Physicians’ and Patients’ Perspectives on Office-Based Dispensing

The Central Role of the Physician-Patient Relationship

Princess Ogbogu, MD; Alan B. Fleischer, Jr, MD; Robert T. Brodell, MD; Gaurav Bhalla; Zoe D. Draelos, MD; Steven R. Feldman, MD, PhD

Objective: To describe physicians’ and patients’ reasons for participating in office-based sales of dermatologic products.

Design: Survey data on the attitudes, opinions, and beliefs of dermatologists and their patients were analyzed.

Setting: A market research study of office-based selling.

Participants: Thirty dermatologists involved in direct selling from the office, 20 dermatologists not involved in direct selling, 22 patients who purchase products from their dermatologists’ offices, and 25 office managers.

Main Outcome Measures: The hypotheses of this study were formulated after the market research study had been done. The main outcome measure was the physicians’ and patients’ reported reasons for patients purchasing skin care products from dermatologists rather than from retail stores.

Results: “Trust” was the most frequent reason cited by physicians for patient purchases, while “physician knowledge” was the most frequent reason cited by the purchasing patients. The most common location to display the products was the waiting room (20 [67%] of the physicians). The most common types of products sold included glycolic acid products (15 [50%]), moisturizers (13 [43%]), sunscreens (12 [40%]), and α-hydroxy acid products other than glycolic acid (9 [30%]).

Conclusion: The interaction between physicians who sell products in their offices and their patients is highlighted by 2 key elements of the physician-patient relationship: trust and physician knowledge.

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The practice of dermatology has changed dramatically, with constraints on medical dermatology imposed by managed care and the advent of new cosmetic procedures (tumescent liposuction, laser surgery, dermabrasion, chemical peels, sclerotherapy, and hair transplantation) developed by dermatologists. With these changes, office sales of products have become a common practice, with an estimated 40% to 70% of dermatologists participating in the practice in 1998.2,3

The sale of cosmetic and skin care products in the physician’s office is a controversial practice.8 The American Medical Association Council on Ethical and Judicial Affairs initially strongly discouraged physicians from selling vitamins and other health-related nonprescription products in their offices for profit.2 The Council on Ethical and Judicial Affairs now states that “a physician may own or operate a pharmacy, but generally may not refer his or her patients to the pharmacy... unless there is a demonstrated need for the pharmacy in the community and alternative financing is unavailable” and that “physicians may dispense drugs within their office practices provided there is no resulting exploitation of patients.”7(pp130-132)

The practice of dispensing medications that patients can obtain at local pharmacies is an ethical dilemma according to the Council on Ethical and Judicial Affairs. Some argue that office dispensing allows dermatologists to provide better patient care; others argue the practice undermines the professional image of dermatologists.8 Specific reasons to participate in office dispensing include providing the patients with “one-stop shop-
PARTICIPANTS AND METHODS

A market research study on office dispensing was performed by Westwood-Squibb Pharmaceuticals, Inc., Buffalo, NY, in 1998. The objective of the study was to understand the attitudes, opinions, and beliefs of targeted dermatologists who were selling products in their offices and of a group of dermatologists who do not dispense these products. The study also evaluated the factors that motivate patients to purchase products directly from the physician’s office.

The physicians were identified from a list of all physicians in 7 specific geographic regions (Boston, Mass; Chicago, Ill; Dallas and Houston, Tex; Los Angeles, Calif; Phoenix, Ariz; Tampa, Fla; and New York, NY). The screening criteria were as follows: the physicians had to treat 100 or more patients in a typical month; the physician must not be a resident or associated with a university, academic group, or the military; the physicians must have been in practice for 2 to 30 years; and 80% or more of the practice must be office based. Direct-selling physicians were younger than 59 years, and non-direct-selling physicians were younger than 40 years. Of 168 offices contacted, 93 did not meet the screening requirement. Physicians were then interviewed in person. The dermatologists’ offices provided the patient sample. Patients were aged between 30 and 60 years. Of the 58 recruited, 22 completed the interview, which was performed by telephone. The final study population included 30 dermatologists who are involved in direct selling from the office, 20 dermatologists who are not involved in direct selling, 22 patients who purchase products from their dermatologists’ offices, and 25 office managers.

RESULTS

DEMOGRAPHICS

Direct-selling physicians had been in practice a mean of 13.7 years and had been involved in office dispensing for an average of 6.8 years. Of the 30 direct-selling physicians, 29 did not have a direct-selling contract with any pharmaceutical company. The most common location to display the products was the waiting room (20 [67%] of the physicians), although 2 physicians (7%) displayed products in the examining room. Nearly all (29 [97%]) of the direct-selling physicians sold nonprescription prod-

Table 1. Ethical Limits of Drug Dispensing in the Dermatologist’s Office: American Academy of Dermatology Advisory Board Resolution 199.7*

