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Ethical Evaluation of "Retainer Fee" Medical Practice

Mervin H. Needell and John S. Kenyon

Mervin H. Needell, MD, is Clinical Professor at and the Medical Director of the Bioethics Program at the University of Miami in Miami, Florida, *Parmenides@bellsouth.net.*
John S. Kenyon, BA, is a Medical Student at the University of Miami School of Medicine.© 2005, *The Journal of Clinical Ethics.* All rights reserved.

THE PROBLEM

Modern changes in the economics of healthcare are pressuring doctors to increase their patient loads while decreasing their fees for services performed.[1] As a result, many practitioners see once highly regarded medical care threatened by a variety or combination of the following consequences:

- Tight office schedules, long delays for appointments, and little flexibility to accommodate patients whose problems consume more than the 15 minutes that third-party payers allot to primary physicians per patient visit.[2]
- Authorization by insurance companies, health-maintenance organizations (HMOs), and Medicare to pay only for services based on cost-control. This often means providing a minimum quantity and quality of acceptable care, even if other choices are preferable. Reports indicate that to cover expenses, doctors must now increase their patient loads, sometimes to levels that deny patients needed individual attention.[3]
- Insufficient time to return telephone calls promptly, if at all.
- Congested emergency rooms, with long delays for patients who have minor illnesses that their harried primary physician cannot find time to manage.
- Patients referred to specialists for problems that do not necessarily require a specialist's care.
- Frequent changes in patients' primary physicians, abetted by:
  - Patients who require hospitalization treated by a dedicated "hospitalist."
  - Employers who seek cheaper plans, which may provide a narrower range of coverage.
  - Insurance company rosters that list and "de-list" doctors based on economic criteria.
  - Dissatisfied patients who float from doctor to doctor seeking more attention.
  - "Physician extenders," such as nurse practitioners and physician assistants, who are now being increasingly used to reduce the amount of time that (higher paid) physicians spend with patients.
  - Less time for patient-care advocacy.
  - Less time and economic incentive for primary physicians to maintain and update their credentials.[4]

These changes reduce the public's confidence in doctors and distance patients from their doctors, resulting in a form of rationing through fear and inconvenience.

Although some patients may expect or need minimal service and remain satisfied under the current paradigm, other patients

- Have many concurrent medical problems and wish to use a "one-stop shop" physician, rather than shuttle among different subspecialists for each separate malady;
- Want to see their own doctor in the emergency room or at home (rather than wait for hours for an unfamiliar doctor);
- Choose not to wait for a doctor whose schedule consistently runs late;
- Want their doctor to intercede for them (with payers, employers, attorneys, medical consultants, nurses, and pharmacists);
- Value their relationship with their particular physician and his/her credentials, and do not wish to change doctors.

ATTEMPTS AT SOLUTION

Comprehensive insurance and managed-care programs have arisen in response to progressively increasing medical costs. These programs typically save money by setting limits to patient care. But cost-cutting has not solved waiting room delays and diminished professional time per patient visit. For example, in the interest of cost-containment, the *Miami Herald* reports that employers "herded workers into plans where they got doctors they didn't know and care they regarded as second rate, which was ladled out begrudgingly to boot."[5]

In response, some primary physicians in the United States and Canada have reduced the number of patients in their practices to accommodate the needs and wishes of those patients who are willing and able to pay extra for prompt access to and more personal attention from their physicians.[6] They do not claim thereby to solve all problems of current medical practice. Retainer fee medical practice (RFMP) offers patients round-the-clock cell phone access to its doctors, appointments on the same day they call, home visits when necessary, nutrition guidance, exercise physiology exams at patients' homes or health clubs, doctors to accompany them to specialists, and online access to their medical records.[7] In return for these benefits, and to compensate for the physicians' loss of income as a result of reducing patient load, each patient registered in such a practice pays a surcharge. This modification in medical practice has taken various names, such as Premier Care, Luxury Primary Care, Valet Care, Gold Card Care, VIP Care, Boutique Care, Deluxe Care, and Platinum Care. In this article, we refer to it as retainer fee medical practice, or RFMP. Variations exist among physicians' practices in the details of the arrangements, the amenities offered, and the amount of surcharge levied.[8]

