PERSPECTIVES

Luxury Primary Care, Academic Medical Centers, and the Erosion of Science and Professional Ethics

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Medical schools and teaching hospitals have been hit particularly hard by the financial crisis affecting health care in the United States. To compete financially, many academic medical centers have recruited wealthy foreign patients and established luxury primary care clinics. At these clinics, patients are offered tests supported by little evidence of their clinical and/or cost effectiveness, which erodes the scientific underpinnings of medical practice. Given widespread disparities in health, wealth, and access to care, as well as growing cynicism and dissatisfaction with medicine among trainees, the promotion by these institutions of an overt, two-tiered system of care, which exacerbates inequities and injustice, erodes professional ethics. Academic medical centers should divert their intellectual and financial resources away from luxury primary care and toward more equitable and just programs designed to promote individual, community, and global health. The public and its legislators should, in turn, provide adequate funds to enable this. Ways for academic medicine to facilitate this largesse are discussed.

KEY WORDS: **luxury primary care; uninsured; ethics; justice; professionalism.**
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Most training in professional ethics, as well as the development and teaching of evidence-based practice guidelines, occurs in medical schools and at teaching hospitals. These institutions, historically the providers of last resort for the poor and destitute, have been particularly hard hit by the financial crisis affecting health care in the United States, due to the higher costs associated with medical training, a disproportionate share of complex and/or uninsured patients, erosion of their infrastructure, and shrinking funds.[1–6] Insurance companies and the U.S. government have not been willing to adequately compensate them for their losses.[7]

To survive financially, academic medical centers have been forced to compete with more efficient private and community hospitals. Due to limited success, teaching hospitals have undertaken 2 initiatives to improve their competitive financial edge: 1) active recruitment of wealthy foreigners as patients; and 2) development of luxury primary care (or executive health) clinics.[8]

Recruitment of Wealthy Non-U.S. Citizens as Patients

Academic medical centers recruit wealthy foreign patients both to augment clinical revenues and to find potential monetary donors for their research and clinical programs.[9–12] It has been estimated that the number of foreign persons visiting the United States for health care will quadruple in the next few years.[9] These individuals have not paid taxes in support of medical education and health care subsidies, and their health needs may not be as pressing (and are usually more costly) than the needs of those living in poverty within their home countries. The recruited wealthy patients have immediate access to face-to-face translators,[11,13] a diagnostic and therapeutic asset sometimes only spottily available to uninsured, non-English speaking patients and their doctors. Furthermore, academic medical centers often refuse nonemergent care to non-U.S. citizen refugees and undocumented aliens, because provision of such services would rapidly deplete their financial resources (both through the care itself and the informal referral base that would develop once the institution gains a reputation for caring for these individuals).

Luxury Primary Care Clinics

While the exact number of academic medical centers sponsoring luxury primary care clinics is not known, the list includes many U.S. medical schools and teaching hospitals, including such well-known institutions as Massachusetts General Hospital, Johns Hopkins, New York Presbyterian, University of Pennsylvania, University of California—San Francisco, Stanford, University of Miami, Vanderbilt, Wake Forest, Washington University, Emory, Georgetown, George Washington, University of California—Irvine, Ohio State, Bowman Gray, Duke, Mayo Clinic, Northwestern, Cleveland Clinic, Oregon Health and Science University, Virginia Mason (affiliated with the University of Washington), Cedars-Sinai (affiliated with the University of California—Los Angeles), and others.[8,11,12,14]

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Some of these institutions participate in the Executive Health Registry, which provides services to 150 corporations and 10,000 traveling executives worldwide.[15] One recent survey of U.S. corporations found that less than one half offered executive physicals as an employee benefit, although top-level managers still may have taken advantage of these on their own.[16]

Approximately 3,000 individuals visit the Mayo Clinic each year for executive health physicals;[17] 3,500 go to the Cleveland Clinic,[18] and 1,950 are seen at Massachusetts General Hospital. Executive Health Exams, International has a nationwide network of 600 health care providers who perform 25,000 exams per year.[19] While this company is not affiliated with any specific academic medical center, many of its providers have academic appointments.

