

Why Executives Don't Need Executive Health

Alex Lickerman, MD

IMAGINE  MD

Introduction

Traditional Executive Health programs designed for business executives take advantage of the widespread belief that more medicine is better medicine. That is, if a test is available to detect disease, it should be done. For this reason, such programs typically offer a full day of testing designed to detect hidden disease at an early (and therefore theoretically curable) stage and assess the risk for future disease.

While this sounds like a prudent idea—and an attractive one from a marketing perspective—in fact the number of tests that actually make sense to perform are far fewer than the number that are usually offered. For example, screening exercise treadmill tests are almost always included in Executive Health physicals. Counterintuitive as it may seem, however, offering exercise tests to people without symptoms of heart disease is a serious mistake.

How can that be?

The Risks of Screening

There are two reasons. First, every test has what's called a *false positive rate*. Stated simply, this is the likelihood that the test says someone has heart disease when they don't. Depending on your risk profile for cardiac disease, the false positive rate for exercise treadmill tests can be as high as 50%. Further, every test also has what's called a *false negative rate*. This is the likelihood that the test says that someone doesn't have heart disease when they actually do. Because the blood vessels in the heart that can be responsible for heart attacks are not necessarily the ones with the greatest blockages and therefore often don't result in positive treadmill tests, it's possible to pass a treadmill test and have a heart attack the very next day.

Second, every test and every intervention, from a routine blood draw to major surgery, carries with it a set of predictable risks. And though these risks are usually acceptably low at the level of the individual (or at the very least outweighed by the benefits), when viewed at the level of whole populations their impact becomes considerable. In December 1999, for example, the Institute of Medicine reported that medical errors cause up to 98,000 deaths each year in the United States.¹ As startling as the rates of death are from medical error, however, they pale in comparison to the rates of death *from*

properly performed tests and procedures themselves: approximately 686,000 people die each year as a result of undergoing medical tests and procedures *even when no error occurs*.² Certainly these tests and procedures save far more lives than they take (otherwise we wouldn't perform them), but the take home point is clear: tests and procedures that are *unnecessary*, and which therefore expose patients to *unjustified risk*, must be avoided at all costs.

This is why the commonly held belief that more medicine is better medicine is patently false. In the U.S. there exists an epidemic of unnecessary medical testing that is putting the population at greater, not lesser, risk.

Of course, some screening tests—that is, tests done on a person who has no signs or symptoms suggesting they actually have the disease the test is looking for—are not only justified but also important to perform. But there are a well-researched set of strict criteria that must be satisfied first:

1. The disease being screened must be an important one. That is, it must be prevalent *and* be the cause of significant harm in the population. It makes no sense to screen for brain cancer because it's not prevalent, even though it causes great harm. It makes no sense to screen for allergies because they don't cause significant harm, even though they're prevalent. It makes no sense to screen for accessory nipples because they're neither prevalent nor harmful.
2. There needs to exist a stage where the disease for which we're screening is present without producing any symptoms. If a disease causes symptoms the moment it begins, there's no need to screen for it. The symptoms announce its appearance.
3. The test needs to detect the disease earlier in its course than it otherwise would be detected if we waited until symptoms appeared. There are many tests that do this. But—
4. —the test also needs to detect the disease *early enough* that whatever treatments we currently have available will change the outcome of the disease. Chest x-rays, for example, have been demonstrated to detect lung cancers earlier than they would otherwise be detected by waiting for the appearance of symptoms (cough, weight loss, etc.). *But they still don't detect lung cancers early enough to make a difference in the*

outcome of the disease. That is, by the time a lung cancer becomes visible on a chest x-ray, it's often *already* too late to cure it with currently available therapies. As a screening test for lung cancer, therefore, chest x-rays are worthless.

5. The screening test can't cause more harm than good. While chest CTs *do* detect lung cancers in high-risk populations (like smokers) early enough to change the outcome of the disease, they also detect numerous lesions that are benign. The problem is, doctors can't tell they're benign just by looking at them on a chest CT. So they end up doing more biopsies to determine if the lesions the CTs show are cancer or not. This leads to an increased rate of complications, one of which is death. Thus, the effect of doing screening chest CTs to improve outcomes of lung cancer is mixed: though the chance of dying from lung cancer overall goes down (in high-risk populations), the chance of suffering a complication (perhaps even dying) from a subsequent procedure goes up. The end result: doing screening chest CTs to search for lung cancer doesn't, on average, prolong life.

Unfortunately, the number of tests that actually meet these criteria and therefore are justified as screening tests are far fewer than are usually offered in Executive Health programs. The end result? Executives are actually being placed at greater risk for adverse health outcomes by participating in Executive Health physicals.

Becoming Informed

In contrast, then, to a day or two of largely unnecessary testing in an Executive Health program, a far better strategy to ensure the long-term health of executives would be to connect them to a primary care doctor who not only has the time to discuss the pros and cons of screening tests, but who also has the time to address all their medical needs. This is where a new model of primary care called direct primary (DPC) care comes in.

Just as drivers don't use car insurance to pay for oil changes and tire rotations, in direct primary care employers don't use medical insurance to pay for primary care. Instead, employers are charged a modest retainer fee on a per executive per month basis—a fee that amounts to a fraction of the cost of an Executive Health program—to provide their executives an *ongoing* relationship with a

primary care physician. In DPC, physicians have the time to explain their reasoning behind the tests they do recommend, reasoning that's based on evidence from the medical literature rather than on a marketing strategy. Further, DPC physicians don't just counsel executives once about quitting smoking, beginning an exercise program, or losing weight (which studies show isn't enough to yield long-term behavioral change). They provide *ongoing* coaching that leverages the executive's psychology, taking into account not only that executive's personal values but also their schedule.

The reason this rarely happens in a traditional fee-for-service primary care practices is that it takes time that fee-for-service physicians don't have. Time, however, in a DPC practice, is what physicians have in abundance. As a result, DPC physicians are able to work with executives for as long as it takes to help them achieve maximum health and longevity. They do this not only by providing lifestyle coaching, but also by being immediately available 24/7—no matter where the executive is in the world—to address acute medical problems before they become more serious. In this way, DPC physicians combine the best of Executive Health programs and traditional primary care all in one for a fraction of the cost.

So when considering the cost of an Executive Health program, companies would be wise to compare the value of a single day of largely unnecessary testing to the value of establishing a full-time relationship with a DPC doctor who has the time to not only meet executives' preventative care needs but their acute ones as well.

¹ <http://www.csen.com/err.pdf>

² <http://www.webdc.com/pdfs/deathbymedicine.pdf>