Comments and Responses

Can the Practice of Retainer Medicine Improve Primary Care?

TO THE EDITOR: In their article, Huddle and Centor (1) present a very thoughtful exposition of the social obligations of primary care physicians and their understanding of the ethical commitment those of us practicing retainer medicine have toward our patients. I would like to offer some additional thoughts.

I decided to leave traditional medicine because I had a visceral need to do my job, and I could not be the professional my patients deserved if I spent 9 to 15 minutes with them per visit. I found it disquieting to charge a patient to sit in my waiting room for 4 hours, just to ask me a question when I knew that a phone call would be more appropriate.

Retainer medicine allows me to work directly for my patients without conflict. About 10% of my patients don't pay me a dime, and they get the same individualized attention that my paying patients get. I enjoy the privilege of giving and can do that without hesitation in my retainer practice. We answer the phone with, "How can we help you?" not "What insurance do you have?"

I gave my ethical responsibilities a lot of thought when I decided to enter into a private contract with my patients, and I am very comfortable that I am fulfilling my professional duty as a retainer physician better and without conflict than as a doctor working for a hospital, an insurer, or a group.

I sell my patients a better, more productive day. In the end, society is better off when every person has a physician advocate who has that person's personal interest as his or her primary focus. That said, every person needs a primary doctor—not necessarily a primary care doctor, which might be an endocrinologist or a rheumatologist.

The discussion of health care reform should concentrate on the care we offer rather than the financing of the system. We can never get back to every doctor's instinctive need to do right by their patients only because it is the right thing to do if we continue to direct reforms at financing systems.

Thank you for respecting the opportunity that physicians practicing retainer medicine provide for thousands of patients, both rich and poor.

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Potential Conflicts of Interest: None disclosed.

Reference

1. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. Ann Intern Med. 2011;155:633-5. [PMID: 22041952]

TO THE EDITOR: Although I think that there is plenty of room for debate on many of the points mentioned in the article by Huddle and Centor (1), I'd like to focus on a different point: Not all retainer models are the same. I think we are making a basic mistake of assuming that all "insurance-free" models are designed for the upper crust.

My model is not. We charge $10 to $100 a month per patient on the basis of age (all preexisting conditions welcome) for unlimited home, work, office, or technology visits with no copay. We offer steep discounts on laboratory testing and medications by contracting directly with laboratories and pharmaceutical wholesalers.

Owing to this broad menu of services, we are able to work with insurance companies to drastically decrease cost. We have saved young families over $1000 per month and reduced the cost for businesses by 30% to 50%.

We feel that this model, compared with usual retainer models, addresses many concerns. Each physician focuses on 400 to 600 patients. This allocation improves quality of life, increases time with patients, and allows for moderate income yet still ensures flexible after-hours visits to decrease emergency department use. I believe that this will drive physicians back into primary care, keep them there longer, decrease system fragmentation, and improve patient care for less cost. A full 30% of our patients are uninsured, and it works beautifully for them.

The answer will not be found in insurance companies or the government. We as physicians only have ourselves to blame for not using sound business principles to help lower cost and improve quality.

I am very curious about other physicians' opinion of a model like this. Does it change anything? Does it help?

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Potential Conflicts of Interest: Dr. Umbehr is the owner, operator, and chief executive officer of a concierge medical practice.

Reference

1. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. Ann Intern Med. 2011;155:633-5. [PMID: 22041952]

TO THE EDITOR: Huddle and Centor (1) argue that "retainer medicine is compatible with professional ethics and will more likely aid in solving the difficulties facing primary care than add to them." The purported benefits of retainer medicine for patients include enhanced access, streamlined specialty referrals, and other perquisites. Benefits for practitioners include a manageable practice size and a more satisfying practice experience. The ethical defense of retainer medicine is reasoned and presents an ethically legitimate vision for the practice of primary care medicine. However, given the current and projected shortages of primary care physicians, there are better alternatives to the concierge model of practice. Primary care practice in an integrated health care system achieves significant benefits for both patients and physicians, without the public health implications of significantly reduced panel sizes. By leveraging technology and physician leadership, large systems, such as Kaiser Permanente, have achieved unparalleled access to primary and specialty care, market leading preventive health outcomes, and have created a culture of primary care practice that is both sustainable and rewarding. Members of Kaiser Permanente can send secure e-mails to their primary and specialty care physicians, see specialists within days (sometimes within the hour), and reap the benefits of the nation's largest civilian electronic medical record. Primary care physicians and patients both have the unique advantage of being supported in preventive health

