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MEDICAL CREDIT CARDS: A CLASH BETWEEN PHYSICIANS' INTERESTS AND PATIENTS' RIGHTS

*Lauren Horwitz**

As health care costs rise and patients become more dependent on credit to pay medical bills, state legislatures should regulate the influence doctors have over their patients' financial decisions. There is a growing need for legislation that regulates the role physicians play in the financial decisions their patients make to fund health care costs. Rather than extend their own lines of credit, some physicians market the services of credit-lending institutions to patients at times when the patients are least likely to make financially responsible decisions. In these instances, physicians overstep their bounds when they provide financial advice to their patients, particularly when their own financial interests are in conflict with the financial interests of their patients.

I. INTRODUCTION

On Monday, your painful toothache served as a reminder to see a dentist for a checkup. Today, just four days later, your dentist diagnoses you with more than a simple cavity: your toothache is actually evidence of a rather extensive oral health problem, advanced periodontal disease. Should you choose to forego the \$1,500 soft-tissue grafts¹ that your dentist recommends today, the problem could rapidly develop into an even more serious issue. Because you have diabetes, periodontal disease presents the risk of significant health

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1. WebMD.com, Dental Health: Gum Disease Treatments, <http://www.webmd.com/oral-health/guide/gum-disease-treatments> (last visited Feb. 21, 2009).

complications.² The dentist's \$1,500 solution, which represents a hefty sum, could restore the health of your gums and bones, and stop any developing damage.³ Unfortunately, you don't have \$1,500 to spare, and like so many other Americans,⁴ you have no dental insurance. Thankfully, your dentist accepts medical credit cards as a form of payment. The line of credit your dentist accepts is offered by a credit card company you have heard of before, and according to the literature in the dentist's examination room, you could be approved before you leave the office. The dentist's office manager can even help you contact the credit card company, submit the application, and recommend repayment options, as she has done for many other patients. You choose to apply for the card so that you can proceed with treatment as soon as possible.

In the hypothetical scenario above, the patient expected to incur some sort of medical expense when visiting the dentist. When faced with the possibility of losing teeth and suffering complications of periodontal disease associated with diabetes, the patient heeded the dentist's warnings and recommendations for treatment, just as the court in *Magan Medical Clinic v. California State Board of Medical Examiners*⁵ predicted the patient would.⁶ However, the dentist described above not only recommended treatment for a health issue but also recommended a way to pay for it, provided the patient with the option of borrowing the cost of treatment from a third-party lender without ever leaving the office, and helped the patient choose a repayment rate.

2. Diane B. Wayne, Cynthia P. Trajtenberg & David J. Hyman, *Tooth and Periodontal Disease: A Review for the Primary-Care Physician*, 94 S. MED. J. 925, 928-29 (2001).

3. American Academy of Periodontology, *Soft Tissue Grafts*, <http://www.perio.org/consumer/grafts.htm> (last visited Feb. 21, 2009).

4. More than 100 million people in the United States do not have dental insurance. Alex Berenson, *Boom Times for U.S. Dentists, But Not for American's Teeth*, N.Y. TIMES, Oct. 11, 2007, at A1.

5. 57 Cal. Rptr. 256 (Ct. App. 1967).

6. *Id.* at 263. The court in *Magan Medical Clinic* recognized that in the physician-patient relationship,

the patient is a captive consumer. There is no other profession or business where a member thereof can dictate to a consumer what brand [s]he must buy, . . . how fast [s]he must consume it and how much [s]he must pay with the further condition to the consumer that any failure to fully comply must be at the risk of [her] own health.

Id.

Physicians have always had the ability to impact patients' financial health through normal price setting.⁷ Typically, in nonemergency situations, physicians can turn away patients who cannot pay the price of treatment;⁸ at other times, they may choose to extend a personal line of credit to patients so the patients can pay their balance directly to the physician over time.⁹ Issues arise when physicians move far beyond their traditional role of providing therapeutic treatment and accepting payment for it, and instead choose to market a specific type of credit or loan to their patients, aid their patients in obtaining those lines of credit or loans, and influence the financial terms that will dictate their patients' relationships with third-party lenders.

This Note identifies the need for legislation that regulates the role of physicians in recommending, and aiding patients in obtaining, medical credit cards and loans on the spot as opposed to simply accepting these lines of credit and loans as forms of payment.¹⁰ Furthermore, the legislation proposed in Part V would complement proposed changes in the regulation of the financial markets.¹¹

Additionally, this Note explains why the California state legislature is justified in regulating physicians who aid patients in obtaining a certain line of credit or loan geared toward paying medical bills, regardless of whether their motivation is driven by profit, sincere concern for patients' physical health, or a combination of the two. The solution requires physicians to maintain a traditional

7. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 660–63 (2008).

8. Lois Shepherd, *HIV, the ADA, and the Duty to Treat*, 37 HOUS. L. REV. 1055, 1082–84 (2000).

9. See, e.g., Lisa Girion, *Why the Doctor Won't See You Now*, L.A. TIMES, Dec. 15, 2008, at A1.

10. California State Senate Bill 1633, which addressed some of the concerns presented in this Note, was vetoed by Governor Arnold Schwarzenegger on September 27, 2008. He cited the "historic delay" in passing a 2008–2009 state budget as the main impetus for his decision. S.B. 1633, 2007–2008 Leg., Reg. Sess. (Cal. 2008), Veto Message, http://info.sen.ca.gov/pub/07-08/bill/sen/sb_1601-1650/sb_1633_vt_20080927.html (last visited Feb. 21, 2009). The bill's attributes are discussed further in Part V.

11. See, e.g., Kara Scannell & Sudeep Reddy, *Greenspan Admits Errors to Hostile House Panel*, WALL ST. J., Oct. 24, 2008, at A1; Press Release, Bd. of Governors of the Fed. Reserve Sys., Federal Reserve Approves Rules That Will Better Protect Credit Card Users (Dec. 18, 2008) (on file with author).

professional relationship with their patients and avoid unduly influencing their patients' financial decisions.¹²

The remainder of this Note is divided into five sections. Part II discusses the characteristics of medical credit cards and loans. Part III describes how the California judiciary and legislature currently regulate conflicts of interest that relate to physicians' financial interests, patients' interests in sound treatment, and patients' financial interests. Part III provides examples of California legislation employed to curb specific types of conflicts of interest in the medical profession. Part IV explains why California law does not directly address the problems associated with medical credit cards and loans. Parts V and VI propose and justify legislation to regulate the influence of physicians on their patients' financial affairs. Part VII provides an overview of the themes and ideas presented in this Note.

12. This Note does not discuss the underlying reasons that patients need to assume credit card debt to pay their medical bills, namely, an American system where "health care is expensive, both in terms of health insurance premiums and for specific medical needs that insurance does not cover." Melissa B. Jacoby, *Collecting Debts from the Ill and Injured: The Rhetorical Significance, But Practical Irrelevance, of Culpability and Ability to Pay*, 51 AM. U. L. REV. 229, 234 (2001); see also Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453 (2004) (explaining the effects of managed health care, money management, and credit cards on the debtor-creditor/physician-patient relationship); E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207 (2006) (comparing the focuses of health care litigation in different historical stages of the American health care system); E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1 (1997) (discussing the contribution of the Employee Retirement Income Security Act to health care for the poor); Hall & Schneider, *supra* note 7 (highlighting the new consumer role of patients in the medical marketplace).

Nor does this Note address the flaws in existing laws governing consumer credit. See generally Nefertara Clark, *Finance and Other Charges: Is Disclosure for the Sake of Disclosure Sufficient?*, 33 S.U. L. REV. 313 (2006) (discussing the nature of finance charges under the Truth in Lending Act); Peter V. Letsou, *The Political Economy of Consumer Credit Regulation*, 44 EMORY L.J. 587 (1995) (discussing coercive remedies in the context of the lender-borrower relationship).

Further, this Note does not address whether physicians who aid patients in obtaining lines of credit or loans through third-party lenders, or even the lenders themselves, could be sued as violators of the Consumer Credit Protection Act or other similar regulations. Consumer Credit Protection Act, 15 U.S.C. §§ 1601-13 (2006).

For an interesting discussion of the range of regulations affecting the credit card industry, see Margot Saunders & Alys Cohen, *Federal Regulation of Consumer Credit: The Cause or the Cure for Predatory Lending?* (Mar. 2004) (unpublished manuscript), available at http://www.jchs.harvard.edu/publications/finance/babc/babc_04-21.pdf.

