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DR. DANIEL CARLIN'S WORLDCLINIC DELIVERS AROUND-THE-CLOCK MEDICAL CARE TO ITS AFFLUENT CLIENTS, NO MATTER WHERE IN THE WORLD THEY MAY BE.

Global Healing

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BY RUSS ALAN PRINCE
I recently sat down with Dr. Daniel Carlin, founder and CEO of WorldClinic, a New London, N.H.-based medical concierge that—through the use of the Internet and other technologies—gives affluent executives, individuals and families access to doctors at all hours, anywhere in the world. A former U.S. Navy medical officer, Carlin founded WorldClinic in 1998 and is considered a pioneer in the field of concierge healthcare.

PRINCE: Let’s begin by you telling us about WorldClinic. What is it and what does it do?

CARLIN: WorldClinic is a total care private medical practice. We provide state-of-the-art medical diagnosis and treatment, on an anytime, anywhere basis. Though we are something of a high-tech operation in our use of the Web and digital technologies, our core culture is high touch and total accountability. By this I mean: Your problem is our problem, and remains so until its complete resolution by our doctors and staff.

Our core team consists of four full-time emergency physicians with another 15 supporting them or assisting them with special assignments. Our group’s operations are also integrated with the on-call schedule of more than 800 physicians and surgical specialists located at the University of Pittsburgh Medical Center and the Lahey Clinic in Boston. This direct connection gives us the ability to bring any specialist to the phone or video in less than ten minutes. We also have a long history of high quality referral relationships with virtually every major metropolitan medical center in the U.S.A. as well as a large number outside the United States.

PRINCE: Tell us about the range of medical services you provide.

CARLIN: The scope of our services is broad, but starts with a single promise: Wherever you are, at any hour of the day, our doctors will provide emergency diagnosis and treatment via phone, e-mail or video. To do so requires strong attention to detail and this quality extends into the rest of our practice. Whether it’s sourcing national field leaders for a complex disease or calendaring a personal plan for sustained wellness and longevity, the details of the case are crucial. Every day’s work is focused on managing the myriad of details required to deliver excellent healthcare to a population accustomed to excellence.

We customize the care plan for each client and there are a number of key services that must be fulfilled in order to create an exceptional plan. The collection and processing of medical records is principal among these services. The records are often in multiple states, among multiple providers. With these records, we can then create the personal prescription medical kits, lockers and even stand-alone care spaces required to meet each client’s particular needs.

One task particularly unique to WorldClinic is our detailed physician-to-physician research on foreign hospitals and doctors. The knowledge learned in person by our doctors is critical to making the right referral in a foreign country, especially in a crisis. For example, we know from the Web and commercial insurance travel assistance databases that there are three hospitals with a cardiac catheterization lab in Cancun, Mexico. However, after sending one of our doctors to Cancun to conduct personal interviews with the local physicians, we discovered that only one hospital actually has a credentialed interventional cardiologist. If you were having a cardiac event in Cancun, you would be a lot safer if you knew in advance which hospital to use.

PRINCE: You can be considered a concierge level healthcare provider. What are the key characteristics of WorldClinic that sets it apart from other concierge healthcare providers?

CARLIN: This is a great question. Concierge medical practices are a growing industry and are often a good fit for a family that does not travel much and lives near a large tertiary medical center.

Our practice differs from the typical concierge practice in three important ways.

First, most concierge practices confine their practice to business hours, typically 40 to 44 hours per week, and are affiliated with a single local hospital system. The care is delivered in the office and scheduled by a phone-in appointment. This model is generally inadequate for the typical high-net-worth family that wants access to a physician for the other 128 hours of the week, and especially when they travel.

Second, another way we differ is that our group is composed entirely of board-certified emergency physicians. This is a key point as the typical concierge physician is an internist or family practitioner who is seeing the same 1,500 patients over and over. Our physicians have each averaged more than 50,000 unique patient encounters over the course of their careers, giving them a very broad scope of clinical experience across all major medical and surgical specialties. This experience has given them a knowledge base far beyond the average concierge physician. This is critical when dealing with cardiac, trauma or pediatric emergencies, particularly those that are present in an unusual way.

