potential to do much harm to patients—there is no substitute for a large randomised clinical trial for the formulation of healthcare policy.

The halo of ACE inhibition has been dented by this trial. There was no evidence of the much touted benefits of ACE inhibition “independent of blood pressure” in terms of protection against cardiovascular disease and stroke. It is well recognised that older people and black people respond less well to ACE inhibition with regard to reduction of blood pressure than younger people and white people because their renin-angiotensin systems are more suppressed. Blood pressure was less well controlled in patients randomised to lisinopril throughout the trial, especially in black patients. Small differences in blood pressure (2–4 mm Hg) in large clinical studies can have a major impact on outcome and are the most likely explanation for the reduced protection against stroke and cardiovascular disease with ACE inhibition in this trial. But this is a double edged sword, and the same argument must also apply to explain the benefit when similarly small blood pressure differences occurred in favour of ACE inhibition compared with placebo in studies such as HOPE.^{7,8} Such small blood pressure differences can no longer be dismissed as unimportant or irrelevant to clinical outcomes.⁹

When ALLHAT was designed in the early 1990s much debate arose about the need to define first line treatment for hypertension. This has become less relevant in clinical practice as trials continue to confirm that most patients require more than one drug to control blood pressure. This was also confirmed in this trial, which showed that 63% of patients required two or more drugs to control blood pressure to less than 140/90 mm Hg. Moreover, blood pressure control was more difficult in patients at highest risk—older patients, patients with highest systolic blood pressure at baseline, black patients, or diabetic patients—who generally require more than two drugs.¹⁰ ALLHAT does not give information about the ideal combination of drugs required to achieve optimal blood pressure targets. One cannot conclude that the combination of a diuretic with a newer drug would not be more effective than a diuretic and β blocker combination at reducing blood pressure, morbidity, and mortality.

The key message from this trial is that what matters most is getting blood pressure controlled, and that this

is overwhelmingly more important than the means. Combinations of several drugs will be required for most patients, and such an antihypertensive treatment cocktail should include a thiazide diuretic. ALLHAT perhaps heralds the end of an era of initial treatment comparisons for hypertension and points to a new need for “real world research.” In managing hypertension we have a range of effective and safe drugs and a robust evidence base for treatment. But if patients are to benefit from this trial, and all before it, we now need to define the best way of implementing the evidence in clinical practice.

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Intimate examinations and other ethical challenges in medical education

Medical schools should develop effective guidelines and implement them

In this issue, Coldicott et al report an exploratory survey that shows, among other findings, that up to a quarter of intimate examinations in anaesthetised or sedated patients seem not to have had adequate consent from patients (p 97).¹ This paper will generate a firestorm of controversy, wide media interest, and perhaps even calls for a public inquiry. Through the controversy, let us keep one point uppermost in mind: identifying the problem is only half the battle—the other half is coming up with an effective solution.

The fact that this report has been published at all represents a triumph of academic freedom. In particular, Coldicott, a medical student, deserves high praise for seeing this controversial study through to publication. The medical school examined in the study is probably not the only medical school in the world with similar practices, and the authors and their institution have done patients and the medical community a service by highlighting this problem.

Education and debate
p 97

BMJ 2003;326:62–3

The issue of intimate examinations is the tip of a much larger iceberg related to ethical challenges in medical education. In 2001 a group of medical students from the University of Toronto published in the *BMJ* a study on the ethical dilemmas that shape medical students' ethical development.² The study identified the sort of conflicts between medical education and care for patients that are the focus of the Coldicott study. It also identified two other types of ethical challenges: responsibility exceeding a student's capabilities and involvement in care perceived to be substandard.

Although the Coldicott study found that 17 of 25 medical schools in Great Britain had a formal policy on teaching vaginal examinations, a broader policy approach to the ethical challenges in medical education is required.

Doyal has presented a policy on the rights of patients in medical education developed at Barts and the London School of Medicine and Dentistry in the United Kingdom.³ This pioneering policy emphasises patients' rights to consent to educational activities and to expect that information gained in the course of educational activities will be kept confidential. Importantly, the policy places a positive obligation on students and teachers to follow the guidelines: "Encouraging students to ignore these guidelines is unacceptable."

As a result of the 2001 *BMJ* publication, the University of Toronto and its affiliated teaching hospitals developed guidelines for ethics in clinical teaching.⁴ These build on the guidelines from Barts in two important ways that are relevant to the Coldicott study.

Firstly, the guidelines highlight the responsibility of clinical teaching staff to serve as appropriate role models to trainees for ethical practice and to provide trainee healthcare professionals with an opportunity to discuss an ethical or difficult situation.

Secondly, the guidelines require the university and teaching hospitals to develop processes for reporting ethical concerns. They also require that trainee healthcare professionals and clinical faculty are aware of individuals they could approach with ethical concerns and have the right to consult with a bioethicist or con-

sultant in clinical ethics. When a trainee expresses concern about ethical issues, refuses to participate in activities related to care for patients or clinical teaching on the basis of ethical grounds, or seeks consultation on an ethical issue, this will have no repercussions for the trainee.

The value of any guideline is not in how artfully it is crafted but in how well it is implemented and what effect it has. This is particularly critical in an area such as the role of ethics in medical education, where the informal curriculum reigns, and deep cultural change is needed.

In considering the Coldicott study, we should follow the lessons of the medical error movement, since the paper reports a type of ethical error in medical education. Rather than seeking to fix blame, we should try to find systemic solutions to the ethical challenges of medical education. Each medical school should develop and implement guidelines for ethics in clinical teaching, evaluate their impact, and share the findings of these evaluations.

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New edicts for letters to the editor

Be electronic, bold, and concise—no more than 300 words

Your letters are very important to us. They are crucial to the success of the *BMJ*, and we appreciate their enthusiasm, different perspectives, diversity, and ability to stimulate debate, not to mention their wit and thoughtfulness. In the printed version of the *BMJ*, letters are edited only lightly for clarity and readability so that the author's voice is still audible and louder than in any other part of the journal. The letters pages are the readers' forum.

We select letters for the paper journal from the unedited rapid responses posted daily on bmj.com.¹ We consider the electronic journal to be the *BMJ*, and we want the letters columns in the paper journal to reflect the liveliness of conversations on the web and be

a bridge for the two communities of readers to access the two forms of the journal. In essence, we are saying: "Here are what we thought were the most interesting responses, but why not visit bmj.com yourself to see the full debate and how it unfolded?"

We have also been trying over the past year to alert readers to this bridge with our occasional summaries of responses for debates that have generated a lot of interest.²⁻⁸ We accept letters for the paper journal largely on the grounds of readability—not, as in the past, for their detailed critique of science. The critique is freely available in all its glory on bmj.com forever, and readers should seek it there. In the paper journal we are trying to add value by exploiting the medium of