SUBMISSION TO

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM:

THE PLACE OF ELECTROCONVULSIVE TREATMENT IN PSYCHIATRY.

N McLaren MBBS FRANZCP
Psychiatrist,
[redacted]

INTRODUCTION AND CASE

This submission addresses Pt 2.1 of the terms of reference, viz:

> 2. How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:
>
> 2.1 best practice treatment and care models that are safe and person-centred;

With permission, I will use the case of a long-term detained patient to examine the place of electroconvulsive treatment (ECT) in modern psychiatry. The patient, who is now in his early forties, was very well-known to Victorian Mental Health Services before he moved interstate some years ago. From about the age of nineteen, he had been in hospital perhaps fourteen years in all, including two years in [redacted], although he had never been convicted of any offences. As an involuntary patient in hospital in 2014-15, he was tied to his bed for months on end while being forced to take large doses of medication. He was then subjected to ECT even though, before each episode, he stated he did not want it and did not give permission for it.

In November 2015, his family were gravely concerned that he had been given in excess of 100 ECT at a rate of three per week, and the hospital freely stated it would continue indefinitely. Before each order for twelve sessions expired, the hospital lodged an application for a further order, on the basis that he was completely unmanageable by any other means and ECT was needed as an emergency, life-saving treatment. I attended two applications before the Mental Health Tribunal and heard the hostpital staff state this explicitly.

I was asked to review his case as his family had learned through my publications that I do not use ECT. Early in 2016, the family indicated they were planning to move to Queensland and asked whether I would be available to continue his management in Brisbane. This necessitated a considerable amount of organisation and in May, I went to Melbourne to meet the director of Eastern Metropolitan Mental Health Services to discuss the move. However, a few days later, I was told that the patient had arrived in Brisbane to reside with his elderly parents. As his father had guardianship and power of attorney, [redacted] was able to continue management as a private, bulk-billed outpatient. The ECT ceased and, with standard medication over the next few months, his condition remained essentially unchanged.

However, it emerged that he had been charged with assault by the former hospital so, in about September, the parents had to go to Melbourne for the case, leaving him home alone for a few days.

He was intensely fearful of being imprisoned and, over the next week, his condition deteriorated. He argued with his parents and left their home one night, but was found by police and taken to hospital. After a few days, he was discharged but the problem with the court case in Melbourne persisted and his condition deteriorated. One day, he stormed out of their unit and was taken back to hospital by police. He has remained in hospital more or less since but has not had ECT. According to his family, his mental state is completely unchanged from when he was in Victoria.

Over some 24 years, Victorian MHS spent about $10million on this man, and Qld MHS have spent more since. Having reviewed thousands of pages of his files in Victoria, the only psychiatrist to have done so, I am satisfied that his management has been misconceived since the day he first arrived at a hospital, in a disturbed state after smoking marijuana. Just as an example, his Victorian files, which filled a shopping trolley, did not contain anything that approximated a proper psychiatric history or assessment. It also emerged that the first eight years of his files had disappeared years before, archived somewhere but nobody knew where. The four hundred or so psychiatrists and registrars who had seen him over the years knew nothing of his early history. More tellingly, meetings showed that while they weren't aware of this gap in their knowledge, they were entirely satisfied that they had a full understanding of his mental disorder ("a brittle psychosis," to quote the Director, even though there is no such thing). For better or for worse, that is typical of psychiatric practice these days but it is not the point of this submission. The question I raise is the immoderate use of ECT in this case, which leads to the broader question of whether ECT can ever be justified.

EVIDENCE

In their applications and in oral submissions, the hospital stated, and the Tribunal accepted, that this man had to have apparently endless ECT as the only means of treating him; essentially, it was to save his life. Subsequent events have established that that was factually incorrect, that there was no basis to their claims. Since then, I have reviewed the literature on ECT and have published the results in the paper appended [1]. This rebuts every claim made on behalf of ECT by the Royal Australian and New Zealand College of Psychiatrists. It lists the evidence that there are massive discrepancies locally, nationally and internationally in usage of ECT, differences which do not affect treatment outcome to even the slightest degree.

Despite anything mainstream psychiatrists say, ECT is not effective; it is not safe; it is not cost-effective; it has no scientific basis; but above all, it is not necessary. That is to say, it is possible, as I have shown, to practice psychiatry in both public and private sectors without ever resorting to ECT.

