including curative measures) to prevent suicide 'in any case where he does not have reason to believe that the determination on self-destruction is fixed and unalterable'—and ECT could be regarded as a means of determining how fixed and unalterable was the intention. Even Jacob,[3] citing Skegg, allows doctors 'to impose treatment to alleviate the immediate condition . . . of the suicidally depressed'. In general, Jacob permits nursing care of the detained; but such care cannot usually be afforded to the detained without such concomitant medically imposed treatments as sedative drugs—and if drugs why not ECT? It is arguably no more drastic. While, then, it would always be reasonable to discuss both with detained patients and their relatives, whenever possible, the reasons underlying the need for ECT, the authoritative position of the RMO in deciding should never be dissimulated.

As to (4) above, the Percy Commission[4] made its intention clear that 'the law should no longer prevent mentally ill patients from entering hospital without being subject to detention if they cannot make a valid positive application for admission' (para 22). Expanding, it claimed that 'most non-volitional patients of the type who are now admitted as temporary patients' (under the Mental Treatment Act, 1930) 'could be treated without powers of detention' (para 290). As the result of their proposal (para 291) for '. . . the offer of care, without deprivation of liberty, to all who need it and are *not unwilling* to receive it' (my italics), the Mental Health Act repealed the Mental Treatment Act and its provision for temporary treatment; and the above-cited Memorandum[1] (para 16) stated that 'arrangements for the informal admission . . . of patients who are *not unwilling* to be admitted . . . are already in operation' (my italics). The College's proposal, then, to detain under Section 26 all such patients needing ECT is patently retrograde. Surely it can suffice that the case file should have inserted the written statement of the consultant in charge (preferably after discussion with the nearest relative) that (a) the patient needs ECT to preserve his/her life and health and (b) he/she is incapable by reason of the illness of either giving or withholding consent?

I can but hope that most psychiatrists will not feel constrained by the College's advice to take mad measures simply to safeguard themselves (if the measures recommended do safeguard) in the administration of ECT.

SEYMOUR SPENCER, F.R.C.Psych.

Consultant Psychiatrist,
The Warneford Hospital,
Headington, Oxford

References

[1]HMSO (1960).
[2]SKEGG, P. D. G. (1974) A justification for medical procedures performed without consent. *The Law Quarterly Review*, **90**, 512.
[3]JACOB, J. (1976) The right of the mental patient to his psychosis. *The Modern Law Review*, **39**, 17.
[4]ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY, 1954–1957. HMSO, Cmnd 169.

DEAR SIR,

Although the Memorandum on the Use of ECT, (*Journal*, September 1977, pp 261–72) is one of the most objective and scientific reports on this controversial subject, I find it very difficult to accept its suggestion, under the subtitle: Who decides that a patient needs ECT?, that this decision has to be taken by the consultant responsible for the patient in discussion with his junior staff and *the nursing and paramedical staff*. I do not think that an occupational therapist, a staff nurse or a social worker has the qualification or the experience to have any say in this decision, exactly as they have no say in whether the consultant will prescribe imipramine or amitriptyline to his depressed patient. It is a purely clinical and medical decision, and if we make it a democratic one the medical staff's opinion will be overpowered by the paramedical staff, who for obvious reasons usually oppose this type of treatment, and who in any clinical meeting outnumber the medical staff.

I also wonder how the report can think that a psychiatrist of registrar grade is too junior to decide on the need for ECT (p 268) and at the same time recommend that the consultant's decision on the need for ECT must have the blessing of the nursing and paramedical staff. It is the same story time and again, whenever the psychiatrists step into an uncertain territory they seek the support of other professions by inviting them to share their purely medical decisions, hoping that by doing this they will take part of the blame if things for any reason go wrong.

W. R. GUIRGUIS, M.R.C.Psych.

Senior Registrar,
St Clement's Hospital,
Foxhall Road,
Ipswich, Suffolk

DEAR SIR,

It is disconcerting to see the subjective way in which the College's Special Committee on the use of ECT has approached its task of evaluating the evidence from clinical trials.

