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Treatment for benign positional vertigo

EDITOR,—In their review on benign positional vertigo Thomas Lempert and colleagues place great faith in the histological finding of particulate matter in the posterior semicircular canal,¹ although there is a paucity of evidence that such particles are directly implicated in benign positional vertigo. Schuknecht's original observation was based on two postmortem studies.² He then went on to describe similar findings in 149 temporal bones from 245 subjects without historical evidence of the disorder.³ Furthermore, in this study the same abnormality was found in all three semicircular canals. Most recently, particulate matter has been described in a majority of labyrinths examined, regardless of symptoms.⁴ The theory of canalolithiasis therefore remains plausible only in the absence of any other explanation.

It is wrong to base an entire therapeutic approach on a finding that seems to be common in asymptomatic subjects or may be an artefact. In addition, Epley's manoeuvre as described has been subjected to only relatively short term follow up; account should be taken of the subset of patients with a remitting and relapsing form of the condition. A far more common approach in Britain, which Lempert and colleagues dismiss, is to encourage habituation by the use of the well established and simple to teach Cooksey Cawthorne exercises. This, together with the avoidance of vestibular sedatives, which may prevent habituation,⁵ is a well tested regimen that has the advantage of being self administered. Surely the role of the doctor in chronic conditions should be to empower the patient, not to reduce him or her to the status of a rag doll on a couch.

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Ethics committees

Information that can be given to researchers over the telephone needs to be clarified

EDITOR,—As researchers conducting a follow up study of patients after their discharge from a secure forensic psychiatric unit we wish to report our experiences of dealing with research ethics committees. We have experienced many of the problems experienced by Claire Middle and colleagues¹ but wish to highlight the range of

procedures that we have had to complete before gaining access to information on patients.

Hospitals that had accepted patients after discharge from the unit were contacted about subsequent admission to hospital, the patient's current address, and the identity of professionals involved with the patient's care. In some cases this information was given directly over the telephone by the medical records department after a brief explanation of the research. Some hospitals returned the telephone call to check on our identity. If we were directed to the patient's psychiatrist, again we might be given the information orally or be asked to put the request in writing. One consultant wanted us to contact the patient for permission, but this proved difficult as the patient had been lost to follow up from that hospital for over five years.

Similar variation in response was experienced for the second part of the study, which involved a short interview with patients. One consultant stated that he did not care what we did to any of his patients, some wanted a written request, and a few requested a copy of the research protocol. Three hospitals that we contacted had their own research ethics committees, which required us to complete highly complicated proposal forms that were not at all user friendly. One of these hospitals was unable to accept references to the research protocol, which had secured a grant of £170 000, and wrote asking us to complete the form "properly." In total, six months elapsed between our first contact with this hospital and the interviews with the patients being cleared.

Requests for information from government departments produced a similar variation in the amount of correspondence required. One department failed to produce any information despite numerous letters, faxes, and telephone calls and, indeed, never acknowledged our requests.

We wish to emphasise the diversity of the responses we received. There is a need to standardise the type of information about patients, especially psychiatric patients, that can be disclosed to telephone callers, particularly in the light of Claudia Court's news item on employers' view of mental illness.²

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Separate criteria should be drawn up for questionnaire based epidemiological studies

EDITOR,—Epidemiological surveys based on questionnaires are safe. They are non-invasive, do not involve a hazardous procedure or a controlled trial, and do not breach any medical confidentiality. They may also not involve NHS patients. Nevertheless, it is thought to be good practice to apply to research ethics committees before carrying out such a survey, though non-medical questionnaires are not subject to any scrutiny. We support the view that all questionnaire based studies should be reviewed but do not think that this should be under the current system.

Establishing national or regional committees to consider multicentre applications¹⁻³ cannot be justified if their decision might be vetoed locally, as the applications would then still need to be sent to all relevant local research ethics committees. This would not save time or money. We have two proposals that might be more appropriate,

effective, and efficient for both applicants and committee members.

Preferred option—Questionnaire only studies could be approved effectively by the local research ethics committee covering the base from which the study is run, which could be the nominated local research ethics committee as suggested in guidance from the Department of Health.⁴ This is likely to screen out unethical aspects of such studies 90% of the time and would alleviate some of the overburdened meetings. Repetitive review by several committees is unlikely to add anything constructive.