To the extent that the circumstances described above fairly summarize current conditions in modern medical practice in the United States, a change of medical practice from the present fee-for-service or managed-care designs to RFMP would seem at first sight to be both socially and ethically desirable for those patients who are able and willing to pay for it. By reducing the size of practice rosters, RFMP makes adequate time available for physicians to attend to every patient in their practice. It does not claim to remedy the ills and shortcomings of contemporary medical care. Supporters of RFMP make the lesser claim that it serves an unfulfilled need and is available to those who can afford it. This principle accords with a capitalistic system such as ours. Whether or not medical care itself is ethically consistent with a capitalistic system is beyond the scope of this analysis. Private practice has always been taken as an axiomatic paradigm in the U.S., but RFMP has generated a set of ethical concerns for the public and within the medical community. In this article, we explore the question: "Is it morally permissible for a physician to practice RFMP?" We do not want to give weight here to arguments that judge RFMP as merely socially desirable or undesirable. Social desirability is not incompatible with ethical impermissibility, or vice versa. Arguments that count in our analysis must have an ethical component. We do consider, however, a conditional argument that RFMP may be ethically permissible if only a few (but not too many) doctors practice in that style. By "argument," we mean a reason overridable by a stronger, competing reason.

We shall review and analyze relevant ethical concerns and arguments (both supportive of and opposed to RFMP) that have come to our attention. The chief ethical issues relate to access to care, quality of care, professional ethics and patients' rights, justice as fairness (including the cost of care), and physicians' reimbursement. Although we group these issues or arguments for the sake of convenient analysis, they are inextricably interrelated and are not neatly separate topics. For example, we would expect, with all things being equal, that decreasing the cost of care would increase access to care, and thereby improve the overall quality of care to the community while also fulfilling the ethical obligations of justice.

ACCESS

As the patient load of primary physicians in private practice increases, the time available for care per patient decreases. Patients then tend to wait longer to obtain appointments, endure waiting room delays, and spend less time in consultation with their doctors. As noted in the *Miami Herald*, "millions of Americans during the past decade have been enlisted in managed-care plans that tried to clamp down on medical spending by impeding access to care."[9] Although some patients may accept this inconvenience, others may bolt to another healthcare resource or deny themselves the care they seek. Either way delays or bars access to medical care. Since every physician's time and energy has realistic limitations, so must the number of patients and the time allotted to their patients be limited. It is reasonable to expect physicians to determine those limits for their own practices, according to their physical and emotional capacities. RFMP allows doctors to regulate their professional time per patient visit by limiting the number of patients on their individual rosters.

Various types of medical arrangements other than private practice care appeal to particular patients. For example, managed care has enrolled large numbers of workers and retirees. Others rely on comprehensive health insurance plans. These methods project attractive economic and utilitarian advantages and provide the public with alternatives to traditional private medicine.

On the other hand, third-party payers often limit benefits and present financial and practical barriers (such as copayments, restrictions in coverage, and rationing via frustrating or obfuscating administrative procedures), thereby impeding the care.[10] Such strategies represent cost-saving rationing, resulting in a market that puts goods out of reach of citizens, even when the citizens can afford to pay for these goods. Moreover, for patients who encounter delays and overcrowding in emergency departments, HMOs, and physicians' offices, access problems threaten quality of care through delayed or hurried treatment.

If only a few doctors limited their practices to RFMP, we would not expect an overall physician shortage. However, by excluding patients who are unable to pay a surcharge, conversion to RFMP by *all* primary doctors would surely constrain public access to medical care. We might need to determine how many RFMP physicians a community could accommodate without precipitating a shortage of medical care. At the present time, since only a few doctors have done so, that concern is moot, except that RFMP doctors might be guilty of "free riding" (engaging in a practice that would be impermissible if all doctors did it), a philosophically suspect action, even if not illegal or immoral.