II. BACKGROUND: MEDICAL CREDIT CARDS AND LOANS

The negative impact of the credit crisis in the United States is widely documented.¹³ The average American household carries \$8,565 in credit card debt,¹⁴ and the total consumer revolving credit¹⁵ owned and securitized as of August 2008 is at an all-time high of over \$969 trillion.¹⁶ Reliance on credit cards to pay medical bills is also a common phenomenon.¹⁷ For example, patients used Visa credit cards to pay for \$19.5 billion in health care expenses in 2001.¹⁸

Medical credit cards and loans are offered by many of the same major creditors as other nonspecialty credit cards. For example, Citibank offers the Citi Health Card,¹⁹ Capital One offers Healthcare Finance loans,²⁰ GE Money offers the CareCredit credit card,²¹ and Chase offers the ChaseHealthAdvance credit card.²² The difference between a medical credit card or loan and a regular credit card or loan is that the former is geared toward patients in need of financing for medical treatment; the lines of credit or loans can only be used

13. According to Federal Reserve Chairman Ben Bernanke, “the trajectory of economic activity beyond the next few quarters will depend greatly on the extent to which financial and credit markets return to more normal functioning.” Sudeep Reddy et al., *Economic Fears Reignite Market Slump*, WALL ST. J., Oct. 16, 2008, at A1. For a concise explanation of the current credit crisis and related materials on the topic, see Nytimes.com, Credit Crisis—The Essentials, http://topics.nytimes.com/top/reference/timestopics/subjects/c/credit_crisis/index.html (last visited Mar. 21, 2009).

14. Gretchen Morgenson, *Given a Shovel, Digging Deeper into Debt*, N.Y. TIMES, July 20, 2008, at A1.

15. Consumer credit is defined as “[s]hort term loans to individuals for [the] purchase of consumer goods and services.” BLACK’S LAW DICTIONARY (6th ed. 1990). Revolving credit is a “[t]ype of consumer credit . . . which permits . . . a borrower to purchase goods or secure loans on a continuing basis . . .” *Id.*

16. The Federal Reserve Board, Federal Reserve Economic Research and Data: Consumer Credit (October 7, 2008), <http://www.federalreserve.gov/releases/g19/Current/>.

17. See, e.g., Amanda Gardner, *More Americans Paying Their Medical Bills with Credit Cards*, MSN HEALTH & FITNESS, Jan. 16, 2007, <http://health.msn.com/health-topics/article.page.aspx?cp-documentid=100153442>.

18. Cindy Zeldin & Mark Rukavina, Access Project: Demos, Borrowing to Stay Healthy: How Credit Card Debt Is Related to Medical Expenses 9 (2007), available at http://www.accessproject.org/adobe/borrowing_to_stay_healthy.pdf.

19. Citi Health Card, Home Page, <https://www.citicards.com/cards/portal/healthcard/nsc/content.do?screenID=5000> (last visited Feb. 21, 2009) [hereinafter Citi Health Card, Home Page].

20. Capital One Healthcare Finance, Home Page, <http://www.capitalonehealthcarefinance.com> (last visited Feb. 21, 2009) [hereinafter Capital One, Home Page].

21. CareCredit Home Page, <http://www.carecredit.com> (last visited Feb. 21, 2009) [hereinafter CareCredit, Home Page].

22. ChaseHealthAdvance Home Page, <http://www.chasehealthadvance.com/> (last visited Feb. 21, 2009) [hereinafter ChaseHealthAdvance, Home Page].

for medical treatment.²³ The president of CareCredit recently commented that its medical credit card was developed to finance elective procedures only but noted the difficulty associated with determining whether the procedure is actually elective before the patient borrows on the card.²⁴

The number of physicians who accept these cards as a form of payment is staggering. CareCredit is accepted by over 100,000 providers across the nation.²⁵ As of October 15, 2008, 2,153 physicians of various specialties within 100 miles of downtown Los Angeles accepted the Capital One Healthcare Finance loan in their offices.²⁶ One hundred seven health practitioners within 25 miles of downtown San Francisco accepted the Citi Health Card as of the same date.²⁷

As with any vendor who accepts credit cards, physicians must pay a fee to that lender in proportion to the charges their patients incur on their accounts.²⁸ A physician gains benefits in exchange for paying this fee. For example, physicians receive their compensation from the third-party lender the day after the patient charges the cost of treatment to the credit card or loan.²⁹ Additionally, the

23. Daniel Costello, *Hospital Bills—but with Interest*, L.A. TIMES, Dec. 12, 2005, at F1.

24. Stacey L. Bradford, *The Dangers of Medical Credit Cards*, SMARTMONEY, Aug. 25, 2008, <http://www.smartmoney.com/spending/rip-offs/the-dangers-of-medical-credit-cards-23744>.

25. CareCredit, *How CareCredit Works*, <http://www.carecredit.com/howcarecreditworks.html> (last visited Feb. 21, 2009) [hereinafter *CareCredit, How Carecredit Works*].

26. This number is the sum of the physicians listed as those who accept Capital One Healthcare Finance within 100 miles of zip code 90015 as of October 15, 2008. Capital One Healthcare Finance, *Find A Doctor*, <http://www.capitalonehealthcarefinance.com/dental/find.asp> (select “Doctors/Clinics that offer Capital One Healthcare Finance”; then enter “90015” in the “Zip/Postal Code” search function; then select “100 miles” in the “Find a doctor within” search function).

27. This number is the sum of the physicians listed as those who accept Citi Health Card within 25 miles of zip code 94102 as of October 15, 2008. Citi Health Card, <https://www.citicards.com/cards/portal/healthcard/sc/providerSearch.do?screenID=5042> (select “Dentist” under “Provider type” on the pull-down menu; then select 25 miles in the “search within” pull-down menu; then type “94102” in the “miles of zip code” search function).

28. Susan Davis, *Why Your Medical Practice Should Take Credit Cards*, ALLBUSINESS, <http://www.allbusiness.com/services/health-services-offices-clinics-doctors/4354111-1.html> (last visited Feb. 21, 2009); Interview with Dr. X, Dentist, in Beverly Hills, Cal. (Sept. 26, 2008) (identity of the interviewee withheld upon request) (audio recording on file with author). See, e.g., *CareCredit, Costs*, <http://www.carecredit.com/practices/dental/costs.php> (last visited Jan. 16, 2009) [hereinafter *CareCredit, Costs*]. For a fuller discussion on the overall concept of these charges, see *Mastercard Interchange Rates*, http://www.mastercard.com/us/merchant/how_works/interchange_rates.html (last visited Feb. 21, 2009).

29. Interview with Dr. X, *supra* note 28.

physician's responsibility to collect payment from patients is eliminated, and the burden of collecting outstanding balances shifts from the physicians and their staff to a third-party lender.³⁰ This can "ease payment headaches[,] . . . reduce billing costs . . . [and] improve cash flow" for the physician.³¹ In the current economic climate, where small businesses like medical practices are suffering financially because clients are unable to pay their bills on time,³² the benefits of not relying directly on patients to pay their costs of treatment can be significant.

There are three general levels of participation in which physicians may choose to engage. The first level is simply distributing information about the line of credit or loan of their choice and then accepting that line of credit or loan as payment; the second level is facilitating the application process; the third level is influencing the patient's relationship with the third-party lender. Each is discussed in turn below.

A. Physicians Marketing and Accepting Credit

Physicians who accept medical lines of credit and loans commonly market them to patients.³³ A dentist who accepted CareCredit in years past and now accepts the Capital One Healthcare Finance loan commented that both companies offer optional assistance to physicians and their office staff about how to approach patients on obtaining a line of credit or loan through third-party lenders.³⁴ For example, third-party lenders provide physicians with

30. Davis, *supra* note 28.

31. *Id.*

32. Kelly K. Spors & Simona Covell, *Slow Payments Squeeze Small Business-Owner*, WALL ST. J., Oct. 31, 2008, at B1; Girion, *supra* note 9.

33. Many third-party lenders tout access to marketing tools as part of the reason physicians should accept their lines of credit and loans as payment. The specific ways that third-party lenders aid physicians in marketing these lines of credit and loans is discussed more fully in Part II.B. See, e.g., CareCredit, How to Offer CareCredit, <http://www.carecredit.com/practices/dental/how-to-offer.php> (last visited Feb. 21, 2009) [hereinafter CareCredit, How to Offer]; Citi Health Card, Features & Benefits: Ongoing Support, <https://www.citicards.com/cards/portal/healthcard/nsc/content.do?screenID=5013#5> (last visited Feb. 21, 2009) [hereinafter Citi Health Card, Features]; Capital One Healthcare Finance, Tools for Success, <http://www.capitalonehealthcarefinance.com/dental/doctors/tools-for-success.asp> (last visited Feb. 21, 2009) [hereinafter Capital One, Tools]; ChaseHealthAdvance, Marketing Support, <http://www.chasehealthadvance.com/patient-financing/procedures/dental.asp> (last visited Feb. 21, 2009) [hereinafter ChaseHealthAdvance, Marketing].