As my review established, there are only three possible justifications for a psychiatrist to use ECT:

1. "As your psychiatrist, I am firmly committed to the concept of depression as a genetically-determined, biological disease of the brain and, as such, I believe that physical methods of management are irreplaceable. If drugs don't succeed, we go straight to ECT."

2. "I have tried everything I can but I have reached the limit of my skill set. I don't know what else to do."

3. "It pays well."

My research shows that the first reason is wrong; the second is an indictment of current psychiatric practice; and the third needs no elaboration. In public practice, the major driver for using ECT is

justification No. 1, closely followed, as in the case of [redacted], by No. 2: the psychiatrists don't know what else to do, but adamantly refuse to obtain a second opinion from somebody who doesn't use ECT. Finally, readily available figures establish beyond the slightest doubt that the major justification for the rapidly rising rates of private ECT in Australia is No. 3: it is highly lucrative to those who use it.

As the paper shows, in over forty years in a highly diverse psychiatric practice, large parts of which were spent in isolated regions of this country, I have personally assessed and managed well in excess of 12,000 individual patients. I have seen, and mostly managed alone, practically everything that psychiatry has to offer, including Zar possession. Not one of those patients has been given ECT. I have repeatedly offered a challenge to psychiatrists who do use it: If I can manage without it, why can't you? Not one of them has ever offered a response. Instead, all we hear is a blizzard of obfuscation, misrepresentation and self-justifying propaganda which says nothing more than: We like it.

There is no point asking academic psychiatrists whether they like ECT because they do. It dovetails neatly with their narrative that all mental disorder is brain disorder, and gives them something "doctorish" to teach students and trainees, not that there is much to teach about pressing an electrode against an anaesthetised head (note that in some countries, general practitioners and nurses give ECT). Mental hospitals like it as it allows them to conceal the fact that they operate with no published model of mental disorder, and no longer take proper histories from their patients. It is a waste of time asking private psychiatrists and their friends in the private hospitals whether they like ECT. Of course they like it, they make hundreds of millions of dollars from it each year.

It is unquestionably the case that non-clinical pressures can lead to overuse of medical services, and I will give two examples before returning to ECT. The first is caesarean section. In the Kimberley Health Region of Western Australia in the late 1980s, the rate of deliveries by caesarean section was about 21%. This was for an almost exclusively Aboriginal population where, despite the best efforts of medical and nursing staff, maternal health standards were generally poor. Pregnant woman in the region had high rates of diabetes, cardiac, hepatic and renal disease, asthma and COPD, hypertension, alcohol abuse, etc, all complicated by high rates of teenage pregnancy.

At the same time, the rate of caesarean section in the wealthy eastern suburbs of Sydney, where women enjoy the very highest standards of health and of medical care, was about 40% and rising. That is, the wealthy suburbs were over-using a medical service for their convenience, which had the effect of diverting a substantial part of the health budget away from people who needed it to people who, by any impartial standard, didn't show any medical need for it.

Among OECD-33 countries, Finland has the lowest rate of caesarean section, at 15% of all births; improbably, Turkey has the highest, of 53%. Australia and US are now about 33% but rising fast. This is purely a social phenomenon, not medical. It is funded by the unwitting taxpayers who are led to believe they are supporting an essential medical service when actually they are paying for an option for the wealthy. We could cure the "epidemic" of caesarian sections at a stroke, by refusing to pay for it privately. If the operation could be performed only in public hospitals on specified grounds, the rates would plummet.

The second example also comes from Western Australia. In 1987, when I left Perth for the Kimberley, there were apparently less than one hundred people in the state taking prescribed stimulants. Over the next 16 or so years, that number increased very dramatically, to over 20,000. In the early stages of the use of stimulants in child psychiatry, a practitioner who wanted to

prescribe them had to call the Health Department for a treatment authority for each patient, as well as submit a form. However, practitioners who wanted to prescribe these drugs resented this procedure on the basis that it wasted time and reduced their turnover. Under pressure, the Department waived the process for child psychiatrists and paediatricians, allowing them to prescribe the drugs without prior permission.

