Brit. J. Psychiat. (1978), **132**, 315–20

Correspondence

Letters for publication in the Correspondence columns should not ordinarily be more than 500 words and should be addressed to:
The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

THE COLLEGE MEMORANDUM ON ECT

DEAR SIR,

Since you (Editor's comment, 1977) have brought courtesy into the issue, may I first thank you for yours in abrogating editorial unassailability to permit me a riposte?

Sedman (1977) and I (1977b) have made joint headway in that you do not follow the Memorandum (Royal College of Psychiatrists, 1977) in pressing for Section 26 as against 25 (which equally requires that a second medical recommendation and applicant have 'concurred in . . . judgement . . .'). By default you appear also to accept my strictures on the Memorandum's advice to certify, solely for the purpose of ECT, the informal but confused and to determine *in advance* the number of treatments for which consent is sought.

The issue remaining, therefore, is that of consent required of detained patients and their relatives. Readers will see that, despite your apparent unwillingness to acknowledge it, we stand in *agreement* as between your admirable '. . . communicate openly . . . discuss the reasons for . . . decisions . . . *all* should receive an explanation of the treatment proposed . . .' and my discourteous, inhumane, senseless '. . . it would always be reasonable to discuss both with detained patients and their relatives, whenever possible, the reasons underlying the need for ECT . . .'. They will see, furthermore, that, in changing 'consent' to 'agreement', you seat yourself on a semantic fence. Please—your position is influential—come off it. The defence societies insist on formal, written consent, in a form prescribed by them, for ECT and its anaesthetic from all informal patients who can understand the issue. This consent *must* be honoured. Indeed this discourteous Spencer argues that it is *insulting* to any patient and relative to seek their consent and then disregard it. Elsewhere inhumane Spencer (1977b) argues that so to behave debases the coin of consent. 'Consent should never be asked unless the decision of the one asked is to be honoured.' But for you, 'agreement' (which you seem to equate with 'consent' at the moment you castigate me for not seeking it—why then did you change the word?) *can* be disregarded when '. . . treatment must nevertheless go ahead'.

Does, then, your 'agreement' from detained patients and their relatives mean the same as 'consent' from informal ones or something subtly different? Do you think consent, once sought, should or should not always be honoured? I do—absolutely.

SEYMOUR SPENCER

The Warneford Hospital,
Headington, Oxford

References

EDITOR'S COMMENT (1977) *British Journal of Psychiatry*, **131**, 647.

ROYAL COLLEGE OF PSYCHIATRISTS (1977) Memorandum on the use of electroconvulsive therapy—part III. *British Journal of Psychiatry*, **131**, 271.

SEDMAN, G. (1977) College Memorandum on ECT. *British Journal of Psychiatry*, **131**, 647.

SPENCER, S. J. G. (1977a) The debasement of consent. *British Medical Journal*, *ii*, 1082.

—— (1977b) College Memorandum on ECT. *British Journal of Psychiatry*, **131**, 645.

DEAR SIR,

I have long been quietly appalled by discussion of manipulation of the Mental Health Act in order to enforce a particular form of treatment on a patient, the more especially as some have envisaged doing this in respect of leucotomy, and I am very grateful for the Memorandum produced by the College (*Journal*, **131**, 261, September 1977) on the use of ECT, which will give those of us opposed to such suggestions some ammunition.

By a practice which is quite closely in line with College recommendations, I have found that endogenous depressives, when offered an effective alternative to ECT will consent to that alternative. I am quite prepared as a last resort to insist that I am paid

'to know what is better' for the patient in the medical respect, and my insistence needs to go no further than that. If ECT were the only choice for a moderately severely affected endogenous depressive, then I have found that their attitude to treatment is, 'Do something that makes me better.' Those more severely depressed than that really are past caring what one does. I have in any case, in an anecdotal though large experience, found that the continuance of antidepressives for only a week or two longer than the three weeks which was used as the trial period in the recent paper by Davidson *et al* (1977), the deludedly depressed do respond to antidepressives. One can argue about the relative merits of ECT and antidepressives in such cases, but there is still a choice.

