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## Editor's choice

We were interested to read the article by Glew and colleagues on opt-out testing for HIV.<sup>1</sup> In 2009, our team demonstrated the feasibility and acceptability of opt-out point-of-care (POC) HIV testing in general practice. Building on these data we have undertaken a cluster randomised controlled trial of opt-out POC HIV testing in primary care. In the RHIVA2 trial, all general practices in Hackney were invited to take part.<sup>2</sup> Forty of 45 practices were randomised to either intervention (testing) or control (usual care). Intervention practices received education and training to promote and deliver opt-out POC HIV testing to new registrants. The trial data are very encouraging. We observed a POC testing uptake of 45% (4978 of the 11 180 rapid tests offered were accepted). Intervention practices identified more patients with newly diagnosed HIV than control practices. Furthermore, patients in the intervention practices were diagnosed with higher baseline CD4 counts than in the control group.

We recommend that HIV testing be introduced in UK general practices located in high HIV prevalence areas.

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DOI:10.3399/bjgp14X679969

## What did the questionnaire say?

It is a cause for serious concern that many

at-risk patients in Holland use OTC NSAIDs, presumably without knowing the risk they take.<sup>1</sup> However, the authors do not indicate in their paper whether their questionnaire asked only about oral preparations. Topical NSAIDs are very popular in the UK and it is likely that they are much safer (though perhaps also much less effective), and if some of the patients in this survey used these, the results would be less worrying. The wording of the questionnaire is therefore crucial, but is not disclosed even in the online version of the article. Nor do the authors indicate which NSAIDs their sample admitted to using, and there are huge differences in gastrointestinal risk between the different drugs.

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DOI: 10.3399/bjgp14X679981

## Authors' response

In the first questions of our questionnaire we did not make the distinction between oral and topical preparations expressly clear,<sup>1</sup> although the Dutch word for 'painkiller' was used, which would suggest an oral formulation. However, in later questions we explicitly asked participants about the number of tablets/capsules/sachets/suppositories used per day. The use of NSAID gel was not an option. This question was answered by all but one of the 35 OTC NSAID users in the general population, and all but one of the 33 OTC NSAID users in the high-risk sample. It is possible that these two participants failed to complete this question because they had used topical NSAIDs. Even if this were the case, the prevalence of OTC NSAID use would still be 29% in the general population and 12% in the high-risk sample.

With regards to the types of NSAIDs used

by the participants,<sup>1</sup> these are reported in the results section of our paper: 54% concerned ibuprofen, 28% high-dose acetylsalicylic acid, 9% diclofenac, and 9% naproxen. In the high-risk sample, these percentages were: 53% high-dosed acetylsalicylic acid, 29% ibuprofen, 11% diclofenac, and 8% naproxen.

Those interested may contact the corresponding author directly, as we are happy to supply a copy of the original questionnaire and a translation into English.

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DOI: 10.3399/bjgp14X679993

## Assessment of risk communication

Lyndal Trevena discusses the influence risk communication has on patients' perceptions of risk and the importance of clear, effective communication in order to aid good quality decisions and shared decision making.<sup>1</sup>

Having recently made a successful application for GPVTS, I feel there is a place for assessment of risk communication skills as early as selection into the training programme, as this is such a key competency needed in general practice. Although the selection process effectively assesses both communication skills and clinical problem solving skills separately, the assessments do not integrate these two aspects. Evidence shows that using quantitative information improves the accuracy of risk perception, but there is a delicate balance between presenting this information appropriately to the patient, and overloading them with statistics and jargon that they would find difficult to process.<sup>2</sup> This skill could be assessed, for example, in a simulated scenario where the candidate is given statistics such as Number Needed to Treat for a particular medication. The

candidate is then required to explore the patient's ideas, concerns and expectations, and by using any significant information gleaned from that discussion explain the need for the medication, incorporating any statistics provided on the candidate sheet. In this way assessment of risk communication can be incorporated into a station assessing other skills such as empathy and problem solving, reflecting 'real world' clinical practice more accurately.

