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Executive Physicals: Harmful to Health?

Do you get a plush bathrobe and a slipper with your physical exam Executive Physicals seem to be the hottest trend but are these exams are worth thousands of dollars paid by the top business executives and corporations. Welcome to the Business of Medicine. I am your host, Dr. Larry Kaskel. Joining me today is Dr. Brian Rank, Medical Director of Health Partners Medical Group and Clinics in Minneapolis, Minnesota.

DR. LARRY KASKEL:

Dr. Rank, welcome to the show.

DR. BRIAN RANK:

Hi Larry, thanks for having me.

DR. LARRY KASKEL:

I read the perspective you wrote in the New England Journal of Medicine about executive physicals being bad medicine on three counts and thoroughly enjoyed it and was wondering why you've got such passion about this topic.

DR. BRIAN RANK:

I am a medical director of a large medical group here in the Twin Cities. We work very hard to create care that's consistent with what we call the triple aim. It is healthcare that improves the health of a population, one patient at a time, the experience of individuals and work on affordability. I go to the Institute for Healthcare Improvement Forum every year and as I walk down one of the aisles in the airport to come home, each year almost I saw large clinic advertising for executive physicals in the airport. It bothered me that here we were working on affordability on one side and a retail service that was unproven and costly on the other. So for about three years it sat as a bur under my saddle and eventually I decide to write something about it. (**01:30**)

DR. LARRY KASKEL:

Well, in the end of your article, you say that as efforts to reform the healthcare system continue, the executive physical is a perfect example of what American medicine should be working to expunge, the expensive the ineffective and the inequitable. As I read that, I thought, well, do you think under our new President that things will change at all or will the retail executive physicals just kind of continue on?

DR. BRIAN RANK:

Boy! I don't know under the new President. I think that, you know.

DR. LARRY KASKEL:

I got no problems.

DR. BRIAN RANK:

We've got problems. I think in general the healthcare system in the United States needs to be much more reliable, it needs to work on the things that can really help people and have an evidence base behind them. It needs to work on creating a great experience for patients whether they are an executive or a line worker and we need to not do the things that don't have an evidence base, not just because they are costly, but because they are harmful too.

DR. LARRY KASKEL:

Before this interview, I was talking with the engineer Mike and we were discussing how everyone comes on this show and just says lose weight and exercise more and he would really like to hear some voices from outside our country and how they run their healthcare systems and perhaps learn a few things from them so that we can actually change our healthcare system. So question to you is what have you learned from outside this country that we could perhaps adopt and improve our healthcare system.

DR. BRIAN RANK:

The Commonwealth Foundation has a really good analysis (**03:00**) of healthcare around the world and there are good things and bad things about almost every healthcare system around the world. We are more expensive and not as efficacious as some , and I think that one of the things that's happened in healthcare around the world and in the United States is that healthcare and public health have gotten divorced from each other and we actually have to think through how medicine works with schools and social services to make it possible for people to actually walk to work or to create green spaces and to create a culture that actually has better eating habits and better exercise and not smoking, so I think that continuing to increase the cigarette tax is a really good idea too, but I think one of the things that in the United States in particular, we have this belief that more is better, that more healthcare is better, more trans-fats are better and I think that there is a group of people at Dartmouth, Jack Wenberg and Elliott Fisher who actually do a lot of work on variation in healthcare around the United States and affordability. Interestingly, Elliott Fisher has split care into usual care, preference sensitive care, and supply sensitive care, and strangely enough there are some things that between all zip codes, all states have about the same level of service like hip fracture repair, but there are things that the more you build and the more we do (**04:30**) like CTs and MRIs. Interestingly also in the New England Journal last year, it looks like about between 1.5 and 3% of all cancers in the country are caused by the radiation from diagnostic imaging. So the harm is real in overuse, the harm is real in doing things to people that aren't needed and aren't proven.

DR. LARRY KASKEL:

So, let's explore that a little bit in relation to the executive physical. Let's look at one that uses a coronary calcium scan, quick CT scan usually part of every executive physical and what do you think the harm is of doing that test versus the benefit?

DR. BRIAN RANK:

I think that there is some growing data about which people could potentially benefit from the use of coronary CT scanning for calcium and it is high-risk people, but not average risk people. So the harm is in (1) radiation therapy to people who may not need it and may not fit the profile of somebody who could benefit from it. (2) We also find things on CT scans like that like small nodules in the lung.

DR. LARRY KASKEL:

The incidentalomas.

DR. BRIAN RANK:

The incidentalomas, I heard interesting acronym for this from Great Britain yesterday. People who have these are victims of medical imaging technology (VOMITS) and then that person will need to get probably 3-5 more over the years to prove that it's a benign lesion.

DR. LARRY KASKEL:

So we've proved that and we've given them cancer as a result (**06:00**).

DR. BRIAN RANK:

If you do 100,000 of these and if you look at the websites on executive physicals, there is lots of these things happening and people are competing to do them out there, but I think that if we do enough of them, we are going to create some cancers and we estimate in Minnesota that of the 26,000 new cases of cancers somewhere between 300 and 400 of them could be related to diagnostic imaging radiation.

DR. LARRY KASKEL:

Do we have any evidence based medicine that has looked at that particular topic of that particular scan and cost benefit analysis.

