

Is Boutique Medicine a New Threat to American Health Care or a Logical Way of Revitalizing the Doctor-Patient Relationship?

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INTRODUCTION

The American health care system is changing. Doctors are decreasing their patient load so they can spend more time with the patients they have. They are allowing patients to have access to a twenty-four-hour cellular number or pager in case of emergencies. Some doctors are even accompanying patients to specialists, and making house calls.

So why have most Americans not yet experienced such special attention at their doctor's office? The most likely answer is that the new luxury health care services popping up around the country come with a hefty price tag. Some physician groups are charging a yearly retainer fee of \$20,000 for the benefit of what they call "personalized care" or "boutique medicine."¹ While some argue that boutique health care is simply an example of a capitalist society at work,² others worry that providing health care services catering to the rich is unethical.³

Part I of this Note examines the current state of the United States health care system and provides a brief history of the health care

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1. Howard Gleckman, *Want a Doctor Who Treats You Like Royalty?*, BUS. WKLY., May 6, 2002, at http://www.businessweek.com/magazine/content/02_18/b3781606.htm.

2. E.g., Uwe E. Reinhardt, *Doctors Are More Interested in Having Higher Incomes than Providing Better Health Care*, 324 BRIT. MED. J. 1335 (2002).

3. E.g., Troyen A. Brennan, *Luxury Primary Care—Market Innovation or Threat to Access?*, 346 NEW. ENG. J. MED. 1165 (2002).

system. It also examines how doctors are paid in the United States health care system so as to introduce why some doctors are switching to boutique practices. Part II discusses how boutique medical practices work and some of the advantages from both a physician and a patient perspective. Part III explores the various ethical and legal implications of boutique medicine. Ultimately, this Note suggests that boutique medical practices are unethical and the easy way out of a failing health care system for a select segment of society. Furthermore, it is suggested that the health care industry take steps to assure equitable distribution of health care for all. In the short term, this Note urges that several limits be placed on existing boutique practices.

I

A. *A Brief History of Health Care in the United States*

Originally, medical costs in the United States were borne “out-of-pocket.”⁴ When a person was sick, he went to a doctor or to a hospital, and paid for the services received in cash.⁵ But this practice eventually changed.⁶

As medical care was improving in the United States, the Great Depression began and the United States economy plummeted.⁷ People were unemployed and could no longer pay their medical expenses out-of-pocket.⁸ Hospitals adapted by offering “service benefit contracts,” which allowed patients to pay a fixed sum for medical care.⁹

Even though the concept of insuring against need for hospital services was established, it was not until World War II that modern employer-sponsored health insurance came into existence.¹⁰ With a large number of the American labor force at war, and with companies

4. James R. Kimmey, *Health Reform—The Context*, 39 ST. LOUIS U. L.J. 45, 45 (1994).

5. *Id.*

6. *Id.*

7. *See id.* at 45–46.

8. *Id.* at 45.

9. *Id.* Under this system, patients could expect affordable health services and hospitals could expect a steady stream of income. *Id.* at 45–46.

10. *Id.* at 46.

experiencing a large demand for industrial output, employers began offering health insurance as a means of attracting new employees.¹¹ The idea appealed to all parties, and the not-for-profit health insurance¹² now known as Blue Cross came in to existence.¹³

Realizing the large available market, private companies began to compete with Blue Cross and Blue Shield to manage health care in the 1980s and 1990s.¹⁴ The federal government also worked to subsidize health care services for the elderly and the poor by establishing Medicare and Medicaid in the 1960s.¹⁵

Today, employer-sponsored health insurance is dominant.¹⁶ However, even with the government trying to fill the gaps, there are

11. *Id.*

12. Because of their not-for-profit status, these plans were often touted as “hospital (and medical) service corporations” as opposed to insurance companies. Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs*, 21 J.L. MED. & ETHICS 141, 143 (1993).

13. Kimmey, *supra* note 4, at 46; see also Anne Maltz, *Health Insurance 101*, in PRACTISING LAW INSTITUTE, INSURANCE LAW 2003, at 523 (2003), Westlaw: 690 PLI/Lit 523. Blue Cross was formed in 1930 and was originally called the American Hospital Association. *Id.* at 533. Blue Shield followed a decade later as the American Medical Association. *Id.* at 533–34. Together, the two have been referred to as “the Blues.” See MARK A. HALL ET AL., HEALTH CARE LAW & ETHICS 44 (6th ed. 2003).

Blue Cross plans were usually formed at the state level by hospital associations. *Id.* Physicians also began organizing their own Blue Shield plans. *Id.* By 1938 over 1.4 million Americans were receiving care under Blues plans. See *id.* at 45. The traditional Blues plan allowed patients “free choice of provider,” and “low out-of-pocket cost[s].” *Id.* Insurance companies reimbursed providers after “medically necessary” services were rendered. *Id.*

It is important to note that while the United States was establishing a non-government, market-based health care system, other countries were developing government-based health care programs. Kimmey, *supra* note 4, at 46.

14. Maltz, *supra* note 13, at 534. While in fee-for-service medicine, physicians are paid for each service rendered, doctors participating in managed care groups are usually paid a salary or a flat fee per patient regardless of the services rendered. *Id.* at 549–52. This type of payment system is known as capitation. *Id.* at 551.

15. Bovbjerg et al., *supra* note 12, at 148. Medicare is a health insurance program for the disabled and persons over sixty-five years of age. Maltz, *supra* note 13, at 536. Medicaid is a joint federal/state assistance program that provides health insurance for the poor. *Id.*

16. Two thirds of Americans under the age of sixty-five receive health insurance through employer-sponsored programs. This amounts to over 158 million people. See Karen Davis, *Work in America* (2001), available at http://cmwf.org/usr_doc/presmess.pdf.

Another study gives a breakdown of health care coverage in the United States by source. See Bovbjerg et al., *supra* note 12 (as updated and reprinted with permission in HALL ET AL., *supra* note 13, at 43). The study found that twenty-seven percent of insurance is purchased by private insurers, seventeen percent of insurance is self-funded by employers, thirteen percent of insurance is provided by Medicare, ten percent of insurance is provided by Medicaid, ten percent of insurance is provided by the government to its employees, eight percent of insurance is purchased by individuals, and two percent is provided by the government to members of the

still approximately forty-two million Americans without health insurance.¹⁷ Many of the millions of uninsured are the “working poor”—those in low paying jobs, who are not poor enough to qualify for Medicaid, but who receive too little pay to afford to purchase their own health insurance.¹⁸

B. How Are Physicians Compensated in Today’s Health Care System?

To understand why some physicians are switching to boutique medical practices, it is first necessary to explain how physicians are currently being compensated in the United States health care system. This provides the necessary background for understanding what is at the heart of many doctors’ frustrations.

1. Fee-for-service

Although fee-for-service compensation systems have become less prevalent as managed care has become the norm,¹⁹ it is necessary to mention the system to understand the advent of managed care. Before managed care, a patient would see her doctor and pay for each

military. *Id.* at 50. The remaining fourteen percent of people are uninsured. *Id.* By adding together the employer based insurance, this study found that only fifty-six percent of insurance is purchased by employers. *Id.*

17. Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 660 (2003). The National Center for Health Statistics (part of the Centers for Disease Control and Prevention) has reported the number of individuals without health insurance as follows: 41.0 million in 1997, 39.3 million in 1998, 38.7 million in 1999, 40.4 million in 2000, and 38.9 million in 2001. The National Center for Health Statistics, *Early Release of Selected Estimates from the National Health Interview Survey* (last visited Feb. 19, 2004), at http://www.cdc.gov/nchs/about/major/nhis/released200202/table01_1.htm. Another source estimates that the number of non-elderly uninsured individuals was 42.1 million in 1999. Steven A. Schroeder, *Prospects for Expanding Health Insurance Coverage*, 344 N. ENG. J. MED. 847, 847 (2001); see also Susan Adler Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?* 39 CAL. W. L. REV. 303, 311 (2003) reporting that the United States’ health care system “excludes approximately 43 million people . . .”

