3. We would plan to hold a one day open meeting some time in the early Spring where all interested parties could meet.
4. Following those discussions we would organise one or two day induction course, perhaps after Easter of 1992 and begin the scheme formally from that point.
5. Noting your interest at this stage and coming to the initial meeting obviously would not commit you to anything.
6. It is unrealistic to think that we could provide a nationwide network from scratch and we would plan to begin the network in a number of districts and build it up from that point.
7. Finally where efficient supervision already exists, we would not want to duplicate that so we would very much like to hear about schemes that already function.

CHRIS FREEMAN
Chairman of Research Committee

Approved by the
Executive and Finance Committee
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The following paper is a summary of a special report to Council, based on a paper to the Annual Meeting of the College on 2 July 1991 as part of the Research Unit's presentation of work in progress. The full report will be published in due course in the *British Journal of Psychiatry*.

Auditing the administration of ECT

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ECT has been valued for over 50 years as an effective treatment for mental illness and especially for depressive illness, and its value has been confirmed by many double-blind comparisons of real and simulated ECT.

Ten years ago I reported to the College on the Survey of ECT in Great Britain which Les Ellam and I had carried out in 1980 (Pippard & Ellam, 1981a). Three years ago (Pippard, 1988) I tried to alert psychiatrists to important research on ECT from America and to the persistence of out-dated habits of practice. It had been hoped that, after the 1981 report, a follow-up survey might have been done within five years to see what had happened, but unfortunately funding could not be found and the project had to be abandoned.

As a Mental Health Act Commissioner and Second Opinion Appointed Doctor, I observed that in some hospitals patients were not getting effective ECT and so were not improving as expected; consultants assumed that because patients had had a course of seizures they had been adequately treated. These patients were being treated with earlier constant current apparatus on too low a setting and their seizures were not therapeutic. It was also clear that the doctors administering the treatment were not being adequately taught to do so. It seemed probable that conditions elsewhere were similarly unsatisfactory and eventually Professor Wing asked me to undertake a limited audit of ECT practice for the Research Unit. We decided to limit this to two NHS Regions and, for convenience in travelling and the widely different communities involved, from rural to inner city, agreed on the North-East Thames and East Anglian Regions. Practice in other Regions is unlikely to differ much. Between February and May 1991 I visited all 35 NHS Hospitals and five private units in the two Regions where ECT is given and talked with the staff involved. I attended a routine treatment session in 29 NHS and two private clinics. The six NHS hospitals in which I could not see ECT give only about 5% of all ECT in the two Regions and the private clinics only treat about six patients a year between them.

In 1989 the College booklet on *The Practical Administration of ECT* was published. This incorporates much of the good advice of the College Guidelines for ECT of 1977, which I used as a standard for the 1981 survey. Using similar criteria I have rated aspects of present practice and compared them with 1981.

The settings in which ECT is done have been greatly improved: nearly all now have separate waiting, treatment and recovery rooms, sometimes of a very high standard, but three large hospitals have not yet achieved this and have to move the equipment from bed to bed, albeit now in cubicled wards, but still with insufficient privacy or shielding from noise. They have been criticised for this by College accreditation teams. In general 80% are excellent or reasonably satisfactory compared with 50% in 1980.

All clinics are now well supplied with *essential anaesthetic, resuscitatory and other equipment*; sometimes they seemed to be over-equipped. *Anaesthetic practice* has made great progress and a high standard of care is now expected of anaesthetists. I have criticisms which do not reflect on the safety of practice but are directed at unsatisfactory rota arrangements which may send any one of a dozen or more doctors to do the clinic, sometimes with little specific experience of ECT. Responsibility for the anaesthetic service rests with the consultant anaesthetists, and half of all clinics are served by a consultant or senior associate anaesthetist on at least one day each week. The consultant psychiatrist in charge of the clinic is responsible for ensuring that the service provided is satisfactory; this was not so in about a quarter of the hospitals.

Nursing administration of ECT clinics is generally good or excellent, as is *patient care* in 75%. However, many clinics are short of staff and some consultant anaesthetists want nurses to be seconded to appropriate units for additional training and experience in intensive care. In several clinics there was unseemly haste in getting patients up and back to their wards after ECT without enough time to sleep or rest quietly, sometimes because there was too little room in the clinic. Standards were less than satisfactory in about a quarter of clinics, but none was so unsatisfactory as were some 20% in 1981.

ECT equipment. After the 1981 survey a DHSS committee recommended replacement of a large number of obsolete ECT devices. Ectron Ltd introduced its first constant current apparatus and within a few years most sinewave equipment had been replaced, including the Mark 4 apparatus which had been the most up-to-date in 1981. However, some patients known to be ECT-responders did not get better with the newer apparatus and only a minority of clinics took up Ectron's offer to increase the output of existing equipment to make it more effective. From 1987, clinics have gradually re-equipped with the more powerful series 5 and by now just over half the clinics have this. One in six still use Mark 4 apparatus.