<table>
<thead>
<tr>
<th>Description</th>
<th>Example</th>
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<tbody>
<tr>
<td>1. To place the dermatologists’ own financial interests above the welfare of their own patients.</td>
<td>It is ethical to dispense, by sale, prescription or nonprescription drugs to patients in the dermatologists’ office except in the following circumstances:</td>
</tr>
<tr>
<td>2. To create an atmosphere that is coercive to patients such that they feel compelled to purchase drugs from the physician.</td>
<td>1. To place the dermatologists’ own financial interests above the welfare of their own patients.</td>
</tr>
<tr>
<td>3. To dispense drugs under a physicians’ private label without clearly listing ingredients, including generic names of the drugs.</td>
<td>2. To create an atmosphere that is coercive to patients such that they feel compelled to purchase drugs from the physician.</td>
</tr>
<tr>
<td>4. To dispense to patients drugs that are easily available at proprietary pharmacies without advising patients of this availability.</td>
<td>3. To dispense drugs under a physicians’ private label without clearly listing ingredients, including generic names of the drugs.</td>
</tr>
<tr>
<td>5. To represent drugs as being a special formula not elsewhere available, when that is not the case.</td>
<td>4. To dispense to patients drugs that are easily available at proprietary pharmacies without advising patients of this availability.</td>
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<tr>
<td>6. To sell health-related products whose claims of benefit lack validity.</td>
<td>5. To represent drugs as being a special formula not elsewhere available, when that is not the case.</td>
</tr>
<tr>
<td>7. To refuse to give refills of drugs except that they be purchased from the dermatologist.</td>
<td>6. To sell health-related products whose claims of benefit lack validity.</td>
</tr>
<tr>
<td>8. To charge patients at an excessive markup.</td>
<td>7. To refuse to give refills of drugs except that they be purchased from the dermatologist.</td>
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Open-ended questions were used to give physicians, patients, and office managers great latitude in their responses; however, the questions asked of the physicians, patients, and office managers were not identical. For example, one question of the direct-selling physicians was, “In your opinion, what are your patients’ reasons for purchasing skin care products from dermatologists?” We compared the responses with those of the corresponding question asked of patients, “What aspects make you comfortable or uncomfortable with purchasing products directly from your dermatologist?” Responses were classified into categories of “convenience,” “trust,” or “physician’s knowledge,” if these terms were specifically mentioned. If these specific responses were not mentioned, we assigned the response to categories according to our best interpretation of the response. Categories of “patient convenience,” “knowledge of products,” “income,” and “products not available elsewhere” were used to classify responses to the question, “What are the benefits of selling products directly to patients through your office?”

The office managers were asked, “In your opinion, why do you think patients purchase pharmaceutically available products from your office?” The responses were categorized into “physician recommendation,” “trust,” “convenience,” and “other reasons.”

The office managers were also asked the following questions: (1) “What is your role in selling products directly to patients in your office?” (2) “What were some of the key factors in making the decision to participate in direct selling to patients?” (3) “What, if any, are the major difficulties in selling products directly to patients through your office?” (4) “Have you ever received any complaints from the patients about the products that are sold directly through your office?” and (5) “What type of complaints have you received from patients?”

Table 1. Ethical Limits of Drug Dispensing

*From the American Academy of Dermatology.
products. Two physicians (7%) sold prescription products. Of the 30 direct-selling physicians, 14 (47%) stated that some or all of the products that they sold were available in pharmacies, drug stores, or other retail stores.

The most common products sold were glycolic acid products (15 [50%]), moisturizers (13 [43%]), sunscreens (12 [40%]), alpha-hydroxy acid products other than glycolic acid (9 [30%]), topical vitamin preparations (6 [20%]), photoaging creams (6 [20%]), cleansers (6 [20%]), shampoo (5 [17%]), topical retinoids (5 [17%]), topical corticosteroids (2 [7%]), self-tanners (2 [7%]), toners (2 [7%]), astringents (2 [7%]), skin-lightening agents (2 [7%]), and hair conditioner (2 [7%]). The following products sold were mentioned by one physician each: topical antibiotics, beta-lift peels, facial-firming cream, lip conditioner, topical psoriasis or eczema medication, oral antibiotics, and prednisone.

COMPARISON OF DIRECT-SELLING PHYSICIANS’ AND PATIENTS’ REASONS FOR PURCHASING

The physicians listed trust and convenience as the most frequent reasons why patients purchased a product (Table 2). Other reasons included quality of products, efficacy of products, products not available elsewhere, and to improve appearance. The patients listed physician knowledge and trust most frequently. Other reasons included convenience, quality of products, money-back guarantee, efficacy of products, and price of products. None of the patients reported that they felt coerced to purchase skin care products directly from their dermatologist.

Of the 25 office managers, 7 (28%) believed that physician recommendation was the primary reason why patients purchased products directly from offices. Other reasons listed by the office managers were convenience (12%) and trust (16%). Other responses included the fact that patients “liked the product results” and that the products “improved looks.”

DISADVANTAGES OF OFFICE DISPENSING

The non-direct-selling physicians were asked about the disadvantages of office dispensing. Most (14 [70%] of 20) believed that there were ethical issues or conflicts of interest involved in office dispensing. Eleven (55%) reported that being involved in the business aspect of office dispensing was a disadvantage. Other reasons were the time and liability involved.