18. Maltz, *supra* note 13, at 538. However, “the fastest growing segment of the newly uninsured is the group that has been earning in excess of \$75,000.” Channick, *supra* note 17, at 303. This group consists of about 800,000 individuals. *Id.*

19. Maltz, *supra* note 13, at 547. The corresponding health insurance plan is called an indemnity plan. An indemnity health policy was the prominent group health insurance plan until the 1990s. *Id.*

service rendered.²⁰ A patient insured on a fee-for-service basis would submit a claim to her insurance company and might ultimately end up paying twenty percent of the bill; the insurance company would pay for the rest.²¹ Under fee-for-service insurance plans, doctors had no incentive to contain costs because they made more money with the more treatment they provided.²² The business world recognized this cost-containment problem and responded by creating managed care organizations.²³

2. Managed Care: Health Maintenance Organizations “HMOs” and Preferred Provider Organizations “PPOs”

Managed care is the term used to describe the various health care systems created to supplant typical fee-for-service health insurance.²⁴ “The goal of managed care is to limit the services rendered by the provider” and thereby save money for both the patient (in the form of lower premiums) and the insurer.²⁵ The most prominent managed care organizations are HMOs and PPOs.²⁶ In general, the managed care organization recruits physicians that contract to care for patients.²⁷ The patients pay premiums to the insurer, and in exchange for the services provided to the patient, the insurer pays the physician

20. Mark O. Hiepler & Brian C. Dunn, *Irreconcilable Differences: Why the Doctor-Patient Relationship is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street*, 25 PEPP. L. REV. 597, 603 (1998).

21. *Id.*

22. *See id.*

23. *Id.* at 603–04. It is interesting to note that turning the health care industry into a business is somewhat counter-intuitive. *See id.* at 604. This is because health care is unlike any other business. *Id.* For example, while most companies profit when their customers use their products, this is not true of the health care industry because HMOs lose money when sick patients require care. *Id.* “[O]nce the patient needs health care, especially if that care is continuing or otherwise expensive, the HMO is financially better off if the patient dies, because its costs basically cease where family funeral expenses begin.” *Id.*

24. *Id.* at 602.

25. Maltz, *supra* note 13, at 549. The ability to keep monthly premiums down has attracted many customers and thereby proven profitable for managed care. Hiepler & Dunn, *supra* note 20, at 603.

26. Hiepler & Dunn, *supra* note 20, at 602.

27. *See* Maltz, *supra* note 13, at 550–52. The physician can contract with the HMO individually, through a professional corporation, through a professional limited liability corporation, or through an independent practice association. *Id.* at 552.

a discounted, pre-negotiated fee per patient²⁸—this is known as capitation.²⁹ If the negotiated fee is too low, or if a number of the physician's patients develop expensive illnesses, the physician may suffer a loss.³⁰ This may cause physicians to feel forced to “cut corners” to make an acceptable salary.³¹ In some instances, the HMO may even provide incentives for the physician to reduce the number of specialist referrals.³²

“A PPO is an organization that creates a network of health care providers . . . who have agreed to accept a discounted fee as payment in full for the service to be rendered directly to the patient.”³³ The group of providers can include hospitals, general practitioners, nurse practitioners, and specialists.³⁴ Although paid at a discounted rate, physicians are still paid on a fee-for-service basis.³⁵ Typically, physicians agree to the discounted rate because they believe they will attract more patients by being part of the organization, thereby making up the lost earnings resulting from the discount.³⁶

28. *Id.* at 550–52. The managed care organization will often limit the patient's access to providers by contracting to pay only if the provider is part of the managed care organization's panel and has agreed to the discounted rate. *Id.* at 550–51. Furthermore, the doctor often receives the same amount of money per patient regardless of whether the patient is a health risk or not. Hiepler & Dunn, *supra* note 20, at 606. This has resulted in doctors taking on more patients to increase their monthly incomes in case a large number of their patients become ill. *Id.*

29. Hiepler & Dunn, *supra* note 20, at 606. Capitated payments are expected to cover all medical costs per each patient per month, including “testing, referrals to specialists, or even necessary hospitalizations.” *Id.*

30. Maltz, *supra* note 13, at 551. “[T]he risk of the patients getting sick has been shifted from the HMO to the doctor,” causing physicians, in essence, to become insurers. Hiepler & Dunn, *supra* note 20, at 606.

31. Maltz, *supra* note 13 at 551. Capitated payment amounts per patient vary with each managed care organization, ranging from thirty-five dollars per patient per month. Hiepler & Dunn, *supra* note 20, at 606.

For information discussing the different types of incentive payments made to physicians by HMOs and the potential conflicts of interest involved, see generally Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. MED. 399 (1996).

32. Maltz, *supra* note 13, at 550–52. While this may sound less than ideal for doctors, because HMO's control a large portion of the population's patients, many physicians are forced to participate in managed care organizations to maintain a client pool. Hiepler & Dunn, *supra* note 20, at 606.

33. Maltz, *supra* note 13, at 554. Although the first PPO was established in 1911, “modern PPOs emerged in the 1980s.” *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

3. Salary

Some physicians contract with managed care organizations, hospitals, insurance companies, or physician hospital organizations to become salaried employees.³⁷ Salaries may be paid on a weekly, biweekly, or monthly basis, but remain stable throughout the year.³⁸ Some organizations may provide a salary plus a productivity bonus.³⁹ Besides being paid their yearly salary, bonuses are distributed based on a periodic evaluation for quality and volume of care provided.⁴⁰

C. *The Right to Health Care in the United States*

Although there is no legal right to health care in the United States, many ethicists argue that there should be.⁴¹ Ethicists note that illness strikes at random and “does not allow people to have equal opportunities to succeed.”⁴² For this reason, they argue that society should require health care for everyone.⁴³ One commentator suggests

37. Deborah Epstein, *Keeping Salaried Physicians Satisfied and Productive*, MANAGED CARE MAG. (Mar. 1996), <http://www.managedcaremag.com/archives/9603/MC9603.salaried.shtm>.

According to the American Medical Association, approximately one-third of physicians are now salaried employees. In fact, according to one source, six percent of the nation's 757,000 practicing physicians have joined unions. Shelley Ross, *Medicine and Society, the Feminization of Medicine*, 5 VIRTUAL MENTOR, ETHICS JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (Sept. 2003), at <http://www.ama-assn.org/ama/pub/category/10967.html>.

38. Wayne M. Casper & Barbara J. Gibson, *Physician Compensation: New Models for a Managed-Care Marketplace*, PHYSICIAN RECRUITER, at <http://www.physicianrecruiter.com/Dept/retention/9961.htm> (Feb. 19, 2004). Health Maintenance Organizations with salaried physicians are usually called staff-model HMOs. *Id.*

39. *Id.* A major weakness of a basic salary arrangement has been a lack of incentives for hardworking physicians; bonuses are often used to encourage doctors to provide quality care that is also efficient. *Id.*

40. *Id.*

41. See Christine Cassel, *The Right to Health Care, the Social Contract, and Health Reform in the United States*, 39 ST. LOUIS U. L.J. 53, 55 (1994). For a general discussion of the right to health care, see generally MARC D. HILLER, *MEDICAL ETHICS AND THE LAW* 53–72 (1981); William T. Blackstone, *On Health Care as a Legal Right: An Exploration of Legal and Moral Grounds*, 10 GA. L. REV. 391 (1976); Sarah C. Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATH. U. L. REV. 492 (1974).

42. Cassel, *supra* note 41, at 55.

43. *Id.* To understand this argument, public health scholar Lawrence Gostin suggests that one analogize a right to health care to the right to education. See Sharona Hoffman, *supra* note 17, at 682 (quoting Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L.J. 7, 27 (1994)). The

that the United States demonstrates its belief in a right to health care not in its words, but in its actions:⁴⁴ if the United States did not believe in a right to health care, we would not have Medicare and Medicaid,⁴⁵ federally funded programs providing expensive medical care to the elderly and indigent.⁴⁶

Conversely, health care can be viewed as a market commodity.⁴⁷ For instance, today access to health care for most Americans is based on, or at least rationed by, one's ability to pay.⁴⁸ According to Lawrence Gostin, "the concept of a right to health is too broad to have legal meaning. . . . An unfettered constitutional right to health care is not currently tenable."⁴⁹

government justifies providing a minimum level of public education by acknowledging that education helps to foster fair opportunities for all children. Similarly, a certain level of health care is just as necessary to ensure equal opportunity among individuals. *Id.* Although health care does not arm a person with intelligence or skill, it allows the person to function normally, often a prerequisite for gaining knowledge. *Id.*

44. Cassel, *supra* note 41, at 58–59. According to Cassel:

[i]t is both unfair and dishonest to say that we do not believe there is a right to health care, because we are behaving as if there is. If we really believed that health care is simply a market commodity (as some still argue), then uninsured sick people without the means to pay would be refused care regardless of the consequences to them. Indeed, this "right" to care is so imbedded in our social values that refusing to provide health care is not only viewed as unethical, but is also illegal under federal law.

