Executive Physicals — Bad Medicine on Three Counts

Brian Rank, M.D.

In corporate boardrooms throughout the United States, executives are wrestling with the management of health care costs. They are demanding health care services that are effective and evidence-based and that don't entail excess or unjust costs. They are meticulously assessing insurers and providers on all these counts as never before. And rightly so. There's some irony, then, in the fact that many of these executives leave these boardrooms for days at a time to take part in one of modern medicine's most expensive and least proven approaches to care: the executive physical.

If you want to have an executive physical (and have the money to pay for one), you won't have to look far. These services are marketed heavily by many of the country's largest and most highly regarded health systems and hospitals, including the Mayo Clinic, the Cleveland Clinic, and dozens of others. Although the specific components of these programs vary, certain traits are common. Most involve a dedicated block of time — a day or two — during which the executive undergoes an extensive and comprehensive battery of in-depth medical tests and evaluations, with results made available immediately. Most such physicals are marketed as a yearly event. Most cost thousands of dollars and are not covered by insurance. Many of the centers that provide them tout an environment of exclusivity, personal attention, and luxury of the type one might expect to see at a four-star hotel or high-end resort. Those who undergo these physicals clearly appreciate the indulgent touches, such as complimentary bathrobes and slippers or the performance of the whole process in a so-called VIP area.[1]

It's easy to understand the appeal of the executive physical to companies and their executives. With executive compensation high and competition for top talent fierce, it's not surprising that companies want to do everything they can to protect the investment they make in senior management. Nor is it surprising that the executives themselves, with heavy demands on their time, would be drawn to the convenience of one-stop shopping, the pampering, and the peace of mind that the executive physical seems to represent. Like a four-star hotel, the executive physical is, at least outwardly, "the best" — just what executives are accustomed to getting.

It's also easy to understand why the executive physical appeals to the hospitals and systems that offer it. The physical represents an opportunity for the provider to show off its ability to serve high-profile patients with the most advanced testing available. It also represents a new and attractive revenue stream.

Nevertheless, in my view, the emergence of executive physicals is not a good thing. It's not good for the patients who undergo them, it's not good for the companies that pay for them, and it's not good for the health care system overall. As an example of progressive medicine, the executive physical fails on three important counts: efficacy, cost, and equity.

Inherent in the provision of this service is the notion that the most health care is the best health care. If a standard physical exam entails three tests, the thinking goes, then an exam with a dozen tests must be better. Similarly, an exam that takes 2 days must be better than one that takes an hour. Of course, there is no evidence for either premise, and indeed a growing body of research suggests quite the opposite — that unnecessary testing may cause more harm than good, owing to false positive findings, unwarranted follow-up visits and costs, needless worry, and harmful side effects of the tests themselves.

Consider, for example, the inclusion in many executive physicals of a computed tomographic (CT) scan of the heart to determine the executive's calcium score. Although most patients would probably find information gleaned from this examination interesting, it is rarely meaningful as a predictor of disease. In its current summary of recommendations, the U.S. Preventive Services Task Force concludes that the potential harms of routine screening for coronary heart disease in low-risk adults exceed the potential benefits.[2]

Among the battery of screening tools that executive physicals include with little regard to medical evidence are whole-body CT scans, electrocardiograms, and chest radiographs. As clinicians, we should be applying increasingly rigorous standards of justification and efficacy to every test we request for our patients. Our goal should be to limit tests to those warranted by medical evidence to improve health, lengthen life, and do more good than harm. The executive physical seeks, by its very structure, to broaden testing, under the false assumption that more is better.

According to a 2006 study by Wennberg et al.,[3] evidence-based medicine does not play a role in governing the use of supply-sensitive services — services whose supply has a major influence on their use. Wennberg said of the study, "Three issues drive the differences in the cost and quality of care. Variation is the result of an unmanaged supply of resources, limited evidence about what kind of care really contributes to the health and longevity of the chronically ill, and falsely optimistic assumptions about the benefits of more aggressive treatment of people who are severely ill with medical conditions that must be managed but can't be cured."

Executive physicals also reinforce a related misperception — that costlier is better, that a $3,000 examination must be worth more than one that costs 1/10 of that amount. This is an indefensible idea that should not be promoted by the health care industry. Even as individual hospitals sell these services for exorbitant fees, gratuitously overusing our health care resources, our system as a whole is appropriately straining in precisely the opposite direction, toward cost-effectiveness, transparency, competition, and accountability. With its outrageous cost and unproven efficacy, the executive physical is almost a parody of the high-cost, low-return procedures that prudent companies rightly want clinicians to eliminate for other employees.

The executive physical is a perfect example of what American medicine should be working to expunge: the expensive, the ineffective, and the inequitable.

But perhaps the most lamentable idea perpetuated by the executive physical is the implication that some patients — namely, those who have the ability to pay out of pocket or with company resources — are more worthy of effective, respectful, and personalized treatment than others. Much good work is being done these days to identify and reduce health care disparities that are based on income, race, geography, or other demographic factors. The executive physical runs exactly counter to these efforts, suggesting that a company is justified in paying thousands of dollars to maintain the health of its wealthy senior executives while relegating the masses to something less.

As efforts to reform the health care 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. Perhaps if it didn't fail on all three of these counts, allowances could be made for it as a whimsical extravagance that satisfies certain people's need for exclusivity. As it stands, however, there is little to excuse it. As an industry, we can't expect to get credit for working to make health care affordable and effective for all if we're offering the "best" health care, for a price, to a few — when it isn't.

No potential conflict of interest relevant to this article was reported.

Dr. Rank is the medical director of HealthPartners Medical Group and Clinics, Minneapolis. The HealthPartners Medical Group does not have an executive physical program.

1. Brink S. For the busy exec, a $2000 physical. Los Angeles Times. February 18, 2008: F1.

2. Screening for coronary heart disease. Rockville, MD: Agency for Healthcare Research and Quality, February 2004. (Accessed September 12, 2008, at http://www.ahrq.gov/clinic/uspstf/uspsacad.htm.)

3. Wennberg JE, Fisher ES, Sharp SM, McAndrew M, Bronner KK. The care of patients with severe chronic illness: a report on the Medicare program by the Dartmouth Atlas Project. Lebanon, NH: The Trustees of Dartmouth College, 2006. (Accessed September 12, 2008, at http://www.dartmouthatlas.org/atlases/2006_Chronic_Care_Atlas.pdf.)