The proposed Charter will have a profound influence on the psychiatric service. On the positive side, it may lead to an improved out-of-hours service. However, by making unrealistic promises, this Charter is setting up the service for failure. Our most serious concern is that by reinforcing the bias of service provision to those who 'shout loudest' the Charter will further marginalise the seriously mentally ill: would a reclusive psychotic ask for an appointment on a specific day, giving 48 hours notice?

The draft edition of the Charter invited comments before 26 April 1996. We have written to Mr Tony Day of the NHS Executive requesting that the publication of the Charter is delayed until there has been consultation with a wide group of mental health care professionals.

R. DENNY
Fromeside Clinic, Stapleton, Bristol BS16 1ED
S. FORSHALL
Robert Smith Unit, 12 Mortimer Road, Bristol BS8 4EX
H. REES
Knowle Clinic, Knowle, Bristol BS4 2UH

Propofol and ECT

Propofol was introduced as an induction agent for ECT in our hospital last year but, after four months of its use, it was discontinued as seizures were often described by the medical officer giving the ECT as brief or inadequate. Also, the ECT machine had to be set at a higher than average setting using a higher dose of electricity. In the Royal College of Psychiatrists' guidelines (1995) propofol is specifically not recommended for ECT.

It was decided, as an audit topic, to look retrospectively at the last 53 patients who had ECT under either propofol or methohexitone. Clinical outcome after the course of ECT was obtained from case notes. Recorded clinical improvement was rated as marked, moderate or none, based on what was stated in the case notes after the last administered ECT application. The sample included 31 patients who received ECT under methohexitone and 22 patients under propofol.

Duration of seizures was significantly longer with a mean of 25 seconds with methohexitone compared with 18 seconds with propofol ($P<0.01$). The mean setting of the ECT machine was 226 mQ for ECT given with methohexitone compared with 269 mQ with propofol ($P<0.01$). There was no evidence to suggest that patients who received ECT under propofol, and despite the significantly shorter seizure duration compared with methohexitone, required additional ECT applications. The mean number of ECTs were 5.1 and 4.8 for methohexitone and propofol induced ECT respectively ($P=6$). The recorded clinical outcome following the ECT course given under either agent was not significantly different ($P>0.05$).

This may imply that ECT under either anaesthetic was equally effective. Also the similar clinical outcome after ECT given under either agent may suggest that the reduced, visible, seizure duration may be misleading and should not be taken to indicate poor therapeutic effect of ECT. However the retrospective nature of data collection, with non-randomisation, also the possibility that in some cases, the number of ECTs may have been determined in advance by some consultants are flaws of this review which may limit any conclusion that can be made.

ROYAL COLLEGE of PSYCHIATRISTS (1995) *The ECT Handbook*. London: RCPsych.

E. SALIB, C. BARLOW and J. HARRISON
Winwick Hospital, Warrington

Information of interest

The medical director and representatives of the Association of British Pharmaceutical Industries (ABPI) and representatives of the RCPsych held their second 9-monthly meeting on 29 September 1995. We felt it would be worthwhile to inform members of various points which arose during the meeting concerning patient prescribing and clinical trials.

The pharmaceutical industry will be introducing a procedure to put a leaflet with prescriptions which inform patients about the drugs that are being dispensed under prescription, including their actions and side-effects. The industry will also continue its practice of supporting Continuing Professional Development, medical education, postgraduate meetings and scientific meetings of interest to the profession.

The ABPI has produced a draft contract for pharmaceutical companies to indemnify Trusts and patients who participate in clinical trials. A survey carried out over the past 5 years with the intention of recording the requirement for indemnity payments found that there were only 20 cases out of 415 000 patients who participated in clinical trials during the survey period, an incidence of 0.005%. Three-quarters of these came from one clinical trial and there were no court proceedings.

The ABPI can provide any one who is interested with a list of standards they have established for training for both industry funded and non-industry funded research projects involving the treatment of patients. The public should be

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