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COMMENTS AND RESPONSES

Academic Medicine and Concierge Practice

TO THE EDITOR: Doherty (1) neglects to mention that many

luxury care clinics are sponsored by academic medical centers.

Some partner with national concierge care companies.

Marketing for such clinics is directed at the heads of successful

small and large companies, who are disproportionately

white men. Many physicians who staff luxury care clinics limit

their practices to the wealthy (2, 3). Physicians in retainer practices

care for fewer African Americans, Hispanics, and Medicaid

patients than those in other types of practices; moreover,

physicians who switch to a retainer practice keep an average

of only 12% of their former patients, thus burdening other,

already overworked physicians in the community (4).

The general public contributes substantially to the education

and training of new physicians through state and federal

taxes and thus might find it hard to accept physicians limiting

their practices to wealthy persons (5). Although academic

medical centers, traditional providers for the poor and underserved,

might justify sponsoring luxury clinics via a utilitarian

argument, only 2 programs use income from these ventures

to cross-subsidize care for indigent persons or teaching

programs. *[Refs 2 and 3 and recent review of literature]*

There is no high-quality evidence documenting a higher

caliber of care in concierge practices, and few data support

the clinical or cost-effectiveness of many of the unnecessary

tests offered to asymptomatic clients (2, 3). Over-testing may

result in false-positive results, leading to further unnecessary

investigations, additional costs, and heightened anxiety. True positive

results may lead to over-diagnosis of conditions that

would not have become clinically significant, leading to further

risky interventions and possibly impairing future insurability.

The use of clinically unjustifiable tests erodes the scientific

underpinnings of medical practice, runs counter to the

ethical obligations of physicians to responsibly manage limited

health care resources, and likely leads to worse care.

Most training in professional ethics, as well as the development

and teaching of evidence-based practice guidelines,

takes place in medical schools and teaching hospitals. No

data are available on the participation of medical students

and residents in luxury care clinics at teaching hospitals. For

such institutions to teach students to treat all patients equally,

combat inequalities in health care access and outcomes, and

practice evidence-based medicine while at the same time

supporting clinics that do the antithesis is troubling. At the

least, trainees should not be allowed to work in such clinics.

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IN RESPONSE: I appreciate Dr. Donohoe's observations about

academic medical centers that sponsor “concierge” clinics. He

is correct that our paper did not specifically address academic

medical centers; rather, we looked at the broader movement

to practices that charge retainer fees, do not accept insurance,

and/or limit the number of patients they see. (We called

such practices “direct patient contracting practices” [DPCPs]

because descriptions of concierge practices commonly used

in the literature lack consistency.) I agree that attention needs

to be paid to the ethical, educational, and patient care implications

of academic medical centers that operate such practices

and on their potential effect on the poor.

However, our paper does provide a policy framework for

evaluating DPCPs, which can include academic medical centers.

We state, “Physicians in all types of practices must honor

their professional obligation to provide nondiscriminatory

care, serve all classes of patients who are in need of medical

care, and seek specific opportunities to observe their professional

obligation to care for the poor”; this includes physicians

in academic medical centers who operate concierge clinics.

We advocate that physicians consider the potential effect of

changes in their practices that could make it more difficult for

poorer patients to access medical care and that they consider

steps to mitigate any such effect. We note that some evidence

shows that concierge practices are at a greater risk for excluding

poor and other vulnerable populations. However, we also

note that the literature includes examples of direct primary

care practices (1 variation of DPCPs) that have structured

themselves to provide accessible, low-cost care to the poor,

including patients enrolled in Medicaid. We conclude, “Although

the growing physician interest in DPCPs may be an

understandable reaction to such external factors, it must also

be recognized that such models potentially exacerbate racial,

ethnic, and socioeconomic disparities in health care and impose

too high a cost burden on some lower-income patients.”

We agree with Dr. Donohoe that little high-quality evidence

is available on the clinical impact and costeffectiveness

of the “extra” services often offered by DPCPs.

Because good evidence on this and other effects of such practices

is lacking, we propose a robust research agenda. We

especially endorse the need for research on “the impact and

structure of [such] models that may affect their ability to provide

access to underserved populations.”

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I believe that it is important that, as we research and consider

the policy and ethical implications of DPCPs, we also

consider the external factors that are driving many physicians

toward them—including excessive paperwork associated with

insurance interactions, electronic health records that are designed

to meet the needs of payers and regulators and not

the clinical needs of physicians and their patients, and

productivity-based payments that penalize physicians for

spending more time with their patients. I have met many physicians

who have gone into concierge and direct primary care

practices precisely because they want to get back to doing

what they love most, which is spending time with patients.

Many say that they charge low monthly fees so that they can

be accessible to moderate- and low-income patients at less

out-of-pocket cost to patients than many high-deductible insurance

plans offer. I caution against painting with too broad

a stroke in assessing the motivations of physicians in practices

that charge retainer fees or limit the numbers of patients they

see and about the effect that such features have on poorer

patients. Rather, we need more unbiased research and

evidence—while strongly reminding physicians, as we do in

our paper, of their ethical obligations to provide care that is

nondiscriminatory based on a patient's income, gender and

gender identity, sexual orientation, race, or ethnicity, regardless

of the type of practice— concierge or not.

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