If a shortage were to occur as a result of RFMP, we would also have to address the ethical responsibilities of individual physicians to public safety, as opposed to the welfare of their individual patients. We could all probably agree that doctors are accountable to some degree for both their individual patients and for the health of and equitable distribution of health to the public at large. However, where lies the caregiver's greater responsibility? In traditional ethics, the patient-physician relationship has held priority over individual physicians' responsibility for political and public health issues.[11]

Moreover, where there is no shortage of doctors, patients with insurance/Medicare should always be able to find a licensed physician to attend them. According to Frank A. Riddick, Jr., "Physicians have an obligation to meet the needs of a community. You could do that with 10 percent of physicians in the area practicing boutique medicine." However, Riddick qualifies his contention, "if it gets much more than that then I think you really have to question the process."[12]

RFMP improves patients' access to medical care by ensuring prompt appointments, reducing or avoid-

ing waiting room delays at physicians' offices, allowing adequate time spent with the doctor, and providing 24-hour on-call physician availability.[13] Moreover, critics of the market system acknowledge that even managed care and insurance plans have not fulfilled our needs. They look to a better and more "ethical" healthcare system, perhaps a single-payer universal program, which would facilitate simultaneous cost-control and universal access. As for RFMP, critics protest that it would exclude the neediest patients, cause "extravagant overhead costs and constraints on good medical practice and . . . endorse a system that stratifies patients even further according to their ability to pay."[14]

Large-scale social change may well be needed. However, only our policy makers can make major improvements on the public system. As a small-scale measure, implemented on an individual basis, RFMP does not purport to solve the access problems of all members of the society. The neediest patients are probably not those who cannot pay an extra fee; they are those who lack the resources to pay any fee or who earn too much to qualify for welfare assistance and too little to afford insurance. Given an imbalance of supply and demand for medical care, a level that society can afford for those unable to pay would probably not be acceptable to everyone. According to K. Sikora and others, "Widespread access may have to compromise quality."[15] In a society with scarce resources, tiers of need and demand necessarily call for different levels of response. RFMP is but one of those levels.

A capitalistic system such as ours offers alternatives. Those who prefer private practice care have the option to continue with the traditional system or, for a retainer fee, upgrade to RFMP. Just as not everybody flies first class or buys loge seats at the theatre, not everybody would choose RFMP for their medical care plan. All passengers on a plane touch down at the same moment and all spectators at a theater see the same play. RFMP patients receive the same care as others, but, in addition, pay for their privileges. This view neither ethically justifies RFMP nor condemns it as an unethical system.

QUALITY OF CARE

Quality healthcare may be defined differently by those who receive it, those who provide it, those who pay for it, and those who are personally uninvolved in the care. Patients would probably judge according to health outcomes (that is, the best health realizable). Physicians' perceptions of high-quality care also relate to adequate time with patients, clinical autonomy (freedom to make clinical decisions that meet the patient's needs), and continuity of patient-physician relationships.[16] According to G.D. Schiff and colleagues, high-quality care requires knowledgeable, caring, skillful, and humane caregivers achieved at the lowest reasonable cost, which should result in improved health for individuals and the community.[17] Although managed care has attempted to assess and improve quality of medical care, third-party payers tend to give emphasis to economic criteria. While the National Committee for Quality Assurance states, "the nation's healthcare system is riddled with 'quality gaps' that prevent millions of Americans from receiving 'best practice' care'," it admits, "among health plans that publicly reported their performance data, clinical care improved in most areas, such as coronary heart disease."[18] Disinterested parties, such as politicians and social planners, may use a combination of these criteria. The definition of quality care that is utilized in the following analysis will reflect the views of patients and physicians.

Provision of quality care is the primary ethical imperative for physicians. Judged intuitively, hasty examinations and hurried judgments and treatments are not likely to yield results as beneficial as careful and deliberate clinical care. Arguably, then, medical practitioners do better quality work when they have sufficient time to give their patients personal attention, exercise considered judgment, and are familiar with their patients' problems. Recent studies on overworked interns and residents have prompted mandatory rules guaranteeing relief from excessive hours on the job, for the benefit of both the interns and their patients.[19] Even truck drivers are not allowed to drive more than a limited number of consecutive hours.[20] To our knowledge, however, no such regulation governs the work of physicians in private practice.

