
Correspondence

Restimulation with ECT

Sir: I found the paper by Gee & White (*Psychiatric Bulletin*, 1993, **17**, 606–607) where they stress the need for a formal restimulation policy in ECT very useful as we are working on a similar policy.

Timing of seizure duration should be viewed as a form of process outcome measure for the procedure but the confounding effect of muscle relaxant suggests that the cuff technique should also be routinely employed (Addersley & Hamilton, 1953).

It should be stressed that the 25 seconds minimum is not based upon clinical outcome studies, and there has not as yet been a demonstration that actual seizure duration is clinically relevant, although the presence of a seizure is.

The American studies use EEG seizure measures, so if a minimum adequate fit duration is ever demonstrated, it will be shorter by at least 10% in the UK as we use motor seizure timings (Fink & Johnson, 1982).

ADDERSLEY, D.J. & HAMILTON, M. (1953) The use of succinylcholine in ECT. *British Medical Journal*, **19**, 541–550.

FINK, M. & JOHNSON, R.N. (1982) Monitoring the duration of electroconvulsive therapy seizures. *Archives of General Psychiatry*, **39**, 1189–1191.

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Care of people with a mental handicap

Sir: In 'Psychiatric emergencies in people with a mental handicap' (*Psychiatric Bulletin*, 1993, **17**, 587–589) Dora Kohan write . . . "A trained, experienced and harmonious community team, a well organised back-up service of generic hospital beds and admission-assessment units for mentally handicapped people will deal with emergencies effectively".

The question is how many satisfactory admission-assessment units (NHS) for the mentally handicapped are there? The running down of large hospitals for the mentally handicapped without developing adequate numbers of new NHS units, a range of community homes, incentive for training staff and managerial fragmentation diminish morale and make the service inadequate, unsatisfactory and unpopular.

The time has come for the College to give strong leadership and send an urgent signal to the Government to focus on mentally handicapped people with neuro-psychiatric problems who

need health care in the NHS in new small accommodation with adequate numbers of beds and qualified staff.

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Audit of outcomes

Sir: "And how his audit stands who knows save Heaven" (*Hamlet*, Act 3). It is now clear from the White Paper (DoH, 1989) and from subsequent injunctions that how a doctor stands will depend on how diligently he pursues self-audit in general and the audit of the outcome of his work in particular. Many of those who urge the virtue of outcome audit on us believe it to be easy. On two occasions in the last month, I have been told authoritatively that reliability is a 'scientific' issue and not one that should trouble us when determining clinical outcome. Although acknowledging the difficulties of assessing outcome, the College's preliminary report on medical audit (*Psychiatric Bulletin*, 1989, **13**, 577–580) remarks "Clinical audit . . . is not research as no hypothesis is tested". May I put a contrary view?

Some might regard exploratory data analysis (Tukey, 1977) and the analysis of residuals (Herschel, 1849) as research although neither is necessarily preceded by any clearly formulated hypothesis. Conversely, auditing clinical outcomes is likely to entail a hypothesis. To take a 'simple' example: there may be differences in mean wound-healing times after operations by different surgeons. Before drawing any large conclusions, the null hypothesis that such differences are no more than a reflection of the intrinsic variation in wound-healing time would need consideration.

Wound-healing time is univariate, continuous and, being directly observable, manifest. The outcomes of interest to psychiatrists are much less tractable, being multivariate, usually ordinal and often latent. If this were not bad enough, the audit of outcomes will not have the protection against false inferences afforded by double-blind conditions and random allocation to treatment or to procedure.

I would suggest, therefore, that the audit of outcomes, far from being an investigation purged of the difficulties of research, is research of especial difficulty.

DEPARTMENT OF HEALTH (1989) *Working for Patients: Medical Audit*. London HMSO.