

Anaesthetists' views of electroconvulsive therapy clinics

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Electroconvulsive therapy (ECT) involves the close collaboration of psychiatrists and anaesthetists (Freeman *et al*, 1987). The Royal College of Psychiatrists' audits of ECT in 1980 (Pippard & Ellam, 1981) and 1991 (Pippard, 1992a, 1992b) relied on psychiatrists rating the facilities and performance of staff in ECT clinics. In contrast we are unaware of any research assessing anaesthetists' views of ECT clinics. Considering their different roles and expectations, opinions may well differ. To investigate this possibility we conducted a survey between November 1990 and February 1991.

The study

All anaesthetists employed in the North West Health Region were sent an anonymous questionnaire. They were asked to rate their *personal* experience of anaesthetising for ECT under eight headings (see Table I) using one of five responses (excellent, good, satisfactory, poor and abysmal). For analysis the poor and abysmal categories were combined to form an 'unsatisfactory' category. The data for respondents who graduated from medical school in 1980 or after were compared to that for respondents who graduated prior to 1980. In all comparisons a χ^2 test was used with the conventional 5% significance level.

Of the 460 anaesthetists in the region, 261 (57%) returned completed questionnaires (124 consultants, 20 senior registrars, 31 associate specialists/clinical assistants, 46 registrars, and 40 SHOs). All respondents had anaesthetised for ECT at some point in their careers, and 128 (49%) within the last six months.

Findings

Table I shows the number of respondents rating each area as unsatisfactory. A comparison of the pre- and post-1980 graduates ($n = 156$ and $n = 105$ respectively) revealed no significant difference in the proportion rating each area as unsatisfactory. For the total group, 188 out of 261 respondents (72%) rated at least one of the eight areas as unsatisfactory, indicating that the results in the Table do not reflect a disgruntled minority giving uniformly poor ratings. This proportion increased from 67% in the pre-1980

TABLE I
Numbers (percentages) of respondents giving an unsatisfactory rating in eight areas ($n = 261$)

Clinic area rated	Unsatisfactory
<i>Psychiatrist</i>	
Appreciation of anaesthetic problems	113 (43%)
Willingness to arrange medical investigations	61 (23%)
Bedside manner with patient	42 (16%)
<i>Nursing staff</i>	
Staffing levels	61 (23%)
Necessary practical skills	76 (29%)
<i>Anaesthetic provisions</i>	
Equipment provided (including emergency equipment)	101 (39%)
Drugs provided (including emergency drugs)	43 (16%)
Overall suitability of premises for general anaesthesia	85 (33%)

group to 80% in the post-1980 group ($P = 0.019$). This may indicate that anaesthetists expect higher standards than in the past.

Breakdown of respondents' comments

Respondents were invited to comment on difficulties they had experienced in ECT clinics, 120 (46%) did so. There were 265 comments which fell into seven categories.

Inadequate anaesthetic facilities (108 comments)

Fifty-two respondents mentioned deficiencies in monitoring equipment, including ten SHOs or registrars who reported having to anaesthetise with no monitors at all. Others mentioned monitors being locked away and inaccessible, 'disappearing', being poorly maintained, and ECT clinics being given second rate monitors from elsewhere.

Twelve respondents cited lack of tipping trolleys. Problems with resuscitation equipment, including defibrillators, were mentioned by nine. Others

mentioned poor suction facilities, faulty oxygen supplies, masks and connectors that did not fit together, poor lighting and the inadequate range of routine and emergency drugs available. Such problems had led several to cancel lists. To help rectify the situation, nine respondents suggested having an operating department assistant (ODA) at clinics. Several stressed that theatre was the best place to perform ECT on medically high risk patients.

Problems with nursing staff (46 comments)

All 46 comments referred to inadequate staffing levels or nurses' lack of medical skills. Nearly half related to recovery staff, e.g. an SHO and a registrar described clinics in which nursing auxiliaries had been left to manage recovery. Several suggested that psychiatric nurses working in ECT clinics should spend time in theatre to learn necessary skills.

Suitability of clinics (34 comments)

Most referred to isolated ECT clinics and stressed the dangers of lack of access to equipment and staff in an emergency. Four respondents complained of situations in which waiting patients could see those recovering.

Problems with the psychiatrist (26 comments)

Several stated that psychiatrists were inadequately trained in ECT. Specific criticisms included trainees making poor electrode contact and having little idea of the size of stimulus to deliver. A senior registrar recounted his experiences of an ECT clinic in 1988, "it was painfully obvious that the psychiatric SHOs doing the ECT had received little or no training from their consultants, and certainly had no understanding of what they were doing". Several respondents reported having to show psychiatric trainees how to administer ECT.