34. Interview with Dr. X, *supra* note 28. For example, CareCredit touts the "FREE customized training and . . . materials" available to physicians as a way to aid patients in

pamphlets³⁵ that advertise the benefits of these lines of credit and loans so that patients can reference official information, albeit general and incomplete,³⁶ before they leave the office. Some of the lenders go so far as to provide scripts to physicians and their office staff that provide the exact words that can aid in effectively encouraging patients to borrow the cost of treatment on the medical credit card or loan.³⁷

B. Physicians Aiding Patients to Obtain Credit

Physicians who accept medical credit cards and loans as a method of payment can also use their own staff to aid patients in applying for, and obtaining, the funds.³⁸ After physicians and their staff use the marketing materials described above, they can help the patient complete her credit or loan application and then submit it online or via telephone.³⁹ Additionally, some third-party lenders allow physicians to use a “preapproval” credit check to determine the patient’s eligibility before the physician discusses the payment options with the patient.⁴⁰ In these ways, the physician goes beyond recommending a method of payment and actually helps the patient assume debt from a third-party lender.

“successfully add[ing] CareCredit as a payment option.” CareCredit, Myth Busters, <http://www.carecredit.com/practices/dental/myth-busters.php> (last visited Feb. 21, 2009) [hereinafter CareCredit, Myth].

35. *E.g.*, Citi Health Card, Features & Benefits: Ongoing Support, <https://www.citi.cards.com/cards/portal/healthcard/nsc/content.do?screenID=5013#1> (last visited Feb. 21, 2009).

36. For example, the Capital One Healthcare Finance pamphlet provided in physicians’ offices is a total of eight panels and provides minimal information about what an average patient could expect to incur in finance charges. The only projected costs provided in the pamphlet are for fixed-rate plans, for which the pamphlet notes that only customers with excellent credit history will qualify. Individual monthly payments and interest rates are disclosed when the application is approved. CAPITAL ONE HEALTHCARE FINANCE, SMART PAYMENT PLANS (2008) (pamphlet on file with author).

37. *See supra* note 34 and accompanying text.

38. *E.g.*, CareCredit, Frequently Ask [sic] Questions: <http://www.carecredit.com/practices/dental/dental-faqs.php> (last visited Feb. 21, 2009) [hereinafter CareCredit, How Patients Apply]; ChaseHealthAdvance, Frequently Asked Questions, <http://www.chasehealthadvance.com/providers/faq.asp> (follow “How do patients apply?” hyperlink) (last visited Feb. 21, 2009) [hereinafter ChaseHealthAdvance, How Patients Apply].

39. *E.g.*, CareCredit, How Patients Apply, *supra* note 38; ChaseHealthAdvance, How Patients Apply, *supra* note 38.

40. *E.g.*, CareCredit, How Patients Apply, *supra* note 38.

C. Physicians Determining Terms of Financial Relationships

The financial relationship created by a patient's use of a line of credit or loan to pay a medical bill is between the lender and the patient—the physician is not part of this relationship.⁴¹ In order to accept the medical credit card or loan as a form of payment, the physician pays a portion of what the patient borrows from the third-party lender as a transaction fee to that lender,⁴² and the lender and patient conduct their lender-borrower relationship apart from the physician.⁴³ Although the financial relationship is between the patient and the third-party lender, some third-party lenders also allow physicians to choose, or help their patients choose, from among a list of options that will dictate the patient's relationship with the third-party lender.⁴⁴ For example, the physicians who accept CareCredit as a form of payment select which available promotional rates⁴⁵ to offer their patients.⁴⁶ Even though a patient can apply for the line of credit online without a physician's suggestion,⁴⁷ the specifics of the financial relationship between the lender and borrower are not determined until the patient charges the credit card and the physician

41. *E.g.*, CareCredit, Myth, *supra* note 34; Citi Health Card Program, For Providers: Frequently Asked Questions, <https://www.citicards.com/cards/portal/healthcard/nsc/content.do?screenID=5014> (follow "What if my patients/clients don't pay their bills?" hyperlink) (last visited Mar. 21, 2009) [hereinafter, Citi Health Card, Using the Program]. This fee system is identical to the relationship that any vendor has with a credit card company. Mastercard Interchange Rates, *supra* note 28.

42. *E.g.*, ChaseHealthAdvance, Frequently Asked Questions, <http://www.chasehealthadvance.com/provider/faq.asp> (follow "Why is there a service fee charged to the practice?" hyperlink) (last visited Mar. 21, 2009) [hereinafter ChaseHealthAdvance, Service Fee]; Citi Health Card, Plan Options & Fees, <https://www.citicards.com/cards/portal/healthcard/nsc/content.do?screenID=5016> (last visited Feb. 21, 2009) [hereinafter Citi Health card, Plan Options].

43. *E.g.*, Citi Health Card, Using the Program, *supra* note 41.

44. *See, e.g.*, Telephone Interview with Dawn, Patient Customer Service Representative, CareCredit (Oct. 24, 2008); Citi Health Card Program, For Providers: Frequently Asked Questions, <https://www.citicards.com/cards/portal/healthcard/nsc/content.do?screenID=5014> (follow "Can I choose which payment plan options I offer to my patients?" hyperlink) (last visited Mar. 21, 2009) [hereinafter Citi Health Card, Enrolling].

45. There are currently two promotional rates a physician can choose between: a low-interest plan and a no-interest plan. Of course, the no-interest plan stipulates that should the patient fail to make timely payments, the "promo[itional rate] may be terminated and finance charges assessed from [the] purchase date." CareCredit, Payment Plans, <http://www.carecredit.com/paymentplans.html> (follow "Click here for Details and Terms" hyperlink) (last visited Feb. 21, 2009).

46. Telephone Interview with Rebecca, Healthcare Provider Customer Service Representative, CareCredit (last name withheld) (Oct. 24, 2008).

47. CareCredit, Apply Now for Instant Approval, <http://www.carecredit.com/apply/index.html> (last visited Feb. 21, 2009) [hereinafter CareCredit, Instant Approval].

approves a specific repayment plan.⁴⁸ If the physician chooses not to approve a patient for a promotional rate, GE Money's online credit application indicates that "the Purchase Standard Rate and Cash Standard Rate APRs will equal the prime rate plus 18.99%, but in no event will be less than 22.98%."⁴⁹

Some third-party lenders incentivize physicians to recommend specific payment options by offering to lower the physicians' merchant discount rates in exchange. For example, the Citi Health Card's merchant discount rate, the fee a physician pays to Citibank to accept the credit card as a form of payment,⁵⁰ is directly related to which payment plan the patient assumes.⁵¹ If the patient borrows on a three-month, no-interest plan for a treatment of \$99 or more, the physician pays a 1.5 percent merchant discount rate.⁵² However, if the patient borrows on the "budget payment plan" for a treatment exceeding \$1,000, the physician pays a substantially higher 4.5 percent merchant discount rate.⁵³

Thus, where physicians can determine the financial details of a contract between their patients and a third party, a risk exists that physicians will recommend repayment plans based on their own financial well-being rather than their patients' welfare. Returning to the hypothetical situation described in Part I, upon the dentist's recommendation, the patient borrows the cost of treatment from a lender. However, had the patient visited another physician that day or been provided with a more thorough explanation of available options, the patient could have received a better rate on her loan or line of credit, or perhaps the patient could have been made aware that the physician had a financial incentive to recommend that particular plan.

48. Telephone Interview with Rebecca, *supra* note 46; Telephone Interview with Dawn, *supra* note 44.

49. CareCredit, Online Credit Application: Key Credit Terms, <http://www.carecredit.com/apply/index.html> (follow "I'm not ready to choose a doctor yet" hyperlink; then select "Dental" in the drop-down menu; then click "Next") (last visited Nov. 2, 2008) [hereinafter CareCredit, Online Application].

50. Mastercard Interchange Rates, *supra* note 28.

51. Citi Health Card, Plan Options, *supra* note 42.

52. *Id.*

53. *Id.*

III. STATEMENT OF EXISTING LAW

There are two types of conflicts of interest that may arise in the physician-patient relationship. First, conflicts arise in which the physician's own interests conflict with the patient's interest in sound treatment. Second, conflicts arise in which the physician's own interests conflict with the patient's non-treatment interests. Currently, California law does not directly address concerns arising from medical credit cards and loans. Nonetheless, key statutory and common law concepts regulating conflicts of interest in the medical profession provide guidance on legislative protection for patients who choose to borrow on medical credit cards and loans.

