Retainer Practice Docs Work Less, Earn More

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

DALLAS — Physicians in retainer practices are reporting better quality of care and fewer hassles, but the new approach is not without its flaws, according to a survey presented at a national conference on concierge medicine.

The retainer practices see fewer minorities and fewer patients with chronic illnesses than do regular practices, said Matthew Wynia, M.D., an internist and director of the American Medical Association's Institute for Ethics, who presented the findings. In addition, "the number of Medicaid patients in retainer practices is much smaller—6% vs. 15% in traditional practice," Dr. Wynia said.

The AMA mailed out surveys to 144 physicians from retainer practices—also known as concierge or boutique medicine practices—and received 83 responses. As a control group, researchers mailed surveys to 463 primary care physicians in nonretainer practices from the AMA's master list, and received 231 responses. Data were collected between December 2003 and February 2004.

"We wanted to find out who was entering into these types of practices, what types of patients were they seeing, and what types of services were being offered," Dr. Wynia said at the conference, sponsored by the Society for Innovative Medical Practice Design.

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Weighing in on some of the potential benefits of concierge care, 50% of the retainer physicians said they thought they were offering more diagnostic and therapeutic services than traditional practices. In terms of more revenue, 70% of retainer physicians said they were doing better in this type of practice than they had in traditional practice. Fifty percent of the retainer physicians said working fewer hours was one of the benefits of being a retainer physician.

Not surprisingly, physicians in the nonretainer practices did not see as many benefits to concierge care. While 90% of the retainer physicians believed the type of care they provide was better quality care, only 50% of the traditional physicians thought that was true. Eighty percent of the retainer physicians thought that concierge care would result in fewer administrative hassles, yet only half of the nonretainer physicians felt the same way.

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When queried about the potential risks of a retainer practice, respondents from both groups expressed concern that society and their peers would disapprove of their decision to start a retainer practice.

You risk having people "look down their noses at you," Dr. Wynia said. In a surprising statistic, "5% of people in retainer practices thought they should be discouraged" from pursuing this approach.

Indeed, several participants at the meeting told this newspaper that their employer or practice partners did not know that they were attending a conference on concierge care.

More than half of retainer physicians and 80% of nonretainer physicians thought that concierge care created a risk of a more tiered system of access to health care.

Loss of patient diversity and insurance contracts and legal challenges were other concerns cited by the survey respondents.

Despite these potential risks, the vast majority of respondents thought that these practices should be allowed to exist. "Only 25%-30% of nonretainer physicians thought they should be discouraged or illegal," Dr. Wynia said.

Conversion to retainer practices takes time, he said. Retainer physicians surveyed said most of their patients—about 88%—didn't follow them to the new practice. In addition, most retainer practices have some patients who do not pay the retainer fee (a mean of about 17%).

Once these factors are taken into account, transitioning from an average nonretainer practice of 2,300 patients to a retainer practice would involve transferring 2,025 patients to someone else and adding

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Brand Power: Meds Are More Than Just Chemistry

BY CARL SHERMAN
Contributing Writer

NEW YORK — The branding of pharmaceuticals—the creation and manipulation of product identity through such media as direct-to-consumer advertising—exerts a potent influence on the way patients think and feel about their medication and their illness, Nathan Greenslit said at a meeting sponsored by the American Psychoanalytic Association.

"The marketers I've interviewed routinely think that compliance needs to be reframed as a problem of brand loyalty," said Mr. Greenslit, a cultural anthropologist and doctoral candidate in the program in science, technology, and society at Massachusetts Institute of Technology, Cambridge.

To illustrate the impact of branding, Mr. Greenslit considered the case of Sarafem, a formulation of fluoxetine first marketed by Eli Lilly to women for premenstrual dysphoric disorder (PMDD). The rights to Sarafem have since been sold to another pharmaceutical company, Warner Chilcott Inc.

When Lilly was still marketing the drug, the "physician information" section of its Web site for Sarafem said that "fluoxetine was initially developed and marketed as an antidepressant (Prozac, fluoxetine hydrochloride)," while patients were told, in their section of the Web site, that "Sarafem contains fluoxetine hydrochloride, the same active ingredient found in Prozac."

While both statements are technically true, "socially they produce very different meanings," Mr. Greenslit said. Physicians were informed that Sarafem and Prozac were the same drug with different packages, while the message to patients was that "they are different drugs with the same ingredient."

A contrast in appearance—Prozac is a green and white capsule, while Sarafem is pink and lavender—emphasized the distinction, he said.

The separate branding was justified by Lilly as a response to consumer demand, Mr. Greenslit said, citing a Lilly marketing associate who noted that women don't look at their PMDD symptoms as depression, that Prozac is closely associated with depression, and that "women told us they wanted a treatment with its own identity."

The branding phenomenon underlines the idea that a person's relationship to a drug is more complex than his or her body's relationship to a chemical compound "whose only clinical relevance is its pharmaceutical activity," he said.

A close look at direct-to-consumer advertising suggests the extent of pharmaceutical companies' concern with "the social—that is, precisely *not* the chemical—effects of these drugs," he said. The companies manipulate the symbolic meanings of their products by "mobilizing images and texts," and take great care to avoid mistakes that would increase stigma surrounding the drug and condition for which it is prescribed (e.g., a pink Viagra).

Mitchell D. Wilson, M.D., who discussed Mr. Greenslit's presentation, suggested that "drugs as brands take on the character of objects of fantasy, with a quality of aliveness ... they are personified." ■

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560 new patients, he said. In addition, physicians on average would continue to see 140 patients who didn't pay a retainer.

When queried about the transition to a retainer practice, 63% of retainer physicians said they gave their patients more than 90 days notice before making the transition, Dr. Wynia said.

In other survey findings:

► Retainer-physicians panels averaged 835 patients vs. 2,300 patients for nonretainer practices.

► Retainer physicians saw an average of 11 patients per day; nonretainer physicians saw an average of 22 patients.

► Retainer physicians provide slightly more charity care than do their peers in traditional practice. Charity care for retainer physicians averaged 9.14 hours per month vs. 7.48 hours per month for nonretainer practices.

► Most retainer practices are located in metropolitan areas and on both coasts. Most started in 2001 or later and most physicians transitioned to retainer practice from another practice model rather than straight from residency.

► House calls, same-day appointments, 24-hour access pagers, and coordinated hospital care were services provided. ■

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