Second option—At present, approval from each local research ethics committee is deemed necessary. It is asserted that local factors should be considered, although what these might be in relation to questionnaire based studies is unclear, as is how well committee members represent them. If this system is to be applied then the following are urgently required. Firstly, regularly updated details of ethics committees should be easily accessible. Published registers become out of date quickly and are not widely known about. We have approached the editors of the *Health Services Year Book* to see whether this information could be included in it. Ideally, updated information should be accessible in an electronic form suitable for mail merges and labels. Secondly, there should be a standard application form for questionnaire based studies that is acceptable to all committees. Most current forms are designed for clinical trials in hospitals and are inappropriate. Thirdly, approval by the chairperson, if necessary with advice from an appropriate member of the committee, should be supported for questionnaire only studies. Finally, a basic service should be supported and should include acknowledgement of applications within one week of receipt, consideration of applications within two months, and the notification of the decision to applicants within 10 days of the meeting.

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Communities' confidentiality should be maintained and community consent sought

EDITOR,—Individual rights in the context of medical research receive much attention,¹ and ethical principles of epidemiological studies reflect this emphasis.² We believe that the rights of communities with respect to epidemiological investigations will need greater consideration in future for two reasons. Firstly, infectious diseases, such as HIV infection and AIDS, that are transmitted by certain risk behaviours elicit strong personal feelings, and stigmatisation may result if information is disclosed. Secondly, geographical information systems, which enable rapid and precise mapping of the distribution of infection or disease, are being used increasingly.

A hypothetical example illustrates our concern. Suppose that an epidemiological study of infection A is undertaken in a community (a city or administrative unit), requiring collection of serum and questionnaire information from a representative sample. Individual informed consent regarding infection A is obtained. Results are published. In the same population an epidemic of infection B,

with important public health implications, has given rise to a need for information on its spread. Serum residues from the study of infection A, together with the epidemiological database, provide the ideal resource. Their use is justified on the grounds that (a) further collection of serum samples from the community would be unethical while suitable samples are available, (b) the whole community would benefit from the provision of important epidemiological data on infection B to public health authorities, and (c) absolute anonymity of people who participated in the study of infection A could be assured. The study is conducted and data presented, after the use of a geographical information system, in the form of precise maps of the distribution of infection B by subpopulation within the community. Molecular "fingerprinting" through phylogenetic analysis^{3,4} reconstructs the pattern of the epidemic, with its origin and spread from sector to sector. If infection B was measles no one would raise an eyebrow; substitute HIV infection and alarm bells ring.

Although anonymity for the individual has been maintained, social stigma can apply to sections of a community and not just to individuals. International ethical guidelines advise that investigators should protect groups as well as individuals from possible harm or disadvantage, including adverse criticism relating to sensitive information.² How should these principles be put into practice? At what mapping resolution does "community confidentiality" become a problem? Does informed consent need to be obtained from communities, and, if it does, who should be their representative? We believe that more discussion is needed to determine how to disseminate and use information in ways that support community rights.

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Long term care in later life

A mixed economy of care is necessary

EDITOR,—On behalf of the hundreds of thousands of residents and staff living and working in private nursing homes I take issue with the implication of one of the questions in J Grimley Evans's editorial on long term care in later life: "Should profit making nursing homes join tobacco companies and manufacturers of antipersonnel mines as industries in which decent people do not buy shares?"¹ I assume that Grimley Evans has chosen these latter two industries for comparison because they make products that maim or kill people. I know of no evidence showing that private nursing homes maim or kill elderly people. Their rates of admis-

sion, length of admission, and mortality are comparable to those of voluntary or state nursing homes, as is shown by the most authoritative survey of long term residential care.² If Grimley Evans has evidence to the contrary he should share it with us.

Grimley Evans describes private nursing homes as "inadequately regulated." Yet private (and voluntary) homes are subject to a stringent registration process and twice yearly independent inspections. State nursing homes are not bound by any such regulation, and most commentators, right across the political spectrum, agree that by far the most pressing reform is to create a "level playing field" by regulating state homes in precisely the same way as private and voluntary homes are regulated.

