Chapter 9

Commitment to Maintaining Trust by Managing Conflicts of Interest

Cases and Commentaries

MANAGING CONFLICTS OF INTEREST – PRIMARY CARE

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A family physician becomes increasingly frustrated with his medical practice. He notes that his income has decreased, relative to inflation, over the past twenty years. He also notes that the time he is able to spend with patients had decreased – now thirty minutes for new patients and about ten minutes for established patients. Two of his long-standing patients are also frustrated with his practice. They complain about the long wait to see him and the decreased time for the visit. Both of these patients suggest that the family physician consider starting a retainer or "boutique" medical practice. This type of practice would increase the physician's income by requiring patients to pay a retainer fee and would allow him to spend more time with his patients. The physician considers this change.

A Perspective from a Family Physician

Control of today's typical primary care practice has passed to third parties including Medicare, Medicaid, HMOs (health maintenance organizations), PPOs (preferred provider organizations), and employers since they, not patients, control the ever diminishing flow of funds to physicians and other providers of health care. Patients are churned, one problem at a time, with brief visits, to maximize ever shrinking third party per-visit revenue. After-hours and hospital care is shunted to the emergency department and to hospitalists. The former financial and personal rewards of practice are now replaced by frustration and bureaucracy. As a result, primary care, the indispensable backbone of our profession, is crumbling. Concierge medicine is the rational reaction to these realities.

Rather than continuing to play the Medicare and managed care game the concierge doctor has returned to focusing on serving and pleasing patients. Millions of patients are or would be happy to pay a premium for an attentive, available, consumer-focused primary physician. They are sincerely embarrassed by how little Medicare and insurance pay their doctor. When my own active patients were polled in 2005, 33 percent said they would gladly pay extra for such service, but most doctors have no mechanism to accommodate them.

Some doctors, often those who have not experienced the private practice environment, actually believe that such singular care would be unjust. Concierge physicians, in contrast, firmly believe that in America a mechanism must exist to serve patients seeking such singular care and that in

fact such care could be the standard by which all primary care is judged. We further believe that it is possible for most Americans, regardless of income level, to eventually have this kind of "medical home." This is the care Americans say they want and it translates, we believe, into better outcomes.

Retainer practice (also referred to as concierge medicine or direct practice) strongly resembles the "medical home" advocated by various academies and study groups. Adequate funding is the key to any such design, but when that funding comes from third parties or government it tends eventually to become insufficient since control of the level of funding is determined by a third party payer uninvolved in the actual value transaction. And that third party payer fails to see the appropriate value. Therefore, concierge doctors believe the funding must come directly from patients. Only the actual consumer appreciates the real value of any service.

"Retainer practice provides sufficient income to allow extended, same day, or next day visits with almost no waiting. It offers a rested, cheerful physician willing to be available 24/7 to this selected group of patients. All issues that concern the patient are covered at each visit, greatly reducing the number of visits necessary later. Care the physician was trained to deliver is actually done on site and at the time rather than deferred or referred due to lack of time or economics. Patients are followed by their own doctor when hospitalized. The patient's concerns, time, and convenience are paramount, not the insurance company's.

Once a physician concludes that he or she must make this transition, as did I, several ethical concerns must be addressed. The first issue is abandonment. In my own situation, the year of transition was instructive. My demographic files contained 7,000 verifiable patient names. I attended 1,500 different individual patients in the previous twelve months and 2,500 in the previous twenty-four months. All 7,000 patients in my files were offered participation in my redesigned practice and advised that the practice size, being dominantly geriatric, would be limited to 600. By the launch date about 500 had enrolled, so clearly, and as expected, most patients chose not to join. I had clear obligations to those non-joining patients.

It was mandatory to identify several comparable doctors in the community willing to accept patients not joining the retainer practice. It was necessary to provide emergency care to all patients until such time as they were firmly established with that new doctor. Records must be transferred at no charge and smooth transition must be ensured.

The offer to join the retainer practice must be made to patients months in advance of launch date, free of undue pressure and with clear terms, conditions, and contracts. It must include usable information about alternatives, an effective system to assist in transition, and declination forms to sign for patients who choose not to join, linked to the smooth transfer of care to a new doctor.

Of course, thousands of patients, most in fact, never responded at all. When those patients later called, they had to be cared for until they were officially and smoothly directed elsewhere for follow up and future care. While abandonment is the most important concern, it is not the only ethical issue facing physicians launching or converting to retainer practice.

Critics of retainer medicine claim it removes doctors from the overall pool needed to care for everyone else. This is a false allegation. Concierge physicians usually have no trouble identifying comparable, local physicians willing to assume the care of non-joiners. Further, the actual number of concierge doctors is insignificant. At this writing there are probably fewer than 2,000 concierge physicians nationwide while there are 900,000 doctors.

Furthermore, though some recently trained physicians do start retainer practices, most are rather senior. Many would have retired, had they not converted to a retainer model, leaving all their patients in need of a new physician. In contrast, once converted, the concierge doctor, though still quite busy, is usually very happy with practice and negative thoughts about the practice of medicine fade away.

In fact, I have never met a more positive group of physicians than at a concierge practice society meeting. They work only for patients, determine their own compensation, control the quality of their care and have a strong sense of professional fulfillment. They rarely think about early retirement. Thus, conversion to concierge medicine preserves these physicians in practice perhaps decades longer and may actually expand the pool.

Concierge medicine could serve most Americans. About 300,000 physicians now do primary care. That number of physicians could serve 240 million patients in an 800-patient retainer model, even without extenders. The fee to be in such a practice should be about $100 per month, often less. The majority of Americans can easily afford such a fee.

Charity care is an ethical issue. Typical retainer practices have about 10 percent charity cases. Most concierge doctors believe they have no absolute obligation to extend charity except in emergencies, but do so because they want to and can afford to. The AMA's statement on the ethics of retainer medicine, as well as our professional society's statement on ethics, address this issue explicitly. Sadly, many primary care doctors in today's typical practices cannot afford to extend charity care at all for lack of time and fear of further economic damage.

In summary, retainer medicine, seen first in 1997, is growing slowly. It will further evolve to serve varied population groups as consumer-directed health care expands and empowers patients. Preliminary impressions suggest retainer or direct practice saves money by preventing and shortening hospitalizations, limiting ER visits and practice errors and providing exceptional preventive care. Lives are probably saved and prolonged, but empirical studies are lacking. Research on the impact and efficacy of the concierge medicine issue is needed. I would argue that concierge medicine is an ethical mode of practice; indeed, it could well be the salvation of our now critically ill primary care system."

Excerpt From: John Spandorfer, Charles A. Pohl, Susan L. Rattner & Thomas J. Nasca. "Professionalism in Medicine." Cambridge University Press, 2012-07-02. iBooks.