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'.

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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?

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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

to explain his treatment and discuss the reasons for his decisions, and he must keep written records of so doing. When patients or relatives sign 'consent to treatment' forms they are not relieving the doctor of any part of his responsibility to act properly but they are providing formal records that he has communicated with them. Likewise when a patient is put on a Section 26 Order it does not lessen responsibility to act properly but it is a formal record that another doctor and a non-medical person have concurred in a judgement of the patient's state. Possibly other written records of communication and second opinion would be equally good evidence, but the matter has never been tested in Court. The College's legal advisers, being lawyers, naturally prefer to play safe and use the law, but a psychiatrist who does not wish to is, in my opinion, not obliged to use Section 26—but if he faces trouble he will have to produce other good evidence of his good faith and proper actions.

The consultant or his experienced deputy loses none of his responsibility when he discusses a patient with nurses and others in the process of forming his opinion (*pace* Dr Guirguis); and particularly when he decides that ECT is essential for an unwilling patient, he will want to explain his reasons to the ECT team, who will have to find a way to give the treatment with minimum unpleasantness all round.

All patients, whether informal or detained, have a right to be treated with courtesy and with humanity —with full respect as persons. Therefore *all* should receive an explanation of the treatment proposed for them and what it is to achieve, and asked to agree to it. It does not matter that some patients may not really take it in, and that there could be doubt about the real validity of their agreement. Such things may be misjudged and it is better to err on the side of courtesy. If a detained patient refuses agreement it is still wise to review the matter again and then tell the patient why treatment must nevertheless go ahead. I am frankly astonished by Dr Spencer who, if I understand him aright, does not ask detained patients (or their relatives) for consent to treatment. This seems to me discourteous, inhumane, contrary to the spirit of the Mental Health Act, and not very sensible.

A CORRECTION

In the article by Drs Ann Buchanan and J. E. Oliver published in the last issue (November 1977) there is an error on page 459. The first sentence under the heading "The Children" should read "The 140 children resident in or admitted to the two Wiltshire subnormality hospitals... ".