

Concierge Medicine: Tension Between Physician Autonomy and the Ethical Obligation to Provide Indigent Care

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Introduction

Primary care physicians and patients alike are becoming increasingly unhappy with the way primary care is currently being delivered. Physicians often see in excess of 2,000 patients per year,¹ receive reduced reimbursement rates, and experience other frustrations associated with not being able to deliver the best care possible due to time restraints.² Similarly, patients are frustrated by the difficulty in scheduling appointments and short, impersonal visits with their physician. Concierge medicine³ addresses some of these concerns by allowing physicians to drastically reduce their patient loads and conduct more personal visits with their patients. In a common model of concierge care, physicians provide enhanced services to patients beyond those available in traditional practices in exchange for a yearly retainer fee.⁴ However, only those able to pay these fees, which range from hundreds to thousands of dollars, are able to access this type of care. Therefore, a critical concern with the growth of concierge medicine is whether this type of care is discriminatory in practice, because these physicians are in effect only treating wealthier patients.⁵ As one doctor puts it, “[t]his is not how any of us doctors wanted care to be set up, but the system, as it is now, is broken. Patients are asking for more, doctors are under huge pressures, and there is not enough money in primary care.”⁶

Discrimination Concerns: Under or Over Exaggerated?

¹ Thomas Bodenheimer, M.D., *Primary Care – Will it Survive?*, 355 NEW ENG. J. MED. 861, 862 (2006) (stating that the mean U.S. panel size is 2,300).

² *Id.* at 861-62 (explaining that it would take physicians 10.6 hours per work day to deliver all recommended care for patients with chronic conditions, and an additional 7.4 hours per day to provide evidence-based preventative care, to an average of 2,500 patients).

³ Concierge medicine is also referred to as boutique medicine, retainer-based medicine, and direct care.

⁴ Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15 No. 5 HEALTH LAW 1, 2-3 (2003) (listing several of the amenities in concierge care including, priority or same day appointments; nicer, less crowded waiting rooms; 24-hour pager or cell phone access to the physician; house calls; extensive preventive care; telephone and email consultations).

⁵ *See Id.* at p. 5 (citing ACP-ASIM Ethics Manual, Fourth Edition, Am. College of Physicians. ANN. INTERN. MED. 1998; 128:576094 (stating that physicians have an ethical obligation to provide indigent care.); *see also*, Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or is it a Barrier to Access?*, 17 STAN. L. & POL’Y REV. 121, 134-35 (2006) (pointing out that many state statutes prohibit health care plans from discriminating among members of the same health class when setting rates, and from making distinctions among individuals of the same health class with respect to the type of coverage available to them.); Sandra J. Carnahan, *Concierge Medicine: Legal and Ethical Issues*, 35 J.L. MED. & ETHICS 211, 211-212 (Spring 2007) (commenting on the concern that concierge medicine may violate state discrimination statutes by choosing enrollees based upon their ability to pay an additional fee).

⁶ Pauline W. Chen, M.D., *Can Concierge Medicine for the Few Benefit the Many?*, N.Y. TIMES, Aug. 26, 2010, <http://www.nytimes.com/2010/08/26/health/26pauline-chen.html>.

When physicians downsize from larger, traditional practices to smaller, retainer-based practices, patients who cannot pay the retainer fee can no longer access their physicians' care. Many patients must find a new primary care physician in a time when primary care is experiencing a severe shortage of treating physicians. Beyond just an ethical concern, some suggest that this practice may even violate state discrimination statutes.⁷ For example, the New York Commissioner of Health has specifically spoken out against concierge medicine for its effect of prohibiting enrollees based on their inability to pay.⁸ However, others argue that the current health care system is already a two-tiered system replete with discrimination, and concierge medicine is simply filling a market demand.⁹

Conversely, many physicians argue that they are actually in a better position to provide indigent care, because they have a smaller workload and experience fewer daily stresses associated with managed care practices. In fact, a recent research study showed that retainer practice physicians might be more likely than others to provide some indigent care.¹⁰ Some surveys indicate that concierge physicians report improved job fulfillment and satisfaction.¹¹ Less stress and overall fulfillment might lead to a greater willingness to devote time to indigent care. Physicians in traditional practices barely have time to see enough patients to break even, so it is difficult to devote any additional time to indigent care.¹² However, this leaves out everyone who has too much money to be considered indigent but not enough to pay a pricey retainer fee.

Hybrid¹³ Model: One Solution to Address the Tension?

In 2004, the Department of Medicine at Tufts Medical Center developed a retainer-based primary care practice within the Division of General Medicine that tries to provide the financial rewards and job satisfaction of concierge care while addressing the ethical

⁷ Carnahan, *supra* note 5, at 211-12 (citing New Jersey's insurance code, which provides, "[n]o person shall make or permit any unfair discrimination between individuals of the same class. . . in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder [sic], or in any of the terms or condition of such policy or contract, or in any other manner whatever.")). The issue of whether concierge medicine could be classified as insurance practice is, however, not the basis of this article.

⁸ *Id.*

⁹ Am. Med. Ass'n, *Report of the Council on Medical Services on Special Physician-Patient Contracts*, CMS Report 9-A-02, *2-3, June 2002 (available at www.ama-assn.org).

¹⁰ *Id.* at *2-3.

¹¹ Linz, Haas, Fallon and Metz, *Impact of Concierge Care on Healthcare and Clinical Practice*, 105 J. OF THE AM. OSTEOPATHIC ASSOC. 11 (2005), available at <http://www.jaoa.org/cgi/reprint/105/11/515>; see also Frank Pasquale, *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 39, 61-62 (2007) (explaining that many retainer care physicians report that after years of feeling they could never meet their own high standards due to pressures from managed care, they can finally rest assured that they have provided all potentially helpful primary medical care that their patients need.)