care by every specialist within the system, in which sophisticated tools, standardized processes, and a culture of prevention together create a system in which preventive health care is every physician's responsibility. The benefit to physicians is a rewarding practice environment, and patients receive perks similar to those that would otherwise cost extra in a retainer practice. There are important implications for the future of primary care medicine and for the nation's health care workforce. In contrast to retainer practices, physicians working in an integrated system do not need to limit their practice size to a few hundred patients to provide superior service to their patients or to help them attain the best outcomes. The concept of the medical home is already well-established in integrated systems of care. The Kaiser Permanente model has demonstrated the ability to significantly improve health outcomes. As an alternative to concierge medicine, we should recognize the inherent advantages of integrated health care. The future of primary care lies in physician leadership of systems designed to utilize technology in new and powerful ways and through physicians working collaboratively to achieve the best access and outcomes. In doing so, the professional satisfaction of all physicians will be enhanced and the practice of primary care medicine will be improved.

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Potential Conflicts of Interest: Dr. Van Zoeren is an employee of the Permanente Medical Group. Reference 1. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. Ann Intern Med. 2011;155:633-5. [PMID: 22041952]

TO THE EDITOR: Retainer or concierge practices, as discussed by Huddle and Centor in their article (1), make a commercial contract with selected affluent patients who pay a fee, covering future services. The primary goal of this endeavor, no matter how it is presented, is revenue enhancement for the proprietors. Physicians involved with these practices breach their pact with society. They clearly violate, reject, and disregard the faith and implied contractual duties arising from the large federal and state subsidies that generously supported their undergraduate and postgraduate medical education. They should repay those dollars or, if they choose not to, at the very least they must be required by the profession to donate public service time to help resolve the problems of access and health disparities, as Lo (2) suggests. At its foundation, medicine is a calling to service, not a business. Retainer practices turn this principle upside down.

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Potential Conflicts of Interest: None disclosed.

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1. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. Ann Intern Med. 2011;155:633-5. [PMID: 22041952]
2. Lo B. Retainer medicine: why not for all? [Editorial]. Ann Intern Med. 2011;155:641-2. [PMID: 22041955]

TO THE EDITOR: I read the article by Huddle and Centor (1) with great interest. Social justice is a fundamental component of medical ethics and professionalism (2). Physicians have an obligation—borne of their privileged status, the public's investment in their training, and their roles as stewards of the public's health—to work for social justice by addressing, individually and collectively, the social, economic, gender, racial, and cultural factors that contribute significantly to morbidity and mortality (3).

Retainer practices will adversely affect the growing shortage of primary care physicians available to care for our aging population. Although there are some lower-cost retainer practices, many provide luxury or concierge care, in which physicians limit their practices to the wealthiest patients. Physicians in retainer practices have much smaller patient panels and care for fewer African American, Hispanic, and Medicaid patients than other physicians (4). Physicians who convert to a retainer practice keep a small percentage of their former patients, increasing the burden on other primary care providers (4).

Many retainer practices (especially luxury care clinics) are sponsored by academic medical centers, traditional providers for poor and underserved patients (5, 6). For teaching institutions to promote these centers will increase growing cynicism among medical students, practicing physicians, and the general public. Although medical centers might justify sponsoring luxury clinics via a utilitarian argument, there are only 2 programs that use income from these ventures to cross-subsidize indigent care or teaching programs (5, 6).

There is no evidence documenting a higher quality of care in concierge practices, and few data support the clinical or cost-effectiveness of many of the unnecessary tests offered to their asymptomatic clients (5, 6). Overtesting may result in false-positive results, which lead to further unnecessary investigations, additional costs, and heightened anxiety. True-positive results may result in overdiagnosis 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 and runs counter to the ethical obligations of physicians to responsibly manage limited health care resources.

Finally, access for all is unlikely to be achieved soon. The Patient Protection and Affordable Care Act will provide insurance only to an additional 26 million Americans, leaving 23 million without insurance. The Act is complex, perpetuates current inefficiencies, increases bureaucracy, and benefits insurance companies that fulfill their primary responsibility to maximize profits for their shareholders by minimizing "medical loss ratios." Physicians should advocate for a single-payer national health care plan, which would justly and cost-effectively provide coverage for everyone.

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Note: Articles and open-access slide shows are available on the "Luxury Care/Concierge Care" page of the Public Health and Social Justice Web site at http://phsj.org/luxury-care-concierge-care/.

Potential Conflicts of Interest: None disclosed.

