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I hypothesize that physicians who structure their practice around the annual examination have higher rates of adherence to quality measures, and their patients have a stronger sense of their medical home and are more likely to access continuity of care when needed.

To extend the recommendations by O'Malley and Greenland,[2] we need research that explores how to best structure an office practice for patient satisfaction, physician satisfaction, and quality care. In my experience, the annual examination has been an effective tool to organize complex care and to strengthen the physician-patient relationship.

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The Annual Examination: A Touchstone for Contextualized Care

Prochazka et al[1] address the lack of evidence for the annual examination. In the accompanying editorial, the authors ask if physicians and patients might be telling us something by their preference for it.[2]

As one of the first 16 physicians recognized for both cardiovascular prevention and diabetes care by the National Committee for Quality Assurance, as a member of a clinic whose patient satisfaction was ranked top 10 in the nation, and as a physician committed to patient-centered quality, what I would tell is this: I structure my entire practice around the annual examination. It is when I address prevention, coach patients on healthy lifestyles, and do the annual review of each chronic medical condition. Invariably, patients bring new symptoms for evaluation as well. It is a complex visit, focused on integrated, longitudinal care.

One can dissect the endeavor and point to the lack of evidence for listening to the lungs in an asymptomatic patient, and I would agree and might not do it, if not for the art of medicine—it gives me a chance to touch the patient—or the burden of medicine, bullet points and all. But to focus on pulmonary auscultation and not on the overall organization of care that occurs is to miss the main event.

Calls for doing prevention on the fly, catch as catch can, one more thing to add to the mix of responsibilities when a patient happens to present for a sick visit, is too loose for me. I prefer to be intentional about both prevention and chronic disease management. Americans are only getting 50% of the recommended medical care.[3] It is worth considering the role annual examination could play in increasing the overall quality of care patients receive.

Omission of Drug Dose Information

Participants of the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) continue to write descriptive articles that omit the information on the dose of the drug used.[1] This is especially important in the case of renal disease, for which the issue of the effectiveness of an angiotensin-converting enzyme inhibitor is addressed. The study design allowed the use of as little as 10 mg of lisinopril, which is too low a dose for efficacy. Many readers would like to know whether 3% of the patients were receiving 10 mg of lisinopril or 30% or more than half. Did the dose influence the outcome? We will have to reserve judgment on the meaning of the data until that information is available.

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In reply

We appreciate Hollenberg's interest in our article.[1] As reported previously, participants were assigned to chlorthalidone (12.5-25 mg/d), amlodipine (2.5-10 mg/d), or lisinopril (10-40 mg/d). The distribution of doses prescribed at years 1, 3, and 5 are given in the **Table**. *At year 1, the low-*