

Chapter XVIII

FAMILY MEDICINE SHOULD ENCOURAGE THE DEVELOPMENT OF LUXURY PRACTICES: NEGATIVE POSITION

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ABSTRACT

Luxury practices have been flourishing over the last few years in the United States and to a lesser extent in other parts of the western world. The concept of luxury care is antithetical to sound science, to public health, and to fundamental ethical principles such as equity and justice. It erodes the scientific underpinnings of medical practice and can harm patients. Luxury practices also perpetuate our two-tiered system of care. Given widespread disparities in health, wealth, and access to care, as well as growing cynicism and dissatisfaction with medicine among trainees and practitioners, family medicine should divert its intellectual and financial resources away from luxury care. Family medicine should develop more equitable and just programs designed to promote individual, community and global health. Academic institutions should lead this process, and physician activism should be modeled and encouraged. As such, family medicine, indeed medicine as a profession, should not promote the development of luxury practices.

Mankind has become so much one family that we cannot ensure our own prosperity
except by ensuring that of everyone else.

Bertrand Russell

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INTRODUCTION

Luxury care – also known as boutique medicine, concierge care, retainer practice, executive health care, and premium practice – has been flourishing over the last few years in the United States (US) and, to a lesser extent, other parts of the western world [1-3]. I will use these terms interchangeably and, focusing on the US experience,¹⁵ argue that the concept of luxury care is antithetical to sound science, to public health, and to fundamental ethical principles of modern medical care. As such, family medicine, indeed medicine as a profession, should not promote the development of luxury care.

LUXURY PRIMARY CARE CLINICS

Concierge clinics began in 1996 when the former team doctor for the National Basketball Association's Seattle Supersonics founded MD2. Since then, MD2 has grown, as have other groups like MDVIP and Platinum Health Service LLC.

In retainer practices, patients are charged an average fee of between \$2000 and \$4000.

At luxury clinics, patients are indulged with perks. These include valet parking, escorts and plush bathrobes; seating in oak-paneled rooms lined with fine art and outfitted with televisions, computer terminals and fax machines; buffet meals with herbal tea; and saunas and massages [1-3]. Subspecialty referral appointments occur on the same day as the general physical exam. Vaccines in short supply elsewhere are readily available. Physicians are available by cell phone or pager year-round; some doctors will even make house calls. Waiting times for an initial appointment are short, and patient-physician ratios are between 10 and 25% of typical managed care levels [1-3].

In general, two or more full-time clinicians staff luxury primary care clinics, with many subspecialists available for immediate referral appointments. The only published study of the costs and benefits of executive physicals evaluated the Bank One in-house program, which is ironically much more evidence-based in its selection of tests than the programs offered by academic medical centers [4]. At a cost of \$400 per exam for executives earning at least \$125,000 per year, participants in this voluntary program had fewer short-term disability days and decreased overall medical costs over a 3-year period [4]. However, the cost of this exam was significantly lower than the typical cost of an executive physical.

Between 5 and 10% of the nation's nearly 3,000 nonprofit hospitals are experimenting with boutique health care service models [5]. Marketing for luxury primary care clinics is directed at the heads of successful small and large companies [1]. In addition to obtaining full reimbursement for services (patients are responsible for what insurance does not cover), hospitals hope these high-level managers will steer their companies' lucrative health care contracts towards the institution and its providers. Some programs give discounted rates in exchange for a donation to the hospital.

Luxury primary care clinics cater to 'busy executives' who 'demand only the best' from their physicians [1-3]. Patients who work two jobs on an hourly pay scale and must find child

¹⁵ Data on specific programs come from their websites and promotional brochures unless otherwise noted.

care each time they return for a diagnostic test or subspecialty appointment 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 the worst health outcomes and most need efficient, comprehensive health care [1, 6].

Corporate clients for executive health programs include tobacco companies, organizations with extensive histories of environmental pollution, pharmaceutical companies (whose egregiously inflated profits and lack of true innovation contribute to health care disparities), and health insurers (whose own policies increasingly limit the coverage of sick individuals) [1, 2, 7]. Interestingly, a substantial proportion of university presidents serve on the boards of directors of such companies [8].

