CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

A threat to psychiatric research?

SIR,—As a contributor to both the Secretary of State's draft code of practice[1] and the Mental Health Act Commission's discussion document on consent to treatment[2] I would like to express a personal point of view in response to the comments by Professor R E Kendell, Dr John R Hamilton, and Dr Denis Pereira Gray (10 May, p 1249, 1219, 1220). The view is expressed that the recommendations, worded rather differently in each of the two documents, would hinder psychiatric research.

Firstly, in both the code of practice and the commission's document on consent the terms "therapeutic" and "non-therapeutic" are used in the widely publicised sense of the Declaration of Helsinki and the subsequent reports of the Medical Research Council and the Royal College of Physicians of London.[3-11] Perhaps we should have quoted from the declaration and these reports, but these documents were extensively consulted.

Secondly, in the patient who is incapable of giving real consent in the broad terms described in both documents therapy (and by that token therapeutic research) may be undertaken when, on balance, the ethical and legal duty of care so requires. Doctors exercise their discretion in this way every day when they *treat* handicapped or demented patients, even if they do so with some unease. When an intervention is non-therapeutic (and research is perhaps the only example of such intervention that would be ethical) the duty of care cannot justify the intervention on the grounds of benefit to the patient and may, if the intervention is risky, preclude it. For non-therapeutic interventions the problem of obtaining real consent is therefore of much greater import.

Thirdly, it is intervention with the patient in experimental research that gives rise to concern. In the commission's document descriptive research, where no experimental agent is applied, is omitted from all the safeguards suggested (para 13.6 a). Furthermore, it could be argued that many modern investigations which are non-invasive or only slightly invasive could be descriptive in the sense that there is little or no interference with the patient that has any effect on him. If these investigations aid the understanding of that individual case they are also "therapeutic."

Fourthly, it is generally understood in the documents on the ethics of research that techniques of assessment that promote the better understanding of the individual case and preventive measures are classed as "therapeutic" and would therefore not evoke the safeguards suggested for "non-therapeutic research." Furthermore, "incidental" research that uses measures or specimens undertaken or obtained for bona fide therapeutic reasons escapes from all the safeguards suggested except reference to the ethics committee.

Fifthly, while many demented or handicapped patients may be incapable of giving real consent this is not necessarily so for all, particularly those mildly afflicted or in the early stages of their disease. The understanding of information in "broad terms" may not be beyond all sufferers.

Sixthly, it may thus appear that the restrictive influence of the commission's discussion document on consent has been overestimated. In this context it is also worth drawing attention to the advice offered in a separate section of the commission's document (para 10.6 (iv) and the code of practice (para 4.9.7, 4 subpara))—namely, that:

> If the patient is incapable of giving consent [and] there is no prospect of the patient ever recovering his capacity to give consent, or if the condition is causing suffering which should be alleviated the treatment may properly be given without waiting for the "point of no return."

This suggestion does not carry the force of law as currently expressed in any statute or judicial decision. Nevertheless, it is in sympathy with the general trend of the development of law in Britain, and reference to the advice could usefully support doctors when exercising their duty of care.

Finally, those measures that would remain subject to the more severe restrictions would, in the main, be those which are non-therapeutic, in that they are not directed at an understanding of the patient's own disease or, even if they are, are so invasive or dangerous as to be proscribed by the duty of care.

At this stage of the debate it would assist in the definition of any remaining problems to know of the specific difficulties which projects might present to ethical committees if they were guided by the commission's suggestions. Even better would be a reformulation of the commission's suggestions to accommodate both the difficulties and the law.

At the same time, because there is a clear difficulty with the law as it now stands, and because doctors, as members of an honourable profession, should not have to evade or ignore the law to do their job, there should be legal comment on how their standing in law could be regularised.

As a psychogeriatrician I have no wish to inhibit research from which patients under my care may benefit, but I would also like to keep within a professional understanding of the law in respect of

real consent. Doing so in clinical practice can be difficult enough. Here the professional ethic of the practitioner is the main safeguard, with additional safeguards from consultation or discussion with others available as required. The further that practice deviates from clinical care and is motivated by other considerations then the more it seems necessary to establish the guidelines for sharing responsibility with others—notably, relatives (if available) and local ethics committees.

