Mental Health Act 1983 would be a standard course of action if he or she refused voluntary admission. It is wrong to suggest that if such a patient took an overdose his or her refusal of treatment while distressed should be considered to be valid. In most cases of self poisoning presenting to casualty departments the history is scanty, the patient is uncooperative, and treatment is needed immediately. If fleeting refusals of treatment were to be honoured many lives would negligently be lost; this is not what English law requires of doctors. The common law allows doctors to act in the best interests of patients if they do not have the capacity to consent.

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1 Hodgkinson DW, Gray AJ, Dalal B, Wilson P, Szawarski Z, Sensky T, *et al.* Doctors' legal position in treating temporarily incompetent patients. *BMJ* 1995;311:115-8. (8 July.)
2 ReT (adult: refusal of medical treatment) [1993] Fam 95.
3 ReF [1990] 2 AC 1.

Failure to treat outweigh risk of non-voluntary treatment

EDITOR,—Petra Wilson, the legal contributor to the debate on doctors' legal position in treating temporarily incompetent patients, adopts a pessimistic position concerning the legal justification for treating the two patients discussed.[1] The intuition of most doctors would suggest that these incompetent patients should be spared the immediate consequences of their disastrous decisions. Fortunately, in Re F the House of Lords confirmed that it was possible for a doctor to give surgical or medical treatment to incompetent adult patients provided the treatment was in their best interests.[2] Furthermore, the involvement of the court was not necessary, which must be a relief to hard pressed casualty officers. In Re T the Court of Appeal found that T, a pregnant Jehovah's Witness, could be given a blood transfusion even after her apparent refusal (as in the case discussed in which the patient had taken an overdose) since her mental state had deteriorated to the extent that she could not make a competent choice between having a blood transfusion and probable death.[3] This is similar to the problem of advance directives in that patients, in giving their wishes, may not have anticipated all the circumstances that can occur when they are unconscious.

Failure to treat in such circumstances could itself leave a doctor open to the possibility of an action for negligence, in which case the reasonableness of any decision not to treat would presumably be assessed according to whether it accorded with a responsible body of medical opinion—the Bolam test.[4]

I also strongly doubt the application of the case of Majewski to questions of consent to treatment.[5] It may be good public policy that criminals cannot use intoxication to prevent the requisite criminal intent being proved against them, but this does not alter the fact that autonomy is decreased by alcohol and that when necessary doctors should treat intoxicated patients as they would any other incompetent subject. The case of Malette *v* Shulman, cited by Wilson, is a Canadian case.

I have no doubt that for most doctors the legal risks of non-treatment outweigh those of non-voluntary treatment by a substantial margin.

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2 Re F; F *v* Berkshire Health Authority [1990] 2 AC 1.
3 Re T [1992] 4 All ER 649.
4 Bolam *v* Friern Barnet HMC [1957] 2 All ER 118.
5 DPP *v* Majewski [1977] AC 443.

No reliable evidence that folate is harmful in B-12 deficiency

EDITOR,—E H Reynolds cites his interesting observations on a case of subacute combined degeneration caused by an abnormal vitamin B-12 binding protein.[1] He suggests that administration of folic acid may have precipitated the neurological condition.[2] Recently I carefully examined the literature before and after the discovery and introduction of folic acid and vitamin B-12 but found no reliable evidence that folic acid is a neurological poison,[3] although many people still think it is. Before liver and B-12 therapy for pernicious anaemia were introduced, neurological deterioration was often very rapid, whether or not folic acid had been given. Furthermore, as Reynolds and colleagues have shown, not only can folic acid deficiency in the mother cause neural tube defects in the fetus, but in adults it is associated with neuropsychiatric, especially affective, disorders.[4]

Food additives always excite controversy, even when the additive is a normal and essential vitamin whose deficiency can be devastatingly damaging. Fortification is needed; otherwise, avoidable harm will continue. A standing committee should be set up to monitor the efficacy and safety of a national fortification policy, and to amend the guidelines as appropriate.

