

care. The authors do not elaborate on how such treatment can be provided adequately. In the highest model of the three models presented for mental healthcare all kinds of subspecialist treatments become available. However, integrated clinics for people with comorbid physical and mental health problems are not mentioned.

Taking the current epidemiological and pathophysiological perspectives into account, the Editorial Board of a journal such as the *British Journal of Psychiatry* should consider inclusion of an integrated perspective in their review process. Such an approach will reduce psychiatrists' blind spot and psychiatrists' illusion (Cohen & Cohen, 1984) and will initiate an inspiration in health care comparable with that arising from the description of the previously fragmented and now integrated research institute (McGuffin & Plomin, 2004).

#### Declaration of interest

F.J.H. has received a fee for writing the editorial comment circulated with the Dutch edition of the *British Journal of Psychiatry*.

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#### Quality of life and ECT

The first author of this study (McCall *et al*, 2004) has an apparent career, if not financial, conflict of interest in the treatment being reviewed. He is the President of the Association for Convulsive Therapy, the industry trade organisation, as well as the editor of its journal which he calls 'the voice of ECT' (McCall, 2004). This ought to have been revealed to readers directly; as it is, it reveals itself in the many flaws of research design which bias the study towards minimising the risks of electroconvulsive therapy (ECT).

The study included those who had had ECT as recently as 4 months previously, thus building into the research design the assumption that the adverse effects of ECT resolve within that time period; but there is evidence that this is not so. If it is not, then the study is simply comparing those who are still suffering the after-effects of ECT with those suffering more severe after-effects, a comparison which tells us nothing about the effects of ECT *per se*. The fact that those at baseline averaged a score of only 18 on the Mini-Mental State Examination suggests some type of cognitive dysfunction, perhaps due to ECT, even at that point.

The measures chosen by McCall *et al* in all areas – cognition, amnesia and, most importantly, what he calls quality of life and functioning – are the grossest possible, and cannot register the deficits known to be associated with ECT because they are simply not designed to do so. The authors must be aware of the work of the Service User Research Enterprise (SURE) group (Rose *et al*, 2003) in which patients describe a highly specific pattern of permanent memory and cognitive deficits post ECT. This was a rigorous systematic review of the literature on ECT's effects, and encompasses what most people would call quality of life and functioning. It revealed that for at least one-third of individuals ECT had deleterious, often devastating, effects on these areas which lasted more than 6 months and appeared to be permanent.

Individuals lost the ability to perform their jobs. They lost memory of up to 20 years of their lives. They were unable to handle schoolwork because of impaired memory function and concentration. They did not recognise persons previously well known to them. They waited anxiously for the promised 'return of memory' which

never came. None of this is consistent with improvement in quality of life.

Why then are McCall *et al*'s results so seemingly contradictory? Because he did not ask about these things. Instead, participants were asked, quite literally, whether they could wipe their own backsides. If they were simply able to get out of bed, feed and dress themselves, and use a bus or a telephone they were graded as functioning at the highest possible level. No one has ever reported that ECT affected their ability to use a toilet.

Finally, 4 weeks after ECT is too soon for individuals, who are unlikely to have tried to go back to work or school yet, to be able reliably to assess their altered memories and abilities.

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**Author's reply:** We are grateful for Ms Andre's interest in our paper. She is the director of the Committee for Truth in Psychiatry (CTIP), which is a vocal anti-ECT group in the USA (see <http://www.harborside.com/~equinox/ect.htm>). As such, we feel that our work must be on target and of some importance to attract their criticism. Ms Andre has some specific complaints with our work, which we address as follows.

First, Ms Andre suggests that I have an apparent 'career, if not financial, conflict of interest' that invalidates the paper, especially as pertains to my role as President of the Association of Convulsive Therapy (ACT). I receive no financial or material support for serving as president of ACT; ACT is self-supporting through the dues of its members. The idea of a 'career conflict of interest' is not a concept endorsed by the American Medical Association Code of Ethics, per section 8.031 (Council on Ethical and Judicial Affairs, 1997). It is just as likely that she has a conflict of interest as director of CTIP in writing her letter – any information that supports the use of ECT threatens the position of CTIP. We would