ensure that preventive care services are up to date. Other approaches, including automated methods of screening such as online health risk assessments, questionnaires delivered in the waiting room, and delivery of preventive care at any type of health care encounter, could better ensure that preventive care is current for the entire patient population. Payers could encourage such a shift by using pay-for-performance incentives.

Third, except for relationship-initiation visits, we recommend that health plans and federal payers no longer reimburse for annual physicals or use receipt of physicals as a measure of health care quality. Many private health plans have created a financial incentive for physicians to provide annual physicals by reimbursing for them at a higher rate than for other office visits. Eliminating this reimbursement differential would be an important step. The Centers for Medicare and Medicaid Services could also eliminate coverage for the annual Medicare wellness exam and change its policies to discourage Medicaid plans from paying for such visits.

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These payment changes would not eliminate all annual physicals — physicians would, in many cases, substitute regular office visits — but they would reduce their prevalence. Any savings achieved could be invested in other aspects of primary care, such as remote chronic care management or health coaching — care that's typically not reimbursed but that has been shown to improve outcomes.

Eliminating the annual physical might appear contradictory to our health care system's increased attention to prevention. Indeed, Medicare just began reimbursing for the annual wellness exam in 2011. But it is evidence-based prevention that's key, and the annual physical is not evidence-based: research has demonstrated both its minimal benefit and potential harms. We believe it's time to act on this evidence and stop wasting precious primary care time by having a third of the adult population come in for such visits. Eliminating coverage for annual physicals, shifting our approach to preventive care delivery, and creating and reimbursing for a visit whose sole goal is to establish primary care relationships are key first steps to move us forward.

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Toward Trusting Therapeutic Relationships — In Favor of the Annual Physical

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Continued enthusiasm among both patients and physicians for the annual physical (also known as the periodic health examination) despite the dearth of hard evidence for its benefit raises the question of what drives its persistent appeal. Educational efforts and financial incentives that encourage screening and prevention certainly contribute, but most evidence-based screening can be done without a specific annual physician visit. Perhaps the answer lies in the less commoditized aspect of primary care — people's desire or need to establish and maintain a close, trusting relationship with the doctor they consider their personal physician (a role that may also be filled by specialists providing principal care).

Much of the evidence for the

effectiveness and value of a trusted doctor–patient relationship derives from the mental health literature, which has extensively documented the requirements and benefits of a therapeutic relationship. Benefits include enhancements in functional status, patient satisfaction, and adherence to medication regimens,[1] valuable elements of all forms of medical care. Although there's some evidence that such relationship benefits are also achieved in primary care,[2] they've been harder to demonstrate in systematic reviews of the annual visit. Most available studies are observational, and the visits' contents are too heterogeneous to permit investigators to draw conclusions.[3]

In the current environment of time-pressured primary care, it's hard to envision having sufficient opportunity during a periodic health exam for the type of in-depth, personalized conversation necessary to create and sustain a meaningful doctor–patient relationship. The annual visit frequently becomes a rushed, impersonal, and largely bureaucratic exercise entailing little more than a brief interview focused on a review of health habits, medications, and allergies, supplemented by a perfunctory physical examination and ordering of recommended screening tests and procedures — in essence, checking all the requisite boxes for reimbursement. Patients report sitting and watching as their physician enters the required information into the computer. No wonder some observers question the value of the annual physical as it is currently implemented. Physician-ethicist-commentator Ezekiel Emanuel, for one, views it as an antiquated habit of little worth (and even of potential harm) that consumes scarce physician time; he has called for the public to skip it — while acknowledging that the opportunity to "reaffirm the physician–patient relationship" is an important draw for patients.[4]

Discussion about eliminating the annual physical should take into account factors that impede its robust implementation and limit its contributions to care, especially in terms of relationship building. Time and continuity are clearly in short supply in primary care, yet both are critical to establishing and maintaining a trusting doctor–patient relationship. There needs to be sufficient time for an unhurried inquiry into the aspects of a person's life (work, personal relationships, family issues, financial pressures) that can affect health and well-being. Eliciting and reviewing a person's values and health care preferences are important complements to that inquiry and help build a sense of caring, respect, mutuality, and trust. Trust is reinforced by the relationship's continuity and the availability, reliability, and safety of the care provided over time.

