs for eligible patients. The pool was structured such that payments were made to hospitals for free and reduced cost care for low income patients but bad debt for nonemergency services was not reimbursed. Qualifying patients for charity care was part of the incentive structure of the uncompensated care pool. Yet, about 80 percent of eligible patients were inappropriately excluded from the pool. In other words, despite the incentive for the hospital to receive reimbursement for the cost of care for low income patients, many low income patients were billed for services.[1994] The uncompensated care pool was also plagued by a lack of transparency and accountability. The Massachusetts Office of the Inspector General found in a 2005 audit: "The pool lacks reasonable management systems to control costs, ensure appropriate levels of treatment, and safeguard against improper billing."[1995] Among the findings were that the pool sometimes paid higher rates for services than those paid through commercial or public health insurers and that "the system is highly susceptible to waste, abuse, mistakes and, even fraud."[1996] The pool was converted to a Health Safety Net Trust Fund and changes were made to improve accountability, fairness, and transparency in 2008.[1997]

[1994] Joel S. Weissman, Paul Dryfoos, and Katherine London, "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals," *Health Affairs* 18, no. 4 (1999).

[1995] Gregory W. Sullivan, "Ongoing Review of the Uncompensated Care Pool Pursuant to Chapter 240 of the Acts of 2004," (Boston, MA: Massachusetts Office of the Inspector General, 2005), 5.

[1996] Ibid., 31.

[1997] Gregory W. Sullivan, "Ongoing Analysis of the Uncompensated Caretrust Fund/Health Safety Net Trust Fund: Medicare Based Claims Payment System Implementation," (Boston, MA: Massachusetts Office of the Inspector General, 2008).

In the highly publicized case of Yale-New Haven Hospital, extensive research showed that the 944 bed nonprofit teaching hospital had charity care costs of about $1.5 million in 2001. Free care charges comprised 0.3 percent of total hospital charges. Bad debt was more than ten times greater than charity in 2001. The bad debts were not "written off."[1998] As detailed in *Wall Street Journal* articles, patients with debt to the hospital had wages garnished, bank accounts seized, homes foreclosed on, and they were sent to jail.[1999] Yet, the hospital had a $37 million "free bed" fund created by donors and, according to hospital documents, the fund should have been available to patients with an income up to two and a half times the poverty level. Only 20 percent of the investment income from these funds was spent on free care. The low application rate for the funds was primarily due to hospital staff not informing patients of its existence which is contrary to Connecticut law and, in fact, interviewed patients were often specifically told that there was no charity care. Connecticut also has an Uncompensated Care Pool which provided $24 million to the hospital in 2001. As described by advocates for patients, the hospital spent more on payments to debt collecting firms than on charity care.[2000]

Laxness in accountability for charity care funds and processes is not rare. Recently, an audit of the state and local taxpayer supported Quality and Charity Care Trust, which provides funds to University Medical Center in Louisville, Kentucky showed that there was a "near-total lack of governance" in accounting for the $32 million a year in trust funds. The funds could not be accounted for at the patient level, according to the audit. The required indigent-care log could not be reconciled to the Medical

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[1998] Grace Rollins, "Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices," (New Haven, CT: Connecticut Center for a New Economy, 2003).

[1999] Lagnado, "Twenty Years and Still Paying: Jeanette White Is Long Dead but Her Hospital Bill Lives On." ———, "Medical Seizures: Hospitals Try Extreme Measures to Collect Their Overdue Debts." ———, "Call It Yale v. Yale," *Wall Street Journal*, November 14, 2003.

[2000] Rollins, "Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices."

Center's indigent care reports.[2001] The audit found that funding for indigent care, when Medicaid DSH funds were included, exceeded the cost of such care for two of the three years it surveyed. Though the hospital stated funds were not used for bad debt, the log showed that collection attempts were made prior to "writing off" the charges. Funds were applied generally to unfunded costs instead of to specific patient accounts as required by the charter of the trust.[2002]

The concept that funds for uncompensated care could even exceed the cost of such care, as outlined in one section of the report from Louisville is startling. Again, however, in the case of the value of hospital tax exemption, the subsidy *usually* exceeds the cost of charity care. Even when 50 percent of bad debt is included, more than half of the nonprofit hospitals' value of tax exemption exceeds the cost of uncompensated care.[2003]

In Texas, estimates by the health care consultants Deloitte and Touche determined that the cost of uncompensated care after subsidies to all of the hospitals in the state in 2003 and 2004 was between 3 percent and 25 percent of what was reported depending on the methodology used.[2004] In a subsequent report, estimates for many Texas counties showed an excess of uncompensated care funding compared to uncompensated care cost.[2005] The consultants in Texas noted that there is "little audit oversight or

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[2001] Laura Ungar, "Trust to Fund Indigent Care at University Hospital Lacks Oversight, Audit Finds," *Louisville Courier-Journal*, May 24, 2012.

[2002] Adam H. Edelen, "Examination of the Quality and Charity Care Trust, Incorporated," (2012), http://khpi.org/dwnlds/2012/2012QualityandCharityCareReport.pdf (accessed March 14, 2013).

[2003] Kane and Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption."

[2004] Texas Health and Human Services Commission, "Senate Bill 1, Article II, Health and Human Services Commission: Rider 61, Texas Hospitals' Uncompensated Care," (Austin, TX: Texas Health and Human Services Commission, 2006).

[2005] ———, "Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs," (2009), http://www.hhsc.state.tx.us/News/present80.asp (accessed March 14, 2013).

enforceability for uncompensated care reporting" and that their analysis of hospital reporting showed "areas in which reporting is so ambiguous and subject to judgment that accurate estimation of the exact value of unreimbursed care actually borne by hospitals is not possible."[2006] Following the consultant's report, the Texas Legislature created a Hospital Uncompensated Care Work Group which coined a new term, "residual unreimbursed uncompensated care."[2007] The work group followed some of the recommendations of the consultants, such as reporting uncompensated care based on cost. However, the consultants had recommended defining uncompensated care as charity care plus bad debt but the work group greatly expanded the definition to include Medicaid and Medicare shortfalls.[2008] When the Texas Health and Human Services Commission analyzed 2008 data from all Texas hospitals, the commission found that, of the $13.9 billion in uncompensated care reported, about $1.5 billion was unreimbursed cost.[2009] It remains uncertain how the standardization of reporting through the IRS Form 990 and changes to the Medicare Cost Report concerning uncompensated care will affect the reporting of uncompensated care in Texas.

New York has been relatively generous in providing funds to cover the cost of uncompensated care but the state has been negligent in requiring accountability for the funds. When the New York Legal Aid Society first began to look at the state's Bad Debt and Charity Care Pool in 2003, the findings were that there was "virtually no

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[2006] ———, "Senate Bill 1, Article II, Health and Human Services Commission: Rider 61, Texas Hospitals' Uncompensated Care," 7, 12.

[2007] ———, "Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs." iii.

[2008] Ibid.

[2009] ———, "2008-2009 Report on Residual Uncompensated Care Costs," (2011), http://www.hhsc.state.tx.us/reports/2011/Rider-40-0111.pdf (accessed March 14, 2013).

accountability" for the $837 million in funds allocated to hospitals.[2010] Of the twenty two hospitals the Legal Aid Society surveyed for its review, none used the funds for specific uninsured or underinsured patients' accounts. This meant that none of the patients could have the funds credited toward their account. Instead, the funds were used entirely for pooled uncompensated care charges. At the same time, some hospitals engaged in aggressive collection efforts from low income uninsured patients. None of the hospitals provided a charity care or financial assistance policy to Legal Aid staff during the surveys. Eight of the hospitals routinely required uninsured patients to pay 100 percent of their anticipated bill prior to admission.[2011]

The assumption that funds provided for charity or uncompensated hospital care will increase such care can be questioned on the basis of the above cases and on the basis of national data. For example, two sources of funds clearly intended to support the provision of uncompensated care are state uncompensated care pools and Medicaid DSH payments. National data show that spending in these programs does not have a statistically significant effect on hospital uncompensated care spending.[2012] The idea that hospitals must earn a profit in order to fund charity or uncompensated care is firmly entrenched in the health policy literature and is intuitively sensible. Yet there is wide evidence that the amount of profits at hospitals, even among nonprofit hospitals, does not correlate with the amount of charity.[2013] The health policy researcher Nancy Kane has

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[2010] Elisabeth R. Benjamin and Kat Gabriesheski, "The Case for Reform: How New York State's Secret Hospital Charity Care Pool Funds Fail to Help Uninsured and Underinsured New Yorkers," *Legislation and Public Policy* 8, no. 5 (2004): 7.

[2011] Ibid.

[2012] Anthony T. Lo Sasso and Dorian G. Seamster, "How Federal and State Policies Affected Hospital Uncompensated Care Provision in the 1990s," *Medical Care Research and Review* 64, no. 6 (2007).

[2013] Kane and Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption." Carlson and Evans, "Short of the Mark. A Modern Healthcare Analysis of Form 990s Shows Some Very Profitable Hospitals Offering Little Subsidized Care." John Carreyrou and Barbara Martinez, "Nonprofit Hospitals: Once for the Poor, Strike It Rich," *Wall Street Journal*, April 4, 2008. Kenneth E. Thorpe and Charles E. Phelps, "The Social Role of Not-for-Profit Organizations: Hospital Provision of Charity Care," *Journal of Economic Inquiry* 29, no. 3 (1991).

summarized this: “Although ‘no margin, no mission’ is a frequently recited mantra of the hospital industry, having a larger margin is no guarantee that the charitable mission will be better served.”[2014] A hallmark of these sources of funds including the free bed funds, the uncompensated care pools, the charity trust, DSH payments, and tax exemption is that there is no obligation to use these funds for any specific person. The existence of these funds does not guarantee medical care for anyone. While minimal accountability, lax reporting standards and lack of transparency contribute to problems with charity care, fundamentally charity care is optional. This is precisely the problem that activists identified with the Hill-Burton charity care obligations.

How is Hospital Uncompensated Care Funded?

Since the data on charity care is not generally available and researchers have become accustomed to using uncompensated care in their analyses, there is no information on the funding of charity care as a separate category. The exception to this are the already cited studies comparing the value of hospitals’ tax exemption to the amount of charity care provided. The most widely cited data from researchers at the Urban Institute on the funding of uncompensated care defines the term as: “[C]are received but not paid for by either the uninsured themselves or by a health insurer.”[2015] It is important to understand that, as a group people who are uninsured receive about half of the medical care that insured people receive. Of the medical care that uninsured people receive, more than one third of such care is paid for out of pocket.[2016]

[2014] Kane and Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption," 205.

[2015] Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," w402.

[2016] Ibid., w401.

The researchers at the Urban Institute estimated that in 2008 the cost of uncompensated care was $56 billion with hospital uncompensated care of $35 billion. About 82 percent of hospitals' uncompensated care costs were potentially covered by current government subsidies, as shown in Table 1. The Urban Institute researchers' definition of uncompensated care includes bad debt and does not include implicit subsidies from tax exemption. The source of government funds to hospitals was primarily federal funding comprising almost half of the total. State and local government sources accounted for 30 percent of funds. The remaining hospital portion of uncompensated care, the authors estimate, is funded by private sources such as forgone profits or increases in efficiency, cost shifting to insured patients, and philanthropy.[2017]

[2017] ———, "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage." 46.

Table 5: Hospital Uncompensated Care, 2008: Total Cost and Sources of Funding[2018]

Hospital Uncompensated Care, 2008 **Total Cost and Sources of Funding** (*Amount in billions)*				
Hospitals' Cost of Uncompensated Care				**$35.0**
Sources and Amounts of Funding		Federal	State/ Local	Total (Percent)
Medicare	DSH Payments	$5.1	-	$5.1
	IME Payments	2.1	-	2.1
	Total Medicare	**7.2**	**-**	**7.2 (21%)**
Medicaid	DSH Payments	8.6	2.0	10.6
	Supplemental Provider Payments	12.2	0.9	13.1
	Less Medicaid Underpayments	-11.2	-1.6	-12.8
	Total Medicaid	**9.6**	**1.3**	**10.9 (31%)**
State and Local Governments	Tax Appropriations	-	8.6	8.6
	Public Assistance Programs	-	2.0	2.0
	Total State and Local	**-**	**10.6**	**10.6 (30%)**
Total Government Expenditures		**16.8**	**11.9**	**28.7 (82%)**
Private (Profits, Surplus from Insured Patients, Philanthropy)		-	-	**6.3 (18%)**
Total Government + Private Funds		-	-	**$35.0**

The researchers provide the rationale for including each source of funding for uncompensated care. A feature of most of the government sources of funding is that they

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[2018] Ibid.

are often poorly targeted to the providers actually responsible for uncompensated care. Even when the funds are clearly meant to support uncompensated care, other uses may be legally permissible, reinforcing the optional nature of uncompensated care. It is unlikely that these sources of funding are widely understood by hospital administrators and staff to be intended to cover the cost of uncompensated care since the method of receiving payments may not occur as a separate category. For example, Medicare DSH payments are a percentage increase in hospital payments.[2019] Adding to misunderstandings about the funds are the lack of or conflicting definitions of uncompensated care and the loose or absent accountability for the funds.[2020]

There are two main subsidies in the Medicare program for uncompensated care, DSH and Indirect Medical Education (IME) payments. The Medicare DSH program provides payments to hospitals based on proxy measures of the proportion of low income patients. MedPAC has repeatedly urged Congress to link these payments specifically to uncompensated care. In 2007 MedPAC found that uncompensated care provision is highly concentrated and Medicare DSH payments are not targeted properly to hospitals with the highest level of uncompensated care. Hospitals in the top percentile for providing uncompensated care were responsible for over 40 percent of such care but only received 10 percent of the Medicare DSH funds. Hospitals in the bottom percentile for providing uncompensated care were responsible for less than 2 percent of such care but received 8 percent of Medicare DSH funds.[2021] The Urban Institute researchers took this

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[2019] This feature of Medicare and Medicaid DSH funds was discussed in Chapter 2 as well. Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program," 3.

[2020] For a more detailed account of the origin of some of the government programs that provide funding for uncompensated care, see Chapter 2 on medical education and charity care, pages 95-118.

[2021] MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," 78.

information into account and only included half of Medicare DSH funds as a source of uncompensated care funds.[2022]

IME funds have been set at a level that is more than twice what can be empirically justified on the basis of the estimated effect of teaching on the cost of hospital care. The IME payments have been explained by many observers as subsidizing uncompensated care. A hospital's share of uncompensated care, however, has not correlated to the amount of IME funds. MedPAC found that, similar to Medicare DSH payments, there is a mismatch between the level of provision of uncompensated care and the amount of IME funding. [2023] For these reasons, the Urban Institute researchers attribute one third of the total IME payments to uncompensated care.[2024]

Medicaid also has two programs that subsidize the cost of uncompensated care, the Medicaid DSH program and other supplemental programs such as the Upper Payment Limit (UPL) program.[2025] The Medicaid DSH program and other supplemental Medicaid payments are related to each other because the combination of these payments cannot exceed the "uncompensated" cost of treating Medicaid patients plus the cost of treating uninsured patients at each hospital.[2026] For the purpose of the Medicaid program, uncompensated care cost is defined as "the sum of costs incurred to provide services to

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[2022] Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," w405.

[2023] See Chapter 2, pages 52-59, for more information on the IME payments. MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," 68,80.

[2024] Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," w405.

[2025] See Chapter 5 on Medicaid and charity care for more information on the funding of uncompensated care through Medicaid supplemental payments.

[2026] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition," *Federal Register* 77, no. 11 (January 18, 2012).

Medicaid and uninsured patients less payments received for those patients."[2027] As in the Medicare program, Medicaid DSH funds are not necessarily targeted to hospitals on the basis of the amount of uncompensated care provided to patients. For example, many states reimburse certain categories of hospitals, such as state-owned hospitals, a much higher percentage of uncompensated care costs as compared to local public or private hospitals.[2028] The federal government provides matching payments to states for their DSH expenditures but creative financing arrangements have resulted in a greater share of federal payments than would occur without these arrangements.[2029] In addition, some states have not used the federal funds from DSH matching payments for health related purposes.[2030] For these reasons, the Urban Institute researchers only counted 30 percent of the state portion of Medicaid DSH funds as available to fund uncompensated care.[2031] As shown in Table 1, the portion of Medicaid DSH funds spent on Medicaid patients was subtracted so that only funds available for uninsured patients are included. As a percentage of hospital uncompensated care funding, Medicaid provides the most funds, just over 30 percent.

In determining the portion of state and local tax appropriations available for uncompensated care, the researchers only counted the amount paid to hospitals and then estimated that one half of this amount would be available for uncompensated care. Similarly, with state and local public assistance programs, only the portion provided to

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[2027] Department of Health and Human Services Office of Inspector General, "Review of Medicaid Disproportionate Share Hospital Payment Distribution," (Washington, DC: Department of Health and Human Services, 2010), 1.

[2028] Office of Inspector General, "Review of Medicaid Disproportionate Share Hospital Payment Distribution."

[2029] The Medicaid DSH program history and details are discussed further in Chapter 5.

[2030] Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[2031] Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," w404.

hospitals was included.[2032] One point is that the researchers were interested in determining the sources of funds that are actually used to fund uncompensated care and not the funds that are theoretically available, which would be much higher. In other words, the researchers from the Urban Institute were not making a normative assessment of the use these funds. Nancy Kane, the previously mentioned health policy researcher, has pointed out that the magnitude of "funded non-mandates" in the hospital sector is large.[2033] Her work has focused on hospital tax exemption, a source of implicit government funding that was not taken into account by the Urban Institute researchers in estimating the sources of funding for uncompensated care. Kane advocates setting a "higher and more articulated" standard for tax exemption.[2034] Another point about funded non-mandates is that what is occurring can be considered a redistribution of funds in the "name" of the poor. Whether low income uninsured people are the beneficiaries of these funds or not, the amount is "charged" to this amorphous group's "social account."[2035]

Once the funds available through government sources were determined, the remaining cost of uncompensated care was attributed to the private sector. The Urban Institute researchers provide a detailed analysis of whether and to what extent there is cost shifting to people with private health insurance because of uncompensated care. Their data shows that cost shifting from the privately insured to fund uncompensated care accounts for less than 2 percent of private health insurance costs. This issue turned out to be a contentious one during the debate on the Affordable Care Act. The authors of the

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[2032] ———, "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage." 32-33.

[2033] Nancy M. Kane, "Statement to the United States Senate Committee on Finance: Taking the Pulse of Charitable Care and Community Benefit at Nonprofit Hospitals," (2006), http://www.finance.senate.gov/imo/media/doc/091306nktest.pdf (accessed March 14, 2013).

[2034] Ibid.

[2035] This concept is discussed further in Chapter 5. Rand E. Rosenblatt, "Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care," *Brooklyn Law Review* 60 (1994).

Urban Institute study determined that cost shifting to the privately insured was limited because the overall share of uncompensated care attributable to private sources is small and because hospitals have a limited ability to cost shift due to market conditions. As compared to a study commissioned by Families USA, the researchers provide evidence of government sources of uncompensated care that were not included in that study and attribute some of the cost of uncompensated care to forgone profits instead of cost shifting to the privately insured.[2036] The Families USA study reported that the cost of uncompensated care resulted in families with insurance paying $1,017 more in premiums and individuals paying $368 more in insurance premiums.[2037] The Urban Institute authors did not agree with the Families USA analysis. Yet, they responded to this issue by pointing out that funding for uncompensated care is primarily from government sources so that reducing this cost through the Affordable Care Act will result in a lower tax burden even if it will not directly affect private insurance premiums in the manner suggested by the Families USA study.[2038]

The ACA and Uncompensated Care

The Affordable Care Act makes several changes that affect the provision of charity or uncompensated care. The most significant change will come about because of the number of people who will gain health insurance coverage and, therefore, will not need charity. Uninsured people with the lowest income, up to 133 percent of the poverty level, will decrease as a result of becoming eligible for Medicaid. The individual mandate

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[2036] Hadley et al., "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage." Families USA, "Hidden Health Tax: Americans Pay a Premium," (2009), http://www.familiesusa.org/resources/publications/reports/hidden-health-tax.html (accessed March 14, 2013).

[2037] ———, "Hidden Health Tax: Americans Pay a Premium."

[2038] John Holahan and Jack Hadley, "Health Reform and 'Cost Shifting,'" (2011), http://www.urban.org/publications/901419.html (accessed March 14, 2013).

to maintain health insurance coverage and the premium and other cost sharing subsidies will mean that more Americans will have affordable insurance coverage through health insurance exchanges. Employers will be required to offer health insurance plans if they have more than fifty employees or be required to pay a penalty in certain circumstances. Bad debt from underinsured people will decrease because of market regulations such as guaranteed availability, and a prohibition on lifetime limits and pre-existing condition exclusions. These reforms will prevent many of the practices that have left insured patients financially devastated.[2039] Noncitizens who are unauthorized to be in the United States, however, are not eligible for Medicaid coverage or participation in health insurance exchanges.[2040]

The Census Bureau reported that almost 50 million people were uninsured in 2010.[2041] The Congressional Budget Office recently estimated that, by 2022, an additional 30 million people will gain health insurance coverage out of about 56 million people who would have been uninsured without reform. This estimate is lower by 3 million than in previous estimates because of the Supreme Court ruling allowing states the option to expand Medicaid. About one-third of people who do gain coverage will do so through Medicaid and the Children’s Health Insurance program (CHIP) and about two-thirds will gain coverage through health insurance exchanges or other private health insurers. Most people who gain coverage through health insurance exchanges will receive

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[2039] Principe et al., "The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals." Lisa Clemans-Cope, Bowen Garret, and Matthew Buettgens, "Health Care Spending under Reform: Less Uncompensated Care and Lower Costs to Small Employers," (2010), http://www.rwjf.org/healthpolicy/product.jsp?id=55092 (accessed March 14, 2013).

[2040] Alison Siskin, "Treatment of Noncitizens under the Patient Protection and Affordable Care Act," (Washington, DC: Congressional Research Service, 2011).

[2041] In 2010, 49.9 million people were uninsured. The percentage of people in the nation who are uninsured was just over 16 percent. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2010," (Washington, DC: United States Census Bureau, 2011).

federal subsidies to purchase insurance because their income will be below four times the poverty level.[2042]

About 25 million people will remain without health insurance coverage in 2020.[2043] Prior to the Supreme Court ruling, the following percentages were estimated for the people who will remain uninsured. About a quarter of people without health insurance will be undocumented immigrants who are not eligible for either public health insurance or insurance through exchanges. The largest group that will remain uninsured will be people who are eligible for Medicaid or CHIP but are not enrolled, comprising more than one third of people remaining uninsured. Just over one quarter of those remaining uninsured will be subject to the individual mandate but will not enroll in coverage and these individuals will be subject to a penalty. About 8 percent of people will be exempt from the individual mandate because they do not have access to affordable health insurance.[2044]

Prior to the Supreme Court ruling it was estimated that total uncompensated care, which includes hospital and nonhospital uncompensated care, would decrease by just over 60 percent compared to costs without reform.[2045] The Affordable Care Act will reduce several sources of funds that have been considered potentially available to cover the cost of uncompensated care as detailed in Table 1. Beginning in 2014, the Affordable Care Act decreases Medicare DSH hospital payments to 25 percent of the current

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[2042] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People."

[2043] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision."

[2044] Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act," (2010), http://www.urban.org/publications/412267.html (accessed March 14, 2013).

[2045] Ibid.

level.[2046] This amount is the empirically justified Medicare DSH payment that MedPAC reported to Congress in 2007.[2047] In 2009, Medicare DSH payments were $9.6 billion.[2048] For the years 2014 through 2019, the Congressional Budget Office estimated the reduction in Medicare DSH funds to be $22 billion.[2049] In addition to the savings in Medicare DSH funds, a new pool of funds will be created. Each hospital will receive the additional pool payments on the basis of the change in the hospital's DSH payment, the national change in the uninsured rate, and the percentage of uncompensated care provided by the hospital as compared to other acute care hospitals.[2050] The Medicare IME payments were essentially left intact by the Affordable Care Act.[2051]

Federal Medicaid DSH payments, which totaled over $11 billion in 2009, will be reduced as a result of the Affordable Care Act beginning in 2014. According to the Urban Institute researchers and shown in Table 1, Medicaid DSH and other supplemental payments accounted for 31 percent of the amount of funds spent on hospital uncompensated care in 2008 when federal and state funds are combined. In the first year the reduction in federal DSH is $500 million and by 2019 the reduction is $5.6 billion, nearly half of the federal matching payment that would have been available without

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[2046] *Patient Protection and Affordable Care Act*, §3133.

[2047] MedPAC, "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments," 68.

[2048] Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[2049] Congressional Budget Office, "Letter to Speaker Nancy Pelosi," March 20, (2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf (accessed March 14, 2013).

[2050] *Patient Protection and Affordable Care Act*, §3133.

[2051] Nguyen Xuan Nguyen and Steven H. Sheingold, "Indirect Medical Education and Disproportionate Share Adjustments to Medicare Inpatient Payment Rates," *Medicare and Medicaid Research and Review* 1, no. 4 (2011): E15.

reform.[2052] For the years 2014 through 2019, the reduction in federal Medicaid DSH funds was estimated to be $14 billion by the Congressional Budget Office.[2053] The exact methodology for allocating the Medicaid DSH funds as they are reduced has not been published yet. The law does require that the largest reductions occur in states with the lowest uninsured rates and in states that do not target their DSH payments to hospitals with high uncompensated care costs and high volumes of Medicaid patients.[2054]

The Affordable Care Act does not directly affect state and local tax appropriations or public assistance programs. State funds that were committed to the Medicaid DSH program will be left intact giving states the opportunity to target those funds toward increased Medicaid payment rates.[2055] The law does provide a new source of funding for trauma centers with two $100 million grant programs, the Trauma Care Center Grants and Trauma Service Availability Grants.[2056] One of the purposes of the grants is to "to assist in defraying substantial uncompensated care costs," with the funding prioritized according to the level of care provided to "charity or self pay patients."[2057] All of the changes in the payment methodologies for federal sources of funding for uncompensated care will increase accountability and transparency while improving the targeting of funds to hospitals that are actually providing uncompensated care.[2058]

[2052] Bachrach, Braslow, and Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net." Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[2053] Congressional Budget Office, "Letter to Speaker Nancy Pelosi."

[2054] *Patient Protection and Affordable Care Act*, § 2551.

[2055] Bachrach, Braslow, and Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net." 21.

[2056] Hassan R. Mir, "Who Is Funding Your Trauma System?" *AAOS Now* 5, no. 5 (2011).

[2057] *Patient Protection and Affordable Care Act*, § 3505.

[2058] Bachrach, Braslow, and Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net." 20-21.

The Affordable Care Act includes several new requirements that nonprofit hospitals must adhere to. The law creates Section 501(r) of the Internal Revenue Code, which applies to all hospitals that are charitable under Section 501(c)(3). Nonprofit hospitals are required to have a written financial assistance policy that includes eligibility criteria and whether assistance includes free or discounted care. The policy must include the basis for calculating the amounts charged and the process for applying for financial assistance. The policy must include the actions taken in the case of nonpayment including collection actions and reporting to credit agencies, if the hospital does not have a separate billing and collection policy. The policy must also include the measures taken to widely publicize the policy within the community to be served by the organization. The policy must address adherence to the requirements of the Emergency Medical Treatment and Labor Act for individuals regardless of their eligibility under the financial assistance policy.[2059] The IRS issued proposed regulations in June 2012 regarding the Affordable Care Act's requirements for charitable hospitals under 501(r). The proposed regulations clarify that hospitals have flexibility in determining eligibility criteria and the amounts and kinds of financial assistance. The policy must contain specific criteria, however, and the regulations make detailed requirements about notifying patients and the public about the financial assistance policy.[2060]

The Affordable Care Act limits the amount that nonprofit hospitals may charge patients who are eligible for financial assistance for emergency and medically necessary care to not more than the amounts generally billed to individuals who have insurance and it prohibits the use of gross charges. The hospital may not engage in extraordinary collection actions before the organization has made reasonable efforts to determine

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[2059] *Patient Protection and Affordable Care Act*, § 9007. See also, Rosenbaum and Margulies, "Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice." Davis, "Nonprofit Hospitals and Community Benefit."

[2060] Internal Revenue Service, "Additional Requirements for Charitable Hospitals," (2012), http://www.irs.gov/pub/irs-drop/reg-130266-11.pdf (accessed March 14, 2013).

whether the individual is eligible for assistance under the financial assistance policy.[2061] In the IRS proposed regulations, the meaning of “extraordinary collection practices” includes any legal or judicial process such as placing a lien on property, foreclosure on a property, garnishing wages, or body attachments.[2062] These are the practices that were highlighted in the 2004 *Wall Street Journal* articles and subsequent Congressional hearings. The proposed regulations also specify that a hospital’s policy on emergency treatment will not comply with the law unless the policy prohibits the hospital from engaging in actions that discourage people from seeking emergency medical care such as demanding payment before treatment of emergency conditions or allowing debt collection activities in the emergency department.[2063] The *New York Times* and other media sources detailed the activities of debt collectors in emergency departments who were hired by hospitals and were “indistinguishable” by patients from hospital staff in early 2012. Some patients described instances where treatment had not yet been provided for their acute illnesses in the emergency department when they were approached by debt collectors. The patients feared treatment would be withheld in the emergency department if they did not pay upfront.[2064] Congressional hearings on this issue and a court settlement with one of the collection agencies named in media reports were happening just as the IRS issued the proposed regulations.[2065]

The Affordable Care Act also requires nonprofit hospitals to conduct a community health needs assessment every three years and to adopt an implementation

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[2061] *Patient Protection and Affordable Care Act*, § 9007.

[2062] ———, "Additional Requirements for Charitable Hospitals."

[2063] Ibid.

[2064] Jessica Silver-Greenberg, "Debt Collector Is Faulted for Tough Tactics in Hospitals," *New York Times*, April 24, 2012. ———, "Medical Debt Collector to Settle Suit for $2.5 Million," *New York Times*, July 30, 2012.

[2065] Jenny Gold, "New Rules Will Ban ER Debt Collections at Charitable Hospitals," *Kaiser Health News*, June 27, 2012.

strategy to meet those needs. The assessment must take into account input from people who represent the broad interests of the community served and specifically mentions people with an interest in public health. The assessment must be made widely available. The law imposes a $50,000 tax on hospitals that do not meet the community health needs assessment requirement.[2066] Although the community health needs assessment does not require any specific action that affects the provision of charity care, a July 2011 IRS Notice does state that in defining the community a hospital serves:

> [A] community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs.[2067]

The Notice also clarifies that, at a minimum, taking into account the broad interests of the community means including input not only from people with a special knowledge of public health but also health departments and "[l]eaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs."[2068]

The Affordable Care Act in combination with changes that were already occurring to the IRS Form 990 Schedule H and the Medicare Cost Report has resulted in a focus on many of the terms that are related to hospital charity care. Table 2 shows the most recent definitions and related comments on the terms "charity care," "bad debt," and "uncompensated care."

[2066] *Patient Protection and Affordable Care Act*, § 9007.

[2067] Internal Revenue Service, "Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals," *Compliance and Enforcement*, July 25, (2011), http://www.irs.gov/irb/2011-30_IRB/ar08.html (accessed March 14, 2013).

[2068] Ibid.

The Meaning of Uncompensated Care in the Supreme Court's Ruling on the ACA

The U.S. Supreme Court upheld the constitutionality of the Affordable Care Act on June 28, 2012. The government, through Solicitor General Verrilli, argued that the Commerce Clause grants the federal government broad power to regulate activities of interstate commerce and, secondarily, that if the Justices could not agree to the individual mandate's constitutionality based on the Commerce Clause, that the court could still uphold the individual mandate on the basis of Congress' power to levy a tax.[2069] The decision to uphold the individual mandate was based on Chief Justice Roberts, and four concurring judges, determination that the law is a constitutional exercise of Congressional power to tax. The chief justice did not find authority for the individual mandate under the Commerce Clause.[2070]

The arguments related to the Commerce Clause were partly made on the basis of a narrow understanding of uncompensated care. The word "uncompensated" was used twelve times in the oral arguments on the day that concerned the individual mandate and Congress' power to regulate interstate commerce and levy taxes.[2071] The term was used in briefs submitted to the Supreme Court and in earlier briefs.[2072] The meaning of

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[2069] *National Federation of Independent Business v Sebelius*, 132 S.Ct. 2566 (2012). For the transcript of the oral argument, see the following Donald B. Verrilli, Paul D. Clement, and Michael A. Carvin, "Department of Health and Human Services et. al., v. Florida, et. al.," (March 27, 2012), http://www.supremecourt.gov/oral_arguments/argument_transcripts/11-398-Tuesday.pdf (accessed March 14, 2013).

[2070] Wendy K. Mariner, Leonard H. Glantz, and George J. Annas, "Reframing Federalism — the Affordable Care Act (and Broccoli) in the Supreme Court," *New England Journal of Medicine* 367, no. 12 (2012).

[2071] *National Federation of Independent Business v Sebelius*.

[2072] Neil S. Siegel, "Free Riding on Benevolence: Collective Action Federalism and the Minimum Coverage Provision," *Law and Contemporary Problems* 75, no. 29 (2012).

"uncompensated care" is simple in these documents: economic harm to others. Justice Ruth Bader Ginsberg's opinion puts this view succinctly: "Those with health insurance subsidize the medical care of those without it. As economists would describe what happens, the uninsured "free ride" on those who pay for health insurance."[2073] Justice Ginsburg cites a study that is also widely cited in government documents and briefs that determined there is a "hidden health tax" of just over $1,000 on the insurance premiums of families because of the cost of uncompensated care.[2074] This study was commissioned by Families USA and is the one that Urban Institute researchers did not agree with. Justice Ginsburg goes on to say that because uninsured people delay seeking care, they end up requiring more costly treatment, the implication is that these costlier treatments are paid by others. Furthermore, "the extra time and resources providers spend serving the uninsured lessens the providers' ability to care for those who do have insurance," which lowers the quality of care for insured people. To make this point, Justice Ginsburg cites a *Washington Post* article describing a new study that links higher mortality rates for patients with health insurance who have a heart attack to the level of uninsured people in a community.[2075] Justice Ginsburg argues for the relevance of the Commerce Clause by making the point that states cannot regulate the market for health insurance on their own. She cites the fact that, in Massachusetts, unhealthy people from other states are

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[2073] *National Federation of Independent Business v Sebelius*.

[2074] Families USA, "Hidden Health Tax: Americans Pay a Premium."

[2075] *National Federation of Independent Business v Sebelius*. Sarah Kliff, "High Uninsured Rates Can Kill You — Even If You Have Coverage " *Washington Post*, May 7, 2012. N. Meltem Daysal, "Does Uninsurance Affect the Health Outcomes of the Insured? Evidence from Heart Attack Patients in California," *Journal of Health Economics* 31, no. 4 (2012).

contributing to uncompensated care costs by coming to Massachusetts for medical care.[2076]

Justice Ginsburg likely does believe that the fifty million Americans who are uninsured do suffer needlessly in their health and economic security. The argument she is making is the argument that President Obama set forth and that an entire host of proponents of the Affordable Care Act have used.[2077] The argument is that not having health insurance is a decision that invokes the Commerce Clause because factually those without insurance will pay for care out of pocket or receive care that others pay for which places uninsured people within the market for health care. Even though uninsured people have much more difficulty getting medical care than insured people, the focus in the Supreme Court's decision has been on the care that uninsured people do receive. The health law scholar Mark Hall stated many of the facts that were used in the arguments and briefs in a 2011 law review article. For example, Hall reports that almost two-thirds of uninsured adults with an income at or below 133 percent of the poverty level have had at least one visit to a health care provider in the past two years.[2078] This is stating in the converse what was reported by the Kaiser Family Foundation: "Among adults at or below 133% FPL who were uninsured for at least two years, almost four-in-ten (38%) received no medical care during the two years when they lacked coverage."[2079] Hall also reports

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[2076] *National Federation of Independent Business v Sebelius*.

[2077] See, for example, Sara Rosenbaum and Jonathan Gruber, "Buying Health Care, the Individual Mandate, and the Constitution," *New England Journal of Medicine* 363, no. 5 (2010).

[2078] Mark A. Hall, "The Factual Bases for Constitutional Challenges to Federal Health Insurance Reform," *Northern Kentucky Law Review* 38, no. 3 (2011).

[2079] Karyn Schwartz and Anthony Damico, "Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years," (2010), http://www.kff.org/uninsured/8083.cfm (accessed March 14, 2013).

that “among those who do avoid insurance for longer terms, virtually all of them (94%) receive some level of medical care at some point.”[2080] The citation refers to a study that reported on whether currently uninsured people had “ever received” a particular health care service and the authors admit that “for many procedures ‘ever’ may be too long ago to be meaningful.”[2081] On the cost of uncompensated care, the Solicitor General’s brief to the Supreme Court states that $43 billion in uncompensated care costs in 2008 were shifted to Americans who do have health insurance.[2082] This information leaves out the fact that $30 billion was paid out of pocket for health services by uninsured people that year and that more than half of uninsured people pay the full price of medical services at their usual source of care.[2083]

While staunch supporters of the Affordable Care Act and of improved care for uninsured people may have taken an approach that emphasizes the economic toll to others of uncompensated care because this seemed to be the pragmatically and legally best way to achieve needed reform, at the same time this focus adds to the already common belief that people without health insurance can get the care they need and that the problem facing America is caused by uninsured people. So, a question that arises is this: Can this portrayal of uninsured people and the cost of their uncompensated care as

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[2080] Hall, "The Factual Bases for Constitutional Challenges to Federal Health Insurance Reform," 31.

[2081] June E. O’Neill and Dave B. O'Neill, "Who Are the Uninsured?: An Analysis of America’s Uninsured Population, Their Characteristics, and Their Health," (2009), http://epionline.org/study_detail.cfm?sid=122 (accessed March 14, 2013).

[2082] Donald B. Verrilli, "National Federation of Independent Business, et al., Petitioners v. Kathleen Sebelius, Secretary of Health and Human Services, et. al.," *Nos. 11-393 and 11-400* (2012), http://www.fb.org/legal/files/id_83/HHS%20Reply%20Brief%20Severability.pdf (accessed March 14, 2013).

[2083] Carrier, Yee, and Garfield, "The Uninsured and Their Health Care Needs: How Have They Changed since the Recession?"

one of the primary problems result in a sustainable effort to improve access to medical care for all Americans? Perhaps *how* the nation gets to a point where everyone can expect to have access to care is less important than that we do achieve nearly universal coverage. Social Security and Medicare are examples of collective national programs that, once created, have become a source of cohesiveness and shared social expectation. On the other hand, the elderly were not vilified but cast as worthy beneficiaries in order to achieve these programs.[2084] There is danger in portraying uninsured people as free-riders who cause individuals with insurance, hospitals and other health care institutions, as well as taxpayers, financial hardship while threatening insured patients' health. Negative characterizations can have normative and political power that affects public policy.[2085] Much of the story about the Affordable Care Act is yet to be written and its achievements are not assured.

Conclusion

America is on the cusp of seismic changes in health care, though these changes are not assured. Hospitals are the most visible symbol of American health care. A conversation about the role of charity in hospital care could contribute to a deeper understanding of what we all long for in moving closer to the ideals that we associate with charity such as kindness, compassion, and the deeply meaningful interactions that comprise human healing. The question of whether relying on hospital charity care promotes or impedes the qualities we cherish as morally fundamental and defining has

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[2084] Meredith Rosenthal and Norman Daniels, "Beyond Competition: The Normative Implications of Consumer-Driven Health Plans," *Journal of Health Politics, Policy & Law* 31, no. 3 (2006).

[2085] Anne Schneider and Helen Ingram, "Social Construction of Target Populations: Implications for Politics and Policy," *Amercian Political Science Review* 87, no. 2 (1993).

been explored in this chapter. The ideal of hospital charity, the meaning of charity in the hospital setting, is worth clinging to. This is essentially what history shows we have done. Yet what we have not done, and this chapter attempts to do, is to look beyond these necessary moral ideals to the ways in which hospital charity care is practiced, funded, and captured in public policy.

Since the 1940s our nation has relied on symbolism and vague assurances that charity is part of every hospital's obligations. Attempts to define charity have been in constant flux and have imbued terms such as "uncompensated care" with moral goodness, while at the same time allowing such terms to come to mean little more than economic harm to others. The capriciousness of the definition of uncompensated care became overpowering during the latter half of the twentieth century. The unique ability of hospital accounting practices to mix costs, charges, and unreimbursed care has resulted in the inability to document identifiable trends in the true expenses or the effects of policy changes.

Funding of charity through federal, state, and local sources has occurred through lump sums and other implicit measures that are not well targeted and do not guarantee hospital care for any person. In the hospital world of charity care, often money has been fungible, and people in need of charity have been indistinguishable as well. Hospitals have at times had policies in place to deliberately discourage or turn away charity patients. At other times, hospitals have "merely" been careless or inattentive to the practices that have devastated patients financially and emotionally.

Still, there is room for hopefulness. If the Affordable Care Act and the changes in reporting of charity care through the IRS and CMS result in greater transparency in the provision of hospital charity care, the veil of opacity will be lifted further than it has been in our nation's history. If the promised changes in funding charity care direct those funds more closely to the actual provision of such care, then people who receive charity will be less indistinguishable. Our nation will be one step closer to what we have always envisioned.

Chapter 5: Medicaid and or as Charity Care

Ethel Hines lost her health insurance when she divorced. She was admitted to a hospital in Ohio where the doctors discovered she needed a pacemaker, which was placed in her heart. After struggling to pay off as much as she could of the bill, the hospital and her physician "excused" the remaining balance. Ethel paid the doctor's fees for monthly checkups out of pocket until she moved to Tennessee. Now working as a newspaper delivery carrier and still uninsured, she went to a free clinic after over four years with no checkups. The doctors there noticed a skin problem on her face. It turned out to be skin cancer but she was eligible for TennCare, Tennessee's Medicaid program, so she was treated for cancer and started getting checkups for her pacemaker again.[2086]

Ginny was five years old when she "met" her doctor on his first night as a pediatric cardiology fellow at a Virginia hospital. She had just gotten out of surgery to repair a congenital heart defect when her heart stopped and Dr. Garson revived her. Over the next several years Ginny did "beautifully." When she was sixteen, Ginny developed a heart rhythm problem that, after trying several medications, was controlled by an expensive one. The treatment kept her from developing a fatal rhythm and she did remarkably well. After high school Ginny applied for every possible job in her small town but no one would hire her, perhaps because she so willingly and proudly told potentially employers about her heart condition. Then, a few months after Ginny turned nineteen, she died suddenly one night. The cause was a fatal heart rhythm. Lying in a drawer beside her bed was an empty pill bottle. Ginny had "aged out" of Medicaid and, knowing her parents could not afford the medication, she stopped taking it.[2087]

[2086] Julie Winokur and Ed Kashi, *Denied: Crisis of the Uninsured* (San Francisco: Talking Eyes Media, 2003), 35.

[2087] Garson, "Heart of the Uninsured."

Keeshun Lurk was twenty years old and working part time at Washington Hospital Center in the nation's capitol when he developed debilitating headaches. Because he was a temporary worker, he was not offered health insurance. He did go to the hospital's emergency department where he was diagnosed with migraines and an ear infection which presumably was causing a lump on his neck. When his symptoms worsened, he became completely unable to work. He went to the Washington Free Clinic where they confirmed that Keeshun needed a biopsy of the lump that had not gone away. Their clinic used a network of volunteer providers and one agreed to do a biopsy. The lump was caused by brain cancer. Keeshun started receiving cancer treatment about a year after his symptoms began, though he did not know how he would pay for it. When his unemployment benefits ran out, he became eligible for Medicaid, which covered the cost of his treatment from that point but his medical debt was not erased.[2088]

In Houston, Texas, a forty-two year old woman went to a county hospital's emergency department ten times for back pain and related symptoms. On the tenth visit a doctor performed a pelvic examination and found what he thought was a problem with the uterus. The problem turned out to be cervical cancer at a late stage. She was uninsured but tried to bring the necessary documentation for county health care coverage at each visit. At each of these visits, some piece of the required documentation was incomplete. Four months after she was briefly hospitalized with complications from blocked kidneys due to the cancer, she became eligible for emergency Medicaid. Almost immediately after becoming eligible for Medicaid, she was seen by oncologists for cancer treatment. She missed some appointments because of difficulty with transportation and the care giving she was providing to her paralyzed mother, her one child, four of her sister's children, and a grand-niece. More than two years after her first visit to the

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[2088] Editorial, "Second-Class " *Consumer Reports* 65, no. 9 (2000).

emergency department and thirteen months after her diagnosis, she died from complications of cervical cancer.[2089]

The stories of these patients from Tennessee, Virginia, Washington, D.C., and Texas show some of the ways in which Medicaid, hospital charity care, free clinics, physician volunteers, and delaying or forgoing medical care interact in the lives of people who are ill and have a low income. Medicaid may be seen *as* charity care to institutional and individual health care providers when costs for treating Medicaid patients exceed payment. People with a low income who are uninsured may visit a free clinic or receive charity or discounted care from hospitals or physicians and sometimes, because of their illnesses, become eligible for Medicaid. Medicaid's history demonstrates that it has been linked to certain categories of low income people, particularly people receiving "welfare," and not to impoverishment alone. Beginning in the 1980s, Medicaid became one of the most important sources of funding for hospitals that provide care not only to low income Medicaid beneficiaries but also to uninsured people. In many instances at the state level, Medicaid and charity are closely intertwined in policy decisions. The Affordable Care Act promised to eliminate the categorical nature of the program but the recent Supreme Court ruling allows states not to implement Medicaid expansion. This chapter explores these aspects of Medicaid.

Medicaid: What is It?

Medicaid is a public health insurance program enacted in 1965 under Title XIX of the Social Security Act. Medicaid is a means-tested entitlement program for low income people that finances the delivery of primary and acute medical services as well as long-term care. In 2010, Medicaid financed health and long-term care services to more

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[2089] Shannon N. Westin et al., "Social Factors Affecting Treatment of Cervical Cancer: Ethical Issues and Policy Implications," *Obstetrics & Gynecology* 111, no. 3 (2008).

than 68 million people.[2090] Medicaid provides benefits to more people than any other public or private insurance program, including Medicare. In 2010, Medicare provided health insurance coverage to 47 million people.[2091] The combined cost of Medicaid to the federal and state governments was about $380 billion in 2009, whereas the cost of Medicare was about $510 billion.[2092] Unlike Medicare, Medicaid is administered by the states and jointly funded by the federal and state governments. State participation in the Medicaid program is voluntary, though all states participate. State Medicaid agencies operate under broad guidelines established by federal law and the Centers for Medicare and Medicaid Services (CMS). States have considerable discretion in determining eligibility, benefits, and provider payments within broad guidelines such that there are more than fifty distinct programs.[2093]

States and the federal government jointly finance Medicaid. The federal government pays no less than 50 percent of the program's costs up to 76 percent of the cost. The federal match, or Federal Medical Assistance Percentage (FMAP), is calculated based on the state's per capita income relative to the national average. On average, the state's share is 43 percent and the federal share is 57 percent of Medicaid program's cost.[2094]

To qualify for Medicaid, individuals must meet financial eligibility criteria and belong to a group that is "mandatory" under federal law or "optional" under the flexibility allowed to state programs. States can also operate their Medicaid programs outside of the regular rules by seeking a federal waiver under Section 1115 of the Social

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[2090] Elicia J. Herz, "Medicaid: A Primer," (Washington, DC: Congressional Research Service, 2010).

[2091] Kaiser Family Foundation, "Medicare: A Primer."

[2092] Herz and Tilson, "CRS Report for Congress: Medicaid and Graduate Medical Education."

[2093] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People."

[2094] Ibid., 27.

Security Act. The mandatory groups include children under age six with family income below 133 percent of the poverty level and children age six to eighteen below 100 percent of the poverty level; pregnant women up to 133 percent of the poverty level; parents with income below states' 1996 cash welfare eligibility levels; and most elderly, blind or disabled people who receive cash assistance through the Supplemental Security Income (SSI) program, which equates to about 75 percent of the federal poverty level. Medicaid is the largest source of health insurance for children, providing coverage to one in three children. Medicaid provides maternity and prenatal coverage for women with a low income, covering 40 percent of births in the nation. Medicaid is the largest insurer for long-term care, providing coverage to more than two-thirds of nursing home residents. Certain low income Medicare beneficiaries are also eligible for Medicaid, or are "dual-eligibles," for which Medicaid covers Medicare premiums, cost sharing, and long term care services.[2095]

Low income adults are among the least likely to qualify for Medicaid. Adults who are not disabled and do not have dependent children are generally excluded from Medicaid unless the state operates under a waiver. Over 40 percent of low income adults without dependent children were uninsured in 2008.[2096] Adults without dependent children comprised 59 percent of all uninsured people in 2010.[2097] Low income parents are much less likely than their children to be eligible for Medicaid because of much stricter income requirements. For example, seventeen states set the income eligibility for parents below 50 percent of the poverty level.[2098] In 2008, Medicaid covered 45 percent

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[2095] Ibid. Herz, "Medicaid: A Primer."

[2096] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 11-12.

[2097] ———, "Uninsured: A Primer," (2011), http://www.kff.org/uninsured/7451.cfm (accessed March 14, 2013).

[2098] ———, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 11.

of people with an income below the poverty level and 29 percent of people with an income up to 200 percent of the poverty level.[2099] Eligibility for Medicaid is limited to American citizens and specific categories of legal permanent resident immigrants.[2100] Undocumented immigrants who would otherwise qualify for Medicaid may have emergency services paid for by the program.[2101]

As discussed in Chapter 4, the Affordable Care Act expands the Medicaid program's mandatory coverage groups by requiring that participating states cover nearly all people under age 65 with an income below 133 percent of the poverty level, beginning in January 2014. The expansion includes some of the groups that have been categorically excluded from the program including adults without dependent children and it increases the number of eligible parents as well. The Supreme Court's recent ruling to uphold the constitutionality of the individual mandate also makes the Medicaid expansion optional for states. The Congressional Budget Office estimated prior to the Supreme Court ruling that the Affordable Care Act would increase the number of people covered by health insurance by about 32 million and that about 17 million people would gain coverage through the Medicaid expansion or the Children's Health Insurance Program (CHIP).[2102] CHIP was established in 1997 to provide health insurance coverage for uninsured, low-income children in families with incomes above Medicaid eligibility levels. CHIP is similar to Medicaid in that it is administered by states under broad federal rules and it is funded by federal matching payments to states. In contrast to Medicaid, CHIP provides

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[2099] Ibid., 7.