Shortly thereafter, there was an explosive increase in the numbers of children being found to have primary disorders of attention, followed a few years later by large increases in the numbers of amphetamine-addicted young adults. After an investigation in about 2003, the Department decided to reverse its waiver and require all patients to be granted a specific authority. Rather abruptly, the "epidemic" of ADHD in WA abated, probably the only place in the world where this has happened. All because doctors who had to spend five minutes on the phone justifying why they wanted to use the drugs apparently realised they didn't need to prescribe them after all [2]. That is, the treatment was always optional.

My case is that ECT is always optional, never essential, but we now have clearly documented proof of this assertion from Victoria. In the 1986 Victorian Mental Health Act, if an involuntary patient were deemed incapable of giving informed consent to ECT, or refused it, the psychiatrist could approve it regardless. Under the 2014 Act, this authority was moved to the Mental Health Tribunal. Naturally, this resulted in a lot more work and inconvenience for the hospital staff. In a short letter to the editor of the RANZCP journal, *Australasian Psychiatry,* Lee [3] showed that introducing these bureaucratic procedures halved the perceived need for involuntary ECT. His figures indicate a 54% drop in applications in the two years after the new Act.

Advocates of ECT who see these figures are most likely to interpret them as a matter of unnecessary bureaucracy preventing seriously ill people gaining the essential treatment they need to recover. That is incorrect. This dramatic reduction in ECT did not result in mental hospitals becoming choked with pitifully distressed patients who could not get better, nor did it lead to a surge of suicides in Victoria. What it shows is that a procedure which was previously considered "indispensable, life-saving" proved very dispensible once it inconvenienced the psychiatrist, and life continued much the same.

This is absolutely consistent with every criticism I have made of ECT: psychiatrists use it because it is easy; it requires no great intellectual effort; they believe people who refuse it are clearly incapable of deciding what's good for them; while those who complain after the event (of memory damage, etc.) are obviously insightless and can be ignored.

One sometimes hears claims that if psychiatrists were to follow some particular form of management or other, they could sharply reduce their usage of ECT, or even stop it altogether. Two comments should be noted. In the first place, it is exceedingly unlikely that the psychiatrists who use the bulk of ECT in this country will be moved by such claims. For reasons listed above, they like ECT; they're not going to stop using it just because somebody comes up with a better form of management. The history of insulin coma treatment in schizophrenia is germane. Even though insulin therapy was shown to be completely useless (by Harold Bourne, a very junior registrar at the time [4]), the "big names" in psychiatry continued to use it for many years, pouring quite vitriolic scorn on Dr Bourne's efforts while quietly ensuring that he was never able to work in Britain again. Second, it doesn't matter what treatment is proposed to reduce ECT, it could be reduced anyway just by imposing restrictions, as happened in Victoria in 2014. It's that simple (mainstream psychiatrists hate people bringing up their history of failures; they much prefer to talk of their roseate future).

Finally, ECT's advocates are very quick to quote patients who say they were dramatically improved by ECT. No credibility attaches to these often lurid statements, as they are anecdotal, as the enthusiasts know full well (anecdotes do not add up to a general truth). For every patient claiming to have been improved by ECT, I can find two who say they were damaged or who wish they had not had it. Undoubtedly, some people will say they like ECT, but the question is not whether it benefits a few people some of the time; rather, we need to be sure it benefits the overwhelming majority of people practically all of the time. It certainly does not.

CONCLUSION

I submit to this honourable Royal Commission that readily-available evidence shows overwhelmingly that ECT cannot be justified on any rational grounds. It has no place in psychiatry. The Commission should, however, be fully aware that mainstream psychiatrists are highly experienced in seeing off critics. They spin a narrative that there is only one conceivable model of mental disorder, namely, whatever they espouse at the time, coincidentally one which gives them enormous power and is also remarkably lucrative.

It is well-established that psychiatrists have an extremely poor record of questioning their methods or theories [4-9]. Overwhelmingly, psychiatrists bitterly resent being forced to justify their actions in public. Socieity can no longer afford to take at face value the wrathful expostulations of mainstream psychiatrists whose methods have been questioned. Almost inevitably, this takes the form of quite vicious ad hominem arguments and can safely be ignored.

In particular, the Commission needs to be aware of a small group of highly visible and well-connected psychiatrists who appear to have the ear of both the political set and the media while they push what is essentially a highly profitable, political agenda.