The elaborate guidelines and protocols that are available to managed-care facilities include criteria and methodology for evaluating the quality of medical care. Nevertheless, Kongstvedt warns that predicting the future of outcomes, particularly in managed care, involves complex and daunting data analysis.[21] If this

analysis is successful and fully implemented by managed-care organizations (MCOs), this strategy might well result in improved health outcomes and satisfy the unmet needs of patients and physicians. However, one can argue that, at present, both insurance companies and MCOs demand cheaper care and delay paying beneficiaries' bills, but have rarely advocated for better-quality care for patients.[22] On the contrary, RFMP offers patients more attention at a time when managed care pressures physicians to crowd ever more patients into ever shorter appointments.[23] Under the price and time constraints of managed care, physicians protest that they cannot ethically deliver the quality of medical care they and their patients desire.[24] In RFMP, however, physicians claim improved quality of care, achieved by eliminating important causes of impersonal or hurried care, diagnostic errors and iatrogenesis (inadvertent adverse events), and greater attention to quality-of-life and psychosocial issues.[25] Thus patients who choose RFMP use their own financial resources in the service of their own interests. The RFMP physician fulfills the ethical duty to provide excellence in medical care, and to respect patients' needs, comfort, and right to self-protection.

PROFESSIONAL ETHICS

Primary care physicians complain that managed-care and health insurance plans promote disincentives to professional excellence. The *Bulletin of the American College of Surgeons* reports that some of these disincentives include disallowals of payment for lengthy office visits (even when medically necessary), limitations on quantity and selection of treatments by "gatekeepers," (often an insurance employee empowered to allow or disallow payment for a treatment proposed by a physician), rewards to physicians for undertreatment, and contracts that make medical providers assume "financial risk" for their patients (for example, capitation, a strategy to tie physicians' incomes to cost-saving treatments).[26] Third-party payers have also rewarded doctors directly or indirectly for withholding hospitalization, referrals, or specialty consultations. These measures create an unacceptable conflict between a patient's welfare and a physician's financial interest. Fixation on cutting costs rather than on improving quality of care invites both lower quality and higher costs.[27] To economize at the risk of compromised quality of care sabotages treatment, undermines professional excellence, and violates the avowed ethical duty of physicians to safeguard their patients' health above other considerations.

RFMP's proponents claim that ensuring adequate compensation removes economic pressure on doctors to overload patient appointments.[28] This practice would avoid an ethically suspect source of conflict of interest. RFMP physicians disagree with the judgment of managed-care institutions that improved medical decision making can result from tinkering with physicians' rewards.[29] Again, to deny expensive treatment on economic grounds to patients who can afford to pay for it violates their right of self-protection. A further possible benefit of RFMP, because it is not burdened by a congested schedule, is to provide such basic services as immunizations or perhaps prenatal care, that overcrowded medical delivery systems are more likely to overlook.[30] On the other hand, managed-care supporters would reply that rather than rewarding physicians for undertreatment, the rewards are to avoid overtreatment. Similar arguments can support financial incentives to physicians for overutilization of hospital facilities and specialists.

Primary doctors are trained to manage many conditions that specialists also treat. When overburdened, physicians are tempted to refer patients to specialists for relatively minor problems that primary doctors are qualified to manage. When primary care physicians no longer have the time to manage these conditions, they may refer these patients, which results in "dumbing down" of their practice style, the overutilization of specialists, inconvenience for patients, and more delay in resolving problems.

Switching physicians and health plans discourages ongoing patient-doctor relationships.[31] Moreover, patients in managed-care clinics may not even see the same physician on successive visits.[32] Continuity of primary care, then, is a further strength of RFMP. Thus, RFMP tends to strengthen the patient-physician relationship while it assures choice of physician. These factors should lead to increased patients' satisfaction with their care. The patient-physician relationship supports ethical goals of physician professionalism and promise keeping, and patients' right to choose their own physician (autonomy).

