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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

alternative treatment regimes.

Majeed's⁵ editorial noted that general practices in England could face reductions of 20% in their annual budgets. Is it only a matter of time before prescribing is limited? Could this be based on guidelines with a weak evidence base?

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Asking the shisha question

In an excellent editorial, Jawad and colleagues¹ highlighted the need for increased awareness of the prevalence and health effects of shisha pipe smoking. By not asking about shisha use, GPs may be missing the opportunity to give smoking cessation advice.

In each of the past 3 years, a St George's medical student has conducted a research project on shisha pipe smoking. In the first survey conducted in 2010, Sajjaad Ismail gave a questionnaire to consecutive shisha café attenders in Manchester. The response rate was 85% (202/237). We found that 40% (95/237) of responders did not know

the constituents of shisha, 52% (123/237) were unaware of the health risks, and 40% (95/237) would not tell their doctor about shisha if asked about smoking.

A similar survey by Abdelaziz Elgindi of 103 shisha café attenders in London in 2011 (response rate 94%, 103/110) found that of the 42 responders who also smoked cigarettes, 89% (34/38) reported that smoking shisha relieved the cravings they had for cigarettes compared with only 52% (22/42) who said that cigarettes relieved the cravings they had for shisha ($P = 0.001$). A head of shisha is estimated to contain around 10 times as much nicotine as one cigarette.²

Most recently in 2012 David Rawaf conducted an online survey of medical students at St George's, London, with a response rate of 62% (137/222), of which, 65% (89) were white, 11% (15) Middle Eastern, 10% (14) Indian, 7% (10) Pakistani, with the rest Bangladeshi, black, Chinese, and others. It was found that 79.4% (43) have smoked a shisha pipe before, of which the majority are white (58%, or 25). However, only 12 students were 'regular' shisha smokers (more than once a week), out of those, three smoked cigarettes. Of the regular smokers, six were Pakistani, four were Indian, and one each of black and white origin. The majority of responders (79%, or 108) did not smoke cigarettes, with 77% (83) having smoked a shisha pipe once. As an aside, it was discovered that medical students had a good understanding of the constituents and health risks of shisha, and most (85%, or 116) felt that clinicians should ask about shisha smoking.

As can be seen, shisha smokers are from varying backgrounds, so it is indeed a culture-wide trend, especially among students. However, the dangers are not fully understood by the public, and it is on the shoulders of current and future clinicians to raise awareness.

We agree with Jawad and colleagues that GPs, particularly those working in areas with many ethnic-minority patients, should consider 'asking the shisha question'.

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PHQ-9

The advent of the PHQ-9 has changed depression assessment in primary care in the UK. The 9th question always troubles me when I look at the record of the consultation. The question asks whether the patient has thoughts that they would be better off dead or hurting themselves in some way in the last 2 weeks. When this question scores positively (that is, scores 1, 2, or 3), a GP must further assess and clearly document the patient's suicide risk in that consultation record. This can often be missed in the complexities of the consultation.

We are under enormous time pressure, but this is always necessary. It worries me that the form filling would be considered to suffice.

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Enhancing consultations with interpreters: learning more about how

I am a GP who has worked for 15 years in inner-city London. I also work at the Helen Bamber Foundation for victims of cruelty. This is a non-NHS role and one of my duties is to liaise with our patients own GPs ensuring that they have access to good quality health care. Our patients are often extremely traumatised victims of torture