

Letters

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Patient-held clinical guidelines for hypertension — a step too far?

The aim of the study by McKinstry and colleagues¹ was to determine if a clinical guideline posted to patients with hypertension improved their blood pressure control with the underlying assumption that any improvement would probably be due to patient empowerment.

As part of the routine patient–health professional relationship patients should be fully informed about what high blood pressure is, why it needs to be treated and how this could be achieved, including a discussion of possible lifestyle interventions. However, rather than empowering patients to take control of their health, the guideline was in effect asking patients to audit their own treatment. It should not have to be the patients' responsibility to ensure that they receive good basic health care.²

The study design used by the investigators was also unlikely to show any difference between the intervention and standard care, regardless of the underlying assumptions. The same health professionals were providing treatment to both groups of patients. Therefore, when they became aware of the guidelines, which presumably occurred during the set up of the trial, it would be difficult for them not to provide the same care to all patients. The power of the study was also reduced — according to the data at baseline, the accuracy of which is unknown, 50% of participants already had controlled blood pressure. Finally, the conclusion that it caused no harm needs to be reviewed. The HADS depression

and anxiety scores were both increased at the end of the trial to higher levels in the intervention group, although not significantly.

An alternative use of the resources used in the study would have been to train the health professionals to provide good care, use the hypertension register to set up a system of routine appointments and develop clinical audit to ensure standards. If problems arose, such as patients not attending, an analysis of the reasons could then be undertaken, with perhaps a more suitable, targeted intervention being designed and piloted.

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REFERENCES

1. McKinstry B, Hanley J, Heaney D, *et al.* Impact on hypertension control of a patient-held guideline: a randomised controlled trial. *Br J Gen Pract* 2006; **56**: 842–847.
2. National Institute of Health and Clinical Excellence. *Hypertension. Management of hypertension in adults in primary care.* NICE clinical guideline 34. London: National Institute of Health and Clinical Excellence, 2006.

Authors' response

We agree with Dr Smith and his colleagues that as part of routine care patients should be fully informed about blood pressure and how it may be ameliorated. We also know

that there are well defined, agreed guidelines for blood pressure control with which doctors, for one reason or another, do not comply. This intervention was an attempt to empower patients, partly through education and partly through exhortation to challenge their care, to ensure that they were getting the best possible treatment. Clearly, it would have been better if their care had been superb and such intervention was unnecessary, but we believe the practice that undertook this study at the time was little different from most others with regard to the management of blood pressure.

We included patients whose blood pressure was already controlled because a significant portion of such patients will become uncontrolled over time. If that were not the case then there would be little point in following up patients once control was achieved.

We anticipated that the biggest impact on the HADS of the intervention would be shortly after patients had read the guideline and possibly became concerned about their care. In fact the HADS score for both intervention and control information fell significantly in the 2 weeks after the guideline was distributed ($P = 0.02$ for the anxiety component and $P = 0.001$ in the depression component). The rise at the end was not statistically significant.

We agree that well organised care is an effective method of managing blood pressure, but our trial was to determine if a simple patient intervention (such as is being proposed for many chronic illnesses) improved outcomes. Our work, for all its limitations suggest that this is not a course of action, despite its seeming logic, that should be undertaken without further study.

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Connecting for health

I really do not think that Connecting for Health's *Care Record Guarantee*¹ has been properly thought out. I am particularly concerned about the final two commitments:

11. We will keep a record of everyone who accesses the information the NHS Care Records Service holds about you. You will be able to ask for a list of everyone who has accessed records about you and when they did so.

There may be times when someone will need to look at information about you without having been given permission to do so beforehand. This may be justifiable, for example, if you need emergency care. We will tell you if the action cannot be justified.

12. We will take action when someone has deliberately accessed records about you without permission or good reason. This can include disciplinary action, ending a contract, firing an employee or bringing criminal charges.

These commitments seek to protect patients from those who would abuse their positions with respect to other people's data, but they completely fail to protect the innocent who have to look at many patients' records for various reasons every single day. Those in general practice who have to look into records to understand why any particular patient was

showing up as outstanding on one of the Quality and Outcomes Framework areas; to discover when a patient was last seen; to see if a patient was or was not on certain medication; to see if the patient usually has medication sent to a particular pharmacy; to check whether another member of staff had taken the correct action in relation to some matter regarding a patient; and so on and so forth, will simply not be able, days later, to recall why they did so, and so will be unable to justify themselves. I look at dozens of patient notes every day and as soon as the next day will probably have forgotten why I did so. In these circumstances — and I cannot believe I am unique in this regard — how will one be able to demonstrate that they looked at any given patient's records legitimately? One simply will not be able to. The care record guarantee is thus unrealistic and unworkable in this regard.

A senior information officer at NHS Connecting for Health merely tells me that in such situations the courts may have to decide whether I was guilty or not of any offence. He does not suggest what defences might be open to me when I say I cannot remember.

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REFERENCE

1. Care Record Development Board. *The care record guarantee: our guarantee for NHS care records in England*. London: Department of Health, 2006.

Correction

Some errors occurred in the article: O'Flynn N. Menstrual symptoms: the importance of social factors in women's experiences. *Br J Gen Pract* 2006; **56**: 950–957.

The final sentence of the introduction (page 951) should read: 'An explicit recognition of the social rules relating to

menstrual behaviour in our society may provide a context in which women's needs and choices can be more clearly understood.'

The final sentence of the third paragraph in the Method section (page 951) should read: 'Coding and the development of analysis were discussed with an experienced qualitative researcher.'

Point 2 of Box 1 on page 952 should read: 'She should avoid any episode of staining or leakage by changing activities, and/or by wearing adequate protection in advance of her period.'

The second sentence of the first paragraph on page 955 should read: 'Simone was 57 years old and had experienced heavy periods for many years.'

The fourth sentence of the first paragraph of the section Strengths and limitations of the study (page 956) should read: 'However, the verbatim accounts do not adequately communicate women's horror and fear of leakage threats which were emphasised by facial expressions and physical movement.'

The corrected version of this article is available online at www.rcgp.org.uk/bjgp.