

baseline.<sup>3</sup> A risk of hypotension could then be calculated. If the risk of developing first dose hypotension was divided into quarters (from low to high) the incidence of hypotension was 0.8% and 3.3% in the placebo group versus 4.1% and 23.7% in the enalapril group. The corresponding mortality among the same patients, however, was 7.4% and 13.7% in the placebo group versus 8.2% and 15.6% in the enalapril group. These differences are consistent with the overall neutral result of the study and with no significant difference between treatment groups. Thus first dose hypotension after enalapril in this setting seems to identify patients with a high risk of death regardless of enalapril. Early death within 30 days seems to be related to the index infarct and the extent of myocardial injury and is not amenable to enalapril treatment.

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## Cardiovascular disease in developing countries

EDITOR,—The World Health Organisation's slogan of 1988—"Heart attacks are developing in the developing countries—prevent them now"—was not ill conceived. Developing countries face an epidemic of cardiovascular disease despite Uffe Ravnskov's assertion to the contrary.<sup>1</sup>

The overall pattern of diseases is changing from communicable to non-communicable diseases in the developing world. A multicentre collaborative study in the international clinical epidemiology network recently concluded, "It would appear that many communities in the developing world have high levels of risk factors for cardiovascular diseases and that steps should be taken to prevent the emergence of cardiovascular diseases epidemics in the future."<sup>2</sup> The 15% mortality from cardiovascular disease in these countries is likely to escalate to 25%, and, according to the World Bank, by the year 2000 cardiovascular disease will be the leading cause of death in many developing countries. A WHO report a couple of years ago stated that the prevalence of hypertension in some groups in developing countries was about the same as that in Finland, which has one of the highest rates of heart disease among the middle aged population. Death certificates may be unreliable, only a fraction of the deaths may be reported, and central registries may be poorly organised with insufficient or incorrect information being fed into them, but enough evidence is available globally to verify the increase in cardiovascular disease in developing countries. Newly industrialising east European countries are experiencing a similar increase in cardiovascular disease.

The pattern of cardiovascular diseases varies in different developing countries. China has a higher incidence of strokes, while hypertension and cardiomyopathies predominate in Africa, ischaemic heart disease is becoming rampant in

south Asia, and Latin America has a mixture. Pakistan, like most of these countries, is in a phase of epidemiological change: it has a declining incidence of infectious diseases and a rapid increase in non-communicable diseases, especially cardiovascular disease, with the pretransitional diseases like rheumatic heart disease coexisting with post-transitional diseases such as hypertension, ischaemic heart disease, and cardiomyopathies. The increase in the incidence of atherosclerotic coronary heart disease has indeed been phenomenal and can be rightly termed an epidemic, rather than being due to better awareness or improved diagnostic facilities.

Ravnskov's presumption that developing countries are likely to have age related coronary heart disease because more people are growing old is not entirely true. Longevity has improved in these countries, but the incidence of coronary heart disease is not always age related. In Pakistan coronary heart disease is becoming more common in the young male population. Westernisation may not be the appropriate term for factors responsible for the increase in cardiovascular disease. Cardiovascular diseases have been labelled as diseases of lifestyles. In Pakistan industrialisation has resulted in mass migration with rapid urbanisation and large segments of populations being catapulted into an era with a highly accelerated pace of life, physical inactivity, and smoking. Dietary change is a part of the new culture and one of the risk factors. No large scale population surveys are available, but existing observational data show that the conventionally established multiple risk factors for cardiovascular disease operate with some variations in the developing world as well.

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## Informed consent

EDITOR,—I agree with D D Kerrigan and others that informed consent is becoming increasingly important in modern surgical practice.<sup>1</sup> Colleagues and I studied informed consent in 190 patients admitted for a variety of ear, nose, and throat procedures.<sup>2</sup> Our patients were randomly allocated to one of four groups, and baseline anxiety was assessed on admission with linear visual analogue scales. Patients in group A were given no further information, while those in group B gave their consent in the usual informal manner. Patients in group C had an information sheet read through with them before signing their consent but were not allowed to read the sheet themselves. Patients in group D were given the information sheet to read at their leisure. A second assessment of anxiety was made four to five hours after the first.

Patients in all groups had raised anxiety levels on admission, but only those in group A maintained this higher level. Patients in the other groups reverted to lower anxiety levels. There was no significant difference in anxiety levels between these three groups, which concurs with Kerrigan and colleagues' assertion that the use of information sheets does not raise patients' anxiety.

We also found that patients' recall of the proposed procedure improved with use of information sheets. This is important medicolegally because it has been shown that patients frequently forget or mistakenly attribute information to the consent interview.<sup>3,4</sup> Information sheets would provide a permanent record, which could be referred to in the event of a dispute. If information sheets are not

used I suggest that notes should be made at the time of the consent interview detailing the points discussed with the patient.

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EDITOR,—We agree with D D Kerrigan and colleagues that it is time to think again about informed consent.<sup>1</sup> When patients consent they "approve of, concur, permit, or sanction" actions taken by their medical attendants. Implicit in this is an abrogation of responsibility—to passively permit, not actively decide. They have been advised that this is the best course of action by people who "know better" than they do and therefore, sometimes reluctantly, consent to the operation proposed. Patients' consent can, however, be withdrawn retrospectively or at least challenged. If proof of sufficient information having been given and understood is lacking, the consent form is invalid.

We suggest that consent reinforces a paternalistic attitude to patients by the medical staff and does not reflect the reality of contemporary attitudes. Importantly, it also automatically puts medical staff at a disadvantage with regard to medicolegal consequences.

Patients come to doctors because something is wrong with them. If an operation is the answer they should be so advised and should simultaneously be informed of the potential complications and risks. If they wish to proceed they should request the medical staff to perform the operation. Request, not consent, should be the patient's responsibility. The medical staff can then agree to the patient's request knowing that both patient and staff know the risks.

This issue goes to the heart of our attitudes to patients: we exist to serve the public. They should not have to consent to our actions, they should desire them. If we wish patients to be able to take more responsibility for their health we must give them both the information with which to make such decisions and the opportunity to exercise their rights to make such decisions.

We accept that these arguments and indeed this concept of request could not apply to emergencies or to patients of limited intellectual capability. The current practice under these conditions, however, is hardly better. Of what value is informed consent for an emergency caesarean section when the form is signed by a mother who has been having intramuscular pethidine every three hours and breathing 50% nitrous oxide?

If we wish to avoid escalating litigation we should welcome such a role reversal. We may still know best, and we still have a duty to our patients, but society now demands that consumers of health care have greater rights and are more informed about their care. By the same token, why should not the medical profession ask that the consumers of health care take on some of the responsibility? Does not every right have a corresponding responsibility?

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