In addition to medical obligations, physicians, like everyone else, are morally obligated to obey the law. According to the Florida Board of Medicine, "there are no statutes pertaining to Retainer Fee Medical

Practice per se."[33] Although physicians may not legally charge more for medical services than the Medicare promulgated fee schedule, Medicare does allow doctors to charge for noncovered medical services, such as voluntary cosmetic surgery.[34] Most private health insurance plans do not pay all fees and services, the difference often being covered by an additional copayment or "balanced" billing (supplemental billing for fees not paid by insurance).[35] However, at least one state, Massachusetts, banned this practice.[36] The RFMP fee also covers an annual comprehensive physical exam, a service that Medicare excludes.[37] RFMP physicians argue that they adhere to the law by ensuring that their fees pay only for noncovered extras, that is, services not paid for by insurance or Medicare.[38] They therefore fulfill their civic obligation to obey the law while allowing patients autonomy in selecting their physicians and type of practice. Furthermore, a review by the Massachusetts Board of Registration in Medicine reports it had found nothing illegal in RFMP.[39] The American Medical Association has not taken a position on concierge practices.[40]

The practice of medicine is a profession, distinct from a commercial enterprise. Yet, in judging RFMP, partisans invoke ethical distinctions intrinsic to each. Libertarian and egalitarian values conflict when patients are not allowed to supplement their Medicare or health insurance by buying extra amenities. A libertarian view, taken by O.F. Norheim, asserts that to forbid people to purchase healthcare in addition to that available in a publicly funded scheme cannot be ethically justifiable.[41] By this argument, RFMP protects patients' right to use their money as they see fit.

However, an egalitarian position sees that RFMP undermines cross-subsidized care, a technique that helps to pay for poor and uninsured patients with funds from those able to pay.[42] Limits based on ability to pay amount to discrimination against the poor. As Relman argued in the *Boston Globe,* "The implication that well-heeled patients have the right to something more is abhorrent."[43] Robin Fiore argues that, by Plato's (that is, Socrates's) definition of the goal of medicine, the physician's self-interest must be subordinate to the interests of the patient. Fiore says that anyone who practices medicine with a different primary goal is not a doctor but a "schmocter" (a term she borrows from Robert Nozick), that is, is unworthy of the mantle of medical professionalism. In this appeal to social justice, she concurs with Bernard Williams that "the proper ground for the distribution of health care should be ill health or need, not ability to pay," and that physicians are elites with power to subvert the general health system. She concludes that injustice results from unequal access to healthcare, and therefore that RFMP does not qualify as "a moral practice."[44]

Edmund Pellegrino has argued that a medical license is not entirely a proprietary asset. Public funds largely subsidize medical education; also, because physicians learn their skills by practice on the public, they owe something back to the public in return, namely, making medical care accessible and not restricting access.[45]

Other critics of RFMP believe that physicians should not favor the wealthy over the poor. According to one indignant correspondent to the *Miami Herald*, RFMP is a greed-ridden concept;[46] it eliminates patients' choice of individual physicians except at substantially higher costs—payable by the patient.

These three egalitarian arguments against RFMP appeal to professional integrity (Nozick, Williams, and Fiore), to the obligation of all those who have received a publicly subsidized medical education to repay their debt to society (Pellegrino), and to renounce any self-interest that exploits innocent others by abandoning those unable to pay or charging extortionate fees.

In response to Fiore and colleagues, proponents of RFMP can argue that Socrates distinguishes health, the primary goal of medicine, from wage earning, a necessary accompaniment to the craftsman's art, without which the craftsman would not be expected to work and for which he provides benefit to the patient.[47] Each society determines the level of compensation. Although our own capitalistic system traditionally has rewarded physicians generously, RFMP physicians hardly expect to earn as much as professional athletes, entertainers, or CEOs, although on the basis of merit (as opposed to market), a case might be made for physicians doing so. In forming an opinion about the moral qualities of RFMP, Fiore cites the injustice of unequal access to healthcare, without acknowledging the inequities of our prevailing system, which, as a matter of policy, favors some groups (for example, elderly citizens, via Medicare) and excludes others (for example, uninsured poor people). Fiore also does not address quality of care as an ethical imperative, which

RFMP strives to improve, while she ignores indictments of managed care for sacrificing quality for the sake of economy. However, are physicians "schmocters" because they limit the volume of their practice to give adequate professional attention to those patients for whom they have assumed medical responsibility, and in return expect to be paid fairly for their time and services rendered?

