

### Administration of ECT

Sir: Ramsay & Phillips (*Psychiatric Bulletin*, 1993, 17, 716–718) report on knowledge of ECT and its practical administration by junior psychiatrists in a large London training rotation. Their audit, taken with our work in the West of Scotland (Henderson *et al*, 1993), confirms that problems with the administration of ECT are not confined to any one area.

There is no doubt that ECT is effective in carefully selected patients, and it behoves mental health services to deliver the treatment in a manner likely to maximise benefit to the patient. Despite College guidelines (Royal College of Psychiatrists, 1989), there seems to have been limited improvement in administration of ECT in the last decade, although there have been structural improvements in services (Pippard, 1992). Poor practice must inevitably expose patients to unnecessary repeat treatments with the hazards of extra general anaesthetics, and potential loss of confidence in ECT as a treatment.

Ramsay & Phillips make the point that College courses for consultants and senior registrars may result in improvements in administration of ECT. We are less sure that this initiative will be as successful as the College would hope. Informal discussion with senior psychiatrists suggests little lack of knowledge about the administration of ECT. Rather, the problem seems to occur at the level of training of junior doctors and monitoring of administration of ECT. Research into other complex medical skills, such as resuscitation, suggests that skills decay rapidly even in those who have been taught appropriate techniques (Gass & Curry, 1983), and that evaluation of the effectiveness of training is essential.

We believed that the College should expand its 1989 guidelines to include explicit recommendations on the form of training juniors should receive; how this training should be assessed and how often it should be repeated. A recommendation for yearly audit of ECT cards would also be welcome. Such guidelines could be included as contract standards by purchasers. Mental health services should not be hesitant to scrutinise their performance, and the Royal College of Psychiatrists is best placed to drive forward these improvements.

GASS, D.A. & CURRY, L. (1983) Physicians and nurses retention of knowledge and skill after training in cardiopulmonary resuscitation. *Canadian Medical Association Journal*, 128, 550–551.

HENDERSON, T., ANDERSON, M. & STARK, C. (1993) Administration of electroconvulsive therapy: training, practice and attitudes. *Psychiatric Bulletin*, 17, 154–155.

PIPPARD, J. (1992) Audit of electroconvulsive treatment in two National Health Service regions. *British Journal of Psychiatry*, 160, 621–637.

ROYAL COLLEGE OF PSYCHIATRISTS (1989) *The Practical Administration of Electroconvulsive Therapy (ECT)*. London: Gaskell (Royal College of Psychiatrists).

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Sir: Henderson *et al* can be reassured. The 1994 guidelines will contain recommendations on training which include all the points they make. I would hope that most ECT clinics have moved past the use of ECT cards.

I fully agree with their comments about training and monitoring of administration of ECT. However, it has not been our experience from the ECT courses we have run so far that there is little lack of knowledge among senior psychiatrists. We have been impressed by their openness about their lack of knowledge about up to date ECT techniques and their willingness to learn.

In Scotland the CRAG (Clinical Research and Audit Group) Sub Committee on ECT will shortly produce guidelines on contracts standards for purchases.

The College ECT video, and teaching pack, is now available directly from the College for those who have not attended ECT courses.

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### Philosophy and psychiatry

Sir: David Foreman states that one of philosophy's strengths is that "it may rationally address areas in psychiatry that seem impervious to a scientific approach, or appear too obvious to question" (*Psychiatric Bulletin*, 1993, 17, 675–676). We feel it unfortunate that he seems to have a specific, and regrettably narrow, understanding of what philosophy is and what its use for psychiatry may be.

The author's view appears to be shaped by logical empiricism and mentions Carl Hempel's work, illuminating as it is for contemporary efforts of operationalisation in psychiatry. We would argue that future efforts of the special interest group and future research work done "at the interface of philosophy and psychiatry" should also include alternative philosophical concepts. In particular, investigations into diagnostic processes and judgements in psychiatry reveal that it is not mere subsuming under logical classes but rather a situation-tied and project-determined typification which is the most basic and influential step towards diagnosis (Schwartz & Wiggins, 1986). The use of ideal types informs both an idiographic understanding