Id. at 59.

45. *See supra* text accompanying note 15.

46. *See* Cassel, *supra* note 41, at 57–59. Also consider the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA is an act passed by Congress that requires any hospital that receives government funding to screen any patient that arrives in the emergency room. Sharona Hoffman, *supra* note 17, at 672. The emergency room must stabilize the patient, even the ones that cannot pay, before transferring the patient. *Id.*

47. *See* Brennan, *supra* note 3, at 1165. For an argument that health care should not be viewed as a market commodity, consider the following by commentator John C. Render:

A characteristic of the health care field that distinguishes it from most other commodities and services is the provision of a vital human service. Most other vital human services such as water and power are subject to state oversight in the form of public utility commissions or similar entities. This is based, at least in part, on the notion that such services are so significant that determining their availability by market forces is contrary to civilized values and should therefore not be subject to the varieties of the market system.

John C. Render, *Recognition of Health Care Market Anomalies*, 31 IND. L. REV. 119, 121 (1998).

48. Jeanne Schulte Scott, *Boutique Health Care: Opportunity or Inequity?*, 56 HEALTHCARE FIN. MGMT. 26, 26 (2002).

49. Gostin, *supra* note 43, at 11–12 (footnotes omitted). Although Gostin does not argue

II

A. A New Type of Health Care—The Basics of Boutique Medicine

Although known by many different names—“concierge care”, “luxury health care,” “retainer medicine,” and “personalized health care”—boutique medical practices all work on the same basic premise: a physician charges his or her patients a yearly retainer fee in exchange for more personalized services.⁵⁰ The yearly fee can range from \$1,000 to \$20,000 per year.⁵¹ In exchange for the yearly retainer fee, patients can expect more personalized services, including twenty-four-hour doctor access, coordinated referrals to specialists, online access to their medical records, same day appointments, and longer appointment times.⁵² Most boutique practices charge a membership fee in addition to the cost of insurance the patient already pays.⁵³

One of the first boutique medical practices—MDVIP, started by Dr. Robert Colton—began in southern Florida.⁵⁴ The MDVIP annual membership fee is \$1,500 per individual.⁵⁵ With the payment of the retainer fee, MDVIP guarantees specific amenities⁵⁶ and promises

that there is a right to health care, he does argue that health care is necessary for an individual to pursue a livelihood, to exercise his or her rights, and to achieve satisfaction and happiness. *Id.* at 12–14.

50. Brennan, *supra* note 3, at 1165.

51. *Id.*

52. *Id.* at 1165; Fred Charatan, *US “Boutique Medicine” Could Threaten Care for the Majority*, 324 *BRIT. MED. J.* 187, 187 (2002); Gleckman, *supra* note 1. Other amenities include telephone and email consultations, nicer waiting rooms, preventive care, nutrition advice, and spa-like perks such as bathrobes and slippers. Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, 15 *HEALTH LAW.*, Aug. 2003, at 1, 3.

53. Brennan, *supra* note 3, at 1165.

54. Kris Hundley, *Doctors Offering “Concierge” Care*, *ST. PETERSBURG TIMES*, July 28, 2001, at 1A. Boutique medical practices began in Seattle in the mid-1990s. *Id.* MD², a Seattle-based practice established in 1996, is considered the first boutique medical practice. Portman, *supra* note 52, at 3.

55. MDVIP, Membership Agreement para. 3, at 2 [hereinafter Membership Agreement] (Attachment 2 to Letter from Senator Richard Durbin and Representatives Henry A. Waxman, Sherrod Brown, Pete Stark, and Benjamin Cardin to Tommy G. Thompson, Secretary of Health and Human Services and Janet Rehnquist, Inspector General, Health and Human Services (Mar. 4, 2002) (on file with the Washington University Journal of Law & Policy) [hereinafter Letter]).

56. The membership agreement states that the program provides the following amenities:

Annual Physical Examination

Comprehensive Preventive Healthcare Plan And Lifestyle Planning

that all participating physicians will limit their practice to a maximum of 600 patients.⁵⁷ Although MDVIP originally began with four physicians, Dr. Colton plans to franchise MDVIP in New York, California, Illinois, Texas, Maryland, and Virginia.⁵⁸

In addition to the price of the retainer fees, the patient load per doctor, and the exact amenities included with membership, there are other subtle differences between each boutique practice.⁵⁹ Some practices, like MD², only accept boutique patients, while others, like Miami Medical Consultant PA in Coral Gables, Florida, still treat non-boutique patients.⁶⁰

While most of the patients in boutique practices retain their health insurance or Medicare, paying the retainer fee in addition to their

Same Day Or Next Day Preferred Appointments
Support Personnel Dedicated Exclusively To Members
Physician Availability (24 X 7)
E-mail/Fax Access
Prescription Facilitation
Coordination Of Necessary Referrals
Claims Facilitation For Members
Travel Medical Services
Private Reception Area Replete With Amenities

Id. para. 1, at 1.

57. Charatan, *supra* note 52, at 187. It has been quoted that standard physician practices have approximately a 1200–1600 patient load, but a boutique doctor in Seattle estimated his original panel of patients at 3000. Brennan, *supra* note 3, at 1165; William Hoffman, *Fed Up, Some Doctors Turn to “Boutique Medicine”*, ACP-ASIM OBSERVER, Oct. 2001, http://www.acponline.org/journals/news/oct01/new_model.htm.

The Dare Center in Seattle charges \$3,000 per year and caps patient loads at 200–300 per physician. Brennan, *supra* note 3, at 1165. MD², a boutique practice in Seattle, charges \$13,500 for individuals and \$20,000 per couple. Portman, *supra* note 52, at 3. To add children to the plan, the practice charges \$2,000 per child over the age of 14. *Id.* MD² limits its patient load to fifty families per physician and accepts no insurance. *Id.*

58. Charatan, *supra* note 52, at 187. MD² offers franchises to other physician groups. Portman, *supra* note 52, at 3. The physician group will have to pay \$75,000 upfront and a five-percent royalty to use the MD² name and program. *Id.*

While the number of boutique medical practices in the country is growing, the numbers are still small. One commentator suggests that “no more than several dozen” physicians out of the 800,000 physicians in the country are currently practicing boutique medicine. Portman, *supra* note 52, at 4.

59. Portman, *supra* note 52, at 3.

60. William Hoffman, *supra* note 57. Miami Medical Consultant, PA offers boutique medicine as an option to 150 of its already existing patients. Portman, *supra* note 52, at 3. The fee is a sliding scale based on age. *Id.* Patients over the age of sixty-five are charged the highest annual fee. *Id.*

insurance premiums,⁶¹ a few practices refuse to accept any form of insurance.⁶² Accepting health insurance is not critical to the implementation of a boutique practice, but many boutique practices choose to accept insurance to reduce the price of the yearly retainer fee.⁶³ Moreover, health insurance is used to cover hospitalization and special treatments.⁶⁴

Offering a different spin on the boutique medical practice, the Tufts–New England Medical Center now offers boutique hospital care.⁶⁵ The center, a teaching hospital faced with losing money by providing care to poor patients, decided to become one of the first teaching hospitals in the United States to “open a boutique primary-care practice.”⁶⁶ The annual fee is \$1800 per patient. In return, subscribers can expect longer appointments and nicer waiting areas.⁶⁷ The hospital explains that charging boutique clients a retainer fee will allow the hospital to continue caring for its poor patients; instead of

61. Brennan, *supra* note 3, at 1166. The MDVIP contract states: “The membership fee does not affect the co-payments, co-insurance or deductibles that you are required to pay pursuant to the terms of your insurance coverage. You will be financially responsible for any co-payments, co-insurance or deductible amounts required by your insurer.” Membership Agreement, *supra* note 55, para. 6, at 3.