[2100] Ibid., 8.

[2101] Ibid., 12.

[2102] Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," no. March (2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf. Kaiser Family Foundation, "A Guide to the Supreme Court's Affordable Care Act Decision," July (2012), http://www.kff.org/healthreform/upload/8332.pdf (accessed March 14, 2013).

no individual entitlement to coverage and the federal matching funds are capped instead of open-ended.[2103]

The Congressional Budget Office estimated after the Supreme Court's ruling that by 2022 there will be 30 million more people with health insurance than would have been insured without the Affordable Care Act. Medicaid is estimated to cover about 11 million more people by 2022.[2104] Estimates of the number of Medicaid enrollees vary widely, however. This is due to the methods used to make the estimates and to the uncertainty of the policies that will be put in place to either encourage or discourage enrollment.[2105] About one-third of people who do gain coverage will do so through Medicaid and CHIP and about two-thirds will gain coverage through health insurance exchanges or other private health insurers.[2106]

Under the Affordable Care Act, newly eligible Medicaid enrollees will have the cost of their coverage entirely paid by the federal government for the years 2014 through 2016. In other words, the FMAP will be 100 percent in these first two years for newly eligible enrollees. The proportion of new enrollees' costs paid by the federal government will be phased down over the next few years such that, by 2020, the federal match rate will be 90 percent of the cost and remain at that level. This means that, over the law's

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[2103] Julie Stone et al., "Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline," August 19, (2010), http://assets.opencrs.com/rpts/R41210_20100819.pdf (accessed March 14, 2013). See also Herz, "Medicaid: A Primer."

[2104] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision."

[2105] Benjamin D. Sommers, Katherine Swartz, and Arnold Epstein, "Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians under Health Reform," *Health Affairs* 30, no. 11 (2011).

[2106] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision."

first decade, the federal government will pay 96 percent of the cost of the people becoming eligible under the law.[2107]

The Origin of Medicaid and Links to Charity

Clearly the importance of Medicaid cannot be overstated as a program that is a critical source of health insurance coverage for children, disabled people, residents of nursing homes, and other groups. Though the future of Medicaid is not entirely certain because states' efforts to expand the program and to enroll eligible residents will matter, the program is poised to play an even more important role in essential health care coverage. Yet, its roots in public assistance that began in the early twentieth century have meant that it continues to be associated with a pejorative notion of "welfare." The journalist Niall Ferguson recently claimed that "[n]early110 million individuals received a welfare benefit in 2011, mostly Medicaid or food stamps."[2108] As he sees it, the people receiving these benefits are a drain on the country. This sentiment is not unusual: "Medicaid is the quintessential program detested today by radical conservative forces: its entitlement status signifies an open-ended right to benefits, in this case by America's impoverished households."[2109] The contentiousness of the cost of Medicaid is fueled by the dual source of payment from states and the federal government. Medicaid accounts for about 8 percent of the federal budget. Among domestic programs, Medicaid is the

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[2107] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 29.

[2108] Ferguson, "Why Obama Must Go," 22.

[2109] Laura Katz Olson, *The Politics of Medicaid* (New York, NY: Columbia University Press, 2010), 5.

third largest after Social Security and Medicare. In most states' budgets, Medicaid is the second largest program after education.[2110]

One of the many ironies of Medicaid is that despite the public perception that Medicaid is the poor person's health insurance, two-thirds of the people without health insurance are poor or near-poor.[2111] Of course, the Affordable Care Act was to have eliminated eligibility based on membership in a certain group for the Medicaid program after 2014 and, instead, make the program's eligibility based on income.[2112] If states choose not to expand their Medicaid program as the Supreme Court allows, then it will remain a categorical program in those states. The reason that so many people with a low income have been left out of the program and the basis for the categories of eligibility can only be understood in historical context. Children and mothers are two categories of people eligible for Medicaid that were most likely to be considered "deserving" in earlier eras.

In colonial times in America, there was "outdoor relief" modeled after the British poor laws. It was seen both as a public responsibility and a profoundly local practice to provide this "charity" or relief to the poor.[2113] Taxes for poor relief were often collected

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[2110] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Matters: Understanding Medicaid's Role in Our Health Care System," (2011), http://www.kff.org/medicaid/8165.cfm (accessed March 14, 2013).

[2111] Poor is usually defined as an income less than the federal poverty level and near-poor is an income less than 200 percent of the federal poverty level ———, "Uninsured: A Primer," (Menlo Park, CA: Kaiser Family Foundation, 2009).

[2112] Categorical eligibility will remain in states that choose not to expand Medicaid and in groups of Medicaid enrollees whose income is above the level of 133 percent of federal poverty guidelines as specified in the Affordable Care Act.

[2113] Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: BasicBooks, 1996), 14-15.

separately, emphasizing the expense and enhancing resentment.[2114] Proponents of outdoor relief often believed a small sum could tide over a distressed family whereas proponents of the almshouse or institutionalized care were convinced otherwise.[2115] Effects of outdoor relief, opponents believed, included: “The demoralization of the poor through the erosion of independence and self-respect, the spread of idleness and the loss of the will to work; the promotion of immorality in all its ugly forms; and the increase in public costs through the growth of poorhouses and jails.”[2116] Instead, said these opponents, public relief should go toward institutions such as almshouses or poor houses and private charity should be the only source of outdoor relief.[2117]

In the wake of criticism regarding outdoor relief, a new theory of *scientific charity* took hold. Scientific charity meant the practice of returning poor relief to private charity alongside maintaining almshouses and county poorhouses, just as opponents of outdoor relief had urged. This view was clearly one that emphasized the unequal nature of charity giver and receiver. Even when provided by public officials, assistance was considered a gratuity, not an entitlement. A gratuity was closely linked to discretion. For example, a county board in Ohio could pass judgment on individuals in their community at their whim, cancel relief at any time, and could emphasize that there was “no recourse to the law at all…no right in court. It is purely a gratuity.”[2118] Scientific charity by any measure

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[2114] Ibid., 17. From the earliest times, there has been a seemingly contradictory sense of charity. For instance, to what extent can taxes collected by local or other governments be considered charity?

[2115] Ibid., 55-56.

[2116] Ibid., 41-42.

[2117] Ibid., 73.

[2118] Edward D. Berkowitz, *America's Welfare State: From Roosevelt to Reagan*, The American Moment (Baltimore, MD: Johns Hopkins University Press, 1991), 17, quoted in Timothy S. Jost, *Disentitlement?:*

failed, despite its staunch supporters. By the early twentieth century, there was at least some awareness that there were causes of poverty beyond individual moral flaws.[2119]

The early twentieth century was also a time in which reformers focused particularly on maternal and child health and well being. Children had often been removed from their homes in the latter nineteenth century under the scientific charity movement's influence. Orphanages or foster care were considered a way to prevent the generational continuance of poverty and immorality. Institutionalizing or placing children could occur when tragedy struck the male wage earner or when less socially approved causes of poverty such as desertion, illegitimacy, or divorce occurred, throwing the family into deep impoverishment.[2120] About 1,000 children were placed in orphanages in New York as late as 1913 because a widowed mother had become ill and almost three times that many were placed in orphanages because of family poverty.[2121]

By 1909 at a White House Conference on Children, the first recommendation was that: "Children of worthy parents or deserving mothers should, as a rule, be kept with their parents at home."[2122] "Mother's pensions" seemed to be the answer. Theodore Roosevelt explained to Congress in 1909 that Mother's Pensions were for "parents of good character suffering from temporary misfortune and above all deserving mothers fairly well able to work but deprived of the support of the normal breadwinner [so that

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The Threats Facing Our Public Health-Care Programs and a Rights-Based Response (Oxford, NY: Oxford University Press 2003), 69.

[2119] Walter I. Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America*, 6th ed. (New York, NY: The Free Press, 1999), 101-102.

[2120] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 128-134.

[2121] Mimi Abramovitz, *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present*, Rev. ed. (Boston, MA: South End Press, 1996), 197.

[2122] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 128.

they could] maintain suitable homes for the rearing of their children."[2123] By 1919, Mother's Pensions laws had been enacted in thirty-nine states. Though often woefully inadequate and accompanied by extreme moralistic and behavioral rules, these pensions did help families stay together. Among the mother's pensions many flaws was that minority women were much less likely to benefit from them. Ninety-six percent of women receiving pensions in 1931 were white.[2124] Yet, these pensions were public programs that acknowledged some societal responsibility. As the historian Michael Katz noted: "Even more, mothers' pensions were a small, halting, but consequential step away from charity and toward entitlement."[2125] These pensions, importantly for the future Medicaid program, were the model for the Aid to Dependent Children (ADC) provisions in the Social Security Act.[2126] The mothers' pensions existed alongside two other kinds of pensions directed at "deserving" groups in some states, impoverished old people and the blind.[2127] At the federal level, the pensions to Civil War veterans and their families were provided to the "deserving core of a special generation" but not to all similarly situated Americans.[2128]

The focus of Progressive Era reforms on mothers and children was responsible for the creation of the Children's Bureau by Congress in 1912. Though the Bureau was

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[2123] Abramovitz, *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present*: 200.

[2124] Ibid., 201.

[2125] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 133.

[2126] Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Belknap Press of Harvard University Press, 1992), 535.

[2127] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 6.

[2128] Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*: 151.

primarily a research agency with no administrative power and no mandate to provide any services, its irrefutable data on infant and maternal health showed a higher maternal mortality rate in America than all other comparable nations and a ranking of eleventh among the nations on infant mortality. The Children's Bureau served as one model for what would later become the Department of Health, Education, and Welfare (HEW) and later still, the U.S. Department of Health and Human Services.[2129] During a period when the United States was otherwise inimical to social and health programs on a national level, the Children's Bureau reformers were able to accomplish the passage of the first explicit federal social welfare legislation directed at medical care.

The "Federal Act for the Promotion of the Welfare and Hygiene of Maternity and Infancy," commonly known as the Sheppard-Towner Act passed in 1921. The Act provided states with federal matching funds to establish prenatal and child health centers. The centers focused on education and prevention and, therefore, initially did not encounter much resistance from organized medicine, even though the American Medical Association (AMA) clearly opposed any government expansion into medical care.[2130] Public health nurses and mostly female physicians staffed the clinics and mobile health trucks that brought preventive medical care to remote and poor areas. Despite its apparent success and popularity among its beneficiaries, however, the Act faced bitter opposition from conservatives and the AMA as it came up for renewal of appropriation. The AMA decried the Sheppard-Towner Act as "an imported socialistic scheme" of "state

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[2129] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 6. Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*: 481. Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America*: 218.

[2130] Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*: 481.

medicine."[2131] Its administrators, hoping to have a less hostile environment after a few years, cut a deal that called for the Act's eventual phase out. Unable to garner enough support, the Sheppard Towner Act ceased in 1929.[2132]

Mother's Pensions Become the Model for Aid to Dependent Children

With the stock market crash in 1929, and the long, devastating depression which followed, the nation was projected into an undeniable realization that economic instability could occur as a result of forces beyond the control of the individual, and that private sector charity and local public resources could not hope to stem the tide of destitution. About a third of the nation's philanthropic organizations disappeared in the face of so much need.[2133] By 1933 as many as 40 percent of the population of some states was on relief.[2134] Nationwide, the unemployment rate was almost 25 percent, though it was much higher in some areas.[2135] The New Deal, according to Michael Katz, "set in motion not only an extension of governmental responsibility or an increase in public spending on social welfare; it also stimulated a profound and enduring shift in the nature of federalism and, hence, in the character of American government itself."[2136] Social insurance seemed in 1934 to be, at last, a possibility when Franklin Roosevelt created the Committee on Economic Security. Germany had implemented a comprehensive system

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[2131] Ibid., 513.

[2132] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 149.

[2133] Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America*: 273-275.

[2134] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 7.

[2135] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 214.

[2136] Ibid., 229.

of social insurance as early as 1884, and all the countries of continental Europe had some form of social insurance by the turn of the century.[2137]

Although the Committee made recommendations on health insurance, a national health insurance covering all failed to stand up to the strong opposition from the AMA and the worry by the President and congressional supporters that its inclusion would defeat the other recommendations.[2138] Nevertheless, the federal welfare state came into being when President Franklin Roosevelt signed the Social Security Act in 1935. It was the "seminal event in the creation of entitlements in the United States."[2139] The Social Security Act was an omnibus measure that included the Old Age Insurance program; what we now think of as Social Security. It also included the Old Age Assistance program, Aid to the Blind, unemployment insurance, and Aid to Dependent Children or ADC. Maternal and child health services were covered under Title V, known now as the Maternal and Child Health Services Block Grant. Its focus was similar to Sheppard-Towner, but in some respects it was less far reaching. Anyone could take part in the services offered through Sheppard-Towner, but Title V was a means tested program. ADC, Title IV, was modeled directly after the Mother's Pension laws. ADC and, later, AFDC (Aid to Families with Dependent Children) became known as *welfare.*[2140] The following paragraph by Michael Katz helps to explain how the meaning of this word came to be transformed during the twentieth century:

[2137] Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America*: 226.

[2138] Starr, *The Social Transformation of American Medicine*: 266-270.

[2139] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 74.

[2140] Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935* (New York, NY: Free Press, 1994), 253-260. In 1962, ADC was renamed AFDC. David G. Smith and Judith D. Moore, *Medicaid Politics and Policy, 1965-2007* (New Brunswick, NJ: Transaction Publishers, 2008), 13.

> *Welfare* once signified a broad and progressive program with wide public support; the welfare state embodied a generation's hopes and aspirations for universal economic security and protection from the worst consequences of life's ordinary hazards. But by the 1960's this meaning of welfare and *welfare state* had changed completely. No longer understood to protect everyone against risk, "welfare" had become a code word for public assistance given mainly to unmarried mothers, mostly young women of color, under Aid to Families with Dependent Children. No other public benefits carried the stigma of welfare. The political left, right, and center all attacked it. In the early 1990's, when President Bill Clinton promised to "end welfare as we know it," everyone knew that he meant AFDC—the most disliked public program in America.[2141]

So, despite the clear improvements that many Americans could claim regarding financial security and other benefits, in some respects, the Social Security Act set up a clear division between social insurance and public assistance. On the one hand, the historian Walter Trattner noted: "the charitable and the temporary gave way to the just and permanent, and the dominance of private charity over public welfare came to an end."[2142] On the other hand, these benefits foreshadowed the entrenchment of the dichotomy between social insurance which was contributory and primarily federally funded as with Old Age Insurance or Social Security, and later Medicare; and public assistance, later to include Medicaid, which was means tested and administered locally through states or counties and required state funding.[2143] Within less than fifty years, Social Security had become an "impregnable" national institution when it was rescued by Ronald Reagan.[2144] Shortly thereafter, as discussed later in this chapter, AFDC, or

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[2141] Michael B. Katz, *The Price of Citizenship: Redefining the American Welfare State*, 1st ed. (New York, NY: Metropolitan Books, 2001), 1.

[2142] Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America*: 294.

[2143] Katz, *The Price of Citizenship: Redefining the American Welfare State*: 1-5. Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 11.

[2144] Michael Katz states: "Even a conservative president, Ronald Reagan, had to promise to rescue social security with only the most minor modifications." Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 242.

"welfare as we know it" was gone. The social historian Linda Gordon has suggested that "[w]hile universal benefits reinforce social coherence, the U.S. welfare system exacerbates resentments."[2145]

In a myriad of ways, these resentments were created out of the same kinds of moralistic and bureaucratic tendencies that nineteenth century charity organizations had displayed. These tendencies included the use of wide discretion in program procedures. In contrast, Social Security criteria for eligibility were elaborately detailed, leaving little to bureaucrats' discretion. Discretion in the provision of ADC benefits often involved intrusive and personal monitoring and judgments of the trustworthiness and character of those receiving benefits. Particularly during the 1940's and 1950's, ADC clients were subjected to frequent monitoring by caseworkers who would search for hidden resources and deduct any earnings that were found from the ADC stipends. Far more intrusive and moralistic was the practice of monitoring for a "suitable home." The presence of a man in the house, sometimes discovered through surprise raids, or the birth of an illegitimate child, made the home unsuitable and therefore not eligible for benefits.[2146] Although it is unclear to what extent these practices exacerbated or created households headed by single women, between 1950 and 1960, the proportion of ADC children listed as illegitimate increased 25 percent, to 34 percent of black and 11 percent of white children, far greater than the proportion in the general population.[2147] ADC clients were required to be "needy," which resulted in constant surveillance by caseworkers who determined not

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[2145] Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935*: 299.

[2146] Ibid., 298-299. Administratively, this process was called "deeming" by the caseworker. In 1958, the Supreme Court ruled in *King v. Smith* that such restrictions violated the Social Security Act.

[2147] Katz, *The Price of Citizenship: Redefining the American Welfare State*: 7.

only whether there was a need but also the amount of the need.[2148] In essence, and in contrast to social insurance, there was "administrative discretion at the lowest levels of government."[2149]

The first suggestion of an entitlement to health care among ADC recipients came in the form of Amendments to the Social Security Act in 1950. The basic premise was that the federal government would match state funds for the purpose of paying medical vendors for health care for people receiving public assistance. Although President Truman pushed harder for national health insurance than had Roosevelt, the postwar period was particularly hostile to government expansion into health care. What survived the legislative battleground, as discussed in Chapters 3 and 4, in addition to the 1950 amendments, was the 1946 Hospital Survey and Construction Act, commonly known as the Hill-Burton Act. The Act had provisions to encourage construction in underserved areas, though it also required local matching funds. There was also a vague obligation for hospitals receiving Hill-Burton funds to provide a reasonable volume of uncompensated care.[2150] The opponents of national health insurance endorsed vendor payments and their enactment was celebrated as a victory.[2151] This celebration of an inadequate program of health care coverage by opponents of far –reaching expansions was destined to be reenacted many times.

[2148] Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935*: 293-299.

[2149] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 11.

[2150] Starr, *The Social Transformation of American Medicine*: 347-349. Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 80-83.

[2151] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 23.

The Kerr-Mills Act Creates Medical Vendor Payments for ADC Recipients

By 1960, more than half a billion dollars was spent on medical care through public assistance programs and forty states were participating in a federally approved vendor payment plan.[2152] This meant that ten states were not participating in federal vendor payments and, in addition, there were wide variations among the states that were participating. Vendor payments were often much less than the cost of care. There was a "web of enormous complexity" because payment procedures could vary by county.[2153] These were some of the reasons that health care for the elderly became a key political issue.[2154] Proponents of national health insurance were willing to focus on the provision of care to the elderly as a compromise. The result was the 1960 Kerr-Mills Act. The Act as envisioned would provide comprehensive benefits to people receiving Old Age Assistance.

Though it was means-tested, Kerr-Mills created a new category of the "medically indigent" which meant that people who were not receiving public assistance could become eligible if illness caused them to become indigent. Long term care was included among Kerr-Mill's benefits and so the link between long term care provision and medical indigency was established. In large part due to payments under Kerr-Mills, nursing homes constructed with Hill-Burton funds continued their growth. There was a tenfold increase in vendor payments to nursing homes between 1960 and 1965.[2155]

[2152] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 80.

[2153] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 27.

[2154] Ibid., 26.

[2155] Colleen M. Grogan, "A Marriage of Convenience: The Persistent and Changing Relationship between Long-Term Care and Medicaid," in *History and Health Policy in the United States: Putting the Past Back*

Yet, the Kerr-Mills provisions were implemented slowly and many states did not participate other than minimally. It was difficult to know how many additional people were covered by Kerr-Mills since states sometimes merely transferred the cost of care under less generous vendor payments to the program.[2156] A particularly humiliating experience for elderly Kerr-Mills recipients was the requirement to provide their children's addresses, each of whom was subject to a means test.[2157] Hospitals were distressed at the delay between the provision of care and receipt of payment for Kerr-Mills patients. The result, according to the author Jonathan Engel, was that "Kerr-Mills patients began to be seen as glorified charity patients rather than private paying patients with government-subsidized insurance policies."[2158]

The Enactment of Title XIX

The next window of opportunity for legislation to provide medical care to more people came after the election of President Johnson by a landslide. Signed into law in 1965, Medicare, Title XVIII, and Medicaid, Title XIX, became part of the Social Security Act. These programs were the first of Johnson's Great Society initiatives. Often described as a "three-layered cake," the law provided hospital insurance for the people over sixty-five through Medicare Part A, voluntary insurance for physician's office visits through Medicare Part B, and an expansion of the Kerr-Mills program through

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In, ed. Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns (New Brunswick, NJ: Rutgers University Press, 2006), 205-210. Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 30-41.

[2156] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 80-81.

[2157] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 35.

[2158] Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965*: 37.

Medicaid.[2159] The bulk of the legislative debate surrounded Medicare which was a program of public health insurance based on Social Security. It was a federal program that required new governmental infrastructure. Medicaid was literally seen as an extension of Kerr-Mills and not the creation of an entirely new program. Like Kerr-Mills, federal funding for Medicaid was open-ended for those within the categorically eligible groups and who also met means and assets testing. States would have the rate of their matching funds determined yearly as in Kerr-Mills and this rate would be no less than 50 percent, depending on the per capita income of the state. States' participation was voluntary, but states choosing to participate had to cover all the public assistance categories, including AFDC-eligible people, the blind and the disabled, not only the elderly as in Kerr-Mills. Medicaid, then, administered most often by the states' welfare department was tightly connected to public assistance.[2160]

HEW had the task of implementing both Medicare and Medicaid, though Medicaid was a state administered program. The federal response was hampered by the lack of clarity on the goals of Medicaid: Was Medicaid primarily a "health" or a "welfare" program?[2161] Historical precedence conflicted with aspirations of proponents: "Many in 1965 assumed that Medicaid would provide the basis for widespread health care for the poor, yet its historical evolution pointed clearly to the narrower welfare mold."[2162] Medicaid was not a program based on medical need at its inception, it was a

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[2159] Oberlander, *The Political Life of Medicare*: 28-31.

[2160] Judith D. Moore and David G. Smith, "Legislating Medicaid: Considering Medicaid and Its Origins," *Health Care Financing Review* 27, no. 2 (2005).

[2161] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: xx.

[2162] Ibid., 77.

program based on categories linked to public assistance. Congress furthered the dichotomy and confusion by naming patients “beneficiaries” under Medicare and “recipients” under Medicaid.[2163] From the beginning, as the social historian Rosemary Stevens wrote in 1974, there was lack of clarity: “Recipients have never been clear about their ‘rights;’ providers have not been clear whether they are to treat Medicaid patients as ‘real’ patients or charity cases.’”[2164]

Provider Participation in Medicaid

One of the pervasive problems in the Medicaid program has been the low payment rates as compared to either Medicare or private health insurers. This problem was recognized early in the program’s history. An editorial in the New England Journal of Medicine in 1967 makes this point:

> The welfare directors seeking cut-rate payments to physicians under Medicaid are virtually demanding that physicians subsidize the Government – a Government that has assumed the responsibility of paying for medical services to a large segment of the population. The traditional ethical principle that physicians should treat patients in need of medical care without regard to their ability to pay is noble in concept and practice. Once, however, the patient becomes the beneficiary of a federal or state program that guarantees that he will receive high-quality medical care, and that it will be paid for, he cannot justifiably be classed as a medical charity case. The concept of the federal Government as a charity case is ridiculous.[2165]

Originally, Medicaid hospital payments were based on “reasonable cost” as in the Medicare program. For other services, according to Rosemary Stevens, states “could include the continuation of the long welfare tradition of reimbursing at less than cost, in

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[2163] Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965*: 49.

[2164] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 356-357.

[2165] Editorial, "Resistance to Change under Medicaid," *New England Journal of Medicine* 277, no. 14 (1967).

other words, expecting providers to donate out of charity."[2166] The provision of hospital care to poor patients on the basis of reasonable cost was not entirely hailed as an achievement. Medical educators sometimes considered the treatment of Medicaid patients as private patients to be a conundrum. The American Hospital Association's past president worried in 1966 about "the clear probability of the disappearance of the 'ward service' patient—the 'charity patient'—the 'second class' patient—upon whom has rested nearly the whole reliance for graduate medical education and a major part of undergraduate medical education'"[2167]

Hospital payment requirements for Medicaid patients changed in 1981 under the Boren Amendment to allow states to pay an amount "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated institutions."[2168] The result was that while forty states paid for Medicaid hospital services on the basis of Medicare rates in 1981, only four states did so by 1991.[2169] The trend in hospital payments under Medicaid and Medicare have converged as of 2010 with the American Hospital Association reporting that both programs' payments covered just over 92

[2166] Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*: 66.

[2167] Ibid., 99. See also Chapter 2 on medical education and charity care.

[2168] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 167. The Boren amendment was repealed in 1997 after many "Boren lawsuits" had resulted in states being forced to increase their payment rates to hospitals and nursing homes when they were found not to be "reasonable and adequate." Olson, *The Politics of Medicaid*: 60-61. When the Boren amendment was repealed, the Medicaid DSH requirement, discussed subsequently, was retained. Charles Luband, "Medicaid Supplemental Payments and Financing Issues," (2011), http://www.healthlawyers.org/Events/Programs/Materials/Documents/MM09/luband.pdf (accessed March 14, 2013).

[2169] Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965*: 169.

percent of costs.[2170] Medicaid physician fees, on the other hand, continue to lag significantly behind Medicare fees. In 2008, Medicaid physician fees were 72 percent of Medicare fees. Among payment for specific services, Medicaid fees vary such that on average Medicaid pays 66 percent of Medicare fees for primary care services but 93 percent of obstetrical fees. Medicaid fees also vary among states with, for example, Wyoming Medicaid physician fees on average more than 40 percent above Medicare fees and New York on average more than 40 percent below Medicare fees.[2171]

Low physicians' fees are usually cited as the most important reason for low participation in the Medicaid program. About half of physicians nationwide accept all new Medicaid patients whereas more than 70 percent accept all new commercially insured or Medicare patients. Other reasons for low physician participation in Medicaid are delays in payment and high administrative burdens.[2172] In other research, the attitudes and perceptions of providers have been shown to be a factor in Medicaid participation. For example, in the 1983 President's Commission Report on access to care, the authors included research demonstrating that additional contributing factors to low participation included physicians' personal dislike for Medicaid patients and holding political attitudes against the involvement of "government in medicine."[2173] A letter from a Baltimore

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[2170] In 2010, the payment to cost ratio for Medicare was 92.4 percent, for Medicaid 92.8 percent, and for commercial insurers 133.5 percent. See: American Hospital Association, "Trendwatch Chartbook 2011. Table 4.4," (2011), http://www.aha.org/research/reports/tw/chartbook/2012/table4-4.pdf (accessed March 14, 2013).

[2171] Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs* 28, no. 3 (2009).

[2172] Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs* 28, no. 1 (2008).

[2173] Janet B. Mitchell and Jerry Cromwell, "Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare," in *Securing Access to Health Care: The Ethical Implications of Differences in* physician in 1982 described the physician's experience with Medicaid patients in a nuanced way:

> The effort and time required for the care of a Medicaid patient is often greater than that for one's regular practice because of: (a) The tendency for many of the patients to ignore the making and keeping of appointments. They either don't show up, placing an additional burden on the physician for retrieval, or they arrive with four children instead of the one for whom the appointment was made; (b) The frequent lack of telephone facilities; (c) The restriction against telephoning prescriptions: (d) The additional and often cumbersome paperwork; (e) The usual delay of the agency in making payment to the physician; (f) the difficulty of securing consultation through the usual channels.[2174]

In a 2000 survey of pediatricians, lower payments and a greater paperwork burden for physicians seeing patients enrolled in Medicaid managed care were associated with reduced participation rates, suggesting a continuation of many of the same problems.[2175] Managed care arrangements have increased over the past few decades such that Medicaid patients received about 70 percent of their services through managed care in 2008.[2176] In a 2001 survey, physicians tended to have negative attitudes toward Medicaid patients and Medicaid managed care but these attitudes did not predict acceptance of new Medicaid patients. About half of the physicians in the survey believed that Medicaid patients were more likely to sue them, and almost three-fourths believed that Medicaid patients were likely to be noncompliant and require extra time. About 80 percent of physicians believed that Medicaid patients have complex clinical and psychosocial problems. Greater than

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the Availability of Health Services: Volume 3: Appendices, Empirical, Legal, and Conceptual Studies, ed. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, DC: U.S. Government Printing Office, 1983).

[2174] Stephen M. Davidson, "Physician Participation in Medicaid: Background and Issues," *Journal of Health Politics, Policy and Law* 6, no. 4 (1982): 711.

[2175] Steve Berman et al., "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics* 110, no. 2 Pt 1 (2002).

[2176] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 18.

one third of physicians believed that Medicaid patients “unsettle other patients in the waiting room.”[2177] On the other hand, in one survey almost 60 percent of physicians stated that participation in their state’s Medicaid program was the “right thing to do.”[2178] The rise in the number of Medicaid patients enrolled in managed care is associated with the concentration of Medicaid patients among smaller numbers of physicians and practice settings.[2179]

Together, the low fees, delays in payment, and administrative burdens may act in synergistic ways with the already pervasive negative attitude among physicians about Medicaid patients. As Medicaid patients are increasingly concentrated, a question arises about how these factors may continue to perpetuate the strong historical ties between Medicaid and charity and inhibit efforts to improve care so that it is equivalent to care provided to people with other types of health insurance. Although obvious, it bears noting that people who do have health insurance through Medicaid would primarily be uninsured if Medicaid were not available. This is one of the reasons that Medicaid and charity care interact in a myriad of ways. For example, through the 1980s states often limited the number of days of hospital payment for patients enrolled in Medicaid to two weeks or twenty-one days: “If a patient is admitted and then needs to stay past the limit, the person must be covered as a charity case, moved to a public hospital—or forced to

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[2177] Lisa Backus et al., "Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care," *Journal of General Internal Medicine* 16, no. 12 (2001).

[2178] Frank A. Sloan and Christopher J. Conover, "Physician Participation and Nonparticipation in Medicaid Managed Care: The Tenncare Experience," *Southern Medical Journal* 92, no. 11 (1999): 1065.

[2179] Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated among Physicians," no. 16 (2006), http://www.hschange.com/CONTENT/866/ (accessed March 14, 2013).

leave."[2180] Limiting hospital payment for Medicaid enrollees has not ended; several states recently implemented such limits.[2181]

Yet, Medicaid is sometimes credited with the dismantling of a traditional source of charity care, the public hospitals, in what has been called one of the "great paradoxes" of the program.[2182] Both Medicaid and Medicare allowed patients who would have been charity patients to obtain services from private hospitals to a greater extent than prior to their enactment. The mass closings of public hospitals that were predicted by some, however, did not occur after the enactment of Medicaid and Medicare. Changes in the distribution of care did occur but this did not fundamentally alter the distribution of hospitals. From 1966 to 1980 the number of beds in urban public hospitals declined by close to 40 percent while private hospital beds increased by 60 percent.[2183] Also, the number of public hospitals declined from 1,700 in 1978 to 1,360 in 1995. Yet this is by no means the complete picture because public hospitals, in particular, have come to rely on Medicaid funds.[2184]

A difficult to assess factor in access to care has also been the subtle and not so subtle influences of provider or institutional behavior and their effect on the patient's

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[2180] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services*, vol. One: Report (Washington, DC: U.S. Government Printing Office, 1983), 157. See also chapter 4 on hospital charity care for the relationship between aggressive debt collection and limits on Medicaid hospital days in the case of *Newsom v. Vanderbilt*.

[2181] Phil Galewitz, "States Are Limiting Medicaid Hospital Coverage in Search for Savings " *USA Today*, October 31, 2011.

[2182] Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965*: 126.

[2183] F. William Blaisdell, "Development of the City-County (Public) Hospital," *Archives of Surgery* 129, no. 7 (1994): 763.

[2184] Bruce Siegel, "Public Hospitals: A Prescription for Survival," (1996), http://www.commonwealthfund.org/Publications/Fund-Reports/1996/Oct/Public-Hospitals--A-Prescription-for-Survival.aspx (accessed March 14, 2013).

choice of hospital. For example, in the 1970s three fourths of the patients interviewed at Philadelphia General Hospital preferred that hospital even when they could go to other hospitals. It is unknown whether this was due to the history of hospital racial segregation in the city or some other combination of factors.[2185] Feeling "welcome" at an institution is one factor difficult to assess.[2186] In other words, Medicaid has worked in both directions to dismantle some traditional sources of charity care and to simultaneously shore up those same sources. In 2010, the National Association of Public Hospitals (NAPH), discussed in Chapter 2, reported that Medicaid provided 35 percent of total net revenue for member hospitals. In addition to regular Medicaid payments for services, supplemental Medicaid payments discussed below are considered essential to maintaining member hospitals' financial well being.[2187]

Enrollment in Medicaid Affects Uncompensated Care

It remains largely unknown how many people who are potentially eligible for Medicaid are not enrolled and whose care then results in uncompensated services.[2188] The General Accounting Office studied this issue in two reports in the early 1990s.[2189] In the District of Columbia, hospital officials estimated that they enrolled one third of patients

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[2185] Gary Henderson, "The Impact of National Health Insurance on the Public Hospital," *Health Care Management Review* 9, no. 4 (1984): 62.

[2186] Siegel, "Public Hospitals: A Prescription for Survival."

[2187] Obaid S. Zaman, Linda C. Cummings, and Sandy Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey," (2012), http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf (accessed March 14, 2013).

[2188] The term "uncompensated care" is used here because this is how the term for charity and bad debt is referred to in the literature.

[2189] The General Accounting Office became the Government Accountability Office in 2004. Government Accountability Office, "GAO's Name Change and Other Provisions of the GAO Human Capital Reform Act of 2004," (2004), http://www.gao.gov/about/namechange.html (accessed March 14, 2013).

eligible for Medicaid during admission. Other research had shown that 17 percent of District residents, not just those entering hospitals, were eligible for Medicaid but not enrolled.[2190] Most of the District's hospitals had hired proprietary vendors to enroll patients eligible for Medicaid. The vendors were paid on a contingency basis at a cost of up to 17 percent of the reimbursement gained by the hospital from the Medicaid program.[2191] In a follow up study in three states, about half of the denials for Medicaid coverage occurred for procedural reasons such as the applicant not providing the necessary documentation or not appearing at a required interview. It is not known how many of the denied applicants would have been eligible for Medicaid. When patients were asked, the most common reasons for not providing the completed application was the limited amount of time given, not understanding what was required, and being unable to attain the necessary documents. Hospital officials believed that some people were too sick or too embarrassed to go the welfare agency for the interview.[2192] State welfare agencies face penalties for enrolling people who are not eligible but do not face a penalty for failing to enroll a person who is eligible because the application is incomplete.

Significantly, no one can be enrolled in Medicaid without applying for it. Hospitals have a powerful incentive to ensure that people who have received care enroll in Medicaid when they are eligible because the costs are generally uncompensated without enrollment. Medicaid covers hospitalization for ninety days prior to enrollment if the applicant would have been eligible during that time. Although hospitals in the follow

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[2190] General Accounting Office, "District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care," (Washington, DC: U.S. General Accounting Office, 1992), 5.

[2191] Ibid., 3.

[2192] ———, "Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People," (Washington, DC: U.S. General Accounting Office, 1994), 10.

up study believed that the state Medicaid caseworkers should provide more help in enrolling patients, the caseworkers were generally too overworked and also faced prohibitions on patient advocacy since they were also charged with final eligibility determinations. Two proprietary vendors at one hospital in 1992 obtained an additional $10 million in Medicaid reimbursement and were paid $2 million. While hospitals employed staff to assist Medicaid applicants, the vendor firms provided more intensive assistance.[2193] The General Accounting Office cited the following as one example:

> The child of a single uninsured working mother incurred a $20,000 hospital bill. The mother also had young twins at home. The hospital referred this case to an enrollment vendor firm after determining that it was a potential Medicaid case. After contacting the mother, the firm initiated and submitted a Medicaid application. The firm gave the applicant a list of the verification items she would have to provide. However, the applicant did not provide the requested items and Medicaid coverage was denied. Upon learning of the denial, the firm contacted the applicant twice weekly for a period of 2 months to get her to cooperate by either providing the verification document or signing a power of attorney that would allow the firm to obtain the documents. However, during this time, the applicant had pressing demands on her life. In addition to working, she was caring for her sick child and young twins. When the applicant stopped responding to the firm's many calls, the firm assigned another caseworker. Eventually, the applicant responded and submitted the verification items and a signed power of attorney to the firm. The verification items included copies of a birth certificate, a Social Security card, and pay stubs. According to an official at the firm, the applicant had been carrying these items in her purse for some time but did not attach any priority to providing them to the firm. The signed power of attorney allowed the firm to appeal the denial successfully and obtain Medicaid coverage for the children.[2194]

Needless to say, while the benefit to hospitals and to patients in reducing uncompensated care and medical debt, respectively, is real, the net effect of paying proprietary vendors to enroll patients in Medicaid is a loss of public funds for medical care to a private for-profit business that does not provide any medical services.

[2193] Ibid.

[2194] Ibid., 24-25.

While it is important to recognize that people who are eligible for Medicaid may receive care that ends up as uncompensated, that is, as bad debt or charity care, it is also the case that uninsured people are significantly worse off than people with Medicaid coverage. When people lose Medicaid coverage, they are three times more likely to lack a regular source of care and twice as likely to have no physician visits as compared to someone with health insurance.[2195] Access to care in the Medicaid program comes close to the access to care for low income privately insured people, though this varies by state.[2196]

Ending Welfare as We Know It Does Not Make Medicaid Free of Stigma

Another factor that resulted in a decline in Medicaid enrollment was the already mentioned welfare reform. The formal legislative link between welfare and Medicaid was severed in the mid-1990s. The 1935 Social Security Act established ADC, based on the widely implemented Mother's Pensions, which was commonly known as "welfare," or cash assistance. As already described, both Mother's Pensions and ADC were linked to the notion of charity. When Medicaid was enacted the now-AFDC became one of the categories that determined eligibility.[2197] Prior to 1996, people receiving benefits through AFDC were automatically enrolled in Medicaid. AFDC beneficiaries comprised more

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[2195] Sara Rosenbaum, "Medicaid," *New England Journal of Medicine* 346, no. 8 (2002): 637.

[2196] Teresa A. Coughlin, Sharon K. Long, and Yu-Chu Shen, "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs* 24, no. 4 (2005).

[2197] As mentioned earlier, ADC was renamed Aid to Families with Dependent Children in 1962 out of concern that the program's benefits and eligibility rules discouraged marriage. Susan W. Blank and Barbara B. Blum, "A Brief History of Work Expectations for Welfare Mothers," *The Future of Children* 7, no. 1 (1997).

than one third of all people enrolled in Medicaid and about half of children enrolled in Medicaid.[2198]

In 1996, under pressure to reform welfare and live up to his promise to "end welfare as we know it," President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). The federal program for cash assistance, AFDC, was replaced by Temporary Aid to Needy Families (TANF) and it was given over to states as a block grant.[2199] Although Medicaid eligibility remained at the same income level, there was confusion about the new law on all sides as well as reports of states engaging in aggressive tactics to deter enrollees.[2200] Proponents of severing the link between AFDC and Medicaid argued that it would allow states to expand their eligibility criteria and that it would decrease the stigma associated with public assistance for those enrolled in Medicaid. A summary of this view follows:

> The decision to separate welfare and Medicaid eligibility was well intentioned; the goal was to protect poor families' Medicaid coverage from possible cutbacks in welfare. Further, this might allow Medicaid to begin to operate apart from welfare and some day evolve into a freestanding health insurance system for low-income persons.[2201]

What actually happened was that a variety of direct and indirect factors led to a reduction in health insurance even among the people who remained eligible for cash assistance

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[2198] Judith D. Moore, "Welfare Reform and Its Impact on Mediciad: An Update," (1999), http://www.nhpf.org/library/issue-briefs/IB732_WelfRef&Mcaid_2-26-99.pdf (accessed March 14, 2013).

[2199] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 243-244.

[2200] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 168-170.

[2201] Marilyn R. Ellwood and Leighton Ku, "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid," *Health Affairs* 17, no. 3 (1998): 148.

through TANF. After TANF implementation, women eligible for TANF were 8 percent and children were 3 percent less likely to have health insurance coverage.[2202]

Although PROWRA had the potential to allow states to expand Medicaid eligibility and it was seen as both a practical and symbolic severing of the link between welfare and Medicaid, its passage was largely attributable to a national abhorrence of "dependency."[2203] The entitlement status of AFDC ended with the enactment of PROWRA. Its fate was more a matter of political mobilization than a well thought out plan to improve the opportunities for people with a low income. Cash assistance "would become, instead, a form of public charity. Asked what would happen to the children of women denied cash assistance, Speaker Gingrich recommended orphanages."[2204] The implementation of TANF occurred during the same period of time that President Clinton vetoed proposals to turn Medicaid into a block grant program that would have ended its fiscal entitlement status as well.[2205] As Michael Katz noted, the word "'entitlement' had developed a connotation nearly as negative as 'welfare.'"[2206] Often using racially coded language, the problem as many conservatives saw it, was "[n]ot jobs, wages, or globalization, but the collapse of family threatened America's future, and its major source was welfare."[2207] According to this view:

[2202] John Cawley, Mathis Schroeder, and Kosali I. Simon, "How Did Welfare Reform Affect the Health Insurance Coverage of Women and Children?" *Health Services Research* 41, no. 2 (2006).

[2203] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 246.

[2204] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 328.

[2205] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 169.

[2206] Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: 328.

[2207] ———, *The Price of Citizenship: Redefining the American Welfare State*: 319.

> “[T]he welfare system has paid for non-work and non-marriage and has achieved massive increases in both. By undermining the work ethic and rewarding illegitimacy, the welfare system insidiously generates its own clientele…Welfare bribes individuals into courses of behavior which in the long run are self-defeating to the individual, harmful to children, and increasingly a threat to society.[2208]

Perhaps the threat of welfare faded somewhat with its loss of entitlement status but the sentiments may not have. According to the health policy scholar Laura Katz Olson, views of poverty have had sticking power:

> Poverty in the United States is characterized as stemming from personal inadequacies, with welfare recipients viewed as “lazy and shiftless,” “welfare queens,” “deceitful,” “immoral,” and “conniving,” For the most part, it is assumed that young adults receiving income assistance are gaming, cheating, and abusing the system. Government’s main role has thus been to “motivate,” “educate,” “control,” and even “punish” individuals and their families who have not attained sufficient funds to meet their basic needs. Blaming victims, especially black and Hispanic low-income, single mothers, has become the national norm among Democrats and Republicans alike.[2209]

Still, there were many people who hoped that severing Medicaid eligibility from AFDC would result in greater access and less stigma. A publication from the predecessor to CMS described the changes as “an opportunity for states to recast and market Medicaid as a freestanding health insurance program for low income families, improving the possibility of destigmatizing Medicaid and enhancing the potential of the program to reach families that come into contact with the TANF system.”[2210] In the intervening years, with as much as Medicaid has been able to accomplish, it has not shed its status as somehow connected to charity medicine. In fact Olson’s *The Politics of Medicaid*,

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[2208] Ibid.

[2209] Olson, *The Politics of Medicaid*: 67.

[2210] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 247.

published in 2010, refers to the program as "welfare medicine" throughout the entire book.[2211]

Recent estimates show that over 70 percent of potentially eligible children are not enrolled in Medicaid or CHIP.[2212] In 2004, about 14 percent of uninsured adults were eligible for Medicaid.[2213] When New York's United Hospital Fund studied the Medicaid eligibility process in 2008, the program was still administered by local social service agencies that were also responsible for cash assistance and food stamp programs. Other states had adopted new health insurance processes to eliminate any stigma of "welfare" that might discourage people from applying for coverage.[2214] Proponents of the Affordable Care Act are again hopeful that the Medicaid expansion will mean that the program becomes one of many health insurance options that are acceptable and without a negative connotation to people enrolled and those looking on.

The Medicaid Program from the Patient's Point of View

In 2005, the Kaiser Family Foundation surveyed the American public on their views of the Medicaid program. While more than half of the people surveyed did not know about details of the program, about the same number knew someone who was enrolled in Medicaid or had been covered by Medicaid at some point. According to the news release: "Perhaps surprisingly given years of debate about Medicaid, frequent

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[2211] Olson, *The Politics of Medicaid*.

[2212] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 13.

[2213] Diane Rowland and Adele Shartzer, "America's Uninsured: The Statistics and Back Story," *Journal of Law, Medicine & Ethics* 36, no. 4 (2008): 624.

[2214] Barbara Coulter Edwards, Vernon K. Smith, and Greg Moody, "Reforming New York's Medicaid Eligibility Process: Lessons from Other States," (2008), http://www.medicaidinstitute.org/assets/516 (accessed March 14, 2013).

references to the program as the “Pac Man” of state budgets, and periodic calls for reform, public attitudes toward Medicaid are remarkably positive, and opposition to cuts is reasonably strong.”[2215] More than three-quarters of the people surveyed said they would be willing to enroll in Medicaid if they were eligible. Medicaid was viewed almost as favorably as Medicare and Social Security among those surveyed.[2216] More recently, after the economic recession began, researchers from the Kaiser Family Foundation conducted focus groups in four communities about concerns related to their health care. Many people who had recently lost their jobs could not understand why Medicaid was not available when they needed it. One woman who lost her job and health insurance coverage said: “It would be wonderful [to have Medicaid]. It would be such a relief to know that if you had a problem, you’d be able to have that taken care of and not go into the hole even further.”[2217] Researchers also recently conducted a study on people in Oregon who had been selected by lottery in 2008 to be eligible for Medicaid. Although the effects on health were difficult to determine based on objective data because of the short time frame, self-reported health did improve. Medicaid coverage improved financial well being and even happiness.[2218]

At the same time, people insured through Medicaid do often perceive that their care is less than it should be. When the American Academy of Family Physicians published their endorsement of extending Medicaid coverage to more people in 1991, a

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[2215] Kaiser Family Foundation, "National Survey on the Public's Views About Medicaid, 2005," (2005), http://www.kff.org/medicaid/kcmu062905nr.cfm (accessed March 14, 2013).

[2216] Ibid.

[2217] Michael Perry et al., "Rising Health Pressures in an Economic Recession: A 360 Look at Four Communities," (2009), http://www.kff.org/uninsured/upload/7949.pdf (accessed March 14, 2013).

[2218] Katherine Baicker and Amy Finkelstein, "The Effects of Medicaid Coverage--Learning from the Oregon Experiment," *New England Journal of Medicine* 365, no. 8 (2011).

mother of an adult son with Down's syndrome on Medicaid wrote a letter describing how "he was refused care by several primary care physicians and was denied admission by two highly respected hospitals because they did not want 'another Medicaid patient.'" Although he had a fever, was severely dehydrated, and was vomiting, the mother wrote: while "[a]drift in a sea of white coats, the only mercy we were shown was a towel to catch the vomitus."[2219] When Medicaid managed care was being initiated widely in Connecticut, an advocate related the following story about her child:

> I had a child who was on Medicaid and who needed to see a specialist…So I went out for a nine o'clock appointment…I was put in this big waiting room with a hundred people, all women and children. And by about 10:30 I went over and knocked on a window and said to the woman, "I have a 9:00 appointment." And the woman said, "So does everyone else…" It was a very dehumanizing experience.[2220]

One of the most nuanced accounts of the situation faced by poor Americans in obtaining health care is from the book, *Poor Families in America's Health Care Crisis*, by Ronald Angel, Laura Lein, and Jane Henrici. The book provides details from an ethnographic study of mostly minority families in three cities along with supporting data and commentaries from other research. One of the aspects of the lives of the people that were studied rarely is portrayed in the literature but affects the health care that people receive and whether they are enrolled in Medicaid. This is an account from the authors:

> [T]he lives of the people we worked with were often confusing and chaotic. Unlike fictional accounts, the story plots are not complete and there are often large gaps in the narratives. Although for the most part the mothers we interviewed were remarkably candid about their lives and were forthcoming with information, we could not always be sure when members of the family were employed and when they had health insurance because their lives were simply too complex and confusing to be easily entered into the sort of time and activity matrix that

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[2219] Jane A. Zanca, "Letter to the Editor," *Journal of the American Medical Association* 18, no. 266 (1991).

[2220] Colleen M. Grogan and Michael K. Gusmano, *Healthy Voices, Unhealthy Silence : Advocacy and Health Policy for the Poor* (Washington, DC: Georgetown University Press, 2007), 105.

> researchers often use (or that a well crafted novel might portray.) Even in directed interviews, the sequence of events and the identification of who did what when was often unclear to us and probably to the mothers themselves.[2221]

Throughout the book, what has been called “churning” or the cycling on and off Medicaid is a constant.[2222] The complexity and instability of the families’ circumstances were daunting and reached all aspects of living include employment, housing, other basic necessities, and health care. One family’s example of churning occurred in the family of a single mother, “Cecilia.” She lost Medicaid coverage as well as food stamps and TANF benefits when she missed a meeting with a caseworker during her second pregnancy. Later, Medicaid was discontinued for one child because his immunizations were not up to date.[2223] When Cecilia was not eligible for Medicaid, she used a local public program but she owed hundreds of dollars to the program. Even though the local program was intended for low income uninsured people and the price is discounted, it was certainly not free.[2224] Medical debt was mentioned by many of the people interviewed for the book. This is not unusual even for extremely impoverished people. Less than half of uninsured people receive discounted prices when they pay for medical care and this has been the case for many years.[2225]

Some of the people interviewed in the book had “cordial” relationships with their caseworkers but many others did not. At the time of the study all of the mothers were

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[2221] Ronald Angel, Laura Lein, and Jane Henrici, *Poor Families in America's Health Care Crisis* (Cambridge, NY: Cambridge University Press, 2006), 5.

