Annual history and physical examination has been dead for decades

I read Dr Ladouceur's editorial in the January issue with interest.[1] When I was a medical student in the 1970s at McGill University in Montreal, Que, I was overwhelmed by the conflicting recommendations from various services to include specific questions and investigations in the complete examination—so overwhelmed that I took a 3-month sabbatical in my third year to explore this subject.

This resulted in a paper published in the *Canadian Medical Association Journal*[2] that challenged the conventional model of the "complete history and physical" examination and recommended 2 things: selective examinations based on the reason for the patient presenting, and getting to know the patient as a person in all her or his rich complexity.

A few years later, the Canadian Task Force on the Periodic Health Examination was formed, and in 1979 it published its report, which concluded that "the task force's main recommendation is, therefore, that the routine annual check-up be abandoned in favour of a selective approach that is determined by a person's age and sex."[3]

The reason the annual checkup has persisted for nearly 4 decades since these findings were first shared reflects the often convention-ridden and protocol-oriented core of much medical practice, embedded in a fee-for-service system that rewards many short visits and most procedural interventions more than it encourages careful and comprehensive critical thinking.

Then add in a certain amount of irrational paranoia about negative medical-legal outcomes if some clinical stone is left unturned. There is a conspicuous absence of downward pressure against the constant expansion of investigative procedures—especially our increasing reliance on computed tomography scans. There seems to be little appetite for truncating our relentless scanning for nonexistent diseases or "pre-diseases," most of which are simply proxy markers—lipid profile, hemoglobin A_{1c} level, or even blood pressure.

When I researched my paper 45 years ago, I found one research project that compared an exhaustive complete history and physical examination, replete with intricate questions and multiple investigations, with another approach that relied simply on 7 open-ended questions—questions like "Is there anything you'd care to tell me about your health?" and "Is there anything you might have forgotten?"—with no examination at all. The 2 approaches attained very similar comprehensive and useful results; neither was perfect, but both were effective. The advantage of the second approach, however, was that it was much less expensive, while producing similar patient benefits.

We need less paint-by-numbers medicine and more genuine and meaningful human interactions between doctors and patients.

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Competing interests
None declared

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Antimicrobial stewardship by family physicians

We commend Smith et al[1] on their efforts to measure knowledge about antimicrobial use and antimicrobial resistance (AMR) in Canada with a national survey. It is certainly a research gap worthy of attention. However, we have some concerns regarding the interpretation of the survey results.

The authors conclude that, based on survey results, "Canadian physicians are demonstrating behaviour patterns of AMR stewardship (eg, patient counseling, refusal to give inappropriate antibiotics)."[1] Although we agree that, in recent years, there has been increasing awareness about AMR and antimicrobial stewardship, we question whether these responses truly reflect the behaviour of Canadian physicians. There is evidence that clinician perception does not necessarily align with actual practice when it comes to antibiotic prescribing, suggesting that self-reported responses from a survey do not accurately reflect appropriateness of prescribing.[2]