Moving Forward: Family Physicians & Hypertension

While little evidence exists to support the role family physicians play in the treatment of hypertension in Canada, Dr. Petrella outlines why they are ideally suited and integral to successful management.

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In Canada, 4.1 million adults have hypertension; only 16% are treated and controlled, while 42% are unaware they have high blood pressure.[1]

Family physicians play a key role in implementing any comprehensive, national program to improve hypertension management.

Why are family physicians ideally suited?

Several attributes suggest family physicians should be a key link in any hypertension management program, including:

- family physicians have contact with 80% of the population at least three times/year, and even more regularly as patients age;
- many visits are preventive in nature, aimed at monitoring chronic cardiovascular disease;
- patients see their family doctor as a preferred source of preventive health education and a partner in the management of chronic health problems;
- family doctors offer a continuity of care, an invaluable resource to meet the individual needs of patients; and
- the patient-centred approach of a family physician means the patient—not just the high blood pressure—is treated.

Other attributes also suggest benefits in terms of long-term adherence and compliance with treatment plans (Table 1).

What's the evidence?

Surprisingly, little evidence exists to support the key role family physicians play in hypertension treatment.

Perhaps the best support comes from an ambitious five-year study of hypertension practices among 34 family physicians and 32,000 of their patients. The study was conducted by Dr. Martin Bass at the University of Western Ontario in the late 1980s.

In Canada, 42% of adults with hypertension don't know they have high blood pressure.

Dr. Bass measured the impact of a physician assistant versus usual care family practice upon detection and management of hypertension. In terms of dietary salt advice and restriction and hypertension screening, education, and patient outcome, no difference in cardiovascular morbidity and mortality

were observed between groups.[2,3] There were, however, significant differences in the degree of compliance with treatment.

The study concluded that, while further modifications could improve meeting targets for compliance with treatment, family physicians can provide effective care for hypertensive patients without the aid of expert assistant programs.

Since that large trial, few subsequent studies have examined the impact of primary care on treating hypertension.

Guideline implementation is driven by awareness.

In Italy, Avanzini *et al.* reported the efforts of 73 family physicians and 1,200 hypertensive patients to achieve blood pressure control.[4] It was found only 56% of hypertensive patients took medication and > 63% of those on hypertensive medications failed to reach target values for control. Therefore, it was concluded that hypertension was not being aggressively treated; in fact, medications were being underused.

New treatment guidelines in Canada suggest individualized targets, including tailoring management to setting. The implementation of these guidelines and approach to management are not yet clear.

Looking backward

Past dissemination and proposed implementation strategies have been passive. Traditionally, the publication of hypertension guidelines signaled the key dissemination method. Interest groups have often republished these guidelines and developed a variety of dissemination systems (*i.e.*, speakers bureaus, tailored decision aids), but these have not been co-ordinated or scrutinized. Criticism of the guideline's lack of usefulness in practice and adaptability to new evidence has impacted further on the generally low impact on family physicians.[5] While new technology enables the wider dissemination of material, it is also limited by evolving evidence and need for rapid access.

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Table 1

Attributes of hypertension treatment in family practice

Setting

- Family practice enivronments can screen, counsel, diagnose, educate, treat, and manage large numbers of hypertension patients.
- Health information from various sources can be provided, discussed, and scrutinized.
- Family practice can link with other providers to complement care, while providing a link with the patient-family dynamic; this may facilitate adherence to screening and treatment programs.

Continuity of care

- Continuity of care is the best environment for managing chronic health problems beacuse it presents opportunities to introduce screening and prevention.

Family

- Patient behaviour and family dynamics can be enhanced in the context of chronic family disease and understanding issues of compliance.

Patient-centred approach

- Family physicians are ideally suited to prepare patients regarding readiness to control their high blood pressure, encourage the patient to explore compliance to treatment, and to manage side-effects.
- The patient's behaviour and lifestyle becomes central to motivating and moving this change towards a healthier outcome.