This is most apparent in the section of the Memorandum which deals with the 'Mechanism of Action of ECT'. Five studies are cited which compare ECT with 'pseudo-ECT' (i.e. anaesthesia without the shock, or with subconvulsive shock). The Committee acknowledges that two of these studies are methodologically unsound, in that in one case (Study 4) patients were not randomly allocated to treatment groups, and in another (Study 2) there were rather wide variations in pre-treatment ratings of the treatment groups. They also recognize that Study 5, which compared ECT and placebo tablets with pseudo-ECT and imipramine, is difficult to interpret since the dose of imipramine (which is shown on p 263 of the Memorandum to be a significant factor determining the relative effectiveness of ECT and imipramine) is not given, and insufficient data are provided to substantiate the alleged differences between treatment groups. This leaves two studies (Nos. 1 and 3), both of which found no significant difference between the effects of ECT and pseudo-ECT. It is hard to see how, on the basis of this evidence, the Committee could conclude that 'There is good if not conclusive evidence that the induction of a convulsion is necessary for the therapeutic effects of ECT'.

WENDY FARRANT, M.Sc., Ph.D.

Senior Research Officer,
Institute for Social Studies in Medical Care,
18 Victoria Park Square,
Bethnal Green,
London E2 9PF

DEAR SIR,

The guidelines produced by the College on the use of ECT must surely invite comment. Whilst one might commend the authors for Parts I and II of the Memorandum for a balanced appraisal of the value of ECT and a sensible approach to the standards of its administration, ably backed by suitable references, when one reaches Part III concerning the medico-legal aspects of ECT the advice is ambiguous and in my view ill-considered.

For example, under paragraph (b) relating to the unwillingness of a patient to undergo ECT it is stated that 'where treatment is given against a patient's wishes, present legal advice is that Section 26 should be applied and not Section 25'. Are we not entitled to ask on what such advice is based and on whose recommendations? Is it for the benefit of the patient or the protection of the psychiatrist? Most courses of ECT are completed within twenty-eight days and the Mental Health Act makes it quite clear that treatment can be given under Section 25 (despite its absurd title of Admission for Observation), so one may well ask what is the necessity of detaining a patient for up to one year.

In the same paragraph it suggests that two consultant opinions should be obtained (as part of the sentence pointing out that the risks involved largely derive from anaesthesia). Surely this is absurd, for in the September *Bulletin* (p 4) the consultant's responsibilities are outlined as the ultimate medical opinion and as such autonomous within the professional framework described above; and later it states categorically that the consultant 'by reason of his training and qualifications undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person . . .'.

In the management of a difficult patient any consultant may well feel he would like the backing and helpful suggestions of his colleagues, but surely he is not obliged to seek it. The Memorandum produced by the College may well assume a legal respectability which as yet it has not earned. Before it becomes mandatory may we have clarity, until we finally abrogate our responsibility to a committee?

G. SEDMAN, M.R.C.Psych.

Consultant Psychiatrist,
St Ann's Hospital,
Canford Cliffs,
Poole, Dorset BH13 7LN

The EDITOR comments:

Medical treatments are not an entirely private matter between patient and doctor. They are of concern also to the patient's relatives and friends, and to nurses and other colleagues of the doctor, who may have to cope if the treatment fails in some way. Society at large is also concerned, and regulatory laws are passed from time to time to define the permissible and to diminish error. No human being, not even a consultant, is infallible. When things go wrong the doctor may have to show that he has acted in good faith, responsibly and with knowledge, in the patient's best interests, and that other doctors might have acted as he did. How is the doctor challenged over ECT to show all this?

In my view the College's advice (and it is only *advice*) is that when prescribing ECT the doctor must not only act wisely but be seen to act wisely. He must all along communicate openly, he must be prepared