Duke to Phase Out Its Family Medicine Residency

There is concern that other institutions will begin to question and reexamine their residency programs.

BY MARY ELLEN SCHNEIDER
New York Bureau

Earlier this year, officials at Duke University announced plans to phase out the school's family medicine residency program, drawing criticism from many in the academic family medicine community.

The officials announced the plan in May, citing a need to provide "more consistent care by senior clinicians" and to better coordinate "innovative programs" in the community with the on-campus faculty practice.

But Dr. Lloyd Michener, professor and chairman of the department of community and family medicine at Duke, left the door open to revisiting the decision at some point if the Accreditation Council on Graduate Medical Education would give the university more flexibility in how it structured the residency program.

Most of the care being provided by Duke clinicians is outpatient care and chronic disease management, Dr. Michener said, but they found that the residency training requirements had too much of an emphasis on other areas such as inpatient care and obstetrics. "What we were teaching no longer matched what we were practicing."

Under the phase-out plan, Duke will continue to train current residents, including four new first-year residents who began training in July.

The officials also plan to ramp up training of nonphysician providers such as physician assistants and physical therapists. The idea is not to replace physicians, Dr. Michener stressed, but to train an adequate number of nonphysician providers who would work as part of a physician-led team approach to care.

Duke says it would revisit its decision to close the residency program if it were allowed more flexibility in structuring it to meet community needs.

In addition, they also plan to expand their community and family medicine fellowship program. Fellowship training may be a better environment than residency in which to teach physicians about community health.

Although the move was right for Duke, Dr. Michener said, officials at the institution wouldn't want to see other academic medical centers following their lead. Instead, they hope that their action will encourage officials at the Accreditation Council for Graduate Medical Education's Residency Review Committee to allow for greater flexibility in structuring residency programs to meet the individual needs of the community, he said.

If and when that greater amount of flexibility becomes available, Dr. Michener said, Duke officials would gladly revisit their decision to scrap their program.

"When they're ready, we're ready," he commented.

The Duke move was greeted with disappointment by much of the academic community in family medicine. The American Academy of Family Physicians, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, and the Society of Teachers of Family Medicine issued a joint statement this summer that took issue with Duke's argument for closing the program.

"Most respected family medicine departments across the nation, including those at other top-tier private universities, have been able to balance the priorities of patient care, research, and training while maintaining the integrity of their residency training programs," the groups said in a statement.

Each year, a few family medicine residency programs close for a variety of reasons, some of which are financial, said AAFP President Larry Fields. But the move by Duke is not a signal of any type of larger trend among residency programs, he said.

But although other programs have not followed suit, there is concern that other institutions will begin to question their residency programs, said Roger Sherwood, executive director of the Society of Teachers of Family Medicine. The announcement has already caused some ripples from outside family medicine, with some institutions taking a second look at their residency programs. "This shouldn't be happening," he said.

But being able to create innovative residency programs within the requirements mandated by the Residency Review Committee is not a concern unique to the Duke program, said Dr. Warren Newton, president of the Association of Departments of Family Medicine and chair of the department of family medicine at the University of North Carolina, Chapel Hill.

Many residency directors feel that the Residency Review Committee has been too conservative, he said, but many programs have been successful in making changes even in that environment. ■

Motivations for Making the Switch to Concierge Care Vary

BY JOYCE FRIEDEN
Senior Editor

BALTIMORE — Some of the physicians who embrace concierge care are ideologues who want the government and insurance companies to stop interfering in the doctor-patient relationship. And others? They're in it for the money and the lifestyle, John R. Marquis said at a meeting of the American Society of Law, Medicine, and Ethics.

"A large portion of these doctors have as their primary motive that they want to earn more money," said Mr. Marquis, a partner in a Holland, Mich., law firm. However, while money plays a big role, other factors also influence the decision, said Mr. Marquis, who helps physicians set up concierge practices.

Another reason for the move to concierge care is lifestyle, he said. "If [I've] heard the analogy to the hamster wheel once, I've heard it a million times. 'I get up every day, I get on the hamster wheel, I run for 10 hours, I get off, and I hope to God I've seen enough patients to pay the light bill.' Concierge medicine does offer them some degree of better lifestyle as they perceive it."

Another reason physicians give is to improve patient care. "You'd be surprised at the number of physicians who list [improving patient care] as their top priority," he said. But there are two levels to the patient care issue.

"Some say, 'I could practice better medicine if I spent more time with patients.' But there has been no proof of that whatsoever. I think that is bogus," said Mr. Marquis, adding that from an ethical perspective, physicians are not supposed to imply that concierge care will mean better care for their patients.

Others profess the desire to provide better preventive care, Mr. Marquis said, noting that, to him, this seemed like a legitimate reason for moving to concierge care.

"Physicians don't get paid for doing preventive care, generally speaking. You'd be surprised at the number of physicians who say, 'I really would love to see healthy patients, because I have a lot to say to them. I'd like to plan their diet, their lifestyle, get them on nonsmoking programs, and I want to be part of their lifestyle.' It sounds hokey, but I think they're being sincere when they tell me that," he said at the meeting cosponsored by the University of Maryland.

According to Mr. Marquis, there are two basic models of concierge practice. The first, practiced by the ideologues, is a "fee-for-care" model, in which the physician charges a set fee—say, $100 per month—in exchange for giving patients access to all the primary care they need, including sick visits, physicals, immunizations, and lab work. These physicians opt out of Medicare and don't bill insurance, though they may remain on some managed care panels.

From an ethical perspective, physicians are not supposed to imply that concierge care will mean that their patients will receive better care.

The second model, used more by physicians interested in increasing their incomes, is a "fee-for-noncovered-service" model, in which the doctor charges patients a per-visit fee but also charges an annual fee for services not covered by Medicare, such as a yearly physical. "These people are driven more by money," said Mr. Marquis. "They just want to game the system a little bit, and get a little more money out of it."

Proponents also say that the type of intensive medical care provided is very good for sick people with chronic illnesses, and that the increased income ultimately will make medicine more attractive and lead more people toward a medical profession. Frank Pasquale of the Seton Hall University School of Law in Newark, N.J., agreed. Mr. Pasquale noted that concierge practices provide preventive care; "directly therapeutic" care, in which patients have the ability to jump the line and be seen the same day; and nonmedical amenities such as fluffy exam robes or a private waiting room.

"The current [critics] are attacking concierge care as a unitary phenomenon," Mr. Pasquale said. "I say, don't attack preventive care, but the other two [directly therapeutic care and nonmedical amenities] are a problem."

Concierge care has "amazing benefits" for the doctors and patients who participate, such as more income for the physicians and more attention for the patients, he continued. But there are also problems, such as a disruption of care relationships for patients who can't afford or don't want to join the concierge practice.

"There's the worry of the 'death spiral,' where all the better physicians will go into concierge practice and everyone who can't afford a concierge practice will be left with physicians who don't have quite as good a reputation," Mr. Pasquale said.

Proponents of concierge care say that such a disaster scenario is not likely, because concierge medicine is not apt to spread. "It's just a new product," Mr. Pasquale said.

Rather than regulating concierge care out of existence, Mr. Pasquale suggests that lawmakers tax directly therapeutic care and nonmedical amenities, and use the tax proceeds to help provide access to care for the poor.

Sandra J. Carnahan of the South Texas College of Law in Houston suggested that private insurers consider dropping concierge practices from their networks. In the case of physicians who treat Medicare patients, because taxpayer money is used to pay for the physicians' medical education, "that ought to [dictate] that they have a reasonable patient load … and physicians should not be able to use the system to choose the wealthiest, healthiest patients who can pay the fees." ■