In general, luxury primary care clinics are staffed by 2 or more full-time clinicians, with many subspecialists available for immediate consultations.[14] The only published study[20] of the costs and benefits of executive physicals evaluated the nonacademic, in-house program offered by Bank One, whose program is much more evidence based in its selection of tests than those offered by academic medical centers.[14] Investigators found that at a cost of $400 per exam for executives earning at least $125,000 per year, participants in the voluntary program had fewer short-term disability days and decreased overall medical costs over a 3-year period. However, the cost of this exam was far lower than the typical cost of an executive physical.[14]

At academic medical center-affiliated primary care clinics, patients are charged anywhere from $1,500 to $20,000 per visit (average cost between $2,000 and $4,000), and are indulged with perks such as valet parking, escorts, and plush bathrobes; seated in oak-paneled rooms lined with fine art and outfitted with televisions, computer terminals, and fax machines; served buffet meals with herbal tea; and pampered with saunas and massages.[8,12–14] Necessary or requested subspecialty consultations occur on the same day as the general executive physical exam. Vaccines in short supply elsewhere are readily available.[12–14] For those willing to pay extra, physicians are available by cell phone or pager year-round; some doctors will even make house calls.[13] Waiting times for an initial appointment range from a few days to, intriguingly, 8 months.[21] Patient–physician ratios are often between 10% and 25% of typical managed care levels.[22]

Corporate clients for teaching hospital-based executive health programs include tobacco companies, organizations with extensive histories of environmental pollution, and health insurers (whose own policies increasingly limit the coverage of sick individuals).[8,23] Patients come from the United States and abroad; some are not U.S. citizens. Most patients are asymptomatic, fairly healthy, and come from upper management (i.e., disproportionately white men, based on data from one executive health program;[20] the fact that women, who make up 46% of the U.S. work force, hold less than 2% of senior-level management positions in Fortune 500 companies;[24] and the lower socioeconomic status of nonwhites[25–27]). Some programs offer a package of evaluation and testing benefits to upper management employees, raising questions of patient confidentiality when the employer directly purchases clinical services for these employees.

Marketing for luxury primary care clinics is directed at the heads of successful small and large companies.[8,12–14] In addition to obtaining full reimbursement for services (patients are responsible for what insurance does not cover),[22] hospitals hope these high-level managers will steer their companies' lucrative health care contracts toward the institution and its providers. Some programs give discounted rates in exchange for a donation to the hospital.[28]

Luxury primary care clinics cater to the "busy executive" who "demands only the best" from his physician.[8,12–14] Many of my patients, who work two jobs on an hourly pay scale and must find child care each time they return for another diagnostic test or subspecialty consultation, would be offended by these clinics' promotional materials, which imply that high-level executives are busier and lead more hectic lives than other patients and thus require same day service. In fact, it is the lower socioeconomic status workers/patients who have worse health outcomes and are in greater need of efficient, comprehensive health care.[29]

There are no data available on the participation of medical students and residents in luxury primary care clinics, start-up costs, or degree of profitability, nor regarding whether financial resources are diverted to other programs, and if so what programs (Troyen Brennan, MD, written personal communication, September 29, 2002). My experience calling and then sending a very brief questionnaire to the heads of 10 major programs, and receiving only 1 response, suggests that programs may be reluctant to divulge such information. Future research might examine these issues, as well as the effects on physicians of participating in luxury primary care clinics (e.g., satisfaction, paperwork and administrative load, case mix, etc.), the health and financial consequences to patients and their companies, and the indirect costs (financial and social) to other patients at academic medical centers sponsoring such clinics.

