Checking in on the annual checkup

In the article on periodic preventive health visits published in the November 2017 issue of *Canadian Family Physician*, Birtwhistle and the team from the Canadian Task Force on Preventive Health Care provide an excellent review of the (lack of) evidence that the traditional routine annual checkup decreases mortality in asymptomatic patients.[1] They propose attractive alternatives to reorganizing preventive services.

I am not sure, however, how much we can improve the landscape by redesigning one of the silos.

It is surely true that medicine is weighed down by the baggage of unproven interventions and unnecessary practices. Many waste time and resources, some harm patients, all rob us of opportunities to make care—and patients—better. This is true even for preventive care.

In theory there is no difference between theory and practice, but in practice there is. In family practice, there is no such thing as the asymptomatic patient, certainly not for people in middle age or beyond. Few patients have no targeted risk factors.

I have never seen a patient with hypertension or at risk of a cardiovascular event. I have seen Mrs Jones, who has hypertension, diabetes, vaginitis, depression, unknown lipid values, and a teenager who uses drugs. I have also seen Mr Gomez, Miss Anderson, and little Timmy. All were individuals, not diseases, interventions, or outcomes.

The Canadian Task Force on Preventive Health Care and the US Preventive Services Task Force have pioneered and refined scientific methods for evaluating the evidence to support recommendations for screening tests, preventive drugs, and behavioural counseling services. Family physicians have been important leaders and big beneficiaries of these advances.

The approach has been to parse diseases and clinical interventions into stand-alone entities for evidence review and analysis. Crisp as this method might be, it does not reflect the complexity of practice or the richness of care. Just as when we try to apply data from randomized clinical trials to primary care, we soon see that the map of controlled research does not match the territory of community practice. Primary care is the management of undifferentiated problems in unselected patients. It is not a series of decisions about how frequently to do a Papanicolaou test, or whether obesity counseling is indicated at this visit. Playing each note perfectly does not make for a virtuoso performance and certainly cannot create a symphony.

Doctor-patient encounters are routine only if we let them be.[2] The risk of the routine is even greater when the content and pace of care are driven by clinical protocols, algorithms, and productivity demands. Even routinely scheduled visits can quickly become key encounters. Some patients fail to recognize important symptoms, underestimate health risks, or need help changing behaviour. Just because the patient does not need an annual checkup does not mean she cannot benefit from a conversation with her personal physician. Just because she does not need a complete physical examination does not mean she does not deserve complete care.

The authors wisely call for "a more appropriate approach to delivering preventive services."[1] But we need more: a more thoughtful and powerful approach to delivering care to whole patients (and populations). Evidence-based preventive services are but one key component of value-based comprehensive care. Primary care is not a schedule of discrete encounters and services, but the orchestration of care delivered over time, across problems, and through conversations.

Birtwhistle and colleagues do emphasize that "preventive health service delivery should support the development and maintenance of the core ideas of the patient-physician relationship as part of providing continuity of care."[1] They understand that there is more to care and health than is dreamt of in meta-analysis.

The complete physical examination we were taught in medical school and hospital wards was never designed to be a prevention tool. It is little surprise that annual recital of the ritual is of little value.[3] What is exciting is our opportunity to ask meaningful questions, design high-quality research in primary care settings, and re-engineer the ways we connect with patients and deliver the care they want and need.

Do we have good data describing how many doctors and patients do annual checkups, complete physical examinations, or periodic preventive health checks? What do patients and doctors actually discuss and do at these "annual exams"? I suspect only a small part of the

interaction was ever about preventive services, physical examinations, or reviews of systems. Do we know how patients, doctors, and teams would like to organize regular interactions? Do we know what they want to get out of them? Can we measure the needs, expectations, services, and outcomes? What should, or could, occur at regular encounters between patients and their personal primary care physicians? As health care needs, expectations, and resources all change, we should ask the question of how best to use the time clinicians and patients have together.[4] Enlarge the primary care team and the questions become more complex and probably more important.

Prevention facilitators, waiting-room kiosks, and Web-based patient portals might contribute to getting services of proven value performed at recommended intervals. They might even help activate patients, improve shared decision making, and help patients change health-related behaviour. We agree that more research is needed to test such interventions and better funding will be required to implement what is demonstrated to work.

The challenge, of course, is that the processes and outcomes of greatest value might well be the hardest to measure. Interactions occur at regular or random encounters and outcomes might be seen only in the future at varying times and places. Family medicine is the specialty devoted to care of the whole patient, the whole time, and each visit is an opportunity to activate, orchestrate, and integrate. A conversation at the periodic health care visit might be the foundation for helping patients choose wisely[5,6] and for key decisions at later encounters in the office, emergency department, hospital, or hospice. The patient's (and family's) trust in the physician, built over routine encounters, might help avoid the unnecessary computed tomography scan for headache months or years later. Such discussions—and the relationships they help build—might help avoid low-value routine tests, inappropriate emergency department visits, or unneeded hazardous procedures. They might get the family on the same page for birth plans or end-of-life care. Just because these processes and outcomes are not easy to measure does not mean they are not important. If we leave them out of the discussion and off the research agenda, we threaten the appreciation and understanding of family medicine and primary care.

The value of family medicine and the importance of a continuous relationship with a personal physician are under attack from many quarters.[7,8] If we are to defend their potential, study their benefits (and harms), and pursue this shared vision, we must raise our sights to horizons beyond the silos.

The real question is not whether annual checkups are worthwhile, but how we can make scheduled visits and clinician-patient encounters as valuable as they can be.

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Competing interests
None declared

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Addressing the objections to an article

I want to respond to the objections[1,2] published in the April issue of *Canadian Family Physician* regarding Dr Gallagher's article "New category of opioid-related death."[3] Dr Gallagher is considered by palliative care physicians to be a leader nationally. She has helped physicians to prescribe opioids such as methadone safely by providing education on the Canadian Virtual Hospice with her Methadone for Pain in Palliative Care program. So, although it is fair to make points in favour of medical assistance in dying[2] or to ask about the extent of her opioid honoraria,[1] you might want to check out her curriculum vitae before trolling her. I work with elderly patients and in palliative care and I think we need to have open discussions about these topics.

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Competing interests
None declared

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Complexity of the opioid problem

I thank Drs Ferguson[1] and Weiss[2] for their letters in response to my article "A new category of opioid-related death,"[3] which was published in the February issue of *Canadian Family Physician*.

Dr Ferguson writes that the article is "touting the benefits of treating noncancer pain with opioids in the elderly by someone who has received honoraria from Purdue Pharma"[1] and claims it is akin to literature that he claims got the opioid crisis going. His black-and-white view of this complex situation is one of the reasons I wrote the article. I was concerned about my clinical experiences in treating pain in older adults. For a variety of reasons (fear of scrutiny of prescribing, fear of harming the patient, lack of interest) many physicians are not