62. Steven M. Goldstein, *The Legal Risks of Boutique Medicine*, at <http://www.legaliq.info/articles/healthcare/20030827.asp>. MD² does not accept any form of insurance. Portman, *supra* note 52 at 3.

63. *See* Brennan, *supra* note 3, at 1166.

64. *Id.* at 1166. According to Brennan, boutique “patients leave the luxury practice whenever they are hospitalized or receive care from a specialist.” *Id.*

Brennan suggests that boutique medical practices may threaten insurance companies for three reasons. First, some believe it is unfair to charge insureds a retainer fee because they are already paying a premium to the insurance company. Second, some may fear that patients who join boutique practices will begin to expect more than just special personal services. For example, patients may also begin to expect luxury diagnostic and therapeutic procedures. Third, insurance companies may fear that boutique doctors will become inefficient gatekeepers, as their main source of income becomes retainer fees and they become less concerned with insurance company incentives. *Id.* at 1166–67.

Although research shows insurance companies generally have not refused to insure boutique practices or physicians, many are studying the situation. *Id.* at 1167. One scholar found that an executive of one managed care organization does not believe his company will contract with boutique doctors. *Id.* This executive fears the retainer fee is too similar to the prohibited “access fee.” *Id.*

65. Steve Smith, *The Boutique Medicine Boom: Perspectives on the Growth of a Controversial Trend*, PRACTICE BUILDERS, Sept./Oct. 2003, at 1, available at http://www.practicebuilders.com/pdf_newsletter/whatsworking_1003.pdf.

66. *Id.*

67. *Id.*

passing the retainer fee from wealthy patients to wealthy physicians, the hospital is using the money to subsidize the hospital's primary care practice.⁶⁸

Conversion to a boutique medical practice can be very informal.⁶⁹ After deciding to convert to the MDVIP boutique practice, Dr. Robert Colton sent letters to all of his patients informing them of his decision and inviting the first 600 people to respond into his new personalized practice.⁷⁰ The remaining patients were instructed that they would need to find a new doctor.⁷¹

B. Advantages of Boutique Medicine

Although some might blame the emergence of this new kind of class-based medicine on the sheer greed of physicians, many doctors claim they entered the new practice out of frustration with medicine due to the restrictions imposed by managed care.⁷² The advent of managed care robbed doctors of unfettered control and replaced it with foreign concepts like "preauthorization, utilization review, and economic incentives to reduce the cost of health care."⁷³ The decrease

68. *Id.*

69. William Hoffman, *supra* note 57.

70. *Id.*

71. *Id.* It is often difficult for patients to learn that his or her doctor is converting to a boutique practice that they may not be able to afford. *Id.* One physician stated that although most of his patients wished him well, some expressed anger. *Id.* He also acknowledged that "[t]he biggest hurdle for anybody is extricating yourself from your previous life In essence, you're retiring from private practice." *Id.*

72. See generally Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 370 (2003). A study on managed care and physician satisfaction indicates that primary care physicians who receive income from capitated managed care contracts are significantly unhappier than those physicians who do not receive capitated income. Sharon B. Buchbinder et al., *Managed Care and Primary Care Physicians' Overall Career Satisfaction*, 28 J. HEALTH CARE FIN. 35 (2001).

Dr. Kaminetsky, an internist for MDVIP, has claimed that he was so unhappy with practicing medicine under managed care that he was ready to stop practicing altogether: "I was seeing 30 patients a day on an accelerating treadmill. It was either do this, or leave clinical practice. I don't think the public realizes the depth of physicians' dissatisfaction." Hundley, *supra* note 54; see also William Hoffman, *supra* note 57.

73. Jacobson, *supra* note 72, at 370. In fact, some have claimed that the onset of managed care has destroyed the doctor-patient relationship. Hiepler & Dunn, *supra* note 20, at 598. One commentary suggests: "By interfering with and constraining the relationship between patients and doctors, health maintenance organizations (HMOs) have made the two no longer accountable to each other, all the while standing back and claiming that they have nothing to do

in physician autonomy, combined with low reimbursement rates, rising overheads, and rising malpractice premiums,⁷⁴ makes it easier to understand why some doctors were looking for a change.

Dr. Maron, internist at MD² and the alleged pioneer of boutique medicine, claims he came up with the concept after asking himself what he would do “if [he] could practice medicine in the ideal.”⁷⁵ The “ideal” of boutique medicine has ultimately functioned to remove the financial pressures imposed by managed care. For example, with money coming into the practice from annual retainer agreements, physicians no longer have to rely solely on insurance reimbursements.⁷⁶ With the retainer as supplemental income, physicians in boutique practices can see fewer patients per day⁷⁷ while actually increasing their salaries.⁷⁸

with medical decisions.” *Id.*

74. One commentator noted, “doctors frequently practice ‘defensive medicine’ due to rising malpractice premiums . . . For example, the onslaught of medical malpractice claims in the 1970s resulted in alarming 500% increases in malpractice premiums in some states.” Susan L. Cockrell, *Joint Tortfeasors Beware: Double Recovery May Be Allowed*, 50 S.C. L. REV. 1081, 1090 n.63 (1999) (citing Patricia M. Danzon, *Malpractice Liability: Is the Grass on the Other Side Greener?*, in TORT LAW AND THE PUBLIC INTEREST 176, 178, 180 (Peter H. Schuck ed., 1991)) (citation omitted).

In an August 2003 report to Congressional Requestors, The United States General Accounting Office noted the implications of the rising cost of medical malpractice premiums on access to care:

Medical malpractice insurance premium rates increased rapidly in some states beginning in the late 1990s after several years of relative stability, similar to previous cycles of rising premiums that occurred during the 1970s and 1980s. Between 2001 and 2002, premium rates for the specialties of general surgery, internal medicine, and obstetrics/gynecology (OB/GYN) increased by about 15 percent on average nationally, and over 100 percent for certain of these specialists in some states. In response to these rising premiums, representatives of health care providers—including physicians, hospitals, and nursing homes—and the media have reported that physicians have moved out of states experiencing the highest increases, retired, or reduced or eliminated certain high-risk services.

United States General Accounting Office, Report to Congressional Requestors, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, available at <http://www.gao.gov/new.items/d03836.pdf>.

75. William Hoffman, *supra* note 57.

76. Brennan, *supra* note 3, at 1165.

77. *Id.*; William Hoffman, *supra* note 57.

For the results of a survey indicating that doctors are discontented with the amount of time spent with each patient, see David G. Fairchild et al., *When Sick Patients Switch Primary Care Physicians: The Impact on AMCs Participating in Capitation*, 75 ACAD. MED. 980 (2000).

78. The doctors at MDVIP receive two-thirds of each retainer fee. Hundley, *supra* note

Smaller patient loads can create many benefits for the physician.⁷⁹ First, the physician will be able to spend more time with the patients he or she sees,⁸⁰ increasing the intimacy of the physician-patient relationship.⁸¹ Second, the doctor will have more time for courtesy activities, such as accompanying patients to specialists or making house calls.⁸² Third, the physician will have more time for career development in the form of workshops and seminars.⁸³ Fourth, the physician can enjoy more personal time with his or her family.⁸⁴

Not only do physicians benefit by gaining more time, they also increase their yearly income.⁸⁵ Even though the fee schedules

54; *see also infra* text accompanying notes 85–87.

79. Brennan, *supra* note 3, at 1165.

80. *Id.* A typical primary care physician will see twenty patients per day for fifteen minutes, or for twenty-five minutes if it is the patient's first visit. *Id.* Dr. Bernard Kaminetsky of MDVIP claims that before he was a boutique physician he was forced to spend as little time with a patient as ten minutes. Under MDVIP he claims that his "routine patient visit is 30 minutes; new patients receive 90 minutes." Bernard Kaminetsky & Jay Jacobson, *Is "Boutique Medicine" Ethical?* PHYSICIAN'S WEEKLY (Jan. 7, 2002), at <http://www.physweekly.com/pc.asp?issueid=28questionid=~4pintable=1>.

