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LETTERS TO THE EDITOR

Dear Dr. Radhakrishnan:

We are dismayed by an SGIM committee's recent admonition that physicians should see patients only "for acute illness, specific evidence-based preventive strategies, or chronic care management."[1] This advice to avoid periodic visits with patients that are not driven by a specific disease-based agenda ignores the human connection that has been central to the doctor-patient relationship for millennia and oversteps (and even misrepresents) the relevant evidence.

Doctors—especially primary care physicians—are not merely technicians of the body who perform maintenance at prescribed intervals. Truly patient-centered care requires intimate knowledge of our patients and an understanding of their values and perspectives about life and disease. Time spent getting to know patients as human beings may not yield readily measurable improvements in disease outcome but is essential to the art of healing. "Routine" visits allow us to learn about patients' changing life circumstances, understand their social situations and mental states, and raise our antennae for subtle signs of deteriorating health or substance misuse. We cannot expect patients to feel comfortable divulging painful secrets unless we have a relationship built over time. "The physical is not merely an anatomic exploration, but also a trust-promoting endeavor. It is the doctor's most ancient tool. Beyond providing a wealth of information it is an act of bonding."[2]

The two systematic reviews that the committee cited as the basis for its recommendation mainly demonstrate the paucity of relevant evidence—not evidence against health checks or so-called "routine" visits.[3-5] Moreover, the bottom line of one of those reviews was that "*evidence of benefits in this study justifies implementation of the PHE [periodic health evaluation] in clinical practice.*"

The other more-negative review specifically excluded elderly patients, found negligible data from the modern era, and mainly encompassed old studies of "add-on" screening interventions. Most patients in both the intervention and control groups of these studies had primary care doctors who, as has long been customary, saw patients for routine health checks. The intervention groups generally received additional screening exams (e.g. blood tests) administered by a clinic or physician separate from their ongoing primary care relationship.

For instance, Kaiser Health Plan's multiphasic screening trial, the largest and longest US study included in the review, was carried out between 1964 and 1980, predating the introduction of many of today's effective therapies. Both the intervention and control group patients were members of the Kaiser Health Plan who were age 35 to 54 at the outset. Both groups averaged 3.2 outpatient visits annually.[6] The intervention added to this routine care was an annual battery of lab tests, optional sigmoidoscopic and (for women) pelvic examinations, and a follow-up visit with a physician for a physical exam and review of test results. While the intervention group's death rate from potentially preventable causes (an outcome measure specified prior to the study) was 30% lower than among controls at 16 years (p=.012), the 2% difference in all-cause mortality was not significant.[7]

Eliminating visits that are not disease oriented on the basis of such flimsy—even irrelevant—evidence threatens the very foundations of doctoring. Why would we devalue the most important thing we have to offer? We ask that SGIM join us in repudiating this recommendation.

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Dear Dr. Radhakrishnan:

We appreciate the response regarding SGIM's recommendation about the value of periodic health examinations for the Choosing Wisely® campaign. The objective of the American Board of Internal Medicine's Choosing Wisely® campaign is "to promote conversations between physicians and patients by helping patients choose care that is: supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary."[1] We believe our recommendation regarding the value of periodic health examinations meets this goal.[2]

Himmelstein et al. critique the evidence behind our selection. While we acknowledge that there are limitations to the existing data, we disagree with the authors' response. Their citations include anecdote and process measures (the positive study they cite refers to benefits like "receipt of cholesterol screening"), and the cited meta-analysis found no benefit in clinical endpoints. In addition, their criticism fails to acknowledge the harms and burdens of unnecessary visits to patients, to doctors, and to the health care system. Indeed, in keeping with our recommendation, the most recent comprehensive Cochrane Review of the subject, the United States Preventive Services Task Force, and the Canadian Task Force on Periodic Health Examination have all recommended against routine general health checks for asymptomatic adults.[3-5]

It may not be surprising that the routine periodic health examination in healthy adults provides little objective clinical benefit. The first comprehensive assessment of a patient provides the most information. From the patient's history we learn about their genetic risk (i.e. family history), their social and economic circumstances, and physical conditions. Basic laboratory testing with this initial assessment seems reasonable. Once we have obtained this information and stratified patients by their cumulative risks, the value of repeating the review of the same information at a defined interval is unclear at best. Repeating the collection of the same information a week later would clearly provide little new information. The question becomes: What is the appropriate interval in low-risk adults for repeating the examination in the absence of clinical problems or the need for recommended evidence-based screening? A conversation around this issue is the point of our Choosing Wisely® recommendation. The healthy 30-year-old patient likely requires a different follow-up interval than the healthy 65-year-old patient. The provision of ongoing maintenance measures, such as immunizations and screening examinations, should be individualized based on the circumstances of each patient. This is most consistent with patient-centered care.

The emotional heart of the author's letter centers on how "beyond providing a wealth of information [the periodic visit] is an act of bonding." These subjective benefits need further evaluation and are not always patient centered. While concerns about threats to patient-physician trust with changes in the health care system are not new, there is little information about what defines trust and what interventions improve patients' trust in their physicians.[6] There is clearly a subset of patients for whom "bonding" with their physician is important. If patient bonding is the purpose of a regular visit, it should be driven by the values of patients and understood as such by payers. It should be an informed reflection of our patients' values, not ours. When a

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healthy patient takes an afternoon off work and has her blood drawn, does she know that the actual reason for the visit is to reinforce a personal connection? Is this a patient-centered visit? The value of "bonding" must be considered through a patient-centered lens within the larger context of the benefits and harms of routine visits.

Perhaps most importantly, the criticism of our recommendation misses its true purpose. As much as we also appreciate the importance of a patient-provider connection, it is not clear why it should happen at pre-specified intervals that are equal for all patients. Our recommendation was about assuring that these visits are tailored to individuals' needs, not based on pre-specified time intervals. We believe that focusing on individual patient needs for preventive care will best serve patients and our health system alike.

We appreciate the deeply held beliefs and commitment to patients that were demonstrated by the critique offered by our fellow SGIM members. We look forward to their constructive research engagement in providing new knowledge regarding the periodic physical exam. We support the goal of the Choosing Wisely® campaign to foster constructive evidence-based conversations between doctors and patients and are grateful for the opportunity to participate in substantive conversations among physicians to help advance that goal.

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Dear Dr. Radhakrishnan:

Many thanks for devoting an entire issue of *Forum* (November 2013) to mental health. The further along I go in my career, the more I realize that our lack of adequate training in behavioral health methods and therapies is a major weakness in our ability to provide (and to role model) excellent care.

I'm disappointed that the Affordable Care Act mandates parity (mental health benefits equal to other health services) but that we seem only to fall further behind, relegating our most seriously mentally ill to the very margins of society. Those with chronic mental illness have more comorbidities, die younger, and almost never vote or donate to political campaigns. It's incumbent on our profession (and I mean especially internists) to raise our voices and improve our knowledge base to help cope with the burdens of mental illness.

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