Finally, over the last 14 years we have become experts in delivering emergency treatment over the phone and via Web video. If you are a risk planner, this unique capacity is essential for maximizing the odds for surviving a crisis and for less acute cases, it also means there is a good chance our treatment will be sufficient enough to avoid a visit to the local ER. This is particularly valuable on nights and weekends when most ERs are filled beyond capacity.

PRINCE: Can you give us an example of how you’re able to deliver emergency medical care?

CARLIN: To do this well, you have to put in place a defined sequence of events and detailed contingency plan. Our care model was well illustrated in the case of Walter Niessen (his real name is used with his permission) who suffered a serious heart
attack at 2 a.m. in his hotel room in Beijing. Walter had just flown in from Boston and awoke with crushing substernal chest pain and shortness of breath. He called our physician hotline and the on-call physician immediately deduced the severity of the situation.

Mobilizing his co-worker, our doctor instructed him to give Walter a nitroglycerin tablet, a beta-blocker pill to slow his heart, and an aspirin to thin his blood. These medications were all in the personal medical kit we gave him in Boston prior to departure. Simultaneously with these actions, our administrative team had contacted the hotel’s concierge who called the local ambulance.

In ten minutes, Walter was being loaded for transport, but there was a hitch: The local ambulance crew had a referral arrangement with a smaller hospital nearby. We quickly provided the funds to have Walter taken to Beijing Union Medical College, which was the only hospital in the city at that time with a 24-hour cardiac catheterization lab and a London-trained interventional cardiologist. While Walter was en route to the hospital, we brought a Mandarin translator online and relayed the details of the case to the receiving emergency physician, along with a copy of Walter’s medical record and his baseline EKG.

Walter’s first EKG in the ER was dramatically changed from his baseline EKG in Boston and approximately 75 minutes later, he underwent a rescue angioplasty and placement of a stent.

After 2½ days in the CCU, we flew him home to Boston and arranged his transfer admission to his home hospital. A copy of translated medical records with a fully detailed report accompa-
nied Walter and was relayed in a physician-to-physician report to the receiving cardiologist.

**PRINCE:** What happens if a patient is off the grid?

**CARLIN:** The short answer, at least among high-net-worth families, is that there is no “off the grid.” They bring their connectivity with them in the form of satellite phone and data link. We care for people on a handful of islands, ranches and remote super yachts that all have the means to connect. Sometimes we help them choose what to put in place using our medical care mission as the fundamental context for equipment purchases. The only place the satellite connection cannot be relied upon is at extreme polar latitudes—greater than 75 degrees north or south.

Occasionally, we will send along a paramedic or doctor for a more remote trek or safari. The driver for this escort is usually a parent or longtime friend whose health is not optimal and our staff is there to keep them healthy on a day-to-day basis for the length of the journey.

**PRINCE:** What happens after you’ve stabilized the patient?

**CARLIN:** After stabilization, we begin the plan to bring the patient home. We are fortunate that we have an evacuation partner who, in exchange for us paying eight times the regular premium, gives our doctors the right to direct the aircraft evacuation. This is a key difference in that most medical evacuation providers are their own insurers and have a built-in motivation to keep you in a foreign hospital long enough so that you can be flown home with a medical escort on a commercial aircraft. For our client base, that dynamic does not work. So we tend to admit, stabilize and call the jet pretty much all at once.

Another key issue is closing the information loop with the home hospital and primary care physician. We make sure that all the records get back, in English, and if there is a particular clinical concern, such as the possibility of a recurrent problem such as malaria, that the primary care physician is fully informed, on a doctor-to-doctor basis.

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**—DAN CARLIN**

**PRINCE:** You’re delivering the full array of concierge health services and an awful lot more. Why do you also focus on real-time emergency medical care?

**CARLIN:** We believe that the single biggest unmanaged risk for the high-net-worth family is a medical emergency. Their risk is compounded by three variables which the average person does not bring to the table: They often reside and travel to areas with limited care resources, like ranches and the tropical islands, and they are often too busy to manage all the records and details of their personal health. Finally, the need for total privacy is non-negotiable.

