Attendance of the RMO at Tribunals

Sir: I would like to bring to attention particular problems encountered when acting as an independent psychiatrist at Mental Health Review Tribunals, particularly when instructed in such matters by the patient's solicitor, in cases involving patients detained under Section 37 and Section 41 of the Mental Health Act 1983.

In cases, far from straightforward, i.e. where the diagnosis has been subject to dispute and the patient's care plan is at issue, those instructing me have made arrangements for me to be available at the Tribunal to give verbal evidence. I am usually given a hearing date rather than the date being subject to negotiation. The routine of the Tribunal office for those who arrange Tribunals is to liaise with the responsible medical officer (RMO) so that he is present at the hearing. Conflicts of interest have arisen, apparently, in some cases which have prevented the RMO from attending the Tribunal, undermining the potential for exploring points at issue and putting the applicant and his legal adviser at a considerable disadvantage.

It is my opinion, particularly in restricted cases, that the RMO as the person responsible for the patient's ongoing detention, should always be available to give evidence at the Tribunal. I appreciate that conflicts over use of time will arise but there is no greater requirement on a doctor's time than attending a Tribunal considering the further management of the detained patient.

I have noted the increasing use of the subpoena and similar methods to ensure the presence of expert witnesses in a variety of settings in the last two to three years. It will now be my advice to those instructing me to prepare independent reports for Mental Health Review Tribunals that the RMO should be routinely subpoenaed where the case involves a patient who is detained and subject to a restriction order so that a fair balance of opinion can be heard by the Tribunal prior to their reaching decisions, if this process of appeal is not to be devalued.

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Propofol and electroconvulsive therapy

Sir: In 1988 reports first appeared suggesting propofol to be unsuitable for electroconvulsive therapy (ECT) anaesthesia as it significantly reduced seizure duration. This finding has been confirmed in subsequent studies. Guidelines laid down by The Royal College of Psychiatrists (1989) made no reference to propofol; however, their recent ECT video clearly recommends that propofol should not be used.

In December 1991 propofol was still being used for ECT anaesthesia in East Suffolk. We conducted a retrospective case-note analysis, with the aim of describing the local anaesthetic prescribing policy, and additionally sought to determine whether compared with methohexitone, propofol anaesthesia was associated with more unsatisfactory ECT applications as described in the College guidelines (absent seizures, doubtful seizures, unilateral seizures, focal seizures and very brief seizures).

Local policy was to stimulate patients initially with 275 mC, from Ectron series 5 apparatus, subsequently adjusting the stimulus depending on the response determined by simple observation and stop-watch timing. One hundred consecutive courses of ECT (1120 applications) were investigated in 95 patients aged between 26 and 93 years (mean 63.3 years); 85% of courses were administered to patients suffering from depressive illness. Patients were anaesthetised with either methohexitone (mean dose 69.2 mg) or propofol (mean dose 53.5 mg); 165 applications (15%) were with propofol anaesthesia. Thirty-nine patients received at least one propofol anaesthetic. Of this group, 26% were anaesthetised predominantly with propofol but in only one patient was propofol exclusively used. In all cases suxamethonium (mean dose 43.8 mg) was used. No patients received atropine.

The observed proportion of unsatisfactory applications was higher (27%) in propofol anaesthetised treatments than methohexitone anaesthetised treatments (12%). This was significant (χ^2=25.175, P<0.0005, one-tailed). Patients receiving propofol did not differ significantly from those exclusively receiving methohexitone, in age, drug consumption, physical health or mode of ECT application.

In summary, propofol was regularly being used for ECT anaesthesia in late 1991 and was associated with an increased rate of unsatisfactory seizures. In some districts it may still be in regular use. Psychiatrists responsible for ECT should ensure that their anaesthetist colleagues are aware of propofol's disadvantages.

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

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Antipsychotic medication use in relation to BNF guidelines

Sir: Two recent audits of antipsychotic medication prescribing in regional secure units highlighted regimes that did not always meet BNF

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