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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