Granting that physicians owe a debt to society, perhaps for several reasons, as Pellegrino argues, physicians continually repay their obligations to society in many ways. They spend time and money to maintain competence through continuing medical education, arrange for round-the-clock availability, and serve without pay on hospital committees and medical societies to monitor and improve medical care. Thus, RFMP can contend that, in return for supporting doctors' initial training, the public receives the ongoing services of competent, caring, and diligent physicians. The public on whom doctors learned their skills may not have freely chosen to be used as teaching material, but did so to receive medical care, which was otherwise unavailable to them. The complimentary care that they received compensated them for their contribution to education. Further, private practice physicians have traditionally lowered or waived fees for indigent patients.

Nevertheless, society does not hold physicians hostage to their education. It does not take recourse against a physician who chooses not to practice medicine (for example, who obtains a Master of Business Administration degree and goes to work for an insurer) to recover the original public investment. We may wish to consider imposing a period of mandatory public service on medical school graduates as part of a program to address the needs of the uninsured, as is done in many countries with state-subsidized medical education. However, it is not in the power of practicing physicians to make medical care universally or uniformly accessible. Access to care is ultimately a political and social decision.

The emergence of RFMP reflects the inability of the current model of healthcare delivery to meet the needs of a particular segment of the population. It is also a challenge to our political policy makers and the profit-motivated insurance industry to improve the system. Paying for medical care has a long and well-established precedent. Historically, those who are able to pay more have borne a portion of the burden for those unable to pay (cost-shifting). The current trend discourages this traditional practice, thus depriving patients and physicians of the option of private charitable care. RFMP allows physicians extra time to treat indigents by the voluntary reintroduction of private charitable medical consultative care, through a return to cost-shifting.

In response to the above third objection, RFMP physicians maintain that they are motivated by professional values rather than greed. They offer personal and direct care to their patients, as physicians have done traditionally. For RFMP, economics should never trump patients' interests. And if the meaning of "professional" entails placing clients' interests above one's own, RFMP physicians find the practice of large volume clinics ethically dubious, especially those with rotating primary physicians who give impersonal, discontinuous service. RFMP represents ethical improvement even over the crowded offices of overworked private practitioners.

Physicians have a time-honored reputation as sincere, hard working, intelligent, educated, and capable individuals. Many have dedicated themselves to the practice of medicine for noneconomic reasons such as altruism, intellectual curiosity, and social prestige. Still, they have alternative options available with which to earn a living. When physicians no longer believe that they are earning incomes commensurate with their level of knowledge and skill, many will opt out of medicine, risking a shortage and mediocrity of physicians. By compensating physicians well, RFMP promotes high-quality care, and actually facilitates, rather than obstructs, eventual access as well.

JUSTICE AS FAIRNESS

We have argued that RFMP encourages and facilitates both therapeutic and preventive visits to the doctor, and provides prompt medical attention. RFMP physicians are not tempted to refer patients with minor health problems, which they themselves could suitably manage, to expensive specialists, to reduce their overloaded schedules. In these ways, it opposes institutionally centered, misguided, economically driven

goals. Thus, RFMP can serve patients' interests by reducing cost and by increasing service. High-quality care for individuals results in improved health for the entire community and an ethically desirable outcome. At the same time, those willing and able to choose RFMP get to enjoy the use of their financial property.

Contrarians object that RFMP addresses the wrong problem; that is, our system needs affordable universal coverage, not expensive, elitist, and exclusionary schemes. An ethical medical practice must work for justice as fairness for all. Critics further contend that it defeats the spirit of equality of care for all. They also claim that RFMP is social discrimination, as it stratifies patients according to their ability to pay. Further, RFMP allows an inferior product to some (non-enrollees) while offering superior medical care to others (enrollees). An individual who can afford to buy into RFMP has access to a service that is not available to others who are treated under the public system. Detractors of RFMP theorize that the only morally legitimate way to rank individual claims on medical services is by clinical need.[48] Further, they state that RFMP promotes the notion that different people are entitled to different qualities of care. As noted in the *Miami Herald*, "maybe it works for selling soap, but it is inappropriate for healthcare."[49] A spokesman for Senator Bill Nelson of Florida noted: "We are not against a doctor providing quality care and being adequately compensated in the private market. But you cannot impose a tiered system on seniors getting Medicare."[50] At stake in these arguments are ethical concerns of justice as fairness, and the special humane ethic of medical care, rather than crass commercial insensitivity in providing medical care.

