Virtual Mentor
American Medical Association Journal of Ethics
July 2013, Volume 15, Number 7: 576-580.

ETHICS CASE

Ethical Concierge Medicine?

Commentary by William Martinez, MD, MS, and Thomas H. Gallagher, MD

Dr. Lamb opened her e-mail inbox on Monday to find a message from her group practice manager—the third one that month—explaining more upcoming changes in how to code for what government and private insurers call E&M (evaluation and management services). The physician groaned and rolled her eyes. As members of a medium-sized group (40 members) that cared for many patients on Medicare, Dr. Lamb and her colleagues had been notified that the Affordable Care Act required them to phase in a value-based payment modifier (VPM) starting in 2015. The details of VPM and the measurement data participating groups had to provide if they did not want to accept an automatic reduction in payments seemed overwhelming to many group members whose primary goal was patient care.

Before the VPM reporting business started, it had been a new electronic records system. The original electronic records system the practice acquired just a few years before did not talk properly to other systems or report certain performance measures, and now Dr. Lamb and others had to learn the new system, apologizing to each patient as they searched for the right boxes and codes on the screen.

Then there was the upcoming switch from the current ICD-9 diagnosis coding system to the ICD-10 coding system, the latter containing 68,000 codes—a fivefold increase from the current number. In addition to these government requirements, physicians had the usual insurance filing to keep up with.

Dr. Lamb knocked on the office door of her co-worker, Dr. Tau, a pediatrician.

"Did you get the latest e-mail about the value-based payment modifier?" she asked.

"Sure did," Dr. Tau answered with a groan. "You know, for the first time, I'm thinking about 'going off the grid' and starting my own concierge practice just to escape all of this paperwork. Sure, my patients will have to pay me directly, but instead of spending my time trying to understand the next government scheme and filling out forms, I'll be able to spend my time helping them—which is why I went into medicine in the first place."

Back in her office, Dr. Lamb thought about what Dr. Tau had said. She'd never even considered concierge medicine and knew that many, probably most, of her patients couldn't afford it. Still, the idea of getting back to simply and purely practicing medicine was tantalizing.

Commentary

Frustrated by excessive paperwork, large patient loads, short visits, and diminished income, some primary care physicians have limited their involvement with traditional health insurance plans and embraced a less conventional model of medical practice known as "concierge medicine" or "retainer medicine." These medical practices generally limit their physicians to somewhere between 300 to 800 patients, rather than the 2,000-plus panel sizes typical of traditional primary care physicians, and charge participating patients an upfront annual fee varying from less than $1,000 to more than $5,000 [1-4]. In exchange, these practices often offer some combination of unhurried office visits, same-day appointments, comprehensive physical exams and screening, house calls, 24-hour physician access, and streamlined (sometimes accompanied) visits to subspecialists [1-4].

At first blush, this arrangement appears to benefit both doctors and patients. After all, who would object to longer visits, improved access, and enhanced coordination of care? And many physicians would certainly welcome less stress and better pay. Providing increased comforts and conveniences at a price is a widely accepted business practice and not typically a cause for concern. Before making her decision to pursue retainer medicine, however, Dr. Lamb should carefully consider the advantages of retainer medicine alongside an important set of ethical concerns raised by the unique fiduciary nature of medical practice. Through thoughtful ethical deliberation, Dr. Lamb can make a decision that best serves her, her patients, and her profession.

Medicine is a profession characterized by fiduciary duties that do not apply to ordinary business practices. A fiduciary relationship acknowledges the imbalance of power between physicians and patients, given the specialized knowledge that physicians possess and the vulnerability associated with being sick. Therefore, unlike commercial interactions in which both parties are expected to act in their own interests, physicians are expected to put patients' interests above their own. Some have extended this fiduciary responsibility beyond a duty to act in the best interests of individual patients to an obligation to all patients or the public as a whole [5]. In this view, the public grants the profession special status and privileges, and, in return, the medical profession is expected to have the advancement of health for all members of society as its primary goal and to adhere to strict ethical standards. This altruistic ideal is, of course, not without limits. Historically, physician altruism has been balanced with the needs and desires of physicians and the commercial dimensions of health care. Physicians have also been acknowledged to have discretion to choose which patients they care for, within limits. Thus, Dr. Lamb must consider how to balance these competing interests when considering a retainer medical practice.

Let us consider what may happen to her current patients if Dr. Lamb switches to a retainer practice. Here data is limited. In one survey of retainer practices, Alexander et al. found physicians who made the transition to a retainer practice maintained only 12 percent of their former patients [1]. Thus, Dr. Lamb's transition practice may

result in discontinuity for the majority of her patients, who will have to find new physicians to care for them. The decreased panel size of retainer physicians must be compensated for by other physicians who may already be overburdened, given current shortages in the primary care workforce.

Proponents of retainer medicine might argue that discontinuity and increased demands on colleagues also occur when physicians move or decide to work fewer hours and that this is generally not considered ethically problematic [2]. True, but it is important to note that the discontinuity and burdens caused by the transition to retainer medicine do not affect all patients equally. Instead, patients who are unwilling or unable to pay an additional fee for extra services that are not associated with improved health outcomes are disproportionately affected. In the context of physicians' fiduciary responsibilities, limiting patients' access to necessary medical care because of their unwillingness or inability to pay for "extra services" is concerning. Retainer fees also differ from charges for elective procedures, in which a patient's inability to pay for medically unnecessary services limits their access to those services but not their access to basic medical care from that physician. Alexander et al. also found that physicians in retainer practices care for fewer African American, Hispanic, and Medicaid patients and fewer patients with certain chronic diseases such as diabetes [1]. More research is needed to confirm and better understand these findings.

