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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Communicating risk

Harmsen *et al*'s interesting paper[1] on risk communication relates closely to work published 13 years ago in this journal. Misselbrook and Armstrong[2] 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 account[3] of a GP consultation about statins, and Gupta's[4] 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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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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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