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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REFERENCES

[1] SNAITH, R. P. & SIMPSON, K. (1987) ECT practice. *Bulletin of the Royal College of Psychiatrists*, **11**, 203.
[2] —— & —— (1987) ECT practice-failed seizures. *Bulletin of the Royal College of Psychiatrists*, **11**, 383.
[3] HOLMBERG, G. (1955) The effect of certain factors on the convulsions in electric shock treatment. *Acta Psychiatrica Scandinavica*, **98** (suppl), 1–19.
[4] D'ELIA, G., OTTOSSON, J. O. & SAND STROMGREN, L. (1983) Present practice of electroconvulsive therapy in Scandinavia. *Archives of General Psychiatry*, **40**, 577–581.
[5] CHRISTENSEN, P. & KOLDBAECK, I. (1982) EEG monitored ECT. *British Journal of Psychiatry*, **141**, 19–23.
[6] FINK, M. & JOHNSON, L. (1982) Monitoring the duration of electroconvulsive therapy seizures. *Archives of General Psychiatry*, **39**, 1189–1192.

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

TABLE I

Consultant vacancies psychiatry: 'British Medical Journal': September 1986–87

	General Adult	*General and Interest*	*Psycho-geriatric*	*General and Psycho-geriatric*	*Psycho-therapy*	*Forensic*	*Child and Adolescent*	*Private*	*Mental Handicap*	*TOTAL*
England and Wales										
Total	56	38	43	16	10	10	43	4	25	245
Readvertised in the year	12	9	7	3	1	5	4	—	1	42
Readvertised twice in the year	2	4	1	—	—	1	1	—	—	9
Full-time academic	2	1	2	0	0	1	1	—	1	8
Academic sessions	3	—	2	—	—	—	3	—	1	9
Scotland										
Total	10	3	2	2	—	—	3	—	3	23
Northern Ireland										
Total	4	—	—	—	—	—	1	—	3	8
Other										
Total	1	—	—	—	1	—	2	—	—	4

psychiatrists, four times the number of posts for psychotherapists or forensic psychiatrists and about twice the number for specialists in mental handicap.

At the present time there are no senior registrar posts offering the prospect of training to become a psychogeriatrician from the time of appointment: training is available within rotation schemes in general psychiatry with the option of one year of specialist training at maximum within a three to four year rotation, with two years devoted to general psychiatry and other specialist experiences offered as alternatives to 'old age' in the third or fourth year. It is most unlikely that appointment committees are selecting senior registrars with a balance of career aspirations that one in three will become a psychogeriatrician. It is most unlikely that training in the first two years of general psychiatry will be designed to encourage senior registrars to specialise in old age. We know that no more than half the senior registrars who chose to take the old age option from amongst the specialist experiences offered go on to become psychogeriatricians.[1] If we are to use our senior registrar posts responsibly to equip people for the careers that are required by Health Districts something must be done to ensure that a greater proportion of trainees are prepared for work with the elderly.

It seems to me there are two main options: for old age psychiatry to become a subspecialty akin to child and adolescent psychiatry, forensic psychiatry, geriatric medicine etc, with designated senior registrar posts that guarantee a training for this work and with numbers tailored to predicted requirements, or general psychiatry adopts a more realistic view of its old age component and all senior registrars be required to receive one year of their training with an old age service, probably in their second or third year of training, with other specialist experiences remaining as additional options in the third or fourth year.

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REFERENCE

[1] JOLLEY, D. & HORTON, R. (1986) Senior registrars posts in old age psychiatry. *Bulletin of the Royal College of Psychiatrists*, **10**, 213–214.

Psychiatric services in North Wales

DEAR SIRS

The Psychogeriatric Department has been recognised as a separate service by the country as a whole for the last 20–25 years. However, a full-time specialist in Clwyd North was appointed only about a year ago. Perhaps this would be a good time to stop, reflect and do some 'stocktaking'.

There are two counties in North Wales, i.e. Clwyd and Gwynedd. The Department of Psychiatry of Old Age, which has emerged in the last year, covers Colwyn and Rhuddlan Districts with an elderly (over 65) population of 24,000. However, as the adjoining county has no psychogeriatric cover at all, the team is in fact shouldering an old age population of 35,000. The guidelines from the College[1]