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1. Huddle TS, Centor RM. Retainer medicine: an ethically legitimate form of practice that can improve primary care. Ann Intern Med. 2011;155:633-5. [PMID: 22041952]
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6. Donohoe M. Luxury primary care, academic medical centers, and the erosion of science and professional ethics. J Gen Intern Med. 2004;19:90-4. [PMID: 14748866]

IN RESPONSE: Dr. Zwelling and Dr. Umbehr describe experiences with retainer practice that comport with the highest standards of medical ethics and professionalism as they have been traditionally understood.

Dr. Van Zoeren argues that primary care physician shortages make integrated practice a better alternative. Dr. Webster and Dr. Donohoe press an ethical case against retainer medicine, elements of which were alluded to in Dr. Lo's editorial (1).

Dr. Webster's and Dr. Donohoe's contention that retainer medicine breaches the social contract between our profession and society is unsupported. To our knowledge, society has not (so far) stipulated to physicians that, in exchange for benefits granted, they will be required to sacrifice some portion of income, quality of work, and job satisfaction to take care of a certain number of medically indigent patients. Dr. Webster and Dr. Donohoe presumably find such an obligation not in a de facto social contract but in the ethical dictates of medical professionalism. We agree that some have asserted such obligations in the recent past, but medical professionalism—understood as the tradition of medical morality articulated by physicians from the time of Hippocrates up to the recent past—has not. American society treats physicians very well, and we have obligations to do exemplary professional work in exchange for the work settings and remuneration it provides. We also have obligations to provide some free care to patients who cannot afford it. A traditional understanding of professionalism does not extend to further social and political obligations that Dr. Webster, Dr. Donohoe, and Dr. Lo would claim for it.

Without reiterating the argument in our article on why we ought not to shift our moral understanding of medical practice in the direction advocated by Dr. Webster and Dr. Donohoe, we observe that doing so would shatter what professional unity amid political diversity that our profession has so far been able to maintain. All physicians should, of course, favor the diminishing of social ills, including health disparities and lack of access to health care. But any given practical stance toward these ills does not merely imply ideals for a good society but a given prioritization of the myriad public and private roles that we each play in combinations as various as our professional membership. Although medicine prescribes a moral approach to our professional work, it has not until now extended its prescription to the broader patterns of our personal, social, and political lives (that is, beyond conformity to norms embodied in law). Imposing specified political duties on physicians, or supposing that particular arrangements for health care financing are condemned by medical morality (even if such arrangements encourage exemplary professional work by physicians on behalf of their patients), are steps in the direction of unwarranted political division and exclusion. We should each fulfill our social responsibilities, but as a profession, we should allow a wide range of views on just what those responsibilities are (2).

Although medicine is not just a job, it is, contrary to Dr. Webster's view, business as well as service. We should welcome retainer medicine, integrated health care systems like Kaiser Permanente, and other attempts to combine high-quality health care with physician and patient satisfaction. And we should permit physicians to make their own decisions in regard to political participation and the importance of societal health compared with other societal goods. Physicians who form retainer practices should offer some free care; if they otherwise conduct their medical practice in conformity with the ideals of professional ethics (excluding any putative bearing of professional ethics on politics), they are exhibiting anything but "a rather thin view of moral responsibility" (1). In performing exemplary professional work, they are providing society exactly what it asks of them and, in so doing, giving the medical profession everything that our profession should demand of us.

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Potential Conflicts of Interest: None disclosed. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M11-0928. Drs. Huddle and Centor have not now nor ever participated in retainer medicine and have no future plans to do so.

References

1. Lo B. Retainer medicine: why not for all? [Editorial]. Ann Intern Med. 2011;155:641-2. [PMID: 22041955]
2. Huddle TS. Perspective: Medical professionalism and medical education should not involve commitments to political advocacy. Acad Med. 2011;86:378-83. [PMID: 21248605]

Observation

IgG4-Related Pachymeningitis: Evidence of Intrathecal IgG4 on Cerebrospinal Fluid Analysis

Background: Hypertrophic pachymeningitis is a clinical disorder caused by thickening of dura mater from chronic inflammation that is labeled idiopathic in the absence of an identifiable cause. Other investigators recently reported a prominent lymphoplasmacytic infiltration of immunoglobulin $G4^+$ (IgG4) cells in 3 patients with hypertrophic pachymeningitis, suggesting that some idiopathic cases may be part of the IgG4-related systemic disease spectrum (1–4).

Objective: To look for IgG4 in cerebrospinal fluid (CSF) from a patient with IgG4-related pachymeningitis.

Case Report: In July 2009, a 65-year-old Italian man with autoimmune hypothyroidism reported fever associated with evanescent nodular skin lesions on his arms. Laboratory examination