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DOI: 10.3399/bjgp14X680005

## Communicating risk

Harmsen *et al.*'s interesting paper<sup>1</sup> on risk communication relates closely to work published 13 years ago in this journal. Misselbrook and Armstrong<sup>2</sup> used a hypothetical scenario to look at the effect of giving patients the same statistical information in different ways: 75% said they would accept medication if given the absolute risk reduction, whereas only 44% would if given a 'personal probability of benefit model'. This is echoed by Harmsen *et al.*'s finding that giving information in a form chosen to be as comprehensible as possible reduced the subsequent uptake of preventative medication; what their study adds, as they say, is supporting evidence based on 'real patients'.

Given the current controversy about statins, this paper is particularly timely in highlighting the tension between being patient-centred and promoting population benefit. Within the extensive literature about this tension, two particularly useful contributions are Summerskill's account<sup>3</sup> of a GP consultation about statins, and Gupta's<sup>4</sup> discussion of the ethical and cost-effectiveness issues involved. These issues are central to considering how evidence-based medicine and shared decision-making interact.

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DOI: 10.3399/bjgp14X680017

## In general practice, doctors record higher blood pressures in the presence of students

The authors of the interesting review come to the conclusion that the white coat effect is greater for blood pressure measurements made by doctors than by nurses.<sup>1</sup> In our trial, patients were randomised into a 'trainee' group ( $n = 133$ ) and a 'no trainee' ( $n = 129$ ) group. The blood pressure was measured at two subsequent contacts. In the 'trainee' group, a student was present at the first visit only. In the 'no trainee' group, both visits were without a student. At the first visit, systolic pressure was higher in the 'trainee' group than in the 'no trainee' (control group) (139.5 versus 133.1 mmHg,  $P = 0.004$ ), with a similar trend for diastolic pressure (80.2 versus 77.8 mmHg,  $P = 0.07$ ). From the first contact to the follow-up visit, blood pressure decreased in the trainee group by 4.8 mmHg systolic ( $P < 0.001$ ) and 1.7 mmHg diastolic ( $P = 0.03$ ), whereas the corresponding changes in the control group were  $-0.1$  mmHg ( $P = 0.90$ ) and  $+1.5$  mmHg ( $P = 0.03$ ). Thus, the between group differences in these trends averaging 4.7 mmHg (95% CI = 1.5 to 7.9,  $P = 0.005$ ) systolic and 3.2 mmHg (95% CI = 1.1 to 5.3,  $P = 0.003$ ) diastolic were statistically

significant. We concluded that in teaching practices, the presence of a doctor-in-training has a significant pressor effect when an experienced GP measures a patient's blood pressure.<sup>2</sup> If confirmed, the findings imply that doctors should be cautious to initiate or adjust antihypertensive treatment when blood pressure readings are obtained in the presence of a student.

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DOI: 10.3399/bjgp14X680029

## White coat hypertension: is it all just in the look?

I have recently done a study for my regional science fair on white coat hypertension in 50 random patients at a local cardiovascular clinic. Participants' blood pressure was measured by a cardiologist, a nurse, and a cardiovascular technician. Each healthcare provider measured blood pressure in the same manner twice, one measurement with a white lab coat, and one measurement without a white lab coat in a randomised order. Participants had an automated 24-hour ambulatory blood pressure monitor (ABPM) reading which served as the control for this study. The difference between the average reading of the systolic blood pressure assessed by ABPM and the average reading of systolic blood pressure assessed by the cardiologist was 23.7 mmHg with a white lab coat and 13.3 mmHg without a white lab coat ( $P < 0.001$ ). The difference between the average reading of the systolic blood pressure assessed by ABPM and the average reading of systolic blood pressure assessed by the nurse was 14.2 mmHg with a white lab coat, and 5.7 mmHg without a white lab coat ( $P < 0.001$ ). The difference between the average reading of the systolic