Patients come from the US and abroad. Most of the patients are asymptomatic, fairly healthy, and come from upper management. Thus they are disproportionately white men, based on: data from one executive health program [4]; the fact that women, who make up 46% of the US work force, hold less than 2% of senior-level management positions in Fortune 500 companies [9]; and the lower socioeconomic status of non-Caucasians. 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.

A recent national survey found that retainer-practice physicians have much smaller patient panels (898 vs. 2303 patients) and care for fewer African-Americans, Hispanics, and Medicaid patients than do non-retainer-practice physicians [10]. Physicians who converted to a retainer practice kept an average of only 12% of their former patients [10]. Most retainer physicians conducted charity care (although the nature and amount of such care is unknown), and many continued to see some non-retainer patients [10]. Another survey found that physicians converting from non-concierge to concierge care reduced their patient panels from an average of 2,716 to an average of 491 patients [11]. Their daily workload decreased from 26 to 10 patients [10]. Once physicians are established in concierge practices, they make substantially more money than non-concierge physicians [12].

Boutique doctors often cite the desire for greater autonomy and more independence in decision-making (less paperwork, fewer prior authorizations), increased time to spend with their families or on altruistic endeavors, and the satisfaction of getting to know their patients more intimately. Such motivations are understandable, even laudable, and an unfortunate consequence of the current US health care system. Even so, increased financial compensation is likely an important factor for some concierge physicians.

LUXURY PRIMARY CARE CLINICS AND ACADEMIC MEDICAL CENTERS

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 US. Reasons

include high costs associated with medical training, a disproportionate share of complex and/or uninsured patients, erosion of their infrastructure, shrinking funds, and the closing of public hospitals [1, 6, 13-16]. Insurance companies and the US government have been unwilling to adequately compensate teaching hospitals for their losses [17].

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

While the exact number of academic medical centers sponsoring luxury primary care clinics is not known, the list includes many well-known US medical schools and teaching hospitals¹⁶, [1, 2]. Approximately 3000 individuals visit the Mayo Clinic each year for executive health physicals; 3500 go to the Cleveland Clinic and 1950 are seen at Massachusetts General Hospital [1].

Some academic institutions participate in the Executive Health Registry, which provides services to 150 corporations and 10,000 traveling executives worldwide. Executive Health Exams, International has a nationwide network of 600 health care providers who perform 25,000 exams per year. While this company is not affiliated with any specific academic medical center, many of its providers have academic appointments.

No data are available on the participation of medical students and residents in luxury primary care clinics at teaching hospitals. Little to nothing is publicly known about start-up costs, degree of profitability, or whether financial resources from these clinics are diverted to other programs, and if so what programs. My experience calling and then sending a very brief questionnaire to the heads of ten clinics associated with major programs, and receiving only one response, suggests that institutions may be reluctant to divulge such information.

OTHER FORMS OF BOUTIQUE MEDICAL CARE

Other trends in boutique medical care include the proliferation of VIP floors in medical centers; the rise of specialty hospitals; medi-spas providing alternative or cosmetic services in luxurious surroundings; professional sports contracts; travel medicine clinics that stock vaccines and provide preventive health information and accessories for exotic destinations; second opinion and e-consulting services provided via the internet; and practices which sell health and nutritional products [2].

As a medical student in the late 1980s, I remember visiting patients on the penthouse VIP ward. I was distressed to observe that some, but not all, faculty spent much more time with patients on that ward than with their other charges. The behavior of a few physician-teachers

¹⁶ Institutions include 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

bordered on the obsequious. One such ward, Mount Sinai Hospital's Eleven West, is supervised by managers who typically have a background in the hotel industry. It offers private rooms, higher nurse-patient ratios, luxurious décor, and gourmet meals. Operated since 1993, it currently generates profits of more than \$1 million annually on about \$2.5 million in revenue [5].

Despite an ever-widening socioeconomic gap in access to health care and in response to increasing privatization, China and other Asian countries have likewise built VIP floors and sometimes entire VIP hospitals [18]. Wealthy Westerners have received care in these institutions, sometimes to avoid publicity.

Since 1990, over one hundred specialty hospitals have opened in the US, primarily offering cardiac, surgical, and orthopedic procedures [19, 20]. An 18 month moratorium on construction of new facilities expired last year. These hospitals adversely impact nearby community hospitals, as they tend to cherry pick younger, healthier, and wealthier patients and avoid the costs of providing traditionally money-losing emergency services [19, 20]. Patient selection likely accounts for their slightly better outcomes. These hospitals have been criticized for avoiding the ban on physician self-referral to institutions in which they have a financial stake and for inadequate provider coverage [19, 20]. The American Hospital Association and the Federation of American Hospitals have vigorously opposed the development of these facilities [19].