DR. BRIAN RANK:

I think we were woefully short on some of that research. The American College of Radiology has done some studies to know which studies are beneficial and which are more or less beneficial. We as a medical group are trying to put that information right at the point of care in our physicians and patients hands so that they can know which studies are more beneficial than harmful and so I think that there is some evidence out there, not enough, but there is evidence about which things are beneficial, when. Since I wrote that article, I have gotten a lot of feedback from physicians around the United States saying these things are really unhelpful. They create this perception of two levels of care, that executives get one thing and I get another, when everyone of us medical groups strives to give the right care to the right person at the right time, a 100% of the time. (**07:30**).

DR. LARRY KASKEL:

But you know, you mentioned that they are getting better care and all I can tell is that it's costlier care. I don't know that it is necessarily better; we are providing just an illusory sense of health.

DR. BRIAN RANK:

Absolutely. I think there are false positives in which we find the incidentalomas that turn out to be benign after a number of CT scans and they also create anxiety and they also create a false sense of I am doing well.

DR. LARRY KASKEL:

Right, we all know the guy who goes in for his stress test and drops dead the next day. So there are limitations to all these tests.

DR. BRIAN RANK:

If you remember Bill Clinton story, I think he is getting a yearly physical from somebody, may be Bethesda, and it didn't stop him from having a heart attack and needing a bypass.

DR. LARRY KASKEL:

What if the costs came down dramatically, would you still be against it as the executive physical, we've renamed it the normal guy's physical and it was 200 dollars, would you still be against doing all the testing.

DR. BRIAN RANK:

I would be against doing all the testing if it wasn't evidence based. If it was something that the US Preventative Services Task Force didn't recommend, I would not recommend doing it. I had thought about titling this article "are our executives that expendable" if doing more is more harmful, then doing just the right amount of healthcare and so it's not just costly, it's actually harmful too.

DR. LARRY KASKEL:

How big is your group, how many docs are in your medical group.

DR. BRIAN RANK:

We have about 670.

DR. LARRY KASKEL

So I imagine you own some of your own radiology equipment. (**09:00**)

DR. BRIAN RANK:

We do.

DR. LARRY KASKEL

Has anyone in your organization said, hey we need to do one of these executive physical programs because it will be a really good idea to get some money from people that are not using their insurance to pay and we could cover the costs of our new CT scan.

DR. BRIAN RANK:

Every once in a while, particularly in tight budget seasons, those suggestions come up, yes.

DR. LARRY KASKEL

And so you can understand why human beings do that.

DR. BRIAN RANK:

Absolutely, I think I can understand why people look to make more money. It's part of, we are capitalist system, and I do not quibble with being in a capitalist system, the question is, is healthcare a social good or is it just a caveat emptor business. I think it has to be more than that, I think that as professionals, we physicians must think about what's beneficial for patients and what could be potentially harmful and drive our preventive care in ways that are consistent with the US Preventative Services Task Force, the eminent body in the United States that sifts through the evidence for us.

DR. LARRY KASKEL:

I know that Britain has their own task force and Canada. Have any of these countries done the analysis and shown that some of these tests are really not evidence based, that we have to wait for us to do it ourselves.

DR. BRIAN RANK:

Actually the National Institute of Clinical Effectiveness or NICE was in the New England Journal this week too and the experience of that national institute in Great Britain over the past 10 years or so of the challenges that they have had and what gets paid for in terms of the national health service in Great Britain (**10:30**). I think other countries are doing some of the technology assessment and comparative effectiveness work and really that's what us docs want, and typically our pharmaceutical data and our clinical trial data doesn't necessarily give us phase III comparative effectiveness recommendations. As an oncologist in many of the phase III clinical trials that we put together do give that which one's best, but for most things we don't. We don't get that data from pharmaceutical companies whether Prilosec is better than something else and what people really want is the best care for the least expensive money for whatever issue that they have.

DR. LARRY KASKEL:

I am a general internist and I will do my annual physical, spend 30 minutes with the patient, how can I convince my patient that what I have done in that 30 minutes is equivalent to him spending 2 days and 3000 dollars.

DR. BRIAN RANK:

Retitle your annual physical. The annual physical is probably a thing of the past. I am sure you are customizing your physicals to what your patient's need. Sometimes it may be more than an annual physical for the best preventive services and in some people they can go a couple of years. For example, Pap smears used to be set once a year, and now evidence has told us that in people with multiple negative Pap smears that every third year is just fine.

DR. LARRY KASKEL:

Where can I go to see what is evidence based (**12:00**) that I should be including in my physical?

DR. BRIAN RANK:

In Minnesota we were really lucky. We have a state-wide institute for clinical systems improvement and that's a collaboration of most of the physicians in the state of Minnesota that worked to synthesize the most recent data into preventive services guidelines, work flows, and supports for our electronic medical records. Around the country, US preventive services task force is probably the best website to know what is clinically effective or not.

DR. LARRY KASKEL:

On that note, Dr. Brian Rank it was a pleasure talking with you today.

DR. BRIAN RANK:

Oh, thanks, it was fun talking with you.

Dr. Brian Rank is the Medical Director of Health Partners Medical Group and Clinics in Minneapolis, Minnesota, and author of a recent perspective in the New England Journal of Medicine: Executive Physicals – Bad Medicine on Three counts.

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