Annual physical examinations

I am writing, as a retired family physician who performed annual physical examinations for more than 40 years, regarding your recent articles in the January issue of Canadian Family Physician. I often thought these annual health examinations offered no direct benefit to patients, but there was an indirect benefit because the examinations gave me time to do some health education with patients.

As part of this, for many years I used the Health Hazard Appraisal program from the Canadian government. This computerized program originally involved patients’ filling out a form and mailing it to offices in Ottawa for analysis and then receiving, some weeks later, a print-out of their results. Later we were able to run the program on a computer in my office. The results were easy to understand and showed any problem behaviour, such as not wearing seat belts, smoking, lack of exercise, and drinking and driving. The results showed patients’ current age and their assessed age according to their answers. Thus, they might be 22 years old, but have an assessed age of 44 because of their risk factors. They would then be shown how much they could reduce their risks if they followed the advice given.

I was struck by how honest patients were in answering the questions and how they accepted the advice. I think this program got more patients to quit smoking than my own advice ever did; they seemed to believe the printed word more than verbal discussions. Most patients were happy to do the questionnaire; many even demanded to do it year after year. Occasionally there were further indirect benefits. In one case I found the patient could not read or write; I realized that I had to change my approach to ensure this patient understood instructions.

There were multiple problems with this program, starting with the fact that with government cutbacks it was among the first to go. There was also no maintenance or development of the program. It was too generalized; the same questions were asked of all patients older than 18 (which were the youngest to start using the program). It needed to be different for each sex and various age groups. There was no aggregate statistical feedback about patients using the program, which might have been useful for future developments. There was no way for the program to do individual follow-up, such as asking if patients had changed in the past year. There was also no way to see whether the program was effective over time in improving patients’ health.

Another similar program, which I had the opportunity to critique, was developed by Dr Larry Weed, the developer of the problem-oriented medical record. It had a health appraisal incorporated into a medical record. One problem was that the program came with a disclaimer that any changes to the program would be up to the individual purchaser. Very few private doctors have the time or the knowledge to do this.

I think programs such as these could be very valuable in improving the health of Canadians. Such programs, however, need to be developed by a national group that would undertake to maintain and further develop them. Such organizations as the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, and the Canadian Pharmacy Association would have to oversee development. In the past, individual drug companies have developed partial programs, but devoted only to their own interests. A program developed by a national organization could be used in individual offices or run over the Internet. For offices that are not computerized, various provincial Colleges of Physicians and Surgeons might allow physicians to accept computers from an organization as there would not be any financial incentive to any drug companies.

—W.J. Blight
Winnipeg, Man
by mail

Strategic priorities and initiatives—crucial omission

It was nice to read in February’s Vital Signs (2006;52:271-2) about the College of Family Physicians of Canada’s efforts to revitalize family medicine. Sadly the article did not address the most critical issue—money. Being less than 2 years into practice, I am well aware that family doctors cannot speak of cash, for we are supposed to be wholeheartedly compassionate to our patients and to ignore our monetary issues. These sentiments are extinguishing traditional family medicine at a rapid pace. Currently, family doctors are greatly underpaid compared with specialists, physicians in walk-in clinics, hospitalists, and doctors focusing on cosmetic procedures. Until this drastically changes, with proper funding for family medicine, any attempts to revitalize family medicine will be hopeless.

—Dr Joelle Bradley
New Westminster, BC
by e-mail

Response

Thank you, Dr Bradley, for reinforcing this important point. The College has been and will continue to include the need for better remuneration for family doctors as one of our key messages to governments and...
Celebrating our role as generalists

The issue of family medicine as a specialty, while seemingly straightforward, is a critical discussion, as it speaks volumes about our own search for identity.

The question of whether family medicine is a specialty is subtly different from whether we wish to have it designated as such. Specialty can be a designation for a domain of knowledge, a political statement, or a prestigious term. We must be clear in what sense we are using the word. In the world of medicine, the term connotes extremely focused areas of knowledge or skills.

Specialism is, by its nature, reductionist in approach. It begins with a closely defined knowledge or skill category and focuses on this category to the exclusion of others. It arises out of the production model of activity. Ursula Franklin\(^1\) has argued that the production model is a product of prescriptive technologies, those that require complex tasks to be broken down into codified steps. In this approach a particular activity is reduced to its elements and each component is attended to by someone who is concerned only with that element, not with the overall process. Such models ignore context as an externality to be controlled for.

The growth model, on the other hand, is aligned with holistic technologies, which allow the worker control over making and doing and which emphasize context. Franklin clearly states that health care should be conducted using a growth model. Family physicians find it easy to think in terms of the growth model she describes; indeed, the fruit of this approach has been one of the contributions of family medicine to medical care in the latter part of the 20th century.

The re-emergence of family medicine as a distinct discipline began in North America 50 years ago and has grown, in part, in response to the move toward increasing specialization in medicine. Complexity science makes clear that, paradoxically, the more complex a system becomes, the greater need there is for generalist thinking.\(^2\) Family medicine has been developing and teaching a worldview that is distinctly different from the dominant one.

Taking the title of specialist is acceding to the language of the dominant medical model. It is the language of colonization. In an attempt to become “the noblest of Romans” we risk abandoning that which makes us unique.