One example of a medi-spa involves Wellpoint, the largest US health benefits company, which has joined Dole Food Company, Inc. and Four Season Hotels and Resorts to develop 'Wellbeing Institutes' in California and Hawaii.

Historically, professional sports teams would hire the most qualified physicians to treat their athletes. Today hospitals and medical groups pay teams for the exclusive right to treat their high-salaried players, a marketing ploy designed to encourage non-professional athletes with high income but lesser abilities to visit their clinics [21]. For example, the New York University-Hospital for Joint Diseases pays baseball's New York Mets more than \$1 million a year, and Houston's Methodist Hospital (affiliated with Baylor University) pays baseball's Astros and football's Texans \$2 million annually [21].

Meanwhile, low cost 'boutique' clinics are burgeoning. Wal-Mart, CVS, Rite Aid, Piggly Wiggly, and other supermarket and pharmacy chains have opened walk-in clinics, staffed largely by nurse practitioners, to treat minor acute illnesses for fees of \$30 to \$65 [22]. Such retail mini-clinics do not constitute true primary care, cannot guarantee coordination with patients' other providers, and the uninsured may utilize such quickie checkups as a substitute for the thorough, life- and cost-saving interventions that a more complete evaluation would provide.

BARRIERS TO AND LEGAL RISKS OF BOUTIQUE MEDICINE

The proliferation of boutique practices has spawned boutique health care law firms, which help doctors to navigate the legal requirements and avoid the legal risks of practice transformation. The development of boutique practices has also led to consulting and practice management companies catering to luxury care. Physicians in retainer practice have their

own organization, the Society for Innovative Practice Design (<http://simpd.org>), previously known as the American Society of Concierge Physicians.

Legal risks of operating boutique practices in the US include violation of Medicare regulations, the False Claims Act, provider agreements with private insurance companies, state insurance laws, and the anti-kickback statute and other laws prohibiting payments to induce patient referrals, along with liability for the abandonment of existing patients [23]. Medicare regulations prohibit charging Medicare beneficiaries for services covered by Medicare [23]. A majority of recently surveyed concierge physicians found the Medicare guidelines unclear and insufficient [11]. Nearly three-quarters continued to participate in Medicare, while one-fifth had opted out [11].

Some hospitals have used economic credentialing to deny hospital privileges to physicians practicing concierge care. Certain states have investigated the payment mechanisms of concierge practices [24]. New Jersey prevents insurers from contracting with physicians who charge extra fees for their services [24]. New York State's Department of Health prohibits concierge medicine for enrollees in Health Maintenance Organizations [24]. At the federal level, the Equal Access to Medicare Act has not moved beyond Congressional committee discussions.

PROBLEMS ASSOCIATED WITH LUXURY MEDICAL CARE

Erosion of Science

There is no evidence documenting a higher quality of care in concierge practices, and little data support the clinical- or cost-effectiveness of many tests offered to their asymptomatic clients. Examples include % body fat measurements, chest X-rays in smokers and non-smokers aged 35 and older to screen for lung cancer, electron-beam computed tomography (CT) scans and stress echocardiograms looking for evidence of coronary artery disease, and abdominal-pelvic ultrasounds to screen for ovarian or liver cancer [1]. Other examples, such as mammography starting at age 35 and genetic testing, are also controversial. Ironically, this over-testing occurs despite the well-documented under-utilization of validated, beneficial interventions in both uninsured and insured patients [25].

While clients pay for these procedures, technicians and equipment time are diverted to produce immediate results. Since patients jump the queue in the radiology and phlebotomy suites [1], tests may be delayed on other patients with more appropriate and urgent needs.

False-positive results may lead to further unnecessary investigations, additional costs (and increased profits), and heightened anxiety. Multiple tests increase the likelihood of false positive results. Nevertheless, some people's need for reassurance is so strong that they will pay exorbitant amounts of money for such testing, and companies have sprung up to meet this demand. For example, Biophysical 250 charges \$3400 'to screen for hundreds of diseases and conditions...including cancer, cardiovascular disease, metabolic disorders, autoimmune disease, viral and bacterial disease and hormonal imbalance.'