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1 Reynolds EH, Bottiglieri T, Laundy M, Stern J, Payan J, Linnell J, *et al.* Subacute combined degeneration with high serum vitamin B12 level and abnormal vitamin B12 binding protein. New cause of an old syndrome. *Arch Neurol* 1993;50:739-42.
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4 Shorvon SD, Carney MWP, Chanarin I, Reynolds EH. The neuropsychiatry of megaloblastic anaemia. *BMJ* 1980;281: 1036-8.

Qualitative study on patients with stroke

Leaves questions unanswered

EDITOR,—Pandora Pound and colleagues' qualitative research on the views of patients with stroke on their admission to hospital raises several issues.[1]

Firstly, how representative of patients with stroke was the study population? The information provided is mainly on exclusions. What proportion of all patients with stroke admitted to the two hospitals were included? How many patients had had more than one stroke?

Secondly, is it "probably safe to assume that a reasonable spread of different views has been achieved," particularly with a 49% response rate?

Thirdly, it would be helpful if the full methodology had been described. Despite reading the related publications[2,3] we had to contact the authors to establish that the scores comparing responders and non-responders in table I were derived from a variety of questionnaires completed by carers, interviewers, and patients, involving a mixture of telephone, postal, and personal interviews. Are P values meaningful for the subsequent lack of differences in the mean scores derived? Why did the population that was interviewed decrease by 5% (2/40) but the population that was not interviewed decrease by 32% (13/41)?

Fourthly, why was patients' satisfaction in the above two groups not compared?

Fifthly, it is stated that "carers are sometimes present... and their accounts were also included here." Is this a study of the views of patients with stroke or their carers? A qualitative study should have been able to distinguish these views more clearly than quantitative methods.

Sixthly, cross tabulation of combined categories of components of care is not given, and 8% (3/40) of interviews were excluded because they talked about housing. If housing is what patients with stroke (rather than researchers) are interested in 10 months after their stroke why was the opportunity not taken to explore this qualitatively? The same number of people (3/40) were dissatisfied with the information they received, yet this merits a whole section in the results.

Seventhly, why were quantitative methods used at six months but qualitative methods at 10 months? The possibility of bias being introduced by the questionnaires used four months previously is not discussed.

Finally, while this study confirms the findings of Anderson[4] and others, what does it add? Are there good grounds for repeated surveys of the same group of frail patients on a stroke register?

We raise these issues because we believe that the value of qualitative research will become apparent only if the methodology of the research is sound.

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1 Pound P, Bury M, Gompertz P, Ebrahim S. Stroke patients' views on their admission to hospital. *BMJ* 1995;311:18-22. (1 July.
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3 Pound P, Gompertz P, Ebrahim S. Patients' satisfaction with stroke services. *Clin Rehabil* 1994;8:7-17.
4 Anderson R. *The aftermath of stroke. The experience of patients and their families.* Cambridge: Cambridge University Press, 1992.

Authors' reply

EDITOR,—The study population was representative of survivors of stroke admitted to hospital within the inner city; it did not claim that it was representative of all patients with stroke. We are confident that a reasonable spread of different views was achieved since we have information about non-responders, which was presented in the paper.

As we have already explained to Ann Bisset, the methodology used in the stroke outcome study follows the standard practice of seeking the best available source of information. While we recognise the danger of patients' views being misinterpreted, carers who were able to contribute to interviews with patients with cognitive or speech impairments were highly valued. Asking carers to be absent from the interviews would have been unnecessarily distressing for many of the patients.

The three interviewees who discussed their housing problems were excluded from this analysis since people's views of their care, not housing, was the topic of this paper. Their interviews will be used in other analyses of the data—for example, those relating to the consequences of stroke. This paper confirms only one aspect of Anderson's findings[1]—that relating to nursing care. The main message, that patients evaluate their care in a multidimensional manner rather than focus on function and death, is in our view an important one with implications for research and clinical practice in stroke.

The other points raised by Ann Bisset and Rosemary Chesson are of little relevance in determining the methodological standard of qualitative research but are more important in quantitative work. Both quantitative methods and qualitative methods were used at different times as the stroke