publicised error made in the diagnosis of brain stem death for the transplant programme would be horrendous. It would be helpful for those actually diagnosing brain stem death if the time between neurological examinations was stipulated. I would suggest 12 hours where raised intracranial pressure from subarachnoid or intraparenchymal haemorrhage is the mechanism and 24 hours for other diagnoses. Particular care has to be exercised where brain stem demyelination may be a factor as it can contribute to loss of brain stem reflexes [1].

References

1 Ringel RA, Riggs JE, Brick JF. Reversible coma with prolonged absence of pupillary and brainstem reflexes: an unusual response to a hypoxic-ischemic event in MS. *Neurology* 1988;**38**:1275–8.

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An appropriate admission depends on your viewpoint

Editor—Whether admission is appropriate or not (July/August 1995, pages 311–4) depends on your standpoint. An admission deemed inappropriate by clinicians may be deemed essential by frightened patients or their anxious, hard pressed carers.

With the growing emphasis on consumer issues, complaints, rights and charters within the health service, the views of patients and their relatives are increasingly influential. They will frequently feel that admission to hospital is required in situations where doctors may not. I suspect that this is more fully appreciated by general practitioners than by hospital-based physicians. As a GP trainee I have learnt the importance of negotiating an agreed plan of action with patients and carers. Day hospitals, urgent domiciliary visits and GP units are all valuable options when agreeing a management plan to maintain an individual in the community. There are, however, occasions when patients or their relatives/ carers are obviously not happy with a situation and press for admission to hospital. On purely clinical grounds the admission is inappropriate but taking a wider view one could argue that in such situations admission is entirely appropriate and unavoidable. It is not easy at a patient's home to explain on the telephone to junior doctors that one is well aware that there are scant clinical grounds for admission but that the home situation and patient's carer's expectations are such that there is no feasible alternative. In such circumstances admission is appropriate.

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Why do research ethics committees disagree?

Editor—Claire Foster (July/August 1995, pages 315–8) explains the inconsistent performance of ethical committees [1] by describing three moral outlooks which may be represented to a greater or lesser extent in any committee. She suggests an 'ideal' committee would balance these outlooks. If one committee is ideal, it follows that less balanced ones are less than ideal. If committees do not give reliable answers, it is reasonable to question the validity of their answers. Providing an explanation for a flawed system does not make the flaws go away.

Quite apart from the ethical debate, the present system is costly: I have recently been obliged to send the same proposal on a multicentre randomised controlled trial to 18 committees. In addition to the obvious drain on research and secretarial time this involved for the project, there are considerable costs to the NHS. Assuming each committee had six health service employees (say two consultants, a general practitioner, a senior nurse, another health care worker, and an administrator) and the proposal took each person one hour to digest (ie reading, discussing, reaching conclusion, reviewing revisions and deciding to accept or reject) in all, 108 hours (ie two and a half weeks) of senior staff time were used to process this project. Multicentre studies are not uncommon so this sort of waste is being multiplied many times. There is a valid utilitarian argument that such waste is unethical, and staff could be more usefully employed elsewhere.

We are paying through the nose for an inefficient system. The most ethical and cost effective system must surely be a properly funded national committee for multicentre research.

Reference

1 Hotopf MH, Wessely S, Noah N. Are ethical committees reliable? *J R Soc Med* 1995;**88**:31–3.

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