In 2002, one year after television talk show host Oprah Winfrey underwent a full-body screening CT scan, 32 million Americans paid up to \$1000 apiece for this test [26]. A 2004 survey of 500 Americans found that 85% would choose a full-body CT scan over \$1000 cash.

These scans can deliver a radiation dose nearly 100 times that of a typical mammogram [26]. A single scan exposes the patient (victim?) to a level of radiation linked to increased cancer mortality in low-dose atomic bomb survivors from Hiroshima and Nagasaki [26]. Receiving such scans annually would substantially increase one's lifetime risk of malignancy [26].

On the other hand, true positive results can lead to the over-diagnosis of conditions that would not have become clinically significant, leading to further risky interventions and possibly impairing future insurability [1].

The use of clinically unjustifiable tests erodes the scientific underpinnings of medical practice and sends a mixed message to trainees and patients about when and why to utilize diagnostic studies [27]. It also runs counter to physicians' ethical obligations 'to contribute to the responsible stewardship of health care resources' [28]. Some might argue that if patients are willing to pay for a scientifically-unsupported test, they should be allowed to do so. However, such a 'buffet' approach to diagnosis over-medicalizes care and makes a mockery of evidence-based medicine.

Erosion of Professional Ethics

The general public contributes substantially, through state and federal taxes, to the education and training of new physicians [17]. Even so, many physicians who staff luxury primary care clinics limit their practices to the wealthiest fraction of our citizenry [1, 2]. Given their investment in the training of physicians, the public might find it hard to accept physicians limiting their practices 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 (HIV) syndrome patients solely on the basis of their HIV seropositive status, or African-Americans solely on the basis of their race).

Similarly, medical centers might justify sponsoring luxury primary care clinics via a utilitarian argument, if income from these ventures cross-subsidizes indigent care or teaching programs. One economic analysis suggests that an average 600 bed luxury hospital in a city of one million people with average incomes could generate, with profit margins of 30 to 55% as much as \$6 million in incremental annual profit, which could be used to cross-subsidize research or other patient care activities [29]. Nevertheless, there are few publicized instances of cross-subsidization. Virginia Mason's (University of Washington's) Dare Center uses a portion of its approximately \$650,000 annual profit to offset the cost of caring for the uninsured and money losing community programs [5]; Tufts New England Medical Center's Pratt Diagnostic Clinic intends to begin transferring roughly \$350,000 to \$400,000 to the institution's money-losing primary care practice in 2006 [5]; and the two VIP medical wards at one Chinese hospital in Hong Kong cross-subsidize some uncompensated care [18]. Nevertheless, such arrangements do not promote equality and solidarity, and hospitals can use other ways that display beneficence and social justice to attempt to improve their financial circumstances (see below).

The American Medical Association (AMA) believes that, with appropriate safeguards (e.g., physicians ensuring ongoing care for their former patients when converting to luxury primary care practices), luxury primary care diversifies health care delivery. The AMA also believes that increasing the choices available to health care purchasers should increase the total amount of health care available to the entire population [30], a variation of former President Ronald Reagan's failed 'trickle down' economic theory of the 1980s.

Some comments regarding the state of contemporary health care will hopefully illuminate how luxury care will not solve current problems, but rather magnify existing inequities and injustices. The trend toward luxury primary care has been occurring at a time of increasing injustice in health care in the US and worldwide, and during a period of increasing dissatisfaction and cynicism among patients, practicing physicians and trainees. Today 47 million Americans lack health insurance [17]. 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 proportion of physicians providing charity care has declined over the last decade [31]. The development of luxury care has diverted attention from these issues without improving health outcomes at the population level.

Despite spending a larger proportion of its gross domestic product on health care than any other westernized nation, the US ranks near the bottom among such nations in life expectancy and infant mortality, and 20-25% of its children live in poverty [7, 25]. Disparities have grown in wealth, access to care, and morbidity and mortality between rich and poor [6, 7, 25]. Racial inequalities in processes and outcomes of care persist, some seemingly explainable only by racism or poverty (itself in part a consequence of past and present racism) [32]. Differences between developed and developing nations, in terms of financial, economic, environmental and health-related resources, have further widened and are especially dramatic [7, 33]. For instance, hunger kills as many individuals in two days as died during the atomic bombing of Hiroshima, one billion people lack access to clean drinking water, and three billion lack adequate sanitation services [7, 33].