81. Kaminetsky & Jacobson, *supra* note 80. According to Dr. Kaminetsky, an internist at MDVIP:

In my former practice of 17 years, I felt like a "provider"—devalued and invisible. I would finish seeing up to 30 patients a day at 9 p.m. and congratulate myself for having survived it. Due to the sheer volume and pace required to maintain an economically viable practice, I was burning out and considering leaving medicine.

Id.

82. William Hoffman, *supra* note 57. Dr. Kaminetsky of MDVIP expressed a sense of fulfillment when speaking about a house call he made: "You get a sense that you've really attended to a problem and it's so much more gratifying. I even paid a house call to a patient who was dying last week. It's been years since I did that." Hundley, *supra* note 54.

83. *See* William Hoffman, *supra* note 57.

84. Portman, *supra* note 52, at 1.

85. Doctors in the United States earn an average of 5.5 times the average wage. Reinhardt, *supra* note 2 (citing data from the Organization for Economic Cooperation and Development). Reinhardt suggests that boutique medicine is not an effort by American doctors to provide better, more personalized care to their patients, but an effort "to keep the income ratio at 5.5 or above." *Id.* For a comprehensive survey of physician salaries broken down by specialty and the organization releasing the data, see Physicians Search, Physician Salary Surveys (last modified Mar. 7, 2001), at <http://www.physicianssearch.com/physician/salary.html>.

It is important to note that most physicians taking advantage of the new boutique medical practices are general practitioners or family physicians. *Id.* According to one survey, the average family practitioner makes \$122,625. Specialists make significantly more money than family practitioners. *Id.* For example, the average anesthesiologist makes \$203,326, the average gynecologist makes \$206,031, the average general surgeon makes \$190,273, and the emergency medical specialist makes \$157,286. *Id.*

between boutique practices vary, all boost the participating physicians' incomes.⁸⁶ A Seattle-based retainer medicine practice claims that switching over from a standard practice increased its physicians' salaries by ten to twenty percent.⁸⁷

In addition to benefiting physicians, boutique medicine also benefits certain patients. Those who pay yearly retainers can spend more time with their physicians and less time waiting for appointments.⁸⁸

III

A. The Ethical Implications

While some view boutique medicine as a market innovation serving the interests of a group of patients and physicians,⁸⁹ many view boutique medicine as unethical and discriminatory.⁹⁰ The following sections discuss the ethical implications of boutique medicine, including the possibility of undermining the social responsibility aspects of health insurance, the widening of the gap between health care for the rich and the poor, and the disregard for the professional responsibility of doctors. An opinion examining

86. Brennan, *supra* note 3, at 1165.

87. William Hoffman, *supra* note 57.

88. In fact, a sixty-year-old patient of an MDVIP physician raved about being part of the elite practice:

"I go to other doctors and have to wait an hour and a half for a three-minute visit . . ."
 "With MDVIP, I paged my doctor at 10 o'clock one night and heard from him five minutes later. I was on my way to the drug store in 15 minutes." . . . "They say this program is only for the rich," . . . "And you know what? So be it. How many poor people can afford a country club? This is like joining a county club, and I am paying \$1,500 for the best one in town."

Hundley, *supra* note 54, at 8A.

The MDVIP Brochure lists a page of quotations from satisfied customers, including the following: "I never felt so secure with my medical needs." MDVIP, VIP Access 6 (Attachment 1 to Letter, *supra* note 55). "No more waiting and worrying — I get quick responses to all of my medical questions." *Id.* "I was so surprised when the morning after my eye surgery, the doctor called to see how I was doing. My doctor has the time to care!" *Id.* "I never felt so good when I felt so bad. My doctor really cares and has time to give the personalized service I want!" *Id.*

89. See Brennan, *supra* note 3, at 1165.

90. See generally Kaminetsky & Jacobson, *supra* note 80; Charatan, *supra* note 52; Brennan, *supra* note 3.

boutique practices drafted by the American Medical Association's Council on Ethical and Judicial Affairs⁹¹ is also discussed.

1. The Social Implications of Health Insurance

Health insurance can be viewed as a system serving a societal purpose.⁹² It brings society together by pooling people's money for use by those who need the most expensive medical care.⁹³ Some scholars speak of insurance as a "societal responsibility"⁹⁴—a way of spreading the unexpected future losses of one person among the members of society who are willing and able to pay.⁹⁵

In reality, however, individuals most likely do not purchase insurance out of a sense of responsibility toward the community.⁹⁶ Nonetheless, one can argue that boutique medical practices that make it unnecessary for individuals to contribute to the health insurance pool⁹⁷ undermine cross-subsidized care.⁹⁸ By taking the wealthy people who often purchase the most elaborate and expensive

91. See *infra* note 119 (explaining the role of American Medical Association's Council on Ethical and Judicial Affairs).

92. See John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 407 (2003).

93. *Id.*

94. *Id.* Deborah Stone is the commentator attributed with speaking of insurance as a societal responsibility. She once expressed:

Insurance is a social institution that particularly invites moral contemplation about questions of suffering, compassion, and responsibility. . . . The basic premise of insurance is collective responsibility, for harms that befall individuals, because insurance pools people's savings to pay for individuals' future losses. Thus, whenever insurance is discussed, questions of allocating responsibility between individuals and society are barely beneath the surface.

Id. (quoting Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 16 (1999) (footnotes omitted)).

95. "[T]he American health care system has been dependent on cross-subsidies from patients with good insurance coverage to those with poor coverage or none." Brennan, *supra* note 3, at 1167. For example, a hospital can care for a poor person without insurance because it often receives payments in excess of the cost of care from well-insured patients. *Id.*

96. Sharona Hoffman, *supra* note 17, at 670. This author ventures, "consumers do not purchase insurance for altruistic reasons or out of a sense of social responsibility. Rather, they try to obtain maximum protection for the cheapest rate, to their own advantage." *Id.*

97. See *supra* note 64.

98. Some boutique practices refuse to "take any Medicare or private insurance." Goldstein, *supra* note 62.

insurance plans out of the market, boutique practices are decreasing the amount in the pool and reducing affordable access to care.⁹⁹

2. Widening the Gap

A huge gap in health care already exists between the wealthy and the poor.¹⁰⁰ Accordingly, many opponents of boutique medicine argue that its “effect on access” to care—access that is already so disjointed—is the main problem.¹⁰¹ If a large number of doctors begin charging retainer fees to access their care, access to health care will become a problem.¹⁰² In effect, boutique care will begin to widen the existing gap in the United States health care system, polarizing the wealthy from everyone else.¹⁰³

On the other hand, proponents of boutique care argue that boutique practices do not threaten the majority of health care practices and are only being used to “fill[] a small niche.”¹⁰⁴ Furthermore, proponents might argue that inequalities have always existed in health care and been accepted.¹⁰⁵ For example, few physicians choose to work in “impoverished inner-city or rural areas.”¹⁰⁶ Some physicians do not even accept Medicaid. As a result, the poor have always had less access to medical care.¹⁰⁷

3. The Professional Responsibility of Doctors

Physicians have always been held to high standards.¹⁰⁸ In fact, being a doctor is one of the most respected professions in the

99. See also the AMA principles of medical ethics discussed *infra* Part III.A.4.

100. Gostin, *supra* note 43, at 28. “Health disparities between poor people and those with higher incomes are almost universal for all dimensions of health.” *Id.* at 31. (footnote omitted) “[T]he Institutes of Medicine estimates that one-third to one-half of the gaps in mortality rates are attributable to difficulties in obtaining access to care.” *Id.* at 33.

101. Brennan, *supra* note 3, at 1167.

102. *Id.*

103. *Id.*

104. *Id.*

105. *See id.* at 1168.