Patients reported inconvenience (7 [32%] of 22) and price (4 [18%] of 22) as the most common disadvantages of office dispensing. Half of the patients (11 [50%] of 22) believed that there were no disadvantages. Other reasons listed included limited choices of products to purchase, not enough information on the products, and the products were not available elsewhere. One patient feared that his physician might take advantage of him.

OFFICE MANAGERS’ VIEWS ON OFFICE DISPENSING

Of the 25 office managers surveyed, 13 believed that their main role in office dispensing was to explain the products to patients. Twelve (48%) of the office managers sold products to the patients, and 5 (20%) recommended the products to the patients. One office manager noted that although she did not recommend the products to the patients, the nurse did. Of the 25 office managers, 4 (16%) stated that they participated in office dispensing because the physician chose to participate, another 4 (16%) stated that they participated because they were offering patients good products, and 1 (4%) participated because of a commission for product sales. Of the office managers, 8 (32%) stated that there was no major difficulty with office dispensing, 7 (28%) believed that patient expense was a difficulty, and 4 (16%) believed the time involved was also a difficulty. Twelve (48%) of the office managers stated that they had received complaints from patients about the products that they sold, while 11 (44%) had not. The most frequent complaints received from patients were irritation from products (4 [16%]), not liking products (4 [16%]), and not getting a desired result from products (2 [8%]).

COMMENT

Office dispensing is a controversial and emotionally charged issue.

Preservation of the physician-patient relationship is the cornerstone of medicine on which ethical judgments should rest. The key finding of this study is that the practice of office-based dispensing relies on the physician-patient relationship. For the most part, patients do not purchase directly from physicians because of convenience (more patients found it inconvenient than convenient); they do so because of their perception of their physician’s knowledge and because of their trust in their

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Convenience</th>
<th>Trust</th>
<th>Physician’s Knowledge</th>
<th>Miscellaneous</th>
<th>Physician’s Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct-selling physicians (n = 30)</td>
<td>6 (20)</td>
<td>23 (77)</td>
<td>0</td>
<td>8 (27)</td>
<td>0</td>
</tr>
<tr>
<td>Patients (n = 22)</td>
<td>5 (23)</td>
<td>6 (27)</td>
<td>12 (55)</td>
<td>6 (27)</td>
<td>0</td>
</tr>
<tr>
<td>Office managers (n = 25)</td>
<td>3 (12)</td>
<td>4 (16)</td>
<td>0</td>
<td>2 (8)</td>
<td>7 (28)</td>
</tr>
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*Data are given as the number (percentage) of subjects. Some subjects chose more than 1 reason for purchases. Physicians and office managers were asked the reasons why patients purchase products directly from the dermatologists’ offices. Patients were asked the reasons why they are comfortable or uncomfortable purchasing products directly from the dermatologists’ offices.
physician. Three of 4 dispensing dermatologists recognized that this trust is the reason patients purchase from the physician.

Physicians’ knowledge of their products and of the validity of product claims is, therefore, essential. For the “cosmeceutical” products commonly dispensed in the office, it may be difficult to impossible to have the same level of confidence of safety and efficacy that is expected for prescription drugs. The cosmeceutical products may contain active agents, but these products are not regulated by the Food and Drug Administration and there is little information available with regard to their efficacy. Moreover, because these are not Food and Drug Administration–regulated drugs, there are no federal requirements regarding bottle-to-bottle variation of the products or even a meaningful expiration date. When dispensing cosmeceuticals, physicians should accurately communicate to patients the limitations of these products and the difference in expectations compared with better-characterized prescription agents. The marketing of patients’ trust in their physician should not be permitted to replace proof of efficacy in the sale of unproved products.

Other issues that should be considered include potential coercion of patients and the role of office staff in product dispensing. Physicians frequently display products in the waiting room. This does not appear to cause patients to feel “coerced” into purchasing products. Display of products in the examining room is much less frequent, and we question whether such a display would be considered ethical. Displaying products in the examining room appears not to be the “standard of care” and may create an atmosphere in which patients feel compelled to purchase drugs from the physician.

In some cases, the office manager or the nurse recommended products to patients. One office manager stated that she “pushed” a particular product that she liked during sales; one reported receiving commissions from sales. The role of nonphysicians in the process of office dispensing should be considered carefully. If the major reason supporting the practice of office dispensing is the special knowledge of the physician of the benefits of particular products for particular patients, then it is incumbent that sales initiated by the physician’s staff be guided by that knowledge.

Our study has some key limitations. The sample of physicians and patients surveyed was small. Even with this small size, the study was able to detect differences between physician and patient perspectives on office dispensing and the agreement on the role of the physician-patient relationship (trust and physician knowledge) at a qualitative level. The sample was not randomized and was geographically limited. These reasons limit the generalizability of our conclusions. Moreover, we cannot comment on the opinions of patients who choose not to purchase products. Study of a representative sample of physicians and patients would permit a more quantitative understanding of factors associated with office dispensing in the community.

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Corresponding author and reprints: Steven R. Feldman, MD, PhD, Department of Dermatology, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1071 (e-mail: sfeldman@wfubmc.edu).

REFERENCES