columns

year we switched to the alternative agent propofol, and very quickly found the expected trends emerging – on average patients have shorter fits, fewer have 'adequate' fits (according to either the motor fit or the electroencephalogram), and in consequence higher stimulus charges were being used as well as routine caffeine augmentation and hyperventilation. Unsurprisingly, our local clinical teams soon began commenting on the increase in the post-ECT confusion.

We have, therefore, begun using thiopentone for those patients who have an unacceptably high seizure threshold with propofol. We have found that thiopentone appears to have noticeably less anticonvulsant effect so that relatively lower charges and longer fits are possible – in one case a 90% reduction in charge was achieved.

Interestingly, with propofol, a number of patients are responding well even though their fit duration does not meet the usual criteria for 'adequacy' in line with the observations on monitoring seizure activity in the College's *ECT Handbook* (1995).

We would, therefore, suggest keeping the dose as low as possible if using propofol, to minimise its anticonvulsant effect. If the patient is having short fits it may not be necessary to significantly increase the charge, if feedback from the clinical team indicates the patient is responding well anyway. Thiopentone may be an acceptable alternative for those patients who cannot be given effective treatment using propofol.

A comparison of the last 23 courses of ECT using methohexitone alone with the first 20 not using methohexitone showed 13/23 'unequivocally good' outcomes in the methohexitone group versus 17/20 in the non-methohexitone group, a non-significant trend in favour of 'non-methohexitone' ($0.10 > P > 0.05$ using χ^2 with Yates correction).

Thus, the administration of effective ECT is possible without the use of methohexitone.

Reference

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Specialist registrars and responsible medical officer status

Sir: The Mental Health Act 1983 defines certain duties as being the sole remit of the responsible medical officer (RMO). These include the ability to discharge a section; power to bar discharge of a detained patient by the nearest relative; the granting of Section 17 leave; authorisation of consent to treatment and formulation of aftercare under Section 117 of the Act. The RMO, in relation to a detained patient is "the registered medical practitioner in charge of the treatment of the patient" (Mental Health Act 1983, Section 34(1)). The term 'in charge' is defined in the 1998 Memorandum as meaning "not responsible or accountable for the patients treatment to any other doctor". In the absence of the RMO, such duties are delegated to the acting RMO – usually another consultant covering their colleague's duties.

Can the RMO delegate such tasks to his or her specialist registrar (SpR) during leave of absence? In practice it would appear not, as is the case at present in our trust. However, we argue that delegation should be adopted as best practice. The SpR is a senior psychiatric trainee, is member of the Royal College of Psychiatrists (having passed the Membership Exam) and is likely to have a better knowledge of the RMO's patients than a consultant colleague nominally deputising. Furthermore, should not a SpR be able to practise, under supervised conditions, the skills of the RMO, the role for which they are training? Indeed, if a SpR covers as a locum consultant, they exercise full RMO powers. It is difficult in our view to understand how training to become a consultant could be considered complete without supervised experience of working with the complexities of the Mental Health Act.

There is support for our proposal in the relevant literature. Jones (1996) discusses the role of the RMO and notes that the medical practitioner need not necessarily have consultant status. The Mental Health Act Memorandum (1998) states that a SpR approved under Section 12(2) can exercise the role of the RMO when the patient's usual doctor is not available and swift action under the Act is required. The new Code of Practice (1999) names the Specialist Registrar as one of those able to grant Section 17 leave in the absence of the RMO, if they are at the time "the doctor in charge of the patient's treatment" (Section 20.3). Indeed, being the doctor 'in charge' of detained patient's treatment at a given time appears to be the key determinant in defining RMO status.

To conclude, we propose that in the absence of a consultant it should be accepted practice that the SpR may practise, under supervised conditions, utilising all the powers allocated by Section 12(2) status and exercising full responsibilities vested in the RMO role. We refer specifically to four areas:

(a) Granting of Section 17 leave.
(b) Review of consent to treatment under section.
(c) Discharge of sections, with aftercare planning under Section 117.
(d) Attendance at mental health review tribunals or hospital manager review meetings, to review the section.

We argue that new mental health legislation or guidance should encourage such practice.

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Retention of psychiatric trainees

Sir: I was delighted to read Sally Pidd's review regarding the College census and plans to establish an integrated database allowing production of statistics regarding career pathways of psychiatric trainees (*Psychiatric Bulletin*, October 1999, **23**, 630–633).

I am interested in the retention of junior psychiatry trainees in the speciality and, anecdotally, have been aware throughout my training of the ease with which many good trainees have left without the opportunity to tell their stories. I recently attempted to set up an audit project to identify how many basic level trainees in one teaching hospital scheme went on to pursue psychiatric careers, what became of those who did not and importantly identify the reasons given for leaving using a design method similar to that described by Harvey *et al* (1998).

Using medical staffing lists I was able to identify that 59% (27/45) of new recruits to the scheme over the years 1988–1990 were members of the Royal College of Psychiatrists 10 years later. Medical staffing lists are destroyed after 10 years and I was, therefore, unable to trace back any further than 1988. Unfortunately, no information was kept on individual doctors other than an initial and surname. It was evident that these handwritten lists were incomplete and inaccurate and made identifying and therefore tracing doctors who had left impossible.

I applaud the College's efforts to collate this type of information and would hope that individual schemes could be involved in auditing their retention of trainees. I

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