SCENARIO

Invited for a health check

Mr Junior Earle Jones is surprised to receive a letter from his GP, Dr Kitty Knight, inviting him for an 'NHS health check' *(a 'disease management programme' rather than one of the 'NSC'-approved systematic population screening programmes)*. He is a 50 year-old jazz musician who has not been to the surgery in years, and has a 20-a-day smoking habit and a family history of heart disease. After searching the NHS website to find out what this 'vascular assessment' would involve (and why), Mr Jones decides to attend. He asks why the practice nurse, Nurse Jennie Marchese, is also measuring his waist. His systolic blood pressure is 155 mm Hg – *"are you sure your machine is working right? I felt fine until you told me that. Is this about my family having heart problems?"*. Nurse Marchese reassures him about measurement error and comments on the complicated genetics of hypertension. Later, Dr Knight explains options for managing his hypertension under current guidelines. Mr Jones finds it a lot of information all at once.

After reflecting on the benefits and risks of being treated or not, Mr Jones agrees to start on a calcium-channel blocker, amlodipine, but soon has to change this because he develops marked leg swelling. The angiotensin-II receptor antagonist, candesartan, Dr Knight's next choice, is well tolerated. Mr Jones' blood pressure is measured regularly over the next year, and further drugs are added: 18 months after starting treatment, Mr Jones' blood pressure is consistently satisfactory. He considers that he has received good quality health care, conveying this in a patient satisfaction survey of a random sample of Dr Knight's patients (which used a few techniques to reduce information bias).

Dr Knight is concerned about the population attributable risk for cardiovascular and cerebrovascular complications amongst people with hypertension, and is aware of Rose's prevention paradox (and the need to 'shift the curve to the left' via health promotion). She is satisfied that the 'vascular assessment checks' are complementing her policy of 'opportunistically' targeting patients likely to be hypertensive amongst the under-40s who consult her. Indeed, Dr Knight remembers taking Mr Leon Margrave's blood pressure opportunistically, when he consulted her about stopping smoking:

> *Mr Margrave was an asymptomatic 36 year-old unemployed man smoking 20 cigarettes per day, who was overweight, on a poor diet, and not exercising regularly. He denied being stressed, having chest pain, or headaches. Dr Knight found his blood pressure to be 200/100 mm Hg, then 190/96 mm Hg when rechecked a week later. At his third visit, it was 190/102 mm Hg. Dr Knight found 'silver wiring' of the arteries and arteriovenous 'nipping' on fundoscopy. Mr Margrave agreed to have a blood test, provide a specimen of urine, and receive dietary advice from Nurse Marchese. Like Mr Jones, Mr Margrave also felt fine until news of his hypertension, and wanted to know the implications, especially when the ECG was consistent with left ventricular hypertrophy (with a normal chest radiograph and normal plasma creatinine). Unlike Mr Jones, Mr Margrave was reluctant to be treated. "I cannot see why, when I've got no symptoms. Perhaps, I was just wound up coming here three times to wait for my blood pressure to be taken?" Dr Knight explained that his consistently high blood pressure was not due to measurement error (and would use 24-hour monitoring if she suspected 'white coat effect'). Although Mr Margrave said "…oh, OK, I suppose so", he was not sure that he would collect the prescription.*

After seeing Mr Jones, Dr Knight is ready to see Mr Margrave about how his treatment is going – he does not seem to want to know about the consequences of non-compliance, and she tries to explain the 'risk' in simple terms. (She is aware that the 'gold standard' evidence and the guidelines may show which medication to use, and its cost-effectiveness, but whether her patients will take the medication is another issue.)