Prescribing ECT: do psychiatrists behave oddly?

Sir: In the treatment of depression with electroconvulsive therapy (ECT), there was in the past controversy about the number of applications needed to give maximum benefit. Six seemed a popular number. However, Barton *et al* (1973) showed that once clinical recovery had occurred, treatment should be stopped. Thus there is no reason to suppose that a patient would be more likely to respond to an even number of applications than to an odd number. Likewise, if a patient failed to respond to ECT, it would seem illogical to abandon ECT after an even rather than an odd number of applications. However, we had a clinical impression that even numbers of applications were prescribed more often than odd numbers. We therefore obtained prescription records for courses of ECT from 1 May 1991 to 31 April 1992 from one Glasgow hospital, and counted the frequencies of different numbers of applications.

A total of 103 courses of ECT was prescribed over the period of study: courses varied from one to 17 applications. The numbers of applications and (in brackets) the frequency at which they were prescribed, were as follows: 1 (3), 2 (6), 3 (9), 4 (15), 5 (8), 6 (27), 7 (5), 8 (17), 9 (5), 10 (5), 11 (1), 12 (0), 13 (1), 14 (0), 15 (0), and 17 (1). Thus there were 70 'even' but only 33 'odd' courses of ECT (binomial $P<0.001$, one-tailed).

We are tempted to speculate that in showing a preference for even numbers, psychiatrists are superstitious, obsessional or both! Indeed the Royal College of Psychiatrists encourages such neurotic behaviour in its official video on ECT, in which a patient is seen being told to expect six or eight applications. A more mundane explanation may lie in the College booklet on ECT (1989), which recommends that no more than two applications be prescribed at one time. Ideally, the patient would be assessed after every application. However, the psychiatrist with a heavy workload might well prescribe two applications at a time with a consequent bias towards even numbers.

It seems likely that in the case of a patient for whom the optimal number of applications was odd, the psychiatrist would round up to an even number rather than stop at one application short of recovery. Thus some patients would get one application too many. While the anaesthetic risk from ECT is small, it should not be ignored and there is also the time and cost of extra anaesthesia. We therefore recommend that psychiatrists examine their prescribing practice since some may need encouragement to behave oddly.

BARTON, J.L., MEHTA, S. & SNAITH, R.P. (1973) The prophylactics value of extra ECT in depressive illness. *Acta Psychiatrica Scandinavica*, **49**, 386–392.

ROYAL COLLEGE OF PSYCHIATRISTS (1989) *The Practical Administration of Electroconvulsive Therapy*. London: Gaskell (Royal College of Psychiatrists).

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Consent or no consent

Sir: A 36-year-old caucasian male with a 20 year history of schizophrenia was admitted in a catatonic state having refused to eat or drink for some days. He later explained that he "had run out" of risperidone tablets one week earlier. He had presented in a similar way on previous occasions when he responded dramatically to one application of electroconvulsive therapy, usually requiring three to four treatments to gain maximum response.

In view of his physical condition on arrival, his favourable response to ECT in the past and the approval of his nearest relative, he was given a single emergency treatment. He responded as anticipated and signed a consent form for further electroconvulsive treatments.

Some hours later he informed his psychiatrist that he did not feel the consent was valid and would have to withdraw it. He explained that, although he consented to further therapy, he believed he had only signed the form under the influence of Satan and that it was Satan and not he who had signed. He endeavoured to sign another form but did not believe he was signing under his own volition. He was happy to give verbal consent and did so in front of a witness. Two further treatments were given and he was discharged much improved (with an ample supply of risperidone) one week after admission.

The patient made it clear that he understood the nature of the treatment offered and potential dangers, that he agreed to and indeed wanted to be treated and that he did not wish to be detained under a section of the Mental Health Act. Due to his delusion, however, he felt that he could not give valid written consent although he was happy to give oral consent in front of a witness.

In these circumstances is oral consent acceptable?

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Mental disorder and driving

Sir: Lawrie & Milne have provided a useful overview and sensible reminder to doctors concerning the effects of mental illness and psychotropic treatments on driving (*Psychiatric Bulletin*, April 1994, **18**, 214–216). We had also been struck by the implications of the Driver and Vehicle Licensing Agency's recent guide (DVLA, 1993), in

particular relating to 'Alcohol Misuse/Abuse' and 'Alcohol Dependency'.

