

Transparency of care

Patrick¹ is to be applauded for her enlightening editorial on electronic medical records (EMRs). She wonders, “is sharing the entirety of the electronic medical record with a patient not the obvious next step in the laudable movement toward shared decision-making and patient–physician collaboration?”¹

I could not agree more. Like Patrick, I am a newcomer to Canada. In Israel (where I come from), EMRs have been used for over 15 years with enormous success. Access to EMRs is an integral part of patient rights and is available at the click of a button. Lab results are shared and accessible to patients within minutes of being reported. As Patrick points out, with judicious application of appropriate security measures, like those employed to protect banking, pension, tax and insurance information, there should be more advantages than disadvantages to the open access of medical information.¹

I would like to expand on Patrick’s editorial¹ and suggest that transparency and sharing also extend to the clinic visit summary letter. I am a consultant pediatrician, and in my practice in Israel, I used the EMR to print two copies of my visit summary notes/letter. These were given to the parent or guardian to take with them, one copy to keep for their records and one for their family physician or pediatrician. I have recently started following this practice in Canada. My patients feel so much more empowered and involved in the clinical decision-making process. They leave the appointment armed with a summary of the visit and are able to review the information immediately or later at their convenience. These patients are now questioning why other health care providers do not offer the same open access to their patients’ medical records.

The benefits for me are that I have no more dictations to complete after clinic, I do not have to wait for a transcriptionist to type my letters, and there

is no editing required. The consult letter is delivered directly to the referring physician via the returning patient. As a precaution, I do currently send a copy by mail to the family doctor/pediatrician. However, I suspect that as time goes by, this will become unnecessary.

I believe that patients will increasingly demand such transparency from other clinical encounters as well. It is indeed time to embrace transparency!

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Reference

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Management of resistant hypertension

In their review, Padwal and colleagues¹ made an interesting and important omission. Variants of Liddle syndrome (genetic mutations affecting the renal tubular epithelial sodium channel, ENaC, causing salt and water retention and loss of potassium), are far commoner than most physicians suppose.

Baker and colleagues² report that a variant of ENaC (T594M) was responsible for 5% of hypertension in black patients mainly of Caribbean origin in London, United Kingdom. A different variant, R563Q, was reported in 2003 by Rayner and colleagues;³ this variant is present in 20% of the Khoi San people of the Kalahari, who are not hypertensive with a low sodium intake on the hot, dry Kalahari, but become severely hypertensive when they move to Cape Town, South Africa.⁴ This variant accounts for 6% of hypertension in black patients in southern Africa, and 9% among Nguni–Zulu residents of southern Africa.⁴ Although Liddle variants may be more common in black patients,⁵ a Liddle phenotype was found in 6% of patients attending a hyperten-

sion clinic for veterans in Louisiana, of whom 42.7% were African American.⁶ Surprisingly, the prevalence of a Liddle phenotype was nearly the same as that of primary aldosteronism in that clinic population (6.7%).

Why does this matter? Amiloride was mentioned in the review by Padwal and colleagues¹ as an alternative therapy for primary aldosteronism, but it is important to recognize that it is the specific treatment for Liddle variants.² For that reason, it is important to diagnose Liddle variants among patients with resistant hypertension. The algorithm shown in Appendix 1 (available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.1150014/-/DC1) is useful in determining the physiologic drivers of hypertension so that appropriate therapy can be prescribed.

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