[2222] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation’s Health Coverage Program for Low-Income People." 13.

[2223] This disenrollment should only have affected cash assistance, not Medicaid.

[2224] Angel, Lein, and Henrici, *Poor Families in America's Health Care Crisis*: 3.

[2225] Carrier, Yee, and Garfield, "The Uninsured and Their Health Care Needs: How Have They Changed since the Recession?" 14.

going through their state's welfare office to obtain Medicaid as well as other benefits. One mother stated:

> When you go now [to the welfare office], you have some workers that act like that money comes out of their pockets. I have had some treat me like I wasn't human. They talk down to you. I still get nervous and kind of sick in the stomach when I go back for my six-month review because they do you so bad.[2226]

The authors suggested that daily demeaning interactions had an effect on general well being. Many people were perceived by the authors to exhibit a general psychological distress, or demoralization, from having so many features of their lives that were out of their control. At the very least, these conditions interacted with other factors to increase health risks. At the same time, there were cases in which the people who were interviewed displayed courage and a sense of empowerment. Yet, Medicaid and other sources of health care were a part of an often chaotic existence, and, indeed, often added to it.[2227]

According to the health law and policy scholar Timothy Jost, and sketched in this chapter, the explanation for state administration of the Medicaid program is largely historical and political. Though the adage "all health care is local" resonates to some degree, as discussed in Chapter 1, it is also the case that state and local governments can be "particularly ill-suited for protecting the interests of the poor and of minority groups" and more susceptible to interest groups.[2228] In a nutshell, Jost describes this history as follows:

[2226] Angel, Lein, and Henrici, *Poor Families in America's Health Care Crisis*.

[2227] Ibid.

[2228] Jost, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 173.

> The fact that Medicaid is a federal-state cooperative program, rather than a national program like Medicare, is an artifact of a history of which we should not be proud. It is in part the history of trying to keep poor people on relief under the thumb of local government, where their lives could be managed more closely. It is also in part the history of racism, with which President Roosevelt had to come to terms to get his New Deal programs past Southern Democrats in Congress who insisted on control over who got welfare and how much.[2229]

As compared to requirements for Medicare beneficiaries, the requirements for Medicaid enrollees under federal law can be waived by the federal government through Section 1115 waivers. Whereas wide regional variability in access and administration is problematic for the Medicare program, it is usually seen as a "virtue" for the Medicaid program.[2230] The stories of the families in the ethnographic study are an account of how this history is realized.

Especially with the expansion of Medicaid beginning in 2014, the question of the degree to which people may associate the program with stigma is important. Although in the recent Kaiser Foundation interviews many participants wanted to enroll in Medicaid but were not eligible, some effect of stigma has been a part of research on enrollment during previous expansions of Medicaid and CHIP.[2231] Certainly the family members interviewed in the ethnographic study often felt humiliated. In 2000, researchers interviewed 1,400 people who received health care at community health centers in order to study dimensions of stigma associated with the use of public benefits such as cash assistance and Medicaid. The researchers also identified ways in which stigma and other factors affected actual enrollment. The belief that applying for Medicaid would involve

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[2229] ———, "The Tenuous Nature of the Medicaid Entitlement," *Health Affairs* 22, no. 1 (2003): 151.

[2230] ———, *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*: 172.

[2231] Lisa Dubay and Genevieve Kenney, "The Impact of CHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families," *Health Services Research* 44, no. 6 (2009).

unfair questions and that Medicaid enrollees would not receive the same treatment by physicians as people with private health insurance were associated with lower decisions to enroll. The researchers did not find evidence of what some have called "welfare stigma," which is the belief that the enrollee will feel bad about herself or that others will look down upon her, as separate causes for not enrolling. Changes in the enrollment process such as applying for Medicaid at places other than the welfare department were associated with much less stigma.[2232] States have tended to increase outreach efforts and simplify enrollment in Medicaid when budgets are strong and to dampen such procedures or create other barriers during economic downturns. The enrollment process will be an important factor in the number of eligible people who do enroll in Medicaid after 2014.[2233]

The Medicaid Disproportionate Share Hospital Program Is Created

Another way that charity care and Medicaid became linked in complex ways that continue to be debated is through the use of Medicaid supplemental payments which have been discussed in the previous chapters. When Congress enacted the Boren Amendment in 1981 which resulted in states lowering Medicaid hospital payments, it required states to "take into account" hospitals that serve a "disproportionate number of low-income people with special needs" when determining reimbursement.[2234] The law explicitly allowed these funds to help pay for care of uninsured patients, some but an indeterminate

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[2232] Jennifer P. Stuber et al., "Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid," (2000), http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/beyond_stigma_no3.pdf (accessed March 14, 2013).

[2233] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 13.

[2234] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 168.

number of whom, were receiving charity care. Since states were primarily interested in their new ability to lower payments to hospitals, the provision was largely initially ignored.[2235] Also, the requirement as enacted was broad and vague such that only seventeen states had a Medicaid Disproportionate Share Hospital (DSH) by 1985.[2236]

Congress amended the Medicaid DSH provisions in 1987 out of concern that states were not implementing these additional payments. States were now required to submit a plan describing their DSH policy. The law also set minimum criteria for defining a hospital as a DSH hospital and minimum criteria for calculating DSH adjustments. States were required to designate a hospital as a DSH hospital if it had a Medicaid inpatient utilization rate greater than one standard deviation above the mean rate for that state or if it had a low income utilization rate above 25 percent. The Medicaid low income utilization rate is specifically calculated in part on the basis of the percentage of charity care provided by the hospital. Beyond this minimum, states had great latitude in defining other hospitals as eligible for DSH funds. The FMAP for DSH payments was the same as the match for traditional Medicaid but there was no upper limit or ceiling on the federal match for DSH payments as long as the requirements were met.[2237] In 1983 regulations had been issued by CMS that prohibited Medicaid federal matching payments for inpatient hospital and nursing home care to no more than what

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[2235] Michael S. Sparer, *Medicaid and the Limits of State Health Reform* (Philadelphia, PA: Temple University Press, 1996), 51.

[2236] Robert Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," (Washington, DC: National Health Policy Forum, 2004), 5.

[2237] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments."

would be paid under the Medicare program, referred to as the “Medicaid upper payment limit.”[2238] This limit did not have to be adhered to in the DSH payments.

The intended purpose of the law was clearly to provide states with matching payments for hospitals that were providing the most care to low income patients whether or not the patients were covered under Medicaid or were receiving charity care.[2239] What actually happened over the next few decades was that some of the intended purpose of the law was realized but in other ways the Medicaid DSH story became a “painful paradox.”[2240] As described by health law scholar Rand Rosenblatt in a somewhat different context: “in the name of the poor” funds may flow “[m]ost ironically” back to those with the most political power while the “poor’s ‘social account’” is charged.[2241] In a 1995 survey of the Medicaid DSH program in thirty-nine states, the primary beneficiaries of the program were state governments. One third of the DSH funds were retained by states suggesting that “only a small share of the funds currently generated by DSH programs are actually used to cover uncompensated care.”[2242] Since, according to officials, “money is fungible” at the state level, the funds could be used to balance overall

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[2238] Teresa A. Coughlin and David Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues," (1997), http://www.urban.org/UploadedPDF/anf_14.pdf (accessed March 14, 2013).

[2239] The law specifies that the Medicaid DSH low income utilization rate is the sum of two ratios. The first is the share of the hospital’s total revenue for patient services that are paid by Medicaid or state and local subsidies. The second is the percent of total hospital charges for inpatient services accounted for by the net (of state and local subsidies for inpatient care) amount of charity care provided to inpatients. Wynn et al., "Analysis of the Joint Distribution of Disproportionate Share Hospital Payments," 10.

[2240] Rosenblatt, "Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care," 115.

[2241] Rosenblatt attributes this insight to Edward Sparer. Ibid.

[2242] Leighton Ku and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* 16, no. 3 (1995).

state budgets.[2243] The Washington Post called the program "a worthy idea gone terribly awry."[2244]

The controversy tended to be less about the failure of the funds to be used for uncompensated care and aimed more toward the use of the funds to increase the federal share of Medicaid payments. The ability of states to increase the federal share of payments arose in part from a regulation issued in 1985 by the predecessor to CMS which allowed states to receive donations from private medical care providers or to tax providers and use these funds to draw down federal dollars according to the federal matching rate. For example, in West Virginia the state began collecting millions of dollars in donations from large nonprofit hospitals. The funds became state funds which were then given back to the hospitals in an amount that exceeded the original donation. Once the hospitals were paid, the state received a federal match but most of the match was retained by the state. There was a net gain by the hospital, though the largest gain was to the state budget.[2245] An illustration of how the program could work follows:

> State A requests a donation or imposes a tax on a hospital of $10 million. The state then makes a DSH payment of $12 million to the hospital, either as lump sum or by means of increased Medicaid rates. This nets the hospital $2 million and "costs" the state $2 million. The state then claims the $12 million as a "legitimate" Medicaid expense and, assuming a fifty percent match, receives $6 million from the federal government. Final result: the provider netted $2 million from the transaction; the state is ahead by $4 million; the federal government is out $6 million; and Medicaid recipients may or may not benefit from this transaction.[2246]

[2243] Ibid.

[2244] Dan Morgan, "Small Provision Turns into a Golden Goose; States Use Subsidy to Balance Budgets," *Washington Post* 1994.

[2245] Coughlin and Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments."

[2246] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 208-209.

Once states understood the possibility of these financing strategies, the DSH program payments exponentially increased from less than $600 million in 1989 to $17.4 billion in 1992. Program costs were increasing so rapidly that federal officials were becoming alarmed. The Inspector General called the use of provider donations and taxes an “uncontrollable virus” and “egregious.”[2247] The reason that the DSH program was used in conjunction with the donations and taxes was that Congress had specifically made the program unlimited and not tied to specific beneficiaries or services.[2248] Officials in the Bush administration at the Office of Management and Budget, and the CMS, saw the program as “highly irregular if not illegal.”[2249] The political implications were powerful, threatening alliances between state and federal government officials at both the political and budgetary level. As a result, Congress embarked on measures that vacillated between clamping down on program loopholes and increasing funds for the program over the next few decades.[2250]

In 1991 Congress enacted the first legislative reform of DSH with the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments. The law was intensely negotiated between the Bush administration and the National Governor’s Association and was a compromise measure.[2251] The law prohibited the use of donations and provider taxes that were not broad based. The taxes had to be “real” and could not be written to

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[2247] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," 6.

[2248] Ibid.

[2249] John K. Iglehart, "The American Health Care System--Medicaid," *New England Journal of Medicine* 328, no. 12 (1993): 898.

[2250] Olson, *The Politics of Medicaid*: 210.

[2251] Coughlin and Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." 3.

hold providers “harmless” for the cost.[2252] The law set a national limit of 12 percent of total Medicaid spending for the DSH program curtailing the escalation from about 2 percent of spending in 1990 to over 13 percent in 1992.[2253] State DSH payments were also capped at the 12 percent level but were to be phased up or down based on the individual state’s allotment since some states had much higher or lower percentages of DSH. One effect of the cap was to lock in the highly inequitable distribution of DSH funds at the state level. For example, by 2001 there were five states that reported a DSH payment of at least $1000 per resident below the poverty level and sixteen states that reported DSH payments of less than $100 per poverty level resident. [2254] The law also specifically protected the use of intergovernmental transfers as a source of financing, considered by some to be another “loophole,” which had not been in wide use prior to the legislation.[2255]

The Growth of Medicaid DSH is Curtailed

The effect of the law was to limit the growth in the DSH program though the controversies were far from over. The DSH program by this time had become politically explosive and a vehicle for fundamentally divergent strategies among powerful

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[2252] Teresa A. Coughlin, Leighton Ku, and Johnny Kim, "Reforming the Medicaid Disproportionate Share Hospital Program," *Health Care Financing Review* 22, no. 2 (2000): 139.

[2253] Teresa A. Coughlin and David Liska, "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals," *Health Affairs* 17, no. 3 (1998): 119.

[2254] Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 9.

[2255] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," 6-7.

stakeholders.[2256] As the two health policy scholars, David Smith and Judith Moore, put it:

> And the DSH experience provides a good example of how the flexibility and loopholes in our American system of fiscal federalism enable venturesome and public-spirited officials to work a power of good. They also reward the shrewd and greedy, punish those who live by the rules and make do with their share, and breed lies, hypocrisy, distrust, and cynicism.[2257]

The use of intergovernmental transfers in which states use public funds from state, local, or county health care facilities as the state match works much the same way as the provider donations and taxes. In short, states switched the source of Medicaid state funds for the DSH program to intergovernmental transfers, achieving the same ends as when provider donations and taxes were used.[2258] States also began to use other questionable practices. Some states were reporting grossly inflated charges at public hospitals or were paying significantly more in DSH payments to certain hospitals than the total cost of caring for Medicaid and uninsured patients. In some cases states were providing DSH payments to hospitals with few Medicaid patients especially at mental hospitals where most care for adults is the financial responsibility of the state. As a response to these continued problems, in 1993 Congress imposed a hospital-specific limit to DSH payments which could be no more that the total cost of unreimbursed care to Medicaid enrollees and uninsured patients for an individual hospital. The 1993 amendments also

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[2256] Morgan, "Small Provision Turns into a Golden Goose; States Use Subsidy to Balance Budgets."

[2257] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 208.

[2258] Almost all states continue to use provider taxes, though these are the ongoing subject of reforms.Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financing Issues: Provider Taxes," (2011), http://www.kff.org/medicaid/upload/8193.pdf (accessed March 14, 2013).

prohibited DSH payments to hospitals, such as mental health institutions, that did not have at least a 1 percent Medicaid utilization rate.[2259]

The hospital-specific limits were transitioned such that certain usually state-owned hospitals could continue to receive DSH payments up to 200 percent of their Medicaid shortfall and uninsured cost. Congress created exceptions to the hospital-specific limit on DSH payment several times. In 2000, for example, the hospital-specific limit for public hospitals for the years 2003 to 2004 was increased from 100 percent to 175 percent of the unreimbursed Medicaid and uninsured cost.[2260] When the Office of the Inspector General specifically reviewed the increase in the DSH limit for public hospitals in 2001, it concluded that the increase should be delayed or repealed. The recommendation was in part based on the Inspector General's findings that as much as 90 percent of DSH payments to some hospitals were returned to the state; the calculation of uncompensated care costs varied widely; many hospitals already overstated uncompensated care costs; and some states included the cost of providing care to prisoners even though this was not allowed. CMS agreed but the increase in DSH limits for public hospitals was left intact for those years.[2261] This is consistent with the history of the DSH program as "intensely political and rife with special deals."[2262]

[2259] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," 7-8.

[2260] The Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA 2000) required that public hospitals in all states have a DSH limit of 175 percent of uncompensated care cost for the two fiscal years beginning after September 2002. California's public hospitals already had this higher limit. Office of Inspector General, "Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted," (Washington, DC: Department of Health and Human Services, 2001).

[2261] Ibid.

[2262] Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 8.

When forty states were surveyed about their DSH programs in 1997, states were netting 40 percent of the financial gains while hospitals were receiving about 60 percent of new additional funds.[2263] As mentioned, Congressional attention continued on DSH payments to hospitals though still vacillating between curtailing and expanding the program. Reliable and detailed information on DSH programs was severely lacking and states resisted attempts to develop accurate reporting systems.[2264] In the 1997 Balanced Budget Amendment, Congress required states to report to CMS the methodology used to identify and to make payments to DSH hospitals on the basis of the proportion of low income and Medicaid patients served by the hospitals and the report was required to include individual hospital information.[2265] In a 2002 report by the Urban Institute, however, researchers found that "compliance with this requirement appears lax and federal enforcement is limited."[2266] Even the most minimal information was often not provided by states such as identifying hospitals accurately. The newly reported information also did not necessarily correlate with information on an existing CMS form further calling into question the validity of both reports.[2267]

The researchers at the Urban Institute were also hampered by the lack of a national database that provides uniform information on the quantity of care provided to

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[2263] Coughlin, Ku, and Kim, "Reforming the Medicaid Disproportionate Share Hospital Program," 155.

[2264] Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 9.

[2265] *Balanced Budget Act of 1997*, Public Law 105-33 (August 5, 1997), § 4721, Reforming Disproportionate Share Payments Under State Medicaid Programs.

[2266] Wynn et al., "Analysis of the Joint Distribution of Disproportionate Share Hospital Payments," 107.

[2267] Ibid., 108.

low income patients or uncompensated care.[2268] At the time, no information was collected on charity care on the Medicare Cost Report which is the report that almost all hospitals must complete. The AHA Annual Hospital Survey information on charity care is not available on the public use file.[2269] Nevertheless, the researchers were able to describe the information that was available, what additional information was needed, and a framework for analyzing DSH policies. The researchers concluded that the policy goals for DSH funding should be clarified and that a national database is needed to fully understand the program, uncompensated care, and alternative allocation strategies. Despite the shortcomings of the information available, the researchers found that the program targeted funds to financially vulnerable safety net hospitals at least as well as the alternatives they theorized.[2270]

Other Medicaid Maximization Strategies Are Utilized

In response to the relative crack down on DSH payments, states began to use other "Medicaid maximization" strategies to increase the federal share of funds. One of the primary ways states could do this was through the upper payment limit rules (UPL). While the Medicaid DSH program is mandatory for states, the UPL programs are not. The process was similar in the UPL program to that used in the DSH program in the early years. A Louisiana journalist described the process: "Borrow $20 from a friend. Show it to your Dad. He gives you $50. Give the $20 back to your friend. Walk away with a

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[2268] Ibid., xxi-xxii.

[2269] Ibid., 18.

[2270] Ibid., 100, 104.

wallet $50 fatter."[2271] UPL supplemental payments are tied to Medicaid expenditures and not statutorily linked to uncompensated care. At the individual hospital level, however, when states report uncompensated care for DSH audits (explained subsequently), reported Medicaid revenue must include UPL payments.[2272] For this reason, these two sources of supplemental payments, DSH and UPL, potentially are available to cover the cost of uncompensated or charity care.

The UPL supplemental Medicaid payments are not based on one hospital's Medicaid revenue but are based on the aggregate amount of Medicaid payments across a class of hospitals or providers.[2273] States could make large payments to a specific hospital or category of hospitals because the aggregate Medicaid expenditure across many institutions left "room under the upper limit."[2274] If the UPL payments went to public hospitals, some states would retain most of the funds. For example, in Michigan the state provided over $100 million to county hospitals because all county hospitals in the aggregate had Medicaid payments that were less than payments that would have been paid by the Medicare program. The federal match was about $150 million making a total of $350 million that was provided to the county hospitals under the UPL program. The county hospitals then, through an intergovernmental transfer, sent all but about $5 million

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[2271] Andy Schneider and David Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing," (2002), http://www.kff.org/medicaid/4043-index.cfm (accessed March 14, 2013).

[2272] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule. "

[2273] Other supplemental Medicaid payments are made on the basis of 1115 Waivers which are state specific demonstrations approved by CMS. Government Accountability Office, "Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments," (Washington, DC: U.S. Government Accoutability Office, 2008), 6.

[2274] Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 9.

back to the state. In Michigan, the funds transferred back to the state were deposited into a separate general fund that "recycled" the money to generate additional federal matching dollars. Other states clearly used the funds for non-Medicaid purposes.[2275] The complexity of the financing arrangements occurs partly because of the variety of ways in which states implement DSH and UPL arrangements. Also, the "absence of reliable data protects states that engage in questionable practices and limits the momentum of efforts to change the program in ways that would benefit low-income patients."[2276]

The rapid growth in DSH spending in the late 1990s and later UPL spending was responsible for some of the unexpected rise in the cost of the Medicaid program.[2277] The increase in spending in Medicaid did likely accrue to the social account of the poor and it definitely accrued to the economic account of the poor. While, as states argued, these programs may have allowed federal funds to stabilize states' budgets and this may have contributed to a given state's ability to maintain Medicaid services, the evidence is mixed. Clearly, in some states the ability to obtain additional federal funds was far removed from any health care related purpose and has even been associated with statewide tax cuts.[2278] Even if there is a belief that some of these funds are used to make positive changes, states as well as hospitals have wide discretion and little accountability

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[2275] The transactions are simplified for the purpose of illustration. General Accounting Office, "Intergovernmental Transfers Have Facilitated State Financing Schemes," (Washington, DC: U.S. General Accounting Office, 2004).

[2276] Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 14.

[2277] Morgan, "Small Provision Turns into a Golden Goose; States Use Subsidy to Balance Budgets."

[2278] Schneider and Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing." 8.

for the use of the funds.[2279] The use of these supplemental Medicaid programs may also increase the likelihood of cuts to the program. There is at least some distortion in the data on Medicaid costs when DSH and UPL spending does not result in spending for services provided to Medicaid enrollees (or uninsured patients in the case of DSH).[2280] At the state level, reducing spending on Medicaid generally becomes a priority during economic downturns since states must balance their budgets.[2281] At the federal level, reducing spending in the Medicaid program has dominated many strategies and initiatives.[2282] To the extent that DSH funds increase expenditures for Medicaid, the funds create more pressure to cut spending.

Medicaid Section 1115 Waivers and Charity Care

The ability for states to operate their Medicaid programs with greater flexibility is allowed under a Section 1115 waiver if approved by CMS. Often, the impetus to create a waiver stems from the desire to preserve Medicaid supplemental funding. One of the most ambitious Section 1115 Medicaid waivers was the TennCare program which began in 1994 when the financing of Tennessee's DSH program was in question. Approval of

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[2279] Karen Matherlee, "The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy," (Washington, DC: National Health Policy Forum, 2000), 7.

[2280] Schneider and Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing." 8.

[2281] Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People." 28.

[2282] Olson, *The Politics of Medicaid*: 2.

the TennCare waiver meant that the state could continue to receive the equivalent of the amount of supplemental funds it would have received through DSH payments.[2283]

By 2005 CMS was negotiating the terms of several Section 1115 waivers. Many of the waivers incorporated changes in the financing and use of Medicaid DSH and UPL payments toward financing methods that were more acceptable to CMS, while maintaining more flexibility for states. In some cases, states developed uncompensated care pools that shifted resources from hospital DSH and UPL payments to broader programs that provided funding for free care or reduced the number of uninsured people.[2284] Recently, CMS approved a Section 1115 waiver in Texas that allows the state to expand Medicaid managed care and continue to receive UPL funds that would have been lost without the waiver. UPL funds are paid on the basis of fee-for-service Medicaid utilization. If states wish to lower costs by enrolling patients in managed care arrangements, there is a potential to lose federal UPL matching payments.[2285] The Texas waiver uses savings from managed care and UPL funds that would have been paid by the federal government under fee-for-service predictions to create an uncompensated care

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[2283] Matherlee, "The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy," 6. See also: Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 7.

[2284] Jennifer Ryan, "Medicaid in 2006: A Trip Down the Yellow Brick Road?" (2006), http://www.nhpf.org/library/issue-briefs/IB810_Medicaid2006_03-29-06.pdf (accessed March 14, 2013). Aaron McKethan and Joel Menges, "Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion," (2006), http://www.lewin.com/~/media/lewin/site_sections/publications/upl.pdf (accessed March 14, 2013).

[2285] ———, "Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion," (Falls Church, VA: Lewin Group, 2006).

pool and make delivery system reforms. Over a five year period, the amount of federal funds Texas will receive is $29 billion under the waiver.[2286]

Although many Section 1115 waivers involve the use of Medicaid supplemental funding, in Utah in 2002 the state implemented a waiver that did not use supplemental funds. Instead, the state paid for a capped number of people with an income below 150 percent of the poverty level to enroll in a Medicaid "Primary Care Network" by reducing benefits and increasing cost sharing for certain people already enrolled in Medicaid. Most of the Medicaid enrollees who had their benefits reduced and who had increased cost sharing requirements were parents with an income at about half of the poverty level. This group is called the "Non-Traditional Medicaid group.[2287] About two years after the Utah waiver was implemented, a survey of the Primary Care Network and the Non-Traditional Medicaid groups was done. Of the very poor patients who had their benefits reduced and cost sharing increased, the Non-Traditional Medicaid group, 80 percent had significant financial distress and had difficulty meeting basic needs. Among those in the Non-Traditional Medicaid group who reported medical bills were difficult to pay, almost all were having difficulty with basic needs.[2288]

What is remarkable about the Utah waiver is not only that some of the most vulnerable Medicaid enrollees partially "paid" for the expansion but also that the Primary Care Network provides no coverage for hospitalization or specialty care. Hospital care

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[2286] Kaiser Commission on Medicaid and the Uninsured, "California and Texas: Section 1115 Medicaid Demonstration Waivers Compared," (2011), http://www.kff.org/medicaid/upload/8266.pdf (accessed March 14, 2013).

[2287] Caitlin Oppenheimer et al., "A Case Study of the Utah Primary Care Network Waiver: Insights into Its Development, Design, and Implementation," (2006), http://www.kff.org/medicaid/7470.cfm (accessed March 14, 2013).

[2288] Samantha Artiga et al., "Can States Stretch the Medicaid Dollar without Passing the Buck? Lessons from Utah," *Health Affairs* 25, no. 2 (2006).

and specialty care depend on the “good will of doctors and hospitals to provide charity care.”[2289] Several commentators indicated that the reliance on charity is due to the state’s “strong history of and belief in providing charity”[2290] or “an ethic of private charity codified and encouraged by religious belief from the dominance of the Church of Jesus Christ of Latter –day Saints.”[2291] The history of charity care by Utah’s nonprofit hospitals has not been one of generosity, however.[2292] Some charitable community groups have tried to pay the enrollment fee of $50 for the Primary Care Network patients but this has been inconsistent. The fee has been lowered for certain eligible people.[2293]

When the Primary Care Network began, there was a volunteer physician network operating in Salt Lake City, much like the volunteer networks discussed in Chapter 1. A nonprofit organization, the Health Access Project, agreed to help find specialty care for a limited number of Primary Care Network enrollees but this was only in the Salt Lake area. Difficulties getting specialty care have been particularly problematic when a procedure involves coordinating the donation of more than one professional’s time, equipment, and facility space.[2294] The New York Times reported that a woman enrolled in the Primary Care Network searched for nine months to find a surgeon who would

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[2289] Kirk Johnson and Reed Abelson, "Model in Utah May Be Future for Medicaid," *New York Times*, February 24, 2005.

[2290] Oppenheimer et al., "A Case Study of the Utah Primary Care Network Waiver: Insights into Its Development, Design, and Implementation." 8.

[2291] Johnson and Abelson, "Model in Utah May Be Future for Medicaid."

[2292] Noble, Hyams, and Kane, "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," 120-121.

[2293] Oppenheimer et al., "A Case Study of the Utah Primary Care Network Waiver: Insights into Its Development, Design, and Implementation." 10.

[2294] Ibid., 11.

repair a shoulder injury.[2295] The inability to find sources for referrals has resulted in a "cruel medical paradox. A low-income person might be diagnosed with a serious disease—such as cancer, chronic obstructive pulmonary disease, HIV, or severe mental illness—and then be unable to access the specialty or inpatient hospital care needed to treat the disease."[2296] When key stakeholders were interviewed about a year after implementation of the waiver, one of the problems reported was that primary care providers seeing patients enrolled in the Primary Care Network were concerned about the inability to get specialty care for patients when needed. Some providers were "stretching the scope of their services by providing care that they would usually refer to a specialist."[2297] In some cases, providers were concerned about their liability if a recommended treatment or referral was not covered by the Primary Care Network. This and the program complexity led some providers to stop accepting new Medicaid patients.[2298]

The Primary Care Network was providing coverage to less than 20 percent of the state's uninsured people by 2004. This was about the expected percentage of additionally covered people.[2299] About 50,000 people had been denied enrollment in the Primary Care Network because of missing information or inability to pay the enrollment fee. This is an indication that there was wide interest in health care coverage and that fees were a

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[2295] Johnson and Abelson, "Model in Utah May Be Future for Medicaid."

[2296] Judi Hilman, "Utah's Primary Care Network: States Can Do Better," *Virtual Mentor* 7, no. 7 (2005).

[2297] Oppenheimer et al., "A Case Study of the Utah Primary Care Network Waiver: Insights into Its Development, Design, and Implementation." 3.

[2298] Ibid., 11.

[2299] Artiga et al., "Can States Stretch the Medicaid Dollar without Passing the Buck? Lessons from Utah."

significant problem for people wanting to enroll.[2300] An analysis by the Center for Budget and Policy Priorities concluded that the increases in cost sharing for people enrolled in the Primary Care Network and Non-Traditional Medicaid resulted in a reduction in physician visits, prescription drug use, hospital outpatient clinic visits, and hospitalizations. Even the “nominal” fees of two or three dollars significantly reduced the use of medical care as compared to before the fees were initiated. The use of copayments is often cited as a strategy to reduce unnecessary medical care; yet it is not clear that patients have the ability to reduce only “unnecessary” care.[2301] The former director of the Utah Department of Health explained that the view of administrators is that “requiring significant rather than nominal cost-sharing would help the public and providers to perceive the program as more akin to a commercial insurance product.”[2302]

Utah’s hospitals reportedly worked with then-Governor Michael Leavitt to implement the waiver.[2303] The waiver replaced a “disappointing” state financed program that covered care for very low income people with chronic illnesses.[2304] The arrangement with Utah hospitals is a non-binding voluntary agreement to provide up to $10 million statewide in charity care. Notably, this care is valued at charges, not cost, according to the former director of Utah’s Department of Health. The hospitals would benefit by

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[2300] Kaiser Commission on Medicaid and the Uninsured, "Overview of the Utah Section 1115 Waiver," (2004), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14329 (accessed March 14, 2013).

[2301] Leighton Ku, Elaine Deschamps, and Judi Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah’s Medicaid Program," (2004), http://www.cbpp.org/files/11-2-04health.pdf (accessed March 14, 2013).

[2302] Isabel Friedenzohn, "Profiles in Coverage: Utah's Primary Care Network," (2003), http://www.statecoverage.org/node/484 (accessed March 14, 2013).

[2303] Mark Taylor, "The Utah Solution. HHS Sees State's Medicaid Solution as Blueprint," *Modern Healthcare* 33, no. 7 (2003).

[2304] Hilman, "Utah's Primary Care Network: States Can Do Better."

focusing their bill collection efforts on patients not enrolled in the waiver programs; by having the Department refer patients needing hospital care more evenly across hospitals; by partnering in the evaluation process; and by affirming the charity care tradition. The Primary Care Network does pay for physician services for hospitalized patients. Collecting data on hospital charity care for the purpose of evaluating the waiver has been difficult because the Department of Health "does not have sufficient authority to collect charity care data from Utah hospitals."[2305]

Politically, the Utah waiver was a validation of the Bush administration's strategy to lower costs in the Medicaid program and grant states greater flexibility. It was touted by Health and Human Services Secretary Tommy Thompson as a model for other states.[2306] In a speech in 2005, former Utah Governor Leavitt said: "Wouldn't it be better to provide health insurance to more people, rather than comprehensive care to a smaller group? Wouldn't it be better to give Chevies to everyone rather than Cadillacs to a few?"[2307] This speech occurred after Leavitt had been named the new Secretary of Health and Human Services.

Although the Medicaid DSH and UPL programs have been described as a "tug-of-war" between the federal and state governments, over time some of the practices considered to have threatened the fiscal integrity of Medicaid were at least curbed.[2308] By 2005, states had almost eliminated the practice of retaining funds from the DSH program.

[2305] Friedenzohn, "Profiles in Coverage: Utah's Primary Care Network."

[2306] Taylor, "The Utah Solution. HHS Sees State's Medicaid Solution as Blueprint."

[2307] Johnson and Abelson, "Model in Utah May Be Future for Medicaid."

[2308] Sonya Schwartz et al., "Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity," (Washington, DC: National Academy for State Health Policy, 2006), 6.

As a result, a greater percentage of the funds went to hospitals. In 2005 national spending on DSH, including both state and federal spending, was $17 billion and it was almost $10 billion on UPL. In a survey of thirty-five states, the intergovernmental transfer of funds back to the state had greatly decreased and accounted for less than 1 percent of spending. At the same time, the share of the spending in these programs attributable to federal funds was 80 percent, indicating that some of the problems that most interested federal officials were continuing.[2309] It is also noteworthy that the ability to assess payments under the UPL program was particularly difficult because of the lack of accurate reporting methods. The Government Accountability Office was unable to provide any estimate of the total national 2006 non-DSH supplemental payments such as UPL, stating "the total amount and distribution of payments made in fiscal year 2006 is unknown because states did not separately report all their payments to CMS."[2310]

Medicaid, DSH, and the Safety Net

Even though DSH and UPL programs sent some funds to state treasuries where it was impossible to trace the uses, proponents of the health care safety net have become one of the biggest stakeholders in the debate on the funds. Patricia Gabow, the chief at Denver Health described her state's reluctance to fully utilize DSH payments in the late 1990s when a legislator claimed that "DSH is the cocaine of public hospitals."[2311] Gabow's view was different:

[2309] Teresa A. Coughlin, Stephen Zuckerman, and Joshua McFeeters, "Restoring Fiscal Integrity to Medicaid Financing?" *Health Affairs* 26, no. 5 (2007).

[2310] The report states that CMS had determined that $23 billion was spent on DSH and non-DSH supplemental payments in 2006 but the information was incomplete. Government Accountability Office, "Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments," 6.

[2311] Patricia A. Gabow, "Making a Public Hospital Work," *Health Affairs* 20, no. 4 (2001): 186.

> We saw it more like penicillin. How do you transform cocaine into penicillin? And why shouldn't the federal government support safety-net hospitals like ours, when these institutions provide our national health insurance by default? We needed to convince one of the smartest and most powerful legislators who opposed DSH to support accessing these dollars.[2312]

When the DSH program was enacted, the term "safety net" was not a phrase generally in use to refer to health care.[2313] President Reagan used the metaphor "social safety net" in 1981 with William Safire declaring in that year that "[a]dministration spokesmen carry the safety net around as a kind of security blanket."[2314] In the midst of severe cuts to social welfare programs, Safire proclaimed: "Using the circus metaphor of a 'safety net,' the budget cutters seek to allay fears of many of the 'truly needy' (but not, one assumes, of the 'falsely needy') that society is not about to shove them off the high wire onto the sawdust below."[2315] According to authors David Smith and Judith Moore, Reagan used "safety net" primarily to refer to "middle class" entitlements like social security, Medicare, veterans' benefits, and unemployment insurance and not "welfare" entitlements like Medicaid, food stamps, and AFDC.[2316]

By 1999, the "health care safety net" was firmly entrenched in the health policy and medical literature. Writing for the National Association of Public Hospitals and Health Systems (NAPH) in 1999, Lynne Fagnani and Jennifer Tolbert described "safety net hospitals" as "those whose stated mission is to provide care to anyone in need

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[2312] Ibid.

[2313] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 157.

[2314] Safire, "On Language: Safety Nets."

[2315] Ibid.

[2316] Smith and Moore, *Medicaid Politics and Policy, 1965-2007*: 157. In 1985, Sara Rosenbaum referred to the health care safety net in the following article: Sara Rosenbaum, "Access to Care: Where Are the Holes in the Net? Special Concerns for Women and Children," *Health Matrix* 3, no. 3 (1985).

regardless of their ability to pay."[2317] As discussed in Chapter 2, these authors explain the major sources of funding for the care provided at safety net hospitals: state and local tax appropriations and the Medicare and Medicaid DSH programs. Even though hospitals that were members of NAPH transferred almost 70 percent of their Medicaid DSH payments back to their state treasuries in 1996, the Medicaid DSH program still raised Medicaid payments above costs to member hospitals.[2318] The authors take particular note of how the DSH program lacked accountability for how the funds were spent and that this was a major barrier to reforming the program. There was simply no national data on "how states spend DSH funds, who receives them, how much individual entities receive, and how states finance their share of the program."[2319]

Little is known as well about how hospitals that receive DSH payments use the funds. In a 1995 survey, hospital officials told surveyors that DSH revenue usually was placed in the hospital's general operating fund where the money could have indirectly covered the cost of uncompensated care and Medicaid underpayments. Some hospital officials told surveyors that the funds were used specifically to expand services in the clinics. Some hospitals used the funds as "short-term windfalls" and made many types of capital expenditures.[2320] Since the Medicaid and DSH funds cannot usually be traced, there are few ways other than surveys, to determine the impact of the funds. There is the possibility, however, that responses to the survey question about the use of DSH funds

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[2317] Fagnani and Tolbert, "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs," 1.

[2318] Ibid., 9, 19.

[2319] Zaman, Cummings, and Laycox, "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey." 25.

[2320] Ku and Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs."

could reflect social desirability bias.[2321] The safety net hospital officials may have perceived that it would be expected and socially desirable to report that the funds were used to provide services related to the needs of Medicaid and uninsured low income patients. Alternatively, the answers may have been accurate though there would be few opportunities to verify this. One study has provided evidence that patient mortality rates decline in proportion to the availability of DSH funds at public hospitals. This effect was hypothesized to be due to greater resources as a result of the funds.[2322]

In other research, subsidies provided to hospitals in New York in the 1980s on the basis of the cost of uncompensated care did increase the provision of charity care modestly when matching payments were provided. When lump sums were provided, charity care did not increase. The authors concluded that “hospital subsidies appear relatively inefficient in targeting revenues toward the uninsured patient. Hospitals use some of the revenues received from the pool to support uncompensated care, but a substantial fraction went to support other hospital activities or were simply retained.”[2323] In another study of all hospitals nationwide in the decade from 1990 to 2000, researchers showed that Medicaid DSH spending had no statistically significant effect on hospital

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[2321] Robert A. Pearlman and Helene E. Starks, "Quantitative Surveys," in *Methods in Medical Ethics*, ed. Jeremy Sugarman and Daniel P. Sulmasy (Washington, DC: Georgetown University Press, 2010), 240.

[2322] Katherine Baicker and Douglas Staiger, "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality," *The Quarterly Journal of Economics* 120, no. 1 (2005).

[2323] Thorpe and Phelps, "The Social Role of Not-for-Profit Organizations: Hospital Provision of Charity Care," 482.

uncompensated care. The estimate was considered to be robust and left the researchers to ask “where are the (marginal) Medicaid DSH dollars going?”[2324]

NAPH continues to be a vocal stakeholder in the Medicaid DSH discussion and the organization makes a strong case for DSH funds improving the financial status of safety net hospitals. According to the latest NAPH report, in 2010 Medicaid DSH payments covered almost a quarter of the cost of NAPH member hospitals’ unreimbursed care and other Medicaid supplemental payments covered the cost of more than 10 percent of such care.[2325] The definition of unreimbursed care used by NAPH, however, is not the same as the cost of Medicaid shortfalls and uninsured costs (the costs that DSH payments are directed toward) because it includes losses from Medicare patients as well.[2326] The NAPH report does state that “Medicaid DSH and other supplemental Medicaid payments are essential to the financial viability of safety net hospitals.”[2327] Reflecting the generally more precarious financial status of safety net hospitals, the average margin for NAPH members was just over 2 percent in 2010 while the average margin for all hospitals was just over 7 percent. Without Medicaid DSH the overall NAPH member margin would have dropped to negative 6 percent, and even further to negative 10 percent without UPL payments.[2328]

[2324] The authors were unable to determine at what point the funds became untraceable, that is, the funds were not traceable at either the state or hospital level. Lo Sasso and Seamster, "How Federal and State Policies Affected Hospital Uncompensated Care Provision in the 1990s," 740.

[2325] Zaman, Cummings, and Laycox, "America’s Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey." 13.

[2326] Ibid., 19.

[2327] Ibid., 15.

[2328] Ibid.

Medicaid DSH Reporting Requirements are Finally Implemented in 2010

Like most of the features of the DSH program, the reporting requirements that have been recommended for decades have been mired in political power plays. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 contained a provision that mandated CMS to require an independent certified audit of each state's DSH program and each hospital's DSH program. This requirement was to be implemented beginning in 2004 but CMS did not issue a proposed rule until 2005. The proposed rule was finalized in 2008 and was to be implemented in 2009 with states reporting on their DSH programs for the years 2005 and 2006.[2329] In a letter to state Medicaid directors, however, states were told they would not be considered out of compliance unless they failed to provide the reports by 2010. In the letter, CMS went even further to ensure compliance by stating that the information from the years 2005 to 2010 in the reports "will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter."[2330]

As mentioned previously, the DSH rules specify that one method for determining which hospitals must receive payments is based in part on the amount of charity care provided by the hospital.[2331] Of course, DSH payments by statute are directed toward

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[2329] Government Accountability Office, "Medicaid: Ongoing Federal Oversitght of Payments to Offset Uncomplsated Hospital Care Costs Is Warranted," (Washington, DC: United States Government Accountability Office, 2009).

[2330] Jackie Garner, "State Medicaid Director Letter: July 27," (Chicago, IL: Centers for Medicare and Medicaid Services, 2009).

[2331] *Social Security Act*, 42 U.S. Code (2012), 1923(b)(1923)(B).

hospitals that "serve a disproportionate number of low income patients with special needs."[2332] Yet, the definition of uncompensated care for DSH auditing purposes consists of two components that differ from the definition of charity care as defined by CMS in the Medicare Cost Report and as defined by the IRS in the Form 990.[2333] The first component of uncompensated care in the DSH audit is the unreimbursed cost of care for Medicaid patients and the second component is the unreimbursed cost of care for uninsured patients. Since 1993, federal matching DSH payments are provided to a hospital up to its hospital-specific limit which consists of the two components of uncompensated care. As already mentioned, in some years public hospitals could receive federal matching payments for up to 200 percent of their uncompensated care costs, though these increased payments ended in 2004.[2334]

A point of considerable controversy has been the definition of "uninsured" in the DSH audit. When the final rule on the DSH audit requirements was published in 2008, the narrative accompanying the rule stated that people who have health insurance refers broadly to those individuals who have "creditable coverage" as well as "coverage based upon a legally liable third party payer."[2335] The AHA and other hospital organizations countered that in previous CMS interpretations people without coverage for the service

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[2332] Ibid., 1923(a)(1921).

[2333] See chapter 4 on hospital charity care for a discussion of the definition of uncompensated care in the Medicare Cost Report and IRS form 990. Also see Table 6 in the Appendix for a summary of definitions related to charity care.

[2334] Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," 14.

[2335] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule. "

that was provided were included in the calculation of uninsured cost.[2336] In January 2012, a proposed rule was published which stated that uninsured costs include individuals who have no source of third party coverage for the specific inpatient hospital or outpatient hospital service furnished by the hospital. The definition clarifies that this includes costs for services provided to patients when a lifetime cap has been reached or when a specific service is not covered under the patient's health plan.[2337] Although a final rule has not been published, in May 2012 a technical correction stated that uninsured uncompensated care for the purpose of the DSH audit referred to services and not individuals. As described in the proposed rule, if a person with health insurance does not have coverage for the specific service provided, the cost may be included in the DSH audit.[2338]

The relationship between a hospital's charity care policy and the reporting of uncompensated care for the purpose of the DSH audit is somewhat surprising. A summary of the definitions related to charity care is located at the end of this chapter. The 2008 final rule makes it clear that when states calculate the low income utilization rate in order to determine which hospitals qualify for DSH payments, the cost of charity

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[2336] Rick Pollack, "Letter to CMS: Re: CMS 2315-P: Medicaid; Disproportionate Share Hospital Payments-Uninsured Definition, (Vol. 77, No. 11) January 18, 2012," (2012), http://www.aha.org/advocacy-issues/letter/2012/120216-cl-cms-2315-p.pdf (accessed March 14, 2013). Bruce Siegel, "Letter to CMS: Re: CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments –Uninsured Definition," February 17, (2012), http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Medicaid-and-DSH/DSH-Reporting-and-Audit-Rule/NAPH-Submits-Comments-on-Proposed-Rule-Regarding-Medicaid-DSH-Uninsured-Definition-January-2012.aspx?FT=.pdf (accessed March 14, 2013).

[2337] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition."

[2338] The text states:" with no source of third party coverage for the hospital services they receive." Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Programs; Disallowance of Claims for FFP and Technical Corrections," *Federal Register* 77, no. 103 (May 29, 2012).

care arising from the hospital's charity care policy is the relevant factor.[2339] On the other hand, when determining uncompensated costs for the hospital-specific limit, charity care or other designations such as "self-pay" are not relevant.[2340] According to the narrative of the final rule: "Charity care is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program."[2341] The final rule states that only the cost of care for uninsured patients may be included in the hospital-specific limit reported under the DSH program even if the hospital's charity care policy includes care to underinsured patients: "Depending on the definition used, hospital costs associated with the uninsured may be a subset of charity care in the hospital or may entirely encompass a hospital's charity care program."[2342] Therefore, states and hospitals must develop accounting procedures that segregate costs according to whether a patient has health insurance for the service provided.[2343]

The final rule also specifies that the meaning of "uncompensated care" for the purpose of the DSH audit is not the same as the definition used elsewhere in the hospital industry.[2344] The combined costs of charity care and bad debt are not the relevant costs for DSH reporting. Instead the "unreimbursed costs of providing inpatient and outpatient

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[2339] ———, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule " 77919.

[2340] Ibid., 77914.

[2341] Ibid., 77911.

[2342] Ibid.

[2343] Ibid.

[2344] See Table 6 in the Appendix which provides summaries of common definitions of terms related to hospital charity care.

hospital services to Medicaid eligible individuals and the unreimbursed costs of providing inpatient and outpatient hospital services to individuals with no source of third party reimbursement" are the costs eligible for payment under the DSH program.[2345] Also surprising is that the DSH program uncompensated care does not distinguish, as Hill-Burton charity did, between people unable versus people unwilling to pay. An uninsured person is not subject to any income or asset test to have costs allowable under the DSH program. It is the fact of being uninsured and not the fact of having a low income that is relevant for the DSH program hospital-specific limit.[2346] Allowable costs, according to the final rule, may be on the books as bad debt or charity. As long as the cost is from an uninsured person, it is allowable.[2347] Bad debt related to nonpayment of deductibles and copays is not an allowable cost because it is attributable to people with health insurance. Insurance claims that are denied are not allowed to be included for the same reason.[2348] On the other hand, when a service is provided to a patient whose care is paid for by a state or local indigent health care program, the costs are allowable under the DSH program. The payments made under state and local indigent health care programs are not included in the amounts that are received on behalf of patients.[2349] Presumably, this is because the DSH program payments are not intended to diminish the state and local commitment to indigent care, though this means that in some cases there could be a

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[2345] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule " 77914.

[2346] Ibid.

[2347] Ibid., 77911.

[2348] Ibid.

[2349] Ibid., 77913.

substantial double payment to a hospital for patients covered under an indigent care program.[2350]

The final rule pertaining to DSH audits from the states and individual hospitals requires several separate measures. Hospitals must report the supplemental payments, such as UPL payments, when calculating Medicaid payments for the hospital-specific limit.[2351] For this reason, both of these supplemental payments potentially reimburse hospitals for their uninsured costs and, to the extent that these uninsured costs are attributable to charity care, these supplemental payments cover the cost of charity care. The DSH audit reports are public information and are made available through CMS.[2352]

Medicaid DSH and the Affordable Care Act

When health care reform began to be seriously negotiated in 2009, reductions to Medicaid DSH payments to hospitals was one part of the deal that hospital associations agreed to under the condition that at least 94 percent of the nation's population would become insured.[2353] As discussed in Chapter 4, there will be substantial reductions in Medicaid DSH funds as a result of the Affordable Care Act. In the first year the reduction in federal DSH is $500 million and by 2019 the reduction is $5.6 billion, nearly half of

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[2350] States and counties support public hospitals in a patchwork fashion and also target programs for people not eligible for Medicaid through various efforts. For example, by 1985, thirty-four states had indigent health care programs. Randolph A. Desonia and Kathleen King, "State Programs of Assistance for the Medically Indigent," (Intergovernmental Health Policy Project, Georgetown University, 1985).

[2351] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule " 77950.

[2352] Deborah Bachrach and Melinda Dutton, "Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?" (2011), http://www.chcs.org/usr_doc/Medicaidsupplementalpaymentbrief.pdf (accessed March 14, 2013).

[2353] Mathew DoBias and Jennifer Lubell, "The Numbers Game. DSH Payments, Uninsured Counts Roil Senate," *Modern Healthcare* 39, no. 39 (2009).

the federal matching payment that would have been available without reform.[2354] For the years 2014 through 2020, the reduction in federal Medicaid DSH funds is estimated to be $18.1 billion. These estimates do not include reductions in state spending.[2355]

The Government Accountability Office (GAO) recently reported that $17.6 billion in federal and state DSH payments were made in 2010. About $14.4 billion in non-DSH supplemental payments, some of which were UPL payments, were made in 2010 but the exact amount of supplemental payments is not known because some states did not separately report non-DSH payments. The federal and state share of the combined DSH and other Medicaid supplement payments was at least $32 billion, with the federal share totaling at least $19.8 billion.[2356] However, as a proportion of hospital spending, the combined DSH and UPL payments are about one third of Medicaid fee-for-service payments.[2357] In other words, DSH and UPL payments are a significant part of hospital reimbursement. In some states, the significance of Medicaid supplemental payments is particularly great. For example, in 2002 five states reported that their DSH payments exceeded regular Medicaid payments.[2358]

The exact methodology for allocating the Medicaid DSH funds as they are reduced has not been published yet. The Affordable Care Act does require that the largest

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[2354] Bachrach, Braslow, and Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net." See also Peters, "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program."

[2355] Government Accountability Office, "Medicaid: States Reported Billions More in Supplemental Payments in Recent Years," (Washington, DC: U.S. Government Accountability Office, 2012), 7.

[2356] Ibid., 9.

[2357] Bachrach and Dutton, "Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?" 1.