Perhaps Grimley Evans objects to the principle of making profit from caring for elderly people. If so, does he condemn his medical colleagues who practise privately, specialist builders, private hospitals, manufacturers of specialist equipment, and all those who provide support services to elderly people, such as caterers? Indeed, perhaps Grimley Evans should consider his own position. As a professor with merit awards he earns considerably above a bare living wage and might therefore be said to "profit" from elderly people.

Grimley Evans rightly raises the serious issue of funding of long term care. The debate has moved on, however, from the old public versus private divide. The future lies with a mixed economy of care, in which all three sectors have an important role. Each needs to teach and learn from each other in an area in which asking questions is much easier than providing real solutions.

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- 1 Grimley Evans J. Long term care in later life. *BMJ* 1995;311:644. (9 September.)
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Best providers should win contracts irrespective of their ownership

EDITOR,—Although J Grimley Evans's editorial on long term care in later life raises important issues, some of his assumptions and emotive language undermine the spirit of the open and informed debate that we so desperately need on the future of long term care in Britain.¹ Although it is useful for commentators to acknowledge the diversity and range of philosophies of ownership in the independent sector—indeed, much of Britain's independent health and social care sector relates to such traditions as cooperation, mutuality, and charity—the debate should surely be the best way to ensure that people's needs are met. Indeed, the future demands a move away from the old and sterile world of the "them versus us," "public versus private" rhetoric beloved of politicians and activists on all sides.

Three quarters of all nursing and residential care homes in Britain are now provided by the independent sector,² and a recent study by the University of Kent based on costs for 1993-4 found that NHS care for elderly people was over 92% more expensive (residential care provided by a local authority was found to be 31% more expensive).³ Accordingly, one must ask whether Grimley Evans should not instead be calling for a boycott of all statutory providers.

I believe that when statutory authorities fund care they must guarantee real choice and start to contract for care packages and not simply buy beds. A nationally agreed system for scoring dependency should also be introduced throughout Britain, which would be used to assess need and specify treatment and packages of care. Above all else, commentators should be primarily concerned

with quality and cost irrespective of ownership: in the future, the best providers should win contracts irrespective of their ownership.

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Accessing the Internet is far from easy

EDITOR,—According to Andrew Millman and colleagues, "accessing the Internet is very easy,"¹ but tales of woe in articles and correspondence in British magazines devoted to the Internet tell another story. Who is telling the truth?

My attempts to get dial up connection to the first Internet service provider I tried took several weeks because of an almost complete lack of advice, difficult access to a helpline, and overloading of the service provider (one of the major ones). The email software was cumbersome and almost unusable. When it proved impossible to log on, the automatic redialling facility was an advantage, but I abandoned this provider after several occasions on which over 500 attempts to log on failed.

A second service provider supplied an incorrect password, which prevented me from logging on, and a helpline was repeatedly engaged. There was no reply to two faxed requests for help, but I obtained a response after sending a letter by post. I abandoned this provider after repeated inability to log on and access the system.

A third service provider could not be contacted by telephone (it was repeatedly engaged) and failed to reply to fax or posted requests for information.

With a fourth service provider, for reasons that it could not explain, email was selectively undeliverable to Manchester University and there were frequent problems with logging on.

I am currently trying a fifth service provider; the early signs are promising. I have not counted the many hours spent in this exercise, but at present I would advise only serious computer enthusiasts with plenty of spare time to attempt to access the Internet from home. The truth is that access to the Internet is at present far from easy. The reasons include rapid expansion in the number of people wishing to access the Internet, which exceeds the ability of service providers to expand their services; user unfriendly software; and poor support.

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- 1 Millman A, Lee N, Kealy K. The Internet. *BMJ* 1995;311: 440-3. (12 August.)

"Probiotic" remedies are not what they seem

EDITOR—"Probiotics," usually called "acidophilus," are claimed to contain "friendly" intestinal lactic bacteria, regular consumption of which confers health benefits.¹ As a previous report showed that dietary products sold in the United States as containing *Lactobacillus acidophilus* either contained no viable lactobacilli or contained organisms other than *L. acidophilus*,² we investigated the microbiological content of 13 brands of probiotics bought over the counter in Britain.