

Concierge and Direct Patient Care Models

ARE THEY COMPATIBLE WITH CATHOLIC SOCIAL TEACHING?

KIMBERLY ZOBERI, MD

Concierge medicine, sometimes called retainer medicine, is a model of care in which the patient directly pays the physician a yearly fee — averaging \$1,800 — in exchange for enhanced services.¹ A 2016 survey showed that 4 percent of U.S. physicians reported themselves as being in a concierge practice.²

Based on what doctors and patients have told me, not only is it a complicated decision to change a medical practice to a concierge model, there are ethical considerations with particular resonance for Catholic practitioners. Here is a hypothetical physician — I'll call her "Dr. Angelos" — thinking through what it would mean to become a concierge doctor.

Dr. Angelos is a middle-aged, female internist working in a suburban group practice. After 15 years there, she is well regarded by patients and colleagues and has formed many close relationships, which she cherishes. However, Dr. Angelos finds herself growing frustrated by the ever-increasing burdens of paperwork. She is stressed by constantly changing regulations. She has begun to resent the seemingly endless needs of her patients and the lack of administrative support in the office. She no longer looks forward to going to work.

Dr. Angelos realizes she is suffering from burn-out, but she can't seem to find a solution that will bring back a sense of joy to her work. As a means of coping, she is seriously considering restricting her hours, or even seeking early retirement.

During a continuing medical education conference, she hears a presentation about concierge care, which offers an apparent solution to her feelings of being overworked and rushed all the time. Under this model, the physician has much more time per patient encounter and a lower administrative and paperwork burden. The speaker touts

the benefits of physician autonomy and improved patient care. The promise of a generous income, coupled with more enjoyable working conditions, appeals to Dr. Angelos. As a practicing Catholic, though, she wonders about the ethics of providing care only to patients who can afford the annual retainer.

THE BUSINESS MODEL

A concierge practice generally provides easier access to the physician, unrushed office visits, more comprehensive testing and a personalized plan for preventive medicine.³ Sometimes additional services, such as house calls or facilitation of appointments with specialists, are included. The yearly fee may be deemed payment for the enhanced services, and the concierge practice may still bill the patient's insurance for the usual and customary charges of an office visit.

With a concierge practice, the physician ben-

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efits by having a guaranteed income base and a much smaller patient panel. Patients generally are pleased with the personalized attention and easy access they receive. Although most patients would appreciate that level of service, not all can afford the yearly fee on top of their usual insurance costs. The average patient who subscribes to a concierge practice has an annual household income of \$125,000–\$250,000.⁴

CATHOLIC TEACHING

Catholic social teaching views basic health care as a right to which all humans have equal claim. In the United States, we have struggled to adopt a model of health care reform that guarantees every American the right to basic health care.

The United States Conference of Catholic Bishops stated in a 2009 letter to Congress: “Reform efforts must begin with the principle that decent health care is not a privilege, but a right and a requirement to protect the life and dignity of every person. All people need and should have access to comprehensive, quality health care that they can afford, and it should not depend on their stage of life, where or whether they or their parents work, how much they earn, where they live, or where they were born. *The Bishops’ Conference believes health care reform should be truly universal and it should be genuinely affordable.*”⁵

As Catholic health care providers, it is our duty to embrace models of care that seek to provide high quality, affordable care to all.

Dr. Angelos is uncomfortable with the “two-tier” nature of concierge medicine. She wonders if concierge medicine will provide an abundance of care to a small number of patients, while leaving others with no access to health care at all. However, the idea of alternatives to traditional insurance has piqued her interest. She explores the model of “direct patient care” as an ethical alternative to either concierge medicine or traditional insurance.

DIRECT PATIENT CARE

Direct patient care is a model in which the patient pays the physician a monthly fee based on the patient’s age, usually \$50–\$150, in exchange for appropriate medical care. The physician does not accept or bill any insurance company for the services provided. This model greatly simplifies the business aspect of the medical office — one sur-

vey estimated that as much as one third of medical practices’ overhead is consumed by interaction with insurers.⁶ With a guaranteed income and simplified office flow, the physician can maintain a smaller patient panel than a traditional practice. This translates to easier access for patients and enhanced job satisfaction for physicians.