I have major criticisms of the way in which the ECT apparatus is used. ECT is still given under the mistaken belief that the induction of a generalised seizure is all that is needed and that the actual stimulus administered is not important.

Nearly all clinics use a standard stimulus-dosage but the level differs fourfold between clinics. Few operators appear to understand what the apparatus does or what the settings mean and tend to use it in a rigid way. There is little grasp of the concept that there is a "trade-off" between the extent of cognitive impairment and the efficacy and speed of recovery with ECT, which is related to the electrical stimulus used: too low a stimulus and treatment is less effective and slower; too high and cognitive impairment increases. There is good evidence that the critical variable is the individual patient's seizure threshold: that stimulus which will just induce a generalised seizure (Sackeim, 1990). This varies up to fortyfold between patients and tends to be higher in men, at older ages, as a course of treatment continues and because of other factors, including the drugs used concomitantly or in anaesthesia. To be effective the stimulus needs to be moderately above threshold, perhaps double. The determination of threshold levels empirically is possible and is increasingly being done routinely in clinics in the USA but is beyond the capability of clinics here as they are at present organised, and with their present apparatus. It will require great changes in practice and newly designed equipment if empirical determination of threshold or even intelligent estimation of likely threshold are to be used. In all cases, whether or not this is done, there should be closer clinical observation after each ECT and more involvement by consultants in the process of treatment in the clinic if optimal results are to be achieved.

It is obvious that the full potential even of existing apparatus is not being used.

There is no consistency in policies for restimulating if no seizure is elicited or if a seizure is short, no agreement about what constitutes "short" or clear ideas about the possible significance of short seizures. Although seizures were routinely timed in most clinics and the times usually recorded, little or no use was made of the information. In most clinics the operators lack the knowledge and training which would enable ECT to be given by other than rule-of-thumb.

It is accepted that each clinic should have a nominated consultant psychiatrist responsible for the ECT clinic and for organising appropriate training for junior staff. All but two units had nominated consultants but few seemed actively interested in the treatment, many had not given it themselves since they were registrars and most are probably overcommitted to other important work and do not give ECT as much attention as it merits.

Following the 1981 survey we wrote (Pippard & Ellam, 1981b), and this was endorsed by the College booklet, "(the consultant) should be available to all staff concerned with giving ECT, personally involved in the clinic and seen to be interested, knowledgeable and effective". I found that only four consultants were often in their clinics and seven more take part in training, typically one session with new doctors to show them how to use the particular apparatus. In 18 clinics the consultant in charge is rarely to be seen and training in practical administration is delegated to a junior doctor with some experience.

The treatment is almost invariably given by a junior doctor: in three units there is only one SHO or Registrar so the ECT is always given by the patient's

own doctor. In five others there is a deliberate policy that, wherever possible, doctors will treat their own patients, but two of these give so few ECT that this is no more than a matter of convenience. In three-quarters of clinics ECT is given by a doctor on a rota and in half the clinics the rota involves from 6 to 13 doctors. With these numbers there can be little genuine involvement with the patients or with the work of the clinic and the practical experience is of little value educationally.

No doctor gave ECT as badly as did 12% in 1981 but I find it unacceptable that over half rated no more than mediocre and in no clinic was the training adequate or the rota system such as to inspire confidence. All the criticisms we made of psychiatric practice in 1981 apply equally today. It is not, therefore, surprising that I would personally have had considerable reservations about accepting ECT, had I needed it, in about half of all clinics in which I saw ECT administered.

I enquired about *education for ECT*, other than the practical training. The American Psychiatric Association has recently published a Task Force Report which includes recommendations for training: no hospital visited comes near fulfilling the requirements of this report. I distinguished two categories of teaching programme: those which make some effort at education in that some at least of the doctors in training will have had an hour of formal teaching about ECT in addition to practical training and will have had some encouragement and guidance in reading. Although this is not much only 22 of 35 hospitals did even as well as this, and 13, over one-third, provided little or no teaching.

Department of Health statistics, compiled annually, show that for England as a whole the use of ECT has declined by about a third since 1979, but in North-East Thames by over 50% and more than in any other Region. Only East Anglia shows an increase and usage is up by 20%, much of it in one District. No District in East Anglia uses *less* than two individual applications per thousand population in a year, and no North-East Thames District uses *more* than two per thousand. One East Anglian District uses more than 12 times as much as the lowest user. There is need for research into these differences. Where little ECT is given, as in some inner London Districts, there is need for local audit into how services are provided; the difficulties in arranging a skilled and efficient service probably contribute to further decline in use.

