HASLAM'S VIEW



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Keeping up to date with the changing evidence

DON'T YOU FIND IT FASCINATING HOW FASHIONS IN MEDICINE CHANGE? WHAT IS DREADFUL practice one year can become exemplary practice the next. Many years ago, when I was chairing the MRCGP Examination Board, I was contacted by a medical lawyer who needed to know how serious a crime it was to prescribe a beta-blocker to someone in heart failure. Now it's considered to be good practice.

That's the glory of science, constantly checking and questioning, turning hypotheses upside down, refining the evidence. It's exactly how it should be, but it doesn't half make life confusing at times.

Take the common or garden heart attack. The correct management now is 'take an aspirin and call an ambulance'. Twenty-five years ago this would have been the response of the clinically inept, the lazy, or the overwhelmed doctor. Now it is the treatment of choice.

Back then the patient recovering from a coronary would have been kept on strict bed rest for three weeks, and then allowed only the gentlest of mobilisation. Today, the diamorphine will have barely worn off before he or she is sent to the gym for active cardiac rehabilitation.

But, more than anything else, it is attitudes to high blood pressure that have changed. For years we debated the rights and wrongs of treating mild to moderate hypertension, as blood pressure levels all the way up to 180/100 were labelled. Frequently we would choose not to treat. Now such therapeutic nihilism would leave many guideline writers apoplectic.

One of my patients seemed particularly fired up about this the other day. He had recently purchased a home sphygmomanometer and had arrived with a beautiful multicoloured computer-generated spreadsheet of his results. 'I've shown you mine,' he said. 'Now you show me yours.' I looked puzzled. 'Your collection of my results,' he explained. 'Can you print them out?'

'Back then, there was no evidence that tighter control made any difference'

And so I did. A splendid graph of Himalayan peaks and valleys, with only relatively recently the semblance of normality brought on by more aggressive prescribing, and a worrying degree of polypharmacy (something else we used to frown on). But he looked horrified. 'Look back here, he jabbed his finger angrily at the results from a few years ago. 'Hopeless. Absolutely hopeless. I kept coming to see you, and you kept saying my pressure was okay, and now I can see it was hopeless. Why didn't you say?'

Except his control hadn't been hopeless. At the time, every physician would have accepted his blood pressure readings as being as good as could be expected. Back then, there was no evidence that tighter control made any difference, whereas now there is evidence pouring out of every source.

There was nothing for it but a full-scale tutorial. I patiently explained it all. The changing patterns of medical evidence. The value of the Framingham study. The risks and benefits of aggressive therapy. I searched for a series of research papers on NHS Evidence, and printed a couple out, discussed his concerns, and ended up 15 minutes late for my next patient.

And as he had been my first patient, an inevitable pattern of late consulting developed from the start. I found myself praying for a DNA, or a simple earache in a child whose parents didn't want antibiotics. But no such time-saving case appeared.

Frustrating, isn't it? Sometimes when we do the job well – and I believe that consultation ultimately went as well as either of us might have wished – other patients may be disadvantaged.

It's enough to make anyone's blood pressure soar.

Tell us what you think?

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