I submit that Australia should follow the lead, if not of Slovenia and some Swiss cantons, where ECT is banned, then certainly of Italy, where it is severely restricted. As a matter of empirical fact, Slovenians and Italians are not thereby worse off. Their psychiatrists may not be so wealthy, they may not have as many private psychiatric hospitals as Australia, but the citizenry of those states are coping admirably.

RECOMMENDATION

I urge this honourable Commission to find that ECT can no longer be justified and should be phased out as soon as possible.

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ECT is widely used in the Anglophone world but very much less in the rest of the world. In some places, it is so severely restricted as to be a rarity; in others, it is banned. Comparative data indicate there is no scientific justification for this discrepancy. Instead, there is a prima facie case to say that the major impetus behind ECT usage lies in the financial rewards it generates for psychiatrists.

Keywords: ECT, psychiatry, models of mental disorder; psychiatric mortality.

INTRODUCTION

The official position of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) on electroconvulsive treatment (ECT) is given in their Position Statement on ECT, dated March 2014:

> 1. ECT... has efficacy in treating clinical depression, mania and psychosis... Its primary purpose is to quickly and significantly alleviate psychiatric symptoms.
> 5.6: The use of evidence based pharmacotherapy and other strategies to prevent relapse after improvement from ECT is essential for obtaining a lasting improvement.
> 7.2: ...ECT remains a useful and essential treatment option that should be available to all patients in whom its use is clinically indicated...

Further elaboration is given in the RANZCP submission (2011, pp1-2) to the US Food and Drug Administration's (FDA) hearing to reclassify ECT machines from Class III to Class II medical devices, i.e. requiring a *lower* level of proof of efficacy and safety (see Note 1):

> The RANZCP strongly supports the use of ECT as an established and valuable treatment for patients suffering severe mental disorder... The RANZCP is strongly of the view that ECT remains an important and necessary treatment for various serious psychiatric conditions, most commonly severe depression ...
> ...the RANCZP believes very firmly that it would be an injustice for ECT to be unavailable ... ECT is irreplaceable...
> There is further evidence that ECT does not cause brain damage or personality change, and a lack of evidence or rational reason to suggest or expect any long term ill-effects...
> The high morbidity and mortality associated with the conditions as detailed above, and the high prevalence of medication resistant depression, leaves ECT as the only alternative treatment for a significant number of patients...
> It is recognised that ECT raises anxiety and fearfulness in the community, however much of the opposition to ECT is based on fear and irrational thinking, not science.

ECT is held to be "useful," "essential," "irreplaceable," "effective," "valuable," "clinically indicated," "important and necessary," and harmless, while opposition to it is "irrational," out-dated and not scientific. These are very strong claims. Because ECT evokes strong reactions, they need the highest level of proof. In this brief review, I wish to question these claims, and will present evidence to show that they are not supported in the literature.

Is ECT useful in psychiatric practice?

This claim is not scientific. "Useful" is entirely a subjective decision; at most, it may be said that some practitioners find it useful, but that would be a matter for research, not fiat. In fact, not all psychiatrists find it useful, as Jonathon Phillips, a former president of the RANZCP, commented:

> ...it is very easy to order ECT treatment. I would not like to think that it is being used just because it's easy.... I do hope it is not the start of the slippery slope. Are we going back to an era where we resort to ECT rather than talking to people and using the art of psychiatry?.... In two years in a very busy practice, I have only referred one patient for ECT... (O'Brien, 2011).

In his enquiries, O'Brien noted an unusual discrepancy:

> The Medicare figures show that last year, New South Wales men aged under 24 were given (ECT) at three times the rate of men in that age group in Victoria.

It seems highly unlikely that, on clinical grounds, patients in neighboring states could differ so dramatically; clearly, the perception of "useful" does.

Is ECT essential to psychiatric practice?

This claim is more reliable, as the word 'essential' has a precise and objective meaning:

> Essential *adj*. 1. vitally important; absolutely necessary. 2. basic; fundamental.... 7. something fundamental or indispensable.

If it can be shown that it is possible to practice psychiatry without or rarely using ECT, then it cannot be considered "essential." This is in fact the case. Worldwide, there are very substantial variations in ECT usage internationally, intranationally and even from one locality to the next, as detailed in a lengthy review (Leinkes et al, 2012). These authors use the statistic "treated patient rate" (TPR), meaning the numbers of people who receive ECT per 10,000 population per year.