The Erosion of Science

There are little data to support the clinical or cost effectiveness of many tests offered to asymptomatic VIP clients. Examples include percent body fat measurements, chest X-rays in smokers and nonsmokers age 35 and older for lung cancer, electron beam-computed tomography scans and stress echocardiograms for coronary artery disease, and abdominal-pelvic ultrasounds for ovarian or liver cancer.[12–14,30] Others are controversial, such as genetic testing or mammography starting at age 35. False-positive results may lead to further unnecessary investigations, costs, and anxiety, and increased profits. While clients pay for these procedures, technicians and equipment time are diverted to produce immediate results. In one boutique clinic, patients wear golf shirts emblazoned with the hospital's logo, their "gold card" to jump the queue in the

radiology and phlebotomy suites.[12] Consequently, tests on other patients with more appropriate and urgent needs may be delayed.

The use of clinically unjustifiable tests erodes the scientific underpinnings of medical practice[31] and sends a mixed message to trainees about when and why to utilize diagnostic studies. It also runs counter to physicians' ethical obligations "to contribute to the responsible stewardship of health care resources."[32] While some might argue that if a patient is willing to pay for a scientifically unsupported test that she should be allowed to do so, such a "buffet" approach to diagnosis makes a mockery of evidence-based medical care.

The Erosion of Professional Ethics

The general public contributes substantially, through state and federal taxes, to the education and training of new physicians.[7] Even so, many physicians who staff luxury primary care clinics limit their practices to the wealthiest fraction of our citizenry.[8,13,14] Given their investment in the training of physicians, the public might find it hard to accept a U.S.-trained physician limiting his/her practice to the wealthy. They might also object to physicians refusing to care for Medicaid or Medicare patients. On the other hand, medical students incur significant debt by the end of their education. As doctors, they might justify limiting their practices to the wealthy by claiming a right to freely choose where they practice and for whom they care (within limits, since they cannot, for instance, refuse to care for acquired immunodeficiency virus syndrome patients solely on the basis of their human immunodeficiency virus seropositive status, or African Americans solely on the basis of their race). Similarly, academic medical centers might justify sponsoring luxury primary care clinics via a utilitarian argument, if income from these clinics cross-subsidizes indigent care or teaching programs. Nevertheless, there are other ways in which hospitals can attempt to improve their financial circumstances in manners that display both beneficence and social justice (see below).

By the same token, if we are opening our hospitals and clinics to patients from other developed and developing nations, we should do so in a way that allocates scarce resources to provide the greatest benefit for the greatest number of individuals. A liver transplant for a wealthy foreign investment banker is not nearly as cost effective (or as just) as treating a group of undocumented farm laborers (whose cheap yet dangerous labor provides us with relatively inexpensive produce) for tuberculosis, mental illness, or pesticide-related diseases.[33] For that matter, we ought to share more of our nation's academic medical resources with the developing world, by deploying groups of faculty and students to educate local practitioners regarding the prevention and treatment of common diarrheal and respiratory infections, which unnecessarily kill thousands each day.[23] Instead, market forces have spurred for-profit health care companies to export the most inefficient, unjust elements of American medicine to the developing world.[34,35] Simultaneously, migration of medical professionals from developing countries, where they were trained at public expense, to developed countries like the United States further depletes health care resources in poor countries and contributes to the widening worldwide gap in health inequities between rich and poor.[36,37]

Ironically, the trend toward luxury primary care occurs at a time of increasing injustice in health care in the United States and worldwide, and a period of increasing dissatisfaction and cynicism among patients, practicing physicians, and trainees. Today over 40 million Americans lack health insurance.[7,38] Millions more are underinsured, remain in dead-end jobs to maintain their health insurance, or go without needed prescriptions because of skyrocketing drug prices. The United States ranks near the bottom among westernized nations in life expectancy and infant mortality, and 20% to 25% of our children live in poverty.[23,39] Disparities in wealth, access to care, and morbidity and mortality between rich and poor have grown.[23,39,40] For example, while executive pay at top U.S. corporations climbed 571% from 1990 to 2000, average real wages are at or below those of 1973.[41] Racial inequalities in processes and outcomes of care, some seemingly explainable only by racism or poverty (itself in part a consequence of past and present racism) persist. Differences between developed and developing nations, in terms of financial, economic, environmental, and health-related resources, have further widened and are especially dramatic.[23] For instance, hunger kills as many individuals in 2 days as died during the atomic bombing of Hiroshima, 1 billion people lack access to clean drinking water, and 3 billion lack adequate sanitation services.[23,42]

