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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 colleagues[1] 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 applications[1-3] 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,