106. *Id.*

107. *See id.*

108. More than 2000 years ago, Hippocrates recognized that doctors were special members of society. Hiepler & Dunn, *supra* note 20, at 598. He suggested that a physician’s job came with special esteemed responsibilities. *Id.*

country.¹⁰⁹ As professionals, doctors are dedicated to serving the sick and providing services for the underinsured and the uninsured.¹¹⁰ The doctor-patient relationship is legally important.¹¹¹ Doctors have a fiduciary duty to their patients.¹¹² Because doctors are in a position of power and trust, society relies on their fidelity and integrity to put the medical needs of patients before their own financial interest.¹¹³

Some believe that doctors participating in a boutique practice do not respectfully represent the profession.¹¹⁴ They suggest that these doctors place the burden of caring for the poor on other doctors¹¹⁵ so they may relieve their own stress while simultaneously increasing

109. "Physicians top the list of the 17 most prestigious professions and occupations as perceived by the public, according to the results of a Harris poll." The American Academy of Orthopaedic Surgeons Bulletin, *Physicians Top List of Prestigious Professions, Jobs* (last modified Aug. 12, 1998), at <http://www.aaos.org/wordhtm/bulletin/aug98/fline7.htm>. According to abcnews.com, 61 percent of adults polled said they believed doctors had "great prestige." The Harris Poll, taken in 1998 shows that doctors have not been rated so prestigiously since 1977. Humphrey Taylor, *Doctors' Prestige Rises Sharply*, THE HARRIS POLL (June 17, 1998), available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=177. It has been suggested that the trend may represent the "public's increasing dislike for managed care." *Id.* Patients may often see doctors as being on their side. *Id.*

110. Kaminetsky & Jacobson, *supra* note 80.

111. The doctor-patient relationship has many facets. While historically the relationship has been held sacred, today it is mainly defined by legal principles. Hiepler & Dunn, *supra* note 20, at 599. The courts in the United States have determined several legal principles. *Id.* First, the "doctor owes a fiduciary duty to the patient." *Id.* Second, the doctor has a duty to practice medicine with the applicable standard of care. *Id.* Otherwise the doctor can be liable for malpractice. *Id.* at 599-600. Third, doctors are held to various codes of ethics. *Id.* at 600.

112. Hiepler & Dunn, *supra* note 20, at 599. Fiduciary duty is "a duty to place the interests and well-being of the patient above the interests of the doctor or a third party. *Id.*

113. ONCOLOGY NEWS INTERNATIONAL, vol. 6, n. 12, Dec. 1997. In fact, the Hippocratic oath states that the doctor should "do no harm" and "put the patient's interest first and foremost." *Id.*

One could argue that doctors participating in boutique practices are putting the interests of their wealthy patients first and the interests of their less wealthy, non-boutique patients second.

114. *Id.* According to Dr. Jacobson, "spending more time with patients because they will pay more is not responsible." *Id.* Ira Mandel, a Tampa physician recognizes the struggles today's doctors are facing, but is concerned that boutique health care practices are giving physicians a bad name:

Doctors are seeing more patients, working longer hours, feeling more hassles from managed care and seeing their incomes fall. It is understandable that they want to take charge and accept higher compensation for fewer patients, but it is very unproductive. It gives the appearance that doctors are being greedy and catering to the highest bidder.

Hundley, *supra* note 54.

115. Kaminetsky & Jacobson, *supra* note 80.

their incomes.¹¹⁶ One doctor even suggests that boutique medical practices are unproductive and greedy.¹¹⁷

4. The Opinion of the American Medical Association (AMA)¹¹⁸

At the 2003 annual meeting of the AMA Council on Ethical and Judicial Affairs,¹¹⁹ the council agreed that retainer medical practices are not unethical.¹²⁰ The AMA qualified its statement¹²¹ by noting that while charging a retainer fee for more face time and “personalized” care is ethical, it would be unethical if boutique doctors guaranteed better or more technically advanced care.¹²² The council also explained that it does not currently see boutique medicine as a threat to access because so few physicians are

116. *Id.*; see also *infra* Part II.B.

117. Hundley, *supra* note 54.

118. The AMA is a national professional organization of physicians. The organization works to speak out on certain issues important to the health of the United States and its citizens by drafting policies on issues decided through a democratic, policy making process. See generally AMA Ethics, <http://www.ama-assn.org/ama/pub/category/2416.html>.

119. The AMA Council on Ethical and Judicial Affairs is the body responsible for updating the *AMA Code on Medical Ethics*, one of the most recognized ethics guides for physicians. See generally <http://www.ama-assn.org/ama/pub/category/2498.html> (last modified Sept. 10, 2004). The Council consists of nine members—seven practicing physicians, a resident, and a medical student. *Id.* Each is nominated by the American Medical Association’s president and elected by the House of Delegates. *Id.*

120. applesforhealth.com, *Boutique Medicine Passes Ethics Test* (June 20, 2003), at <http://applesforhealth.com/HealthyFeatures/boumedpase5.html>.

121. The statement was drafted without reviewing a copy of any boutique practice contract. *Id.*

122. *Id.* The ethical opinion states: “it is important that a retainer contract not be promoted as a promise for better, diagnostic or therapeutic service.” *Id.* One commentator criticized the opinion, explaining that it would be hard to believe that a sick patient that gets into her doctor’s office right away is not receiving better care than a person who may have to wait three weeks for treatment. *Id.*

I believe this criticism holds true. Consider the following statement from a patient struggling from a serious, but undiagnosed illness. She and her husband pay \$7,500 to be part of a boutique practice: “I had a lovely doctor who was part of a standard practice. Access to her was nearly impossible, response times were slow. Concerns I had with my health were magnified because of the difficulty I had with the system.” Gleckman, *supra* note 1. She also notes that her new doctor is giving her more attention and finding great specialists for her. *Id.* One boutique doctor reminisced about receiving information from the wife of a man who was suffering from terminal cancer. After making a house call to treat the man, he was told by family members that the man’s wife was “walking on air” because she was so happy about the visit. *Id.* Faster patient attention, coordination of specialists, and house calls, especially for a person with a severe illness, are certainly associated with better patient care.

involved.¹²³ However, one member of the council explained in a report that the standard of medical care should not depend on an individual's ability to pay.¹²⁴

After looking at the AMA's Principles of Medical Ethics,¹²⁵ one may suggest that its opinion on the ethical implications of boutique practices is a curious one. Principle number VII states: "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health."¹²⁶ Principle number IX states: "A physician shall support access to medical care for all people."¹²⁷

Boutique medical practices are inconsistent with both of these principles. First, a boutique retainer agreement often states that a doctor will limit his care to a small, specific number of patients.¹²⁸ A doctor that participates in free care for members of the community may go over that limit.¹²⁹ This could result in a boutique patient bringing a breach-of-contract claim. Second, boutique practices,

123. applesforhealth.com, *supra* note 120. The council on ethical and judicial affairs acknowledged that boutique practices are growing in certain areas—the Pacific Northwest, the Northeast, the Boston area, and throughout Florida. One member of the council commented that if boutique practices did "take over an area, that would be a concern for us and we would have to revisit this issue because it is possible that (retainer practices) could threaten access. We couldn't support anything that would threaten access to care." *Id.*

Some argue that it is hard to suggest that something is ethical as long as it stays in a contained form. Brennan, *supra* note 3, at 1167. Brennan does a good job of explaining this argument:

Since professional ethics is a matter of reasoning on the basis of principles, there is something suspect about this argument. It suggests that in the current situation—that is, with relatively little demand for luxury primary care—the practice can be endorsed by professional ethics. However, if the demands were great and access was reduced, then the practice would be considered unethical. This means that the definition of ethical practice changes with the situation . . . [s]uch situational ethics flies in the face of standard professional principles.

Id.

124. Steve Perlstein, *Boutique Medicine*, *AMA Briefs*, 33 INTERNATIONAL MEDICAL NEWS GROUP FAMILY PRACTICE NEWS 13, 5 (July, 2003).

125. The AMA's Principles of Medical Ethics can be found on the AMA website, <http://www.ama-assn.org/ama/pub/category/2512.html>.

126. *Id.*

127. *Id.*

128. *See supra* note 57 and accompanying text.

129. *See supra* Part II.A.

which base membership on ability to pay, clearly do not support access to care for all people.