Proponents of retainer medicine might argue that individual physicians are not responsible for addressing disparities in access to health care and are not ethically required to individually provide any particular amount of care to any particular group [2]. Instead, individual physicians are only considered responsible for providing ethical and competent care in the settings that society provides for such work [2]. However, the profession of medicine *is* ethically required to address problems of health care access and disparities, and how can it do this unless the individual physicians who make up that profession consider this obligation when making practice decisions?

On the other hand, retainer medicine is not without its benefits. Dr. Lamb would most likely experience an increase in her compensation and a less stressful, more streamlined working environment. Her relationships with her patients, while fewer in number, may be more satisfying. Longer visits with patients also have the potential to increase the quantity and quality of preventive and other health maintenance services that Dr. Lamb could provide. A relatively small number of patients, those willing and able to pay the retainer fee until Dr. Lamb's reduced-size panel is full, may experience enhanced service, more convenient access to care, and better care coordination [6].

So how, then, can we balance these competing interests? Attempting to design medical practice models that enhance both patient and clinician experience and improve health outcomes is a laudable goal likely to be shared by all physicians, including the two in this case scenario. Our professional obligations require that

patient considerations remain paramount in these attempts. Ethics exhorts us to consider all reasonable alternatives for achieving a certain end and to choose means that maximize goods and minimize harms.

In this case, Dr. Lamb might consider moving to a primary care practice within an integrated health system. By leveraging technology, physician leadership, and large systems of care, these practices can offer better working conditions for physicians, excellent access to primary and specialty care, and improved health outcomes [7]. Their patients reap some of the benefits of retainer medicine, including timely appointments and e-mail communication with their physicians [7], although they may not necessarily receive longer visits, or home visits.

Alternatively Dr. Lamb might consider how to mitigate the negative effects of a retainer medicine practice. After all, not all retainer practices are created equal. Some charge fairly modest fees (e.g., $150 per year) to provide slightly longer visits, streamlined scheduling, and modestly reduced panel sizes, while others charge much higher fees for "luxury" services and more severely restricted panel sizes [4]. Some retainer practices waive fees for those who are unable to pay. These differences may have dramatically different implications for access and disparities. Physicians in retainer practices might attempt to address limitations and disparities in access by using retainer fees from some patients to subsidize care for others, by assisting patients displaced by the transition to find new doctors, by advocating and lobbying for just health care policies at a systems or governmental level, and by working in charity clinics [5].

Simply running away from the problems and inefficiencies of our current health care system and into the comforts of "retainer medicine" does little to advance health and well-being for the vast number of patients or address some of medicine's biggest challenges (e.g., cost and access). These are difficult times for physicians and patients alike. We must be careful not to compromise on our commitments and renew our efforts to find sustainable solutions that support physicians in the advancement of the health and well-being of all patients.

References

1. Alexander GC, Kurlander J, Wynia MK. Physicians in retainer ("concierge") practice: a national survey of physician, patient, and practice characteristics. *J Gen Intern Med*. 2005;20(12):1079-1783.
2. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. *Ann Intern Med*. 2011;155(9):633-535.
3. Carnahan SJ. Concierge medicine: legal and ethical issues. *J Law Med Ethics*. 2007;35(1):211-215.
4. Darves B. Access fees have physicians moving cautiously. *ACP Observer*. April 2004. http://www.acpinternist.org/archives/2004/04/access.htm. Accessed May 1, 2013.

5. Lo B. Retainer medicine: why not for all? *Ann Intern Med*. 2011;155(9):641-642.
6. Ko JM, Rodriguez HP, Fairchild DG, Rodday AM, Safran DG. Paying for enhanced service: comparing patients' experiences in a concierge and general medicine practice. *Patient*. 2009;2(2):95-103.
7. Van Zoeren DM. Can the practice of retainer medicine improve primary care? *Ann Intern Med*. 2012;156(5):399-400.

William Martinez, MD, MS, is a fellow in the Division of General Internal Medicine at Brigham & Women's Hospital (BWH) and Harvard Medical School and in the Division of Medical Ethics at Harvard Medical School in Boston. Dr. Martinez is a primary care physician in the Phyllis Jen Center for Primary Care at BWH. His principal research interests concern ethical and communication issues related to the safety and quality of patient care.

Thomas H. Gallagher, MD, is a professor in the Departments of Medicine and Bioethics and Humanities at the University of Washington in Seattle and a primary care physician in the General Internal Medicine Center at the University of Washington Medical Center-Roosevelt in Seattle. His research interests include the disclosure of adverse events and medical errors to patients, interprofessional communication, and transparency in health care.

Acknowledgment
The authors wish to thank Tom McDonald, MD, Brendan Abel, JD, and Lisa Lehmann, MD, PhD, for their thoughtful comments and suggestions on earlier versions of this manuscript.

Disclosure
Dr. Martinez was supported by a Harvard Medical School Center of Excellence in Minority Health and Health Disparities Post-Graduate Fellowship and by the Division of General Medicine and Primary Care at Brigham and Women's Hospital.

Related in VM
AMA *Code of Medical Ethics'* Opinions on Financial Incentives and Conflicts under Various Models of Payment for Care, June 2013

"Concierge" Practice and the Profession's Contract with Society, November 2003

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2013 American Medical Association. All rights reserved.