RFMP physicians may plausibly respond that they do not presume to remedy the existing social stratification that characterizes every aspect of a capitalist society, from healthcare to pastoral care, legal services, access to food and nutrition, education, housing, auto safety, et cetera, many of which can be characterized as special, humane values. The economic stratification of healthcare, while subject to ethical challenge on egalitarian grounds and defended as a capitalist norm, has always existed in the U.S. Broader services and wider treatment networks are open to people who are willing to pay more for their medical care or to select comprehensive insurance. For several years, large corporations have been sponsoring executive annual medical check-ups at posh resorts.[51] While the very rich have always been able to strike their own deals with individual physicians, RFMP doctors across the country now have begun to put such amenities within the grasp of the upper-middleclass. Paul Ginsburg notes, "if private patients want to join a membership-only practice, they should."[52]

Our society has already recognized that different people are entitled to different qualities of care (for example, disabled, those over 65 years old, private insurance, corporate medical retreats, Medicaid, HMOs, the uninsured). RFMP is merely another category of care within an already stratified system.

The objection from Florida Senator Nelson's office to tiers within the Medicare system fails to consider the various options that exist under present regulation, which may readily be categorized as tiers. His argument suggests that Medicare should function as a rigid monolith without regard to differing preferences and requirements on the part of its beneficiaries, who have funded the program.

In further disagreement with RFMP, critics claim that, by imposing a surcharge on fixed fees, RFMP frustrates the intent of Medicare and insurance and managed-care contracts designed to limit escalation of the cost of medical care. Aaron and Schwartz argue that cost-containment measures must apply to everyone, regardless of personal means, to keep healthcare within everyone's reach.[53] In pursuit of this goal, Medicare, the federal health program for people 65 and older, limits payment to doctors for covered services. Demanding more in the form of a retainer fee, Ginsburg says, "is a way of evading that requirement."[54] Even if RFMP is technically legal, ethics forbids circumvention or disregard for the spirit of the law.

The RFMP defense avers that, as currently practiced, neither Medicare nor managed care fulfills the "spirit" for which they were implemented. If these programs do not promote the best interests of all beneficiaries, they should be opposed when they fail. No system devised so far has reconciled economic with ethical medical care goals. Medicare fee schedules do not pay for the level of service that many beneficiaries desire and can afford. The public cannot reasonably expect physicians to underwrite unrestricted service in return for restricted reimbursement. Further, Medicare is inadequate to meet every patient's medical needs; for example, it does not cover hearing aid prostheses. Moreover, mixed private and managed-care treatment

is commonly allowed, both legally and ethically (for example, privately purchased appliances such as infusion pumps, the purchase of expensive drugs, and expensive infertility treatments). According to Norheim, to forbid people to voluntarily purchase healthcare in addition to that available in the publicly funded scheme is not ethically justifiable.[55]

Opponents of RFMP worry that when physicians "opt out" of publicly defined benefit packages, it will erode the quality-enhancing covenant of the overall medical system. Uniform sharing of costs encourages overall improvement. However, under a multitiered system, one that allows RFMP patients and providers to internalize an "everyone for himself or herself" ethos erodes incentives for improving the system overall. Justice as fairness demands placement of everyone's interests ahead of special interests. They reason that cost-containment measures must apply to everyone, including those able and willing to pay, if cost inflation is not to place healthcare beyond everyone's reach. Even a right to life has to be qualified, as there cannot be an indefinite duty for taxpayers to fund every treatment that might possibly be beneficial. Equality of care may be the price we must pay to avoid the vexatious consequences of a multitiered system.[56]

RFMP proponents reply that although cost-containment is prudent, managed economic systems do not have a secure record of fiscal success. In the *Miami Herald,* Wasserman argues that HMOs have suffered a "rash of . . . bankruptcies. . . . Creating a costly corporate bureaucracy whose sole purpose was to hold down costs never made much sense . . . it's fair to say that managed care has failed."[57] Many HMOs barely survive. Socialist systems have attractive aspirations and may work for small groups and communes, but, when applied to large-scale communities, demonstrably yield inefficiency and dissatisfied patients. Rather than brave the long queues and the uncertainty of being treated by their assigned medical professional at home, many patients flee the British and Canadian systems to the U.S. for private medical care in expectation of the prompt delivery of the competent care of their choice.[58] They apparently believe that market competition will more likely give them a higher quality of healthcare than will state-managed care. Not everyone agrees that this flight is widespread or is indicative of the superior quality of healthcare in the U.S.[59]

