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 paper¹ on risk communication relates closely to work published 13 years ago in this journal. Misselbrook and Armstrong² 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 account³ of a GP consultation about statins, and Gupta's⁴ 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.¹ 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.² 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

blood pressure assessed by ABPM and the average reading of systolic blood pressure assessed by the cardiovascular technician was 2.8 mmHg with a white lab coat, and -1.8 mmHg without a white lab coat ($P < 0.001$). This suggests that blood pressure recordings are most erroneous when done by a physician, than by a nurse, and most closely match the gold standard of ABPM when done by a cardiovascular technician, and that wearing a white lab coat also exaggerates the effects of the white coat syndrome. Both the study I performed and the study in your journal demonstrate that when doctors measure blood pressure, the readings may be more erroneous than if measured by a nurse, a cardiovascular technician, or ABPM. Perhaps clinics should have blood pressure measured by allied healthcare professionals not wearing a white coat to reduce the risk of erroneous readings.

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DOI: 10.3399/bjgp14X680041

The effect of clinical inertia on the management of blood pressure

We read with interest the study by Sheppard *et al* regarding missed opportunities in the prevention of cardiovascular disease in primary care.¹ Recently-published ESH/ESC hypertension guidelines (2013) state that patients whose blood pressure fails to fall by at least 15/15 mmHg overnight (so-called 'non-dippers') should be diagnosed with hypertension.² According to the guidelines:

'... night-time blood pressure is a stronger [risk] predictor [of clinical cardiovascular outcomes] than daytime blood pressure'.²

NICE hypertension guidelines 2011 make no reference to identifying or treating 'non-dippers'.³

We reviewed the use of ambulatory blood pressure monitoring (ABPM) in one Irish practice over a 3-year period from 1 January 2010 to 17 December 2012 and identified cases where treatment plans differed from the recommendations of the NICE guidelines 2011. We re-interpreted the data using 2013 ESH/ESC guidelines to include 'non-dippers' and compared the results with those obtained using NICE guidelines to highlight the implications of the 2013 guidelines on clinical practice.

Two hundred and forty-seven ABPMs from 202 patients (57.9% female, average age 62.5 years [standard deviation {SD} 15.6]) were included in the review. Of these, 59.5% ($n = 147$) of the recordings were abnormal according to the NICE guidelines. Of the abnormal recordings, 45.6% ($n = 67$) resulted in no change in patient management. When we re-interpreted the data using 2013 ESH/ESC guidelines, the number of abnormal recordings increased to 73.7% ($n = 182$).

Sheppard *et al* identified a number of possible explanations for differences between patient treatment plans and guideline recommendations, including GP judgement, polypharmacy issues and individual patient preferences. We propose an additional explanation: the incidence of clinical inertia, for example, reluctance to change the treatment regimen of the patient compliant with their antihypertensive medication(s) who on follow-up have a mildly abnormal ABPM.

Those opting to replace 2011 NICE guidelines with 2013 ESH/ESC guidelines will see an increase in the number of patients diagnosed with hypertension, given the inclusion of 'non-dippers' as outlined above, with increased workload as a consequence. Despite this, clinicians should attempt to minimise clinical inertia in the management of hypertension, given the positive benefits optimal treatment may have on the efficacy of vascular screening programmes and, ultimately, on patient outcomes.

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DOI: 10.3399/bjgp14X680053

Correction

In the September 2013 *BJGP*, the article by Scheel BI, *et al*. Cancer suspicion in general practice: the role of symptoms and patient characteristics, and their association with subsequent cancer. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X671614, the authors reported 263 patients with cancer, 106 of whom presented warning signs of cancer (WSC). Further detailed analysis of follow-up data about the diagnostic procedure has revealed that two patients without any WSC recording had established, progressive cancer instead of a new cancer or a new recurrence of cancer, and they were thus protocol deviant. Therefore the correct number of patients with cancer is 261. Also, one patient with lymphoma turned out to be a new case of cancer instead of the recurrent case as reported in the follow-up questionnaire. As the three patients in question had no WSC and therefore no recording of cancer suspicion, there are no changes in the conclusions of the study. The online version has been corrected.

DOI: 10.3399/bjgp14X680065