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