reading subjects adhere to strict guidelines and, if they do not, we withhold approval until the matter is remedied. Those arguing for a different approach in other cases cite American literature, which documents the fact that ethnic minorities and the elderly may be underrepresented in clinical research.¹ Such groups are deemed difficult to recruit for reasons that are not always clearly outlined by those failing to recruit them. In such cases one could conclude that beneficial innovations and advances could not be generalised to groups who have been excluded from trials and that they are therefore ultimately disadvantaged.

In circumstances where a subject cannot comprehend English or any language it may be unethical to include this person in research because of the value we place on the need for informed consent. The difficulties faced by research ethics committees are compounded by the problems of evaluating information provided in a number of languages for each and every clinical trial where there is the potential to recruit a subject for whom English is at best a second language. It seems unreasonable to expect every research team to produce information in all languages spoken in multicultural Britain and if necessary to provide it on an audiocassette where there is a chance that the subject may not be literate. Ethics committees could argue that in multi-centre or large clinical trials the government or multinational pharmaceutical companies may have the resources to deal with this issue. In reality the process of planning and executing research would be considerably retarded by adherence to such a counsel of perfection in every single study.

If the issue of recruitment from every section of our society is overlooked or fudged there is a real danger that the results of research may harm patients or that the process of conducting research will be seen as riding roughshod over the rights of a minority of patients, subjects of this country. National Health Service patients in the UK can, potentially, be invited to participate in medical research. It could be said that patients who are excluded from such recruitment without very good reason are being denied

the full experience of life as a member of our society. This may add to any sense of isolation.

Researchers have suggested that occasionally relatives or local translators could be employed to translate information sheets verbally. However, the possibility that such translators may persuade rather than inform remains a concern and ethics committees may be uneasy about such a proposal when the accuracy of the translation cannot be judged on a written record. Finally it is a matter for those who read and act on the findings of research to ensure that results are generalisable to all their patients. Therefore it is in the interests of researchers to clarify which groups of patients have been recruited and to specify which groups have been excluded and why.

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Medicine and literature: imagine a third way

SIR

I have followed with interest the editorial by R Gillon, 'Imagination, literature, medical ethics and medical practice' and N Pickering's rebutting article, 'Imaginary restrictions'.² In short the former praises the use of literature in medical practice and medical education: "Literature can illuminate our interpretation of our patients' stories; their stories and their interpretation can illuminate both medical science and philosophical medical ethics". Pickering argues—in a more difficult to understand paper—that such a position "restricts the role of the imagination in medical ethics by putting forward an instrumentalist account of the role of literature in ethical reflection". These differences remind me of an anecdote of the

Argentine writer, Jorge Luis Borges. His opponent—in the field of literature as well as politics—was the Chilean Nobel Prizewinner, Pablo Neruda. A very peculiar situation arose over the years because every time Borges was asked about his colleague he would praise, even glorify, him. On the other hand, in similar situations Neruda invariably undervalued Borges. Finally a reporter asked the Argentinian about this whole matter: was he right or was Neruda right? Borges gave a short answer: "Probably both of us were wrong".

From the point of view of a doctor currently using medicine and literature in medical education, the arguing above, of both Gillon and Pickering and Borges and Neruda, is at least difficult to understand and definitely beyond the interests of medical practice. Moreover, it is even disappointing. The days of the so called "Flexner-Osler debate", the controversy between scientific and humanistic medical education, are not gone. Many of us are elbowing our way towards the introduction of humanistic disciplines into the curricula of medical schools. It does not seem fair to jeopardise what has been achieved in this field over the years by cross-fired arguments which a physician cannot even imagine being related to his/her daily practice.

With regards to both sets of persons to whom I have alluded, whom I do not know personally, allow me, finally, to quote Shakespeare:

"If we do meete [again], why we shall smile,

If not, why then this parting was well made".

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- 2 Pickering N. Imaginary restrictions. *Journal of Medical Ethics* 1998;24:171-5.

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