follow-up visits showed that patients had few problems using their home blood pressure monitors and knew that their target for home blood pressure is <130/80 mmHg[2] (as we printed this on labels which were stuck to monitors). However, when patients initially consulted their GPs and showed them their recordings of consistently well over-target home blood pressures, no changes were made to their antihypertensive treatment.

We have therefore developed additional trial information to post to participants' GPs. This includes information on home blood pressure targets (10/5 mmHg lower than clinic blood pressure[2]) and current antihypertensive guidelines.[2] We also developed information for patients with a note for their GP to facilitate discussion about blood pressure targets and to support home blood pressure monitoring. Preliminary reports from both GPs and patients suggest this has been beneficial and led to agreed treatment changes and improved blood pressure control.

As Greaves and Campbell point out, 'Only a minority of people with hypertension achieve target levels for control'. Stroke patients are often highly motivated to consider self-care interventions which will reduce their risk of having another stroke. For those who wish to monitor their blood pressure at home, the support and involvement of the primary health care team is crucial.

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REFERENCES
1. Greaves CJ, Campbell JL. Supporting self-care in general practice. *Br J Gen Pract* 2007; **57(543):** 814–821.
2. Williams B, Poulter NR, Brown MJ, *et al*. Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004-BHS IV. *J Hum Hypertens* 2004; **18(3):** 139–185.

Patient choice

The fascinating paper by Bryant *et al*[1] on patient choice highlights the impact of healthcare policies on human behaviour.[1]

One area that particularly interests me is the concept of choice in relation to abortion and how it may affect decision making.

If 'framing a decision as a choice can enhance the perceived value of a particular option',[1] perhaps the default state for a society in dealing with crisis pregnancy shifts towards abortion and more women may opt for it.

I am at the anti-abortion end of the spectrum of opinion on this issue and realise that most GPs pitch camp elsewhere. But it strikes me that most people agree it would be better for those women (an unknown percentage) who have a termination only to regret it, to somehow be enabled to make a different choice if it is right for them.

Research into this area of decision making will undoubtedly be challenging, but it may help some of those women for whom pro-choice is no choice at all.

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REFERENCES
1. Bryant LD, Brown N, Bekker HL, House A. The lure of 'patient choice'. *Br J Gen Pract* 2007; **57(543):** 822–826.

Continuity of care

I read with interest the views of James Willis[1] on the need for continuity of care: it is certainly an area where there should be increasing debate in what is otherwise an age of increasing fragmentation of medical care. I think it is important to remember that when a diagnosis is made and a care plan agreed on, it is exactly that, a plan that is agreed mutually between patient and doctor. Therefore, ones prior knowledge and ability to relate to the patient in questions are extremely important.

However, I would also argue in an age of protocol-driven health care that there are perhaps more important things going on in a consultation for which we don't readily have the scientific measurement. Our instincts as physicians and ability to tune into unconscious communication means that sometimes we quite appropriately run over zealous 'diagnostic algorithms' past seeming trivia, and equally seek to reassure those whose symptoms on the face of it sound alarming!

It is experience and personal knowledge of the patient and family that allow one to deal intuitively with some of these apparently unscientific incongruities that face us all the time in general practice. Furthermore and not insignificantly, by and large, most physicians enjoy continuity of care but, I think equally so, find it difficult to pick up threads in complex cases where patients have seen many different doctors sequentially.

General practice is a vocation where continuity of care enhances the patient's experiences and outcome rather than its 'bureaucratocentric' health care (apologies for neologism).

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REFERENCE
1. Willis J. The publish properly trap. *Br J Gen Pract* 2007; **57(541):** 671.

Correction

In the November 2007 issue of the *BJGP* (volume 57, page 857), the Contents page should have included the following entry:

919 **Viewpoint** — Prescription benzodiazepines and z drugs — the hidden story', Allan Weatherburn.