columns

instance. My somewhat heretical view is that this is costly and inefficient. Statistics of bed numbers are notoriously unreliable. In the absence of any independent audit to establish that each state is providing honest and accurate figures, and that we are talking about units with the same operating characteristics, it is impossible to establish validity. The 'throughput' issue is critical if comparing service delivery. 'Continuing care' units in the UK provide much of the permanent care seen in nursing homes in Australia. I understand the units in Victoria are essentially continuing care facilities despite the intentions, as are the confused and disturbed elderly (CADE) units in New South Wales. Services in Western Australia have always followed a firm policy of discharge only when difficult behaviours are abated. Western Australia Health Department attempts to shift a minority of long-term but behaviourally challenging patients into the private sector are misguided and so far unsuccessful. Every psychiatric patient, whether long term or acute, needs professional multi-disciplinary care until the reasons for that specialist care are no longer present. Poorly resourced 'continuing care' in either country is simply an excuse for rebuilding the 'back wards' of mental hospitals.

I must also gently disagree with the implication that making long-term care facilities domestic was intended to 'demedicalise' care. The drive for more domestic character was part of a deliberate process using environmental design to help modify and manage behaviours with for example, less use of medication. It was pioneered in Western Australia by Lefroy and also in the state psychogeriatric services well before the Victorian psychogeriatric nursing homes. The CADE units in New South Wales are also similarly influenced by design and behavioural management concepts, unfortunately often ignored in later developments in many states, including Western Australia.

Neville Hills FRANZCP, 3 Jameson Street, Swanbourne, Western Australia 6010

the college

Electoral registration – draft statement

Concerns have been raised by College Members regarding the lack of anonymity for people in vulnerable positions, particularly those working in forensic psychiatry services, because of the printing of names and addresses on the electoral register. This problem has become increasingly important in the light of internet databases of personal data that often use the electoral register as the basis for their information.

The College has learnt that some local authorities run electoral registers whereby names can be included at the end of the relevant ward list but without an address. However, there is no national guidance on this and the Department of Transport, Local Government and the Regions are continuing 'to review the possibility of anonymous registration, with a view to legislating in due course, if necessary' (personal communication, 2001).

The College would like to encourage its Members to contact their local electoral registration officer and ask if it is possible for names to be included on the register without an address and also to write to their local member of Parliament asking him/her to contact Right Honourable Nick Raynsford, Minister for Local Government and the Regions, asking that the Government legislate so local authorities have to allow for anonymous registration.

Psychiatrists' professional opinions to the media – revised guidelines

The College encourages psychiatrists to provide the media with expert and up-to-date information. The External Affairs Department retains a list of experts who are happy to deal with media inquiries.

Certain precautions need to be taken, especially when there is great pressure by the media for psychiatric opinions about individuals whose behaviour – often criminal or violent – has caused public concern. In these situations, it is essential that psychiatrists should (a) understand that they are absolutely entitled to make no comment; and (b) confine themselves to general statements about the behaviour or illness under discussion for the purpose of public education but avoid opinions about individuals. Psychiatrists should be particularly careful when the reporter is not known to them, or works for a tabloid known for sensational reporting – where the 'reporting' is often the sub-editing of the reporter's original material.

The American Psychiatric Association has issued ethical guidelines in this matter, as follows:

> 'On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about him/herself through public media. In such circumstances, a psychiatrist may share with the public his/her expertise about psychiatric issues in general. It is unethical for a psychiatrist to offer a professional opinion unless he/she has conducted an examination and has been granted proper authorisation for such a statement.' American Psychiatric Association, 2001; p. 11.

The College agrees with this principle. Speculation about persons a psychiatrist has never met could be damaging, both to the professional and to the profession as a whole.

The External Affairs Department is always willing to advise psychiatrists in their dealings with the media.

AMERICAN PSYCHIATRIC ASSOCIATION (2001) *The Principles of Medical Ethics*. Washington, DC: APA.

Nominees elected to the Fellowship and Membership under Bye Law III 2 (ii) Categories (a) (b) and (c)

At the meeting of the Court of Electors held on 26 February 2002, the following nominees were approved.

The Fellowship

Dr Saad Kamal Ahmed
Dr Christopher Robin Aldridge
Dr Ian Muir Anderson
Dr Robin Pierce Arnold
Dr David Stewart Baldwin
Dr Lynne Margaret Behennah
Dr Charles Joseph Kennedy Bouch
Dr Dallas John Brodie
Professor Traolach S. Brugha
Dr Richard Paul Caplan
Dr Janet Carrick
Dr Cathal Eustace Cassidy
Dr Paul Caviston
Dr Shashank Chattree
Dr Denise Cope
Dr Alison Corfield
Dr Janice Anne Culling
Dr Margaret M. A. Duane
Dr Christine M. Edwards
Dr Ali El-Hadi
Dr Sandra Irene Rosemonde Evans
Dr James Gallagher
Dr Simon John Groves
Dr Linda Ann Hardwick
Professor Paul Jeffrey Harrison
Dr Matthew Hodes
Dr Stephen Ronald Humphries
Dr David Hunsley
Dr Robert Hunter
Dr Anthony Jaffa
Dr Dorcas Kingham
Dr Annie Yin-Har Lau
Dr Rose-Marie Gudrun Lusznat
Dr George Mathew
Dr Joseph Patrick McKane
Dr Gyan Mehta
Dr Judith Frances Milne

https://doi.org/10.1192/pb.26.6.236-b Published online by Cambridge University Press