A. Physicians' Financial Interests Versus Patients' Interests in Sound Treatment: A Fiduciary Relationship

The most direct way to examine the physician-patient relationship is by evaluating the constellation of fiduciary duties owed by a physician to a patient.⁵⁴ These duties arise as a result of the traditional nature of the physician-patient relationship: the treatment relationship. The court in *Canterbury v. Spence*⁵⁵ emphasized the importance of trust between patients and physicians by finding that the physician-patient relationship deserves accountability beyond that expected of parties in an arm's-length relationship.⁵⁶ However, current case law does not provide a cause of action for a patient whose financial health was damaged by the physician's negligent recommendation of a third-party lender. Instead, courts have limited the scope of a physician's fiduciary duty to his patients to issues relating to treatment only.⁵⁷

In 1947, the court in *Bowman v. McPheeters*⁵⁸ explicitly labeled the physician-patient relationship a fiduciary one.⁵⁹ There, the physician's fiduciary duty to his patient obligated him not to conceal the origin of the patient's ailment, namely, the physician's own

54. See generally, RAFAEL CHODOS, THE LAW OF FIDUCIARY DUTIES (2000) (offering a comprehensive explanation of the fiduciary relationship between physician and patient).

55. 464 F.2d 772 (D.C. Cir. 1972).

56. *Id.* at 782.

57. *Arato v. Avedon*, 858 P.2d 598, 599, 609 (Cal. 1993); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 485 (Cal. 1990).

58. 176 P.2d 745 (Cal. Ct. App. 1947).

59. *Id.* at 748.

negligence.⁶⁰ The court further held that because of the fiduciary duty that physicians owe to their patients, physicians are required to make a “full and fair disclosure . . . of all facts which materially affect [the patient’s] rights and interests.”⁶¹

In *Cobbs v. Grant*,⁶² the California Supreme Court expounded on the fiduciary nature of the physician-patient relationship. The court found that a physician has an obligation to disclose to the patient all of the information “relevant to a meaningful decisional process.”⁶³ The court commented that because patients have “an abject dependence upon and trust in [their] physician,” the physician should be held to a high standard of accountability when advising his patients.⁶⁴

More recently, in *Moore v. Regents of University of California*,⁶⁵ the California Supreme Court noted that while a physician’s fiduciary obligations to his patient require him to disclose his own research or economic interests in the patient’s treatment,⁶⁶ this duty does not flow from an obligation to protect the patient’s financial well-being.⁶⁷ Further, the court explained that “[a] physician is not the patient’s financial adviser.”⁶⁸

Finally, in *Arato v. Avedon*,⁶⁹ the California Supreme Court reiterated that a physician’s duty to obtain informed consent does not require the physician to inform patients of the financial impact of a certain course of treatment.⁷⁰ The claim in *Arato* stemmed from the defendant physicians’ failure to disclose relevant mortality rates of a

60. *Id.* at 749–50.

61. *Id.* at 748.

62. 502 P.2d 1 (Cal. 1972).

63. *Id.* at 10; *see also* *Stafford v. Shultz*, 270 P.2d 1, 7 (Cal. 1954); *Berkey v. Anderson*, 82 Cal. Rptr. 67, 78 (Ct. App. 1969) & *Bowman*, 176 P.2d at 748–49. The state legislature has also formally adopted the holding in *Cobbs* as part of the Book of Approved Jury Instructions (“BAJI”) section 6.11. James D. Nichols, *Lawyer’s Advice on Physician Conduct with Malpractice Cases*, 407 CLINICAL ORTHOPEDICS AND RELATED RES. 14-8 (2003). BAJI section 6.11 is the standard informed consent jury instruction. 1 JUDICIAL COUNCIL OF CALIFORNIA, CIVIL JURY INSTRUCTIONS 446–47 (June 2008).

64. *Cobbs*, 502 P.2d at 9.

65. 793 P.2d 479 (Cal. 1990).

66. *Id.* at 485.

67. *Id.*

68. *Id.*

69. 858 P.2d 598 (Cal. 1993).

70. *Id.* at 599.

certain cancer treatment when recommending it as treatment to the plaintiffs' deceased relative.⁷¹ The plaintiffs alleged that

[s]uch mortality information . . . especially the statistical morbidity rate of pancreatic cancer . . . was material to Mr. Arato's decision whether to undergo postoperative treatment; had he known the bleak truth concerning his life expectancy, he would not have undergone the rigors of an unproven therapy, but would have chosen to live out his last days . . . arranging his business affairs. Instead, . . . in the false hope that radiation and chemotherapy treatments could effect a cure[,] . . . Mr. Arato failed to order his affairs in contemplation of his death, an omission that . . . led eventually to the failure of his contracting business and to substantial real estate and tax losses following his death.⁷²

The plaintiffs further claimed that *Bowman* supported an action for recovery⁷³ because the physicians did not disclose life expectancy data that would have enabled the patient to make a more informed decision regarding his non-medical interests.⁷⁴ The California Supreme Court in *Arato* held that the informed-consent-like requirement imposed by *Bowman* was limited to only medical interests because the court in *Moore* stated that a "physician is not the patient's financial adviser."⁷⁵

Thus, the court in *Arato* differentiated between a physician's duty to protect his patient's physical health by obtaining the patient's informed consent regarding possible *medical* complications arising from medical treatment, and a duty to protect the patient's financial health by obtaining the patient's informed consent to possible *non-medical* (i.e., financial) complications arising from medical treatment. Consequently, for two reasons, it is improbable that a court would afford a remedy to a patient claiming that a physician violated a fiduciary duty to a patient by not revealing the possibility

71. *Id.*

72. *Id.* at 602.

73. *Bowman* held that "[a]s fiduciaries it was the duty of the defendants [physicians] to make a full and fair disclosure to plaintiff of all facts which materially affected his rights and interests." *Bowman v. McPheeters*, 176 P.2d 745, 748 (Cal. Ct. App. 1947) (emphasis added).

74. *Arato*, 858 P.2d at 608.

75. *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 485 n.10 (Cal. 1990).

of financial harm resulting from borrowing on a credit card or loan. First, the court in *Arato* specifically held that the physician is not responsible for disclosing possible financial consequences of treatment.⁷⁶ Second, in our hypothetical situation, the patient's potential financial suffering does not actually result from a treatment recommendation—it results from a personal, non-medical recommendation by the physician.

*B. Physicians' Financial Interests Versus Patients'
Financial Interests: Arbitration Agreements*

A second way to evaluate the physician-patient relationship is by examining how California statutes and common law treat conflicts of interest in which a physician's own interests could conflict with the non-medical interests of the patient. This type of conflict is closer in line with the conflict that arises in the case of medical credit cards and loans. In the hypothetical situation described in Part I, the physician does not stand to profit from recommending a particular treatment. Rather, the physician stands to profit from recommending a non-treatment action—specifically, which medical credit card or loan the patient uses to pay for treatment.

Arbitration agreements are a similar example of how physicians can legally influence their patients' non-treatment interests to protect his own interests. When a physician compels his patients to sign an arbitration agreement, the physician intentionally affects the legal rights of his patients⁷⁷ to gain personal benefits for himself.⁷⁸ Similarly, when a physician recommends that a patient borrow the cost of treatment from a certain loan or on a medical credit card, the physician intentionally affects the financial well-being of the patient to gain personal benefits for himself.

California Code of Civil Procedure section 1295 governs arbitration agreements in the medical arena.⁷⁹ It demands specific

76. *Arato*, 858 P.2d at 608.

77. Weldon E. Havins & James Dalessio, *Limiting the Scope of Arbitration Clauses in Medical Malpractice Disputes Arising in California*, 28 CAP. U.L. REV. 331, 336 (2000) (pointing out that by agreeing to arbitration, both parties surrender their right to a trial by jury).

78. Murray S. Levin, *The Role of Substantive Law in Business Arbitration and the Importance of Volition*, 35 AM. BUS. L.J. 105, 106 (1997) (describing the general benefits of utilizing arbitration to settle disputes as opposed to litigation).

