

long learning. The principles discussed in this paper are applicable not only to medical trainees but may prove useful to junior doctors and even senior doctors attempting new procedures or practices.

The history of research ethics suggests that the medical profession should be proactive rather than reactive in approaching the ethics of medical education. The time has come for the profession to turn its attention to this important issue.

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Commentary: Patients in medical education and research

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While there are undoubtedly parallels between patient involvement in medical education and in research, the differences between the two seem to me to be more profound than Jagsi and Lehmann suppose.¹

Four years ago I underwent angioplasty, during which three stents of a new type were inserted into two of my coronary arteries. Before the operation, I was asked whether I would be prepared to participate in a clinical trial that would require me to have a further angiogram six months later—the only practicable means of establishing the status of the stents.

Having already had two angioplasties, I knew the procedure to be invasive and uncomfortable, and the doctor concerned explained that it was not entirely risk free. He also made clear that it would be carried out purely for research purposes with no direct clinical benefit to me.

I gave my consent for two reasons. Firstly, I believe such clinical research to be important. Secondly, I believe that, as an NHS patient, receiving treatment free at the point of delivery, I have some responsibility to “give something back” to the providers of my health care.

I would not have been prepared to undergo the procedure purely for educational purposes. It is one thing to subject myself to inconvenience, discomfort, and risk if that is the only way a treatment can be properly evaluated. It would be quite another to do so simply for the education of medical students, who can observe or participate in any number of similar procedures being conducted routinely for therapeutic purposes.

I do not believe myself to be unusual. I suspect that many patients would accept a significantly higher degree of risk and inconvenience for research purposes than for educational ones.

Where medical education is concerned, the differences in attitude between patients being treated by the NHS or Medicaid and those being treated privately seem to me to be entirely understandable. I am sure that it has chiefly to do with the non-paying patient's sense of moral responsibility to “give something back,” as against the private patient's perception that he or she has paid for a “private” appointment.

This calls into question the assumptions made by Jagsi and Lehmann about distributive justice. Although some indigent patients may feel unable to withhold consent, it may be that far more, perhaps subconsciously, see consent as a means of “paying” for their treatment. Nor should it be supposed that doctors' children are less likely to be seen by trainees because doctors are better informed about the true risks and benefits of participation. It is more probable that they are simply private patients who see themselves as having paid for private consultations.

Finally, it is of course essential that patients' representatives should be included in the development of mechanisms to ensure high standards of ethical practice in medical education. As in so many things medical, patients' views may surprise those who suppose they can see into other people's minds.

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