The profit motive at the root of America's capitalist economic system has driven, to some extent, the increase in luxury practices. The increasing role played by for-profit corporations in causing and perpetuating worldwide social injustices which exacerbate health disparities is mirrored in the pernicious influence of for-profit entities (health maintenance organizations (HMOs), hospital systems, and pharmaceutical and biotechnology companies) on the American health care system [34]. In the US, investor-owned firms have come to dominate renal dialysis, nursing home care, inpatient psychiatric and rehabilitation facilities and HMOs [35]. They are likewise acquiring a significant share of acute care hospitals, outpatient surgical centers, home care agencies, and even hospices [35]. Services such as billing, auditing, transcription, and radiograph interpretation are being outsourced to the developing world. For-profit health care entities have been widely cited for higher death rates, lower quality of care, and higher administrative costs [35].

Luxury care will not solve, and will likely worsen, other problems with America's ailing health care system. For instance, patient and physician dissatisfaction with many aspects of our current fragmented health care system is growing [34-36]. Basic preventive services at recommended frequencies are commonly missed or delayed owing to time and financial

constraints [24, 25]. Investigators have already described erosion of 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 [37, 38]. Despite strong desire among patients to discuss out-of-pocket costs, such discussions take place infrequently, which contributes to high degrees of noncompliance with more expensive medications [39].

Our failure to provide universal coverage could lead some desperate patients to lie, for example by not disclosing a worrisome personal or family medical problem in order to obtain insurance or by exaggerating symptoms to obtain needed care. Physicians may be more likely to recommend services for insured rather than uninsured patients [38], and a sizeable minority of physicians admit to 'gaming the system' by manipulating reimbursement rules so their patients can receive care that the doctors perceive is necessary [40]. Moreover, increasing numbers of US patients are traveling abroad for heavily discounted, non-cosmetic, surgical procedures [41].

Meanwhile, many medical students and residents display increasingly cynical attitudes as their training progresses; some educators have expressed concern about the adequacy of students' humanistic and moral development [42]. Contemporary ethics training tends to address inadequately the socioeconomic, cultural, occupational, environmental and psychological contributors to the health of individuals and populations [43, 44].

Interest in primary care among medical students has been declining for much of the past decade [45]. Young physicians are leaving general internal medicine much faster than the subspecialties of internal medicine [45]. Increasing numbers of physicians have stopped seeing patients with certain types of insurance, complain of fatigue and burnout, and feel that medicine has lost its soul. Some are even leaving the profession. The proportion of US physicians providing charity care has declined from 76% in 1996-97 to 68% in 2004-05 [31].

DO PHYSICIANS RECEIVE LUXURY CARE?

To some degree many physicians have access to a form of special care for themselves and their families. Doctors can curbside their colleagues, write their own prescriptions (within limits), and sometimes see specialists whose skills they have observed directly. They can (and do) take drug samples intended for indigent patients [46], and tend to get more attentive, personalized care than the average non-physician patient.

On the other hand, the nature of the fragmented US system of health care insurance means that such special treatment is frequently not possible. As a result of changing my employment status four times over the last ten years, I have had four different primary care physicians under three different health plans. My family has mostly been covered by doctors outside the hospital system in which I work. I have waited as long as anyone else for emergency care and for routine medical and dental appointments, my choice of providers is limited, and I receive no special discount on a limited and changing array of covered pharmaceuticals.

Furthermore, it is not clear that, when physicians do get special care, it is better care. Self-treatment is ill-advised, and VIP care carries risks of both under-treatment and over-treatment. Moreover, such care violates the concept of fairness.

SOLUTIONS

Academic institutions have begun to heed the call of educators and policymakers to improve training in, and the practice of, professionalism in medicine [47-49]. 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 [50].

On the other hand, many training programs have adopted teaching models like 'The One Minute Preceptor,' which despite its laudable learner-centered emphasis, capitulates to decreasing visit lengths and the inadequate time available for student and resident teaching. As such, trainees might focus less on patient-centered care, which requires taking the time to understand the social, cultural, economic and religious contributors to patients' beliefs about their health and their abilities to respond to illness. We need to capture the interest and excitement of disillusioned trainees and practitioners, but yielding to methodologies that devalue talking with patients and reimbursement schemes that reward procedural skills far more generously than diagnostic acumen is not the proper approach.