79. CAL. CIV. PROC. CODE § 1295 (West 2008).

language to make such an arbitration agreement legally binding.⁸⁰ When assessing the validity of such agreements, courts rely on general contract principles.⁸¹ Thus, although a unique relationship exists between the physician and the patient in regards to treatment, the judiciary and the legislature disregard this trust-based relationship in favor of general legal principles where the physician-patient interaction does not concern treatment. Notice that the interaction between physician and patient in the hypothetical situation in Part I is similarly a non-treatment aspect of the physician-patient relationship. Thus, it may be safe to assume that the courts would similarly disregard the trust aspect underlying the treatment relationship when evaluating a suit arising from the financial harm a patient suffers as a result of her physician's negligent recommendation of a medical credit card or loan.

C. Situation-Specific Regulation

In certain situations, California courts and the state legislature have identified and curbed specific conflicts of interest that arise when physicians conduct their therapeutic relationships with patients in such a way that the physicians' actions may affect their own financial interests. For example, in 1986, the state curbed the ability of physicians to use the referral process for personal financial gain when it passed section 654.2 of the California Business and Professions Code.⁸² Section 654.2 prohibits any person licensed under division two of the Code, including all types of physicians and physician assistants,⁸³ from referring patients to affiliates in which the licensee, or the licensee's immediate family, has a "significant

80. *Id.* § 1295(a)-(c).

81. *See, e.g.,* *Doctor's Assocs. v. Casarotto*, 517 U.S. 681, 686 (1996); *Victoria v. Superior Court*, 710 P.2d 833, 834 (Cal. 1985). For an example of courts employing general contract principles to resolve disputes over arbitration agreements in the medical arena, see *Havins & Dalessio, supra* note 77 (discussing the conflict over whether to bind nonsignatories to arbitration agreements that fall under the purview of the California Code of Civil Procedure section 1295); *see also Victoria*, 710 P.2d 833 (holding that in assessing the case's facts according to certain basic principles of contract law, it was clear that by signing an arbitration agreement before medical treatment commenced, it was not the patient-signatory's intent to include claims for sexual assault by employees of the company administering treatment in that arbitration agreement).

82. CAL. BUS. & PROF. CODE § 654.2 (West 2009).

83. *Id.* §§ 1600, 3500 (West 2009). Division 2 also includes, but is not limited to, nurses (§ 2700), chiropractors (§ 1000), dentists (§ 1600), dietitians (§ 2585), physical therapists (§ 2600), and optometrists (§ 3000).

beneficial interest” without informing the patients of the financial interest in writing first.⁸⁴

California also protects patients by regulating the dispensing of prescription drugs. Section 4170(a)(3) of the California Business and Professions Code restricts physicians from owning a pharmacy.⁸⁵ In *Park Medical Pharmacy v. San Diego Orthopedic Associates Medical Group, Inc.*,⁸⁶ the court held that while physicians may distribute medications to their own patients for profit, physicians cannot own or operate a pharmacy that caters to the general public.⁸⁷ The court in *Magan Medical Clinic*, interpreting an earlier but substantively identical amendment of the California Business and Professions Code,⁸⁸ expounded that the law was intended to prevent physicians from prescribing drug treatment based on profit motives rather than on their patients’ actual needs.⁸⁹

No section of the California Business and Professions Code specifically regulates physicians’ roles in patients’ choices regarding assumption of debt via medical credit cards or loans. Nor does any current California case law specifically address this phenomenon. In an effort to better regulate dentists in the medical credit card and loan arena, in February 2008, California State Senators Sheila Kuehl and Sam Aanestad introduced Senate Bill 1633 to amend the California Business and Professions Code.⁹⁰ The Senate Bill sought to prohibit dentists, their employees, and their agents from arranging a line of third-party credit on behalf of, or referring patients to, a third-party lender without first providing a written⁹¹ disclosure⁹² regarding the

84. *Id.* § 654.2(a).

85. *Id.* § 4170(a)(3).

86. 120 Cal. Rptr. 2d 858 (Ct. App. 2002).

87. *Id.* at 867.

88. In this case, the court analyzed CAL. BUS. & PROF. CODE § 654 (amended 1979).

89. *Magan Med. Clinic v. Cal. State Bd. of Med. Exam’rs*, 57 Cal. Rptr. 256, 262 (Ct. App. 1967).

90. Complete Bill History, S.B. 1633, 2007–2008 Leg., Reg. Sess. (Cal. 2008), http://info.sen.ca.gov/pub/07-08/bill/sen/sb_1601-1650/sb_1633_bill_20080927_history.html (last visited Mar. 20, 2009).

91. S.B. 1633(1)(c), 2007–2008 Leg., Reg. Sess. (Cal. 2008).

92. Some of the disclosures include the following: the amount the patient is applying for; that the patient may choose not to borrow from the third-party lender; that the credit is offered by a third party and not by the dentist; that the patient is entitled to a written treatment plan prior to applying for the credit card or loan; that the dentist cannot charge treatment and lab costs to the line of credit or loan until the patient actually undergoes treatment or the dentist has provided the

transaction in the patient's primary language.⁹³ Although the California State Assembly and Senate passed the bill, Governor Arnold Schwarzenegger vetoed it on September 27, 2008.⁹⁴ As a result, only general consumer credit laws continue to directly regulate this area.

IV. CRITIQUE OF EXISTING LAW

As discussed in the hypothetical situation in Part I, physicians' choices of which third-party line of credit or loan to market to their patients have the potential to dramatically affect their patients' financial well-being. Presumably, physicians maintain their professional ethical standards and legal responsibilities to their patients when they recommend only necessary treatment. As Part III notes, California is willing to regulate potential conflicts of interest in the medical profession and to impose specific fiduciary duties on physicians to protect the patient's physical well-being. While courts have espoused the notion that the trust-based and confidential relationship between physicians and patients gives rise to a fiduciary duty to protect a patient's physical health, California courts have refused to recognize the financial health of the patient as part of the physician's concern.⁹⁵

A substantial conflict of interest arises when a physician offers medical lines of credit or loans, and can determine his own merchant discount rate by encouraging patients to choose the plan that benefits the physician the most. The issue becomes whether physicians should be required to disclose their financial interest in the plan to their patients. The potential harm to a patient does not satisfy the requirement set forth in *Arato v. Avedon* because the harm is financial in nature. However, the conflict of interest at issue falls squarely into the category of physician actions that the *Magan Medical Clinic* court sought to prevent—situations where a “doctor’s judgment is influenced by a profit motive.”⁹⁶ The court made it clear

treatment plan; that the patient may incur interest or penalties on the charges; that missed payments could hurt the patient's credit rating; and that the patient could be sued as a result. *Id.*

93. S.B. 1633(1)(e), 2007–2008 Leg., Reg. Sess. (Cal. 2008).

94. See *supra* note 10 and accompanying text.

95. *Arato v. Avedon*, 858 P.2d 598, 608 (Cal. 1993); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 485 (Cal. 1990).

96. 57 Cal. Rptr. 256, 262 (Ct. App. 1967).

that protecting patients from profit-driven physicians was a significant priority when it concluded that physicians may not own pharmacies.⁹⁷ Thus, it is certainly possible that the state legislature would be open to regulating the strikingly similar conflict of interest here.

However, judicial reasoning behind limiting the fiduciary duty of informed consent supplies an interesting insight into a potential issue for the legislature in drafting regulations. The judiciary has expressed concern that if physicians' fiduciary duties are extended to include protecting patients' financial health as well as physical health, physicians could be required to make broad predictions about patients' lives just to avoid a malpractice suit. The court in *Arato* stated that a physician's fiduciary duties do not include the duty "to disclose every contingency that might affect the patient's nonmedical 'rights and interests.'"⁹⁸ This clarification was necessary to avoid a limitless informed consent standard that would be impossible for physicians to satisfy.

Earlier, the court in *Cobbs v. Grant* set out to skirt the same problem when it limited the duty of informed consent to issues of medicine.⁹⁹ The *Cobbs* court held that "the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required"¹⁰⁰ The court in *Arato* added that it would be "unwise to require *as a matter of law* that a particular species of information be disclosed" because each patient's mental and physical abilities are different; thus, the physician should have case-by-case discretion as to what information is necessary to fully inform a particular patient.¹⁰¹ This traditional understanding of informed consent prevents a patient from suing a physician for giving advice or withholding information about lenders and financial agreements that may negatively affect the patient's health. Such information does not directly concern the patient's treatment, and requiring physicians to disclose such information would destroy any notion of a limited informed consent doctrine. However, this understanding also

97. *Id.*

98. *Arato*, 858 P.2d at 609 (first emphasis added).

99. *Cobbs*, 501 P.2d at 11-12.

100. *Id.* at 11.

101. *Arato*, 858 P.2d at 606-07.

provides guidance for possible legislation in that the courts do not approve of a limitless informed consent doctrine. Thus, the legislature may be more open to imposing a duty to inform patients of possible non-medical consequences where there is also a well-defined limit to what information the physician is required to disclose and when the physician is required to disclose it.