B. The Legal Implications

With medical technology and theory constantly advancing, it is often difficult for the legal community to keep up with trends in the medical community.¹³⁰ Therefore, as boutique medical practices are relatively new, they remain beyond the reach of the law.¹³¹ For example, there are currently no state or federal statutes banning or restricting boutique medical practices. Furthermore, there is no published case law. Still, boutique practices raise several legal issues. This section explores the possible legal implications of boutique medicine to predict whether the law will ultimately permit or prohibit the relationships.

1. Violation of Medicare Regulations—The Medicare Equal Access to Care Acts of 2002¹³² and 2003¹³³

In a letter to Health and Human Services Secretary Tommy Thompson, five legislative sponsors of the Medicare Equal Access to Care Act of 2002¹³⁴ claim that boutique medical practices violate Medicare law¹³⁵ in two ways.¹³⁶ First, they suggest that boutique

130. Goldstein, *supra* note 62.

131. *Id.*

132. H.R. 4752, 107th Cong. (2002). Sponsors of the bill included four members of the House of Representatives (Henry A. Waxman, Sherrod Brown, Pete Stark, and Benjamin Cardin) and one member of the Senate (Richard Durbin) *Id.* The bill proposed

[t]o amend title XVIII of the Social Security Act to prohibit physicians and other health care practitioners from charging a membership or other incidental fee (or requiring purchase of other items or services) as a prerequisite for the provision of an item or service to a Medicare beneficiary.

Id. pmb1.

133. H.R. 2423, 108th Cong. (2003). Sponsors of this identical bill again included Congressmen Waxman, Brown, Stark, and Cardin. Senator Durbin was no longer a sponsor, but was replaced by Congressman Kleczka.

134. H.R. 4752, 107th Cong (2002).

135. Robert Hayes, president of the Medicare Rights Center agrees. He notes that “[t]his practice of “pay-for-privilege” health care undermines the ability of people to get affordable health care from doctors they know and trust It is in essence a physician end run around federal and state limits on their charges.” Markian Hawryluk, *Boutique Medicine May Run*

practices charge more than allowed under Medicare limits.¹³⁷ Under the Social Security Act, physicians receive Medicare reimbursement only if they agree to abide by the program's rates or by limiting charges to 115 percent of the Medicare rate.¹³⁸ Second, they suggest boutique practices "routinely submit erroneous bills to the federal government."¹³⁹

First, the legislators observe that according to the MDVIP agreement, the practice still bills the patient's insurance for most services.¹⁴⁰ Therefore, a Medicare patient's visit would be covered by the government and the physicians would simultaneously acquire a \$1500 fee.¹⁴¹ This could violate congressional limits on charges for covered services.¹⁴² The legislators also alleged that physicians who accept membership fees for boutique services are not reporting the full amount of their charges.¹⁴³ This would violate the False Claims Act.¹⁴⁴ However, doctors maintain that the retainer only covers "personalized services."¹⁴⁵

Afoul of Medicare Rules, amednews.com, <http://www.ama-assn.org/amednews/2002/04/08/gvsb0408.htm> (Apr. 8, 2002).

136. Letter, *supra* note 55, at 2.

137. *Id.* at 1.

138. 42 U.S.C. § 1395w-4(g)(2)(C) (2000).

139. Letter, *supra* note 55, at 2.

140. *Id.*; see also *supra* text accompanying note 63.

141. Letter, *supra* note 55, at 2.

142. *Id.* The argument is that services offered for the additional membership fees overlap with services covered by Medicare. For example, the MDVIP brochure lists "coordination of necessary referrals" and "travel medical services" as covered amenities. *Id.* The sponsors of the bill explain that these services overlap with Medicare coverage because Medicare pays physicians for care that meets specifications in the diagnostic and management codes written by the AMA. Letter, *supra* note 55, at 3.

143. *Id.* at 3; see also Portman, *supra* note 52, at 4.

144. For example, the legislators noted that if an MDVIP patient who pays a \$1,500 membership fee sees his doctor five times in one year and Medicare is billed \$100 per visit, he would be paying \$400 per visit. See Letter, *supra* note 55, at 3.

145. MDVIP claims that the retainer fee only covers the preventative benefits and annual screenings that Medicaid does not cover. Hawryluk, *supra* note 135. In fact, part of the MDVIP membership agreement seems to try to eliminate any suspicions. It states:

The membership fees specified above cover only the defined MDVIP Amenities and the annual comprehensive physical examination and personalized care preventive care plan ("Physical Exam"). Except for your Physical Exam, you and/or your insurer, as the case may be, will be financially responsible for paying for all healthcare and medical care services received by you from your Affiliated Physician and his or her staff. Your Affiliated Physician will bill you and/or your insurer, as the case may be, for those medical or health care services provided to you.

While the legislators' arguments seem well-reasoned, the Medicare Equal Access to Care Act of 2002 never became law because the bill died in committee. Its 2003 successor, the Medicare Equal Access to Care Act of 2003, suffered the same fate. However, if a substantially similar bill ever passes Congress, physicians in boutique medical practices will be forced to opt out of the federal Medicare program.¹⁴⁶

2. Violations of Private Insurance Company Provider Agreements

Most private insurance company provider agreements forbid physicians from using a "balance billing" technique.¹⁴⁷ Balance billing occurs when a doctor charges an insurance beneficiary more than the covered amount.¹⁴⁸ This provision could be read as banning boutique practices from charging retainer fees, as these fees are paid in exchange for the right to receive both covered and non-covered, personalized services.¹⁴⁹ If the retainer arrangements are found to violate the Medicare regulations, they may similarly be considered a violation of private health insurance provider contracts.¹⁵⁰ Conversely, if the fees are found to comply with Medicare law because they only cover costs of personalized care, then it is unlikely they will be found in violation of private insurance provider contracts.¹⁵¹

Membership Agreement, *supra* note 55, para. 5, at 2.

The Centers for Medicare and Medicaid services (CMS), alerted to the issue of boutique medical practices, is currently monitoring boutique practices to ensure that physicians are not violating Medicare billing laws. William Hoffman, *supra* note 57. MDVIP is currently "under review." *Id.*

146. See H.R. 2423, 108th Cong. (2003). In a letter dated May 1, 2002, Tommy Thompson replied to the legislators that as long as the boutique retainer fees were being used to pay for non-covered services, boutique practices would not violate any Medicare rules. Portman, *supra* note 52, at 5.

147. Portman, *supra* note 52, at 4.

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.* Insurance companies are torn in deciding whether boutique medical practices represent a legal risk. Premera Blue Cross in Washington and Blue Cross and Blue Shield of Rochester have decided that boutique practices and the retainer fees they require violate balance billing and discrimination prohibitions present in their insurance contracts. *Id.* Regency Blue Shield in Washington has gone the other way, determining that retainer fees are legal as long as

3. Violations of Anti-Kickback Statute

If boutique medical practices provide their patients with bonuses such as “heated towel racks, free hotel rooms, [and] special bathrobes,”¹⁵² these amenities could violate the federal anti-kickback statute¹⁵³ or the Health Insurance Portability and Accountability Act¹⁵⁴ prohibiting such inducements.¹⁵⁵ However, since these amenities are offered after payment of a retainer, it is likely that they will be seen as services provided in exchange for payment and not as an “inducement.”¹⁵⁶

4. Violation of State Insurance Laws

Boutique practices that offer guaranteed services for a fixed retainer fee could be found to violate state insurance law.¹⁵⁷ This legal risk is especially directed at boutique practices like MD² that provide unlimited doctor visits in exchange for a retainer fee while refusing to accept private insurance.¹⁵⁸ If there is no risk bearing entity in case of financial failure, the patient is unprotected.¹⁵⁹ While some states are skeptical that a boutique medical practice is legal under their insurance laws, other states’ departments of insurance have found no violation.¹⁶⁰

they are only used to cover personalized services and amenities. *Id.*; see also *supra* note 64 (discussing the reasons why insurance companies may be worried about the implementation of boutique medical practices).

152. Goldstein, *supra* note 62.

153. 42 U.S.C.S. § 1320a-7b(b) (2004).