Finally, according to the *New York Times*, critics of RFMP maintain that physicians who are already in practice who deny their patients access to their services on the basis of ability to pay, in effect unjustly abandon their lower-income patients to cater to the wealthy.[60] In that view, the elitist consequences of RFMP amount to breach of contract and violation of the professional ethical duty of non-abandonment of patients.

RFMP proponents argue in reply that both medical ethics and the common law allow physicians to terminate their relationships with patients. Rather than retire or relocate for economic or professional reasons, physicians now have a way to treat their patients well while earning an acceptable living. At the same time, their patients retain access to care that would otherwise be lost. RFMPs' perspective sees the abandonment that is actually taking place as the one precipitated by reimbursement mechanism schemes that are unacceptable to physicians. These schemes break faith with physicians by denying fair wages for work done. By not rescinding this injustice, society itself is guilty of abandoning the medical profession.

PHYSICIAN REIMBURSEMENT

During the past century, physicians have resisted political efforts to centralize and socialize medical practice, not only because they foresee a weakening of the quality of care, but also because control of medical practice would pass into the hands of nonprofessionals and because others would control doctors' financial destiny. Physicians contend that price controls by Medicare, Medicaid, and HMOs invariably lower physicians' fees and the quality of care, while they ultimately raise costs.[61] However, according to David U. Himmelstein, a national health plan, that is, a single-payer system managed by the government, would cover all our citizens, simplify reimbursement for providers, allow free choice of physicians and hospitals, and provide public accountability for quality and cost.[62]

On the other hand, RFMP helps to reverse this undesirable trend by paying the physician for rendering medical care more realistically than inadequate third-party pay schedules propose. It restores to physicians some control over their fees that they had lost with the advent of managed care. It reduces government

control over professional choices in medical decision making. Ethical justification for this argument is grounded in promoting autonomy (both patients' and physicians') and fulfilling professional obligations (by restoring professional prerogatives and responsibilities) and justice (achieving fair compensation).

SUMMARY

This article examines the reasons that some physicians have recently opted to reduce the size of their practice rosters to allow more time for each patient in exchange for a retainer fee from patients. These physicians also offer supplementary, nonmedical amenities to patients as part of their service. Because physicians have reduced the size of their practice rosters and have increased the price tag for their services, some patients have lost access to their care. We have tried to assess the ethical propriety of such a change in the design of medical practices by weighing plausible, ethically relevant arguments favoring and opposing RFMP.

Physicians are ethically obligated first and foremost to promote and protect the health of their patients. RFMP fulfills this duty directly by ensuring prompt and ample professional time for the care of patients. It does so indirectly by allowing time for physicians' continuing education, which in turn should upgrade the quality of care. It also advances the ethical goals of autonomy as it allows patients to choose their own physicians and to spend their money as they please. On the other hand, these ethical positives are offset by the cost of retainer fees that may exclude access of patients to their physicians' care. Even if ethical tradition obligates physicians primarily to patients under their specific care, as professionals and as private citizens, they also have a responsibility to support the health of the entire community. RFMP does little to advance this cause, except that by optimizing the conditions under which their own private patients receive healthcare, they call attention to shortcomings in prevailing public healthcare policies, which by comparison fall short of that standard. An assumption that health is not properly a market commodity, and that all people should receive healthcare on equal terms, would expose RFMP to moral reproof.

From an ethical perspective, we find sufficient cause for concern and caution in this innovative style of practice. Nevertheless, the weight of arguments presented here does not seem to justify unequivocal moral condemnation of RFMP. As neither pro nor con views seem to have settled the ethical question, definitive moral judgment on RFMP will probably depend on the outcome of future experience and ongoing evaluation. The implications of RFMP for any future healthcare system are not clear, at least to us.

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