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The use of written material in consultations

The November and December issues of the *BJGP* have featured interesting studies on the use of written information in consultations. First the University College London study¹ in the November issue described patients' experiences of presenting health information from the internet in GP consultations. Then in the December issue a Dutch study² reported the effectiveness of physician-targeted interventions to improve antibiotic use for respiratory tract infections.

The findings of these studies are important as they affect the way all of us consult. While it is reassuring that patients prefer information from a physician than a written resource, and I agree that there is no substitute for effective individualised face-to-face communication, I worry that these results dismiss the role of written information and potentially conflict with the growing interest in telemedicine. I will continue to be an advocate for patient education and the use of written resources as a supporting tool. Good communication-skills training needs to remain high on the GP training agenda, but with the inclusion of how to acknowledge the information presented by patients and how to use written information to enhance our explanations rather than replace them. With patient satisfaction surveys becoming an integral part of the revalidation process, further research into this area will no doubt be important for improving patient care and

successful professional development.

Developments in telemedicine are likely to increase in the future due to its potential to be more cost effective than more traditional models of care. I expect telemedicine to be challenging due to the need to make treatment decisions remotely. As anyone who has experience in telephone triage will appreciate, the use of careful history taking, safety netting, and good record keeping is likely to be even more important in an electronic setting. And if we have evidence that patients prefer face-to-face explanations, should we be directing our research in telemedicine into where it will be most effectively used? Are there situations such as chronic disease management and routine outpatient follow-up where telemedicine would be more relevant? I look forward to developments in the use of technology in health care but hope that patient preferences and the clinical challenges are fully appreciated when telemedicine is more extensively introduced.

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Problems with hypertension guidelines

Congratulations to Schofield *et al*¹ on their thought-provoking paper looking at hypertension and ethnicity. Three points occur. How useful are NICE guidelines, and in terms of an ethnic population, how accurate are they? Also in an era of austerity could they be harmful to patient care? Adherence to NICE recommendations was relatively low in the inner-city population studied. No evidence was found of

significantly poorer control in patients on any of the 'incorrect' treatments. In 2006² and 2011² the National Institute for Health and Clinical Excellence (NICE) has stratification of antihypertensives. Other contemporaneous guidelines disagree. The 2007 and 2009³ European Society of Hypertension (ESH) and European Society of Cardiology (ESC) concluded all diuretics, ACE inhibitors, calcium antagonists, angiotensin ii receptor blockers (ARB), and beta-blockers were suitable for the initiation of and maintenance of antihypertensive treatment. ESH argued the traditional ranking of drugs into first, second, third, and subsequent choice with an average patient as reference has little scientific justification.

The American Joint National Committee 7 (JNC) (2003) soon to be superseded by JNC 8 concluded that thiazide diuretics were unsurpassed in preventing the cardiovascular complications of hypertension. Australian 2010 guidelines contradicted NICE arguing that in uncomplicated hypertension ACE inhibitors, dihydroperidone calcium channel blockers were equally effective as a first-line treatment. The World Health Organization (WHO) in 2007 published a document offering a further variation. Given that non-adherence made no difference to blood pressure control and the differing opinions of other authorities, how useful are the current NICE guidelines?

The area of ethnicity is interesting in blood pressure guidelines. Schofield points out that lower renin levels in young black people reduce the response to ACE inhibitors. This is well known. Studies have traditionally neglected both ethnic minorities, and that 50% of the population who happen to be female. The ALLHAT⁴ study was correctly praised for having ratios of 47% female, 35% black American, and 19% Hispanic. ALLHAT provided part of the justification for NICE's recommendation for thiazide diuretics if calcium channel blockers were ineffective for black people of African-Caribbean descent of any age. But ALLHAT looked at patients of 55 years or older, the mean age was 67 years. It provided no evidence for those under 55 years. It didn't look at black British people. Johnson observed that many black British people may belong to what is now viewed as an emergent 'mixed' origin population of the UK that can be genetically significantly different from black Americans. The evidence for NICE guidelines in ethnic minorities I would argue is weak and may answer Schofield's question as to why GPs and patients in this study opted for