Finding a better balance for the periodic health examination

I read the debate on abandoning the periodic health examination[1,2] (PHE) with interest. I can see the value of both arguments.

We might be overusing this examination. The PHE is the most common reason patients visit my office. I have a practice of 1300 patients; in 2008, I provided 564 PHEs. This was reduced to 503 in 2009 and 414 in 2010. Most PHEs are accompanied by investigations, such as blood tests, because of custom or patient expectations.

I am not convinced that every patient should have a PHE every year. It is not clear to me what the frequency of PHEs should be. I agree with Dr Howard-Tripp that electronic medical records (EMRs) can divorce some preventive services from the PHE; for example, we mail reminders for Papanicolaou tests or mammograms to patients who are overdue and the EMR has point-of-care reminders. We use automated reminders for chronic disease management, such as neuropathy examinations for patients with diabetes. The value of the PHE as an organizational tool might lessen as use of the EMR improves.

I value the added time to build a relationship with the patient that the PHE provides, as Dr Mavriplis discusses. As well, it is helpful to review aspects of the cumulative patient profile, such as family or social history. Although I try to discuss tobacco use during routine visits, this is most consistently done at the PHE; the visit is a good fit for addressing lifestyle risk factors such as diet and exercise.

I do not think a periodicity of a year is appropriate for PHEs. Several screening tests are recommended every 3 years (eg, fasting blood sugar and cholesterol levels for men aged 40 years or older). Trying to lengthen the interval between PHEs, perhaps to every 2 or 3 years, might be a pragmatic way to reduce the number of unnecessary investigations and visits while still providing an appointment focused on reviewing the cumulative patient profile, addressing prevention, and maintaining relationships with our patients.

I have reduced the annual number of PHEs in my practice by 27% since 2008. This has improved access for my patients—I am now using an open-access booking system (for same-day appointments). I think trying to reorganize a practice with a goal of reducing the number of low-value PHEs might be a pragmatic way to address this issue.

—Michelle Greiver MD CCFP
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Response

I thank Drs Dickinson,[1] Gray,[2] Bernstein,[3] and Greiver[4] for their contributions to the debate on the future of the periodic health examination (PHE).

Dr Greiver raises some interesting points. In the preceding 3 years she performed approximately 500 PHEs per year. I suspect that these are annual examinations of the same individuals year after year, and if so, what preventive care do the other 800 patients in her practice receive? Again I suspect that they receive preventive care as a component of acute care visits. Why would it not be possible, then, to schedule evidence-based preventive care at appropriate intervals, during visits for regular care, for all of her patients?

Five hundred PHEs a year translate to 1 full day per week, time that would be better spent on improving "open access" for all of her patients, and then some.

Dr Greiver also indicates that certain investigations and blood tests are ordered "because of custom or patient expectations." Why is the "custom" of an annual PHE so difficult to shake in favour of more evidence-based practices? The security associated with this annual ritual is ill-founded, and falsely reassures both physicians and patients alike. I wince at the suggestion that this is the only opportunity to properly communicate with patients, and again wonder about the state of physicians' communication with those who do not attend for PHEs.

The Canadian Medical Association is promoting dialogue on improving health care through the use of best practices and better use of available technologies. Unless change takes place from the ground up, renewal becomes mere political rhetoric. I urge all family physicians to take up the challenge and become the instruments of much needed change in the Canadian health care system.

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Not getting any closer

I read with great sympathy the Commentary published in the February 2011 issue[1] describing the authors' challenges following Dr Charles Mooney's radical prostatectomy. I see couples like this every month, and I feel their frustration. Younger men are often led to believe that their erectile recovery will be better than that of older men. However, in my practice at the Manitoba Prostate Centre, I do not necessarily see this. Erectile problems after radical prostatectomy are the result of a complex set of anatomical and physiological factors, including nerve damage (even with nerve-sparing surgery), penile tissue hypoxia, and vascular insufficiency.[2] Aggressive penile rehabilitation after surgery remains controversial,[3] and as it is expensive for the patient with no immediate benefit, attrition is high. But perhaps what family physicians need to do *before* developing resources for counseling and for specialized erectile dysfunction treatment is consider the evidence for and against prostate-specific antigen screening. I have commented previously in this journal[4] about the role of family physicians in treatment decision making for men with prostate cancer; however, perhaps prevention is better than cure. These same physicians should take a much closer look at their screening practices, and consider the often tragic trajectory from screening to treatment to lifelong consequences.

—Anne Katz RN PhD
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