[2358] Hearne, "CRS Report for Congress: Medicaid Disproportionate Share Payments," 13.

reductions occur in states with the lowest uninsured rates and in states that do not target their DSH payments to hospitals with high uncompensated care costs and high volumes of Medicaid patients.[2359] In general, safety net hospitals and the NAPH have expressed concern over the reduction in Medicaid DSH funding.[2360] The NAPH has made recommendations to CMS that call for targeting the DSH payments on a state-specific basis to hospitals according to their uninsured uncompensated costs and their Medicaid utilization rate.[2361]

At the same time, many health policy researchers and scholars believe that the reduction in DSH funding and the enhanced reporting for both DSH and UPL or other supplemental payments provides an opportunity to increase transparency and accountability for these critical sources of funding. At the present time, "a general problem with the Medicaid DSH program is the lack of transparency and accountability for documenting the direct impact of federal spending on care for vulnerable populations."[2362] The DSH and UPL payments are generally lump sum payments unconnected to any specific patient or service and not tied to quality measures, cost-effectiveness, or improvements in patient care. Therefore some researchers have suggested that Medicaid supplemental payments may "weaken or undermine

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[2359] *Patient Protection and Affordable Care Act*, § 2551.

[2360] Dennis P. Andrulis and Nadia J. Siddiqui, "Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients," *Health Affairs* 30, no. 10 (2011): 1832.

[2361] Bruce Siegel, "Equitable, Sustainable, Reliable Safety Net Financing: Medicaid DSH," (2012), http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/May-2012-Medicaid-DSH-Policy-Brief.aspx?FT=.pdf (accessed March 14, 2013).

[2362] McKethan et al., "Reforming the Medicaid Disproportionate-Share Hospital Program," w927.

comprehensive payment reform efforts and sound purchasing strategies."[2363] That is, when supplemental Medicaid payments are made independent of patient's experiences and without tying the payment to the provision of high quality and cost-effective care, "their use squanders an opportunity" to improve care.[2364]

The Commonwealth Fund Commission on a High Performance Health System made several recommendations recently to sustain safety net hospitals financially while promoting high quality care for vulnerable populations. Specifically the Commonwealth Fund Commission recommended first that enhanced payment through Medicaid should reflect both a disproportionate number of Medicaid patients "*and* the delivery of high-quality, coordinated, and efficient care."[2365] Included in this recommendation is that Medicaid rate increases should encourage outpatient treatment especially for the hospitals that implement the patient centered medical home model.[2366] The Commonwealth Fund Commission also recognized that some safety net hospitals have the ability to cross-subsidize care to low income patients because their status as academic medical centers attracts larger numbers of privately insured patients and allows for higher negotiated rates from commercial payers. The focus of their report is on the hospitals that do not have this ability.[2367]

[2363] Bachrach and Dutton, "Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?"

[2364] Ibid., 6.

[2365] Bachrach, Braslow, and Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net." 10.

[2366] Ibid., 13.

[2367] Ibid., 6.

The Commission recommended that states target increased Medicaid payment to safety net hospitals that utilize care delivery models that are the most effective in coordinating services for vulnerable populations. This could be achieved by increasing the rate that hospitals are paid through a transparent and accountable process.[2368] In targeting Medicaid DSH funds, the Commission recommended as a best approach that hospitals "bill" for each uninsured patient and receive a percentage of the Medicaid rate for these services. This ensures that payments are tied to specific patients.[2369] Finally, the Commission recommended that states use strategies such as grants and waivers to provide necessary access to capital for broad delivery system reforms.[2370]

What Are the Complexities for Advocates of Medicaid Enrollees and Charity Patients?

Broadly speaking, criticisms of Medicaid even by advocates of improved care for low income people can encourage efforts to dismantle the program.[2371] There are several constant problems facing advocates of Medicaid enrollees and other low income patients who need medical care. Some of these difficulties were encountered in Utah when the state decided to implement the Section 1115 Medicaid waiver which raised the financial burden on very low income patients and depended upon charity care from physicians and hospitals. A spokesperson from a Utah nonprofit health advocacy group stated that there was no opportunity to stop the waiver: "It became clear to us that this was a train without

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[2368] Ibid., 12.

[2369] Ibid., 20.

[2370] Ibid., 22.

[2371] David E. Rogers, Robert J. Blendon, and Thomas W. Moloney, "Who Needs Medicaid?" *New England Journal of Medicine* 307, no. 1 (1982): 15.

brakes, and it was going to happen."[2372] The situation was summarized by a Boston advocacy group as resulting from an assessment that "opposition is futile and more likely to harm ongoing working relationships than to produce any concrete benefits."[2373] Another subtle source of conflict among advocates was the "divide and conquer" aspect of potentially pitting current Medicaid enrollee's needs against those of uninsured people.[2374] Other national health care advocacy organizations such as Families USA were more vocal about their concerns, stating the waiver would "do considerably more harm than good for low-income families."[2375]

In the book, *Healthy Voices, Unhealthy Silence: Advocacy and Health Policy for the Poor*, Colleen Grogan and Michael Gusmano explore why advocates may be silent about major issues that are a concern to them.[2376] The authors also offer some ways to overcome such silences. The advocates that the book is based on were staff members of several nonprofit organizations in Connecticut during a transition to Medicaid managed care. Although the advocates were subject to a situation of political inequality and unequal power, this did not seem to account for all of the observations of the authors. Even under the circumstances, the advocates were not docile concerning several aspects of program details. This fact led the authors to consider the practical and theoretical

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[2372] Mark Taylor, "When More Means Less. Utah Gets Federal Approval Limiting Medicaid Services to Some to Provide a Basic Health Package to 25,000 Low-Income Uninsured," *Modern Healthcare* 32, no. 7 (2002).

[2373] Michael Miller, "Waiver Watch Issue Brief #2: The Utah Primary Care Network," (2002), http://www.communitycatalyst.org/doc_store/publications/waiver_watch_issue_brief2_the_utah_primary_care_network_apr02.pdf (accessed March 14, 2013).

[2374] Ibid.

[2375] Ibid.

[2376] Grogan and Gusmano, *Healthy Voices, Unhealthy Silence : Advocacy and Health Policy for the Poor*.

reasons for public silence on certain topics. The concern that was not expressed publicly by the advocates was whether the services provided under Medicaid managed care would be “mainstream.”

The use of the word “mainstream” by advocates meant that they were concerned about the possibility of “apartheid” care or access to providers that differed between people enrolled in Medicaid managed care and people enrolled in commercial managed care plans.[2377] The assumption among policymakers that simply enrolling Medicaid patients in managed care is equivalent to obtaining care that is “mainstream,” when this term refers to access to providers and treatments equivalent to commercially insured patients, has not proven valid.[2378] As the health policy scholar Laura Hermer has noted: “[T]he concept of ‘mainstreaming’ has evolved so that it no longer appears to pertain to the locus and nature of the care provided, but rather to the nature of coverage.”[2379]

The concern of the advocates centered on their realization that providing care through managed care organizations was not the same as improving access to a broad range of providers. In fact, in later interviews enrollees “were angry and hurt to find that their access was restricted to the same Medicaid providers they have always had access to.”[2380] A few of the factors that contributed to the silence of advocates in Connecticut

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[2377] Ibid., 4.

[2378] Colleen M. Grogan, "The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns," *Journal of Health Politics, Policy and Law* 22, no. 3 (1997): 837.

[2379] Laura D. Hermer, "Medicaid, Low Income Pools, and the Goals of Privatization," *Georgetown Journal on Poverty Law and Policy* XVII, no. 3 (2010): 421.

[2380] Grogan, "The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns."

were political infeasibility, lack of data, and lack of a solution.[2381] In addition, many of the organizations were “resource dependent” on the agencies where their advocacy efforts would need to be addressed. This conflict of interest because of resource dependence was exacerbated by the insertion of competition both among the nonprofit groups and other groups. The groups then had the problem of the actual conflict of interest and the potential for a perceived conflict of interest. That is, the advocates were perceived to be acting according to self interest and not according to the needs of Medicaid patients.[2382] The small number of people and groups involved and the close ties among these people also sometimes made deliberation more difficult.[2383] The authors conclude that the process of public deliberation can lead to improvements in policy outcomes. The role for nonprofit community groups as advocates will remain necessary according to the authors, though participation among the people affected by a policy and from nonprofit groups not directly involved would likely mean a better policy outcome.[2384]

The authors of the book note that only about 1 percent of the organizations attempting to influence policy in Washington claim to represent the poor.[2385] In general providers tend to be more interested in reimbursement rates as compared to enrollees or

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[2381] Grogan and Gusmano, *Healthy Voices, Unhealthy Silence : Advocacy and Health Policy for the Poor*: 124.

[2382] ———, "Political Strategies of Safety-Net Providers in Response to Medicaid Managed Care Reforms."

[2383] ———, *Healthy Voices, Unhealthy Silence : Advocacy and Health Policy for the Poor*: 126.

[2384] Ibid., 130.

[2385] Ibid., 25.

potential enrollees who may be relatively more interested in eligibility.[2386] Often, safety net providers are assumed to represent the interest of poor or other vulnerable people. Yet these providers have a clear conflict of interest in many circumstances.[2387] For example, DSH funds are not legally required to be used for any specific purpose and this may be one reason that the funds have not been shown to lead to greater provision of uncompensated care. Safety net providers have a great financial incentive to capture the Medicaid population in part because of the supplemental funds. This situation may or may not be directed toward the best interests of the Medicaid population.[2388]

When cutbacks in care for vulnerable people are made, most often safety net hospitals claim that whatever was undertaken “had” to be done: “[S]afty net administrators respond by pointing out that if they do not take these steps, their basic viability will be threatened, resulting essentially in no care for anybody.”[2389] One problem with this reasoning is that it is rarely the case that only one certain set of actions must be undertaken. There is also the problem that the people most affected by policy decisions are rarely if ever actively involved and even advocates, as mentioned above, may not be effective when their own survival, political or economic, is at stake. Some of

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[2386] Karl Kronebusch, "Medicaid and the Politics of Groups: Recipients, Providers, and Policy Making," *Journal of Health Politics, Policy and Law* 22, no. 3 (1997): 862.

[2387] Bazzoli et al., "The Influence of Health Policy and Market Factors on the Hospital Safety Net," 1177.

[2388] Siegel, "Public Hospitals: A Prescription for Survival."

[2389] Siegel, Regenstein, and Shin, "Health Reform and the Safety Net: Big Opportunities; Major Risks," 430.

the more recent publications on health care reform seem to better recognize these potential conflicts, an important first step in ameliorating them.[2390]

Conclusion

The importance of Medicaid in the provision of medical care for many Americans, some of whom are the most vulnerable, cannot be overstated. At the same time, Medicaid has not provided health care coverage on the basis of impoverishment alone or on the basis of any consistent measure of vulnerability or need. Inconsistency, whim, and discretion have pervaded all aspects of the program and have kept the program firmly rooted in a nineteenth century conception of charity.

A person may be uninsured, and perhaps sometimes a charity patient, and then become eligible and enrolled in Medicaid and vice versa. Culturally in the United States, Medicaid and charity patients tend to share the same "social account." Often this social account accrues to "the uninsured," despite the greater heterogeneity among this group. While the past decades have been marked by some expansion in eligible groups, it is the variability in Medicaid eligibility that overshadows expansion. State budgets and political ideology are as likely as or more likely to drive policy decisions than is the goal of improving health care access, quality, and outcomes.

Perhaps most disturbing is that much of the substantial amount of funding through the Medicaid program that does potentially cover the cost of uncompensated care has for years simply disappeared like a glass of water poured onto the desert sand. And wherever the money goes, it is tallied to the poor's economic account. It may be that this non-

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[2390] Bachrach, Braslow, and Karl, "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net."

traceable funding was viewed as necessary initially given the backlash against public programs associated with “dependence.” The fact remains that the entities with the most power have gained from these payments with little ability to assess the benefits to the people behind the uncompensated care numbers. The process has been deeply enmeshed in the political complexities of federal and state relationships. As such, Medicaid program details and funding for uncompensated care have been subject to a largely unintentional mercilessness, a byproduct of power struggles.

Yet here again there are many reasons to expect changes for the future. The Medicaid program does have the broad base and flexibility to expand under the Affordable Care Act. After decades of struggles back and forth, supplemental payments are on a trajectory toward much greater transparency and accountability. History shows that declaring Medicaid to be a program not linked to welfare or tainted with charity was not enough to change the program’s image. Yet many improvements related to processes of enrollment and coordination of care that are currently available could be used to make Medicaid “mainstream” in the sense that counts for enrollees. Still there are many uncertainties, not the least of which is how to enhance the public voice of the people who are enrolled in Medicaid or who may need charity.

Conclusion

When Frederick Douglass wrote of his escape from slavery, he surprisingly did not approve of the Underground Railroad:

> I have never approved of the very public manner in which some of our western friends have conducted what they call the *underground railroad*, but which, I think, by their open declarations, has been made most emphatically the *upperground railroad*. I honor those good men and women for their noble daring, and applaud them for willingly subjecting themselves to bloody persecution, by openly avowing their participation in the escape of slaves. I, however, can see very little good resulting from such a course, either to themselves or the slaves escaping; while, upon the other hand, I see and feel assured that those open declarations are a positive evil to the slaves remaining, who are seeking to escape.[2391]

Why would a man who had escaped from the moral injustice of slavery think that the group helping those who escaped was wrong? John Glaser, a Catholic bioethicist, has written that "Helping the victims of the brutal injustice of slavery was certainly an immediate and pressing call to conscience. But those who operated the Underground Railroad recognized that their efforts addressed only the symptoms of the problem and that it's real solution lay in system-level reform—abolition of slavery."[2392] It is not easy to set aside the remarks made by Frederick Douglass. The point is clear; for those left behind the situation is worse. Of course, lack of health care is not the equivalent of being enslaved. The entire meaning of what Mr. Douglass said is not certain but he may have been concerned that the people running the Underground Railroad, though brave and noble, had become the focus of attention.

[2391] Frederick Douglass and Robert G. O'Meally, *Narrative of the Life of Frederick Douglass, an American Slave*, Barnes & Noble Classics (New York, NY: Barnes & Noble Classics, 2003), 88-89.

[2392] John W. Glaser, ""Covering the Uninsured" Is a Flawed Moral Frame," *Health Progress* 87, no. 2 (2006).

Another point is that because it is surprising to find out that Mr. Douglass did not approve of the Underground Railroad, most people may not know what those in unjust circumstances believe or hope for. Perhaps it can be taken for granted that poor uninsured people do not want to be turned away when seeking care; less is known about what patients might long for. A free clinic volunteer in Chapter 1 said, “So I have a lot of thankful people, and I have a lot of people who would be even more thankful if they never had to come back.”[2393] As long as that person’s circumstances are similar, they will still be among the excluded. When given the chance, uninsured people use adjectives such as: embarrassed, ashamed, shunned, undesirable, and humiliated. Of the many reasons to continue to work toward health care coverage that includes everyone, this is the most compelling

In the preceding chapters there were two situations where a slim opportunity to give a voice to low income patients or their concerns might have been realized. The first came from several community volunteers at free clinics who expressed a desire to mount broader advocacy efforts. Even the volunteers who strongly believed in equal access to care for the most part did not end up engaging in advocacy. The second occurred when a state changed their Medicaid program to managed care and the planners did not challenge the fact that the enrollees were unlikely to receive a mainstream standard of care. These and many other instances emphasize that groups working with poor uninsured people do not necessarily speak for or act in the best interest of their patients. David Hilfiker, a physician and director of a homeless clinic described the lack of advocacy from his point of view: “[E]ven if we ourselves perceive the need for systemic changes, we may feel compelled to whisper those perceptions rather than shout them for fear of alienating those

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[2393] Weiss, *Grassroots Medicine: The Story of America's Free Health Clinics*: 157.

on whom we most depend. Charity offends almost no one; at one point or another, justice offends practically everyone."[2394] Hilfiker does believe that advocacy for systemic change is needed and he recommends both small and large measures.

Two of the most pervasive themes related to charity in health care throughout the chapters are that charity is optional and does not guarantee care for anyone and that the providers of charity have wide or utter discretion in who is chosen for care and what the care entails.[2395] Discretion in meeting the health care needs of poor people is also one of the reasons that medical education has been so enmeshed with the provision of charity. Discretion and voluntariness are inherent features of charity and while they can be limited somewhat, for instance in the Affordable Care Act's provisions on nonprofit hospital charity care, they are constant. It is also the case, especially as discussed in Chapter 4, that having funding for charity care does not mean it will be provided.

Another theme of most of the chapters is that funds flowing to hospitals in the name of the poor often end up in the hands of the most powerful stakeholders. This is certainly true for the Medicaid Disproportionate Share (DSH) program. It is also true for smaller sources of funding such as the Kentucky hospital that received local funds. Equally as disconcerting is the lack of reporting standards and accountability for what are desperately needed funds. The DSH program was formed in 1981 and the first year that hospitals were required to accurately report these funds was in 2010. Accounting guidelines for hospitals have clearly stated that bad debt and charity should be accounted for separately since 1990. The IRS only began to ask for, but not regulate, charity care and community benefit in 2009. Medicare began asking for information on charity care

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[2394] David Hilfiker, "The Limits of Charity," *The Other Side* 36, no. 4 (2000).

[2395] Rand Rosenblatt and others call this "standardless."

and bad debt in 2010. Hospitals can claim moral praise for uncompensated care, largely because of its moral connection to charity while the funds that may offset such care are not usually reported to the public.

Charity functions at the political level in ambivalent ways. Reagan feared community health centers were a set up for socialized medicine and so did not support them. Community health centers became the darling of George W. Bush, some believed as an alternative to substantive change and in order to claim compassion. The political conflicts and compromises over DSH funds seem to be the result of both sides believing they got something. Conservative governors especially wanted less oversight and more autonomy for federal funds. Progressive members of Congress likely knew that some funds were trickling down to help fund the care of poor patients or perhaps they were satisfied if the hospitals did well and no questions were asked.

Charity care as a symbol came to be seen by some as the very moral foundation of medicine. Although it is not clear how relevant this concept is to the average physician, it should be put to rest. No person should suffer illness, exclusion, or injustice so that someone else can demonstrate altruism by helping them. Many physicians do express a deep sense of fulfillment as a result of providing charity care. Yet, difficulties with ensuring appropriate care for uninsured patients can also lead to moral distress. Regarding student-run clinics and the use of predominantly poor and minority patients for medical education, this is an ethical blind spot that should be addressed.

There seems to be an assumption in the current literature that charity care practices will continue once the Affordable Care Act is implemented.[2396] With so much upheaval concerning the Medicaid expansion and achieving the infrastructure to run

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[2396] Hall and Rosenbaum, *The Health Care "Safety Net" in a Post-Reform World*.

health insurance exchanges, it is no wonder that the emphasis is on what must happen. At the same time, more than 100 years of charity care is too long. Avashai Margolit is a philosopher who is the author of a book on what makes a decent society. According to Margolit, a society is decent if "its institutions do not act in ways that give the people under their authority sound reasons to consider themselves humiliated."[2397] Charity care does not *have* to humiliate but it often does. The opposite of humiliation is respect for humans, considered by many to be one of the core principles that medicine rests upon.

[2397] Avishai Margalit, *The Decent Society* (Cambridge, MA: Harvard University Press, 1996), 11.

Appendix: **Table 6: Common Definitions Related to Hospital Charity Care**

Source	**Charity Care**	**Bad Debt**	**Uncompensated Care**	**Notes**
American Hospital Association Uncompensated Care Fact Sheet[2398]	"Charity care is care for which hospitals never expected to be reimbursed… Charity care…consists of services for which hospitals neither received, nor expected to receive, payment because they had determined, with the assistance of the patient, the patient's inability to pay."	"A hospital incurs bad debt when it cannot obtain reimbursement for care provided; this happens when patients are unable to pay their bills, but do not apply for charity care, or are unwilling to pay their bills…In terms of accounting, bad debt consists of services for which hospitals anticipated but did not receive payment."	"Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides… Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare."	
American Hospital Association Annual Hospital Survey[2399]	"Financial Assistance (Includes Charity care**).** Financial assistance and charity care refer to health services provided free of charge or at reduced rates to individuals who meet certain financial criteria. For purposes of this survey, charity care is measured on the basis of revenue forgone, at full established rates." Section D.5.b.	"Bad debt expense**.** The provision for actual or expected uncollectibles resulting from the extension of credit. Because bad debts are reported as an expense and not a deduction from revenue, the gross charges that result in bad debts will remain in net revenue." Section D.5.a.	"Care for which no payment is expected or no charge is made. It is the sum of bad debt and charity care absorbed by a hospital or other health care organization in providing medical care for patients who are uninsured or are unable to pay." Section D.5.	Prior to 2011 charity care was defined on the Survey: "Health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria."
Internal Revenue Service Form	"Line 1. A financial assistance policy,	The IRS does not include a definition	The IRS does not define or require	The 2009 Form 990 definition

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[2398] American Hospital Association, "American Hospital Association Uncompensated Hospital Care Cost Fact Sheet."

[2399] ———, "2011 AHA Annual Survey."

990 Schedule H[2400]	sometimes referred to as a charity care policy, is a policy describing how the organization will provide financial assistance… Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable pay for all or a portion of the services. Financial assistance does not include: bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing such care to such patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or contractual adjustments with any third-party payors."	of bad debt but Form 990 does ask whether the hospital has adopted the Healthcare Financial Management Association's "Statement 15." Hospitals must include the methodology used to determine bad debt and, if available, the audited financial statement footnotes related to bad debt.	reporting of "uncompensated care." The purpose of the Form 990 is to provide information on the activities and policies of, and community benefit provided by, the hospital.	of "charity care" is the same as the current definition of "financial assistance."[2401] Hospitals are asked to estimate the amount of bad debt attributable to patients eligible for financial assistance under the hospital's policy. Hospitals are also asked to provide the rationale for including bad debt, if any, as community benefit.
Healthcare Financial Management	"Healthcare services that have been or will be provided but	The 2006 Statement 15 of the Principles and	Statement 15 makes the following statement about	

[2400] Internal Revenue Service, "2011 Instructions for Schedule H (Form 990)."

[2401] ———, "2009 Instructions for Schedule H (Form 990)."

Association (HFMA)[2402]	are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.”	Practice Board of the Financial Management Association includes this description: “Bad debts result when a patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim, whereas charity care is provided to a patient with demonstrated inability to pay.”	uncompensated care: “As the magnitude of unreimbursed care grows, so does the urgency to report uncompensated care - and to distinguish between charity care and bad debt - clearly and comparably.”	
Centers for Medicare and Medicaid Services (CMS) Medicare Cost Report, (Form CMS 2552-10)[2403]	“Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a provider’s policy to provide all or a portion of services free of charge to patients who meet certain financial criteria.”	“Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim.”	“Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.”	The Medicare Cost Report states: “Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare.”
Centers for Medicare and Medicaid Services Disproportionate Share Hospital program.[2404]	“Charity care is a term used by hospitals to describe an individual hospital’s program of providing free or reduced charge care to those that qualify for the particular hospital’s charity	“Bad debt arises when there is non-payment on behalf of an individual who has third party coverage…while the Medicaid statute does not specifically exclude bad debt from the	“The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals	The Medicaid DSH program requires that states make additional payments to hospitals that serve a disproportionate number of

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[2402] Healthcare Financial Management Association, "P&P Board Sample 501(C)(3) Hospital Charity Care Policy and Procedures." ———, "Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers."

[2403] Centers for Medicare and Medicaid Services, "Medicare: Provider Reimbursement Manual. Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS 2552-10."

[2404] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule."

	care program." (FR77911)	definition of uncompensated care costs, there is nothing in the statute that would suggest that any costs related to services provided to individuals with third party coverage, including bad debt, are within that definition." (FR77909) "As long as the costs are for services furnished to uninsured patients, they may be included in the calculation of the hospital-specific limit, regardless of whether the hospital treats the costs as bad debt on its own books." (FR 77911)	with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services." (FR77950)	low income patients with special needs. However, when a patient is uninsured and there are unreimbursed costs associated with services provided, the patient does not have to undergo any income or asset test. Also, when costs are paid for under a state or local indigent care program, these costs can be included in uncompensated care cost without including the payments made.

Bibliography

Abramovitz, Mimi. *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present*. Rev. ed. Boston, MA: South End Press, 1996.

Adcock, Joe, and Cynthia Adcock. "Houston's Hospitals: The Smell of Charity." *The Nation* (1965): 5-8.

Agency for Healthcare Research and Quality. "Emergency Room Services-Mean and Median Expenses Per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2008." (2011), http://www.meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2008&Table=HCFY2008%5FPLEXP%5FE&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT08&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug=. Accessed March 14, 2013.

Agich, George J. "Access to Health Care: Charity and Rights." In *Rights to Health Care*, edited by Thomas J. Bole and William B. Bondeson. Norwell, MA: Kluwer Academic Publishers, 1991.

Aitsebaomo, Gabriel O. "The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption." *Campbell Law Review* 26, no. 2 (2004): 75-99.

Allen, Jennifer D., Rachel C. Shelton, Elizabeth Harden, and Roberta E. Goldman. "Follow-up of Abnormal Screening Mammograms among Low-Income Ethnically Diverse Women: Findings from a Qualitative Study." *Patient Education and Counseling* 72, no. 2 (2008): 283-292.

Altevogt, Bruce M. , Clare Stroud, Sarah L. Hanson, Dan Hanfling, and Lawrence O. Gostin, eds. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Edited by Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations; Institute of Medicine. Washington, DC: National Academies Press, 2009.

Altman, Stuart. "Health System Reform: Let's Not Miss Our Chance." *Health Affairs* 13, no. 1 (1994): 69-80.

AMA Council on Ethical and Judicial Affairs. "Caring for the Poor." *Journal of the American Medical Association* 269, no. 19 (1993): 2533-2537.

Ambrose, Sue Goetinck, and Reese Dunklin. "Parkland Memorial Hospital Consent Form Was Full of Gray Areas." *Dallas Morning News*, August 4, 2010.

Amenta, Madalon M. "Free Clinics Change the Scene." *American Journal of Nursing* 74, no. 2 (1974): 284-288.

American Board of Internal Medicine. "Project Professionalism." i-42. Philadelphia, PA: American Board of Internal Medicine, 1998.

American Board of Internal Medicine Foundation, American College of Physicians-American Society of Internal Medicine, and European Federation of Internal Medicine. "Medical Professionalism in the New Millennium: A Physician Charter." *Annals of Internal Medicine* 136, no. 3 (2002): 243-246.

American College of Emergency Physicians. "Code of Ethics for Emergency Physicians." *Annals of Emergency Medicine* 52, no. 5 (2008): 581-590.

———. "EMTALA." (2011), http://www.acep.org/content.aspx?id=25936. Accessed March 14, 2013.

———. "Medical Screening of Emergency Department Patients." (2007), http://www.acep.org/Content.aspx?id=29572. Accessed March 14, 2013.

———. "Quality of Care and the Outcomes Management Movement." (2005), http://www.acep.org/content.aspx?id=30166. Accessed March 14, 2013.

American College of Surgeons. "Operation Giving Back." http://www.operationgivingback.facs.org/about/. Accessed March 14, 2013.

American Hospital Association. "2011 AHA Annual Survey." Chicago, Il: Health Forum, LLC, 2012.

———. "AHA Confirmation of Commitment." http://www.aha.org/aha/content/2004/pdf/cocweblist.pdf. Accessed March 14, 2013.

———. "American Hospital Association Uncompensated Hospital Care Cost Fact Sheet." (2012), http://www.aha.org/content/12/11-uncompensated-care-fact-sheet.pdf. Accessed March 14, 2013.

———. "Billing, Collection, and Tax Exempt Status." (2006), http://www.aha.org/content/00-10/5_1_06_sb_billingcoll.pdf. Accessed March 14, 2013.

———. "Community Accountability and Transparency: Helping Hospitals Better Serve Their Communities." (2007), http://www.aha.org/content/00-10/07accountability.pdf. Accessed March 14, 2013.

———. "Fast Facts on US Hospitals." (2012), http://www.aha.org/research/rc/stat-studies/101207fastfacts.pdf. Accessed March 14, 2013.

———. "Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association " http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf. Accessed March 14, 2013.

———. "Results of the 2009 Schedule H Project." (2012), http://www.aha.org/content/12/09-sche-h-benchmark.pdf. Accessed March 14, 2013.

———. "Trendwatch Chartbook 2011. Table 4.4." (2011), http://www.aha.org/research/reports/tw/chartbook/2012/table4-4.pdf. Accessed March 14, 2013.

American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, and National Association of Public Hospitals and Health Systems. "America's Hospitals and Health Systems." http://www.aha.org/aha/content/2009/pdf/090610-aa-house-senate-dsh-let.pdf. Accessed March 14, 2013.

American Hospital Association v. Schweiker, 721 F.2d 170 (1983).

American Medical Association. "American Medical Association Code of Medical Ethics: Opinion 9.065 Caring for the Poor." (1994), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9065.shtml. Accessed March 14, 2013.

———. "Code of Medical Ethics of the American Medical Association." (1847), http://www.ama-assn.org/resources/doc/ethics/1847code.pdf. Accessed March 14, 2013.

———. "Medical Education in the United States. Section 3. Graduate Medical Education. Annual Report on Graduate Education in the United States." *Journal of the American Medical Association* 206, no. 9 (1968): 2022-2048.

———. "Principles of Medical Ethics." American Medical Association, http://www.ama-assn.org/ama1/pub/upload/mm/369/1957_principles.pdf. Accessed March 14, 2013.

———. "Principles of Medical Ethics." (2001), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page? Accessed March 14, 2013.

———. "State Listing of Licensing Provisions and Liability Laws." American Medical Association, http://www.ama-assn.org/ama1/pub/upload/mm/22/state-licensing.pdf. Accessed March 14, 2013.

American Medical Association Council on Medical Services. "Report of the Council on Medical Services: Free Clinics and the Uninsured." (2009), http://www.ama-assn.org/resources/doc/cms/a09-cms-rpt-1.pdf. Accessed March 14, 2013.

American Nurses' Association. "American Nurses Association: Code of Ethics for Nurses with Interpretive Statements." (2001), http://www.nursingworld.org/codeofethics. Accessed March 14, 2013.

Anderson, Gerard F. "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing." *Health Affairs* 26, no. 3 (2007): 780-789.

Anderson, Karen O., Carmen R. Green, and Richard Payne. "Racial and Ethnic Disparities in Pain: Causes and Consequences of Unequal Care." *Journal of Pain* 10, no. 12 (2009): 1187-1204.

Anderson, Ron J., Paul J. Boumbulian, and S. Sue Pickens. "The Role of U.S. Public Hospitals in Urban Health." *Academic Medicine* 79, no. 12 (2004): 1162-1168.

Anderson, Ron J., Sue Pickens, and Paul J. Boumbulian. "Toward a New Urban Health Model: Moving Beyond the Safety Net to Save the Safety Net--Resetting Priorities for Healthy Communities." *Journal of Urban Health* 75, no. 2 (1998): 367-378.

Andrulis, Dennis , Lisa Duchon, Carol Pryor, and Nanette Goodman. "Paying for Health Care When You’re Uninsured: How Much Support Does the Safety Net Offer?" January (2003), http://www.accessproject.org/paying_for_healthcare_when_youre_uninsured.pdf. Accessed March 14, 2013.

Andrulis, Dennis P., and Nadia J. Siddiqui. "Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients." *Health Affairs* 30, no. 10 (2011): 1830-1836.

Angel, Ronald, Laura Lein, and Jane Henrici. *Poor Families in America's Health Care Crisis*. Cambridge, NY: Cambridge University Press, 2006.

Annas, George J. *The Rights of Patients : The Authoritative ACLU Guide to the Rights of Patients*. 3rd ed, An American Civil Liberties Union Handbook. Carbondale, IL: Southern Illinois University Press, 2004.

———. "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards." *American Journal of Public Health* 76, no. 1 (1986): 74-77.

Anonymous. "Indigent Care: A New Approach for Delivery and Funding." *Case Studies in Health Administration* 3 (1983): 109-115.

Anonymous Book Review. "A Chapter in Social Medicine." *The Nation* 107, no. 2787 (1918): 666.

Ansell, David A., and Robert L. Schiff. "Patient Dumping. Status, Implications, and Policy Recommendations." *Journal of the American Medical Association* 257, no. 11 (1987): 1500-1502.

Appleby, Julie. "Hospitals Sock Uninsured with Much Bigger Bills " *USA Today*, February 24, 2004.

Armstrong, S. Howard. "Private Beds in Medical Teaching." *Journal of the American Medical Association* 153, no. 2 (1953): 82-90.

Arnold, Howard Payson. *Memoir of Jonathan Mason Warren, M.D*. Boston,MA: Privately Printed, 1886.

Arslanian-Engoren, Cynthia. "Explicating Nurses' Cardiac Triage Decisions." *Journal of Cardiovascular Nursing* 24, no. 1 (2009): 50-57.

———. "Gender and Age Bias in Triage Decisions." *Journal of Emergency Nursing* 26, no. 2 (2000): 117-124.

Artiga, Samantha, David Rousseau, Barbara Lyons, Stephen Smith, and Daniel S. Gaylin. "Can States Stretch the Medicaid Dollar without Passing the Buck? Lessons from Utah." *Health Affairs* 25, no. 2 (2006): 532-540.

Asch, David A., and Ruth M. Parker. "The Libby Zion Case." *New England Journal of Medicine* 318, no. 12 (1988): 771-775.

Ashby, John L., Jr. "The Burden of Uncompensated Care Grows." *Healthcare Financial Management* 46, no. 4 (1992): 66-81.

Asplin, Brent R. "Ignoring the Front Door: U.S. Hospital Operations Circa 2009." *Academic Emergency Medicine* 16, no. 7 (2009): 665-667.

Asplin, Brent R., Karin V. Rhodes, Helen Levy, Nicole Lurie, A. Lauren Crain, Bradley P. Carlin, and Arthur L. Kellermann. "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments." *Journal of the American Medical Association* 294, no. 10 (2005): 1248-1254.

Associated Press. "'Dr. Joe' Treats Uninsured Patients with Dignity." (2009), http://www.msnbc.msn.com/id/33197187/ns/health-health_care/t/dr-joe-treats-uninsured-patients-dignity/. Accessed March 14, 2013.

Association of American Medical Colleges. "AAMC: Medicare Disproportionate Share (DSH) Payments." https://www.aamc.org/advocacy/teachhosp/97342/teachhosp_hosp0003.html. Accessed March 14, 2013.

———. "Key Facts About Teaching Hospitals." February (2009), https://www.aamc.org/download/82452/data/keyfactsaboutth.pdf. Accessed March 14, 2013.

———. "Policy Priorities to Improve the Nation's Health from America's Medical Schools and Teaching Hospitals." https://www.aamc.org/download/97686/data/obamatransition.pdf.pdf. Accessed March 14, 2013.

Astor, Avhaham, Marion Danis, and Gopal Sreenivasan. "Providing Free Care to the Uninsured: How Much Should Physicians Give?" *Annals of Internal Medicine* 139, no. 9 (2003): E-795-796.

Atkinson, Graham, W. David Helms, and Jack Needleman. "State Trends in Hospital Uncompensated Care." *Health Affairs* 16, no. 4 (1997): 233-241.

Atwater, Edward C. "Internal Medicine." In *The Education of American Physicians: Historical Essays*, edited by Ronald L. Numbers, 143-174. Berkeley, CA: University of California Press, 1980.

Austin, Marsha. "Hospitals Turn Away Ill, Injured." *Denver Post*, June 29, 2003.

Bachrach, Deborah, Laura Braslow, and Anne Karl. "Toward a High Performance Health Care System for Vulnerable Populations: Funding for the Safety-Net." (2012), http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Vulnerable-Populations.aspx. Accessed March 14, 2013.

Bachrach, Deborah, and Melinda Dutton. "Medicaid Supplemental Payments: Where Do They Fit in Payment Reform?" (2011), http://www.chcs.org/usr_doc/Medicaidsupplementalpaymentbrief.pdf. Accessed March 14, 2013.

Backus, Lisa, Dennis Osmond, Kevin Grumbach, Karen Vranizan, Lucy Phuong, and Andrew B. Bindman. "Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care." *Journal of General Internal Medicine* 16, no. 12 (2001): 815-821.

Baicker, Katherine, and Amy Finkelstein. "The Effects of Medicaid Coverage--Learning from the Oregon Experiment." *New England Journal of Medicine* 365, no. 8 (2011): 683-685.

Baicker, Katherine, and Douglas Staiger. "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality." *The Quarterly Journal of Economics* 120, no. 1 (2005): 345-386.

Baier, Annette. "Trust and Antitrust." *Ethics* 96 (1986): 231-260.

Baker, Gillian K., Alan T. McKenzie, and Paul B. Harrison. "Local Physicians Caring for Their Communities: An Innovative Model to Meeting the Needs of the Uninsured." *North Carolina Medical Journal* 66, no. 2 (2005): 130-133.

Baker, Laurence C., and Linda S. Baker. "Excess Cost of Emergency Department Visits for Nonurgent Care." *Health Affairs* 13, no. 5 (1994): 162-171.

Balanced Budget Act of 1997. Public Law 105-33. August 5, 1997.

Balkin, Jack M. "The Constitutionality of the Individual Mandate for Health Insurance." *New England Journal of Medicine* 362, no. 6 (2010): 482-483.

Ballard, Dustin W., Mary Price, Vicki Fung, Richard Brand, Mary E. Reed, Bruce Fireman, Joseph P. Newhouse, Joseph V. Selby, and John Hsu. "Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits." *Medical Care* 48, no. 1 (2010): 58-63.

Balsa, Ana I., Naomi Seiler, Thomas G. McGuire, and M. Gregg Bloche. "Clinical Uncertainty and Healthcare Disparities." *American Journal of Law & Medicine* 29, no. 2-3 (2003): 203-219.

Bamezai, Anli, Glenn Melnick, and Amar Nawathe. "The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume." *Annals of Emergency Medicine* 45, no. 5 (2005): 483-490.

Bard, Samuel. *Two Discourses Dealing with Medical Education in Early New York*. New York, NY: Columbia University Press, 1921.

Bardack, Michelle A., and Susan H. Thompson. "Model Prenatal Program of Rush Medical College at St. Basil's Free Peoples Clinic, Chicago." *Public Health Report* 108, no. 2 (1993): 161-165.

Barnes, Jim. "More Than a New Building." *Washington Post*, October 12, 2012.

Barnett, Victoria. *Bystanders: Conscience and Complicity During the Holocaust*, Contributions to the Study of Religion. Westport, CT: Greenwood Press, 1999.

Baxter, Raymond J., and Robert E. Mechanic. "The Status of Local Health Care Safety Nets." *Health Affairs* 16, no. 4 (1997): 7-23.

Bay, Emmet Blackburn. *Medical Administration of Teaching Hospitals*. Chicago, IL: University of Chicago Press, 1931.

Bazarian, Jeffrey J., Charlene Pope, Jason McClung, Yin Ting Cheng, and William Flesher. "Ethnic and Racial Disparities in Emergency Department Care for Mild Traumatic Brain Injury." *Academic Emergency Medicine* 10, no. 11 (2003): 1209-1217.

Bazzoli, Gloria J. "Health Care for the Indigent: Overview of Critical Issues." *Health Services Research* 21, no. 3 (1986): 353-393.

Bazzoli, Gloria J., Elizabeth Casey, Jeffrey A. Alexander, Douglas A. Conrad, Stephen M. Shortell, Shoshanna Sofaer, Romana Hasnain-Wynia, and Ann P. Zukoski. "Collaborative Initiatives: Where the Rubber Meets the Road in Community Partnerships." *Medical Care Research and Review* 60, no. 4 Suppl (2003): 63S-94S.

Bazzoli, Gloria J., Jan P. Clement, and Hui-Min Hsieh. "Community Benefit Activities of Private, Nonprofit Hospitals." *Journal of Health Politics, Policy and Law* 35, no. 6 (2010): 999-1026.

Bazzoli, Gloria J., Richard C. Lindrooth, Ray Kang, and Ramona Hasnain-Wynia. "The Influence of Health Policy and Market Factors on the Hospital Safety Net." *Health Services Research* 41, no. 4, Part 1 (2006): 1159-1180.

Bearden, Michelle. "Free Clinic for Uninsured in Tampa Celebrates 40th Anniversary." *Tampa Tribune*, April 16, 2012.

———. "Free Health Clinic Provides Hope for People in Need." *Tampa Tribune*, April 7, 2011.

Beauchamp, Thomas L. "The Principle of Beneficence in Applied Ethics." *Stanford Encyclopedia of Philosophy* (2009), http://plato.stanford.edu/entries/principle-beneficence/. Accessed March 14, 2013.

———. "Viewpoint: Why Our Conceptions of Research and Practice May Not Serve the Best Interest of Patients and Subjects." *Journal of Internal Medicine* 269, no. 4 (2011): 383-387.

Beauchamp, Tom L. "Informed Consent." In *Medical Ethics*, edited by Robert M. Veatch, 185-208. Sudbury, MA: Jones and Bartlett Publishers, 1997.

Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. 5th ed. New York, NY: Oxford University Press, 2001.

Beck, Ellen. "The UCSD Student-Run Free Clinic Project: Transdisciplinary Health Professional Education." *Journal of Health Care for the Poor Underserved* 16, no. 2 (2005): 207-219.

Becker, Gay. "Deadly Inequality in the Health Care "Safety Net": Uninsured Ethnic Minorities' Struggle to Live with Life-Threatening Illnesses." *Medical Anthropology Quarterly* 18, no. 2 (2004): 258-275.

Bell, Bertrand M. "Reconsideration of the New York State Laws Rationalizing the Supervision and the Working Conditions of Residents." *Einstein Journal of Biology and Medicine* 20 (2003): 36-40.

———. "Supervision, Not Regulation of Hours, Is the Key to Improving the Quality of Patient Care." *Journal of the American Medical Association* 269, no. 3 (1993): 403-404.

Belli, Anne. "Suit Alleges 'Patient Dumping':Two Hospitals Deny Accusations by State." *Dallas Morning News*, March 10, 1993.

Bendapudi, Neeli M., Leonard L. Berry, Keith A. Frey, Janet T. Parish, and William L. Rayburn. "Patients' Perspectives on Ideal Physician Behaviors." *Mayo Clinic Proceedings* 81, no. 3 (2006): 338-344.

Bender, Michael. "Dr. Fred Carter, Started Stuart Free Health Clinic." *Palm Beach Post*, June 9, 2006.

Benjamin, Elisabeth R., and Kat Gabriesheski. "The Case for Reform: How New York State's Secret Hospital Charity Care Pool Funds Fail to Help Uninsured and Underinsured New Yorkers." *Legislation and Public Policy* 8, no. 5 (2004): 5-33.

Benjamin, Elisabeth R., Arianne Slagel, and Carrie Tracy. "Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program." (2012), http://www.cssny.org/userimages/downloads/IncentivizingPatientFinancialAssistanceFeb2012.pdf. Accessed March 14, 2013.

Bennard, Bruce, Jim L. Wilson, Kaethe P. Ferguson, and Carolyn Sliger. "A Student-Run Outreach Clinic for Rural Communities in Appalachia." *Academic Medicine* 79, no. 7 (2004): 666-671.

Benrud, Lisa, Jacqueline Darrah, and Alison Johnson. "Liability Considerations for Physician Volunteers in the U.S." American Medical Association, http://virtualmentor.ama-assn.org/2010/03/hlaw1-1003.html. Accessed March 14, 2013.

Berk, Deborah K. "Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation." *American Journal of Law & Medicine* 9, no. 2 (1983): 205-224.

Berkowitz, Edward D. *America's Welfare State: From Roosevelt to Reagan*, The American Moment. Baltimore, MD: Johns Hopkins University Press, 1991.

Berliner, Howard S. "Patient Dumping--No One Wins and We All Lose." *American Journal of Public Health* 78, no. 10 (1988): 1279-1280.

Berman, Steve, Judith Dolins, Suk-fong Tang, and Beth Yudkowsky. "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients." *Pediatrics* 110, no. 2 Pt 1 (2002): 239-248.

Bernstein, Nina. "Hospitals Flout Charity Aid Law." *New York Times*, February 12, 2012.

Bernstein, Steven L. "Frequent Emergency Department Visitors: The End of Inappropriateness." *Annals of Emergency Medicine* 48, no. 1 (2006): 18-20.

Betancourt, Joseph R. "Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal." *Academic Medicine* 81, no. 6 (2006): 499-501.

Bickell, Nina A., Jason J. Wang, Soji Oluwole, Deborah Schrag, Henry Godfrey, Karen Hiotis, Jane Mendez, and Amber A. Guth. "Missed Opportunities: Racial Disparities in Adjuvant Breast Cancer Treatment." *Journal of Clinical Oncology* 24, no. 9 (2006): 1357-1362.

Bigelow, Henry J. *An Introductory Lecture, Delivered at Massachusetts Medical College, November 6, 1849*. Boston, MA: David Clapp, 1850.

Birnbaum, Adrienne, E. John Gallagher, Mark Utkewicz, Paul Gennis, and Wallace Carter. "Failure to Validate a Predictive Model for Refusal of Care to Emergency-Department Patients." *Academic Emergency Medicine* 1, no. 3 (1994): 213-217.

Bitter, Michael E., and Judith H. Cassidy. "The New Healthcare Audit Guide. Its Impact on Hospitals and Hospital Reporting." *Hospital Topics* 71, no. 4 (1993): 32-37.

Bitterman, Robert A. "EMTALA and the Ethical Delivery of Hospital Emergency Services." *Emergency Medcial Clinics of North America* 24, no. 3 (2006): 557-577.

———. "Explaining the EMTALA Paradox." *Annals of Emergency Medicine* 40, no. 5 (2002): 470-475.

Bittinger, Ann M. "Changes to EMTALA Rules Affect Pediatric Emergency Departments." *Pediatric Emergency Care* 20, no. 5 (2004): 347-354.

Bittker, Boris I., and George K. Rahdert. "The Exemption of Nonprofit Organizations from Federal Income Taxation." *Yale Law Journal* 85, no. 3 (1976): 299-358.

Blaisdell, F. William. "Development of the City-County (Public) Hospital." *Archives of Surgery* 129, no. 7 (1994): 760-764.

Blalock, Kaija , and Sidney M. Wolfe. "Questionable Hospitals: 527 Hospitals That Violated the Emergency Medical Treatment and Labor Act: A Detailed Look at 'Patient Dumping.'" (2001), http://www.citizen.org/documents/qhcompletereport.pdf. Accessed March 14, 2013.

Blanchard, Janice, and Nicole Lurie. "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care." *Journal of Family Practice* 53, no. 9 (2004): 721-730.

Blank, Susan W., and Barbara B. Blum. "A Brief History of Work Expectations for Welfare Mothers." *The Future of Children* 7, no. 1 (1997): 28-38.

Blendon, Robert J. "The Changing Role of Private Philanthropy in Health Affairs." *New England Journal of Medicine* 292, no. 18 (1975): 946-950.

Blendon, Robert J., Linda H. Aiken, Howard. E. Freeman, Bradford L. Kirkman-Liff, and John W. Murphy. "Uncompensated Care by Hospitals or Public Insurance for the Poor. Does It Make a Difference?" *New England Journal of Medicine* 314, no. 18 (1986): 1160-1163.

Blewett, Lynn A., Jeanette Ziegenfuss, and Michael E. Davern. "Local Access to Care Programs (LACPs): New Developments in the Access to Care for the Uninsured." *Milbank Quarterly* 86, no. 3 (2008): 459-479.

Bliss, Michael. *William Osler: A Life in Medicine*. New York, NY: Oxford University Press, 1999.

Bloche, M. Gregg "Health Policy Below the Waterline: Medical Care and the Charitable Exemption." *Minnesota Law Review* 80 (1995): 299-405.

Blumenthal, David, and Gregg S. Meyer. "Academic Health Centers in a Changing Environment." *Health Affairs* 15, no. 2 (1996): 200-215.

Blumenthal, David, Joel S. Weissman, and Paul F. Griner. "Academic Health Centers on the Front Lines: Survival Strategies in Highly Competitive Markets." *Academic Medicine* 74, no. 9 (1999): 1038-1049.

Blumstein, James F. "Court Action, Agency Reaction: The Hill-Burton Act as a Case Study." *Iowa Law Review* 69, no. 5 (1984): 1227-1261.

———. "Providing Hospital Care to Indigent Patients: Hill-Burton as a Case Study and Paradigm." In *Uncompensated Hospital Care: Rights and Responsibilities*, edited by Frank A. Sloan, James F. Blumstein and James M. Perrin, 94-107. Baltimore, MD: Johns Hopkins University Press, 1986.

Blustein, Jan. "Who Is Accountable for Racial Equity in Health Care?" *Journal of the American Medical Association* 299, no. 7 (2008): 814-816.

Board of Governors New York Hospital. "Minority Report to Special Committee Report on Training School and Outpatient Department." New York, NY: New York Hospital, 1887.

Bogue, Richard J., Mazda Antia, Rita Harmata, and Claude H. Hall, Jr. "Community Experiments in Action: Developing Community-Defined Models for Reconfiguring Health Care Delivery." *Journal of Health Politics, Policy & Law* 22, no. 4 (1997): 1051-1076.

Bonner, Thomas Neville. *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945*. New York, NY: Oxford University Press, 1995.

Boukus, Ellyn, Alwyn Cassil, and Ann S. O'Malley. "A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey." *Data Bulletin: Center for Studying Health System Change*,no. 35 (2009), http://www.hschange.com/CONTENT/1078/1078.pdf. Accessed March 14, 2013.

Boutin-Foster, Carla, Jordan C. Foster, and Lyuba Konopasek. "Viewpoint: Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence." *Academic Medicine* 83, no. 1 (2008): 106-111.

Bowditch, N. I., and George Edward Ellis. *A History of the Massachusetts General Hospital*. 2nd ed. Boston, MA: Printed by the Trustees from the Bowditch fund, 1872.

Brandenburg, Susan. "Medical Volunteers Serve at Downtown Free Clinic." *Florida Times-Union*, January 21, 2006.