¹² Am. Med. Ass'n, *supra* note 9 at *3.

¹³ The type of "hybrid" model addressed in this article is not the same thing as when physicians offer a hybrid of premium, concierge-type services and regular services to its patients. Here, I am referring to the concept of when physicians have both retainer-paying patients and traditional care patients in their practices. The retainer-paying patients receive the various amenities associated with retainer care while the traditional patients do not.

concerns regarding discrimination. Under the Tufts model, physicians operate both a concierge practice and a traditional medical practice, giving the patients a choice based on their financial situation and other demands. In contrast to operating a purely retainer-based practice, the Tufts model does not restrict net access to care and it neutralizes concerns about patient abandonment.¹⁴ In this particular model, the retainer fees are used to support the traditional medical practice as well as providing some level of indigent care.¹⁵ However, physicians could elect to contribute a portion of or none of the retainer fees to the other type of practice. Regardless, this hybrid model allows physicians to contribute to their ethical obligation to provide care regardless of one's ability to pay, while also embracing the benefits to concierge care.¹⁶

Concerns about the physician's ability to provide consistency of care to both types of his or her patients in this particular model seem to be exaggerated. Evidence supports that concierge care does not provide higher quality care.¹⁷ Patients still get the same doctor, medical advice, and excellent care that they've been used to before. It's not about taking away things. It's about opportunity for people who have different needs to be able to buy more of what they need.

AMA Code of Ethics: Obligation to Provide Indigent Care

The American Medical Association ("AMA") Council on Ethical and Judicial Affairs has issued Codes of Medical Ethics related to what it labels as "retainer practices." Specifically, the AMA states that, "physicians have a professional obligation to provide care to those in need, particularly those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation."¹⁸ It should be noted that the AMA's Council on Medical Services issued a report in June 2001 on Special Physician-Patient contracts that concluded that there is no evidence to suggest that concierge medicine is shifting the amount of uncompensated care on to other physicians.¹⁹ Nonetheless, the AMA encourages physicians who practice retainer-based care to seek out opportunities to fulfill charity obligations. The AMA supports physicians' rights to transition into a retainer-based practice, but acknowledges the inherent tension between physician autonomy and the duty to provide care regardless of one's ability to pay.

¹⁴ See Tufts Med. Center, *Concierge Care at Pratt Diagnostic Center*, <http://www.tuftsmedicalcenter.org/OurServices/InternalMedicineAndAdultPrimaryCare/PrattDiagnosticCenter/default> (last visited Nov. 11, 2010).

¹⁵ Chen, *supra* note 6, at 3 (Dr. Fairchild, chief medical officer at Tufts Medical Center and a physician in this hybrid practice states, "[n]o matter what practice patients are from, we treat them based on their medical need. But we also recognize that there may be a place for a higher level of service.").

¹⁶ However, physicians will still have to reduce total number of patients to best operate this hybrid model, but patient load may still be higher than that of a purely retainer based practice.

¹⁷ Chen, *supra* note 6, at 3. (Dr. Fairchild, of Tufts Medical Center, conducted a study on consistency in care across both practices, which concluded that patients rated the quality of interactions with their doctors similarly regardless of their affiliation. "It's like going first-class in an airplane, [he] said. The experience of people in coach is a little different, but everyone gets to the same place at the same time.").

¹⁸ Am. Med. Ass'n, *AMA delegates adopt ethical guidelines for retainer practices*, AMA News Release, June 17, 2003.

¹⁹ Am. Med. Ass'n, *supra* note 9 at *3.

Conclusion

Undoubtedly, free choice is an important cornerstone in our society, and this holds true in our health care system.²⁰ The AMA has followed the trend in concierge medicine and continues to endorse physicians' right to choose this type of practice.²¹ However, a physician's ethical obligation to provide care regardless of one's ability to pay should be balanced with a physician's autonomy in choosing which patients to treat. The purpose of physician autonomy is to assure that patients receive the best possible care.²² A physician who chooses to transition into concierge care should seek out ways to meet his or her obligations to treat all patients regardless of ability to pay.²³

One way to address this tension and uphold the AMA's Codes of Ethics is for physicians to employ a hybrid model if they are choosing to make the transition into retainer-based care. Under this model, physicians would see both retainer-based patients and non-retainer based patients. Physicians can choose what portion of the retainer fees can go towards the operation of their traditional practice or indigent care practices. Physicians can therefore reap some of the benefits being reported by concierge physicians while still providing care to a substantial population of people unable to pay for retainer based care. Additionally, efforts should be made to develop to a national primary care policy that addresses the overall problems exacerbating the primary care physician shortage in this country. Currently, public policy on primary care does not exist.²⁴ Well-documented information on primary care and the long-term effects of the concierge model should continue to be encouraged.

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²⁰ See Anthony N. DeMaria, MD, MACC, *Concierge Medicine: For Better or For Worse?*, 46 J. AM. COLL. CARDIO., 377-78 (2005), available at <http://content.onlinejacc.org/cgi/reprint/46/2/377.pdf> (stating, "I believe that most Americans would object to the proposition that the quality of health care depends on the amount of money an individual can spend for it. We have come to regard good health as a right rather than a privilege. The thought that an individual might experience more or less morbidity or mortality based on how much money they could devote to medical care would be difficult to accept. Therefore, the ability of concierge care to exist and grow in our system would require that the quality of care provided by such programs be available to every member of society.").

²¹ Pasquale, *supra* note 11, at 51-52.

²² *Id.*

²³ *Id.*

²⁴ Bodenheimer, *supra* note 1, at 863.