The increasing role played by for-profit corporations in causing and perpetuating social injustices worldwide is mirrored in the pernicious influence of for-profit entities (health maintenance organizations, hospital systems, and pharmaceutical and biotechnology companies) on the American health care system.[38] Our failure to provide universal coverage could lead some desperate patients to lie, for example not mentioning a worrisome personal or family medical problem in order to obtain insurance or exaggerating symptoms to obtain needed care.

Meanwhile, patient and physician dissatisfaction with our current fragmented health care (non)system is growing.[38,43] Investigators have already described erosions in professionalism, about which physicians and the public have expressed concern, such as some doctors offering varied levels of testing and treatment for a given illness, depending on a patient's ability to pay.[44] Weiner has noted that physicians may be more likely to recommend services for insured rather than uninsured patients.[45] And Wynia et al. have found that a sizeable minority of physicians admits to "gaming the system" by manipulating reimbursement rules so their patients can receive care that the doctors perceive is necessary.[46]

Many medical students and residents display increasingly cynical attitudes as their training progresses; some

educators have expressed concerns over the adequacy of students' humanistic and moral development.[47] Contemporary ethics training tends to address inadequately the socioeconomic, cultural, occupational, environmental, and psychological contributors to the health of individuals and populations.[48–51]

Solutions

Many institutions have begun to heed the call of educators and policy makers to improve training in, and the practice of, professionalism in medicine.[52–56]

Medical organizations have called for an increased emphasis on professionalism and ethical practice, and for empathic and equal provision of care to all individuals, despite their insurance status, financial resources, or race.[57]

On the other hand, the American Medical Association feels that, with appropriate safeguards (e.g., physicians ensuring ongoing care for their former patients when converting to luxury primary care practices), luxury primary care enhances pluracy in health care delivery and that increases in the choices available to health care purchasers should increase the total amount of health care available to the entire population,[22] a variation of Ronald Reagan's failed trickle down economic theory of the 1980s.

For teaching institutions to promote luxury primary care and the recruitment of wealthy foreign patients in the face of the above-described phenomena perpetuates unscientific practice, erodes fundamental ethical principles of medicine such as equity and justice, and will engender even greater cynicism among student-doctors and the general public. Instead of continuing to promote an overt, two-tiered system of care by recruiting wealthy foreign patients and operating luxury primary care clinics, teaching institutions should renounce the measure of the marketplace as their dominant standard or value;[58] divert their intellectual and financial resources to more equitable and just investments in community and global health; and implement curricular changes designed to encourage trainees to find constructive solutions to the problems caused by our market-based health care system.[7] Closing some academic medical centers and/or consolidating redundant educational and clinical programs in nearby teaching hospitals may save money, which can be diverted toward indigent care programs. Blumenthal et al.[5] have described how academic medical centers can become more competitive by reducing costs (e.g., through quality improvement programs, improving governance and decision making, and augmenting philanthropic contributions). Increasing alliances with industry could provide needed funds, but risk undue corporate influence on academic institutions' agendas.

Physicians must educate the public and policy makers about the important roles they play in research, education, and patient care, particularly in terms that are relevant to individuals and their families.[1] These ideas should be convincingly communicated to business leaders, government representatives, and purchasers of health care,[1] particularly by deans, hospital presidents, department chairs, and division chiefs. In turn, legislators should provide increased funding for the education and training of future physicians and for the continued health of these vital institutions.

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