Braveman, Paula, V. Mylo Schaaf, Susan Egerter, Trude Bennett, and William Schecter. "Insurance-Related Differences in the Risk of Ruptured Appendix." *New England Journal of Medicine* 331, no. 7 (1994): 444-449.

Breuer, Brenda, Ricardo Cruciani, and Russell K. Portenoy. "Pain Management by Primary Care Physicians, Pain Physicians, Chiropractors, and Acupuncturists: A National Survey." *Southern Medical Journal* 103, no. 8 (2010): 738-747.

Brieger, Gert H. "Surgery." In *The Education of American Physicians: Historical Essays*, edited by Ronald L. Numbers, 175-204. Berkeley, CA: University of California Press, 1980.

Brillman, Judith C., David Doezema, Dan Tandberg, David P. Sklar, Kathleen D. Davis, Shelby Simms, and Betty J. Skipper. "Triage: Limitations in Predicting Need for Emergent Care and Hospital Admission." *Annals of Emergency Medicine* 27, no. 4 (1996): 493-500.

Brook, Robert H. "Health Policy and Public Trust." *Journal of the American Medical Association* 300, no. 2 (2008): 211-213.

Brooks, Terri L. "Billions Saved in Taxes While Millions Underserved-What Has Happened to Charitable Hospitals?" *Houston Business and Tax Law Journal* 8 (2008): 391-424.

Brown, E. Richard. *Rockefeller Medicine Men: Medicine and Capitalism in America*. Berkeley, CA: University of California Press, 1979.

Brown, Lawrence D., and Beth Stevens. "Charge of the Right Brigade? Communities, Coverage, and Care for the Uninsured." *Health Affairs* 25, no. 3 (2006): w150-161.

Buchanan, David, and Renee Witlen. "Balancing Service and Education: Ethical Management of Student-Run Clinics." *Journal of Health Care for the Poor and Underserved* 17, no. 3 (2006): 477-485.

Buettgens, Matthew, Bowen Garrett, and John Holahan. "America under the Affordable Care Act." (2010), http://www.urban.org/publications/412267.html. Accessed March 14, 2013.

Buettgens, Matthew, and Mark A. Hall. "Who Will Be Uninsured after Health Insurance Reform?" (2011), http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf. Accessed March 14, 2013.

Buntin, Melinda B., M. Susab Marquis, and Jill M. Yeglan. "The Role of the Individual Health Insurance Market and Prospects for Change." *Health Affairs* 23, no. 6 (2004): 79-90.

Burda, David. "Charity Care: Are Hospitals Giving Their Fair Share?" *Modern Healthcare* 22, no. 24 (1992): cover, 22-25, 28-29.

———. "HCA Rolling out Emergency-Room Screening Program." *Modern Healthcare* (2009), http://www.modernhealthcare.com/article/20090614/REG/306119942#. Accessed March 14, 2013.

———. "Houston's Methodist Hospital Given Charity-Care Ultimatum." *Modern Healthcare* 20, no. 28 (1990): 6.

Burstin, Helen, William G Johnson, Stuart R. Lipsitz, and Troyen A. Brennan. "Do the Poor Sue More?: A Case-Control Study of Malpractice Claims and Socioeconomic Status." *Journal of the American Medical Association* 270, no. 14 (1993): 1697-1701.

Burton, Thomas N. "Chicago Hospital Doctors Protest Planned Bed Cuts." *Wall Street Journal*, March 12, 2009, A6.

Bushey, Claire. "Resurrection Settles Multimillion-Dollar Lawsuit." *Chi Town Daily News*, January 14, 2009.

Butler, Allan M. "Minority Views on Improving Medical Care." *New England Journal of Medicine* 234 (1946): 260-269.

Butler, Peter W., James D. Bentley, and Richard M. Knapp. "Today's Teaching Hospitals: Old Stereotypes and New Realities." *Annals of Internal Medicine* 93, no. 4 (1980): 614-618.

Butterfield, Lyman H., ed. *Letters of Benjamin Rush Volume II*. Princeton, NJ: Princeton University Press, 1951.

Calhoun, Matthew "Evaluation Finds Local Community Care Networks Do Not Reduce Costs, Show Some Improvement in Health Status." (2003), http://pweb1.rwjf.org/reports/grr/029519.htm. Accessed March 14, 2013.

Calvan, Bobby Caina. "Behind the Health Debate: Cancer Patient Leaves Toughest Question Unasked." *Sacramento Bee*, November 30, 2009.

———. "Sacramento Man's Health Ordeal Puts Face on Uninsured." *Sacramento Bee*, November 29, 2009.

Campos-Outcalt, Doug. "Volunteer Clinic Caveats." *Journal of the American Medical Association* 266, no. 6 (1991): 793.

Cantor, Norman L. "The Law and Poor People's Access to Health Care." *Law and Contemporary Problems* 35, no. 4 (1970): 901-922.

Carlson, Joe. "Charity Disparity. Report on Hospital Policy Disclosures Ill-Timed: AHA." *Modern Healthcare* 40, no. 19 (2010): 8-9.

Carlson, Joe, and Melanie Evans. "Short of the Mark. A Modern Healthcare Analysis of Form 990s Shows Some Very Profitable Hospitals Offering Little Subsidized Care." *Modern Healthcare* 41, no. 12 (2011): 6, 14, 16, 11.

Carreyrou, John, and Barbara Martinez. "Nonprofit Hospitals: Once for the Poor, Strike It Rich." *Wall Street Journal*, April 4, 2008.

Carrier, Emily R., Tracy Yee, and Rachel Garfield. "The Uninsured and Their Health Care Needs: How Have They Changed since the Recession?" (2011), http://www.kff.org/uninsured/8246.cfm. Accessed March 14, 2013.

Cathell, Daniel Webster. *Book on the Physician Himself and Things That Concern His Reputation and Success*. 10th ed. Philadelphia, PA: F. A. Davis Company, 1892.

Cawley, John, Mathis Schroeder, and Kosali I. Simon. "How Did Welfare Reform Affect the Health Insurance Coverage of Women and Children?" *Health Services Research* 41, no. 2 (2006): 486-506.

CBS News. "Lifeline: Remote Area Medical." In *60 Minutes*, July 13, 2008.

Center for Tax and Budget Accountability. "An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return." Chicago, IL: Center for Tax and Budget Accountability, 2009.

Centers for Disease Control National Center for Health Statistics. "National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables." (2011), http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2008_ed_web_tables.pdf. Accessed March 14, 2013.

Centers for Medicare and Medicaid Services. "Medicare: Provider Reimbursement Manual. Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS 2552-10." Washington, DC: U.S. Department of Health and Human Services, 2010.

Chambers, Tod, and Kathleen Montgomery. "Plot: Framing Contingency and Choice in Bioethics." In *Stories Matter: The Role of Narrative in Medical Ethics*, edited by Rita Charon and Martha Montello. New York, NY: Routledge, 2002.

Chen, Candice, Frederick Chen, and Fitzhugh Mullan. "Teaching Health Centers: A New Paradigm in Graduate Medical Education." *Academic Medicine* 87, no. 12 (2012): 1752-1756.

Chernew, Michael E., Katherine Baicker, and John Hsu. "The Specter of Financial Armageddon--Health Care and Federal Debt in the United States." *New England Journal of Medicine* 362, no. 13 (2010): 1166-1168.

Chiong, Winston. "Justifying Patient Risks Associated with Medical Education." *Journal of the American Medical Association* 298, no. 9 (2007): 1046-1048.

Chirayath, Heidi T. "Difficult, Dysfunctional, and Drug-Dependent: Sturcture and Agency in Physician Perceptions of Indigent Patients." *Social Theory & Health* 5 (2007): 30-52.

Chiu, Priscilla P., Robert I. Hilliard, Georges Azzie, and Annie Fecteau. "Experience of Moral Distress among Pediatric Surgery Trainees." *Journal of Pediatric Surgery* 43, no. 6 (2008): 986-993.

Chretien, Katherine C., Ellen F. Goldman, Katherine E. Craven, and Charles J. Faselis. "A Qualitative Study of the Meaning of Physical Examination Teaching for Patients." *Journal of General Internal Medicine* 25, no. 8 (2010): 786-791.

Christakis, D. A., and C. Feudtner. "Ethics in a Short White Coat: The Ethical Dilemmas That Medical Students Confront." *Academic Medicine* 68, no. 4 (1993): 249-254.

Church Health Center. "Church Health Center." http://www.churchhealthcenter.org/patientrequirements. Accessed March 14, 2013.

Churchill, Larry R. "What Ethics Can Contribute to Health Policy." In *Ethical Dimensions of Health Policy*, edited by Marion Danis, Carolyn M. Clancy and Larry R. Churchill, 51-64. New York, NY: Oxford University Press, 2002.

Clark, Paul. "Getting Compensated for Uncompensated Care." (2012), http://health.wolterskluwerlb.com/2012/06/getting-compensated-for-uncompensated-care/. Accessed March 14, 2013.

Clark, Peter A. "Prejudice and the Medical Profession: A Five-Year Update." *Journal of Law, Medicine & Ethics* 37, no. 1 (2009): 118-133.

Clemans-Cope, Lisa, Bowen Garret, and Matthew Buettgens. "Health Care Spending under Reform: Less Uncompensated Care and Lower Costs to Small Employers." (2010), http://www.rwjf.org/healthpolicy/product.jsp?id=55092. Accessed March 14, 2013.

Clinton, William J. "Address on Health Care Reform." (1993), http://millercenter.org/president/speeches/detail/3926. Accessed March 14, 2013.

Cohen, Beverly. "The Controversy over Hospital Charges to the Uninsured--No Villains, No Heroes." *Villanova Law Review* 51 (2006): 95-148.

Cohen, Jerry. "Eight Steps for Starting a Student-Run Clinic." *Journal of the American Medical Association* 273, no. 5 (1995): 434-435.

Cohen, Jordan J. "Centers for Medicare and Medicaid Services, Letter." Association of American Medical Colleges, https://www.aamc.org/download/79166/data/102405.pdf. Accessed March 14, 2013.

———. "Disparities in Health Care: An Overview." *Academic Emergency Medicine* 10, no. 11 (2003): 1155-1160.

Cohen, Jordan J., and Robert M. Dickler. "Auditing the Medicare-Billing Practices of Teaching Physicians--Welcome Accountability, Unfair Approach." *New England Journal of Medicine* 336, no. 18 (1997): 1317-1320.

Cohen, Shelley , and Stephen A. Frew. "No. 1 EMTALA Mistake: Confusing Triage and MSE." *ED Nursing*, November (2004): 7-8.

Cohn, Jonathan. *Sick : The Untold Story of America's Health Care Crisis--and the People Who Pay the Price*. New York, NY: HarperCollins Publishers, 2007.

———. "Uncharitable?" *New York Times*, December 19, 2004.

Coleman, Sharon Kearney. "The Hill-Burton Uncompensated Services Program." (2005), http://www.policyarchive.org/handle/10207/bitstreams/719.pdf. Accessed March 14, 2013.

Colias, Mike. "Embattled U of C Med Center CEO Madara to Resign." *Crain's Chicago Business*, August 14, 2009.

———. "Hospitals Slip Madigan's Net: Panel's Watered-Down Charity Care Decision Another Setback for AG." *Crain's Chicago Business*, February 2, 2009.

Columbo, John. "The Failure of Community Benefit." *Health Matrix* 15, Winter (2005): 29-65.

Commonwealth Fund Task Force on Academic Health Centers. "Envisioning the Future of Academic Health Centers." Washington, DC: Commonwealth Fund, 2003.

———. "A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured." Washington, DC: Commonwealth Fund, 2001.

Community Catalyst. "Not There When You Need It: The Search for Free Hospital Care." Boston, MA: Community Catalyst, 2003.

———. "Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-Profit Hospitals." (2010), http://www.communitycatalyst.org/doc_store/publications/Hospital_Accountability_Summary_ACA.pdf. Accessed March 14, 2013.

Cone, David C., Lynne D. Richardson, Knox H. Todd, Joseph R. Betancourt, and Robert A. Lowe. "Health Care Disparities in Emergency Medicine." *Academic Emergency Medicine* 10, no. 11 (2003): 1176-1183.

Congressional Budget Office. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." (2012), http://www.cbo.gov/publication/43472. Accessed March 14, 2013.

———. "Letter to Speaker Nancy Pelosi." March 20, (2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf. Accessed March 14, 2013.

———. "Medicare and Graduate Medical Education." Washington, DC: Congressional Budget Office, 1995.

———. "Nonprofit Hospitals and the Provision of Community Benefits." Washington, DC: Congress of the United States Congressional Budget Office, 2006.

———. "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act."no. March (2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf. Accessed March 14, 2013.

Connolly, Ceci. "Some Finding No Room at the ER." *Washington Post*, April 26, 2004, A1.

Conrad, Douglas A., Sarah H. Cave, Martha Lucas, Jennifer Harville, Stephen M. Shortell, Gloria J. Bazzoli, Romana Hasnain-Wynia, Shoshanna Sofaer, Jeffrey A. Alexander, Elizabeth Casey, and Frances Margolin. "Community Care Networks: Linking Vision to Outcomes for Community Health Improvement." *Medical Care Research and Review* 60, no. 4 Suppl (2003): 95S-129S.

Cook, Nakela L., LeRoi S. Hicks, A. James O'Malley, Thomas Keegan, Edward Guadagnoli, and Bruce E. Landon. "Access to Specialty Care and Medical Services in Community Health Centers." *Health Affairs* 26, no. 5 (2007): 1459-1468.

Coombs, Robert H., and Bernard Virshup. *Surviving Medical School*. Thousand Oaks, CA: Sage Publication, 1998.

Cornely, Paul B. "Segregation and Discrimination in Medical Care in the United States." *Amercian Journal of Public Health* 46, no. 9 (1956): 1074-1081.

Corner, Rosemary, M. Kay Carlyle, Harvey Bunce, and Don W. Micks. "Appraisal of Health Care Delivery in a Free Clinic." *Health Services Report* 87, no. 8 (1972): 727-733.

Corum v. Beth Israel Medical Center, 373 F. Supp. 550 (1974).

Cotting, Benjamin. "A Bit of Professional Reminiscence, Etherwise and Otherwise." *Boston Medical and Surgical Journal* 136 (1897): 1-5.

Coughlin, Teresa A., Leighton Ku, and Johnny Kim. "Reforming the Medicaid Disproportionate Share Hospital Program." *Health Care Financing Review* 22, no. 2 (2000): 137-157.

Coughlin, Teresa A., and David Liska. "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals." *Health Affairs* 17, no. 3 (1998): 118-136.

———. "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." (1997), http://www.urban.org/UploadedPDF/anf_14.pdf. Accessed March 14, 2013.

Coughlin, Teresa A., Sharon K. Long, and Yu-Chu Shen. "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States." *Health Affairs* 24, no. 4 (2005): 1073-1083.

Coughlin, Teresa A., Stephen Zuckerman, and Joshua McFeeters. "Restoring Fiscal Integrity to Medicaid Financing?" *Health Affairs* 26, no. 5 (2007): 1469-1480.

Coulehan, Jack, and Peter C. Williams. "Vanquishing Virtue: The Impact of Medical Education." *Academic Medicine* 76, no. 6 (2001): 598-605.

Crandall, Sonia J., Beth A. Reboussin, Robert Michielutte, Jennie E. Anthony, and Michelle J. Naughton. "Medical Students' Attitudes toward Underserved Patients: A Longitudinal Comparison of Problem-Based and Traditional Medical

Curricula." *Advances in Health Sciences Education Theory and Practice* 12, no. 1 (2007): 71-86.

Crandall, Sonia J., Robert J. Volk, and Vicki Loemker. "Medical Students' Attitudes toward Providing Care for the Underserved. Are We Training Socially Responsible Physicians?" *Journal of the American Medical Association* 269, no. 19 (1993): 2519-2523.

Cross, Lawrence A. "Pressure on the Emergency Department: The Expanding Right to Medical Care." *Annals of Emergency Medicine* 21, no. 10 (1992): 1266-1272.

Cunningham, Peter J. "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001." *Tracking Report: Center for Studying Health System Change*,no. 6 (2002), http://www.hschange.com/CONTENT/505/505.pdf. Accessed March 14, 2013.

———. "Nonurgent Use of Hospital Emergency Departments: Senate Testimony " (2011), http://hschange.org/CONTENT/1204/?words=au07. Accessed March 14, 2013.

Cunningham, Peter J., Gloria J. Bazzoli, and Aaron Katz. "Caught in the Competitive Crossfire: Safety-Net Providers Balance Margin and Mission in a Profit-Driven Health Care Market." *Health Affairs* 27, no. 5 (2008): w374-382.

Cunningham, Peter J., Laurie Felland, and Lucy Stark. "Safety-Net Providers in Some US Communities Have Increasingly Embraced Coordinated Care Models." *Health Affairs* 31, no. 8 (2012): 1698-1707.

Cunningham, Peter J., and Jessica May. "Insured Americans Drive Surge in Emergency Department Visits." *Center for Studying Health System Change Issue Brief*,no. 70 (2003), http://www.hschange.com/CONTENT/613/?words=emergencydepartment. Accessed March 14, 2013.

———. "Medicaid Patients Increasingly Concentrated among Physicians."no. 16 (2006), http://www.hschange.com/CONTENT/866/. Accessed March 14, 2013.

Cunningham, Peter J., and Ann S. O'Malley. "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs* 28, no. 1 (2008): w17-w28.

Curran, William J. "Economic and Legal Considerations in Emergency Care." *New England Journal of Medicine* 312, no. 6 (1985): 374-375.

———. "Legal History of Emergency Medicine from Medieval Common Law to the AIDS Epidemic." *American Journal of Emergency Medicine* 15, no. 7 (1997): 658-670.

Cushing, Harvey. "The Personality of a Hospital." In *Massachusetts General Hospital: Memorial and Historical Volume Together with the Proceedings of the Centennial of the Opening of the Hospital*. Boston, MA: Griffith-Stillings Press, 1921.

Dallas County Medical Society. "Volunteers Needed." http://www.dallas-cms.org/volunteerhealth.cfm. Accessed March 14, 2013.

Dallek, Geraldine. "Hospital Care for Profit." *Society* July/August (1986).

Dame, Lauren A. "The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care." *Journal of Law and Medicine* 8, no. 1 (1998): 3-28.

Darley, Ward, and Anne R. Somers. "Medicine, Money and Manpower--the Challenge to Professional Education. II. Opportunity for New Excellence." *New England Journal of Medicine* 276, no. 23 (1967): 1291-1296.

Darnell, Julie. "What Is the Role of Free Clinics in the Safety Net?" *Medical Care* 49, no. 11 (2011): 978-984.

Darnell, Julie S. "Free Clinics in the United States: A Nationwide Survey." *Archves of Internal Medicine* 170, no. 11 (2010): 946-953.

Davenport, Beverly Ann. "Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless." *Medical Anthropology Quarterly* 14, no. 3 (2000): 310-327.

Davidoff, Amy J., Anthony T. LoSasso, Gloria J. Bazzoli, and Stephen Zuckerman. "The Effect of Changing State Health Policy on Hospital Uncompensated Care." *Inquiry* 37, no. 3 (2000): 253-267.

Davidson, Stephen M. "Physician Participation in Medicaid: Background and Issues." *Journal of Health Politics, Policy and Law* 6, no. 4 (1982): 703-717.

Davis, Corey. "Nonprofit Hospitals and Community Benefit." (2011), http://healthjusticenetwork.files.wordpress.com/2011/07/nhelp_community_benefit.pdf. Accessed March 14, 2013.

———. "Q & A: Disproportionate Share Hospital Payments and the Medicaid Expansion." (2012), http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf. Accessed March 14, 2013.

Davis, Denise A. , Amy M. Tiedemann, and Joel C. Cantor. "HRSA Community Access Program: Local Achievements and Lessons Learned." (2003), http://www.cshp.rutgers.edu/Downloads/270.pdf. Accessed March 14, 2013.

Daysal, N. Meltem "Does Uninsurance Affect the Health Outcomes of the Insured? Evidence from Heart Attack Patients in California." *Journal of Health Economics* 31, no. 4 (2012): 545-563.

DeAngelis, Catherine D. "Professors Not Professing." *Journal of the American Medical Association* 292, no. 9 (2004): 1060-1061.

Deficit Reduction Act of 2005. Public Law 109-171. 109th Cong., 2nd sess., January 3, 2006.

Deitrick, John E., and Robert C. Berson. *Medical Schools in the United States at Mid-Century*. New York, NY: McGraw-Hill, 1953.

DeLia, Derek, and Joel Cantor. "Emergency Department Utilization and Capacity." *The Synthesis Project*, no. 17 (2009), http://www.rwjf.org/pr/product.jsp?id=45929. Accessed March 14, 2013.

Deloitte Consulting. "Rider 61: Texas Hospitals' Uncompensated Care." Austin, TX: Texas Health and Human Services Commission, 2006.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith. "Income, Poverty, and Health Insurance Coverage in the United States: 2010." Washington, DC: United States Census Bureau, 2011.

Department of Health and Human Services Centers for Medicare & Medicaid Services. "Medicaid and Children's Health Insurance Programs; Disallowance of Claims for FFP and Technical Corrections." *Federal Register* 77, no. 103 (May 29, 2012): 31499-31513.

———. "Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition." *Federal Register* 77, no. 11 (January 18, 2012): 2500-2507.

———. "Medicaid Program; Disproportionate Share Hospital Payments; Final Rule " *Federal Register* 73, no. 245 (December 19, 2008): 77904-77952.

———. "Medicaid Program; Premiums and Cost Sharing." *Federal Register* 73, no. 228 (November 25, 2008): 71828-71854.

———. "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates." *Federal Register* 67, no. 90 (May 9, 2002): 31404-31689.

———. "Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency

Medical Conditions." *Federal Register* 68, no. 174 (September 9, 2003): 53222-53264.

Department of Health and Human Services Office of Inspector General. "OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute." *Federal Register* 64 no. 217 (November 10, 1999): 61353-61359.

———. "Public Health Service's Oversight of the Hill-Burton Program." Washington, DC: Department of Health and Human Services, 1992.

———. "Review of Medicaid Disproportionate Share Hospital Payment Distribution." Washington, DC: Department of Health and Human Services, 2010.

Department of Health and Human Services Public Health Service. "Compliance Alternatives for Provision of Uncompensated Services." *Federal Register* 66, no. 187 (September 26, 2001): 49262-49269.

———. "Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable to Pay." *Federal Register* 60, no. 62 (March 31, 1995): 16754-16757.

Derlet, Robert W. "Refusal of Care: The Ethical Dilemma; Author Reply." *Annals of Emergency Medicine* 19, no. 10 (1990): 184.

Derlet, Robert W., Donna Kinser, Lou Ray, Bridget Hamilton, and Judy McKenzie. "Prospective Identification and Triage of Nonemergency Patients out of an Emergency Department: A 5-Year Study." *Annals of Emergency Medicine* 25, no. 2 (1995): 215-223.

Derlet, Robert W., and Denyse A. Nishio. "Refusing Care to Patients Who Present to an Emergency Department." *Annals of Emergency Medicine* 19, no. 3 (1990): 262-267.

Derlet, Robert W., Denyse Nishio, Linda M. Cole, and Joseph Silva, Jr. "Triage of Patients out of the Emergency Department: Three-Year Experience." *American Journal of Emergency Medicine* 10, no. 3 (1992): 195-199.

Derlet, Robert W., and Gary P. Young. "Managed Care and Emergency Medicine: Conflicts, Federal Law, and California Legislation." *Annals of Emergency Medicine* 30, no. 3 (1997): 292-300.

Desonia, Randolph A., and Kathleen King. "State Programs of Assistance for the Medically Indigent." Intergovernmental Health Policy Project, Georgetown University, 1985.

DeVoe, Jennifer E., Alia Baez, Heather Angier, Lisa Krois, Christine Edlund, and Patricia A. Carney. "Insurance + Access Not Equal to Health Care: Typology of Barriers to Health Care Access for Low-Income Families." *Annals of Family Medicine* 5, no. 6 (2007): 511-518.

Diamant, Allison L., Ron D. Hays, Leo S. Morales, Wesley Ford, Daphne Calmes, Steven Asch, Naihua Duan, Eve Fielder, Sehyun Kim, Jonathan Fielding, Gerald Sumner, Martin F. Shapiro, David Hayes-Bautista, and Lillian Gelberg. "Delays and Unmet Need for Health Care among Adult Primary Care Patients in a Restructured Urban Public Health System." *American Journal of Public Health* 94, no. 5 (2004): 783-789.

Dickler, Robert M. "Letter to Leslie Norwalk, Acting Adminstrator, Centers for Medicare and Medicaid Services." Association of American Medical Colleges, https://www.aamc.org/download/55992/data/062207.pdf. Accessed March 14, 2013.

Diesburg-Stanwood, Amy , and Kathleen Oman. "Redirect Nonurgent Patients and Comply with EMTALA." *ED Nursing* 7, no. 12 (2004).

Diesburg-Stanwood, Amy, Jill Scott, Kathleen Oman, and Carolee Whitehill. "Nonemergent ED Patients Referred to Community Resources after Medical Screening Examination: Characteristics, Medical Condition after 72 Hours, and Use of Follow-up Services." *Journal of Emergency Nursing* 30, no. 4 (2004): 312-317.

Dobbertin, Judith L. . "Eliminating Patient Dumping: A Proposal for Model Legislation." *Valparaiso University Law Review* 28, no. 291 (1993).

DoBias, Mathew, and Jennifer Lubell. "The Numbers Game. DSH Payments, Uninsured Counts Roil Senate." *Modern Healthcare* 39, no. 39 (2009): 8-9.

Dobson, Allen, Joan DaVanzo, Julia Doherty, and Myra Tanamor. "A Study of Hospital Charge Setting Practices." i-25: The Lewin Group, 2005.

Dobson, Allen, and Elizabeth W. Hoy. "Hospital PPS Profits: Past and Prospective." *Health Affairs* 7, no. 1 (1988): 126-129.

Dodson, John A., and Allen S. Keller. "Studentjama. Medical Student Care of Indigent Populations." *Journal of the American Medical Association* 291, no. 1 (2004): 121.

Dodson, John Milton. "The Fifth, or Intern, Year." *Journal of the American Medical Association* 73, no. 7 (1919): 469472.

Dohan, Daniel. "Managing Indigent Care: A Case Study of a Safety-Net Emergency Department." *Health Services Research* 37, no. 2 (2002): 361-376.

Dolan, Pamela Lewis "Emergency Departments Turn to Texting Wait Times." *American Medical News* (2011), http://www.ama-assn.org/amednews/2011/08/22/bisb0822.htm. Accessed March 14, 2013.

Dorris, Malcolm S. "Hill-Burton Notice Provisions: Informing the Indigent." *Washington and Lee Law Review* 36, no. 4 (1979): 1095-1109.

Dorsey, E. Ray, Jason de Roulet, Joel P. Thompson, Jason I. Reminick, Ashley Thai, Zachary White-Stellato, Christopher A. Beck, Benjamin P. George, and Hamilton Moses. "Funding of US Biomedical Research, 2003-2008." *Journal of the American Medical Association* 303, no. 2 (2010): 137-143.

Doty, Michelle M. , Melinda K. Abrams, Susan E. Hernandez, Kristof Stremikis, and Anne C. Beal. "Enhancing the Capacity of Community Health Centers to Achieve High Performance." May (2010), http://www.commonwealthfund.org/Publications/Fund-Reports/2010/May/Enhancing-the-Capacity-of-Community-Health-Centers-to-Achieve-High-Performance.aspx?page=all. Accessed March 14, 2013.

Dougherty, Charles J. "Cost Containment, DRGs, and the Ethics of Health Care. Ethical Perspectives on Prospective Payment." *Hastings Center Report* 19, no. 1 (1989): 5-11.

Douglas, Mary. *How Institutions Think*, The Frank W. Abrams Lectures. Syracuse, NY: Syracuse University Press, 1986.

Douglass, Frederick, and Robert G. O'Meally. *Narrative of the Life of Frederick Douglass, an American Slave*, Barnes & Noble Classics. New York, NY: Barnes & Noble Classics, 2003.

Dowell, Michael A. "Hill-Burton: The Unfulfilled Promise." *Journal of Health Politics Policy and Law* 12, no. 1 (1987): 153-175.

Dowling, Harry F. *City Hospitals: The Undercare of the Underprivileged*. Cambridge, MA: Harvard University Press, 1982.

Drentea, Patricia, and John R. Reynolds. "Neither a Borrower nor a Lender Be: The Relative Importance of Debt and SES for Mental Health among Older Adults." *Journal of Aging and Health* 24, no. 4 (2012): 673-695.

DuBard, C. Annette, and Mark W. Massing. "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants." *Journal of the American Medical Association* 297, no. 10 (2007): 1085-1092.

Dubay, Lisa, and Genevieve Kenney. "The Impact of CHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families." *Health Services Research* 44, no. 6 (2009): 2040-2059.

Duff, Raymond S., and August B. Hollingshead. *Sickness and Society*. New York, NY: Harper & Row, 1968.

Duffy, John. *From Humors to Medical Science : A History of American Medicine*. 2nd ed. Urbana, IL: University of Illinois Press, 1993.

Duncan, R. Paul. "Uncompensated Hospital Care." *Medical Care Review* 49, no. 3 (1992): 265-330.

Dunford, Denise. "Screening out Does Little to Address ED Overcrowding." *Journal of Emergency Nursing* 35, no. 4 (2009): 280.

Dunklin, Reese, and Sue Goetinck Ambrose. "Doctors: Double Standard for Residents at Parkland, UT Southwestern." *Dallas Morning News*, August 2, 2010.

Dunklin, Reese, Sue Goetinck Ambrose, and Brooks Egerton. "UT Southwestern Faculty Let Unsupervised Resident Doctors Operate at Parkland." *Dallas Morning News*, August 1, 2010.

Dunklin, Reese, and Miles Moffeit. "Feds Probe Alleged Fraud at UT Southwestern, Parkland." *Dallas Morning News*, May 30, 2010.

Dunn, James R. "Health Behavior Vs the Stress of Low Socioeconomic Status and Health Outcomes." *Journal of the American Medical Association* 303, no. 12 (2010): 1199-1200.

Dunn, Linda L. "Making a Difference: Initiating and Maintaining a Faith-Based Free Health Clinic." *Family & Community Health* 32, no. 4 (2009): 339-344.

Durand, Anne-Claire C., Stephanie Gentile, Benedicte Devictor, Sylvie Palazzolo, Pascal Vignally, Patrick Gerbeaux, and Roland Sambuc. "ED Patients: How Nonurgent Are They? Systematic Review of the Emergency Medicine Literature." *American Journal of Emergency Medicine* 29, no. 3 (2011): 333-345.

Durbin, Dennis R., Angelo P. Giardino, Kathy N. Shaw, Mary C. Harris, and Jeffrey H. Silber. "The Effect of Insurance Status on Likelihood of Neonatal Interhospital Transfer." *Pediatrics* 100, no. 3 (1997): E8.

Durch, Jane S. , Linda A. Bailey, and Michael A. Stoto, eds. *Improving Health in the Community: A Role for Performance Monitoring*. Edited by Institute of Medicine

Committee on Using Performance Monitoring to Improve Community Health. Washington, DC: National Academies Press, 1997.

Eade, Gilbert G. "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789.

Ebert, Robert H., and Eli Ginzberg. "The Reform of Medical Education." *Health Affairs* 7, no. 2 Suppl (1988): 5-38.

Eckenfels, Edward J. "Contemporary Medical Students' Quest for Self-Fulfillment through Community Service." *Academic Medicine* 72, no. 12 (1997): 1043-1050.

———. "Keeping Comminty Service Voluntary." In *Educating for Professsionalism: Creating a Culture of Humanism in Medical Education*, edited by Delese Wear and Janet Bickel, 165-173. Iowa City, IA: University of Iowa Press, 2000.

Eckholm, Erik. "Hospitals Try Free Basic Care for Uninsured." *New York Times*, October 25, 2006.

Edelen, Adam H. "Examination of the Quality and Charity Care Trust, Incorporated." (2012), http://khpi.org/dwnlds/2012/2012QualityandCharityCareReport.pdf. Accessed March 14, 2013.

Edelman, Murray J. *The Symbolic Uses of Politics*. Urbana, IL: University of Illinois Press, 1985.

Editorial. *Los Angeles Record*, May 14, 1912.

———. "Ambulatory Care Quarterly: ED Screening Changes Put Pressure on Competitors." *Hospital Case Management*, June 1, (2005).

———. "Data Watch: The Cost of Health Care." *Health Affairs* 1, no. 1 (1981): 99-104.

———. "Debts Have Hospitals Seeking Payments up Front." *Associated Press*, June 5, 2004.

———. "Emergency Room Delays." *New York Times*, January 19, 2008.

———. "ER Screening Plan at CU Very Troubling." *Rocky Mountain News*, June 14, 2003.

———. "Free Beds for Medical Teaching." *Journal of the American Medical Association* 90, no. 3 (1927): 2194.

———. "The Free Dispensary." *Journal of the American Medical Association* 65, no. 1 (1905): 44-45.

———. "Hospital Work up Funds Down." *The Survey*, September 1933.

———. "Largest for-Profit Hospital Chains." *Modern Healthcare* 37, no. 10 (2007): 44.

———. "Medical Teaching and the Private Patient." *Journal of the American Medical Association* 202, no. 8 (1967): 836-837.

———. "The Propriety of Reimbursement by Medicare for Hill-Burton Free Care." *University of Pennsylvania Law Review* 130, no. 4 (1982): 892-918.

———. "Reducing Emergency Department Volume—and Costs." *Healthcare Financial Management Association* (2010), http://www.hfma.org/Content.aspx?id=3825. Accessed March 14, 2013.

———. "Resistance to Change under Medicaid." *New England Journal of Medicine* 277, no. 14 (1967): 765.

———. "Second-Class " *Consumer Reports* 65, no. 9 (2000): 42-50.

———. "Turning Away Patients: Hospitals, County Need Stronger Safety Net." *Sacramento Bee*, February 10, 2005.

———. "University of Chicago Reconsiders Plan to Redirect ER Patients " (2009), http://blogs.wsj.com/health/2009/03/16/university-of-chicago-reconsiders-plan-to-redirect-er-patients/. Accessed March 14, 2013.

Edwards, Barbara Coulter, Vernon K. Smith, and Greg Moody. "Reforming New York’s Medicaid Eligibility Process: Lessons from Other States." (2008), http://www.medicaidinstitute.org/assets/516. Accessed March 14, 2013.

Egerton, Brooks. "Ethicists Fear Patients Don't Know Students May Be Behind Surgical Masks." *Dallas Morning News*, November 13, 2010.

———. "Level of Trainee Supervision at Parkland Memorial Hospital Has Long Been Debated." *Dallas Morning News*, November 13, 2010.

———. "Parkland CEO: ‘I Did 17 Amputations’ before Getting Medical Degree." *Dallas Morning News*, November 13, 2010.

Eichna, L. W. "Medical School Education for Whom, Student or Patient." *Bulletin of the New York Academy of Medicine* 67, no. 2 (1991): 151-161.

Eichna, Ludwig W. "Medical-School Education, 1975-1979: A Student's Perspective." *New England Journal of Medicine* 303, no. 13 (1980): 727-734.

Eldenburg, Leslie , and Naomi Soderstrom. "Accounting System Management by Hospitals Operating in a Changing Regulatory Environment." *The Accounting Review* 71, no. 1 (1996): 23-42.

Elhai, Laurisa S. "The Quality of Medical Care Delivered by Lay Practitioners in a Feminist Clinic." *American Journal of Public Health* 71, no. 8 (1981): 853-855.

Eliot, Charles W. *American Medical Association Bulletin* 3 (1907).

Ellwood, Marilyn R., and Leighton Ku. "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid." *Health Affairs* 17, no. 3 (1998): 137-151.

Emanuel, Ezekiel J., and Linda L. Emanuel. "Four Models of the Physician-Patient Relationship." *Journal of the American Medical Association* 267, no. 16 (1992): 2221-2226.

Emergency Medical Treatment and Labor Act. 42 U.S.Code § 1395dd (2002).

Enfield, Lisa M., and David P. Sklar. "Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem." *American Journal of Law and Medicine* 13, no. 4 (1988): 561-595.

Engel, Jonathan. *Poor People's Medicine: Medicaid and American Charity Care since 1965*. Durham, NC: Duke University Press, 2006.

Engelhardt, H. Tristram. *The Foundations of Bioethics*. New York, NY: Oxford University Press, 1986.

Epstein, Elizabeth Gingell, and Ann Baile Hamric. "Moral Distress, Moral Residue, and the Crescendo Effect." *Journal of Clinical Ethics* 20, no. 4 (2009): 330-342.

Epstein, Richard Allen. *Mortal Peril: Our Inalienable Right to Health Care?* Reading, MA: Addison-Wesley Publishing Company, 1997.

Evans, Melanie, and Joe Carlson. "Out in the Open. Not-for-Profit Hospitals' Charity Spending Revealed, but Finding a Standard Measure May Not Be So Simple." *Modern Healthcare* 41, no. 51 (2011): 6-7, 14, 16 passim, 11.

ExpectMore.gov. "Detailed Information on the Healthy Community Access Program Assessment." (2005), http://georgewbush-whitehouse.archives.gov/omb/expectmore/detail/10003515.2005.html. Accessed March 14, 2013.

Fagnani, Lynne, and Jennifer Tolbert. "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs." The Commonwealth Fund, 1999.

Fairbrother, Gerry, Michael K. Gusmano, Heidi L. Park, and Roberto Scheinmann. "Care for the Uninsured in General Internists' Private Offices." *Health Affairs* 22, no. 6 (2003): 217-224.

Families USA. "Hidden Health Tax: Americans Pay a Premium." (2009), http://www.familiesusa.org/resources/publications/reports/hidden-health-tax.html. Accessed March 14, 2013.

Farber, Neil J., Charles V. Roche, 3rd, Brian M. Aboff, Virginia U. Collier, and Joan Weiner. "When the Patient Does Not Pay: A Survey of Primary Care Physicians." *Medical Care* 48, no. 6 (2010): 498-502.

Feder, Judith, Jack Hadley, and Ross Mullner. "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982." *Milbank Memorial Fund Quarterly/Health and Society* 62, no. 4 (1984): 544-566.

Feder, Judith, and Bruce Spitz. "The Politics of Hospital Payment." *Journal of Health Politics Policy and Law* 4, no. 3 (1979): 435-463.

Felland, Laurie E. , Robert E. Hurley, and Nicole M. Kemper. "Safety Net Hospital Emergency Departments: Creating Safety Valves for Non-Urgent Care." *Issue Brief No. 120*, May (2008), http://www.hschange.com/CONTENT/983/. Accessed March 14, 2013.

Felland, Laurie E., Cara S. Lesser, Andrea B. Staiti, Aaron Katz, and Patricia Lichiello. "The Resilience of the Health Care Safety Net, 1996-2001." *Health Services Research* 38, no. 1 Pt 2 (2003): 489-502.

Ferguson, Niall. "Why Obama Must Go." *Newsweek* August 27, 2012: 21-25.

Fernandez, Manny. "For Uninsured in Texas, Supreme Court Ruling Adds to Uncertainty." *New York Times*, June 29, 2012.

Feudtner, Chris, Dimitri A. Christakis, and Nicholas A. Christakis. "Do Clinical Clerks Suffer Ethical Erosion? Students' Perceptions of Their Ethical Environment and Personal Development." *Academic Medicine* 69, no. 8 (1994): 670-679.

Fiebach, Nicholas H., and Jeffrey G. Wong. "Taking Care of Patients in Resident Clinics: Where Do We Stand?" *Journal of General Internal Medicine* 16, no. 11 (2001): 787-789.

Fine, David J., Robert J. Baker, Neal A. Vanselow, Victoria L. Leu, and Alastair M. Connell. "Indigent Care Limitation in University-Owned Hospitals." *Health Care Management Review* 8, no. 3 (1983): 19-24.

Finley, Don. "Troubled Clinic No Longer Seeing Patients after Money Runs Out." *San Antonio Express-News*, 2007.

Fiscella, Kevin, and David R. Williams. "Health Disparities Based on Socioeconomic Inequities: Implications for Urban Health Care." *Academic Medicine* 79, no. 12 (2004): 1139-1147.

Fishbein, Morris. "Medical Education - 1905 to 1940." *Journal of the American Medical Association* 114, no. 13 (1940): 1147-1151.

Fishman, Linda E. "What Types of Hospitals Form the Safety Net?" *Health Affairs* 16, no. 4 (1997): 215-222.

Fishman, Linda E., and James D. Bentley. "The Evolution of Support for Safety-Net Hospitals." *Health Affairs* 16, no. 4 (1997): 30-47.

Fitzgerald, Sharon H. "HCA's Bovender on Going Private, the Uninsured and Why He Goes to Work." *Medical News*, July (2007), http://www.medicalnewsinc.com/hca-s-bovender-on-going-private-the-uninsured-and-why-he-goes-to-work-cms-61. Accessed March 14, 2013.

Fletcher, Kathlyn E., David S. Rankey, and David T. Stern. "Bedside Interactions from the Other Side of the Bedrail." *Journal of General Internal Medicine* 20, no. 1 (2005): 58-61.

Flexner, Abraham. *Abraham Flexner: An Autobiography*. New York, NY: Simon and Schuster, 1960.

———. *Medical Education in the United States and Canada*. New York, NY: Carnegie Foundation for the Advancement of Teaching, 1910.

Fogelson, Samuel J., and Chester Moen. "Management of Mechanical Obstruction of the Small Intestine at Cook County Hospital." *Quarterly Bulletin of the Northwestern University Medical School* 23, no. Fall (1949): 287.

Forgione, Dana A. "The Methodist Hospital System: Tax Exemption and Charitable Responsibilities of Not-for-Profit Hospitals." *Issues in Accounting Education* February 1, (2001).

Fothergill, Alice. "The Stigma of Charity: Gender, Class, and Disaster Assistance." *The Sociological Quaterly* 44, no. 4 (2003): 659-680.

Fournier, Arthur M., Alina Perez-Stable, and Pedro J. Greer, Jr. "Lessons from a Clinic for the Homeless. The Camillus Health Concern." *Journal of the American Medical Association* 270, no. 22 (1993): 2721-2724.

Fox, Daniel M., and Daniel C. Schaffer. "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts." *Journal of Health Politics Policy and Law* 16, no. 2 (1991): 251-279.

Freeman, Howard E., Robert J. Blendon, Linda H. Aiken, Seymour Sudman, Connie F. Mullinix, and Christopher R. Corey. "Americans Report on Their Access to Health Care." *Health Affairs* 6, no. 1 (1987): 6-8.

Frenk, Julio. "Medical Care and Health Improvement: The Critical Link." *Annals of Internal Medicine* 129, no. 5 (1998): 419-420.

Friedenzohn, Isabel. "Profiles in Coverage: Utah's Primary Care Network." (2003), http://www.statecoverage.org/node/484. Accessed March 14, 2013.

Friedenzohn, Isabel, and Terry Stoller. "State and Community Collaboration: Lessons from the Communities in Charge Program and Other Local Initiatives." *State Coverage Initiatives* VI, no. 1 (2005), http://www.statecoverage.org/files/State%20and%20Community%20Collaboration%20-%20Lessons%20from%20the%20Communities%20in%20Charge%20Program%20and%20Other%20Local%20Initiatives.pdf. Accessed March 14, 2013.

Fruen, Mary A., and Samuel P. Korper. "Issues in Graduate Medical Education Financing." *Journal of Health Politics Policy and Law* 6, no. 1 (1981): 87-97.

Furin, Jennifer, Paul Farmer, Marshall Wolf, Bruce Levy, Amy Judd, Margaret Paternek, Rocio Hurtado, and Joel Katz. "A Novel Training Model to Address Health Problems in Poor and Underserved Populations." *Jounal of Health Care for the Poor and Underserved* 17, no. 1 (2006): 17-24.

Gabow, Patricia A. "Making a Public Hospital Work." *Health Affairs* 20, no. 4 (2001): 182-187.

Gadomski, Anne M., Victoria Perkis, Lisa Horton, Sheila Cross, and Bonita Stanton. "Diverting Managed Care Medicaid Patients from Pediatric Emergency Department Use." *Pediatrics* 95, no. 2 (1995): 170-178.

Galewitz, Phil. "Caring for the Uninsured: N.C. Leads the Way in Free Health Care." *Palm Beach Post*, February 20, 2005.

———. "States Are Limiting Medicaid Hospital Coverage in Search for Savings " *USA Today*, October 31, 2011.

Galloro, Vince. "Screen Test: HCA Tries to Move Nonemergency Patient out of ER." *Modern Healthcare* 34 (2004): 12.

Garcia, Alexandra A. "Clinical and Life Quality Differences between Mexican American Diabetic Patients at a Free Clinic and a Hospital-Affiliated Clinic in Texas." *Public Health Nursing* 25, no. 2 (2008): 149-158.

Garcia, Tamyra C., Amy B. Bernstein, and Mary Ann Bush. "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" *National Center for Health Statistics Data Brief*, no. 38 (2010), http://www.cdc.gov/nchs/data/databriefs/db38.pdf. Accessed March 14, 2013.

Garloch, Karen. "Free Clinics 'Can't Serve Them All:' The Demand for Medical Service Is Overwhelming as More and More Workers Lack Insurance." *Charlotte Observer*, September 8, 2008.

Garner, Jackie. "State Medicaid Director Letter: July 27." Chicago, IL: Centers for Medicare and Medicaid Services, 2009.

Garson, Arthur "Heart of the Uninsured." *Health Affairs* 26, no. 1 (2007): 227-231.

Gautam, Kanak, Barbara Arrington, and Claudia Campbell. "Inner-City Hospitals: A Call for Research." *Journal of Health Care for the Poor and Underserved* 6, no. 4 (1995): 387-402.

Gawande, Atul A. "Getting There from Here: How Should Obama Reform Health Care?" *The New Yorker*, 2009.

Gawande, Atul, Donald Berwick, Elliott Fisher, and Mark McClellan. "10 Steps to Better Health Care " *New York Times*, August 12, 2009.

Gbadebo, Adepeju L., and Uwe E. Reinhardt. "Economists on Academic Medicine: Elephants in a Porcelain Shop?" *Health Affairs* 20, no. 2 (2001): 148-152.

Geertz, Clifford. *The Interpretation of Cultures: Selected Essays*. New York, NY: Basic Books, 1973.

Geiderman, Joel Martin. "Ethics Seminars: Physician Complicity in the Holocaust: Historical Review and Reflections on Emergency Medicine in the 21st Century, Part II." *Academic Emergency Medicine* 9, no. 3 (2002): 232-240.

Geisz, Mary B. "Volunteers in Health Care Program Establishes Technical Resource Center, Provides Financial Support to Organizations Offering Free Care." Robert Wood Johnson Foundation, http://www.rwjf.org/reports/grr/053639.htm. Accessed March 14, 2013.

Geletko, Karen W., Leslie M. Beitsch, Mark Lundberg, and Robert G. Brooks. "Reducing the Impact of the Health Care Access Crisis through Volunteerism: A Means, Not an End." *American Journal of Public Health* 99, no. 7 (2009): 1166-1169.

Geller, Stephanie, Buck M. Taylor, and H. Denman Scott. "Free Clinics Helping to Patch the Safety Net." *Journal of Health Care for the Poor Underserved* 15, no. 1 (2004): 42-51.

General Accounting Office. "District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care." Washington, DC: U.S. General Accounting Office, 1992.

———. "Emergency Care: EMTALA Implementation and Enforcement Issues." Washington, DC: U.S. General Accounting Office, 2001.

———. "Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People." Washington, DC: U.S. General Accounting Office, 1994.

———. "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities." Washington, DC: U.S. General Accounting Office, 2003.

———. "Hospital Emergency Departments: Unevenly Affected by Growth and Change in Patient Use." Washington, DC: U.S. General Accounting Office, 1993.

———. "Intergovernmental Transfers Have Facilitated State Financing Schemes." Washington, DC: U.S. General Accounting Office, 2004.

———. "Medicare: Concerns with Physicians at Teaching Hospitals (PATH) Audits." Washington, DC: U.S. General Accounting Office, 1998.

———. "Medicare: Documenting Teaching Physician Services Still a Problem." Washington, DC: U.S. General Accounting Office, 1986.

———. "Nonprofit Hospitals: Better Standards Needed for Tax Exemption." Washington, DC: U.S. General Accounting Office, 1990.

Gertz, Alida M., Scott Frank, and Carol E. Blixen. "A Survey of Patients and Providers at Free Clinics across the United States." *Journal of Community Health* 36, no. 1 (2011): 83-93.

Giesen, Dieter. *International Medical Malpractice Law : A Comparative Law Study of Civil Liability Arising from Medical Care*. Norwell, MA: Kluwer Academic Publishers, 1988.

Gilboy, Nicki , Paula Tanabe, Debbie A Travers, Alexander M Rosenau, and David R. Eitel. "Emergency Severity Index, Version 4: Implementation." Rockville, MD: Agency for Healthcare Research and Quality, 2005.

Ginsburg, Paul B., and Frank A. Sloan. "Hospital Cost Shifting." *New England Journal of Medicine* 310, no. 14 (1984): 893-898.

Glaser, John W. "'Covering the Uninsured' Is a Flawed Moral Frame." *Health Progress* 87, no. 2 (2006): 4-9.

Glenn, Michael L. "Challenge to the City Hospitals. An Intern's View." *New England Journal of Medicine* 274, no. 26 (1966): 1476-1480.

Gliatto, Peter, Philip Masters, and Reena Karani. "Medical Student Documentation in the Medical Record: Is It a Liability?" *Mount Sinai Journal of Medicine* 76, no. 4 (2009): 357-364.

Goitein, Lara. "The Girl Who Died Twice: Every Patient's Nightmare: The Libby Zion Case and the Hidden Hazards of Hospitals." *New England Journal of Medicine* 334, no. 3 (1996): 200-201.

Gold, Jenny. "New Rules Will Ban ER Debt Collections at Charitable Hospitals." *Kaiser Health News*, June 27, 2012.