Additionally, this traditional understanding of informed consent relies on the assumption that a physician's only role in his patients' lives is that of medical caretaker. Where physicians choose to market medical credit cards and loans, aid their patients in obtaining them, and influence their own financial wellbeing by manipulating the financial terms of a patient's contract with a third-party lender, physicians step out of their traditional role as medical caretakers. Similarly, as discussed in Part III.B, when physicians draft arbitration agreements and require that potential patients sign them before entering into a treatment relationship, physicians step out of their traditional role as medical caretakers.

The California legislature included California Code of Civil Procedure Code section 1295 as part of the Medical Injury Compensation Reform Act.¹⁰² One could make an argument that arbitration agreements are inherently unconscionable based on the fact that the patient could be denied treatment should the patient decide not to sign the agreement.¹⁰³ However, section 1295(e) states that if the arbitration agreement at issue includes the mandatory language specified in 1295(a), (b), and (c), then the agreement cannot be held to be a "contract of adhesion, nor unconscionable nor otherwise improper"¹⁰⁴ The court in *Rosenfield v. Superior Court*¹⁰⁵ commented that the legislature's incorporation of subdivision (e) signaled that there existed a "determination to avert the creation of" unconscionability and oppressiveness by requiring the specific language requirements detailed in subdivisions (a), (b), and (c).¹⁰⁶ The court further commented that "[i]f an arbitration agreement does not contain the warnings prescribed in section 1295, factual issues are then created concerning the parties' reasonable

102. Havins & Dalessio, *supra* note 77, at 331.

103. See Hall & Schneider, *supra* note 7, at 675.

104. CAL. CIV. PROC. CODE § 1295(e) (West 2009).

105. 191 Cal. Rptr. 611 (Ct. App. 1983).

106. *Id.* at 613.

expectations and whether the contract is in fact oppressive or unconscionable.”¹⁰⁷ Indeed, by mandating the use of specific language, the legislature “encourages and facilitates the *arbitration* of medical malpractice disputes by specifying uniform language to be used in binding arbitration contracts to assure that the patient knows what he is signing and what its ramifications are.”¹⁰⁸ Thus, the legislature could be open to regulating the physician-patient relationship involving medical credit cards and loans as long as it could control how physicians convey information to patients so as to protect the interests of patients.

V. PROPOSAL

The solution that resolves this conflict of interest must be sensitive to the current conditions of the health care market. The court in *Chew v. Meyer*¹⁰⁹ recognized the changing face of medicine when it stated that “as a result of the proliferation of health and disability insurance, sick pay and other employment benefits,” patients rely on physicians to fill out the requisite forms, or to provide information “possessed solely by the treating physician,” and to sign the forms to confirm their truth and validity.¹¹⁰

The hypothetical situation described in Part I presents a related facet of this new world. Like insurance, credit cards provide patients with a means to pay for health care. When physicians have the opportunity to become involved in the application, approval, and payment-plan selection process, the possibility of a conflict of interest arises. Just as physicians may choose to accept certain traditional consumer credit cards as forms of payment and not accept others, and just as they may choose to accept only certain insurance plans and not others, physicians should be able to choose which medical credit cards and loans to accept.

Unfortunately, the current system lacks equilibrium between the interests of the physician and those of the patient. The interest of physicians to conduct their practices as they choose must be weighed

107. *Id.*

108. *Gross v. Recabaren*, 253 Cal. Rptr. 820, 822–23 (Ct. App. 1988) (quoting Barry Keene, *California's Medical Malpractice Crisis*, in *A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 31* (David G. Warren & Richard Merritt eds., 1976)).

109. 527 A.2d 828 (Md. Ct. Spec. App. 1987)

110. *Id.* at 832.

against the interest of patients to feel secure that they can depend on their physician for unbiased information in a no-pressure environment. In order to strike a balance, physicians who accept or aid a patient in obtaining a line of credit or loan should be subjected to regulations. This Note proposes a legislative solution that consists of six components. Violation of any of these components should result in civil penalties. First and foremost, the legislation should apply to all physicians who choose to accept a medical credit card or loan as a form of payment.

Second, a physician's use of marketing tools should be limited to simple pamphlets only, such as the ones commonly distributed today.¹¹¹ Moreover, third-party lenders should not be allowed to counsel or advise physicians or their staff on sales tactics.

Third, before a physician distributes information on a line of credit or loan, both the patient and the physician should be required to sign a short disclosure form provided by the state. The disclosure form could be modeled after a portion of the written notice detailed in Senate Bill 1633(c)¹¹² and might read as follows:

The attached information is for a line of credit or loan to help you finance your medical treatment. You do not have to apply for a line of credit or loan to pay for treatment. You may pay your physician for treatment in a different manner.

This line of credit or loan is not a payment plan with your physician's office. It is a line of credit with [name of third-party lender]. Your physician does not work for this company.

The merchant discount rate your doctor pays as a service fee to [name of third-party lender] may vary depending on the terms of the agreement between you and [name of third-party lender].

There may be other third-party lenders that specialize in lines of credit or loans geared toward medical bills. You are entitled to research all of these options before committing to one line of credit or loan.

111. See Part VI for a more detailed discussion of the attributes of these pamphlets.

112. S.B. 1633(1)(c), 2007–2008 Leg., Reg. Sess. (Cal. 2008). See Part III.C for a complete discussion of this senate bill.

You may be required to pay interest on the amount charged to the line of credit or loan. Missed payments can appear on your credit report and hurt your credit rating. You may also be sued.

The physician would be required to sign the form himself, and have the patient sign the form. Further, the physician would be required to provide a copy of this form to the patient in the patient's primary language. The physician would also be required to keep a copy of this form in the patient's file for a minimum of ten years after the information is distributed.

Fourth, physician should be allowed to aid patients in obtaining these lines of credit and loans. Physicians do have valid interests in doing so,¹¹³ and denying physicians this ability could lead to unethical and illegal behavior by those who would continue the practice to increase their own profits. Additionally, in order to avoid passing unenforceable legislation while still addressing existing deficiencies in patient protection, the proposed legislation would require a cooling-off period between the physician's recommendation of the line of credit or loan and the patient's subsequent submission of a credit application through the physician's office.

Fifth, physicians who choose to aid their patients in obtaining lines of credit or loans should also be required to devote a portion of their required continuing education credits to learning about the issues involved with financing medical procedures and related appropriate boundaries of the physician-patient relationship

Finally and most importantly, a physician should have no authority over the agreement between the third-party lender and the patient. The physician should have absolutely no influence over what rates the third-party lender charges the patient or whether the patient qualifies for a special promotional rate through that lender.

113. Such interests include "[i]ncrease[d] case acceptance, . . . [i]ncrease[d] gross revenue and profitability, . . . [and] [n]on-recourse payment to practice prior to treatment." Capital One Healthcare Finance: Benefits and Details, <http://www.capitalonehealthcarefinance.com/dental/doctors/benefits.asp> (last visited Feb. 21, 2009). Additionally, many professional medical associations recognize the good qualities of these lines of credit and loans, and endorse them as a result. *See, e.g.*, CareCredit, Endorsements, <http://www.carecredit.com/endorsements.html> (last visited Feb. 21, 2009).

VI. JUSTIFICATION

There are several reasons why patients should demand legal protection in this area. First, “health care ‘has a special moral status and therefore a particular public interest.’”¹¹⁴ Also, “the relationship . . . between the members of the profession and those who seek its services cannot be likened to the relationship of a merchant to his customer.”¹¹⁵

Additionally, legal, ethical, and social conventions define the boundaries of the physician-patient relationship so that the two may “maintain a professional helping relationship that meets the patient’s needs.”¹¹⁶ Courts have recognized that “[t]he fiducial nature of the physician-patient relationship flows not from the physician’s ethical duties, but rather as a result of the physician’s unique role in society.”¹¹⁷ Moreover, the Code of Medical Ethics, established by the American Medical Association, influences the ethical conventions of the physician-patient relationship by serving not as a system of legal duties but rather as a compilation of higher ethical standards to which physicians should adhere.¹¹⁸ Further, nearly 100 percent of graduating medical students in the United States take a form of the modern Hippocratic Oath,¹¹⁹ which “has remained in Western Civilization as an expression of ideal conduct for the physician.”¹²⁰ Thus, the interest of a state to maintain the professional integrity of physicians, and especially their moral standing in the community, is great enough to warrant the legislation discussed above.

