Psychiatric Bulletin (1993), **17**, 431–440

Correspondence

Measuring up to Pippard: ECT in practice

DEAR SIRS

Following Pippard's recent recommendations for good ECT practice (Pippard, 1992), I would like to compare findings from our local six month audit of ECT at All Saints Hospital, a 150 bedded psychiatric hospital in inner-city Birmingham, serving a 400,000 population.

According to Pippard's scale, our premises rated five; 51% of Pippard's achieved this. The anaesthetic input includes two sessions by a regular consultant and two by a clinical assistant: this was better than 54%. Medical psychiatric input included a named responsible consultant involved in training; this was better than 69%. Juniors were involved in a rota system which was true in 74% of Pippard's report. It is difficult to compare his definition of quality, however. With nursing input, again comparison was as problematical, but with four trained staff it was better than most. Interestingly, it was noted that operating technicians may also have a place.

During the six months, 23 people received a course of ECT. In terms of record keeping, consent was available in 21 out of 23 patients; two forms had been lost. Timing of fits was not universally employed. Tentative figures derived from these small numbers of ECT gave a rate of 0.78 per 1000 population per annum. When tempted to judge the effectiveness of an ECT service by its relative user rate, Pippard cautions, "This is merely factual", and "should prompt enquiry as to whether ECT is being used appropriately, and the reasons for that usage". (Pippard, 1993, personal communication).

Patients' notes from 22 cases were examined for socio-demographic, diagnostic and outcome data. The mean age was 46 for males and 49 for females. Of the 22 patients, 15 were Caucasian, four Afro-Caribbean and three Asian. Medication revealed some problem areas; namely, concurrent use of anti-epileptics in one and benzodiazepines in four cases. In most, outcome was documented clearly. Seventeen improved, four showed no improvement, one actually deteriorated, but in two the outcome was not recorded.

In conclusion, the clinical use of ECT attained reasonable standards in most areas outlined by Pippard. However, there are areas which need improvement and further audit, including:

(a) to adopt the Royal College Guidelines recommended form
(b) examine recording to include emergencies at the sister district general hospital and incorporate central recording
(c) examine the use of medications, especially benzodiazepines and anti-epileptics
(d) time fits
(e) possibly explore the use of an operating technician
(f) carry out separate review of equipment in due course
(g) study the way ECT stimulus is varied according to the patient's individual seizure threshold
(h) the adequacy of training for the doctors
(i) appropriateness of prescription and possible poor administration in treatment failures.

R. W. SOPPITT

The Archer Centre
All Saints Hospital
Birmingham B18 5SD

Reference

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

Car exhausts and suicide

DEAR SIRS

The government, in *The Health of the Nation*, has set the specific target of a reduction in the overall suicide rate of at least 15% by the year 2000.

Since 1974, there has been a steady increase in the number of suicides using car exhaust fumes (from 7.7% of all suicides in England and Wales in 1974, to 28.6% in 1990). Car exhaust poisoning is now the most common method of suicide in young men aged 15–44 (Hawton, 1992), and in 1990 accounted for 12% of suicides in those aged 65 or more. This parallels the increase in the numbers of motor vehicles in the country.

There is good evidence that the availability of methods for committing suicide affects overall suicide rates (e.g. the large fall in suicides that occurred as a result of the replacement of coal gas with natural gas in the 1960s).

Although it would be impossible to restrict the access of the suicidal to motor vehicles, any reduction in the lethality of car vehicle motor exhausts would be likely to lead to a reduction in the overall suicide

https://doi.org/10.1192/pb.17.7.431-a Published online by Cambridge University Press

rate. In the USA, the introduction of federal car exhaust emission standards in 1968 did lead to a reduction in deaths from exhaust poisoning (Clarke & Lester, 1987). EC legislation regarding exhaust emissions has now been introduced into the UK, and the use of catalytic converters (which reduce exhaust carbon monoxide content by 80–90%) is becoming more widespread. The case of a failed suicide attributable to the car being fitted with a catalytic converter has been reported (O'Brien & Tarbuck, 1992).

Although *The Health of the Nation* rightly stresses the importance of developing comprehensive services and good practice, environmental manipulation may also be helpful. Despite the fact that exhaust emission regulations have been developed primarily for ecological reasons, tighter controls, perhaps combined with an alteration to the design of car exhausts so that it is harder to attach tubing (Hawton, 1992), could result in a major reduction in suicides by this method.

ANDREW F. TARBUCK

St Andrew's Hospital
Norwich NR7 0SS

References

HAWTON, K. (1992) By their own young hand. *British Medical Journal*, **304**, 1000.

CLARKE, R. V. & LESTER, D. (1987) Toxicity of car exhausts and opportunity for suicide: comparison between Britain and the United States. *Journal of Epidemiology and Community Health*, **41**, 114–120.

O'BRIEN, J. T. & TARBUCK, A. F. (1992) Suicide and vehicle exhaust emissions. *British Medical Journal*, **304**, 1376.

Compensation and symptomatology

DEAR SIRS

We wish to bring to your attention a phenomenon that seems to have been increasing over the past few months. We have noted an apparent rise in the number of claims for allowances and compensation being submitted to the DSS and Criminal Injuries Compensation Board by the parents of children attending our Unit for treatment of psychological disturbance. Six cases of particular concern have been identified. All have the common features of admission of the child to a psychiatric unit, claims for allowances and compensation based on the child's psychiatric symptoms, and poor cooperation with treatment and programmes. One mother has indicated that she is in receipt of a considerable amount of benefit, based upon her 8-year-old child requiring treatment by a psychiatrist.

Our concern is not that parents are able to supplement their income, rather that this supplementation requires their child to be maintained as a psychiatric patient. Lishman (1987) described the link between litigation following accidental injury and the subsequent prolongation of symptomatology. Resolution is often at the time that compensation is awarded. While a wish to manufacture symptoms is not consciously motivated there may be strong influences leading to the desire for financial gain. With the phenomenon described ('Compensation or Benefit Neurosis by proxy') such social and financial influences are evident. However, resolution may not be possible until financial gain ceases to be linked to symptomatology. Further research into this area is indicated and we would be interested to hear from other clinicians who share our concerns.

S. A. GRACIAS
S. MEARS

Pollards Well Children's Unit
Lodge Road, Caerleon
Gwent NP6 1XQ

Reference

LISHMAN, W. A. (1987) *Organic Psychiatry, the psychological consequences of cerebral disorder*, 2nd edition. Blackwell Scientific.

Are patient notes sexist?

DEAR SIRS

Having been a registrar at the Maudsley Hospital for a year and a half, I was surprised to learn that a gender-based colour coding system exists for patient files, with one colour file for men and another for women. Very few of the ward staff with whom I currently work are aware of the system, although it is apparently long-standing.

Presumably the system was initiated in order to provide a simple means of coding of some of the demographic information of patients. It could also be of use in the subsequent screening of notes for suitable candidates for research studies.

The system seems rather sexist and I wonder if it exists in other hospitals? I am certainly aware that colour coding of files is sometimes reserved for the identification of the year of first admission of the patient concerned.

Surely, however, the point of the colour coding system is lost if staff, and registrars in training in particular, remain completely unaware of its existence!

M. L. PHILLIPS

The Maudsley Hospital
Denmark Hill
London SE5 8AZ

https://doi.org/10.1192/pb.17.7.431-a Published online by Cambridge University Press