Goldwater, Sigismund S. "Correspondence: Free Beds for Medical Teaching." *Journal of the American Medical Association* 90, no. 3 (1928): 223-224.

———. "The Unfinished Business of General Hospitals." *Medical Record* 73 (1908).

Goodale, Walter S. "The Patient: Some of His Reactions to Hospital Administration." *Journal of the American Medical Association* 94, no. 13 (1930): 906-909.

Gordon, James A. "Emergency Care as Safety Net." *Health Affairs* 19, no. 2 (2000): 277.

Gordon, Jeoffry B. "Quality of Care in Free Clinics." *American Journal of Public Health* 66, no. 10 (1976): 955-956.

Gordon, Linda. *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890-1935*. New York, NY: Free Press, 1994.

Gore, Laura. "University of Chicago Medical Center Is Failing Emergency Patients, Nations Emergency Physicians Say; Urge Congress to Hold Hearings on the State of Emergency Care." (2009), http://www.acep.org/content.aspx?id=44294. Accessed March 14, 2013.

Goslin, Ryllis Alexander, and Omar Pancoast Goslin. *You and Your Hospitals: A Digest of the Hospital Survey for New York*. New York, NY: United Hospital Fund, 1938.

Gostin, Lawrence O., and Dan Hanfling. "National Preparedness for a Catastrophic Emergency." *Journal of the American Medical Association* 302, no. 21 (2009): 2365-2366.

Government Accountability Office. "GAO's Name Change and Other Provisions of the GAO Human Capital Reform Act of 2004." (2004), http://www.gao.gov/about/namechange.html. Accessed March 14, 2013.

———. "Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments." Washington, DC: U.S. Government Accoutability Office, 2008.

———. "Medicaid: Ongoing Federal Oversitght of Payments to Offset Uncomplsated Hospital Care Costs Is Warranted." Washington, DC: United States Government Accountability Office, 2009.

———. "Medicaid: States Reported Billions More in Supplemental Payments in Recent Years." Washington, DC: U.S. Government Accountability Office, 2012.

———. "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements." Washington, DC: U.S. Government Accountability Office, 2008.

Graham, James, Mary E. Aitken, and Steve Shirm. "Correlation of Measures of Patient Acuity with Measures of Crowding in a Pediatric Emergency Department." *Pediatric Emergency Care* 27, no. 8 (2011): 706-709.

Graham, Judith. "Hospital Lawsuit Settlement May Help Tens of Thousands of Uninsured Patients." *Chicago Tribune*, January 14, 2009.

Grant, Alexis, and Todd Ackerman. "New Fees Discourage Noncritical Patients from Using ER." *Houston Chronicle*, August 2, 2006.

Gray, Beth. "Grant Lets Clinic Expand Programs for Uninsured." *Tampa Bay Times*, 2012.

Gray, Bradford H., ed. *For-Profit Enterprise in Health Care*. Edited by Institute of Medicine (U.S.). Committee on Implications of For-Profit Enterprise in Health Care. Washington, DC: National Academy Press, 1986.

———. *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*. Cambridge, MA: Harvard University Press, 1991.

Green, Alexander R., Dana R. Carney, Daniek J. Pallin, Long H. Ngo, Kristal L. Raymond, Lisa I. Iezzoni, and Mahzarin R. Banaji. "Implicit Bias among

Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients." *Journal of General Internal Medicine* 22, no. 9 (2007): 1231-1238.

Green, Ronald M. "Altruism in Health Care." In *Beneficence and Health Care*, edited by Earl E. Shelp, 239-254. Hingham, MA: Kluwer Boston, Inc., 1982.

Greene, Jan. "Sending Low-Acuity Patients Away from the ED: Closing the Door or Stemming the Tide?" *Annals of Emergency Medicine* 49, no. 3 (2007): 317-319.

Grogan, Colleen M. "A Marriage of Convenience: The Persistent and Changing Relationship between Long-Term Care and Medicaid." In *History and Health Policy in the United States: Putting the Past Back In*, edited by Rosemary A. Stevens, Charles E. Rosenberg and Lawton R. Burns, v.-364. New Brunswick, NJ: Rutgers University Press, 2006.

———. "The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns." *Journal of Health Politics, Policy and Law* 22, no. 3 (1997): 815-838.

Grogan, Colleen M., and Michael K. Gusmano. *Healthy Voices, Unhealthy Silence : Advocacy and Health Policy for the Poor*. Washington, DC: Georgetown University Press, 2007.

———. "Political Strategies of Safety-Net Providers in Response to Medicaid Managed Care Reforms." *Journal of Health Politics, Policy & Law* 34, no. 1 (2009): 5-35.

Gross, Robert A. "Giving in America: From Charity to Philanthropy." In *Charity, Philanthropy, and Civility in American History*, edited by Lawrence Jacob Friedman and Mark D. McGarvie, 29-48. New York, NY: Cambridge University Press, 2003.

Grossman, Ellie, Anna T. Legedza, and Christina C. Wee. "Primary Care for Low-Income Populations: Comparing Health Care Delivery Systems." *Journal of Health Care for the Poor and Underserved* 19, no. 3 (2008): 743-757.

Grotto, Jason. "Mauled by Dog, Kid Sent Home by ER." *Chicago Tribune*, February 13, 2009.

Grotto, Jason, and Bruce Japsen. "Are Hospitals Passing Off Their Low-Profit Patients?" *Chicago Tribune*, April 10, 2009.

Grover, Atul. "Comments of the Association of American Medical Colleges to the Senate Finance Committee: Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options." May 28, (2009) https://www.aamc.org/download/73388/data/052809.pdf. Accessed March 14, 2013.

Grover, Maleah, and Tony Greenberg. "Quality of Care Given to First Time Birth Control Patients at a Free Clinic." *American Journal of Public Health* 66, no. 10 (1976): 986-987.

Gruber, Jonathan. "The Cost Implications of Health Care Reform." *New England Journal of Medicine* 362, no. 22 (2010): 2050-2051.

Gruber, Jonathan, and David Rodriguez. "How Much Uncompensated Care Do Doctors Provide?" *Journal of Health Economics* 26, no. 6 (2007): 1151-1169.

Grumbach, Kevin. "Insuring the Uninsured: Time to End the Aura of Invisibility." *Journal of the American Medical Association* 284, no. 16 (2000): 2114-2116.

Guagliardo, Mark F., Stephen J. Teach, Zhihuan J. Huang, James M. Chamberlain, and Jill G. Joseph. "Racial and Ethnic Disparities in Pediatric Appendicitis Rupture Rate." *Academic Emergency Medicine* 10, no. 11 (2003): 1218-1227.

Guggenheim, Ricardo. "Uncompenated Care Is a $31 Billion Problem Waiting to Be Solved." *HealthLeaders News*, September 26, 2008.

Guidry, Vernon A. "Probe Questions Propriety of VA Doctors' Outside Incomes." *Baltimore Sunday Sun*, September 19, 1982.

Gusmano, Michael , and Mark Schlesinger. "The Social Roles of Medicare: Assessing Medicare's Collateral Benefits." *Journal of Health Politics, Policy & Law* 26, no. 1 (2001): 37-79.

Gusmano, Michael K., Gerry Fairbrother, and Heidi Park. "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured." *Health Affairs* 21, no. 6 (2002): 188-194.

Hackbarth, Glenn. "Letter to CMS: Proposed Revisions to the Medicare Cost Report." August 27, (2009) http://www.medpac.gov/documents/Cost_report_comment_MedPAC_final%2010-27-09.pdf. Accessed March 14, 2013.

Hadley, Jack, and Peter Cunningham. "Availability of Safety Net Providers and Access to Care of Uninsured Persons." *Health Services Research* 39, no. 5 (2004): 1527-1546.

Hadley, Jack, John Holahan, Teresa Coughlin, and Dawn Miller. "Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage." August (2008), http://www.kff.org/uninsured/7809.cfm. Accessed March 14, 2013.

———. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs* 27, no. 5 (2008): w399-415.

Hafferty, Frederic W. "Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum." *Academic Medicine* 73, no. 4 (1998): 403-407.

Hall, Judith A., Arnold M. Epstein, Mary Lou DeCiantis, and Barbara J. McNeil. "Physicians' Liking for Their Patients: More Evidence for the Role of Affect in Medical Care." *Health Psychology* 12, no. 2 (1993): 140-146.

Hall, Kelin. "Free Clinics Benefit Future Physicians as Well as Patients." *Medicine on the Midway*, Summer (2011), http://www.uchospitals.edu/pdf/uch_027899.pdf. Accessed March 14, 2013.

Hall, Mark A. "The Factual Bases for Constitutional Challenges to Federal Health Insurance Reform." *Northern Kentucky Law Review* 38, no. 3 (2011): 457-508.

———. "The Impact and Enforcement of Prudent Layperson Laws." *Annals of Emergency Medicine* 43, no. 5 (2004): 558-566.

Hall, Mark A., and John D. Colombo. "The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption." *Washington Law Reveiw* 66 (1991): 307.

Hall, Mark A., and Sara Rosenbaum. *The Health Care "Safety Net" in a Post-Reform World*, Critical Issues in Health and Medicine. New Brunswick, NJ: Rutgers University Press, 2012.

Hall, Mark A., and Carl E. Schneider. "Learning from the Legal History of Billing for Medical Fees." *Journal of General Internal Medicine* 23, no. 8 (2008): 1257-1260.

Hamowy, Ronald. "Medical Responsibility." *Journal of Law, Medicine & Ethics* 40, no. 3 (2012): 532-536.

Handel, Daniel A., Joshua A. Hilton, Michael J. Ward, Elaine Rabin, Frank L. Zwemer, Jr., and Jesse M. Pines. "Emergency Department Throughput, Crowding, and Financial Outcomes for Hospitals." *Academic Emergency Medicine* 17, no. 8 (2010): 840-847.

Hanft, Ruth S. "The Impact of Changes in Federal Policy on Academic Health Centers." *Health Affairs* 1, no. 4 (1982): 67-82.

Hardingham, Lorraine B. "Integrity and Moral Residue: Nurses as Participants in a Moral Community." *Nursing Philosophy* 5, no. 2 (2004): 127-134.

Harris County Hospital District. "Harris County Hospital District: History." http://www.hchdonline.com/about/history.htm. Accessed March 17, 2012.

Hartsuch, David L. "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789-1790.

Hasnain-Wynia, Romana. "Overview of the Community Care Network Demonstration Program and Its Evaluation." *Medical Care Research and Review* 60, no. 4 Suppl (2003): 5S-16S.

Hawes, Kelly. "Clinic Provides Health Care for the Uninsured." *Galveston County Daily News*, May 4, 2006.

Hawkins, Dan, and DaShawn Groves. "The Future Role of Community Health Centers in a Changing Health Care Landscape." *Journal of Ambulatory Care Management* 34, no. 1 (2011): 90-99.

Health Council of South Florida Ethics Committee. "Preserving the Health Care Safety Net." Miami, FL: Health Council of South Florida, 2012.

Health Management Associates. "Long Range Planning Isssues for the Dalllas County Hospital District." Chicago, IL, 2004.

Health Resources and Services Administration. "HRSA Announces $40 Million in CAP Grants." (2001), http://archive.hrsa.gov/newsroom/releases/2001%20Releases/CAP.htm. Accessed March 14, 2013.

Healthcare Financial Management Association. "P&P Board Sample 501(C)(3) Hospital Charity Care Policy and Procedures." (2010), http://www.hfma.org/FinancialAssistancePolicy/. Accessed March 14, 2013.

———. "Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers." *Healthcare Financial Management* 2007, January (2006): 94-103.

Hearne, Jean. "CRS Report for Congress: Medicaid Disproportionate Share Payments." Washington, DC: Congressional Reseach Service, 2005.

Hellinger, Fred Joseph. "Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements." *Journal of Health Politics, Policy & Law* 34, no. 1 (2009): 37-61.

Henderson, Gary. "The Impact of National Health Insurance on the Public Hospital." *Health Care Management Review* 9, no. 4 (1984): 55-65.

Henderson, Tim M. "Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey." American Association of Medical Colleges, https://members.aamc.org/eweb/upload/Medicaid%20Direct_Indirect%20GME%20Payments%20Survey%202010.pdf Accessed March 14, 2013.

Henriksen, Kerm, and Elizabeth Dayton. "Organizational Silence and Hidden Threats to Patient Safety." *Health Services Research* 41, no. 4, Part 2 (2006): 1539-1554.

Henze, Howard. "Refusal of Care: The Ethical Dilemma." *Annals of Emergency Medicine* 19, no. 10 (1990): 1198.

Hermer, Laura D. "Medicaid, Low Income Pools, and the Goals of Privatization." *Georgetown Journal on Poverty Law and Policy* XVII, no. 3 (2010): 405-422.

———. "Personal Responsibility: A Plausible Social Goal, but Not for Medicaid Reform." *Hastings Center Report* 38, no. 3 (2008): 16-19.

———. "The Scapegoat: EMTALA and Emergency Department Overcrowding." *Journal of Law and Policy* 14, no. 2 (2006): 695-733.

Herz, Elicia J. "Medicaid: A Primer." Washington, DC: Congressional Research Service, 2010.

Herz, Elicia J., and Sibyl Tilson. "CRS Report for Congress: Medicaid and Graduate Medical Education." Washington, DC: Congressional Research Service, 2008.

Heubeck, Elizabeth. "Doctors Do Good." *Unique Opportunities: The Physician's Resource* (2002): 40-49.

Higginbotham, Elizabeth L. "Patient-Dumping Cases Still Pose a Problem." *RN* 62, no. 6 (1999): 63-65.

Hilfiker, David. "The Limits of Charity." *The Other Side* 36, no. 4 (2000).

———. "Unconscious on a Corner." *Journal of the American Medical Association* 258, no. 21 (1987): 3155-3156.

Hill, Terry E. "How Clinicians Make (or Avoid) Moral Judgments of Patients: Implications of the Evidence for Relationships and Research." *Philosophy, Ethics, and Humanities in Medicine* 5 (2010): 11-14.

Hillis, Thomas J. "The Hospital Governor and His Staff." *Medical News* 77 (1900).

Hilman, Judi. "Utah's Primary Care Network: States Can Do Better." *Virtual Mentor* 7, no. 7 (2005).

Himmelstein, David U., Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine* 122, no. 8 (2009): 741-746.

Himmelstein, David U., and Steffie Woolhandler. "Care Denied: US Residents Who Are Unable to Obtain Needed Medical Services." *American Journal of Public Health* 85, no. 3 (1995): 341-344.

Himmelstein, David U., Steffie Woolhandler, Martha Harnly, Michael B. Bader, Ralph Silber, Howard D. Backer, and Alice A. Jones. "Patient Transfers: Medical Practice as Social Triage." *American Journal of Public Health* 74, no. 5 (1984): 494-497.

Ho, P. Michael, Chris L. Bryson, and John S. Rumsfeld. "Medication Adherence: Its Importance in Cardiovascular Outcomes." *Circulation* 119, no. 23 (2009): 3028-3035.

Hoadley, John F., Laurie E. Felland, and Andrea B. Staiti. "Federal Aid Strengthens Health Care Safety Net: The Strong Get Stronger." *Issue Brief Center for Studying Health System Change*, no. 80 (2004), http://hschange.org/CONTENT/669/669.pdf. Accessed March 14, 2013.

Hobson, Wendy L., Roberto Avant-Mier, Susan Cochella, Sonja Van Hala, Joseph Stanford, Stephen C. Alder, and Sarah E. Croskell. "Caring for the Underserved: Using Patient and Physician Focus Groups to Inform Curriculum Development." *Ambulatory Pediatrics* 5, no. 2 (2005): 90-95.

Hoeger, Thomas J., and Teresa M. waters. "Problems in Determining a Hospital's Level of Uncompensated Care." Nashville, TN: Health Care Financing Administration, 1993.

Hoffman, Beatrix. "Emergency Rooms: The Reluctant Safety Net." In *History and Health Policy in the United States: Putting the Past Back In*, edited by Rosemary Stevens, Charles Rosenberg and Lawton R. Burns, 250-272. New Brunswick, NJ: Rutgers University Press, 2006.

Hoffman, Beatrix Rebecca. *Health Care for Some: Rights and Rationing in the United States since 1930*. Chicago, IL: University of Chicago Press, 2012.

Hoffman, Lilly. "Housestaff Activism: The Emergence of Patient Care Demands." *Journal of Health Politics, Policy & Law* 7, no. 2 (1982): 421-439.

Hoffman, Lily M. *The Politics of Knowledge : Activist Movements in Medicine and Planning*, Suny Series in the Sociology of Work. Albany, NY: State University of New York Press, 1989.

Hofstra, P. S. "Medicare Reimbursement for Hill-Burton Uncompensated Care Still Controversial." *Health Law Vigil* 5, no. 3 (1982): 3-5.

Holahan, John, and Bowen Garrett. "The Cost of Uncompensated Care with and without Health Care Reform." March (2010), http://www.urban.org/publications/412045.html. Accessed March 14, 2013.

Holahan, John, and Jack Hadley. "Health Reform and 'Cost Shifting'" (2011), http://www.urban.org/publications/901419.html. Accessed March 14, 2013.

Holloway, Karla F. "Accidental Communities: Race, Emergency Medicine, and the Problem of Polyheme." *American Journal of Bioethics* 6, no. 3 (2006): 7-17.

Horwitz, Jill R. "Making Profits and Providing Care: Comparing Nonprofit, for-Profit, and Government Hospitals." *Health Affairs* 24, no. 3 (2005): 790-801.

Hospital Corporation of America. "HCA Facts." (2012), http://hcahealthcare.com/util/documents/HCAFactSheet2012.pdf. Accessed March 14, 2013.

Hospital Financial Assistance Law. New York Public Health Law. 2006.

Hospital Survey and Construction Act of 1946. Public Law 79-725.

House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations. *A Review of Hospital Billing and Collections Practices*, 108th Congress, 2nd sess., June 24, 2004.

House Committee on Ways and Means. *Testimony of Mark Everson, IRS Commissioner: A Review of the Tax-Exempt Health Care Sector*, 109th Congress, 1st sess., May 26, 2005.

———. *A Review of the Tax-Exempt Health Care Sector*, 109th Congress, 1st sess., May 26, 2005.

Hsia, Renee Y., Jia Chan, and Laurence C. Baker. "Do Mandates Requiring Insurers to Pay for Emergency Care Influence the Use of the Emergency Department?" *Health Affairs* 25, no. 4 (2006): 1086-1094.

Hsia, Renee Y., Donna MacIsaac, and Laurence C. Baker. "Decreasing Reimbursements for Outpatient Emergency Department Visits Acrosss Payer Groups from 1996 to 2004." *Annals of Emergency Medicine* 51, no. 3 (2008): 265-274.

Hsia, Renee Y., Donna MacIsaac, Erin Palm, and Laurence C. Baker. "Trends in Charges and Payments for Nonhospitalized Emergency Department Pedicatric Visits, 1996-2003." *Academic Emergency Medicine* 15, no. 4 (2008): 347-354.

Hudson, Robert P. "Abraham Flexner in Perspective: American Medical Education, 1865-1910." In *Sickness and Health in America: Readings in the History of Medicine and Public Health*, edited by Judith Walzer Leavitt and Ronald L. Numbers, 200-210. Madison, WI: University of Wisconsin Press, 1997.

Hurst, Mary. "Samaritan Clinic's Patients Declare Medical Service Is Invaluable." *Florida Times Union*, April 26, 2006, 5.

Hylton, Maria O'Brien. "The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma." *Brigham Young University Law Review* 1992, no. 4 (1992): 971-1033.

Hyman, David A. "The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals." *American Journal of Law and Medicine* 16, no. 3 (1991): 327-380.

———. "Lies, Damned Lies, and Narrative." *Indiana Law Journal* 73 (1998): 797-865.

Hyman, David A., and William M. Sage. "Subsidizing Health Care Providers through the Tax Code: Status or Conduct?" *Health Affairs* 25, no. 4 (2006): W312-315.

Iglehart, John K. "The American Health Care System--Medicaid." *New England Journal of Medicine* 328, no. 12 (1993): 896-900.

———. "Early Experience with Prospective Payment of Hospitals." *New England Journal of Medicine* 314, no. 22 (1986): 1460-1464.

———. "Federal Directions in Health Care Policy." *Journal of Health Politics Policy and Law* 5, no. 4 (1981): 776-781.

———. "Forum on the Future of Academic Medicine: Session II--Finances and Culture." *Academic Medicine* 72, no. 9 (1997): 754-759.

———. "Health Centers Fill Critical Gap, Enjoy Support." *Health Affairs* 29, no. 3 (2010): 343-345.

———. "Health Reform, Primary Care, and Graduate Medical Education." *New England Journal of Medicine* 363, no. 6 (2010): 584-590.

———. "Medical Care of the Poor--a Growing Problem." *New England Journal of Medicine* 313, no. 1 (1985): 59-63.

———. "Medicare Begins Prospective Payment of Hospitals." *New England Journal of Medicine* 308, no. 23 (1983): 1428-1432.

———. "Medicare, Graduate Medical Education, and New Policy Directions." *New England Journal of Medicine* 359, no. 6 (2008): 643-650.

———. "New Jersey's Experiment with DRG-Based Hospital Reimbursement." *New England Journal of Medicine* 307, no. 26 (1982): 1655-1660.

Ignatieff, Michael. *The Needs of Strangers*. New York, NY: Picador USA, 2001.

Illinois Hospital Association. "Response of the Illinois Hospital Association and the Metropolitan Chicago Healthcare Council to CTBA Charity Care Report " (2009), http://www.ihatoday.org/uploadDocs/1/ctbareportresponse.pdf. Accessed March 14, 2013.

Imperato, Pascal James. "Letter to the Editor: Accountability and House Staff." *Annals of Internal Medicine* 100, no. 3 (1984): 456-457.

Institute for Safe Medication Practices. "Intimidation: Practitioners Speak up About This Unresolved Problem: Part 1." (2004), https://ismp.org/Newsletters/acutecare/articles/20040311_2.asp. Accessed March 14, 2013.

Institute of Medicine. "Medicare--Medicaid Reimbusement Policies: Effects on Teaching Hospitals, Physician Distribution, and Foreign Medical Graduates." In *Social Security Studies, Interim Report*. Washington, DC: Institute of Medicine, 1975.

Institute of Medicine Committee on Health Insurance Status and Its Consequences. *America's Uninsured Crisis: Consequences for Health and Health Care*. Washington, DC: National Academies Press, 2009.

Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press, 2001.

Institute of Medicine Committee on the Consequences of Uninsurance. *A Shared Destiny: Community Effects of Uninsurance*. Washington, DC: National Academies Press, 2003.

Institute of Medicine Committee on the Future of Emergency Care in the United States Health System. *Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: National Academies Press, 2007.

Institute of Medicine Committee on Using Performance Monitoring to Improve Community Health. *Improving Health in the Community: A Role for Performance Monitoring*. Washington, DC: National Academies Press, 1997.

Internal Revenue Service. "2009 Instructions for Schedule H (Form 990)." (2010), http://www.irs.gov/pub/irs-prior/i990sh--2009.pdf. Accessed March 14, 2013.

———. "2011 Instructions for Schedule H (Form 990)." (2011), http://www.irs.gov/pub/irs-pdf/i990sh.pdf. Accessed March 14, 2013.

———. "2011 Instructions for Schedule H (Form 990)." (2012), http://www.irs.gov/pub/irs-pdf/i990sh.pdf. Accessed March 14, 2013.

———. "Additional Requirements for Charitable Hospitals." (2012), http://www.irs.gov/pub/irs-drop/reg-130266-11.pdf. Accessed March 14, 2013.

———. "IRS Exempt Organizations Hospital Compliance Project Final Report." (2009), http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html. Accessed March 14, 2013.

———. "IRS Releases Discussion Draft of Redesigned Form 990 for Tax-Exempt Organizations." (2007), http://www.irs.gov/newsroom/article/0,,id=171329,00.html. Accessed March 14, 2013.

———. "Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals." *Compliance and Enforcement*, July 25, (2011), http://www.irs.gov/irb/2011-30_IRB/ar08.html. Accessed March 14, 2013.

———. "Revenue Ruling 56-185." (1956), http://www.irs.gov/pub/irs-tege/rr56-185.pdf. Accessed March 14, 2013.

———. "Revenue Ruling 69-545." (1969), http://www.irs.gov/pub/irs-tege/rr69-545.pdf. Accessed March 14, 2013.

———. "Revenue Ruling 83-157." (1983), http://www.irs.gov/pub/irs-tege/rr83-157.pdf. Accessed March 14, 2013.

Isaacs, Stephen L., and Paul Jellinek. "Is There a (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States." *Health Affairs* 26, no. 3 (2007): 871-876.

———. "Volunteer Health Care Programs: A Report to the W.K. Kellogg Foundation." (2006), http://www.wkkf.org/knowledge-center/resources/2007/05/Volunteer-Health-Care-Programs.aspx. Accessed March 14, 2013.

Iserson, Kenneth V. "Assessing Values: Rationing Emergency Department Care." *American Journal of Emergency Medicine* 10, no. 3 (1992): 263-264.

———. "Refusal of Care: The Ethical Dilemma." *Annals of Emergency Medicine* 19, no. 10 (1990): 1197.

Jackson, George L., Benjamin J. Powers, Ranee Chatterjee, Janet Prvu Bettger, Alex R. Kemper, Vic Hasselblad, Rowena J. Dolor, R. Julian Irvine, Brooke L. Heidenfelder, Amy S. Kendrick, Rebecca Gray, and Jr John W. Williams. "The Patient-Centered Medical Home: A Systematic Review." *Annals of Internal Medicine* 158, no. 3 (2012): 169-178.

Jacobs, Lawrence R., and Theda Skocpol. *Health Care Reform and American Politics: What Everyone Needs to Know*. New York, NY: Oxford University Press, 2010.

Jacobson, Peter D., Vanessa Dalton, Julie Berson-Grand, and Carol S. Weisman. "Survival Strategies for Michigan's Health Care Safety Net Providers: Report to the Blue Cross Blue Shield of Michigan Foundation." 2003.

Jacobson, Peter D., Vanessa K. Dalton, Julie Berson-Grand, and Carol S. Weisman. "Survival Strategies for Michigan's Health Care Safety Net Providers." *Health Services Research* 40, no. 3 (2005): 923-940.

Jacobson, Peter D., Valerie Myers, Judith G. Calhoun, and Jodyn E. Platt. "Examining the Structure and Sustainability of Health Care Safety Net Services." In *The Health Care Safety Net in a Post-Reform World*, edited by Sara Rosenbaum and Mark A. Hall. New Brunswick, NJ: Rutgers University Press, 2012.

Jacoby, Melissa B., and Elizabeth Warren. "Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress." *Northwestern University Law Review* 100, no. 2 (2006): 535-584.

Jain, Manoj. "Equal Treatment for the Uninsured? Don't Count on It." *Washington Post*, October 14, 2008.

James, Rebecca. "Free Clinics Quietly Fill Gap in Health "Safety Net:" Professionals Volunteer to Help the Many Uninsured People in Ithaca, Syracuse." *Post-Standard*, June 10, 2006.

Jameson, Wendy J., Katherine Pierce, and Denise K. Martin. "California's County Hospitals and the University of California Graduate Medical Education System. Current Issues and Future Directions." *Western Journal of Medicine* 168, no. 5 (1998): 303-310.

Japsen, Bruce. "ER Doctors Condemn University of Chicago Plan to Divert Patients." *Chicago Tribune*, February 20, 2009.

Japsen, Bruce, and Jason Grotto. "Burden Higher for Nonprofit Hospitals, Illinois Supreme Court Says." *Chicago Tribune*, March 19, 2010.

Jauhar, Sandeep. *Intern: A Doctor's Initiation*. New York, NY: Farrar, Straus and Giroux, 2008.

Jeffery, J. D. "Thoughts on the Poor-Law, with Reference to the Medical Care of the Poor." *Provincial Medical and Surgical Journal (1840-1842)* 3, no. 27 (1842): 535-536.

Johnson, Kirk, and Reed Abelson. "Model in Utah May Be Future for Medicaid." *New York Times*, February 24, 2005.

Johnson, Nancy J., and Lane P. Johnson. *The Care of the Uninsured in America*. New York, NY: Springer, 2009.

Joint Commission. "Behaviors That Undermine a Culture of Safety." no. 40 (2008), http://www.jointcommission.org/assets/1/18/SEA_40.PDF. Accessed March 14, 2013.

Joint Committee on Taxation. "Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals." Washington, DC: U.S. Congress, 2006.

Jones, Camara Phyllis. "Levels of Racism: A Theoretic Framework and a Gardener's Tale." *American Journal of Public Health* 90, no. 8 (2000): 1212-1215.

Jones, Frank E. "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789.

Jones, Robert F., and Susan C. Sanderson. "Clinical Revenues Used to Support the Academic Mission of Medical Schools, 1992-93." *Academic Medicine* 71, no. 3 (1996): 299-307.

Jonsen, Albert R. *A Short History of Medical Ethics*. New York, NY: Oxford University Press, 2000.

Jonsen, Albert R., Mark Siegler, and William J. Winslade. *Clinical Ethics : A Practical Approach to Ethical Decisions in Clinical Medicine*. 7th ed. New York, NY: McGraw-Hill Medical, 2010.

Jost, Timothy S. *Disentitlement?: The Threats Facing Our Public Health-Care Programs and a Rights-Based Response*. Oxford, NY: Oxford University Press 2003.

———. "The Tenuous Nature of the Medicaid Entitlement." *Health Affairs* 22, no. 1 (2003): 145-153.

Jost, Timothy Stoltzfus. "The Affordable Care Act Largely Survives the Supreme Court’s Scrutiny—but Barely." *Health Affairs* 31, no. 8 (2012): 1659-1662.

Kahntroff, Jeffrey, and Rochelle Watson. "Refusal of Emergency Care and Patient Dumping." *Virtual Mentor*,no. January (2009), http://virtualmentor.ama-assn.org/2009/01/hlaw1-0901.html. Accessed March 14, 2013.

Kaiser Commission on Medicaid and the Uninsured. "California and Texas: Section 1115 Medicaid Demonstration Waivers Compared." (2011), http://www.kff.org/medicaid/upload/8266.pdf. Accessed March 14, 2013.

———. "Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities." March (2012), http://www.kff.org/uninsured/upload/8098-02.pdf. Accessed March 14, 2013.

———. "Medicaid Financing Issues: Provider Taxes." (2011), http://www.kff.org/medicaid/upload/8193.pdf. Accessed March 14, 2013.

———. "Medicaid Matters: Understanding Medicaid's Role in Our Health Care System." (2011), http://www.kff.org/medicaid/8165.cfm. Accessed March 14, 2013.

———. "Medicaid: A Primer: Key Information on Our Nation’s Health Coverage Program for Low-Income People." June (2010), http://www.kff.org/medicaid/upload/7334-04.pdf. Accessed March 14, 2013.

———. "Overview of the Utah Section 1115 Waiver." (2004), http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14329. Accessed March 14, 2013.

———. "Uninsured: A Primer." (2011), http://www.kff.org/uninsured/7451.cfm. Accessed March 14, 2013.

———. "The Uninsured: A Primer." (2010), http://www.kff.org/uninsured/7451.cfm. Accessed March 14, 2013.

———. "Uninsured: A Primer." Menlo Park, CA: Kaiser Family Foundation, 2009.

Kaiser Family Foundation. "A Guide to the Supreme Court’s Affordable Care Act Decision." July (2012), http://www.kff.org/healthreform/upload/8332.pdf. Accessed March 14, 2013.

———. "Medicare: A Primer." (2010), http://www.kff.org/medicare/upload/7615-03.pdf. Accessed March 14, 2013.

———. "National Survey on the Public's Views About Medicaid, 2005." (2005), http://www.kff.org/medicaid/kcmu062905nr.cfm. Accessed March 14, 2013.

Kaiser Permanente. "Kaiser Permanente & Operation Access: Restoring Health & Dignity through Skilled Volunteerism." (2009), http://www.pointsoflight.org/sites/default/files/site-content/files/skillsbasedvolunteeringkaiser_fv.pdf. Accessed March 14, 2013.

Kalvemark, Sofia, Anna T. Hoglund, M.ats G. Hansson, Peter Westerholm, and Bengt Arnetz. "Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System." *Social Science & Medicine* 58, no. 6 (2004): 1075-1084.

Kane, Carol K. "Physician Marketplace Report: The Impact of EMTALA on Physician Practices." (2003), http://www.ama-assn.org/resources/doc/health-policy/pmr2003-02.pdf. Accessed March 14, 2013.

Kane, Nancy M. "Statement to the United States Senate Committee on Finance: Taking the Pulse of Charitable Care and Community Benefit at Nonprofit Hospitals." (2006), http://www.finance.senate.gov/imo/media/doc/091306nktest.pdf. Accessed March 14, 2013.

———. "Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?" *Saint Louis University Law Journal* 51 (2007): 459-473.

Kane, Nancy M., and Stephen A. Magnus. "The Medicare Cost Report and the Limits of Hospital Accountability: Improving Financial Accounting Data." *Journal of Health Politics, Policy & Law* 26, no. 1 (2001): 81-105.

Kane, Nancy M., and William H. Wubbenhorst. "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption." *Milbank Quarterly* 78, no. 2 (2000): 185-212.

Karve, Sudeep J., Rajesh Balkrishnan, Yousef M. Mohammad, and Deborah A. Levine. "Racial/Ethnic Disparities in Emergency Department Waiting Time for Stroke Patients in the United States." *Journal of Stroke and Cerebrovascular Diseases* 20, no. 1 (2011): 30-40.

Kassirer, Jerome P. "Managed Care and the Morality of the Marketplace." *New England Journal of Medicine* 333, no. 1 (1995): 50-52.

Katz, Aaron, Amelia M. Bond, Emily R. Carrier, Elizabeth Docteur, Caroleen Quach, and Tracy Yee. "Cleveland Hospital Systems Expand Despite Weak Economy." In *Community Report*, 1-10: Center for Studying Health System Change, 2010.

Katz, Aaron, Laurie Felland, Ian Hill, and Lucy B. Stark. "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects under Reform." (2011), http://www.hschange.com/CONTENT/1257/. Accessed March 14, 2013.

Katz, Michael B. *In the Shadow of the Poorhouse: A Social History of Welfare in America*. New York: BasicBooks, 1996.

———. *The Price of Citizenship: Redefining the American Welfare State*. 1st ed. New York, NY: Metropolitan Books, 2001.

Katz, Mitchell H. "Future of the Safety Net under Health Reform." *Journal of the American Medical Association* 304, no. 6 (2010): 679-680.

Kaufman, Jeffrey L. "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1789.

Kaufman, Martin. "American Medical Education." In *The Education of American Physicians: Historical Essays*, edited by Ronald L. Numbers, 7-28. Berkely, CA: University of California Press, 1980.

Keenan, Joseph P. "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 269, no. 14 (1993): 1790.

Keirns, Carla C., and Charles L. Bosk. "Perspective: The Unintended Consequences of Training Residents in Dysfunctional Outpatient Settings." *Academic Medicine* 83, no. 5 (2008): 498-502.

Keis, Rachel Mott, Linda Gifford DeGeus, Suzanne Cashman, and Judith Savageau. "Characteristics of Patients at Three Free Clinics." *Journal of Health Care for the Poor and Underserved* 15, no. 4 (2004): 603-617.

Kelleher, Kevin C. "Free Clinics. A Solution That Can Work ... Now!" *Journal of the American Medical Association* 266, no. 6 (1991): 838-840.

Kellermann, A. L. "Deferred Care for Emergency Department Users with Nonacute Conditions; Letters." *Annals of Internal Medicine* 139, no. 6 (2003): 526-528.

Kellermann, Arthur L. "Calculating the Cost of Emergency Care." *Annals of Emergency Medicine* 45, no. 5 (2005): 491-492.

———. "Crisis in the Emergency Department." *New England Journal of Medicine* 355, no. 13 (2006): 1300-1303.

Kellermann, Arthur L., and Ricardo Martinez. "The ER, 50 Years On." *New England Journal of Medicine* 364, no. 24 (2011): 2278-2279.

Kellermann, Athur L., and Bela B. Hackman. "Patient 'Dumping' Post-Cobra." *American Journal of Public Health* 80, no. 7 (1990): 864-867.

Kelley, Joyce V. "Provision of Charity Care by Urban Voluntary Hospitals." In *Hospitals and the Uninsured Poor: Measuring and Paying for Uncompensated Care*, edited by Sally J. Rogers, Ann Marir Rousseau and Susan W. Nesbitt, 49-69. New York, NY: United Hospital Fund of New York, 1985.

Kelley, Thomas. "Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law." *Fordham Law Review* 73, no. 6 (2005): 2437-2499.

Kennedy, Jae, Karin Rhodes, Craig A. Walls, and Brent R. Asplin. "Access to Emergency Care: Restricted by Long Waiting Times and Cost and Coverage Concerns." *Annals of Emergency Medicine* 43, no. 5 (2004): 567-573.

Kennedy, Tara J., Glenn Regehr, G. Ross Baker, and Lorelei A. Lingard. "Progressive Independence in Clinical Training: A Tradition Worth Defending?" *Academic Medicine* 80, no. 10 Suppl (2005): S106-111.

Kerr, Harry D., and James C. Byrd. "Community Hospital Transfers to a VA Medical Center." *Journal of the American Medical Association* 262, no. 1 (1989): 70-73.

Ketsche, Patricia, E. Kathleen Adams, Sally Wallace, Viji Diane Kannan, and Harini Kannan. "Lower-Income Families Pay a Higher Share of Income toward National Health Care Spending Than Higher-Income Families Do." *Health Affairs* 30, no. 9 (2011): 1637-1646.

Kilbane, Kathleen, and Beth Blacksin. "The Demise of Free Care: The Visiting Nurse Association of Chicago." In *Readings in American Health Care: Current Issues in Socio-Historical Perspective*, edited by William G. Rothstein, 359-363. Madison, WI: University of Wisconsin Press, 1995.

Kilgore, David B. "A Piece of My Mind. The Imaginary Safety Net." *Journal of the American Medical Association* 296, no. 14 (2006): 1701-1702.

Kilpatrick, Kerry E., Michael K. Miller, Jeffrey W. Dwyer, and Dan Nissen. "Uncompensated Care Provided by Private Practice Physicians in Florida." *Health Services Research* 26, no. 3 (1991): 277-302.

Kleinke, J. D. "Deconstructing the Columbia/HCA Investigation." *Health Affairs* 17, no. 2 (1998): 7-26.

Kleinman, Lawrence C. "Health Care in Crisis. A Proposed Role for the Individual Physician as Advocate." *Journal of the American Medical Association* 265, no. 15 (1991): 1991-1992.

Klem, Margaret C. "Voluntary Health Insurance on the National Scene: The Present Status of Voluntary Health Insurance." *American Journal of Public Health* 40, no. 3 (1950): 260-267.

Kliff, Sarah. "High Uninsured Rates Can Kill You — Even If You Have Coverage " *Washington Post*, May 7, 2012.

Knapp, Richard M., and Peter W. Butler. "Financing Graduate Medical Education." *New England Journal of Medicine* 301, no. 14 (1979): 749-755.

Knowles, John H. "Medical Care: Its Social and Organizational Aspects. The Balanced Biology of the Teaching Hospital." *New England Journal of Medicine* 269, no. 24 (1963): 401-406.

———. "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part III. Chapter 8. Medical School, Teaching Hospital, and Social Responsibility." *Journal of Medical Education* 40, no. 11 (1965): 167-196.

Koenig, Lane, Allen Dobson, Silver Ho, Jonathon M. Siegel, David Blumenthal, and Joel S. Weissman. "Estimating the Mission-Related Costs of Teaching Hospitals." *Health Affairs* 22, no. 6 (2003): 112-122.

Kofke, W. Andrew, and Michael A. Rie. "Research Ethics and Law of Healthcare System Quality Improvement: The Conflict of Cost Containment and Quality." *Critical Care Medicine* 31, no. 3 Suppl (2003): S143-152.

Kohlberg, Kenneth R. "Modern Reflections on Charitable Immunity." *Massachusetts Law Review* 89, no. 4 (2006): 163-170.

Kolata, Gina. "Medical Fees Are Often Higher for Patients without Insurance." *New York Times*, April 2, 2001.

Koska, Mary T. "States, Hospitals Aim to Cut Costly ED Visits." *Hospitals* 62, no. 23 (1988): 60.

Koziol-McLain, Jane, David W. Price, Barbara Weiss, Agatha A. Quinn, and Benjamin Honigman. "Seeking Care for Nonurgent Medical Conditions in the Emergency Department: Through the Eyes of the Patient." *Journal of Emergency Nursing* 26, no. 6 (2000): 554-563.

Kraft, Scott. "Chains' Role Debated: Hospitals for Profit: What Price Care?" *Los Angeles Times*, March 31, 1985.

Krane, N. Kevin, Richard P. DiCarlo, and Marc J. Kahn. "Medical Education in Post-Katrina New Orleans: A Story of Survival and Renewal." *Journal of the American Medical Association* 298, no. 9 (2007): 1052-1055.

Kronebusch, Karl. "Medicaid and the Politics of Groups: Recipients, Providers, and Policy Making." *Journal of Health Politics, Policy and Law* 22, no. 3 (1997): 839-878.

Krugman, Paul. "A Tale of Two Moralities." *New York Times*, January 13, 2011.

———. "The Waiting Game." *New York Times*, July 16, 2007.

Ku, Leighton. "Charging the Poor More for Health Care: Cost-Sharing in Medicaid." Washington, DC: Center on Budget and Policy Priorities, 2003.

Ku, Leighton , Elaine Deschamps, and Judi Hilman. "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program." (2004), http://www.cbpp.org/files/11-2-04health.pdf. Accessed March 14, 2013.

Ku, Leighton, and Teresa A. Coughlin. "Medicaid Disproportionate Share and Other Special Financing Programs." *Health Care Financing Review* 16, no. 3 (1995): 27-54.

Kumagai, Arno K., and Monica L. Lypson. "Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education." *Academic Medicine* 84, no. 6 (2009): 782-787.

Kusserow, Richard P. "Patient Dumping after Cobra: Assessing the Incidence and the Perspectives of Health Care Professionals." Washington, DC: U.S. Department of Health and Human Services Response to Complaints, 1988.

LaCalle, Eduardo, and Elaine Rabin. "Frequent Users of Emergency Departments: The Myths, the Data, and the Policy Implications." *Annals of Emergency Medicine* 56, no. 1 (2010): 42-48.

Lagnado, Lucette. "Call It Yale v. Yale." *Wall Street Journal*, November 14, 2003.

———. "Full Price: A Young Woman, an Appendectomy, and a $19,000 Debt " *Wall Street Journal*, March 17, 2003.

———. "HHS Chief Scolds Hospitals for Treatment of Uninsured." *Wall Street Journal*, February 20, 2004.

———. "Hospitals Urged to End Harsh Tactics for Billing Uninsured." *Wall Street Journal*, July 7, 2003.

———. "Medical Seizures: Hospitals Try Extreme Measures to Collect Their Overdue Debts." *Wall Street Journal*, October 30, 2003.

———. "Twenty Years and Still Paying: Jeanette White Is Long Dead but Her Hospital Bill Lives On." *Wall Street Journal*, March 13, 2003.

Lale, Allison, Rachael Moloney, and G. Caleb Alexander. "Academic Medical Centers and Underserved Communities: Modern Complexities of an Enduring Relationship." *Journal of the National Medical Association* 102, no. 7 (2010): 605-613.

Larkin, Gregory L., Catherine A. Marco, and Wesley Fields. "Managed Care, Charity Care, and the Common Good." *Journal of the American Medical Association* 282, no. 17 (1999): 1619-1620.

Larson, Eric B. "Deferred Care for Patients in the Emergency Department." *Annals of Internal Medicine* 137, no. 9 (2002): 764-765.

Lee, Tiana Mayere. "An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement " *Annals of Health Law* 13, no. 1 (2004): 145-178.

Lefkowitz, Bonnie. *Community Health Centers: A Movement and the People Who Made It Happen*, Critical Issues in Health and Medicine. New Brunswick, NJ: Rutgers University Press, 2007.

Lehmann, Lisa S., Frederick L. Brancati, Min-Chi Chen, Debra L. Roter, and Adrian S. Dobs. "The Effect of Bedside Case Presentations on Patients' Perceptions of Their Medical Care." *New England Journal of Medicine* 336, no. 16 (1997): 1150-1155.

Lenhart, Jennifer. "A Weekly Dose of Healing." *Washington Post*, February 27, 2000.

Lenihan, Merle. "Clearing the Fog: Achieving Reasonable Public Disclosure of Available Free and Reduced Cost Health Care in Galveston County, Texas." (2009), http://www.communitycatalyst.org/doc_store/publications/Clearing_the_Fog.pdf. Accessed March 14, 2013.

Leone, Andrew J., and R. Lawrence Van Horn. "How Do Nonprofit Hospitals Manage Earnings?" *Journal of Health Economics* 24, no. 4 (2005): 815-837.

Lesser, Cara S., Paul B. Ginsburg, and Kelly J. Devers. "The End of an Era: What Became of the "Managed Care Revolution" in 2001?" *Health Services Research* 38, no. 1 Pt 2 (2003): 337-355.

Levere, Jane. "Helping out at Home." *Diversion* 32, no. 6 (2004).

Levine, Carol. "But Wait, Call Now and Get Two ER Appointments for Only $24.99." *Bioethics Forum Blog* (2011), http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=5488&blogid=140. Accessed March 14, 2013.

Lewin, Lawrence S., Timothy J. Eckels, and Linda B. Miller. "Setting the Record Straight. The Provision of Uncompensated Care by Not-for-Profit Hospitals." *New England Journal of Medicine* 318, no. 18 (1988): 1212-1215.

Lewin, Lawrence S., and Marion E. Lewin. "Financing Charity Care in an Era of Competition." *Health Affairs* 6, no. 1 (1987): 47-60.

Lewin, Marion E., and Raymond J. Baxter. "America's Health Care Safety Net: Revisiting the 2000 IOM Report." *Health Affairs* 26, no. 5 (2007): 1490-1494.

Lewin, Marion Ein, and Stuart Altman, eds. *America's Health Care Safety Net: Intact but Endangered*. Washington, DC: National Academies Press, 2000.

Lewis, Sarah E., Robert S. Nocon, Hui Tang, Seo Y. Park, Anusha M. Vable, Lawrence P. Casalino, Elbert S. Huang, Michael T. Quinn, Deborah L. Burnet, William T. Summerfelt, Jonathan M. Birnberg, and Marshall H. Chin. "Patient-Centered Medical Home Characteristics and Staff Morale in Safety Net Clinics." *Archives of Internal Medicine* 172, no. 1 (2012): 23-31.

Li, James, Hannah K. Galvin, and Sandra C. Johnson. "The "Prudent Layperson" Definition of an Emergency Medical Condition." *American Journal of Emergency Medicine* 20, no. 1 (2002): 10-13.

Liberman, Kate M., Yasmin S. Meah, Andrew Chow, Jeffrey Tornheim, Omayra Rolon, and David C. Thomas. "Quality of Mental Health Care at a Student-Run Clinic: Care for the Uninsured Exceeds That of Publicly and Privately Insured Populations." *Journal of Community Health* 36, no. 5 (2011): 733-740.

Lieberman, Richard. "Refusal of Care: The Ethical Dilemma." *Annals of Emergency Medicine* 19, no. 10 (1990): 1197-1198.

Lippard, Vernon W. *A Half-Century of American Medical Education, 1920-1970*, Josiah Macy, Jr., Foundation. Baltimore, MD: Port City Press, 1974.

Lo Sasso, Anthony T., and Dorian G. Seamster. "How Federal and State Policies Affected Hospital Uncompensated Care Provision in the 1990s." *Medical Care Research and Review* 64, no. 6 (2007): 731-744.

Loewy, Erich H. "Oaths for Physicians--Necessary Protection or Elaborate Hoax?" *MedGenMed* 9, no. 1 (2007), http://www.medscape.com/viewarticle/550118_1. Accessed March 14, 2013.

Loignon, Christine, Jeannie L. Haggerty, Martin Fortin, Christophe P. Bedos, Dawn Allen, and David Barbeau. "Physicians' Social Competence in the Provision of Care to Persons Living in Poverty: Research Protocol." *BMC Health Services Research* 10 (2010): 79 (71-77).

Lombardo, Paul A. "Phantom Tumors and Hysterical Women: Revising Our View of the Schloendorff Case." *Journal of Law Medicine and Ethics* 33, no. 4 (2005): 791-801.

Long Island Health Access Monitoring Project. "Hospital Community Benefits and Free Care Programs: An Initial Study of Seven Long Island Hospitals." Hicksville, NY, 2001.

Longo, Walter E., William Cheadle, Aaron Fink, Robert Kozol, Ralph DePalma, Robert Rege, Leigh Neumayer, John Tarpley, Margaret Tarpley, Ray Joehl, Thomas A. Miller, Douglas Rosendale, and Kamal Itani. "The Role of the Veterans Affairs Medical Centers in Patient Care, Surgical Education, Research and Faculty Development." *American Journal of Surgery* 190, no. 5 (2005): 662-675.

Lopez, Lenny, Andrew P. Wilper, Marina C. Cervantes, Joseph R. Betancourt, and Alexander R. Green. "Racial and Sex Differences in Emergency Department Triage Assessment and Test Ordering for Chest Pain, 1997-2006." *Academic Emergency Medicine* 17, no. 8 (2010): 801-808.

Lottoro, Bill, and Carol Pryor. "Voluntary Commitments: Have Hospitals That Signed a Confirmation of Commitment to the American Hospital Association's Billing and Collections Guidelines Really Changed Their Ways?" (2005), http://www.accessproject.org/new/pages/item75.php. Accessed March 14, 2013.

Louden, Kathleen. "Chicago Hospital to Halt New Emergency Department Policies after Criticism." *Medscape Medical News* (2009), http://www.medscape.com/viewarticle/589704?sssdmh=dm1.445141. Accessed March 14, 2013.