114. *Potvin v. Metro. Life Ins. Co.*, 997 P.2d 1153, 1159 (Cal. 2000) (citation omitted).

115. *Jones v. Fakehany*, 67 Cal. Rptr. 810, 815 (Ct. App. 1968) (quoting *Lyon v. Lyon*, 54 Cal. Rptr. 829, 831 (Ct. App. 1966) (internal quotations omitted)).

116. Ronald M. Epstein, *The Patient-Physician Relationship in FUNDAMENTALS OF CLINICAL PRACTICE*, 403, 419 (Mark B. Mengel et al. eds., 2d ed. 2002).

117. *Petrillo v. Syntax Labs., Inc.*, 499 N.E.2d 952, 960 (Ill. App. Ct. 1986).

118. American Medical Association, *Principles of Medical Ethics*, <http://www.ama-assn.org/ama/pub/category/2512.html> (last visited Feb. 21, 2009).

119. Peter Tyson, *The Hippocratic Oath Today: Meaningless Relic or Invaluable Moral Guide?* NOVA, <http://www.pbs.org/wgbh/nova/doctors/oath.html> (last visited Feb. 21, 2009).

120. AM. MED. ASS'N., *CODE OF MEDICAL ETHICS* xi (Council on Ethical and Judicial Affairs ed., 2006–2007).

A. All Physicians, Everywhere

The major failing of Senate Bill 1633 as proposed is that it only applied to dentists, dental corporations, and their employees and agents.¹²¹ The state legislature must recognize that the problems related to medical lines of credit and loans affect patients of every medical specialty and that the range of specialties is broad.¹²² Additionally, “[s]omeone who is ill and seeking help—unlike someone who is purchasing a pair of socks or a pound of sausages—is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened.”¹²³ These characteristics are not unique to the patients of any one kind of physician. Rather, they affect all patients of all types of physicians. Therefore, the legislation’s reach should be extended to all physicians who accept medical lines of credit and loans.

B. Marketing Tools

The trust and confidence element of the physician-patient relationship should be maintained at all costs because of its integral role in American medicine.¹²⁴ Because trust and confidence are inherent in this relationship, patients might be inclined to take their physicians’ recommendations to apply for a line of credit or loan as gospel and follow it blindly. For example, physicians are traditionally encouraged to dress in a professional manner, to engage in limited personal conversation with patients, and to use formal language during their encounters with patients to maintain appropriate boundaries in patient care.¹²⁵ Additionally, physicians are encouraged to counsel patients in their offices only to maintain a

121. See generally S.B. 1633, 2007–2008 Leg., Reg. Sess. (Cal. 2008).

122. The CareCredit website allows patients to search for physicians that accept the line of credit and lists the following specialties as search options: chiropractic, cosmetic, dental, general medicine, general surgery, hearing, “other health care services,” veterinary, vision, and weight loss. CareCredit Home Page, *supra* note 21 (follow “Find a doctor near you” hyperlink). The Capital One health care finance website allows patients to view information on the loan by selecting from the following categories: dental, orthodontics, cosmetic, fertility, and vision. See Capital One, Home Page, *supra* note 20.

123. Hall & Schneider, *supra* note 7, at 649–51 (quoting Raymond Tallis, *Commentary: Leave Well Alone*, 318 BRIT. MED. J. 1756, 1757 (1999)).

124. Epstein, *supra* note 116, at 411.

125. *Id.* at 420. But see James C. Wade, *The Patient/Physician Relationship: One Doctor’s View*, 14 HEALTH AFFAIRS 209 (1995) (providing a thoughtful discussion on the benefits of developing a more personal relationship with patients).

spatial relationship in which patients feel comfortable divulging sensitive information.¹²⁶

Also, the wide disparity in medical knowledge between physician and patient significantly contributes to the patient's reliance on the physician.¹²⁷ Physicians have the power to significantly alter a patient's life by, for example, making judgments on that patient's ability to work or suggesting that the patient suffers from a terminal disease.¹²⁸ Thus, patients rely on physicians to use their utmost care and discretion when recommending treatment or advising on a future course of action.

When marketing materials such as pamphlets, "customized patient payment options worksheets,"¹²⁹ and scripts for use by office staff to "educate" patients on payment options¹³⁰ invade this unique trust-based relationship, the natural, more professional relationship is compromised, and the physician's role in the relationship is blurred. This situation raises the question of where the physician's medical role ends and his role as financial adviser begins. Physicians should be allowed to inform their patients that they accept a certain line of credit or loan targeted at paying medical bills, but physicians should not be allowed to use their patients' trust as a way to market those lines of credit or loans. By restricting marketing tactics to pamphlets only, the physicians have a controlled outlet to inform patients of an alternative payment option but no outlet to compromise the traditional physician-patient boundaries with extra discussion or strong recommendations in favor of that option.

Note that this does not place a restriction on the ability of lenders to educate physicians and their staff about how to submit applications for credit on behalf of their patients. Educating physicians and their staff on appropriate methods of collecting patient information and submitting forms on behalf of the patients does not involve specialized marketing methods designed to encourage patients to sign up for the service. Eliminating marketing

126. Epstein, *supra* note 116, at 420.

127. Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972).

128. Epstein, *supra* note 116, at 412.

129. ChaseHealthAdvance, Service and Support for Growing Practices, <http://www.chasehealthadvance.com/providers/service-support.asp> (last visited Feb. 21, 2009).

130. See, e.g., Capital One Healthcare Finance, Tools for Success, <http://www.capitalonehealthcarefinance.com/dental/doctors/fee-scripting.asp> (last visited Feb. 21, 2009).

tactics beyond informational pamphlets allows patients to consider the risks and benefits of such a line of credit or loan without additional pressure from physicians and their staff. Then, after the patient decides to borrow from a particular lender, physicians and their staff can employ their own knowledge of collecting information and submitting applications to ease those processes for their patients.

C. *Written Disclaimer*

A notice in writing of the patient's rights concerning payment options is necessary because it adds a layer of professionalism and uniformity to the physician-initiated recommendation process. At the very least, this form provides the patient with a series of considerations that should impact her decision to borrow the cost of treatment on a line of credit or loan.

Senate Bill 1633(c) served as the inspiration for the disclosure detailed in Part V of this Note. The language requirement is based on Senate Bill 1633(e), which proposed that the written disclosure be provided in one of the Medi-Cal threshold languages if the patient's primary language appears on that list.¹³¹ The requirement that the physician keep a copy of the signed disclosure for a minimum of ten years is based on recommendations of the California Academy of Family Physicians for the maintenance of routine patient records.¹³²

D. *Cooling-off Period*

The proposed cooling-off period would allow physicians to continue aiding patients to obtain a line of credit or loan, while protecting the patients' ability to make sound decisions about these financing options. Sickness severely impairs decision-making abilities.¹³³ When people are sick or hurt, their diminished ability to

131. S.B. 1633(e), 2007–2008 Leg., Reg. Ses. (Cal. 2008).

132. California Academy of Family Physicians, Frequently Asked Questions, <http://www.familydocs.org/practice-resources/faq.php> (follow "How long should I keep medical records?" hyperlink)(last visited Mar. 21, 2009).

133. Brooke Myers Sorger et. al., *Decision-Making Capacity in Elderly, Terminally Ill Patients with Cancer*, 25 BEHAV. SCI. & L. 393, 401 (2007). "Even 'a little loss of animal toughness, a little irritable weakness and descent of the pain-threshold, will bring the worm at the core of all our usual springs of delight into full view, and turn us into melancholy metaphysicians.'" Hall & Schneider, *supra* note 7, at 650 (quoting WILLIAM JAMES, THE VARIETIES OF RELIGIOUS EXPERIENCE 140 (Martin E. Marty ed., Penguin Am. Library 1982) (1902)). "Chosen from the traditional literary canon and from among the works of contemporary and culturally diverse writers, novels, short stories, poetry, and drama can convey both the concrete particularity and the metaphorical richness of the predicaments of sick people and the

direct attention to reasonable and rational thinking—like choosing a line of credit or loan—is truncated. The theory of truncated reasoning maintains that because “the person is devoting part of her limited conscious attentional capacity to the stressor . . . [she] has insufficient capacity remaining to cope with the decision” at hand.¹³⁴ Because patients are focused on health issues while in a physician’s office, they have limited abilities to focus on other issues, such as the implications of credit debt on their financial well-being.