154. Pub. L. No. 104-191, 110 Stat. 1936 (1996).

155. Goldstein, *supra* note 62.

156. *Id.*

157. Portman, *supra* note 52, at 4.

158. *Id.*

159. *Id.* at 4–5. Physician networks and IPAs have not been found to be in violation of state insurance laws because there is an HMO or a health insurer that bears the risk. *Id.*

160. *Id.* at 5. For example, The Washington Insurance Commissioner has issued an advisory in which it has determined that any doctor entering into a practice that provides a package of health care services for a prearranged annual fee must register with the states as a health maintenance organization, or as a health care service contractor. *Id.* However, the Massachusetts Board of Registration in Medicine, a group that licenses Massachusetts physicians has reported that it has found “nothing illegal” about boutique medical practices. *Id.*

5. Abandonment of Existing Patients

Physicians that decide to switch over to a smaller boutique practice will have to terminate their relationships with existing patients.¹⁶¹ If this is done incorrectly, the physician may risk an abandonment claim.¹⁶²

Although a physician is under no obligation to form a physician-patient relationship,¹⁶³ once a relationship is formed, it should continue as long as the patient's given condition persists and requires attention.¹⁶⁴ A physician may terminate a given relationship if he gives the patient sufficient notice to allow the patient to obtain another doctor.¹⁶⁵

As most doctors converting to a boutique practice will likely seek legal advice, an abandonment claim is not likely.¹⁶⁶ As long as the doctor sends letters to each patient in advance, explaining that he will need to find a new doctor, the boutique doctor should not be liable. He may be the subject of some ill will,¹⁶⁷ but there should be no legal impediment.¹⁶⁸

161. Brennan, *supra* note 3, at 1167.

162. *Id.*

163. See Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901).

164. HALLET AL., *supra* note 13, at 161.

165. *Id.* at 161. This was the holding in *Payton v. Weaver*. 182 Cal. Rptr. 225 (Cal. Ct. App. 1982). The plaintiff in *Payton* was a woman suffering from chronic end-stage renal disease. *Id.* at 226. After three years of receiving treatment from the defendant doctor, the doctor informed her that he would be terminating their relationship due to her persistent disruptive behavior and failure to follow treatment. *Id.* at 227. He continued to provide care for over three months before completely terminating treatment. *Id.* The court found that the doctor gave sufficient notice and discharged him of his obligations to the plaintiff. *Id.* at 229.

166. "[I]n practice, reducing one's patient load is no different than leaving town or moving to a smaller practice. As long as the physician provides notice and appropriate referrals and does not leave any patients in an unstable condition, the risk of a viable abandonment claim is very small." Portman, *supra* note 52, at 5.

167. Dr. Karton, of Seattle Medical Associates acknowledged that when announcing his intention to convert his practice to a boutique practice, he heard from some patients who were "outraged that anything additional would be charged beyond what their insurance paid." William Hoffman, *supra* note 57; see also *supra* note 71.

168. While a legal claim for abandonment is unlikely, converting to a boutique practice and thereby leaving those patients who cannot afford the new retainer fee does raise a host of ethical concerns. Portman, *supra* note 52, at 5; see also *supra* Part III.A.

C. The Possible Solution

The question that many will have to decide when examining the emergence of boutique medical practices is whether this new type of medical practice is unethical because it is creating a new form of class based medicine, or whether it is an acceptable way for a few physicians who struggle with the complexities of managed care to preserve the doctor-patient relationship they once held dear. And a “yes” to the latter question raises another question: Can a true and ethical doctor-patient relationship exist if medicine is to be treated as a commodity on the open market, available only to those who can afford to pay for it? Or is boutique medicine, while a *logical* solution for some, so inherently unethical that physicians should abandon the idea (and perhaps their sanity) so as to preserve the sanctity of the doctor-patient relationship?

In my opinion, as currently structured, boutique medicine is an unethical and treacherous idea for the United States’ already failing health care system. It is an easy way out for some doctors and the patients who can afford to buy their way out of a disabled health care system. If doctors and patients are discontent with a health care system that puts time limits on visits and turns doctors into the insurers of their own salary, then the industry needs to prepare itself to come forward with new ideas and programs that will assure a more equitable health care system allowing doctors to interact with patients on a caring level. The industry should not settle for a solution that only creates an intimate doctor-patient relationship for the wealthy while removing care for the poor from the agenda.

If boutique practices continue to boom in the medical community, I suggest that the ideal would be for doctors to follow the lead of the Tufts–New England Medical Center.¹⁶⁹ Tufts Medical Center, in an effort to continue quality care for the poor while keeping its institution financially afloat, began a boutique medical practice that charges willing, wealthy patients \$1800 a year for VIP services. However, the hospital does not use the yearly retainer fees to pad its doctors’ pockets; the fees are used to supplement the costs of Tuft’s

169. See *supra* note 65 and accompanying text.

regular primary care practice. The hospital claims that opening the boutique practice has allowed it to “care for all types of patients—wealthy and poor—in an increasingly unforgiving financial environment.”¹⁷⁰ By using a boutique practice to fund a regular medical practice, both doctors and patients are cared for. Wealthy patients receive the care they are willing to pay for and ordinary patients receive at least the level of care they have already been receiving—if not better care—thanks to the boutique retainer fees. Doctors who wish to throw back to the good old times of the forty-minute patient visit and the house call can do so as well.

However, if the current type of boutique practice continues to become a part of the health care world in the United States, I suggest that some limits should be put in place. First, I think that boutique practices should limit their practices to boutique patients.¹⁷¹ If a practice serving VIP patients continues to treat “regular” patients, I believe the “regular” patients could suffer at the hands of the patients who are paying the doctors bills. Second, to ensure that the government is not being defrauded in any way, I suggest that all boutique practices should be banned from accepting Medicare monies.¹⁷² Third, I believe that any boutique practice refusing to accept any form of private insurance should be required to register with the state as an insurance company or should guarantee some form of insurance protection to their patients in case of financial failure.¹⁷³ Last, I believe that each state should place a limit on the number of boutique practices that are allowed to register with the state to guarantee no serious threat to access occurs.

170. Smith, *supra* note 65, at 2.

171. This is in comparison to boutique practices, like Miami Medical Consultant PA in Coral Gables, Florida, which still treats non-boutique patients. See *supra* note 60 and accompanying text.

172. See *supra* note 135 and text accompanying notes 135–36.

173. See *supra* note 159 and accompanying text.

CONCLUSION¹⁷⁴

Managed care has created a world where many doctors no longer enjoy their work. They work longer hours and face more administrative burdens, yet their relationships with patients are deteriorating. A stake has been driven into the heart of the doctor-patient relationship. In order to revitalize the relationship, doctors have begun to create boutique medical practices—restoring medicine to the good old days of house calls and personal attention.

However ideal boutique medicine may seem in theory for some, it is threatening to destroy the already torn fabric of the American health care industry for all. While boutique medicine may face legal problems by violating Medicare regulations, private insurance company agreements, and state insurance laws, it is the ethical implications of boutique medicine that are especially troublesome.

Ethically, boutique medicine threatens to undermine the social responsibility aspects of health insurance, widen the gap between health care for the rich and the poor, and trample on the professional responsibility of doctors. Even if boutique medicine is held to a small number of practices due to the demands of the market, it is one more step in the wrong direction for the United States health care system. The only way for boutique practices to function ethically in today's society would be if doctors used the retainer fees received from boutique medical clients to supplement the health care costs of the poor. If doctors are truly concerned with restoring the doctor-patient relationship, and not with increasing their incomes, then using the extra money to bail out the failing United States health care system should not be a problem.

174. As a side note, several medical groups that are not considered boutique practices have begun to charge patients for "extras" on an *à la carte* fee structure. Portman, *supra* note 52, at 6. While these physician groups do not charge a retainer fee for year round extra amenities and personalized services, they charge patients on an *à la carte* basis for administrative services that are not covered under the basic patient-provider relationship. *Id.* Administrative services include things such as telephone advice, email advice, transferring and copying records, and providing help with completing insurance forms. *Id.* Some practices charge separate fees for each service and some charge a single annual administrative fee. *Id.* The annual fee is often small (less than fifty dollars). *Id.*; see also Sandra G. Boodman, *That's Going to Cost You*, WASH. POST, May 27, 2003, at F1.