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.

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columns

Cons:

- shortens seizure length
- possible effect on seizure threshold
- The Committee on Safety of Medicines have advised special caution in day case surgery because of concerns over convulsions (some delayed); anaphylaxis; and delayed recovery
- may be associated with bradycardia and hypotension.

Comments:

- some clinics have switched to propofol with little significant effect
- several small studies indicate effect on seizure duration does not affect overall efficacy
- some studies suggest ECT courses may be prolonged.

Etomidate

Pros:

- short-acting, with rapid recovery
- little hangover effect
- less associated with hypotension compared with propofol
- may lengthen seizure duration compared with methohexitone and propofol.

Cons:

- high incidence of extraneous muscle movements
- pain at the injection site
- rarely associated with adrenocortical dysfunction in repeated doses.

Comments:

- may be particularly suitable for patients who have brief/abortive seizures with other agents.

Thiopental sodium

Pros:

- little documented effect on seizure threshold or duration.

Cons:

- longer duration of action can delay recovery times
- longer recovery times may cause added problems in the elderly
- not widely used in anaesthetic practice
- availability may also be limited in future.

Comments:

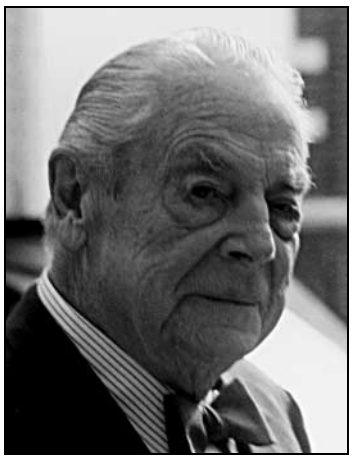
- some units report regular use of thiopentone with minimal problems.

Recommendations

Based on the present evidence the Committee feels that it is not possible to make a clear first-choice recommendation as a replacement for methohexitone. The three agents above would seem acceptable alternatives, although there are disadvantages with each. It is likely that each unit needs to gain experience with more than one agent. It is probably inadvisable for the induction agent to be changed during a course of ECT without consultation between the anaesthetist and psychiatrist. With all the above agents, some disadvantages can be minimised by using the lowest effective dose required for safe and adequate anaesthesia.

ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND (1998) *The Anaesthesia Team*. London: Association of Anaesthetists of Great Britain and Ireland.

obituary



Edward Beresford Davies

Formerly Consultant Psychiatrist Fulbourn Hospital, Cambridge

Dr Davies died of myeloid leukaemia on 13 August 2001, aged 88 years. Beresford, as he was known by all of his professional associates, was one of Cambridge's most distinguished psychiatrists, a statesman-like figure and a legend among his colleagues and patients. He was an indefatigable worker and he continued to see a few patients until shortly before his death.

Edward was born in Liverpool. He went to Oundle and there excelled in shooting. After school he went up to Clare College, Cambridge, in 1931 to read Medical Sciences Tripos. During his first year at Cambridge he developed pneumonia that was slow to resolve. It was decided that he would be helped by a period of mountain air and was sent to Norway to convalesce. While there he was invited to attend a wedding; this was a very important occasion in his life for there he met Hendriette Fuglesang, the girl who eventually became his wife.

Back in Cambridge he took a full part in the life of his college and the university. He continued to shoot and he took up fencing. He became fascinated by the theatre and regularly wrote reviews for the newspapers. He took his BA in 1934 and went to the Middlesex Hospital to continue his medical studies. He married Hendriette soon after he qualified. War was looming and, after a brief period as a junior psychiatrist at the Towers Hospital in Leicester, he volunteered for the Royal Air Force.

With his natural flair for languages he had picked up Norwegian very quickly as the result of his days in Norway and from Hendriette; he soon became fluent in the language. So equipped he was posted to a Norwegian Spitfire unit based variously in North Weald, Manston and Ipswich. Always keen on flying, he undertook pilot training but was frustrated by the fact that, as a medical officer, he was never allowed to fly himself operationally. However, he did fly as an RAF observer over the Battle of the Falaise. He wrote a major part of the *Manual of Air Sea Rescue* and, later, the *Medical History of the RAF*. He reached the rank of Wing Commander, and for a time, served on the staff at the Air Ministry. He went to France within a few days of the invasion and was in Paris before it was liberated.

Having observed the effect of battle stress upon the men with whom he had served, his earlier intention to become a psychiatrist was stronger than ever, and after leaving the Royal Air Force he went back to the Towers Hospital for 2 years. Then followed a year at Banstead Hospital, near Espom, Surrey, and at St Stephen's Hospital in Chelsea. He was then ready to seek a consultant post and he was fortunate enough to be accepted for a job in Cambridge. However, he soon came face to face with the fact that there were considerable problems in the Cambridge psychiatric service. Psychiatry there was entirely centred upon Fulbourn Hospital, a large traditional mental hospital that had been built in the mid-19th century some 4 miles outside the town and was still run along old

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