To sum up: on the whole hospitals have done well in upgrading the premises in which ECT is administered and in providing the appropriate equipment for anaesthetic practice and for the safe care of patients. Anaesthetists are much better trained and supervised than they were; problems with rota systems in a minority and some other problems could probably often be resolved in discussion between the consultant in charge of the clinic and the consultant anaesthetists. Nursing administration and the nursing care of patients is generally good; in many clinics nurses are enthusiastic about their work and eager for more knowledge. For professionals who regard ECT as an essential method of treatment, even when they differ about how frequently it is indicated, psychiatrists have been regrettably neglectful of its practice and are certainly not getting the most benefit from it for their patients.

All psychiatrists need more understanding of ECT and of its practical administration than is now apparent but it is surely not necessary for all to be involved in rotas for its administration, ostensibly as part of training, but, in reality, more as a convenient and customary way of getting it done. ECT requires more of the psychiatrist than just pushing a button.

It was suggested to me by experienced nurses in several clinics that thought be given to having nurses specially trained to take over the administration of ECT from doctors and to run the clinics. They would teach doctors and others. Anaesthetists would continue to be responsible for the unconscious patients. Well-trained nurses would certainly administer ECT more satisfactorily than inadequately trained doctors. These arguments have attractions for many doctors and nurses with whom I discussed them in the two Regions; for nurses, who are frustrated by psychiatrists' failure to take ECT seriously; and for doctors, who would be relieved of what many find a burdensome duty.

It is the failure to take ECT seriously that has to be faced and there are no easy ways of correcting ingrained habits. Prescribing ECT and leaving a supposedly simple procedure to be carried out by doctors with little experience or supervision is incompatible with what is now known about it, and to leave ECT to even well-trained nurses would probably increase the detachment of those who prescribe it. Consultants need to be closely involved in the ECT of each of their patients. With some reluctance I have come to the conclusion that the administration of ECT should not be handed over to nurses and that psychiatrists have to make the changes in their training and practice. ECT should be given by regular, trained and experienced teams of nurses, anaesthetists and psychiatrists. The report makes a number of other recommendations, including the need for explicit College guidelines which set the standards to be expected; success in reaching them can then be regularly audited both locally, with the consultant in charge reporting to his psychiatric division, and by external assessment, perhaps by specially appointed College Regional ECT advisers, and through the College accreditation process.

All involved in ECT, including the consultant in charge, should be trained for it. The provision of education and training should be reviewed, perhaps using the APA Task Force report as a basis. Neglect of ECT practice is likely to continue unless specific sessional time is set aside for the duties of the consultant in charge. It is suggested that about one session a week would be appropriate. A College ECT committee should continue to deal with all ECT matters which concern the College and to work with other College bodies.

Finally, I am convinced that although we do not always agree about when ECT should be prescribed, it remains an important, even essential, treatment and few psychiatrists would say that it should never be used. We *must* ensure that it is given properly.

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Election of President

Notice to Fellows and Members

Fellows and Members are reminded of their rights under the Bye-laws and Regulations, as follows:

Bye-law XI

The President shall be elected annually from among the Fellows.

Regulation XI

(1) As soon as may be practicable after the first day of January in any year the Council shall hold a nomination meeting and shall . . nominate not less than one candidate and not more than three candidates. . . .

(2) Between the first day of January in any year and the date which is four clear weeks after the nomination meeting of the Council, written nominations, accompanied in each case by the nominees' written consent to stand for election, may be lodged with the Registrar, provided that each such nomination is supported in writing by not less than twelve Members of the College who are not members of the Council.

(3) An election by ballot shall be held in accordance with the provisions of the Regulations.

The nominating meeting of the Council will be held on 14 January 1992 and the last date for receiving nominations under (2) above will therefore be 11 February 1992. Professor A. C. P. Sims is in his second year of office as President and is therefore eligible for re-election.

Election to the Fellowship

Candidates for election to the Fellowship are considered annually by the Court of Electors.

Candidates may not make a personal approach to the College for election, *but must be nominated by two sponsors, who must be Fellows of the College.*

Sponsors should *apply in writing* to the Registrar for the relevant forms. Completed nominations should be submitted to the Registrar by 30 September in any year, for considerations by the Court at its meeting the following February.

Eligibility of nominees

a. Candidates must either be Members of the College by Examination of more than five years standing, or Members who have been granted exemption from Examination.

b. The Fellowship is ordinarily awarded to a Member for unusual distinction in teaching, research, and/or administrative ability, or for exceptional service to patients, especially where the supporting services have been inadequate. Sponsors are therefore asked to indicate any factors which go beyond the carrying out of consultant or academic duties by the candidates of their choice.

All sponsors and all successful candidates will be notified by letter of the decision of the Court of Electors.

Individuals elected to the Fellowship become entitled to use the designation FRCPsych after they have paid the prescribed registration fee.