The Affordable Care Act was instituted in 2010 to provide options for obtaining health insurance to all Americans, including those of low income, thereby decreasing the number of uninsured patients in this country. The ACA allows direct primary care to be offered as an option for health care coverage by the health care exchanges. The subscriber must pair a direct care plan with a high deductible, “catastrophic” insurance plan to cover expenses in excess of what the direct patient care physician will provide.⁷ These additional expenses include unforeseen needs such as

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surgery, inpatient hospital fees or specialist consultations, and they may leave the patient with a very substantial deductible (up to \$5,000) to meet before insurance begins to pay these costs.

Such shifting of risk from the insurance company (in traditional insurance) to the patient (in a direct patient care model paired with high deductible plan) raises the ethical issue of patient autonomy versus paternalism. Proponents of the direct patient care plus catastrophic insurance model argue that direct patient care more accurately reflects the actual cost of primary care, while giving patients more autonomy over how much health care they wish to purchase. Direct patient care models usually provide comprehensive, standard primary care, which is relatively low in cost and can meet most of an average patient’s health care needs. The model works well if the patient does not incur extraordinary medical expenses, or if the patient can afford the large deductible under a high deductible plan.

Can we trust patients to perform this medical cost calculus with accuracy? Is the direct patient

care model enticing patients to pick the lowest cost option, exposing them to the risk of disastrously high, unexpected costs? If these costs occur, will the patient be able to meet his financial obligations, or will the costs be shifted back to hospitals and thereby back to society in general?

Including direct patient care under the ACA raises the ethical issue of whether direct patient care will increase or decrease access to primary care for non-wealthy patients. On the one hand, paying the monthly fee plus the relatively low cost of the high deductible plan may be the most affordable option for many patients, allowing a greater number of patients to afford a basic health plan. On the other hand, if direct patient care physicians are downsizing their practices, there may be less physician availability at the very time that it is most needed.

The perfect storm of an aging population, increasing numbers of people obtaining health insurance coverage and a declining number of medical students entering primary care careers has created a large deficit of primary care providers, leaving people struggling to find a primary care physician who is accepting new patients.⁸ If the concierge care model or direct patient care model enhances physician satisfaction, more medical students may elect to enter the primary care field, and current physicians may practice more years before retiring. Whether the concierge/direct patient care models produce greater or less access to primary care in the long term cannot be predicted at this time.

After a great deal of consideration, Dr. Angelos decides that she will achieve more personal and professional good by providing top-quality care to a limited number of patients. She decides to make the move to a direct patient care model. She realizes this raises several questions: Which patients will she invite to join her new practice? Will she invite all of them, only the healthiest, or only the ones she knows can afford it? What will she tell the patients who wish they could join her but cannot afford the retainer fee?

THE DOWNSIZING DILEMMA

Many physicians transition into direct patient care models after working in a traditional model

for some time and, therefore, they face the very real dilemma of “downsizing” their patient panel. Although the recommended panel size for a primary care physician is 1,400-1,900 patients,⁹ the typical primary care physician cares for a panel ranging, on average, from 1,500 patients¹⁰ to 2,300 patients.¹¹ The resultant overwork, stress and low quality interactions are well-known by physicians and patients alike.

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In contrast, the typical direct patient care physician cares for a panel of between 600-800 patients.¹² Clearly, this panel allows the physician to spend much more time with each patient, enhancing satisfaction on both their parts, and possibly providing better quality care. How does a physician shed as many as 1,500 patients? Will the physician resist the temptation to leave behind patients who are noncompliant, sicker, poorer or otherwise undesirable?

There is evidence that physicians in concierge or “retainer” practices care for fewer diabetics, African-American, Hispanic and Medicaid patients.¹³ Is the direct patient care physician creating an increased burden for her colleagues who continue to practice in the traditional model, and is she decreasing access to medical care for the patients she leaves behind?

The American Medical Association Code of Ethics speaks out against abandoning patients during the transition to concierge medicine.¹⁴ Although the document does not specifically address the direct patient care model, the recommendations are applicable: The code says physicians should facilitate the transfer of non-subscribing patients, especially the sickest and most vulnerable, to a traditional medical practice. If such patients cannot find another provider, the physician may be ethically obligated to

continue caring for the patient. The AMA does not subscribe to any method of enforcing this ethical mandate other than the physician's own conscience.