Dr Linda Rose Montague
Dr Brendan Thomas Monteiro
Dr Siobhan Ann O'Connor
Dr Audrey Oppenheim
Dr Walter Edwin Jason Owino
Dr Stefan Karl Freidrick Priebe
Dr Kanchikatta Prabhakar Rao
Dr Philip Robotis
Dr Steven Rowe
Dr Matthew Paul Sargeant
Dr Carolyn Anne Selley
Dr Ian David Smith
Dr Michael Snelson
Dr Helen Thorley
Dr Janet Hilary Truscott
Dr Kenneth Albert Wood

Fellowships – Overseas

Dr Sarah Acland
Dr Numan Serhan Ali
Dr Bassam Hosni Al-Shhab
Dr Ibrahim Omar Awad
Dr Mohamed Hamed Ghanem
Professor Oye Gureje
Professor Afaf Hamed Khalil
Dr Ganapathi Murugesan
Dr Suethar Nilingane Peiris
Dr Joseph Roger Saliba
Dr Ali Abdul-Rahman Younis

The Membership

It was agreed that the following should be awarded Membership under Bye-Law III 2 (ii) Category (a):
Professor Moruk Lanrewaju Adelekan
Professor Philip Boyce
Dr Mahendra Perera
Professor Ramanathan Raguram
Dr Hin-Yeung Tsang

It was agreed that the following should be awarded Membership under Bye-Law III 2(ii) Categories (b) and (c):
Dr Norbert Andersch
Dr Andrew Ashley-Smith
Dr Lionel Bailly
Dr Graham Michael Behr
Dr Hugo Biehl
Dr Walter Pierre Bouman
Dr Matthias Broeker
Dr Klaus-Malte Flechtner
Dr Robert William Holmes
Dr Muhammed Afzal Javed
Dr Jessica Kirker
Dr Johannes Cornelius Leuvennink
Dr Sivanathan Manjubhashini
Dr Wolfgang Meyer
Dr Joseph Daniel Mondeh
Dr David J. Oberholzer
Dr Stefano Palazzi
Dr Bondada Kurma Rao
Dr Fabrizio Schifano
Dr Natwarlall Soni
Dr Deborah Spitz
Dr Malavalli Sundareshan
Dr Fiona Jane Wagg

Guidelines for ECT anaesthesia

Statement from the Royal College of Psychiatrists' Special Committee on ECT

These guidelines have been endorsed by the Royal College of Anaesthetists. The Royal College of Anaesthetists produces guidance on the safety of anaesthetic services in its publication *Guidelines for the Provision of Anaesthetic Services*, to which reference should be made. This document is available on the internet at http://www.rcoa.ac.uk/dload/GLINES.PDF. In the near future the Royal College of Psychiatrists and Royal College of Anaesthetists, in collaboration with the National Institute for Clinical Excellence, will produce fuller guidelines.

Staffing

- There must be a named consultant anaesthetist responsible for the electroconvulsive therapy (ECT) clinic. The consultant should have regular input, and not just be nominally in charge.
- A suitably experienced trainee or non-consultant career grade anaesthetist can administer the anaesthetics as long as he or she is supported by a named consultant who takes responsibility for the delegation. This would preferably be the consultant anaesthetist responsible for the clinic's management. Guidelines for the supervision of trainees can be found in the Royal College of Anaesthetists document, *The CCST in Anaesthesia I: General Principles, a Manual for Trainees and Trainers* (http://www.rcoa.ac.uk/dload.rcoa.ccst1.pdf).
- Continuity of care needs to be established, with a minimum number of people rotating through the service.
- A core group of suitably experienced anaesthetists is required.
- ECT sessions should be incorporated into job plans, and not be done routinely by the on-call anaesthetists, or occasional unsupervised senior house officer.
- All anaesthetists must have a suitably trained assistant present.
- The training and qualifications of anaesthesia assistants are detailed in *The Anaesthesia Team* (Association of Anaesthetists of Great Britain and Ireland, 1998).
- Continuity and experience are also important for assistants.

Remote siting of the ECT clinic

A remote site is defined as not having immediate access to critical care, namely cardiac arrest and intensive care teams. In the majority of cases, where there is no added risk, ECT should not prove any higher risk than minor day-case surgery, which is regularly practised at remote sites. However, the following guidelines should be adhered to:

- For any patient assessed as being ASA3 (see Box 1 for American Society of Anesthesiologists (ASA) definitions) or above, serious consideration should be given to transferring them to the district general hospital (DGH).
- If ECT is given on a remote site, then a protocol needs to be in place for transferring patients who are ASA3 or above to a DGH or training hospital with access to critical care.
- If a patient ASA3 or above, who has been transferred to a DGH, proves manageable after a few sessions, then consideration can be given to transferring him/her back to the remote site.

Box 1. **Definition of American Society of Anesthesiologists (ASA) grading**

ASA1	fit and well
ASA2	documented medical condition(s) not affecting everyday lifestyle
ASA3	medical condition(s) that do affect lifestyle (e.g. reduced exercise tolerance)
ASA4	serious medical condition(s): constant threat to life
ASA5	moribund (anaesthesia/surgery only contemplated to save life)

Anaesthetic agents

Methohexitone

Methohexitone was the drug of choice for ECT, but is no longer available. The three agents below seem to be appropriate alternatives.

Propofol

It is a widely used anaesthetic agent and is popular among anaesthetists.
Pros:

- well-tolerated
- short-acting anaesthetic with rapid recovery
- can be useful where attenuation of hypertensive response to ECT is needed.

https://doi.org/10.1192/pb.26.6.236-b Published online by Cambridge University Press