Edwards *et al* (1973) found a prevalence of 3% for 'problem drinking'; while Mayou & Hawton (1986) found about 20% of general hospital in-patients to have 'alcohol problems'. More recently, Goddard (1991) has shown that 23% of men and 8% of women drink more than the recommended 'sensible' limits of 21/14 units per week respectively. Bearing these indications of a high prevalence in mind, it is interesting to consider the DVLA guideline concerning the definition of 'alcohol misuse/abuse':

> "a state which because of consumption of alcohol, causes disturbance of behaviour, related disease of other consequences, *likely* to cause the patient, his family or society harm now or *in the future* and which may or may not be associated with dependency. In addition assessment of the alcohol consumption with respect to current national advised guidelines is necessary" (emphasis added).

Thus, a male drinking more than 21 units or a female drinking more than 14 units in a week showing a "disturbance of behaviour" (such as intoxication?) which may cause "harm . . . in the future" is in the firing line. The subjective assessment of 'likelihood' determines whether the doctor should advise the patient to inform the DVLA that he or she has an alcohol problem, which will entail revocation or refusal of a licence for "at least one year".

'Alcohol misuse' is effectively defined by the DVLA as 'excessive use'. This guideline is too debatable. It might be fatal if, as a consequence, it were ignored.

DRIVER & VEHICLE LICENSING AGENCY (1993) *At a Glance Guide to the Current Medical Standards of Fitness to Drive*. Swansea: DVLA.

EDWARDS, G., HAWKER, A., HENSMAN, C., *et al* (1973) Alcoholics known or unknown to agencies: epidemiological studies in a London suburb. *British Journal of Psychiatry*, **123**, 169–183.

GODDARD, E. (1991) *Drinking in England and Wales in the Late 1980s*. London: HMSO.

MAYOU, R. & HAWTON, K. (1986) Psychiatric disorder in the general hospital. *British Journal of Psychiatry*, **149**, 172–190.

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Sir: I read with interest the article on mental disorder and driving, (Laurie & Milne, *Psychiatric Bulletin*, April 1994, **18**, 214–216). It addressed the important issue of medical standards of fitness to drive with regard to the Driver and Vehicle Licensing Centre. In my experience, patients have been less concerned about this particular area than the potential effect on their insurance cover if they were to have an accident and it was discovered that they were using psychotropic medication.

I am unaware of any test cases but would be interested to hear from colleagues on their views and also their experiences with insurance companies and patients on medication.

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Refusal of visas

Sir: It was interesting to read the article 'Do patients who have been on "sections" get refused visas', by Allen & Allen (*Psychiatric Bulletin*, April 1994, **18**, 216–217).

I worked as a psychiatric registrar in the West Indies and there was a firm belief that the US Embassy tends to refuse visas to patients who have had formal admissions to psychiatric hospitals. It would be interesting to go through the visa application forms completed by these individuals and compare the data with the outcome of how many of them succeed in getting a visa. There may be ethical or policy objections to this kind of survey.

Many countries say that they would not refuse a visa unless there is a written policy stating otherwise, such as Nepal. But even if the real reason to refuse a visa is formal admission to a psychiatric hospital, it may not be officially given as the reason.

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Improving psychiatry's image

Sir: Although the Public Education Committee has been toiling away for the past several years to improve the image of psychiatry by producing the Help is at Hand leaflets, mounting frequent media briefings, producing the careers pack, training members of the College in media activity, promoting the Morris Markowe prize and the Boots prize for the best video on a career in psychiatry, organising a network of regional and public education offices and fielding hundreds of questions every year from the media, with the help of our teams of experts, to say nothing of launching the Defeat Depression Campaign, we are well aware that the image of the psychiatrist is sometimes tarnished, or blurred; it is therefore enormously helpful to have Dr Kwame McKenzie's suggestion that we need an image consultant (*Psychiatric Bulletin*, April 1994, **18**, 231–232). Gosh, if only we had though of that before.

However, there may be light at the end of the tunnel. Nobody presents a better image of the