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2 Mental Health Act Commission. *Consent to treatment.* London: Mental Health Act Commission, 1985.
3 Medical Research Council. *Responsibility in investigations on human subjects.* In: *Annual report 1962-3.* London: HMSO, 1964. (Cmnd 2382).
4 Anonymous. Ethics of human experimentation [Editorial]. *Br Med J* 1964;ii:135-6.
5 Committee on the Supervision of the Ethics of Clinical Investigations in Institutions. *Report.* London: Royal College of Physicians, 1967.
6 DHSS. *Supervision of the ethics of clinical investigations.* London: DHSS, 1968 HM(68)33).
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9 World Medical Association. Code of ethics on human experimentation (the Declaration of Helsinki.) *Br Med J* 1964;ii: 177.
10 DHSS: *Supervision of the ethics of clinical research investigations and fetal research.* London: DHSS, 1975. (HSC(15)153.)
11 Royal College of Physicians. *Guidelines on the practice of ethics committees in medical research.* London: Royal College of Physicians, 1984.

Strokes among black people in Harare, Zimbabwe

SIR,—Dr Jonathan Matenga and others (21 June, p 1649) suggested that primary intracerebral haemorrhage is a more frequent cause of stroke (31%, 95% confidence interval (CI) 21 to 41%) in Zimbabwe than in developed countries. This may be true but the data from their hospital based series are no more than hypothesis generating; to prove such a hypothesis a community based study of stroke would be required since patients with severe strokes are more likely to be admitted to hospital[1] and most people think that primary intracerebral haemorrhages result in more severe strokes than cerebral infarctions. We have analysed data from the Oxfordshire Community Stroke Project to show this.

The Oxfordshire project identified all first ever strokes occurring in 1981-4 in a well defined population[2] and ascertained the pathological subtype in 96% (table). These were divided into those who remained at home and those who were admitted during the first month to either a major hospital or a GP community hospital. Those with primary intracerebral haemorrhage were 2·54 (CI 1·36 to 4·75) times as likely to be admitted as a patient with cerebral infarction. Patients with intracranial haemorrhage (including subarachnoid) were even more likely to be admitted (odds ratio=4·01 (CI 2·33 to 6·92)). In Harare the patients were admitted to two major hospitals. Perhaps more comparable figures from Oxfordshire would be those excluding the community hospitals. The odds ratio then increased to 3·26 (CI 1·80 to 5·91) for primary intracerebral haemorrhage and 5·48 (CI 3·28 to 9·15) for all patients with intracranial haemorrhage. Of our 203 patients admitted with stroke to such major hospitals, 27·6% had intracranial haemorrhage, a proportion not very different from that in Harare, although the numbers of patients with subarachnoid haemorrhage was relatively greater.

Our paper, published in this journal recently,[1] showed how important certain factors were in influencing the admission of patients with stroke to hospital. Here we show that pathological subtype is also important. Clearly factors influencing admission in Oxfordshire may be different from those elsewhere, but when interpreting any hospital based series it is important to take referral practices into account, which can only be done by studying all strokes in the community. Having said this, we welcomed the interesting paper from Harare and hope that the information provided here helps in its interpretation.

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1 Bamford JM, Sandercock P, Warlock C, Gray M. Why are patients with acute stroke admitted to hospital? *Br Med J* 1986;**292**:1369-72.
2 Oxfordshire Community Stroke Project. Incidence of stroke in Oxfordshire: first year's experience of a community stroke register. *Br Med J* 1983;**287**:713-7.
3 Sandercock P, Allen CMC, Corston RN, Harrison MJG, Warlow C. Clinical diagnosis of intracranial haemorrhage using Guy's hospital score. *Br Med J* 1985;**291**:1675-7.