Poor patient rapport was mentioned by three, e.g. a consultant described working with a "button pusher" who appeared "totally disinterested". Several thought psychiatrists had poor appreciation of medical problems, questioned their usefulness should a medical emergency arise and suggested regular training/assessment in resuscitation skills for all ECT staff. Other criticisms related to patients arriving for ECT inadequately fasted, with no recent physical examination recorded in the notes or with missing or incomplete consent forms.

Two respondents thought that ECT was sometimes given inappropriately. Another expressed concern that patients were inadequately assessed for improvement between treatments. One consultant questioned why psychiatric units differed so much in their use of ECT; "it seems to me the better the psychiatric unit the fewer the ECTs".

Poor liaison (26 comments)

These comments mainly referred to poor communication about medically ill patients. A common problem was the psychiatrist and psychiatric nurses at the clinic not knowing the patients. Several suggested ensuring continuity by having regular ECT staff.

Inadequate senior input (16 comments)

Sixteen respondents wanted more input from senior anaesthetists and psychiatrists, e.g. "I would feel much happier if more experienced psychiatrists were involved more frequently in ECT lists to ensure that the juniors were *au fait* with the equipment and that the patients were getting the best possible treatment" (registrar). Several regarded the absence of senior psychiatrists as indicating lack of interest, especially as consultant anaesthetists frequently do ECT lists (23% of consultant respondents in this survey had anaesthetised for ECT within the last six months).

Practical difficulties (9 comments)

Problems included excessive lengths of ECT lists, no regular days for ECT and delegation to on-call anaesthetists and psychiatrists who were often busy with emergencies.

Comment

The 57% response rate means that the results cannot be assumed to represent regional opinion. Nevertheless, a significant proportion of anaesthetists are dissatisfied with ECT arrangements. There is no reason to believe that this region differs from the rest of the country.

The results may give an inappropriately negative view of current standards as respondents' ratings and comments could be biased by experiences several years ago when standards were lower. However, this is unlikely to be the full explanation; individual ratings did not differ significantly when the pre- and post-1980 graduates were compared and over half of the comments came from the post-1980 group.

The wide range of problems noted by respondents have several implications. First, patients do not always receive a high quality, or even effective, ECT service. Second, anaesthetists may be put off becoming involved in ECT practice and research. Finally, patient safety may be compromised, although ECT is associated with low morbidity and mortality (e.g. Heshe & Roeder, 1976).

Our findings are similar to those of the 1980 Royal College audit (Pippard & Ellam, 1981). The main discrepancies are the provision of anaesthetic equipment and drugs; 39% and 16% of our respondents

rated these as unsatisfactory while the 1980 College audit found little cause for criticism with either, findings that were confirmed in the 1991 audit (Pippard, 1992a, 1992b). These differences probably reflect each speciality having its own agenda of requirements. As psychiatrists are not qualified to judge anaesthetic provisions, we suggest that future audits of ECT clinics would benefit from having an anaesthetist and a psychiatrist making joint ratings.

Closer liaison between psychiatrists and anaesthetists is needed to rectify the deficits highlighted in this survey. In particular each ECT clinic should have a designated consultant from each speciality taking an active interest in standards, teaching and the development of joint policies.

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Audit

Neuroleptic usage in a community mental handicap unit

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Increasing concern has been expressed in the psychiatric literature and general press about the use of neuroleptic medication for the treatment of behaviour disturbance in the mentally handicapped (Buck & Sprague, 1989). The issue was highlighted in a television documentary (Public Eye, BBC2, 1 May 1992) which reported a number of cases of tardive dyskinesia in mentally handicapped people who had been treated with neuroleptics. The programme, although taking a characteristically slanted view, will have made an impression on relatives, patients and the general public. It was also intimated that British families may be preparing to test the legal grounds for prescribing these drugs to the mentally handicapped, particularly where there is no formal psychiatric diagnosis.

Previous studies from the UK, USA and Europe have shown that 40–60% of mentally handicapped people in institutions are receiving regular neuro-

leptic medication (Sachdev, 1991), yet the majority of these prescriptions are not being given for the treatment of mental illness. Prescribing rates are often influenced by factors other than the presence of psychiatric disorder, such as local drug review policies, the amount of day therapy on offer, and staff to patient ratios. In the presence of a regular review process prescribing rates drop to about 20%.

There are a number of reasons for concern about prescribing practices: there is no good research demonstrating the benefits of neuroleptics in the management of behavioural disturbance; the high doses that are often used have been discounted even in the treatment of acute psychosis; neuroleptic drugs may have adverse effects on cognitive development; and there is a high incidence of drug-induced movement disorders in this group, with up to 34% of treated patients showing signs of tardive dyskinesia (Sachdev, 1991).