Some large concierge medical franchises refuse to work with physicians unless they have a plan in place to transition their patients to new providers.¹⁵ Despite this, I have seen many letters to patients stating that the current physician is setting up a concierge practice, that patients are invited to subscribe, and that those not choosing to do so should contact their insurer to be reassigned.

The American College of Physicians also has weighed in on the ethical issues surrounding concierge or direct patient care models. In a 2015 position paper, ACP raises concerns about these models reducing access to care, especially for vulnerable patients.¹⁶ The organization reminds its member physicians of their professional obligation to care for the poor. It urges physicians who are downsizing their practices to consider the effect of the downsizing on the local community, and to help patients transition to other providers if necessary. An important contribution of the position paper is the call for policymakers to address the factors that are driving physicians to seek out direct patient care practices and other alternatives to traditional patient care models. It encourages physicians to consider the patient-centered medical home model as an alternative to the traditional medical model.

CATHOLIC SOCIAL TEACHING

A Catholic physician who is adopting an alternative model of patient care faces additional ethical questions. How does Catholic social teaching about the dignity of every human person inform her actions when downsizing her practice?

She should remember that good health, wealth and social standing are as much an accident of geography and genetics as they are an earned achievement.¹⁷ Pope Paul VI, in *Gaudium et Spes*, calls upon us to “make ourselves the neighbor of every person without exception,” specifically citing the elderly, the refugee, the illegitimate child and the hungry.¹⁸

In this spirit, it is ethically mandatory for a physician opening a concierge or direct patient care practice to invite all existing patients into the new care model, without regard to “preferred” patient status or wealth. In practice, many of the difficult or non-wealthy patients may opt not to

join the new practice, but the physician's intent will influence many of her decisions during the downsizing process. Above all, when recruiting patients for her new practice, she should remember Matthew 25:40, “Whatever you did for one of these least brothers of mine, you did for me.”

The ethical physician should consider the principle of nonmaleficence — that is, attempting to avoid harm to others — and work to mitigate any harms incurred by the transition to concierge or direct patient care medicine.

'NEEDS OF THE CHURCH'

Advocates of these models counter criticism by pointing out that having a more reasonable patient panel allows them more time for volunteering. What is a reasonable amount of volunteering? The *Catechism of the Catholic Church* encourages us to support the needs of the church “each according to his own ability.”¹⁹ However, volunteering a certain number of hours per week may not counteract the harms incurred by decreasing panel size and, as a result, decreasing net physician availability.

Perhaps the ethical physician should volunteer a percentage of her time proportional to the percentage of Medicaid patients she is no longer seeing, or proportional to the percentage of Americans who are uninsured. In this way, she would be taking care of her fair share of the Medicaid or uninsured population.

A question to consider: Is it enough? As Catholic physicians, is our duty discharged when we take care of our fair share, or should we follow the teachings of St. Teresa of Calcutta and “Give until it hurts?”

THE COMMON GOOD

The Catholic principle of solidarity acknowledges our interdependence as members of the larger human family, and it calls upon us to promote the full health and well-being of each member of that family. We should not be willing to take for ourselves what we would not also wish to secure for all others. As stated by St. John Paul II in *Sollicitudo Rei Socialis*, “This then is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all.”²⁰

An examination of the calculus of concierge

medicine makes it clear that there is no commitment to the common good. In fact, it achieves nearly the opposite — it creates a more difficult situation for some patients so that others can have a more pleasing experience. The influence of direct patient care is much more nuanced, and it is highly influenced by the intention of the physician. She must strike a balance between achieving a reasonable amount of good for herself, for the average patient and for “the least of these.”

Dr. Angelos decides that she has an obligation as a Christian to take care of all patients, including the poor and uninsured. She plans to reserve 10 percent of her patient capacity for “scholarship” patients, who will not be charged the monthly fee. She also is hopeful that her more manageable workload will allow her to act as a volunteer preceptor for medical students.

Although Dr. Angelos acknowledges that she is taking care of a smaller patient panel than before, she thinks a greater harm would come from seeking early retirement. Dr. Angelos finds her new, direct patient care practice to be an acceptable way to increase her own job satisfaction while allowing her to care for the poor and underserved.

KIMBERLY ZOBERI is a practicing physician and associate professor in the Department of Family Medicine at Saint Louis University School of Medicine, St. Louis, Missouri.

NOTES

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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