

## ***Patient Autonomy in Direct Primary Care***

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### INTRODUCTION

Patient autonomy is a cornerstone of medical ethics in the United States. For patients to exercise their autonomy, they must not only be informed about their medical conditions and possible interventions, but their choices must also be considered and respected even when the clinician favors a different treatment. Achieving a relationship conducive to trust and autonomy often requires a strong bond between patient and physician,<sup>1</sup> as well as a willingness of the physician to share power and engage in honest discussion. Direct Primary Care (DPC) practices, in which patients directly pay a physician a flat fee for their services, can offer opportunities to meet these requirements for patient autonomy. Because DPC practices have a unique structure and payment model, physicians have significant time with patients and power can be shared more evenly between the two. Though there has been discussion in the literature about some ethical risks and shortcomings of DPC practices, particularly around equitable access to care,<sup>2</sup> changes to patient autonomy in this model have thus far been underexplored.

### BACKGROUND

Health insurance has played a role in medical care for many patients in the United States since the 1930s,<sup>3</sup> and now patients rarely see a physician without their insurance company's involvement. DPC practices came about first in the 1990s with a small number of physicians seeking to develop a new model of care,<sup>4</sup> and have continued to grow in number, with many current DPC physicians seeking a way to spend more time with their patients. The practice model is characterized by patients paying a monthly retainer fee for a defined set of primary care services. The services vary from practice to practice but often include frequent visits and more accessibility to the doctor outside of regular business hours. DPC practices sometimes also include discounted prescriptions and labs.<sup>5</sup> Though similar to concierge medicine, which also functions on

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a retainer model, DPC practitioners do not bill patient insurance and are generally less costly for the patient.<sup>6</sup> Additionally, concierge medicine provides more luxury services and caters to patients in higher economic classes.<sup>7</sup> For both models, patients may choose (or in some states, are required) to purchase additional health insurance to cover health services not offered by their personal doctors, such as coverage for inpatient stays.

## ANALYSIS

### I. Potential to Improve Knowledge and Informed Decision Making

In DPC practices, patients can spend more time with their doctors, and appointments are often available for same-day scheduling.<sup>8</sup> As a result, the doctor can better understand a patient's medical history, home life, risk factors, and build a more trusting relationship with the patient. These extended interactions could allow physicians to put forward interventions more in line with their patients' goals, allowing the patients to feel heard. A patient in such a relationship may be more willing to speak up about their wishes. More time together can also be an opportunity for patient education and in-depth discussions about specific conditions, prognosis, or treatment plans. Though data about patient behavior in DPC practices is lacking, it is possible that patients could use frequent appointments to further their understanding of their conditions. Patients could consider questions at home and return to the physician's office a few days later, ready for a more fruitful and complex discussion. This improved relationship and better patient understanding of treatment risks and benefits could foster patient autonomy, as both informed decision making and mutual understanding about goals are important.

### II. Potential to Ameliorate Power Asymmetry

DPC practices contribute to patient autonomy because they encourage power-sharing. DPC practices facilitate it in multiple ways, for instance, by granting the patient control over scheduling. Unlike in a fee-for-service practice where patients often wait weeks for an opening in a doctor's schedule, DPC practices are characterized by shorter wait times for appointments, often offering same-day or same-week visits.<sup>9</sup> Though it may seem insignificant, this feature allocates power to the patient. Instead of fitting appointment times to the physician's schedule, DPC patients have the additional freedom to choose visits convenient to them and aligned with the urgency of their medical issues. Additionally, because patients have more control over scheduling visits, they can be more active in setting the agenda for appointments, ensuring they address the issues most important to them. These changes in scheduling promote more patient control, empowerment, and autonomy.

The fee structure of a DPC practice also affects power sharing and patient autonomy. Each patient on the patient panel directly pays the practice a monthly fee without involvement of insurance. While generally less than with concierge medicine, the fees can be somewhat high and the patient panel may be small, meaning the financial "worth" of a single patient can be substantial. Just a few patients leaving might represent a big loss to the practice, incentivizing physicians to consider their patients' wishes in order to retain them. Furthermore, not only is each patient financially valuable to the practice, but also the direct nature of the payment can contribute to a change in attitude about services rendered. In DPC, both parties are aware of the direct financial value that the patient brings to the practice as there is no obfuscation by insurance processing. The patient, paying the doctor directly for care and access, may feel more like they are owed a certain level of care and could take their money elsewhere if their needs are unfulfilled. Patients could leverage their power in this arrangement to express their views and ensure their wishes are respected, using this power to increase their autonomy.

In the best case, more patient autonomy could result in better shared decision-making between doctor and patient, with both agreeing on a plan of action for patient care. This decision-making sharing could be most meaningful to patients with many chronic health problems; however, these patients are often less wealthy.<sup>10</sup> Even with reductions in annual fees over the last two decades, DPC practices often charge between \$500 and \$1,499 per year, and this does not include the cost of hospitalization or the cost of insurance that patients choose – or may be required – to buy for coverage of services their DPC doctor does not offer.<sup>11</sup> Notably, DPC practice covers some of the same services that patients can get through insurance, but it does not supplant the need or requirement for overall insurance. The remaining concern that DPC practices could be unaffordable for some patients<sup>12</sup> should not discourage its use for patients able to pursue it and for doctors forming practices.

### III. Traditional Systems Could Learn from DPC Practices

Even if DPC practice remains available to only small numbers of patients – either because of panel size, affordability, or geographic location – its model could be implemented outside of DPC to improve patient autonomy. For example, many systems would benefit from scheduling modifications like pre-visit planning with the team directly seeing the patient,<sup>13</sup> ensuring that the patients' needs are addressed effectively at their visits and mimicking some of the patient control over agenda-setting seen in DPC models. The direct payment aspect of DPC could be partially reproduced with upfront clarity about patient-specific service copays to provide price transparency, if not the financial leverage of patients in DPC models. These adaptations would not provide all the patient autonomy benefits as seen in DPC but they may remediate problems in standard practice models.

## CONCLUSION

Overall, the DPC model provides opportunities and examples to support patient autonomy through the transfer of information and power from the doctor to the patient. Though its application may be limited due to cost and availability, the potential to encourage autonomy through better doctor-patient relationships, more patient visits, more meaningful interactions, and reduced wait time for appointments makes DPC a valuable model of care. Physicians have an ethical imperative to make patient education and autonomy central to their practice. Such physicians will likely strive to support patient autonomy regardless of the setting in which they practice.

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