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Correspondence

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The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

COLLEGE MEMORANDUM ON ECT

DEAR SIR,

When the august representative body of us psychiatrists seems to go mad something must be done. What the medico-legal section of our Memorandum on ECT (*Journal*, September 1977, pp 271–2) appears to be saying is:

(1) Obtain consents from all possible compulsorily detained patients; but still give ECT notwithstanding refusal if, under certain precautions, you think it essential.

(2) Obtain approval from relatives; but, notwithstanding refusal, still give ECT after recording their objections.

(3) If a patient is likely to need and refuses ECT, do not detain him/her under Section 25 of the Act but under Section 26; and presumably, if he/she is already detained under Section 25 transfer him/her to Section 26 purely for legal coverage for ourselves (assuming such measures do afford it): despite the fact that (a) the patient has every likelihood of sufficient improvement within 28 days not to need a treatment order, (b) Section 26 has always been regarded as more of a stigma than Section 25 (might not this factor cause the patient to sue for negligence if it became known that the transfer from Section 25 to 26 was purely for the purpose of ECT?), (c) the transfer from Section 25 to 26 requires further medical recommendations, including one from an outside doctor, and (d) the Memorandum[1] on Parts I, IV to VII and IX of the Act makes it clear in para 41 (p 10) that 'medical treatment', as defined in Section 147(1) of the Act, 'may be regarded as wide enough to cover any services provided in hospitals for the care, training or treatment of mental patients', and in para 42 (same page) that 'Section 25 makes it clear that the patient may receive treatment as well as being under observation'. Reference is clearly to the words in Section 25(2) 'with or without other medical treatment'.

(4) Certify under Section 26 of the Act—*purely for ECT*—those who for all other purposes can be perfectly well looked after on an informal basis, simply because they are 'unable to understand . . . and . . ., therefore, . . . give consent'.

(5) Decide in advance with the patient for how many treatments he/she must give consent even though you do not know and are enjoined to review response at intervals during the course, presumably to determine its extent (see p 271, Consent (a) and (c)).

This final insanity and that of (3) above speak for themselves their madness. May the arguments for the other three insanities be briefly expanded?

(1) Derives from the introductory paragraph and that under (b) of Consent taken together. 'If ECT is considered essential but the patient is unwilling, the RMO . . . must consider grounds'—obviously, and confirmed by the following sentence—'for still giving it.' I cannot conceive of giving *unessential* ECT to any, much less a detained, patient. Why then risk the detained patient's refusal to consent when you have anyway the right to give it over his/her head? Is it not merely insulting to the patient to say to him/her: 'Here is an ECT consent form. Please sign it but realize that, as the treatment is essential for you, I shall give it all the same if you refuse'?

(2) Is it not equally insulting to say to a relative: 'We seek your approval for this treatment, but will still disregard your disapproval, as the legal responsibility is entirely ours since you 'cannot give valid legal consent to any treatment'?

As Skegg[2] implies, the nearest relative is not *authorized* to act on an adult patient's behalf in the way a parent can act for a child under 16 or the guardian can act for a patient received into guardianship under Section 34 of the Act. Skegg cites the ruling of Chisholm, CJ, that under emergency a doctor is empowered to act 'to save the life or preserve the health of the patient'. Skegg also believes that a doctor is justified in intervening (presumably

including curative measures) to prevent suicide 'in any case where he does not have reason to believe that the determination on self-destruction is fixed and unalterable'—and ECT could be regarded as a means of determining how fixed and unalterable was the intention. Even Jacob,[3] citing Skegg, allows doctors 'to impose treatment to alleviate the immediate condition . . . of the suicidally depressed'. In general, Jacob permits nursing care of the detained; but such care cannot usually be afforded to the detained without such concomitant medically imposed treatments as sedative drugs—and if drugs why not ECT? It is arguably no more drastic. While, then, it would always be reasonable to discuss both with detained patients and their relatives, whenever possible, the reasons underlying the need for ECT, the authoritative position of the RMO in deciding should never be dissimulated.

As to (4) above, the Percy Commission[4] made its intention clear that 'the law should no longer prevent mentally ill patients from entering hospital without being subject to detention if they cannot make a valid positive application for admission' (para 22). Expanding, it claimed that 'most non-volitional patients of the type who are now admitted as temporary patients' (under the Mental Treatment Act, 1930) 'could be treated without powers of detention' (para 290). As the result of their proposal (para 291) for '. . . the offer of care, without deprivation of liberty, to all who need it and are *not unwilling* to receive it' (my italics), the Mental Health Act repealed the Mental Treatment Act and its provision for temporary treatment; and the above-cited Memorandum[1] (para 16) stated that 'arrangements for the informal admission . . . of patients who are *not unwilling* to be admitted . . . are already in operation' (my italics). The College's proposal, then, to detain under Section 26 all such patients needing ECT is patently retrograde. Surely it can suffice that the case file should have inserted the written statement of the consultant in charge (preferably after discussion with the nearest relative) that (a) the patient needs ECT to preserve his/her life and health and (b) he/she is incapable by reason of the illness of either giving or withholding consent?

I can but hope that most psychiatrists will not feel constrained by the College's advice to take mad measures simply to safeguard themselves (if the measures recommended do safeguard) in the administration of ECT.

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References

[1] HMSO (1960).
[2] SKEGG, P. D. G. (1974) A justification for medical procedures performed without consent. *The Law Quarterly Review*, **90**, 512.
[3] JACOB, J. (1976) The right of the mental patient to his psychosis. *The Modern Law Review*, **39**, 17.
[4] ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY, 1954–1957. HMSO, Cmnd 169.

DEAR SIR,

Although the Memorandum on the Use of ECT, (*Journal*, September 1977, pp 261–72) is one of the most objective and scientific reports on this controversial subject, I find it very difficult to accept its suggestion, under the subtitle: Who decides that a patient needs ECT?, that this decision has to be taken by the consultant responsible for the patient in discussion with his junior staff and *the nursing and paramedical staff*. I do not think that an occupational therapist, a staff nurse or a social worker has the qualification or the experience to have any say in this decision, exactly as they have no say in whether the consultant will prescribe imipramine or amitriptyline to his depressed patient. It is a purely clinical and medical decision, and if we make it a democratic one the medical staff's opinion will be overpowered by the paramedical staff, who for obvious reasons usually oppose this type of treatment, and who in any clinical meeting outnumber the medical staff.

I also wonder how the report can think that a psychiatrist of registrar grade is too junior to decide on the need for ECT (p 268) and at the same time recommend that the consultant's decision on the need for ECT must have the blessing of the nursing and paramedical staff. It is the same story time and again, whenever the psychiatrists step into an uncertain territory they seek the support of other professions by inviting them to share their purely medical decisions, hoping that by doing this they will take part of the blame if things for any reason go wrong.

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DEAR SIR,

It is disconcerting to see the subjective way in which the College's Special Committee on the use of ECT has approached its task of evaluating the evidence from clinical trials.