Types of strokes in patients admitted to hospital in Harare and Oxfordshire and in patients not admitted in Oxfordshire. Results are numbers and percentages

Stroke type*	Harare (All admitted)	Oxfordshire Community Stroke Project		
		Admitted	Not admitted	Odds ratio† (95% CI)
Cerebral infarction	62 (67)	186 (73)	215 (89)	1·00
Primary intracerebral haemorrhage	29 (31)	33 (13)	15 (7)	2·54 (1·36 to 4·75)
Subarachnoid haemorrhage	2 (2)	26 (10)	2 (<1)	15·03 (4·90 to 46·0)
All intracranial haemorrhage	31 (33)	59 (23)	17 (7)	4·01 (2·33 to 6·92)
Uncertain		11 (4)	10 (4)	1·27 (0·53 to 3·05)
Total	93	256	242	

* In the Oxfordshire project pathological type was defined by computed tomography and necropsy in 80%. Remainder based on >90% probability as defined by Allen score.[3]
† Odds ratio of >1 indicates greater chance of admission to hospital compared with patient with cerebral infarction.

Lyme disease in a Hampshire child

SIR,—Dr D Williams and colleagues ask whether their case of Lyme disease in a child is simply a medical curiosity or represents the beginning of an epidemic (14 June, p 1560). From my own experience with Lyme disease in the United Kingdom I would say that the disease is probably endemic in certain areas of the UK and probably has been for many years. In America the disease is new and most probably represents the importation of the organism by birds into a woodland environment that is well suited for rapid spread. Conditions such as these are not found in the UK, making the explosive spread of Lyme disease unlikely.

European dermatologists have been aware of erythema chronicum migrans, the hallmark of Lyme disease, since the beginning of the twentieth century[1] and correctly attributed this to the bite of the hard tick *Ixodes ricinus*. Neurological sequelae from tick bites in patients both with and without preceding erythema chronicum migrans were first recorded in 1922,[2] and there have been many subsequent reports. Only recently has it been fully appreciated that these cases were part of the syndrome now termed Lyme disease. Four patients with Lyme disease acquired in Britain, one of them the patient described by Dr Williams and colleagues, have had severe neurological symptoms, but only two recall a tick bite and erythema chronicum migrans. Lyme arthritis, a common finding in American cases of Lyme disease, is unusual with European tick borne *Borrelia burgdorferi* infection. Reasons for this are unclear but may be due to subtle antigenic differences between strains of *B burgdorferi*.[3]

During the past year I have confirmed serologically 20 cases of "Lyme disease" in the UK, and in 16 of these the only manifestation was erythema chronicum migrans. The skin lesions are often present for more than three months before the diagnosis is made. The complications of Lyme disease may be a host specific response to infection, as Lyme arthritis is reported to occur with increased frequency in patients with HLA DRW2.

Ixodes ricinus, the assumed vector of Lyme disease, is found all over the British Isles, and to my knowledge cases of erythema chronicum migrans have occurred in England, Ireland, and Scotland. Erythema chronicum migrans has certainly been present in the UK for the past 30 years and is recorded in disease indexes kept by dermatologists. These records probably underestimate the number of cases, as some will have been missed when erythema chronicum migrans was absent or when the skin disease was not been seen by a dermatologist. *B burgdorferi* is a novel organism, which, apart from causing Lyme disease, also causes Bannwarth's syndrome, acrodermatitis chronica atrophicans, and lymphadenosis benigna cutis, as well as possibly being implicated in some cases of morphoea. Lyme disease will undoubtedly be recognised more often now that there is a greater awareness of the condition, but it is unlikely ever to reach the epidemic proportions it has reached in parts of the USA.

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2 Garin C, Bujadoux A. Paralysie par les tiques. *Journal de médecine de Lyon* 1922;**77**:765-7.
3 Barbour AG, Heilland RA, Howe TA. Heterogeneity of major proteins in Lyme Disease Borreliae. A molecular analysis of North American and European isolates. *J Infect Dis* 1985; **152**:478-84.

A depressing pursuit of quality

SIR,—Ann Cartwright finds the Royal College of General Practitioners' publication *In pursuit of quality* depressing reading (7 June, p 1497), and remarks that we may have to look to the government's blue paper for the elimination of poor standards.

In her critique she repeats Butler's findings that the performance of general practitioners is largely unrelated to the number of patients on their lists.[1] This view must be challenged before it becomes accepted as a basis for government action: indeed, the blue paper proposes a return to a payment system favouring larger lists. Butler's work was based on a postal survey, mainly concerned with