Medical schools and professional societies have been relatively quiet on the subject of luxury primary care, no doubt in part to avoid drawing attention to their support of profitable enterprises which illuminate existing inequities in health care. Promoting luxury care in the face of current inequities perpetuates unscientific practice and erodes fundamental ethical principles of medicine such as equity and justice.

For teaching institutions to sponsor concierge care will engender even greater cynicism among student-doctors and the general public. Instead of continuing to promote an overt, two-tiered system of care, medical schools should renounce the measure of the marketplace as their dominant standard or value [51]; 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 [17]. 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. 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) [14]. Increasing alliances with industry could provide needed funds, but risk undue corporate influence on academic institutions' agendas. Patient input into systems changes, such as increasing the flexibility of appointment scheduling, could increase satisfaction and compliance and improve outcomes.

Physicians must educate the public and policymakers about the important roles they play in research, education and patient care, particularly in terms that are relevant to individuals and their families [13]. These ideas should be convincingly communicated to business

leaders, government representatives and purchasers of health care [13], 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.

Some might argue that food and shelter are as important as (if not more important than) health care, and that physicians are no more obligated to work for equitable and universal health care coverage than builders are to lobby for universal housing and farmers for food subsidies for the poor. I disagree. Article 25 of the Universal Declaration of Human Rights, adopted in 1948 by the United Nations' General Assembly, states: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' [52]. Leaving aside powerful arguments in favor of food and housing for all, which would in turn improve the overall health and welfare of the populace, physicians do have an obligation, borne of their privileged status, the public's investment in their training, and their roles as stewards of the public's health, to be politically active and ensure that our leaders provide for the sickest among us. This is especially true now, when fewer scientists hold positions of authority than in times past, and when scientific truths have been deliberately obfuscated by the well-funded and sophisticated public relations and lobbying campaigns of those with a vested interest in profiting from the provision of a basic human right like health care.

Role models for physician activism include Rudolph Virchow, Thomas Hodgkin, Margaret Sanger, Albert Schweitzer, Florence Nightingale, and innumerable individuals who labor, often anonymously, in support of the disenfranchised. Virchow argued that many diseases result from the unequal distribution of civilization's advantages [53]. He asserted the moral un-neutrality of medicine, and wrote: 'If medicine is really to accomplish its great task, it must intervene in political and social life' [53].

Furthermore, hospitals must be especially wary of corporate contracts which limit academic freedom and the dissemination of research findings vital to the public's health. Health care organizations should divest themselves of stock holdings in harmful products such as tobacco and advocate for strong laws and treaties to curb tobacco use and obesity, major contributors to morbidity and mortality [54]. They should develop strong policies regarding conflict of interest, especially surrounding the biotechnology and pharmaceutical industries. They should avoid associations with, and divest from, corporations whose business practices harm human health and/or violate human rights [7, 33, 54-56], as well as companies which conduct business in countries with oppressive human rights agendas [7, 33, 55-57]. Finally, they should support evidence-based humanitarian interventions and work toward solutions to poverty.

ACHIEVING HEALTH CARE EQUITY

The Future of Family Medicine report [58] echoes statements of the American College of Physicians [59] and other doctors' groups in calling for universal access. Unfortunately, all

their proposals leave in place our inefficient, wasteful, patchwork, mixed private and public system.

Some individuals advocate consumer-directed health plans, including medical savings accounts, yet fail to recognize that the average person lacks the factual data, research time, and choices needed to make a fully informed decision regarding coverage of current or future illnesses [60]. Cost-sharing leads to adverse outcomes for many people who cannot afford necessary care. Such individuals avoid preventive care, delay needed care, and are non-compliant with medications even when small co-payments are imposed [60].

Analyses show that the US, the only industrialized nation without national health insurance, can afford a single payer health care system. Such a system would be more efficient and effective than our current non-system and have significant advantages for patients, physicians, and businesses [61]. Such a system is supported by a majority of students, residents, faculty, and medical school deans [62] and was endorsed by the American College of Surgeons in the early 1990s.

CONCLUSION

Family medicine should not only withhold support for the development of luxury practices, but also vigorously oppose them, especially in academic medical centers. Family medicine should support a single payer health care system in the US and greater equity in health care delivery worldwide.

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