Additionally, a person under stress “does not assimilate all available information and instead focuses on a very few dimensions of the problem.”¹³⁵ The brevity and simple language of the credit card and loan literature available through a physician’s office caters to this psychological phenomenon.¹³⁶ Patients are given little information, which helps explain their willingness to assume the credit obligation in such a quick fashion.¹³⁷ Without the burden of packets of disclosures, or even very much fine print,¹³⁸ the patient can assimilate the information quickly and make the decision to borrow right in the physician’s office. It is reasonable to assume that the fear of giving up medical care can drive this decision—without the card, the patient may not be able to afford the procedures the physician recommends or even afford to see the physician again at all. Therefore, the patient may not fully consider the implications of taking on extra debt when those implications are directly juxtaposed against the threat of continued pain or suffering.

Truncated reasoning also flows from a “motivation to terminate and escape from the stressful situation as quickly as possible. . . . [As a result, p]eople under stress tend to make choices impulsively, based on a consideration of short-term consequences only.”¹³⁹ For

challenges and rewards offered to their physicians.” Rita Charon et al., *Literature and Medicine: Contributions to Clinical Practice*, in HEALTH CARE ETHICS 554, 554 (John F. Monagle & David C. Thomasma eds., 1998).

134. Lauren E. Willis, *Decisionmaking and the Limits of Disclosure: The Problem of Predatory Lending*, 65 MD. L. REV. 707, 769 (2006).

135. *Id.*

136. See *supra* note 36 and accompanying text.

137. For example, the Capital One Healthcare Finance loan’s brochure lists approximate costs under offered fixed-rate plans in large print over two panels of the brochure. CAPITAL ONE HEALTHCARE FINANCE, SMART PAYMENT PLANS (2008) (pamphlet on file with author).

138. In the same Capital One Healthcare Finance loan brochure, there are only six lines of “fine print”—print that is much smaller than other print used in the brochure. *Id.*

139. Willis, *supra* note 134, at 769.

patients, the choice of whether to borrow on a credit card or loan commonly comes only after they have heard startling news, as described in the hypothetical situation in Part I. At that time, financial considerations only intensify an already stressful situation. In theory, patients whose physicians accept and aid in obtaining medical lines of credit and loans are given an “easy” solution to their financial concerns. Instead of worrying about both their physical and financial health, patients can resolve their financial concerns before ever leaving the examination room¹⁴⁰ and then focus all of their attention on their physical health. In such a situation, the physician influences not only the patient’s physical health but the patient’s financial health as well.

E. Financial Relationship

Physicians essentially assume the role of financial specialist without the proper qualifications when they determine at what rate patients will borrow from a third-party lender. Instead of relying on physicians to influence the patients’ relationships with their lender, the lender should take into account traditional factors of creditworthiness, most notably, the patient’s FICO score.¹⁴¹ Lenders generally determine whether to issue a line of credit or extend a loan based on information contained in the consumer’s credit report, which lenders purchase from credit-reporting agencies.¹⁴² Unless a physician has equally sophisticated methods of buying these credit reports, analyzing them, and predicting how patients will fulfill their debt obligations in the future, that physician should not have the ability to overrule traditional qualifiers.¹⁴³ The court in *Moore v. Regents of the University of California* agreed that a physician’s

140. Interview with Dr. X, *supra* note 28 (discussing that it is common for her office staff to bring a portable phone to the patient with the credit card representative already on the line because the patient is in pain and under stress).

141. A consumer’s credit score is a number that represents her credit risk to lenders. The Fair Isaac Corporation determines a consumer’s credit score based on the individual’s past credit information maintained by the credit-reporting agencies. MYFICO, UNDERSTANDING YOUR FICO SCORE 1 (2007), http://www.myfico.com/Downloads/Files/myFICO_UYFS_Booklet.pdf. The main factors that lenders use to determine whether to allow a consumer to borrow with them is the consumer’s FICO score, the amount of debt the consumer’s income will reasonably allow her to handle, the consumer’s employment history, and the consumer’s credit history. *Id.* at 2.

142. *Id.* at 3–4. *But see* Ricks Brooks & Ruth Simon, *Subprime Debacle Traps Even Very Credit-Worthy—as Housing Boomed, Industry Pushed Loans to a Broader Market*, WALL ST. J., Dec. 3, 2007, at A1 (describing the tactics of the subprime mortgage loan industry).

143. *See supra* note 141.

relationship with patients is *not* that of a financial adviser.¹⁴⁴ Physicians are medical professionals, and their influence over their patients should be restricted to the medical arena.

F. Continuing Education

Continuing education is a key component of the practice of medicine.¹⁴⁵ Like many other professionals, physicians are required to engage in continuing education to maintain, develop, and advance their professional skills¹⁴⁶ in order to “enhance the physician’s ability to care for patients.”¹⁴⁷ For example, the David Geffen School of Medicine at the University of California, Los Angeles planned to offer many continuing education courses in 2009, including a comprehensive update of in vitro fertilization and embryo transfer, a urology course, and a course in sleep medicine.¹⁴⁸ A patient expects that when her physician recommends a treatment or course of therapy, the patient is receiving the most current, thorough, and comprehensive recommendations possible.¹⁴⁹ Continuing education helps make that expectation a reality.

However, when physicians choose to aid their patients in obtaining lines of credit or loans, they expand their relationship with their patients beyond its traditional therapeutic boundaries. Such a physician essentially assumes the role of a financial professional, akin to a person who provides brokerage services for borrowers.¹⁵⁰ Brokerage services include “[o]btaining or attempting to obtain, on

144. 793 P.2d 479, 485 (Cal. 1990).

145. Geoffrey R. Norman, Susan I. Shannon & Michael L. Marrin, *The Need for Needs Assessment in Continuing Medical Education* 328 BRITISH MED. J. 999, 999 (2004).

146. See, e.g., CAL. BUS. & PROF. CODE §§ 2190–2196.5 (West 2009) (regulating the standards and requirements for physician continuing education in California).

147. ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., STANDARDS FOR COMMERCIAL SUPPORT OF CONTINUING MEDICAL EDUCATION 1 (1992), http://med.emory.edu/CME/pdfs/disclosure_pol.pdf.

148. UCLA Health Sciences, Office of Continuing Medical Education: CME Course Listings, <http://www.cme.ucla.edu/courses/> (last visited Feb. 28, 2009).

149. The court in *Brune v. Belinkoff* mandated that comparable education be the standard in negligence suits; physicians are held not to the standard of other physicians in the same location but rather in relation to others who practice their specialty. 235 N.E.2d 793, 798 (Mass. 1968). Thus, all physicians of one specialty are expected to have the same knowledge and training as their fellow physicians. *Id.*

150. In California, brokerage services for borrowers are governed by chapter nine of the California Residential Mortgage Lending Act, CAL. FIN. CODE §§ 50700–50707 (West 2009).

behalf of a borrower, a residential mortgage loan”¹⁵¹ California Financial Code section 50705 mandates that any employee of a residential mortgage lender who provides brokerage services to a borrower complete the continuing education requirements set forth in California Business and Professions Code section 10170.5. That section requires that every four years, the person providing brokerage services for borrowers complete, among other things,

courses . . . that will enable a licensee to achieve a high level of competence in serving the objectives of consumers who may engage the services of licensees to secure the transfer, financing, or similar objectives with respect to real property, including organizational and management techniques that will significantly contribute to this goal.¹⁵²

If physicians choose to incorporate financial recommendations into their practice by selecting a specific third-party lender to endorse for use by their patients and then aiding those patients in obtaining the line of credit or loan, then they should be held to a standard comparable to that of a financial professional. Consequently, the mandate of finance-related continuing education seems appropriate. Business and Professions Code subsections 2190.1(a)(3) and (4) already provide that a portion of a physician’s continuing education hours may be earned by engaging in a professional activity that concerns professional ethics¹⁵³ or one that is “designed to improve the physician-patient relationship.”¹⁵⁴ If designed correctly, courses on patient finance and the implications of excessive credit could greatly enhance a physician’s understanding of the financial hardships that patients face and educate the physician about the appropriate boundaries concerning the financial matters of his patients.

VII. CONCLUSION

The traditional relationship of trust and confidence between physician and patient should be maintained at all costs. Legal, ethical, and professional standards demand it. Luckily, the

151. *Id.* § 50700(b)(1).

152. CAL. BUS. & PROF. CODE § 10170.5 (a)(7) (West 2009).

153. *Id.* § 2190.1(a)(3).

154. *Id.* § 2190.1(a)(4).

California legislature and governor can act to protect patients. A defense against possible conflicts of interest and a safeguard for vulnerable patients, the regulation proposed above allows physicians and patients to continue their unique relationship without infringing on the interests of either party. Only after the state legislature passes such regulation can patients feel confident that their health is their physicians' only priority, and physicians can feel that their patients have sufficient options to fund their medical treatment.