In emergency medicine, we often discuss the concept of “the golden hour.” This is the time window right after the onset of emergency where the right treatment will have its greatest impact. For cardiac events we know this period can be much shorter than one hour and the rapid administration of nitroglycerin and aspirin will be critical. For an anaphylactic reaction, the window can be as short as 30 minutes, and the only cure is an immediate Epi-Pen. Many people think they’ve got the golden hour covered because they live in a metropolitan area, but I can assure you this is not the case. Just imagine how long it would take to get to the ER if you found yourself in traffic on a Friday evening out in the Hamptons (in Long Island, N.Y.). You get the idea. You should have a plan that addresses that delay.

**PRINCE:** What do you do for your clients with ongoing medical conditions? What about clients who presently are not facing any medical concerns?

**CARLIN:** Our promise to the client is to deliver total care. This includes caring for serious and complex disease. For a patient with breast cancer, there are field experts to be sourced, rapid appointments to be scheduled, labs and diagnostic images to be shared, as well as 24/7 availability for the inevitable miscommunication and complications that arise when you bring so many resources to bear on the problem.

I’d also like to inform your readers of what I see as a worrisome development.

There are a number of companies in the business of finding you the best doctors for a particular problem. We’ve observed several physicians gaming the selection process, assembling and utilizing a group of colleagues to refer or recommend each other for the best doctors list. I would caution your readers to not put too much faith
in these lists and instead use their own physician to identify the research funded doctors most active in that particular field and, on an MD-to-MD basis, network from there. On a simpler note, a quick shortcut that we often use to find the best internist in a hospital system is to speak with the ER doctors and the local orthopedic group. Believe me—they know exactly where the talent is.

PRINCE: You’re known for being fairly selective in who you accept as a client. Can you explain your selection criteria and why you are so selective?
CARLIN: We are fairly selective, and frankly, we have to be.

Trust, cooperation, and mutual respect are the cornerstones for making our model work. If any of those elements are not a shared value between us, it cannot work. Imagine trying to manage a crisis with an adversarial spouse or a dishonest patient. The risk to all is egregious.

On an annual basis, we renew on average about 96% of our client base and as the years go by we have developed a strong and enduring attachment to our client families. It is deeply rewarding work in this regard. Unfortunately, there have been less than a handful of families that could not embrace our dynamic and we have opted to not continue the relationship.

I’m happy to report, however, that in 14 years of practice we have never been sued or fired for failure to perform.

PRINCE: Tell us a little bit about your background and credentials to deal with medical emergencies as they come up.
CARLIN: I left Carnegie Mellon with a degree in chemistry and philosophy in 1981 and Tufts Medical School with my M.D. degree in 1985. From there, things got interesting. I was a U.S. naval officer for three years, two of them as the chief medical officer for a guided missile cruiser (the U.S.S. Mississippi). When I was released from naval service in 1988, I took a year off to work in refugee camps on the Afghanistan border and later in the southern Sudan. I met my wife that year and came home to the U.S.A. to complete a residency in emergency medicine in 1992.

Those early experiences gave me a clear appreciation for the problems of delivering care in a remote place with limited resources, not to mention a broad experience of tropical and unusual infectious diseases. My ER training imparted me with what I think are the two most important skills for my current job: a capacity to quickly deduce the worst case scenario in any patient presentation and the experiential knowledge to treat it quickly, often improvising with the tools at hand.

PRINCE: What do you see as the future for medical care and for concierge healthcare?
CARLIN: I think there are some serious problems with the current system, but also some real possibilities for improvement.

In the short term, I think there will be a continued degradation of basic primary care and a worsening of the quality of medical care available to most people. This represents a significant opportunity for the field of concierge medicine, which will no doubt thrive as a result.

I am hopeful about a few promising trends, one of which is the steady promulgation of electronic medical record systems. This will be a game changer, as we know from our own personal experience. A well-organized electronic medical record system can

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endure the record system, whose access across individual physician’s practices and hospitals will enable most people to have something resembling a continuous chain of information about their personal health.

The other trend I am hopeful about is less technical. Among all people, both young and old, a dialogue has begun about the social contract of societal healthcare. The short version of what I am hearing is this: Young people are willing to pay for the healthcare of their seniors as long as the seniors are willing to do the things that keep them healthy and avoid the things that don’t. In essence, my kids agree to foot the bill if I agree to lose a few pounds, exercise a little every day, take my meds, and stay out of trouble with smoking and drinking. If this dialogue can advance, I think there’s a real chance to make things happen for the better.