Lowe, Robert A., and Stephanie B. Abbuhl. "Referral out from the ED-Appropriate? Author Reply." *Academic Emergency Medicine* 3, no. 11 (1996): 1072-1073.

Lowe, Robert A., Andrew B. Bindman, Susan K. Ulrich, Gregg Norman, Thomas A. Scaletta, Dennis Keane, Donna Washington, and Kevin Grumbach. "Refusing Care to Emergency Department of Patients: Evaluation of Published Triage Guidelines." *Annals of Emergency Medicine* 23, no. 2 (1994): 286-293.

Lowe, Robert A., Sheetal Chhaya, Kathleen Nasci, Laurence J. Gavin, Kathy Shaw, Mark L. Zwanger, Joseph A. Zeccardi, William C. Dalsey, Stephanie B. Abbuhl, Harold Feldman, and Jesse A. Berlin. "Effect of Ethnicity on Denial of Authorization for

Emergency Department Care by Managed Care Gatekeepers." *Academic Emergency Medicine* 8, no. 3 (2001): 259-266.

Lowe, Robert A., K. John McConnell, and Stephanie B. Abbuhl. "Deferred Care for Emergency Department Users with Nonacute Conditions, Letter." *Annals of Internal Medicine* 139, no. 6 (2003): 526.

Lowenstein, Regina. "Early Effects of Medicare on the Health Care of the Aged." *Social Security Bulletin*, no. April (1971).

Lown, Beth A., Julie Rosen, and John Marttila. "An Agenda for Improving Compassionate Care: A Survey Shows About Half of Patients Say Such Care Is Missing." *Health Affairs* 30, no. 9 (2011): 1772-1778.

Luband, Charles. "Medicaid Supplemental Payments and Financing Issues." (2011), http://www.healthlawyers.org/Events/Programs/Materials/Documents/MM09/luband.pdf. Accessed March 14, 2013.

Lucas, Bennett. "Clinical Lectures Delivered at the Metropolitan Free Hospital, Lecture I." *Provincial Medical and Surgical Journal (1840-1842)* 5, no. 115 (1842): 216-219.

Ludmerer, Kenneth M. *Learning to Heal: The Development of American Medical Education*. New York, NY: Basic Books, 1985.

———. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York, NY: Oxford University Press, 1999.

Lundberg, George D., and Laurence Bodine. "Fifty Hours for the Poor." *Journal of the American Medical Association* 262, no. 21 (1989): 3045.

Lutz, Sandy. "Charity Care in Texas: Numbers Don't Tell the Story." *Modern Healthcare* 26, no. 19 (1996): 36, 38, 40-34.

Lutz, Sandy. "Indicators Point up for Hospitals' Cash Flow, Profits." *Modern Healthcare* June 10, (1996): 36.

Lynn, Joanne, Mary A. Baily, Melissa Bottrell, Bruce Jennings, Robert J. Levine, Frank Davidoff, David Casarett, Janet Corrigan, Ellen Fox, Matthew K. Wynia, George J. Agich, Margaret O'Kane, Theodore Speroff, Paul Schyve, Paul Batalden, Sean Tunis, Nancy Berlinger, Linda Cronenwett, J. Michael Fitzmaurice, Nancy N. Dubler, and Brent James. "The Ethics of Using Quality Improvement Methods in Health Care." *Annals of Internal Medicine* 146, no. 9 (2007): 666-673.

Lyon, Deborah S. "Medical Education and Indigent Patient Care." *Current Women's Health Report* 3 (2003): 501-504.

Maa, April, and Laurence B. McCullough. "Medical Education in the Public Versus the Private Setting: A Qualitative Study of Medical Students' Attitudes." *Medical Teacher* 28, no. 4 (2006): 351-355.

MacGillis, Alec. "What New Law?" *New Republic*, June 18, 2012, http://www.newrepublic.com/article/politics/104094/tennessee-health-care. Accessed March 14, 2013.

Madera, James L. "Costly ERs Are a Poor Tool for Community Health Care." *Wall Street Journal*, March 13, 2009.

Mainous, Arch G., and Richard Baker. "Service Learning Helps Sustain the Status Quo." *Family Medicine* 41, no. 9 (2009): 656-658.

Manian, Farrin A. "Physicians Vs Physicians." *Archives of Internal Medicine* 161, no. 6 (2001): 801-802.

Mann, Joyce M., Glenn A. Melnick, Anil Bamezai, and Jack Zwanziger. "A Profile of Uncompensated Hospital Care, 1983-1995." *Health Affairs* 16, no. 4 (1997): 223-232.

Mann, Joyce M., Glenn Melnick, Anil Bamezai, and Jack Zwanziger. "Uncompensated Care: Hospitals' Responses to Fiscal Pressures." *Health Affairs* 14, no. 1 (1995): 263-270.

Manning, Joe. "St. Joseph Hopes Fee Will Reduce Minor ER Visits." *Milwaukee Journal Sentinel*, October 24, 2003.

———. "State Tackles Emergency Room Misuse." *Milwaukee Journal Sentinel*, January 31, 2004.

Manoach, Seth M., and Lewis R. Goldfrank. "Social Bias and Injustice in the Current Health Care System." *Academic Emergency Medicine* 9, no. 3 (2002): 241-247.

Margalit, Avishai. *The Decent Society*. Cambridge, MA: Harvard University Press, 1996.

Mariner, Wendy K., Leonard H. Glantz, and George J. Annas. "Reframing Federalism — the Affordable Care Act (and Broccoli) in the Supreme Court." *New England Journal of Medicine* 367, no. 12 (2012): 1154-1158.

Martinez, Barbara. "Safety Net Frays as Hospitals Shift Resources from Poor." *Wall Street Journal* (2008), http://blogs.wsj.com/health/2008/08/12/safety-net-frays-as-hospitals-shift-resources-from-poor/. Accessed March 14, 2013.

Massachusetts General Hospital. "Journeys 2010: Massachusetts General Hospital Annual Report " Massachusetts General Hospital, http://www.mgh.harvard.edu/assets/pdf/AR2009lr.pdf. Accessed March 14, 2013.

Matherlee, Karen. "The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy." Washington, DC: National Health Policy Forum, 2000.

———. "Margins as Measures: Gauging Hospitals' Financial Health." Washington, DC: National Health Policy Forum, 1999.

Matter, Rebecca, Susan Kline, Karon F. Cook, and Dagmar Amtmann. "Measuring Pain in the Context of Homelessness." *Quality of Life Research* 18, no. 7 (2009): 863-872.

May, William F. "Code, Covenant, Contract, or Philanthropy." *Hastings Center Report* 5, no. 6 (1975): 29-38.

McAlearney, J. S. "The Financial Performance of Community Health Centers, 1996-1999." *Health Affairs* 21, no. 2 (2002): 219-225.

McAneny, George, and Henry Wright, eds. *Report of the Committee on Inquiry into the Departments of Health, Charities, and Bellevue and Allied Hospitals in the City of New York*. New York, NY: J.J. Little and Ives Company, 1913.

McArthur, John H., and Francis D. Moore. "The Two Cultures and the Health Care Revolution. Commerce and Professionalism in Medical Care." *Journal of the American Medical Association* 277, no. 12 (1997): 985-989.

McCaig, Linda F. "National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary." *Advance Data from Vital and Health Statistics*, no. 245 (1994): 1-12.

McCaig, Linda F., and Nghi Ly. "National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary." *Advance Data from Vital and Health Statistics* Number 326 (2002): 1-31.

McCaig, Linda F., and Eric W. Nawar. "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary." *Advance Data from Vital and Health Statistics*, no. 372 (2006): 1-29.

McCaig, Linda F., and Barbara J. Stussman. "National Hospital Ambulatory Medical Care Survey: 1996 Emergency Department Summary." *Advance Data from Vital and Health Statistics*, no. 293 (1997): 1-20.

McClellan, Frand M., Augustus A. White, 3rd, Ramon L. Jimenez, and Sherin Fahmy. "Do Poor People Sue Doctors More Frequently? Confronting Unconscious Bias and the Role of Cultural Competency." *Clinical Orthopedics and Related Research* 470, no. 5 (2012): 1393-1397.

McClure, Diana, Carol Scheele, Bob Gray, and Karen Shrock-Jones. "Report of the Commission on Financing Health Care for the Medically Indigent." i-116. Frankfort, KY: Legislative Research Commission, 1987.

McKethan, Aaron, and Joel Menges. "Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion." Falls Church, VA: Lewin Group, 2006.

———. "Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion." (2006), http://www.lewin.com/~/media/lewin/site_sections/publications/upl.pdf. Accessed March 14, 2013.

McKethan, Aaron, Nadia Nguyen, Benjamin E. Sasse, and S. Lawrence Kocot. "Reforming the Medicaid Disproportionate-Share Hospital Program." *Health Affairs* 28, no. 5 (2009): w926-936.

Meah, Yasmin S., Eric L. Smith, and David C. Thomas. "Student-Run Health Clinic: Novel Arena to Educate Medical Students on Systems-Based Practice." *Mount Sinai Journal of Medicine* 76, no. 4 (2009): 344-356.

Mechanic, Robert. "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments." Washington, DC: National Health Policy Forum, 2004.

Medicaid Access Study Group. "Access of Medicaid Recipients to Outpatient Care." *New England Journal of Medicine* 330, no. 20 (1994): 1426-1430.

Medical and Chirugical Faculty of the State of Maryland. *Transactions of the Medical and Chirugical Faculty of the State of Maryland*. Baltimore, MD: Press of Thomas and Evans, 1885.

Medicare Prescription Drug Improvement and Modernization Act of 2003. Public Law 108-173. 108th Cong., 2nd sess., December 8, 2003.

MedPAC. "Payment Basics: Hospital Acute Inpatient Services Payment System." Medicare Payment Advisory Commission, http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_hospital.pdf. Accessed March 14, 2013.

———. "Report to the Congress: Aligning Incentives in Medicare." Washington, DC: Medicare Payment Advisory Commission, 2010.

———. "Report to the Congress: Improving Incentives in the Medicare Program: Chapter 1: Medical Education in the United States: Supporting Long-Term Delivery System Reforms." Washington, DC: Medicare Payment Advisory Commission, 2009.

———. "Report to the Congress: Medicare and the Health Care Delivery System: Chapter 1: Context for Medicare Payment Policy." 3-22. Washington, DC: Medicare Payment Advisory Commission, 2011.

———. "Report to the Congress: Medicare and the Health Care Delivery System: Chapter 6: Federally Qualified Health Centers." 145-160. Washington, DC: Medicare Payment Advisory Commission, 2011.

———. "Report to the Congress: Medicare Payment Policy." Washingon, DC: Medicare Payment Advisory Commission, 2010.

———. "Report to the Congress: Medicare Payment Policy: Chapter 3. Hospital Inpatient and Outpatient Services." Washington, DC: Medicare Payment Advisory Commission, 2012.

———. "Report to the Congress: Medicare Payment Policy: Chapter 3: Updating and Reforming Prospective Payment for Hospital Inpatient Care." Washington, DC: Medicare Payment Advisory Commission, 1999.

———. "Report to the Congress: Medicare Payment Policy: Section 2a: Hospital Inpatient and Outpatient Services: Assessing Payment Adequacy and Updating Payments." Washington, DC: Medicare Payment Advisory Commission, 2007.

Mehta, Seema. "Romney Slams Obama Backers as Dependent on Government, Tax Dodgers." *LA Times*, September 17, 2012.

Melnick, Glenn A., and Katya Fonkych. "Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?" *Health Affairs* 27, no. 2 (2008): w116-w122.

Merigian, Kevin S., Lynda J. Park, and Kari Blaho. "Referral out from the ED--Appropriate?" *Academic Emergency Medicine* 3, no. 11 (1996): 1071-1073.

Meyer, Gregg S., and David Blumenthal. "Tenncare and Academic Medical Centers: The Lessons from Tennessee." *Journal of the American Medical Association* 276, no. 9 (1996): 672-676.

Meyers, David S., Ranit Mishori, Jessica McCann, Jose Delgado, Ann S. O'Malley, and Ed Fryer. "Primary Care Physicians' Perceptions of the Effect of Insurance Status on Clinical Decision Making." *Annals of Family Medicine* 4, no. 5 (2006): 399-402.

Michigan Primary Care Association. "Guide to Michigan Health Centers: MPCA Members 2012-2013." (2012), http://mpca.net/associations/14191/files/2012-13%20directory%20for%20web.pdf. Accessed March 14, 2013.

Mickey, Robert W. "Dr. Strangerove; or, How Conservatives Learned to Stop Worrying and Love Community Health Centers." In *The Health Care Safety Net in a Post-Reform World*, edited by Mark A. Hall and Sara Rosenbaum, 21-66. New Brunswick, NJ: Rutgers University Press, 2012.

Middleton, William S. "Clinical Teaching in Philadelphia Almshouse and Hospital." *Medical Life* 40 (1933): 191-200, 207-225.

Miles, Steven H. "What Are We Teaching About Indigent Patients?" *Journal of the American Medical Association* 268, no. 18 (1992): 2561-2562.

Miller, Michael. "Waiver Watch Issue Brief #2: The Utah Primary Care Network." (2002), http://www.communitycatalyst.org/doc_store/publications/waiver_watch_issue_brief2_the_utah_primary_care_network_apr02.pdf. Accessed March 14, 2013.

Miller, Sandy. "More Volunteers Sign on at Free Clinic." *Twin Falls Times-News* May 1, 2006.

Minow, Martha. *Making All the Difference: Inclusion, Exclusion, and American Law*. Ithaca, NY: Cornell University Press, 1990.

Minyard, Karen , Deborah Chollet, Laurie Felland, Lindsey Lonergan, Chris Parker, Tina Anderson-Smith, Claudia Lacson, and Jaclyn Wong. "Lessons from Local Access Initiatives: Contributions and Challenges." (2007), http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Aug/Lessons-from-Local-Access-Initiatives--Contributions-and-Challenges.aspx. Accessed March 14, 2013.

Mir, Hassan R. . "Who Is Funding Your Trauma System?" *AAOS Now* 5, no. 5 (2011).

Mitchell, Janet B., and Jerry Cromwell. "Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare." In *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services: Volume 3: Appendices, Empirical, Legal, and Conceptual Studies*, edited by President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 105-130. Washington, DC: U.S. Government Printing Office, 1983.

Moberg, Dennis J., and Mark A. Seabright. "The Development of Moral Imagination." *Business Ethics Quarterly* 10, no. 4 (2000): 845-884.

Monico, Edward. "Is EMTALA That Bad?" *Virtual Mentor*, no. 6 (2010), http://virtualmentor.ama-assn.org/2010/06/hlaw1-1006.html. Accessed March 14, 2013.

Moore, Judith D. "Welfare Reform and Its Impact on Mediciad: An Update." (1999), http://www.nhpf.org/library/issue-briefs/IB732_WelfRef&Mcaid_2-26-99.pdf. Accessed March 14, 2013.

Moore, Judith D., and David G. Smith. "Legislating Medicaid: Considering Medicaid and Its Origins." *Health Care Financing Review* 27, no. 2 (2005): 45-52.

Morgan, Dan. "Small Provision Turns into a Golden Goose; States Use Subsidy to Balance Budgets." *Washington Post*, 1994.

Mort, Elizabeth A., Jennifer N. Edwards, David W. Emmons, Karen Convery, and David Blumenthal. "Physician Response to Patient Insurance Status in Ambulatory Care Clinical Decision-Making. Implications for Quality of Care." *Medical Care* 34, no. 8 (1996): 783-797.

Mortensen, Karoline. "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments." *Health Affairs* 29, no. 9 (2010): 1643-1650.

Moskop, John C. "Nonurgent Care in the Emergency Department--Bane or Boon?" *Virtual Mentor* 12, no. 6 (2010), http://virtualmentor.ama-assn.org/2010/06/pfor1-1006.html. Accessed March 14, 2013.

Moskop, John C., David P. Sklar, Joel M. Geiderman, Raquel M. Schears, and Kelly J. Bookman. "Emergency Department Crowding, Part 1--Concept, Causes, and Moral Consequences." *Annals of Emergency Medicine* 53, no. 5 (2009): 605-611.

Moskowitz, David, Jennifer Glasco, Brian Johnson, and Grace Wang. "Students in the Community: An Interprofessional Student-Run Free Clinic." *Journal of Interproffessional Care* 20, no. 3 (2006): 254-259.

Moskowitz, Ellen. "Recent Developments in Health Law: Class Action Suits Allege Improper Charitable Care Practices." *Journal of Law, Medicine & Ethics* 33, no. 1 (2005): 168-170.

Moyer, Carl A. "The Residency Program in a University-Affiliated Hospital; Organization and Administration." *Journal of the American Medical Association* 161, no. 1 (1956): 29-32.

Mozes, Alan. "Not All Chest Pain Treated Equally in U.S. Hospitals." *HealthDay News*, September 24, 2010.

Mullan, Fitzhugh. "Tin-Cup Medicine." *Health Affairs* 20, no. 6 (2001): 216-221.

———. *White Coat, Clenched Fist : The Political Education of an American Physician*. Ann Arbor, MI: University of Michigan Press, 2006.

Muller, David, Yasmin S. Meah, Jeffrey Griffith, Ann-Gel G. Palermo, Arthur Kaufman, Kirk L. Smith, and Steven Lieberman. "The Role of Social and Community Service in Medical Education: The Next 100 Years." *Academic Medicine* 85, no. 2 (2010): 302-309.

Muller, Ralph W. "What Matters: Making the Case for Public Support of Teaching Hospitals and Medical Schools." *Academic Medicine* 76, no. 2 (2001): 201-207.

Murphy, Bill. "Harris County to Limit Emergency Room Access." *Houston Chronicle*, July 31, 2006.

Nadkarni, Mohan M., and John T. Philbrick. "Free Clinics: A National Survey." *American Journal of the Medical Sciences* 330, no. 1 (2005): 25-31.

Nalepa, Robin Cowie. "Free Clinic Strapped for Cash, Volunteers." *The State*, May 8, 2006.

Nasca, Thomas J., Susan H. Day, and E. Stephen Amis, Jr. "The New Recommendations on Duty Hours from the ACGME Task Force." *New England Journal of Medicine* 363, no. 2 (2010): e3 (1-6).

———. "The New Recommendations on Duty Hours from the ACGME Task Force." *New England Journal of Medicine* 363, no. 2 (2010): e3 (1-6).

Nash, Kathleen, Hoang Nguyen, and Melinda Tillman. "Using Medical Screening Examinations to Reduce Emergency Department Overcrowding." *Journal of Emergency Nursing* 35, no. 2 (2009): 109-113.

Nash, Kathleen, and Melinda Tillman. "Screening out Does Little to Address ED Overcrowding: Author Response." *Journal of Emergency Nursing* 35, no. 4 (2009): 281.

National Association of Community Health Centers. "America's Health Centers." (2011), http://www.nachc.com/client/documents/USHealthCentersFS.pdf. Accessed March 14, 2013.

National Association of Free and Charitable Clinics. "National Association of Free and Charitable Clinics." http://www.nafcclinics.org/. Accessed March 14, 2013.

National Council on the Aging. "Principles and Criteria for Determining Medical Indigency: Report of the Committee for the Project of the National Council on the Aging." *American Journal of Public Health* 54, no. 10 (1964): 1745-1765.

National Federation of Independent Business v Sebelius, 132 S.Ct. 2566 (2012).

National Public Radio. "Bartering for Health Care: Yardwork for Treatment." http://www.npr.org/2011/09/26/140737591/bartering-for-health-care-yardwork-for-treatment. Accessed March 14, 2013.

Nawar, Eric W., Richard W. Niska, and Jiamnin Xu. "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary." *Advance Data from Vital and Health Statistics*, no. 386 (2007): 1-32.

Nazario, Sonia. "Treating Doctors for Prejudice: Medical Schools Are Trying to Sensitize Students to 'Bedside Bias.'" *Los Angeles Times*, December 20, 1993.

Needleman, J., J. Lamphere, and D. Chollet. "Uncompensated Care and Hospital Conversions in Florida." *Health Affairs* 18, no. 4 (1999): 125-133.

Nelson, Karin M., Gordon A. Starkebaum, and Gayle E. Reiber. "Veterans Using and Uninsured Veterans Not Using Veterans Affairs (VA) Health Care." *Public Health Report* 122, no. 1 (2007): 93-100.

Neuhausen, Katherine, Kevin Grumbach, Andrew Bazemore, and Robert L. Phillips. "Integrating Community Health Centers into Organized Delivery Systems Can Improve Access to Subspecialty Care." *Health Affairs* 31, no. 8 (2012): 1708-1716.

Neuhauser, Duncan. "Public Opinion Is Our Supreme Court: D W Cathell MD, the Physician Himself." *Quality and Safety in Health Care* 14, no. 5 (2005): 389-390.

Newhouse, Joseph P., and Gail R. Wilensky. "Paying for Graduate Medical Education: The Debate Goes On." *Health Affairs* 20, no. 2 (2001): 136-147.

Newsom v. Vanderbilt University, 453 F. Supp. 401 (1978).

Newton, Bruce W., Laurie Barber, James Clardy, Elton Cleveland, and Patricia O'Sullivan. "Is There Hardening of the Heart During Medical School?" *Academic Medicine* 83, no. 3 (2008): 244-249.

Newton, Manya F., Carla C. Keirns, Rebecca Cunningham, Rodney A. Hayward, and Rachel Stanley. "Uninsured Adults Presenting to US Emergency Departments: Assumptions Vs Data." *Journal of the American Medical Association* 300, no. 16 (2008): 1914-1924.

New York Times. "Dr. Lewis A. Stimson, Noted Surgeon, Dies." *New York Times*, September 18, 1917.

———. "Henry L. Stimson Dies at 83 in His Home on Long Island." *New York Times*, October 21, 1950.

Nguyen, Nguyen Xuan, and Steven H. Sheingold. "Indirect Medical Education and Disproportionate Share Adjustments to Medicare Inpatient Payment Rates." *Medicare and Medicaid Research and Review* 1, no. 4 (2011): E1-E14.

Nicholson, Sean. *Medicare Hospital Subsidies: Money in Search of a Purpose*. Washington, DC: American Enterprise Institute Press, 2002.

Noble, Alice A., Andrew L. Hyams, and Nancy M. Kane. "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives." *Journal of Law, Medicine & Ethics* 26 (1998): 116-137.

Nolen, William A. *The Making of a Surgeon*. New York, NY: Random House, 1970.

Nordling, Mary K. "Starting a Student-Run Homeless Clinic." (1999), http://www.amsa.org/AMSA/Libraries/Committee_Docs/homelessclinic.sflb.ashx Accessed March 14, 2013.

Norman, D. Kent. "Managing Interhospital Patient Transfers." *Hospitals* 59, no. 6 (1985): 98-101.

North Carolina Association of Free Clinics. "North Carolina Association of Free Clinics." http://www.ncfreeclinics.org/free_clinic.aspx. Accessed March 14, 2013.

Norwood, William Frederick. "Medical Education in the United States before 1900." In *The History of Medical Education; an International Symposium Held February 5-9, 1968*, edited by Charles Donald O'Malley, 463-499. Berkeley, CA: University of California Press, 1970.

November, Elizabeth A., Genna R. Cohen, Paul B. Ginsburg, and Brian C. Quinn. "Individual Insurance: Health Insurers Try to Tap Potential Market Growth." *Center for Studying Health System Change Research Briefs*, no. 14 (2009): 1-8.

O'Donnell, Heather, and Ralph Martire. "An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return." (2009), http://www.ctbaonline.org/All%20Links%20to%20Research%20Areas%20and%20Reports/Health%20Care/Executive%20Summary%20and%20Charts_Final.pdf. Accessed March 14, 2013.

O'Grady, Kevin F., Willard G. Manning, Joseph P. Newhouse, and Robert H. Brook. "The Impact of Cost Sharing on Emergency Department Use." *New England Journal of Medicine* 313, no. 8 (1985): 484-490.

O'Neill, Onora. "Charity." In *Encyclopedia of Ethics, Garland Reference Library of the Humanities,* edited by Charlotte B. Becker and Lawrence C. Becker, 134-136. New York: Garland Publications, 1992.

O'Shea, John S. "The Crisis in America’s Emergency Rooms and What Can Be Done." *Backgrounder* (2007), http://www.heritage.org/Research/Reports/2007/12/The-Crisis-in-Americas-Emergency-Rooms-and-What-Can-Be-Done. Accessed March 14, 2013.

———. "Individual and Social Concerns in American Surgical Education: Paying Patients, Prepaid Health Insurance, Medicare and Medicaid." *Academic Medicine* 85, no. 5 (2010): 854-862.

O'Toole, Thomas P., Jose J. Arbelaez, and Christine Haggerty. "The Urban Safety Net: Can It Keep People Healthy and out of the Hospital?" *Journal of Urban Health* 81, no. 2 (2004): 179-190.

O'Toole, Thomas P., Barbara H. Hanusa, Jeanette L. Gibbon, and Sarah H. Boyles. "Experiences and Attitudes of Residents and Students Influence Voluntary Service with Homeless Populations." *Journal of General Internal Medicine* 14, no. 4 (1999): 211-216.

O'Toole, Thomas P., Peter M. Simms, and Bruce W. Dixon. "Primary Care Office Policies Regarding Care of Uninsured Adult Patients." *Journal of General Internal Medicine* 16, no. 10 (2001): 693-696.

O’Neill, June E. , and Dave B. O'Neill. "Who Are the Uninsured?: An Analysis of America’s Uninsured Population, Their Characteristics, and Their Health,." (2009), http://epionline.org/study_detail.cfm?sid=122. Accessed March 14, 2013.

Oberlander, Jonathan. *The Political Life of Medicare*, American Politics and Political Economy. Chicago: University of Chicago Press, 2003.

Office of Inspector General. "The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments." Washington, DC: Department of Health and Human Services, 2001.

———. "Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act by the Health Care Financing Administration." edited by U.S. Department of Health and Human Services. Washington, DC: U.S. Government Printing Office, 1995.

———. "Review of Medicaid Disproportionate Share Hospital Payment Distribution." Washington, DC: Department of Health and Human Services, 2010.

———. "Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted." Washington, DC: Department of Health and Human Services, 2001.

Ohsfeldt, Robert L. "Uncompensated Medical Services Provided by Physicians and Hospitals." *Medical Care* 23, no. 12 (1985): 1338-1344.

Olshaker, Jonathon S. "Managing Emergency Department Overcrowding." *Emergency Medicine Clinics of North America* 27, no. 4 (2009): 593-603.

Olson, Laura Katz. *The Politics of Medicaid*. New York, NY: Columbia University Press, 2010.

Olson, Michael M. , M. Kay Sandor, Victor S. Sierpina, Harold Y. Vanderpool, and Patricia Dayao. "Mind, Body, and Spirit: Family Physicians' Beliefs, Attitudes, and Practices Regarding the Integration of Patient Spirituality into Medical Care." *Journal of Religion and Health* 45, no. 2 (2006): 234-247.

Omnibus Reconciliation Act of 1981. Public Law 97-35.

Opdycke, Sandra. *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900*. New York: Oxford University Press, 1999.

Operation Access. "Annual Report 2008." San Francisco, CA, 2008.

Ophuls, William. "Correspondence: Free Beds for Medical Teaching." *Journal of the American Medical Association* 90, no. 3 (1927): 223.

Oppenheimer, Caitlin, Angela Jaszczak, Sidra Goldman, Daniel S. Gaylin, Samantha Artiga, and David Rousseau. "A Case Study of the Utah Primary Care Network Waiver: Insights into Its Development, Design, and Implementation." (2006), http://www.kff.org/medicaid/7470.cfm. Accessed March 14, 2013.

Orne, Roberta M., Seja Joyce Fishman, Mary Manka, and Mary Ellen Pagnozzi. "Living on the Edge: A Phenomenological Study of Medically Uninsured Working Americans." *Research in Nursing and Health* 23, no. 3 (2000): 204-212.

Oxford English Dictionary. s.v. "Charity." (2012), http://www.oed.com/view/Entry/30731?redirectedFrom=charity&. Accessed March 14, 2013.

Oz, Mehmet. "The Shame in Breaking Records." *Huffington Post* (2009), http://www.huffingtonpost.com/dr-mehmet-oz/the-shame-in-breaking-rec_b_301870.html. Accessed March 14, 2013.

Ozar, David T. "Finding a Voice. Like Individuals, Organizations Are Moral Speakers and Actors." *Health Progress* 87, no. 6 (2006): 24-27.

Parizot, Isabelle, Pierre Chauvin, and Serge Paugam. "The Moral Career of Poor Patients in Free Clinics." *Social Science & Medicine* 61, no. 6 (2005): 1369-1380.

Park, Christine Y., Mary Alice Lee, and Andrew J. Epstein. "Variation in Emergency Department Wait Times for Children by Race/Ethnicity and Payment Source." *Health Services Research* 44, no. 6 (2009): 2022-2039.

Parker, M. Ryan "Issue Brief: Faith-Based Health Services." St. Louis, MO: Missouri Foundation for Health, 2004.

Parvin, Kendi. "Community Connections Free Clinic Providing Health Care and More to Uninsured." *Wisconsin Medical Journal* 111, no. 1 (2012): 8-9.

Patient Protection and Affordable Care Act. Public Law 111–148. 111th Congress, March 23rd, 2010.

Paul-Shaheen, Pamela, and Harry Perlstadt. "Class Action Suits and Social Change: The Organization and Impact of the Hill-Burton Cases." *Indiana Law Journal* 57, no. 3 (1982): 385-423.

Pear, Robert. "Nonprofit Hospitals Face Scrutiny over Practices " *New York Times*, March 19, 2006.

Pearlman, Robert A., and Helene E. Starks. "Quantitative Surveys." In *Methods in Medical Ethics*, edited by Jeremy Sugarman and Daniel P. Sulmasy, 233-249. Washington, DC: Georgetown University Press, 2010.

Pearson, Steven D., James E. Sabin, and Ezekiel J. Emanuel. *No Margin, No Mission : Health-Care Organizations and the Quest for Ethical Excellence*. Oxford ; New York: Oxford University Press, 2003.

Pellegrino, Edmund D., and David C. Thomasma. *The Virtues in Medical Practice*. New York, NY: Oxford University Press, 1993.

Perry, Michael, Julia Cummings, Meredith Lewis, Julia Paradise, Barbara Lyons, and Robin Rudowitz. "Rising Health Pressures in an Economic Recession: A 360 Look at Four Communities." (2009), http://www.kff.org/uninsured/upload/7949.pdf. Accessed March 14, 2013.

Peters, Christie Provost. "The Basics: Medicaid Disproportionate Share Hospital (DSH) Program." Washington, DC: George Washington University, 2009.

Physicians for a National Health Program. "Physicians for a National Health Program." http://www.pnhp.org/. Accessed March 14, 2013.

Pollack, Craig Evan, Shanu K. Kurd, Alice Livshits, Mark Weiner, and Julia Lynch. "A Case-Control Study of Home Foreclosure, Health Conditions, and Health Care Utilization." *Journal of Urban Health* 88, no. 3 (2011): 469-478.

Pollack, Rick. "Letter to CMS: Re: CMS 2315-P: Medicaid; Disproportionate Share Hospital Payments-Uninsured Definition, (Vol. 77, No. 11) January 18, 2012." February 16 (2012), http://www.aha.org/advocacy-issues/letter/2012/120216-cl-cms-2315-p.pdf. Accessed March 14, 2013.

Poppendieck, Janet. *Sweet Charity?: Emergency Food and the End of Entitlement*. New York, NY: Viking, 1998.

Poulsen, Eric J. "Student-Run Clinics: A Double Opportunity." *Journal of the American Medical Association* 273, no. 5 (1995): 430.

Povar, Gail J., Helen Blumen, John Daniel, Suzanne Daub, Lois Evans, Richard P. Holm, Natalie Levkovich, Alice O. McCarter, James Sabin, Lois Snyder, Daniel Sulmasy, Peter Vaughan, Laurence D. Wellikson, and Amy Campbell. "Ethics in Practice: Managed Care and the Changing Health Care Environment: Medicine as a Profession Managed Care Ethics Working Group Statement." *Annals of Internal Medicine* 141, no. 2 (2004): 131-136.

Powers and Duties of Hospitals. Texas Health and Safety Code, Section 311.

Powers, Madison, and Ruth Faden. "Racial and Ethnic Disparities in Healthcare: An Ethical Analysis of When and How They Matter." In *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, edited by Brian D. Smedley, Adrienne Y. Stith and Alan R. Nelson, 722-738. Washington, DC: National Academies Press, 2003.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services*. Vol. One: Report. Washington, DC: U.S. Government Printing Office, 1983.

Price, James H., Sharon M. Desmond, Frank F. Snyder, and Sanford R. Kimmel. "Perceptions of Family Practice Residents Regarding Health Care and Poor Patients." *Journal of Family Practice* 27, no. 6 (1988): 615-621.

PricewaterhouseCoopers for the Louisiana Recovery Authority Support Foundation. "Report on Louisiana Healthcare Delivery and Financing System." April (2006), http://lra.louisiana.gov/assets/docs/searchable/reports/PwChealthcarereport42706l.pdf. Accessed March 14, 2013.

PricewaterhouseCoopers Health Research Institute. "Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape." 2005. http://www.pwc.com/us/en/healthcare/publications/acts-of-charity.jhtml. Accessed March 14, 2013.

Principe, Kristine, E. Kathleen Adams, Jenifer Maynard, and Edmund R. Becker. "The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals." *American Journal of Public Health* 102, no. 2 (2012): 229-237.

Proenca, E. Jose, Michael D. Rosko, and Jacqueline S. Zinn. "Community Orientation in Hospitals: An Institutional and Resource Dependence Perspective." *Health Services Research* 35, no. 5, Part 1 (2000): 1011-1035.

Pryor, Carol , Mark Rukavina, Alex Hoffman, and Aaron Lee. "Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs?" May (2010), http://www.communitycatalyst.org/press_room/press_releases?id=0138. Accessed March 14, 2013.

Pryor, Carol, and Robert Seifert. "Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt." May (2003), http://www.commonwealthfund.org/Publications/Fund-Reports/2003/Jun/Unintended-Consequences--How-Federal-Regulations-and-Hospital-Policies-Can-Leave-Patients-in-Debt.aspx. Accessed March 14, 2013.

Public Affairs Research Council of Louisiana. "Realigning Charity Health Care and Medical Education in Louisiana." May (2007), http://www.parlouisiana.com/s3web/1002087/docs/Publications/Realigning_Charity_May_2007.pdf. Accessed March 14, 2013.

Public Health Service Act. Section 330. 42 U.S.Code § 254b (2010).

Public Health Service, HHS. "Grants, Loans and Loan Guarantees for Construction and Modernization of Hospitals and Medical Facilities." *Code of Federal Regulations* Title 42 (2006).

Pulich, Marcia. "Managing Health Care Volunteer Programs." *Health Care Manager* 27, no. 2 (2008): 159-164.

Quinn, Mariah A., Allison Wilcox, E. John Orav, David W. Bates, and Steven R. Simon. "The Relationship between Perceived Practice Quality and Quality Improvement Activities and Physician Practice Dissatisfaction, Professional Isolation, and Work-Life Stress." *Medical Care* 47, no. 8 (2009): 924-928.

Reed, Louis S. "Private Consumer Expenditures for Medical Care and Voluntary Health Insurance, 1948-63." *Social Security Bulletin* December (1964): 12-22.

Reed, William G., Karen A. Cawley, and Ron J. Anderson. "The Effect of a Public Hospital's Transfer Policy on Patient Care." *New England Journal of Medicine* 315, no. 22 (1986): 1428-1432.

Reich, Warren T. "The Care-Based Ethic of Nazi Medicine and the Moral Importance of What We Care About." *American Journal of Bioethics* 1, no. 1 (2001): 64-74.

Reid, Robert J., Paul A. Fishman, Onchee Yu, T. Ross Ross, James T. Tufano, Michael P. Soman, and Eric B. Larson. "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, before and after Evaluation." *American Journal of Managed Care* 15, no. 9 (2009): e71-87.

Reinhardt, Uwe E. "Economics." *Journal of the American Medical Association* 275, no. 23 (1996): 1802-1804.

———. "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy." *Health Affairs* 25, no. 1 (2006): 57-69.

———. "Spending More through 'Cost Control:' Our Obsessive Quest to Gut the Hospital." *Health Affairs* 15, no. 2 (1996): 145-154.

———. "Uncompensated Hospital Care." In *Uncompensated Hospital Care: Rights and Responsibilities*, edited by Frank A. Sloan, James F. Blumstein and James M. Perrin. Baltimore, MD: Johns Hopkins University Press, 1986.

Reinhold, Robert. "Treating an Outbreak of Patient Dumping in Texas." *New York Times*, May 25, 1986.

Reiser, Stanley J. "The Ethics of Learning and Teaching Medicine." *Academic Medicine* 69, no. 11 (1994): 872-876.

Relman, Arnold S. "Are Voluntary Hospitals Caring for the Poor?" *New England Journal of Medicine* 318, no. 18 (1988): 1198-1200.

———. "Economic Considerations in Emergency Care. What Are Hospitals For?" *New England Journal of Medicine* 312, no. 6 (1985): 372-373.

———. "Texas Eliminates Dumping. A Start toward Equity in Hospital Care." *New England Journal of Medicine* 314, no. 9 (1986): 578-579.

Resar, Roger K., and Frances A. Griffin. "Rethinking Emergency Department Visits." *Journal of Ambulatory Care Management* 33, no. 4 (2010): 290-295.

Reutter, Linda I., Miriam J. Stewart, Gerry Veenstra, Rhonda Love, Dennis Raphael, and Edward Makwarimba. ""Who Do They Think We Are, Anyway?": Perceptions of and Responses to Poverty Stigma." *Qualitative Health Research* 19, no. 3 (2009): 297-311.

Rey-Bear, Daniel "Judicial Enforcement of Charitable Care Requirements for Nonprofit Hospitals' Tax-Exempt Status." *Texas Forum on Civil Liberties and Civil Rights* Fall (1993): 1-8.

Reynolds, Herbert Y. "Free Medical Clinics: Helping Indigent Patients and Dealing with Emerging Health Care Needs." *Academic Medicine* 84, no. 10 (2009): 1434-1439.

Reynolds, P. Preston "The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 through 1967." *American Journal of Public Health* 87, no. 11 (1997): 1850-1858.

Reynolds, Richard C. "The Loss of Charity in the Practice of Medicine." *American Journal of Medicine* 71, no. 2 (1981): 196-198.

Rice, Mitchell F. "Medical Indigency and Inner City Hospital Care: Patient Dumping, Emergency Care and Public Policy." *Journal of Health and Social Policy* 1, no. 2 (1989): 1-29.

Rich, Eugene C., Mark Liebow, Malathi Srinivasan, David Parish, James O. Wolliscroft, Oliver Fein, and Robert Blaser. "Medicare Financing of Graduate Medical Education." *Journal of General Internal Medicine* 17, no. 4 (2002): 283-292.

Richardson, Lynne D., and Ula Hwang. "Access to Care: A Review of the Emergency Medicine Literature." *Academic Emergency Medicine* 8, no. 11 (2001): 1030-1036.

———. "America's Health Care Safety Net: Intact or Unraveling?" *Academic Emergency Medicine* 8, no. 11 (2001): 1056-1063.

Richardson, Lynne D., Charlene Babcock Irvin, and Joshua H. Tamayo-Sarver. "Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine." *Academic Emergency Medicine* 10, no. 11 (2003): 1184-1188.

Richmond, Kelly A., and Pamela C. Smith. "Machiavellian Tendencies of Nonprofit Health Care Employees." *Journal of Health Care Finance* 32, no. 2 (2005): 19-31.

Riesman, David. "Clinical Teaching in America, with Some Remarks on Early Medical Schools." *Transactions and Studies of the College of Physicians of Philadelphia* 4th, no. 7 (1939-1940): 89-110.

Rivara, Frederick P. "Sustaining Optimism." *Archives of Pediatric & Adolescent Medicine* 158, no. 5 (2004): 414-415.

Rivara, Frederick P., Hershel P. Wall, Patricia Worley, and Krista D. James. "Pediatric Nurse Triage. Its Efficacy, Safety, and Implications for Care." *American Journal of Diseases of Children* 140, no. 3 (1986): 205-210.

Robbins, Kevin. "Philanthropy." In *Machiavellism to Phrenology*, edited by Maryanne Horowitz, 1757-1761. Detroit, MI: Charles Scribner's Sons, 2005.

Robert Wood Johnson Foundation. "Communities in Charge: Financing and Delivering Health Care to the Uninsured." April 4, (2007), http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2007/rwjf69549. Accessed March 14, 2013.

Roberts, Rebecca R., Paul W. Frutos, Ginevra G. Ciavarella, Leon M. Gussow, Edward K. Mensah, Linda M. Kampe, Helen E. Straus, Gnanaraj Joseph, and Robert J. Rydman. "Distribution of Variable Vs Fixed Costs of Hospital Care." *Journal of the American Medical Association* 281, no. 7 (1999): 644-649.

Robilotti, Elizabeth, and David Rosner. "The Trustee's Dilemma: Hospitals as Benevolence or Business--Looking Back a Century." In *The Ethics of Hospital Trustees*, edited by Bruce Jennings, 13-40. Washington, DC: Georgetown University Press, 2004.

Robinson, Judy Gibbs. "Doctor's Free Clinic Bucks National Trend." *Daily Oklahoman*, April 4, 2006.

Rogers, David E., and Robert J. Blendon. "The Academic Medical Center Today." *Annals of Internal Medicine* 100, no. 5 (1984): 751-754.

Rogers, David E., Robert J. Blendon, and Thomas W. Moloney. "Who Needs Medicaid?" *New England Journal of Medicine* 307, no. 1 (1982): 13-18.

Rollins, Grace. "Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices." New Haven, CT: Connecticut Center for a New Economy, 2003.

Romano, John. "Patients' Attitudes and Behavior in Ward Round Teaching." *Journal of the American Medical Association* 117, no. 7 (1941): 664-667.

Rosen, George. "Public Health: Then and Now. The First Neighborhood Health Center Movement--Its Rise and Fall." *American Journal of Public Health* 61, no. 8 (1971): 1620-1637.

Rosenbaum, Sara. "Access to Care: Where Are the Holes in the Net? Special Concerns for Women and Children." *Health Matrix* 3, no. 3 (1985): 11-16.

———. "The Impact of United States Law on Medicine as a Profession." *Journal of the American Medical Association* 289, no. 12 (2003): 1546-1556.

———. "Medicaid." *New England Journal of Medicine* 346, no. 8 (2002): 635-640.

———. "Reinventing a Classic: Community Health Centers and the Newly Insured." In *The Health Care Safety Net in a Post-Reform World*, edited by Mark A. Hall and Sara Rosenbaum, 67-90. New Bruswick, NJ: Rutgers University Press, 2012.

Rosenbaum, Sara, and Jonathan Gruber. "Buying Health Care, the Individual Mandate, and the Constitution." *New England Journal of Medicine* 363, no. 5 (2010): 401-403.

Rosenbaum, Sara, and Brian Kamoie. "Finding a Way through the Hospital Door: The Role of EMTALA in Public Health Emergencies." *Journal of Law, Medicine & Ethics* 31, no. 4 (2003): 590-601.

Rosenbaum, Sara, and Ross Margulies. "Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice." *Public Health Report* 126, no. 2 (2011): 283-286.

Rosenbaum, Sara, Peter Shin, and Julie Darnell. "Economic Stress and the Safety Net: A Health Center Update." June (2004), http://www.kff.org/uninsured/upload/Economic-Stress-and-the-Safety-Net-A-Health-Center-Update.pdf. Accessed March 14, 2013.

Rosenberg, Charles. "And Heal the Sick: The Hospital and the Patient in the 19th Century America." *Journal of Social History* 10, no. 4 (1977): 428-447.

———. *The Care of Strangers: The Rise of America's Hospital System*. New York, NY: Basic Books, 1987.

———. "From Almshouse to Hospital: The Shaping of Philadelphia General Hospital." *Milbank Memorial Fund Quarterly/ Health and Society* 60, no. 1 (1982): 108-154.

———. "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary." In *Sickness and Health in America : Readings in the History of Medicine and Public Health*, edited by Judith Walzer Leavitt and Ronald L. Numbers, 309-322. Madison, WI: University of Wisconsin Press, 1997.

Rosenblatt, Rand E. "Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care." *Brooklyn Law Review* 60 (1994): 105-142.

———. "Health Care Reform and Administrative Law: A Structural Approach." *Yale Law Journal* 88, no. 2 (1978): 243-336.

Rosenblatt, Roger A., C. Holly Andrilla, Thomas Curtin, and L. Gary Hart. "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion." *Journal of the American Medical Association* 295, no. 9 (2006): 1042-1049.

Rosenblum, Andrew, Lisa A. Marsch, Herman Joseph, and Russell K. Portenoy. "Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions." *Experimental and Clinical Psychopharmacology* 16, no. 5 (2008): 405-416.

Rosenstein, Alan H., and Bruce Naylor. "Incidence and Impact of Physician and Nurse Disruptive Behaviors in the Emergency Department." *Journal of Emergency Medicine* (2011).

Rosenstein, Daniel N. "Emergency Stabilization for a Wounded Cobra." *Issues in Law and Medicine* 9, no. 3 (1993): 255-295.

Rosenthal, A. M. "On My Mind: A Charity No More." *New York Times*, September 24, 1993.

Rosenthal, Meredith, and Norman Daniels. "Beyond Competition: The Normative Implications of Consumer-Driven Health Plans." *Journal of Health Politics, Policy & Law* 31, no. 3 (2006): 671-685.

Rosner, David. "Health Care for the 'Truly Needy': Nineteenth-Century Origins of the Concept." *Milbank Memorial Fund Quarterly Bulletin* 60, no. 3 (1982): 355-385.

———. *A Once Charitable Enterprise : Hospitals and Health Care in Brooklyn and New York, 1885-1915,* Interdisciplinary Perspectives on Modern History. New York, NY: Cambridge University Press, 1982.

Roter, Debra, and Judith A. Hall. *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*. 2nd ed. Westport, CT: Praeger, 2006.

Roth, Julius A. "Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of the Hospital Emergency Service." *American Journal of Sociology* 77, no. 5 (1972): 839-856.

Rothman, David J. "Our Brothers' Keepers." *American Heritage Magazine* 24, no. 1 (1972): 38-42,100-105.

Rothstein, William G. *American Medical Schools and the Practice of Medicine: A History*. New York, NY: Oxford University Press, 1987.

———. *American Physicians in the Nineteenth Century : From Sects to Science*. Baltimore, MD: Johns Hopkins University Press, 1992.

Rowland, Christopher. "Amid Strained Clinics, Foe Assails 'Obamacare.'" *Boston Globe*, April 20, 2011.

Rowland, Diane, and Adele Shartzer. "America's Uninsured: The Statistics and Back Story." *Journal of Law, Medicine & Ethics* 36, no. 4 (2008): 618-628.

Rubinstein, Helena G. "Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription." *Health Matrix* 7, no. 2 (1997): 381-427.

Rudnicki, Jean West. "Winging It: With Stan Brock and His Remote Area Medical Team." *Change Magazine*, September 2008, 30-36.

Rudowitz, Robin, Diane Rowland, and Adele Shartzer. "Health Care in New Orleans before and after Hurricane Katrina." *Health Affairs* 25, no. 5 (2006): w393-406.

Rundall, Thomas G., Shoshanna Sofaer, and Wendy Lambert. "Uncompensated Hospital Care in California: Prvate and Public Hospital Responses to Competitive Market Forces." In *Advances in Health Economics and Research*, edited by Richard M. Scheffler and Louis F. Rossiter, 113-133. Greenwich, CT: JAI Press, 1988.

Russell, Barbara, and Lynn Lofstrom. "Health Clinic for the Alienated." *American Journal of Nursing* 71, no. 1 (1971): 80-83.

Ryan, Jennifer. "Medicaid in 2006: A Trip Down the Yellow Brick Road?" *National Health Policy Forum Issue Brief No. 810*, March 29, (2006), http://www.nhpf.org/library/issue-briefs/IB810_Medicaid2006_03-29-06.pdf. Accessed March 14, 2013.

Ryskina, Kira L., Yasmin S. Meah, and David C. Thomas. "Quality of Diabetes Care at a Student-Run Free Clinic." *Journal of Health Care for the Poor and Underserved* 20, no. 4 (2009): 969-981.

Safire, William. "On Language: Safety Nets." *New York Times*, March 29, 1981.

Saleh, Shadi S., and Mark Callan. "Trends in Medicare Disproportionate Share (DSH) Distribution in US Hospitals: 1996-2003." *Journal of Health Care Finance* 33, no. 2 (2006): 70-83.

Salinsky, Eileen. "Necessary but Not Sufficient? Physician Volunteerism and the Health Care Safety Net." *National Health Policy Forum Background Paper*. Washington, DC: George Washington University, 2004.

Sardell, Alice. *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986*, Contemporary Community Health Series. Pittsburgh, PA: University of Pittsburgh Press, 1988.

Saunders, Richard H. "The University Hospital Internship in 1960: A Study of the Programs of 27 Major Teaching Hospitals." *Journal of Medical Education* 36 (1961): 561-676.

Savage, Charles. "Dispensaries Historically and Localy Considered." In *Hospital, Dispensaries, and Nursing: Papers and Discussions in the International Congress of Charities, Correction and Philanthropy, Section III, Chicago, June 12th to 17th 1893*, edited by John S. Billings and Henry M. Hurd. Baltimore, MD: Johns Hopkins Press, 1894.

Saviano, Elizabeth C. "California's Safety-Net Clinics: A Primer." Oakland, CA: California HealthCare Foundation, 2009.

Scariati, Paula D., and Cyndy Williams. "The Utility of a Health Risk Assessment in Providing Care for a Rural Free Clinic Population." *Osteopathic Medicine and Primary Care* 1 (2007): 8.

Schappert, Susan M. "National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary." *Vital and Health Statistics* Series 13, no. 125 (1997): 1-108.

