Correspondence

Nosocomial archaeology

DEAR SIRS

Across the country there are plans to close down the large psychiatric hospitals for mental illness and mental handicap. Over the years these hospitals have been the headquarters of clinical psychiatric services. They have represented an enormous national investment in buildings and professional employment, and the accumulation of a large reservoir of information, knowledge, experience and expertise. In many instances their heritage has been built up during nearly a century or more.

The projected run-down of these hospitals over time to end the nosocomial era in psychiatry gives a unique opportunity to collect records, archives and artefacts relating to them for the interest and education of future generations of planners, researchers, historians and students. Experience suggests that records of the past are often valued only when they have all but vanished. There is a danger that much could be lost forever in a hasty reckless 'good riddance' destruction of what has gone before. Historical precedents show that it may be a generation or two before something that has been virtually destroyed has interest in it revived.

Of use and value would be details of hospitals, for example:

(1) a history of the hospital, its foundation, buildings and architectural features;
(2) changes, extensions, alterations and improvements;
(3) a diary of developments and staffing through the years;
(4) publications and research;
(5) statistics relating to finance, admissions, discharges, deaths, diagnoses, treatments, outreach services and resettlement;
(6) a record of voluntary help and effort, league of friends and relatives' association.

As psychiatrists are often the people who have had long associations with hospitals and an involvement in most of their activities they are in a good position to take an initiative in the collection of data about hospitals. They can lead a prospective study of nosocomial archaeology in the disappearing psychiatric hospitals. They have a responsibility to posterity to do so.

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ECT practice-failed seizures

DEAR SIRS

We would like to add two further points to those of Snaith and Simpson regarding ECT practice in general[1] and failed seizures in particular.[2]

Firstly, adequate oxygenation of patients is necessary to avoid submaximal or missed seizures.[3] It is recommended that arterial saturation is maintained above 90% for maximum effect.[4] This can be unobtrusively and non-invasively monitored by the use of a pulse oximeter.

Secondly, clinical observation to confirm the existence, or, in this case, the non-occurrence of electrically-induced seizures is notoriously unreliable and can give rise to frequent and unnecessary re-stimulation.[5] Some form of objective monitoring, either by the BP cuff method[6] or EEG is necessary.[5] In our Unit we use stainless steel needle electrodes to pick up EEG tracing during ECT. These are easily attached to the scalp and can be sterilised in Cidex after use.

Such controls of treatment are essential to ensure that ECT is administered in a safe, efficient manner as befits modern medical practice.

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England expects: Are we prepared?

DEAR SIRS

A major factor in psychiatry's success in obtaining more senior registrar posts from 1987's JPAC negotiations was the evidence that Health Districts were keen to recruit more psychiatrists to run psychogeriatric services (and to a lesser extent other specialist services: the addictions, rehabilitation). A review of consultant posts advertised during the academic year September 1986–87 confirms that there is still a heavy demand for old age psychiatrists (Table I). Within the specialty of adult psychiatry, which includes old age psychiatry, the addictions, rehabilitation and other 'interests', more than one third of the posts in England and Wales required a consultant to take responsibility for, or devote a significant part of the working week toward, services for the elderly. There were as many advertisements for 'pure' psychogeriatricians as for child and adolescent