B. H. Fookes

Highcroft Hospital,
Erdington, Birmingham B23 6AX

Reference

Davidson, J. R. T., McLeod, M. N., Kurland, A. A. & White, Helen L. (1977) Antidepressant drug therapy in psychotic depression. *British Journal of Psychiatry*, **131**, 493–6.

Dear Sir,

The College's Memorandum on the Use of Electroconvulsive Therapy quotes a paper by John Harris and myself in which 15 patients were treated with ECT and placebo tablets and 16 with 'pseudo ECT' and imipramine. The dose of imipramine was not stated in the paper, and Dr Farrant in a letter (1977) refers to this and 'insufficient data . . . provided to substantiate the alleged differences between treatment groups. The original paper was a model of conciseness, and anyone wanting the fuller details has been supplied with them on request (see Barton, 1977). Imipramine was prescribed on a progressive dose schedule for the first seven days—100 mg, 100 mg, 150 mg, 200 mg, 250 mg, 300 mg, 300 mg—thereafter the dose could be varied on clinical grounds.

The original paper contains a table with the results of treatment classified as 'marked', 'moderate', 'slight', and 'no improvement'. Ten of 14 ECT patients who completed the trial showed marked improvement, and only one of 12 imipramine patients who completed the trial is similarly categorized. Where the term 'significant' is used, this may be taken to imply $P < \cdot 05 > \cdot 01$. The within-patient comparisons were made by the Wilcoxon Matched Pairs Sign Ranks Test (Siegel, 1956). The between-treatment comparisons, in which 'ECT produced a significantly greater reduction in six symptoms—depressed mood, suicide, middle insomnia, agitation, psychic anxiety and loss of insight—while imipramine failed to show superiority in any symptom, used the Mann Whitney U-test (Siegel, 1956). While a Behaviour Rating Scale administered by nurses showed no differences between treatments, the paper did specifically comment on the crude nature of the scale.

The patients in this trial were diagnosed by two clinicians as suffering from depression and chosen for ECT assuming that imipramine was not available. At the same time, patients diagnosed as suffering from depression and not thought to require electroplexy were admitted to a trial of imipramine or placebo, with the same dose scheduled for imipramine (Robin and Langley, 1964).

A retrospective comparison of all patients chosen for the ECT trial with those for the conservative trial showed the former to have severe impairment of functional efficiency, heavy night sedation, day sedation required, severe degree of depression, suicidal preoccupations, genital symptoms, loss of insight, paranoid symptoms, more symptoms present; significantly more frequently than the patients in the conservative trial, who had diagnosis of neurotic depression, more than 6 admissions, no night sedation, initial insomnia.

The results of both trials may be combined in the table on p. 320, which appears to show the marked superiority of ECT over imipramine in patients suitably selected, and poorer results of imipramine in those patients when compared with patients treated with the drug who were not thought to require ECT.

Ashley Robin

Runwell Hospital,
PO Box 3,
Wickford, Essex SS11 7QE

References

Barton, J. L. (1977) ECT in depression: the evidence o controlled studies. *Biological Psychiatry*, **12**, 687.

Farrant, W. (1977) *British Journal of Psychiatry*, **131**, 646.

Robin, A. & Harris, J. A. (1962) A controlled comparison of imipramine and electroplexy. *Journal of Mental Science*, **108**, 217.

—— & Langley, G. E. (1964) A controlled trial of imipramine. *British Journal of Psychiatry*, **110**, 419.

Royal College of Psychiatrists (1977) Memorandum on the use of electroconvulsive therapy. *British Journal of Psychiatry*, **131**, 261.

Siegel, S. (1956) *Non-parametric Statistics*. New York: McGraw-Hill.