Schatz, Benard E., and Fred Ebrahimi. "Free Clinic Patient Characteristics." *American Journal of Public Health* 62, no. 10 (1972): 1354-1363.

Scheck, Anne. "U of C Backs Off ED Cuts, but Still Plans to Redirect Patients." *Emergency Medicine News* XXXI, no. 6 (2009): 1, 24.

Schiff, Gordon, and Claudia Fegan. "Community Health Centers and the Underserved: Eliminating Disparities or Increasing Despair." *Journal of Public Health Policy* 24, no. 3-4 (2003): 307-311.

———. "Community Health Centers and the Underserved: Eliminating Disparities or Increasing Despair." *Journal of Public Health Policy* 24, no. 3-4 (2003): 307-311.

Schiff, Robert L., David A. Ansell, James E. Schlosser, Ahamad H. Idris, Ann Morrison, and Steven Whitman. "Transfers to a Public Hospital. A Prospective Study of 467 Patients." *New England Journal of Medicine* 314, no. 9 (1986): 552-557.

Schlesinger, Mark. "Editor's Note: In the Marketplace for Ideas Affecting Public Policy." " *Journal of Health Politics Policy and Law* 28, no. 6 (2003): 964-975.

———. "Paradigms Lost: The Persisting Search for Community in U.S. Health Policy." *Journal of Health Politics, Policy and Law* 22, no. 4 (1997): 937-992.

Schlesinger, Mark, Robert Dorwart, Claudia Hoover, and Sherrie Epstein. "The Determinants of Dumping: A National Study of Economically Motivated Transfers Involving Mental Health Care." *Health Services Research* 32, no. 5 (1997): 561-590.

Schloendorff v. Society of the New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914).

Schneider, Andy, and David Rousseau. "Upper Payment Limits: Reality and Illusion in Medicaid Financing." (2002), http://www.kff.org/medicaid/4043-index.cfm. Accessed March 14, 2013.

Schneider, Anne, and Helen Ingram. "Social Construction of Target Populations: Implications for Politics and Policy." *American Political Science Review* 87, no. 2 (1993): 334-347.

Scholten, James R., Ronald Rubin, and Charles E. Lewis. "Medicare and Medical Students." *Journal of the American Medical Association* 197, no. 5 (1966): 333-338.

Schorn, Daniel. "Hospitals: Is the Price Right?" April 20, (2006), http://www.cbsnews.com/stories/2006/03/02/60minutes/main1362808.shtml. Accessed March 14, 2013.

Schramm, Carl J., and Jon Gabel. "Prospective Payment. Some Retrospective Observations." *New England Journal of Medicine* 318, no. 25 (1988): 1681-1683.

Schuhmann, Thomas M. "National Trends in Uncompensated Care and Profitability." *Healthcare Financial Management* September (2008).

Schull, Michael J., Alex Kiss, and John Paul Szalai. "The Effect of Low-Complexity Patients on Emergency Department Waiting Times." *Annals of Emergency Medicine* 49, no. 3 (2007): 257-264, 264 e251.

Schwartz, Jerome L. "First National Survey of Free Medical Clinics 1967-69." *HSMHA Health Report* 86, no. 9 (1971): 775-787.

Schwartz, Karyn , and Anthony Damico. "Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years." (2010), http://www.kff.org/uninsured/8083.cfm. Accessed March 14, 2013.

Schwartz, Roger. "Re: Medicaid Program; Premiums and Cost Sharing." March 24, (2008), http://www.nachc.com/client/documents/NACHC_Comments_DRA_CostSharing_PremiumFINAL.pdf. Accessed March 14, 2013.

Schwartz, Sonya , Shelly Gehshan, Alan Weil, and Alice Lam. "Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity." Washington, DC: National Academy for State Health Policy, 2006.

Scott, Robert A., Linda H. Aiken, David Mechanic, and Julius Moravcsik. "Organizational Aspects of Caring." *Milbank Quarterly* 73, no. 1 (1995): 77-95.

Seay, J. David "Beyond Charity: Mission Matters for Tax-Exempt Health Care." Washington, DC: The Catholic Health Association of the United States, 2007.

Seay, Timothy, Angela Straface, and John Myers. "Counterpoint: Don Your White Hat!" *Emergency Medicine News* XXIX, no. 12 (2007).

Sedlacek, William E. "Research in Medical Education. Attitudes of Residents toward Their Complex Role in Medical Education." *Journal of Medical Education* 43, no. 3 (1968): 344-348.

Segal, David. "For Hospitals, Charity Often Begins in the ER; Managed Care Cost Cutting Leaves Record Unpaid Bills." *Washington Post*, March 13, 1996.

Selassie, Anbesaw W., Emily E. Pickelsimer, Leroy Frazier, Jr., and Pamela L. Ferguson. "The Effect of Insurance Status, Race, and Gender on ED Disposition of Persons with Traumatic Brain Injury." *American Journal of Emergency Medicine* 22, no. 6 (2004): 465-473.

Semonin-Holleran, Renee. "I Wanted to Come in Early, before It Got Busy." *Journal of Emergency Nursing* 35, no. 2 (2009): 86.

Sered, Susan Starr, and Rushika J. Fernandopulle. "Profiles of the Uninsured: Uninsured Americans Tell Their Stories." (2003), http://www.commonwealthfund.org/Resources/2005/Jan/Profiles-of-the-Uninsured.aspx. Accessed March 14, 2013.

Shactman, David, and Stuart H. Altman. "The Impact of Hospital Conversions on the Healthcare Safety Net." In *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* edited by Stuart Altman, Uwe E. Reinhardt and Alexandra E. Shields, 189-206. Chicago, IL: Health Administration Press, 1998.

Shannon, James A. "The Advancement of Medical Research: A Twenty-Year View of the Role of the National Institutes of Health." *Journal of Medical Education* 42, no. 2 (1967): 97-108.

Shapiro, Howard B., and Andrew L. Warshaw. "Surgeon Volunteers: Charitable Immunity Statutes Shield." *Bulletin of the American College of Surgeons* 87, no. 10 (2002): 8-10.

Shapiro, Marc J., and Gail M. O'Brien. "Deferral out of the Emergency Department: The Wrong Solution?" *Annals of Emergency Medicine* 36, no. 1 (2000): 71-72.

Shaw, Kathy N., Steven M. Selbst, and Frances M. Gill. "Indigent Children Who Are Denied Care in the Emergency Department." *Annals of Emergency Medicine* 19, no. 1 (1990): 59-62.

Shea, Judy A., Ellyn Micco, Lorraine T. Dean, Suzanne McMurphy, J. Sanford Schwartz, and Katrina Armstrong. "Development of a Revised Health Care System Distrust Scale." *Journal of General Internal Medicine* 23, no. 6 (2008): 727-732.

Shea, Steven, Katherine G. Nickerson, Joseph Tenenbaum, Thomas Q. Morris, Daniel Rabinowitz, Kathleen O'Donnell, Ellen Perez, and Myron L. Weisfeldt. "Compensation to a Department of Medicine and Its Faculty Members for the Teaching of Medical Students and House Staff." *New England Journal of Medicine* 334, no. 3 (1996): 162-167.

Sheffield, John V., Audrey Young, Erika A. Goldstein, and James P. Logerfo. "The Public Hospital Mission at Seattle's Harborview Medical Center: High-Quality Care for the Underserved and Excellence in Medical Education." *Academic Medicine* 81, no. 10 (2006): 886-890.

Shelp, Earl E. *Beneficence and Health Care*, Philosophy and Medicine ; v. 11. Boston, MA: Kluwer Boston, 1982.

Shen, Joannie, Ronald Andersen, Robert Brook, Gerald Kominski, Paul S. Albert, and Neil Wenger. "The Effects of Payment Method on Clinical Decision-Making: Physician Responses to Clinical Scenarios." *Medical Care* 42, no. 3 (2004): 297-302.

Shepherd, Lois, and Mark A. Hall. "Patient-Centered Health Law and Ethics." *Wake Forest Law Review* 45, no. 5 (2010): 1429-1452.

Sheps, Cecil G. "Report of the Second Administrative Institute Medical School-Teaching Hospital Relations. Part II. A Perspentive for Today's Realities." *Journal of Medical Education* 40, no. 11 (1965): 76-80.

Sherman, Amy. "Faith in Communities: A Solid Investment." *Society* January/February (2003): 19-26.

Shortliffe, Ernest C., T. Stewart Hamilton, and Esward H. Noroian. "The Emergency Room and the Changing Pattern of Medical Care." *New England Journal of Medicine* 258, no. 1 (1958): 20-25.

Showstack, Jonathon. "The Costs of Providing Nonurgent Care in Emergency Departments." *Annals of Emergency Medicine* 45, no. 5 (2005): 493-494.

Shryock, Richard Harrison. *American Medical Research, Past and Present,* Three Centuries of Science in America. New York, NY: Arno Press, 1980.

Siegel, Bernard. "Medical Service Plans in Academic Medical Centers." *Journal of Medical Education* 53, no. 10 (1978): 791-798.

Siegel, Bruce. "The Emergency Department: Rethinking the Safety Net for the Safety Net." *Health Affairs* Suppl Web Exclusives (2004): W4-146-148.

———. "Equitable, Sustainable, Reliable Safety Net Financing: Medicaid DSH." (2012), http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/May-2012-Medicaid-DSH-Policy-Brief.aspx?FT=.pdf. Accessed March 14, 2013.

———. "Letter to CMS: Re: CMS-2315-P: Medicaid Program; Disproportionate Share Hospital Payments –Uninsured Definition." February 17, (2012), http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Medicaid-and-DSH/DSH-Reporting-and-Audit-Rule/NAPH-Submits-Comments-on-Proposed-Rule-Regarding-Medicaid-DSH-Uninsured-Definition-January-2012.aspx?FT=.pdf. Accessed March 14, 2013.

———. "Public Hospitals: A Prescription for Survival." (1996), http://www.commonwealthfund.org/Publications/Fund-Reports/1996/Oct/Public-Hospitals--A-Prescription-for-Survival.aspx. Accessed March 14, 2013.

Siegel, Bruce, Marsha Regenstein, and Peter Shin. "Health Reform and the Safety Net: Big Opportunities; Major Risks." *Jounal of Law Medicine and Ethics* 32, no. 3 (2004): 426-432.

———. "Health Reform and the Safety Net: Big Opportunities; Major Risks." *Journal of Law Medicine and Ethics* 32, no. 3 (2004): 426-432.

Siegel, Neil S. "Free Riding on Benevolence: Collective Action Federalism and the Minimum Coverage Provision." *Law and Contemporary Problems* 75, no. 29 (2012): 29-74.

Silver-Greenberg, Jessica. "Debt Collector Is Faulted for Tough Tactics in Hospitals." *New York Times*, April 24, 2012.

———. "Medical Debt Collector to Settle Suit for $2.5 Million." *New York Times*, July 30, 2012.

Simmons, B. Brent, Daniel DeJoseph, James Diamond, and Lara Weinstein. "Students Who Participate in a Student-Run Free Health Clinic Need Education About Access to Care Issues." *Journal of Health Care for the Poor and Underserved* 20, no. 4 (2009): 964-968.

Simpson, James B., and Sarah D. Strum. "How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered." *University of Puget Sound Law Review* 14 (1991): 633-670.

Simpson, Scott A., and Judith A. Long. "Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education." *Journal of General Internal Medicine* 22, no. 3 (2007): 352-356.

Siskin, Alison. "Treatment of Noncitizens under the Patient Protection and Affordable Care Act." 1-15. Washington, DC: Congressional Research Service, 2011.

Skocpol, Theda. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge, MA: Belknap Press of Harvard University Press, 1992.

Sloan, Frank A. "Uncompensated Hospital Care: A "Hot" Policy Issue." In *Uncompensated Hospital Care: Rights and Responsibilities*, edited by Frank A. Sloan, James F. Blumstein and James M. Perrin, 185-189. Baltimore, MD: Johns Hopkins University Press, 1986.

Sloan, Frank A., James F. Blumstein, and James M. Perrin, eds. *Uncompensated Hospital Care: Rights and Responsibilities*. Baltimore, MD: Johns Hopkins University Press, 1986.

Sloan, Frank A., and Christopher J. Conover. "Physician Participation and Nonparticipation in Medicaid Managed Care: The Tenncare Experience." *Southern Medical Journal* 92, no. 11 (1999): 1064-1070.

Sloan, Frank A., Joseph Valvona, and Ross Mullner. "Identifying the Issues: A Statistical Profile." In *Uncompensated Hospital Care: Rights and Responsibilities*, edited by Frank A. Sloan, James F. Blumstein and James M. Perrin. Baltimore, MD: Johns Hopkins University Press, 1986.

Smedley, Brian D., Adrienne Y. Stith, Alan R. Nelson, and Institute of Medicine (U.S.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment : Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press, 2003.

Smith, David Barton. "Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda." *Health Affairs* 24, no. 2 (2005): 317-324.

Smith, David G., and Judith D. Moore. *Medicaid Politics and Policy, 1965-2007*. New Brunswick, NJ: Transaction Publishers, 2008.

Smith, Dennis G. "State Medicaid Director Letter." August 15, (2007), https://www.cms.gov/SMDL/downloads/SMD081507.pdf. Accessed March 14, 2013.

Smith, Janice K., and Donna B. Weaver. "Capturing Medical Students' Idealism." *Annals of Family Medicine* 4 Suppl 1 (2006): S32-37; discussion S58-60.

Smith, Sunny D., Michelle L. Johnson, Natalie Rodriguez, Christine Moutier, and Ellen Beck. "Medical Student Perceptions of the Educational Value of a Student-Run Free Clinic." *Family Medicine* 44, no. 9 (2012): 646-649.

Smith, Susan Lynn. *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950*. Philadelphia, PA: University of Pennsylvania Press, 1995.

Smith, Wayne. "Scientific Economic and Humane Conduct of Municipal General Hospitals in the Southern States." *Transactions of the American Hospital Association* 16 (1914).

Smolderen, Kim G., John A. Spertus, Brahmajee K. Nallamothu, Harlan M. Krumholz, Fengming Tang, Joseph S. Ross, Henry H. Ting, Karen P. Alexander, Saif S. Rathore, and Paul S. Chan. "Health Care Insurance, Financial Concerns in Accessing Care, and Delays to Hospital Presentation in Acute Myocardial Infarction." *Journal of the American Medical Association* 303, no. 14 (2010): 1392-1400.

Social Security Act. 42 U.S. Code 1397 § 2012 (2010).

Society for Academic Emergency Medicine Ethics Committee. "Ethics of Emergency Department Triage: SAEM Position Statement. ." *Academic Emergency Medicine* 2, no. 11 (1995): 990-995.

Society of Student-Run Free Clinics. "Society of Student-Run Free Clinics " http://www.studentrunfreeclinics.org/. Accessed March 14, 2013.

Soller, Marie, and Lars Osterberg. "Missed Opportunities for Patient Education and Social Worker Consultation at the Arbor Free Clinic." *Journal of Health Care for the Poor and Underserved* 15, no. 4 (2004): 538-546.

Sommers, Benjamin D., Katherine Swartz, and Arnold Epstein. "Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians under Health Reform." *Health Affairs* 30, no. 11 (2011): 2186-2193.

Soper, Donna. "Free Clinic Will Improve Many Lives." *Atlanta Journal-Constitution*, July 6, 2006.

SoRelle, Ruth. "Tracking a Tangled Path. Physicians at Teaching Hospitals." *Circulation* 97, no. 22 (1998): 2191.

Sox, Colin M., Helen R. Burstin, E. John Orav, Alisdair Conn, Gary Setnik, Donald W. Rucker, Priscilla Dasse, and Troyen A. Brennan. "The Effect of Supervision of Residents on Quality of Care in Five University-Affiliated Emergency Departments." *Academic Medicine* 73, no. 7 (1998): 776-782.

Sparer, Michael S. *Medicaid and the Limits of State Health Reform*. Philadelphia, PA: Temple University Press, 1996.

Spitz, Bruce, and Grant Ritter. "Evaluating Community Partnerships: A Response." *Journal of Health Politics, Policy & Law* 27, no. 1 (2002): 93-103.

Staiti, Andrea, Robert Hurley, and Peter Cunningham. "Balancing Mission and Margin: Hospitals Alter Billing and Collection Practices for Uninsured Patients." Center for Studying Health System Change, 2005.

Starr, Paul. *The Social Transformation of American Medicine*. New York, NY: Basic Books, 1982.

———. "What Happened to Health Care Reform?" *American Prospect* Winter, no. 20 (1995): 20-31.

Steinbrook, Robert. "The Debate over Residents' Work Hours." *New England Journal of Medicine* 347, no. 16 (2002): 1296-1302.

———. "Imposing Personal Responsibility for Health." *New England Journal of Medicine* 355, no. 8 (2006): 753-756.

Steiner, John F., David W. Price, Vijayalaxmi Chandramouli, and Jennifer R. Goodspeed. "Managed Care for Uninsured Adults: The Rise and Fall of a University-Based Program." *American Journal of Managed Care* 8, no. 7 (2002): 653-661.

Stephens, Joe. "Obama Camp Has Many Ties to Wife's Employer." *Washington Post*, August 22, 2008.

Stern, Robert S. "Medicare Reimbursement Policy and Teaching Physicians' Behavior in Hospital Clinics: The Changes of 1996." *Academic Medicine* 77, no. 1 (2002): 65-71.

Stevens, Robert Bocking, and Rosemary Stevens. *Welfare Medicine in America: A Case Study of Medicaid*. New Brunswick, NJ: Transaction Publishers, 2003.

Stevens, Rosemary. *American Medicine and the Public Interest*. Updated ed. Berkeley, CA: University of California Press, 1998.

———. *In Sickness and in Wealth : American Hospitals in the Twentieth Century*. Baltimore, MD: Johns Hopkins University Press, 1999.

———. ""A Poor Sort of Memory": Voluntary Hospitals and Government before the Depression." *Milbank Memorial Fund Quarterly/ Health and Society* 60, no. 4 (1982): 551-584.

Stone, Deborah A. *Policy Paradox : The Art of Political Decision Making*. Revised ed. New York, NY: Norton, 2002.

———. *The Samaritan's Dilemma: Should Government Help Your Neighbor?* New York, NY: Nation Books, 2008.

Stone, Julie , Evelyne P. Baumrucker, Cliff Binder, Elicia J. Herz, Elayne J. Heisler, and Alexandra J. Rothenburger. "Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline." August 19, (2010), http://assets.opencrs.com/rpts/R41210_20100819.pdf. Accessed March 14, 2013.

Stout, Sean. "Time at the Rio Grande Clinic." *Journal of the American Medical Association* 273, no. 5 (1995): 435.

Stowe, Steven M. *Doctoring the South : Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century*, Studies in Social Medicine. Chapel Hill, NC: The University of North Carolina Press, 2004.

Stricker, Thomas L. "The Emergency Medical Treatment and Active Labor Act: Denial of Emergency Medical Care Because of Improper Motives." *Notre Dame Law Review* 67 (1991): 1121-1160.

Strobos, Jur. "Tightening the Screw: Statutory and Legal Supervision of Interhospital Patient Transfers." *Annals of Emergency Medicine* 20, no. 3 (1991): 302-310.

Stroebel, Robert J., Bonnie Gloor, Sue Freytag, Douglas Riegert-Johnson, Steven A. Smith, Todd Huschka, Jim Naessens, and Thomas E. Kottke. "Adapting the

Chronic Care Model to Treat Chronic Illness at a Free Medical Clinic." *Journal of Health Care for the Poor and Underserved* 16, no. 2 (2005): 286-296.

Strom, Stephanie. "Congress Questions the IRS About Delays in Its Oversight of Nonprofit Hospitals." *New York Times*, October 31, 2011.

Stuber, Jennifer P., Kathleen A. Maloy, Sara Rosenbaum, and Karen C. Jones. "Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid." (2000), http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/beyond_stigma_no3.pdf. Accessed March 14, 2013.

Subcommittee on Health of the Committee on Ways and Means, House of Representatives. *Testimony of Richard Lamm: New Health Professions and Graduate Medical Education Recommendations*, 104th Congress, 2nd sess., April 16, 1996.

Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in Medical Ethics*. Washington, DC: Georgetown University Press, 2001.

Sullivan, Gregory W. "Ongoing Analysis of the Uncompensated Caretrust Fund/Health Safety Net Trust Fund: Medicare Based Claims Payment System Implementation." Boston, MA: Massachusetts Office of the Inspector General, 2008.

Sullivan, Gregory W. . "Ongoing Review of the Uncompensated Care Pool Pursuant to Chapter 240 of the Acts of 2004." Boston, MA: Massachusetts Office of the Inspector General, 2005.

Sullivan, Meghan Collins. "Health Clinic Treats Germany's Few Uninsured." (2008), http://www.npr.org/templates/story/story.php?storyId=91963961. Accessed March 14, 2013.

Sullivan, T.J., and V. Moore. "A Critical Look at Recent Developments in Tax-Exempt Hospitals." *Journal of Health and Hospital Law* 23 (1990): 65.

Sulmasy, Daniel P. "Cancer Care, Money, and the Value of Life: Whose Justice? Which Rationality?" *Journal of Clinical Oncology* 25, no. 2 (2007): 217-222.

Sulmasy, Daniel P., M. Gregg Bloche, Mitchell Jean M., and Jack Hadley. "Physicians' Ethical Beliefs About Cost-Control Arrangements." *Archives of Internal Medicine* 160, no. 5 (2000): 649-657.

Szcaepanske, Carolyn. "Jay's Anatomy." *Kansas City Pitch*, September 14, 2006.

Tamayo-Sarver, Joshua H., Susan W. Hinze, Rita K. Cydulka, and David W. Baker. "Racial and Ethnic Disparities in Emergency Department Analgesic Prescription." *American Journal of Public Health* 93, no. 12 (2003): 2067-2073.

Tang, Ning, John Stein, Renee Y. Hsia, Judith H. Maselli, and Ralph Gonzales. "Trends and Characteristics of US Emergency Department Visits, 1997-2007." *Journal of the American Medical Association* 304, no. 6 (2010): 664-670.

Tang, Tricia S., and Eric P. Skye. "When Patients Decline Medical Student Participation: The Preceptors' Perspective." *Advances in Health Sciences Education Theory and Practice* 14, no. 5 (2009): 645-653.

Taureg, Cynthia. "Maintaining Charitable Mission in Tough Times." *Health Progress* July-August (2009): 6-7.

Tax Equity and Fiscal Responsibility Act of 1982. Public Law 97-248.

Taylor, Charles. *The Ethics of Authenticity*. Cambridge, MA: Harvard University Press, 1992.

Taylor, Erin Fries, Peter Cunningham, and Kelly McKenzie. "Community Approaches to Providing Care for the Uninsured." *Health Affairs* 25, no. 3 (2006): w173-182.

Taylor, Jessamy. "Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market." *National Health Policy Forum Issue Brief No. 848*, December 18, (2012), http://www.nhpf.org/library/issue-briefs/IB848_FQHCsandReform_12-18-12.pdf. Accessed March 14, 2013.

———. "Don't Bring Me Your Tired, Your Poor: The Crowded State of America's Emergency Departments." *National Health Policy Forum Issue Brief No. 811*, July 7, (2006), http://www.nhpf.org/library/issue-briefs/IB811_EDCrowding_07-07-06.pdf. Accessed March 14, 2013.

———. "The Fundamentals of Community Health Centers." *National Health Policy Forum Background Paper*, August 31, (2004), http://www.nhpf.org/library/details.cfm/2461. Accessed March 14, 2013.

———. "The Primary Care Safety Net: Strained, Transitioning, Critical." *National Health Policy Forum Background Paper No. 7*, September 28, (2010), http://www.nhpf.org/library/background-papers/BP79_PrimaryCareSafetyNet_09-28-10.pdf. Accessed March 14, 2013.

Taylor, Mark. "The Utah Solution. HHS Sees State's Medicaid Solution as Blueprint." *Modern Healthcare* 33, no. 7 (2003): 7, 16.

———. "When More Means Less. Utah Gets Federal Approval Limiting Medicaid Services to Some to Provide a Basic Health Package to 25,000 Low-Income Uninsured." *Modern Healthcare* 32, no. 7 (2002): 6-7.

Taylor, Pat, Lynn A. Blewett, Michelle Brasure, Kathleen T. Call, Eric B. Larson, John Gale, Amy Hagopian, L. Gary Hart, David Hartley, Peter House, Mary Katherine James, and Thomas Ricketts. "Small Town Health Care Safety Nets: Report on a Pilot Study." *Journal of Rural Health* 19, no. 2 (2003): 125-134.

Taylor, Rosemary C. "Alternative Services: The Case of Free Clinics." *International Journal of Health Services* 9, no. 2 (1979): 227-253.

Terplan, Mishka, Sarah Temkin, Ana Tergas, and Ernst Lengyel. "Does Equal Treatment Yield Equal Outcomes? The Impact of Race on Survival in Epithelial Ovarian Cancer." *Gynecologic Oncology* 111, no. 2 (2008): 173-178.

Tetelman, Alice. "Public Hospitals--Critical or Recovering?" *Health Services Reports* 88, no. 4 (1973): 295-304.

Texas Health and Human Services Commission. "2008-2009 Report on Residual Uncompensated Care Costs." (2011), http://www.hhsc.state.tx.us/reports/2011/Rider-40-0111.pdf. Accessed March 14, 2013.

———. "Senate Bill 1, Article II, Health and Human Services Commission: Rider 61, Texas Hospitals' Uncompensated Care." Austin, TX: Texas Health and Human Services Commission, 2006.

———. "Uncompensated Care in Texas: Moving toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs." (2009), http://www.hhsc.state.tx.us/News/present80.asp. Accessed March 14, 2013.

Texas Higher Education Coordinating Board. "Funding Graduate Medical Education in Texas." (2004), http://www.thecb.state.tx.us/reports/PDF/0778.PDF?CFID=21164330&CFTOKEN=35990020. Accessed March 14, 2013.

Texas State Auditor's Office. "An Audit Report on Charity Care at Health-Related Institutions." (2007), http://www.sao.state.tx.us/reports/main/07-034.pdf. Accessed March 14, 2013.

Thompson, Carter. "UTMB Weighs First Month of ER Screening." *Galveston County Daily News*, April 14, 2005.

Thompson, Steve. "Long Wait Common in Parkland Hospital ER May Have Cost Ex-Restaurateur His Life." (2009), http://www.wfaa.com/news/local/64514612.html. Accessed March 14, 2013.

Thompson, Tommy G. "Letter from Tommy G. Thompson Secretary of Health and Human Services to Richard J. Davidson, President, American Hospital Association." February 19, (2004), http://archive.hhs.gov/news/press/2004pres/20040219.html. Accessed March 14, 2013.

Thompson v. Sun City Community Hospital, 141 Ariz. 597, 688 P.2d 605 (1984).

Thorpe, Kenneth E., and Charles Brecher. "Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?" *Journal of Health Politics Policy and Law* 12, no. 2 (1987): 313-324.

Thorpe, Kenneth E., and Charles E. Phelps. "The Social Role of Not-for-Profit Organizations: Hospital Provision of Charity Care." *Journal of Economic Inquiry* 29, no. 3 (1991): 472-484.

Tomlinson, Mark W., Mitchell P. Dombrowski, Renee A. Bobrowski, Sidney F. Bottoms, and David B. Cotton. "Changes in Health Care Delivery: A Threat to Academic Obstetrics." *American Journal of Obstetrics and Gynecology* 173, no. 5 (1995): 1614-1616.

Trapp, Doug. "Democratic Leaders Stay Cold on Single-Payer." *American Medical News*, June 22, 2009.

Trattner, Walter I. *From Poor Law to Welfare State: A History of Social Welfare in America*. 6th ed. New York, NY: The Free Press, 1999.

Treiger, Karen. "Preventing Patient Dumping: Sharpening the Cobra's Fangs." *New York University Law Review* 61, no. 6 (1986): 1186-1223.

Trzeciak, S., and E. P. Rivers. "Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health." *Emergency Medicine Journal* 20, no. 5 (2003): 402-405.

Tsai, Alexander C., Joshua H. Tamayo-Sarver, Rita K. Cydulka, and David W. Baker. "Declining Payments for Emergency Department Care, 1996-1998." *Annals of Emergency Medicine* 41, no. 3 (2003): 299-308.

Turner, Irene R. "Free Health Centers: A New Concept?" *American Journal of Public Health* 62, no. 10 (1972): 1348-1353.

Tuscarawas Clinic. "Tuscarawas Clinic for the Working Uninsured." http://www.tuscarawasclinic.org. Accessed March 14, 2013.

Tyrance, Patrick H., Jr., David U. Himmelstein, and Steffie Woolhandler. "US Emergency Department Costs: No Emergency." *American Journal of Public Health* 86, no. 11 (1996): 1527-1531.

U.S. Congress. "Congressional Record. Statement of Senator Kennedy." S13892-13901. Washington, DC, 1985.

———. "Social Security Amendments of 1965. Report of the Committee on Ways and Means of H.R. 6675, 89th Congress, 1st Session, Report No. 213." Washington, DC: U.S. Government Printing Office, 1965.

U.S. Department of Health and Human Services. "Community Health Centers." http://www.healthcare.gov/using-insurance/low-cost-care/community-health-centers/index.html. Accessed March 14, 2013.

———. "Healthy People 2010: Understanding and Improving Health." Washington, DC: U.S. Government Printing Office, 2000.

———. "HHS Announces $22 Million in New Grants to Improve Services to Uninsured Americans." *HHS News* (2000), http://archive.hhs.gov/news/press/2000pres/20000907.html. Accessed March 14, 2013.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care,. "Health Centers: America's Primary Care Safety Net, Reflections on Success, 2002-2007." (2008), http://ask.hrsa.gov/detail_materials.cfm?ProdID=4159. Accessed March 14, 2013.

Ungar, Laura. "Trust to Fund Indigent Care at University Hospital Lacks Oversight, Audit Finds." *Louisville Courier-Journal*, May 24, 2012.

University of Chicago. "The University of Chicago Law School: Faculty: Richard A. Epstein." University of Chicago Law School, http://www.law.uchicago.edu/faculty/epstein. Accessed March 14, 2013.

University of Chicago Medical Center. "2007 Annual Report: Evolution of Science and Medicine." (2008), http://www.ihatoday.org/uploadDocs/1/ctbareportresponse.pdf. Accessed March 14, 2013.

Upham, J.H.J. "The Outpatient Clinic." *Journal of the American Medical Association* 102, no. 13 (1934): 980-982.

van Ryn, Michelle, and Janet Burke. "The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients." *Social Science and Medicine* 50, no. 6 (2000): 813-828.

Veeder, Borden S. "Standards for Determining the Suitability of Patients for Admission to a Free Dispensary." *Journal of the American Medical Association* 67, no. 2 (1916): 85-91.

Verrilli, Donald B. "National Federation of Independent Business, et al., Petitioners v. Kathleen Sebelius, Secretary of Health and Human Services, et. al." *Nos. 11-393 and 11-400* (2012), http://www.fb.org/legal/files/id_83/HHS%20Reply%20Brief%20Severability.pdf. Accessed March 14, 2013.

Verrilli, Donald B., Paul D. Clement, and Michael A. Carvin. "Department of Health and Human Services et. al., v. Florida, et. al." (March 27, 2012), http://www.supremecourt.gov/oral_arguments/argument_transcripts/11-398-Tuesday.pdf. Accessed March 14, 2013.

Viner, Kimberly M., Michael Bellino, Thomas D. Kirsch, Paul Kivela, and Julio C. Silva. "Managed Care Organization Authorization Denials: Lack of Patient Knowledge and Timely Alternative Ambulatory Care." *Annals of Emergency Medicine* 35, no. 3 (2000): 272-276.

Vinicky, Janicemarie K., Russell B. Connors, Jr., Richard Leader, and John D. Nash. "Patients as "Subjects" or "Objects" in Residency Education?" *Journal of Clinical Ethics* 2, no. 1 (1991): 35-41.

Virginia Association of Free Clinics. "Virginia Association of Free Clinics." http://www.vafreeclinics.org/our-partners.asp. Accessed March 14, 2013.

Vladeck, Bruce C. "Paying for Hospitals' Community Service." *Health Affairs* 25, no. 1 (2006): 34-43.

Vogel, Morris J. "Patrons, Practitioners, and Patients: The Voluntary Hospital in Mid-Victorian Boston." In *Sickness and Health in America: Readings in the History of Medicine and Public Health*, edited by Judith Walzer Leavitt and Ronald L. Numbers, 323-333. Madison, WI: University of Wisconsin Press, 1997.

Wagner, David. *What's Love Got to Do with It?: A Critical Look at American Charity*. New York, NY: New Press, 2000.

Walker, David M. "Nonprofit, for-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits." Washington, DC: Government Accountability Office, 2005.

Walker, Sara. "Want to Help Improve Access? Become a Volunteer." *ACP-ASIM Observer* 22, no. 5 (2002): 12-13.

Wallack, Marc K., and Lynn Chao. "Resident Work Hours: The Evolution of a Revolution." *Archives of Surgery* 136, no. 12 (2001): 1426-1431.

Walter, Nancy, and Dean Schillinger. "Front-Line Bureaucracies and the Moral Mechanics of US Health Care." *Medical Care* 42, no. 4 (2004): 303-305.

Walzer, Michael. *Spheres of Justice: A Defense of Pluralism and Equality*. New York, NY: Basic Books, 1983.

Wanerman, Robert. "The EMTALA Paradox. Emergency Medical Treatment and Labor Act." *Annals of Emergency Medicine* 40, no. 5 (2002): 464-469.

Wang, N. Ewen, MichaelA. Gisondi, Mana Golzari, TheresaM. van der Vlugt, and Methodius Tuuli. "Socioeconomic Disparities Are Negatively Associated with Pediatric Emergency Department Aftercare Compliance." *Academic Emergency Medicine* 10, no. 11 (2003): 1278-1284.

Wardle, J., and A. Steptoe. "Socioeconomic Differences in Attitudes and Beliefs About Healthy Lifestyles." *Journal of Epidemiology and Community Health* 57, no. 6 (2003): 440-443.

Warren, Benjamin S. "Sickness Insurance: A Preventive of Charity Practice." *Journal of the American Medical Association* 65, no. 24 (1915): 2056-2062.

Warren, J.C. "Administration: Care of Patients General Statements Concerning." In *Some Account of the Medical School in Boston, and of the Massachusetts General Hospital*, edited by Massachusetts General Hospital, 16 p. Boston, MA: Phelps and Farnham, 1824.

Washburn, Frederic A. *The Massachusetts General Hospital; Its Development, 1900-1935*. Boston, MA: Houghton Mifflin Company, 1939.

Washington, Donna L., Paul G. Shekelle, and Carl D. Stevens. "Deferred Care for Adults with Musculoskeletal Complaints." *Effective Clinical Practice* 4, no. 2 (2001): 65-72.

Washington, Donna L., Carl D. Stevens, Paul G. Shekelle, David W. Baker, Arlene Fink, and Robert H. Brook. "Safely Directing Patients to Appropriate Levels of Care: Guideline-Driven Triage in the Emergency Service." *Annals of Emergency Medicine* 36, no. 1 (2000): 15-22.

Washington, Donna L., Carl D. Stevens, Paul G. Shekelle, Philip L. Henneman, and Robert H. Brook. "Next-Day Care for Emergency Department Users with

Nonacute Conditions. A Randomized, Controlled Trial." *Annals of Internal Medicine* 137, no. 9 (2002): 707-714.

Washington, Donna, and Paul G. Shekelle. "Deferred Care for Emergency Department Users with Nonacute Conditions; Author Reply." *Annals of Internal Medicine* 139, no. 6 (2003): 528.

Watson, Sidney D. "In Search of the Story: Physicians and Charity Care." *St. Louis University Public Law Review* 15, no. 2 (1996): 353-369.

Wayne, Sharon, Craig Timm, Lisa Serna, Brian Solan, and Summers Kalishman. "Medical Students' Attitudes toward Underserved Populations: Changing Associations with Choice of Primary Care Versus Non-Primary Care Residency." *Journal of Health Care for the Poor and Underserved* 21, no. 2 (2010): 438-447.

Wear, Delese. "Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education." *Academic Medicine* 78, no. 6 (2003): 549-554.

Wear, Delese, and Janet W. Bickel. *Educating for Professionalism: Creating a Culture of Humanism in Medical Education*. Iowa City, IA: University of Iowa Press, 2000.

Wear, Delese, and Mark G. Kuczewski. "Perspective: Medical Students' Perceptions of the Poor: What Impact Can Medical Education Have?" *Academic Medicine* 83, no. 7 (2008): 639-645.

Weber, Ellen J., Jonathan A. Showstack, Kelly A. Hunt, David C. Colby, Barbara Grimes, Peter Bacchetti, and Michael L. Callaham. "Are the Uninsured Responsible for the Increase in Emergency Department Visits in the United States?" *Annals of Emergency Medicine* 52, no. 2 (2008): 108-115.

Webster, George C., and Francoise E. Baylis. "Moral Residue." In *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*, edited by Susan B. Rubin and Laurie Zoloth, 217-230. Hagerstown, MD: University Publishing Group, 2000.

Weiner, Saul J. ""I Can't Afford That!": Dilemmas in the Care of the Uninsured and Underinsured." *Journal of General Internal Medicine* 16, no. 6 (2001): 412-418.

Weiner, Saul J., Margaret Laporte, Richard I. Abrams, Arthur Moswin, and Richard Warnecke. "Rationing Access to Care to the Medically Uninsured: The Role of Bureaucratic Front-Line Discretion at Large Healthcare Institutions." *Medical Care* 42, no. 4 (2004): 306-312.

Weiner, Saul J., Jonathan VanGeest, Richard I. Abrams, Arthur Moswin, and Richard Warnecke. "Managing the Unmanaged: A Case Study of Intra-Institutional Determinants of Uncompensated Care at Healthcare Institutions with Differing Ownership Models." *Medical Care* 46, no. 8 (2008): 821-828.

Weinerman, E. Richard, S. Robert Rutzen, and David A. Pearson. "Effects of Medical "Triage" in Hospital Emergency Service." *Public Health Report* 80 (1965): 389-399.

Weinermann, E.Richard, Robert S. Ratner, Anthony Robbins, and Marvin A. Lavenhar. "Yale Studies in Ambulatory Medical Care. V. Determinants of Use of Hospital Emergency Services." *American Journal of Public Health* 56, no. 7 (1966): 1037-1056.

Weinick, Robin M., Rachel M. Burns, and Ateev Mehrotra. "Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics." *Health Affairs* 29, no. 9 (2010): 1630-1636.

Weinrich, Michael. "Federal Funding for Graduate Medical Education." *Neurology* 53, no. 6 (1999): 1175-1179.

Weir, Robert F. "Society Report: New York Academy of Medicine." *Medical Record* 62, no. 26 (1902): 1030-1033.

Weiss, Eva, Kathryn Haslanger, and Joel C. Cantor. "Accessibility of Primary Care Services in Safety Net Clinics in New York City." *American Journal of Public Health* 91, no. 8 (2001): 1240-1245.

Weiss, Gregory L. *Grassroots Medicine: The Story of America's Free Health Clinics*. Lanham, MD: Rowman & Littlefield Publishers, 2005.

Weissman, Joel S. "The Trouble with Uncompensated Hospital Care." *New England Journal of Medicine* 352, no. 12 (2005): 1171-1173.

Weissman, Joel S., Eric G. Campbell, Manjusha Gokhale, and David Blumenthal. "Residents' Preferences and Preparation for Caring for Underserved Populations." *Journal of Urban Health* 78, no. 3 (2001): 535-549.

Weissman, Joel S., Paul Dryfoos, and Katherine London. "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals." *Health Affairs* 18, no. 4 (1999): 156-166.

Weissman, Joel S., Ernest Moy, Eric G. Campbell, Manjusha Gokhale, Recal Yucel, Nancyanne Causino, and David Blumenthal. "Limits to the Safety Net: Teaching Hospital Faculty Report on Their Patients' Access to Care." *Health Affairs* 22, no. 6 (2003): 156-166.

Weissman, Joel S., Demet Saglam, Eric G. Campbell, Nancyanne Causino, and David Blumenthal. "Market Forces and Unsponsored Research in Academic Health

Centers." *Journal of the American Medical Association* 281, no. 12 (1999): 1093-1098.

Weitzman, Carol Cohen, Kimberly Freudigman, David J. Schonfeld, and John M. Leventhal. "Care to Underserved Children: Residents' Attitudes and Experiences." *Pediatrics* 106, no. 5 (2000): 1022-1027.

Welch, Shari, Peter Viccellio, John McCabe, and Bruce Janiak. "The Medical Screening Exam: Hold onto Your (White) Hat!" *Emergency Medicine News* XXIX, no. 10 (2007).

Westin, Shannon N., Daniel Bustillos, Jacalyn B. Gano, Margaret M. Fields, Ann L. Coker, Charlotte C. Sun, and Lois M. Ramondetta. "Social Factors Affecting Treatment of Cervical Cancer: Ethical Issues and Policy Implications." *Obstetrics & Gynecology* 111, no. 3 (2008): 747-751.

Wharam, J. Frank, and Norman Daniels. "Toward Evidence-Based Policy Making and Standardized Assessment of Health Policy Reform." *Journal of the American Medical Association* 298, no. 6 (2007): 676-679.

Whitaker, Bill. "Free Health Clinic Lures Hundreds in L.A." CBS News, http://www.cbsnews.com/stories/2009/08/13/eveningnews/main5240824. Accessed March 14, 2013.

Whitney, James L. "Cooperative Medicine in Relation to Social Insurance." *California State Journal of Medicine* 14 (1916).

Wieland, Mark L., Thomas J. Beckman, Stephen S. Cha, Timothy J. Beebe, and Furman S. McDonald. "Resident Physicians' Knowledge of Underserved Patients: A Multi-Institutional Survey." *Mayo Clinic Proceedings* 85, no. 8 (2009): 728-733.

Wielawski, Irene. "Gouging the Medically Uninsured: A Tale of Two Bills." *Health Affairs* 19, no. 5 (2000): 180-185.

Wietecha, Mark, Steven H. Lipstein, and Mitchell T. Rabkin. "Governance of the Academic Health Center: Striking the Balance between Service and Scholarship." *Academic Medicine* 84, no. 2 (2009): 170-176.

Wiggleton, Catherine, Emil Petrusa, Kim Loomis, John Tarpley, Margaret Tarpley, Mary Lou O'Gorman, and Bonnie Miller. "Medical Students' Experiences of Moral Distress: Development of a Web-Based Survey." *Academic Medicine* 85, no. 1 (2010): 111-117.

Wilensky, Gail R. "Solving Uncompensated Hospital Care: Targeting the Indigent and the Uninsured." *Health Affairs* 3, no. 4 (1984): 50-62.

Wilensky, Sara, and Mara McDermott. "Unkindest Cuts: The Impact of State Medicaid Reductions on Health Centers and Their Patients." *State Policy Report #5* (2005), http://www.nachc.com/client/documents/issues-advocacy/state-issues/add-medicaid-info/statepolicyreport5.pdf. Accessed March 14, 2013.

Williams, Robert M. "The Costs of Visits to Emergency Departments." *New England Journal of Medicine* 334, no. 10 (1996): 642-646.

———. "Costs of Visits to Emergency Departments, Author Reply." *New England Journal of Medicine* 335, no. 3 (1996): 210-211.

Williamson, Samuel H. "Seven Ways to Compute the Relative Value of a U.S. Dollar Amount - 1774 to Present." http://www.measuringworth.com/uscompare/. Accessed March 14, 2013.

Wilper, Andrew P., Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein. "Health Insurance and Mortality in US Adults." *American Journal of Public Health* 99, no. 12 (2009): 2289-2295.

Wing, Kenneth R. "The Community Service Obligation of Hill-Burton Health Facilities." *Boston College Law Review* 23, no. 3 (1982): 577-632.

———. "Health Care Reform in the Year 2000: The View from the Front of the Classroom." *American Journal of Law & Medicine* 26, no. 2-3 (2000): 277-293.

———. "Medicare and President Reagan's Second Term." *American Journal of Public Health* 75, no. 7 (1985): 782-784.

Winokur, Julie, and Ed Kashi. *Denied: Crisis of the Uninsured*. San Francisco: Talking Eyes Media, 2003.

Wolcott, B. W. "What Is an Emergency? Depends on Whom You Ask." *Journal of the American College of Emergency Physicians* 8, no. 6 (1979): 241-243.

Wolfskill, Sandra J. *Charity Care: Tools to Manage the Uninsured Population*. Marblehead, MA: HCPro, 2005.

Woolf, Steven H. "Patient Safety Is Not Enough: Targeting Quality Improvements to Optimize the Health of the Population." *Annals of Internal Medicine* 140, no. 1 (2004): 33-36.

Wrenn, Keith. "No Insurance, No Admission." *New England Journal of Medicine* 312, no. 6 (1985): 373-374.

Wynn, Barbara , Theresa Coughlin, Serhiy Bondarenko, and Brian Bruen. "Analysis of the Joint Distribution of Disproportionate Share Hospital Payments." Santa Monica, CA: RAND Corporation, 2002.

Wysocki, Bernard. "The Rules: At One Hospital, a Stark Solution for Allocating Care." *Wall Street Journal*, September 23, 2003.

Yancy, William S., Jr., David S. Macpherson, Barbara H. Hanusa, Galen E. Switzer, Robert M. Arnold, Raquel A. Buranosky, and Wishwa N. Kapoor. "Patient Satisfaction in Resident and Attending Ambulatory Care Clinics." *Journal of General Internal Medicine* 16, no. 11 (2001): 755-762.

Yap, O. W. Stephanie, and David J. Thornton. "The Arbor Free Clinic at Stanford: A Multidisciplinary Effort." *Journal of the American Medical Association* 273, no. 5 (1995): 431.

Young, Gary P., Michele B. Wagner, Arthur L. Kellermann, Jack Ellis, and Doug Bouley. "Ambulatory Visits to Hospital Emergency Departments. Patterns and Reasons for Use. 24 Hours in the ED Study Group." *Journal of the American Medical Association* 276, no. 6 (1996): 460-465.

Zachariah, Brian. "The Right Medical Care at the Right Place." *Galveston County Daily News*, February 1, 2005.

Zaman, Obaid S. , Linda C. Cummings, and Sandy Laycox. "America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey." (2012), http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf. Accessed March 14, 2013.

Zaman, Obaid S. , Linda C. Cummings, and Sari Siegel Spieler. "America's Public Hospitals and Health Systems, 2009." National Association of Public Hospitals, http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Public-Hospital-Financial-Characteristics-.aspx?FT=.pdf. Accessed March 14, 2013.

———. "America's Public Hospitals and Health Systems, 2009: Results of the Annual NAPH Hospital Characteristics Survey." Washington, DC: National Public Health and Hospital Institute, 2010.

Zanca, Jane A. "Letter to the Editor." *Journal of the American Medical Association* 18, no. 266 (1991): 2560.

Zautcke, John L., Lesa D. Fraker, Raymond G. Hart, and Jeremy S. Stevens. "Denial of Emergency Department Authorization of Potentially High-Risk Patients by Managed Care." *Journal of Emergency Medicine* 15, no. 5 (1997): 605-609.

Zerwic, Julie Johnson, Barbara Simmons, and Mark J. Zerwic. "Helping Hands Health Center." *American Journal of Nursing* 107, no. 1 (2007): 48-50.

Zimmerman, Theresa, and Geri Amori. "The Silent Organizational Pathology of Insidious Intimidation." *Journal of Healthcare Risk Management* 30, no. 3 (2011): 5-6, 8-15.

Zink, Brian J. *Anyone, Anything, Anytime: A History of Emergency Medicine*. Philadelphia, PA: Mosby Elsevier, 2006.

Zollinger, Terrell W., Robert M. Saywell, Jr., David K. Chu, Andrea Ziegert, John R. Woods, and Dean LaBov. "A Determination of Institutional and Patient Factors Affecting Uncompensated Hospital Care." *Hospital and Health Services Administration* 36, no. 2 (1991): 243-256.

Zuckerman, Stephen, Aimee F. Williams, and Karen E. Stockley. "Trends in Medicaid Physician Fees, 2003-2008." *Health Affairs* 28, no. 3 (2009): w510-519.

Zuger, Abigail, and Steven H. Miles. "Physicians, AIDS, and Occupational Risk. Historic Traditions and Ethical Obligations." *Journal of the American Medical Association* 258, no. 14 (1987): 1924-1928.

Zussman, Robert. "A Forgotten Classic?" *Sociological Forum* 20, no. 2 (2005).

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Merle S. Lenihan was born in Murfreesboro, Tennessee, on September 29, 1959. Her parents, both deceased, were Patricia and James Sharber. She is married to Daniel Lenihan, and her children are Patricia, Sean, Connor, and Molly Lenihan. After completing a residency in obstetrics and gynecology in Cincinnati, Ohio in 1992, she continued to teach residents there while in private practice. After moving to Texas, Dr. Lenihan became the Director of the Women's Wellness Clinic at St. Vincent's Episcopal House. She was also an Assistant Professor of Obstetrics and Gynecology at the University of Texas Medical Branch and she was responsible for teaching medical and nursing students at the women's clinic. In 2008, Dr. Lenihan received the Teacher of Distinction Award from the medical school. As a Ph.D. student at the Institute for the Medical Humanities also at the University of Texas Medical Branch, Dr. Lenihan taught in the medical school's Humanities, Ethics, and Professionalism course and at Baylor College of Medicine's first year medical ethics course. She served on the Medical Branch's Institutional Ethics Committee. Dr. Lenihan currently lives in Brentwood, Tennessee, but she remains the Coordinator of the Galveston County Free Care Monitoring Project, a local community project partnered with the nonprofit group Gulf Coast Interfaith, which works to improve access to health care for low income residents.

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Lenihan, Merle and Laura Hermer, "On the Uneasy Relationship Between Medicaid and Charity Care." *Notre Dame Journal of Law, Ethics, and Public Policy* 28 (forthcoming).

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