The perceived value of these elements of care is underscored by the generous out-of-pocket payments that patients make to "concierge" physicians for providing what were traditionally considered basic components of all primary care. Having insufficient time to do this type of doctoring is one reason commonly cited by physicians for their dissatisfaction with primary care practice and is a rationale frequently mentioned by those who convert their practices to concierge models.

Calls for abandoning the annual physical also ignore the powerful effect of the "laying on of hands," appreciated by healers over the centuries and recently documented in dramatic neurophysiological terms through functional neuroimaging. When performed in a thorough, gentle, and considerate manner, the physical examination can communicate caring and help build trust. From this perspective, the performance of the physician's annual physical examination becomes as much an act of relationship building and continuity as it is a means of searching for clinically significant findings. In this age of reliance on diagnostic imaging, physicians risk losing an appreciation for the therapeutic effect of the physical examination, not to mention the skills required to perform it.

The challenge facing primary care physicians is how to deliver a more personalized, more comprehensive care experience without shrinking panel sizes to concierge-practice levels, especially in the face of an expanding primary care agenda and increasing demand. One promising solution for enhancing the annual review is the multidisciplinary-team–based approach, exemplified by the patient-centered medical home model,[5] in which all team members contribute care at their highest level of training and certification. Freed of responsibility for personally providing the more commoditized elements of care (e.g., medication renewals, immunizations, routine referrals, screening tests, checking of vital signs, basic documentation) and supported by an interoperable electronic medical record, primary care physicians in medical homes

can devote more time to building and sustaining relationships. The periodic health exam visit becomes a team effort, with increased physician time for a more personalized in-depth review and a more comprehensive and satisfying overall experience for the patient. Sandwiching in such elements of care during problem-focused visits in lieu of an annual health review, as some observers have suggested, can be difficult, given the evaluation and management demands of these encounters.

New models of primary care delivery such as the medical home require shifting away from the volume-based fee-for-service payment that engenders rushed visits; ultimately, some form of comprehensive payment independent of visit volume (e.g., risk-adjusted capitation) might be required. Nonetheless, it's encouraging that even under fee-for-service arrangements, payers are increasingly recognizing the need to pay more appropriately for comprehensive annual reviews.

In sum, I believe that the annual physical should be improved rather than eliminated. Ideally, it might be a team effort that frees the physician from the more routinized aspects of screening, prevention, data collection, and recording to provide time for physician-optimized value-added elements. The physician's tasks would include review of all data collected by team members, an in-depth inquiry into aspects of the patient's life pertinent to health and well-being, and a review of personal values and health care preferences. For patients with active medical problems, a problem-based review could be included, complemented by a careful evidence-based physical examination for relevant items. The visit could conclude with a summation of findings, recommendations for the coming year, and time for discussion. An hour-long visit could include about 30 to 40 minutes of physician time, making it practical and meaningful for both patient and physician. In this conceptualization, the annual physical would become the annual health review.

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For low-risk patients (e.g., healthy young adults with health-conscious lifestyles), the interval between such visits might be longer than a year, but short enough to maintain the relationship and check on life events and stresses with health consequences. In locales where access to primary care physicians is problematic, the physician role for patients without complex medical issues could conceivably be assumed by well-trained advanced-practice nurses or physician assistants with physician backup.

With payment and practice reforms creating time for a revitalized annual health review, there is opportunity to enhance its value. Physicians would need no specific training to use this opportunity effectively: the tasks are those of basic good doctoring taught in medical school and valued as elements of medical professionalism.

Pending advances in measurement science that permit better assessment of the effects of relational elements of doctoring, it seems reasonable for physicians to redouble their efforts to build meaningful relationships that can be trusted and sustained, particularly at a time when patients are encountering an increasingly problematic delivery system. Turning the annual physical into an annual health review represents an opportunity to create new value for both patients and doctors, enabling the latter to serve as physicians rather than merely health care providers.

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