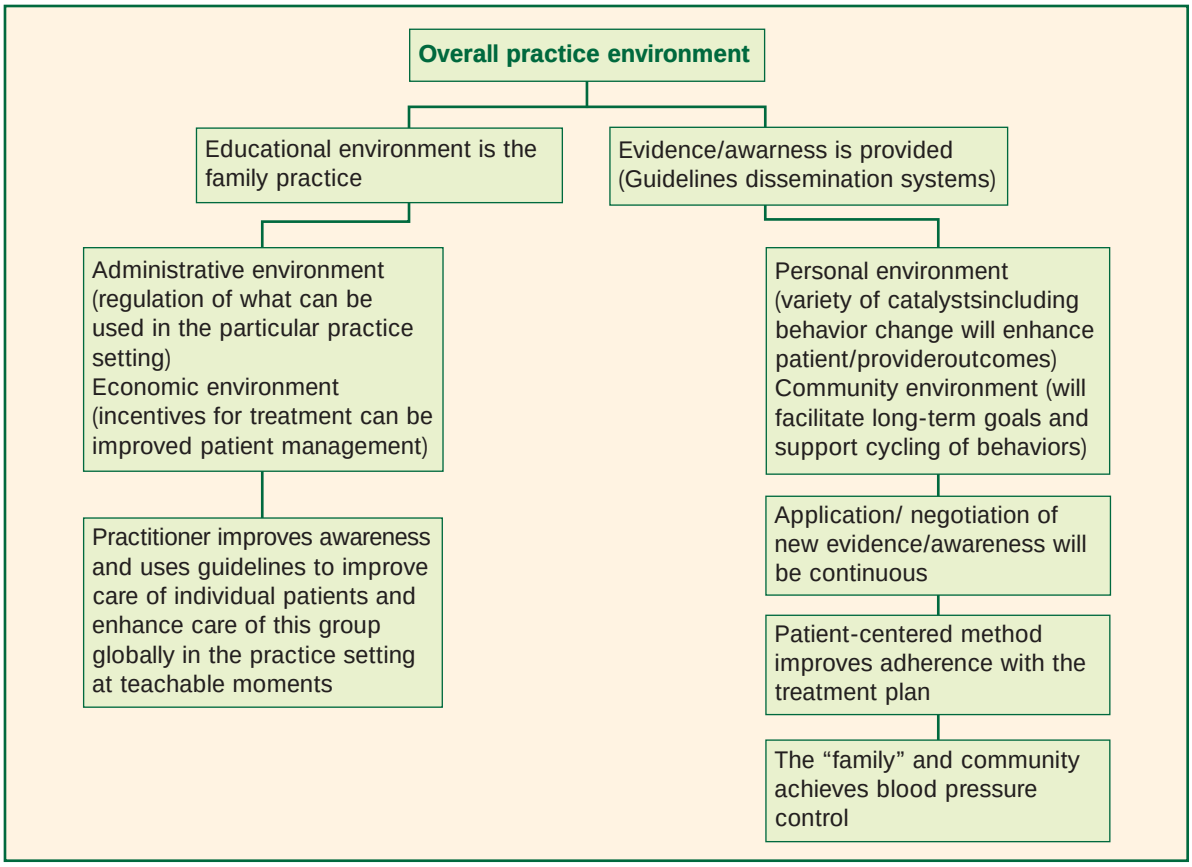

Figure 1. Lomas model of implementation.

Looking forward

New strategies for the dissemination and implementation of guidelines should be active. New guidelines were developed by linking organizations to experts at the national level. The publication of guidelines in tiered resources has improved the availability of evidence.

Most significantly, a continuous system of evidence-based guidelines linking organizations to individuals ready to use it (*i.e.*, opinion leaders, local interest groups, allied health providers, individual physicians and their patients) will address individualization of treatment and tailoring to the practice setting.

Will this succeed?

As always, the implementation of guidelines will be driven by patient and family physician awareness.

The availability of new evidence in a useable form can be provided in the context of patient readiness to change behaviour.

About the author...

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Family physicians' understanding of a patient's readiness to change can be parlayed into the patient-centred method and, over the long-term, continuity of care.

It is natural to cycle through different stages of readiness, including relapse. The continuity of care offered in a family practice provides the ideal setting to support and drive this process. The family practice is a natural conduit for education and advocacy for patients with cardiovascular disease and linking patients with community resources is essential to the long-term sucess of treatment.

An Italian study showed > 63% of medicated patients failed to reach target values.

Figure 1 outlines how such an implementation program for hypertension could be achieved.[6]

How can this work in your practice?

Family physicians need to take blood pressure systematically in regular practice. Instead of adopting a quick fix approach to elevated blood pressure, family physicians can use their knowledge of best current evidence to implement an individualized "treat-to-target" program.

Hypertension is a chronic health condition. In order to achieve long-term treatment success, patients and family physicians will need to rely on continuity of care through the adoption of effective healthy behaviours. *PCard*

Take-home message

- Nearly half of the hypertensive adults in Canada are unaware they have high blood pressure.
- Little evidence exists to support the key role family physicians play in treating hypertension.
- It is important to take blood pressure systematically in regular practice and, rather than a quick fix approach to elevated blood pressure, treat to targets.

References

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