In the US, the TPR is 5.2 people per 10,000 pa, although there are enormous local variations. Australian rates vary from 2.2 to 4.4 (Victoria) while New Zealand gives it to just 0.75 people in every 10,000, one sixth of the maximum Australian rate. Other nations use it far less. In Spain, the TPR is 0.41, Germany 0.26 (western Laender averaged 0.36 while in the former eastern zone, it was only 0.15) and Poland uses it on only 0.11 people per 10,000 pa. In France, only half of approved psychiatric facilities reported using ECT, while in Poland, that figure was one in three. Japan, Finland, Italy and other countries hardly use it, while it is banned in Slovenia and some cantons of Switzerland.

Following the intense restrictions on ECT in Italy in 1978 and again in 1999, in which private ECT was banned, Abrams (2000) predicted disaster:

> (In Italy, ECT) may now be administered only as an emergency procedure in government hospitals after other treatments have failed and if the patient is in a “life-threatening” situation. Because of politically based conflicts, the use of ECT in Italy was already among the lowest in the European community; the new regulations now threaten the very existence of this truly indispensable treatment in the land of its birth.

In 2014, 91 centres in Italy were licenced to give ECT; only fourteen (15%) did, meaning about 53million people did not have access to ECT. Abrams' claim that it is "truly indispensable" has been contradicted by the passage of time. An impassioned plea for increased use of ECT in Italy by Buccelli et al (2016) omitted to mention that, in nearly twenty years since it was effectively banned, the mental health of Italians has not declined.

In the US, TPRs vary from 5.7 for women to 3.6 for men, a pattern which was also seen in England: female rates there were 2.56 per 10,000 while male rates were only 1.12. In Scotland in the 1990s, rates for people aged 65 and over were about five times those for people 18-65, but all rates in that jurisdiction dropped by over 50% during this decade. No explanation was offered. In practically all countries where the information was available, rates of ECT utilisation were higher in urban than in rural regions, ranging from 50-500% higher.

Commenting on an earlier survey of the US, Eranti and McLoughlin (2003) said:

> No ECT use was reported in just over one-third of the 317 metropolitan areas in the 1988-

> 1989 APA survey and, in the remaining areas, annual rates ranged from 4 to 812 patients per 100,000 population.

That is, they found TPR ranged from 0.4 to 81.2 per 10,000, or 20,000% difference in the same country.

In the England-Wales division of the UK NHS, ECT use has declined precipitously over the past thirty years, from a total 137,940 episodes in 1985, to 105,466 by 1991, then to an estimated 65 930 in 1999. The decline has continued apace, down to about 22,500 in 2014-15, or barely one sixth as much as a generation before (Davis and Duncan 2017). As the population has increased by over 20% in this time, the relative decline is even greater.

In this context, my own figures are apposite. 2017 marks forty years of highly diverse practice, in public and in private, in hospitals, prisons and community clinics, in urban areas and remote, including six years as the world's most isolated psychiatrist (McLaren 1995). At present, I operate a solo, bulk-billing private practice in a working class area with high levels of unemployment, of broken families, immigrants and pensioners, as well as high levels of crime, school absenteeism, drug and alcohol abuse, etc. (all patients are eligible for national health insurance). Having worked for years in public services, I am satisfied that the patient profile I see now is the same as would be seen in any public service in the country. In four decades, I estimate I have personally assessed and managed, or been directly responsible for, well in excess of 12,000 patients. These are consecutive, unselected public patients, including about one thousand serving members of defence forces and perhaps two thousand veterans. In forty years, not one of those many thousands of patients has been given ECT.

Twice in that time, I was head of department of 30 bed units in general hospitals (Veterans' Affairs, RGH Hollywood, Perth, for five years, and Royal Darwin Hospital, NT, for three years). In each of those hospitals, ECT had been in use for years prior to my appointment. It stopped for the duration of my stay and was resumed some time later. During my tenure, the admission rate in each hospital dropped, the mean duration of stay dropped and the bed occupancy rate dropped to about half. Following my departure, when ECT resumed, these statistics returned to their previous means. That is to say, psychiatrists seeing exactly the same patient profile and, in some cases, even the same patients, were electing to use ECT in just the circumstances where I had not.

These figures indicate that many psychiatrists and many centres around the world feel able to practice psychiatry using ECT rarely or never. They do not support the claim that ECT is essential, i.e. "vitally important, absolutely necessary, indispensable."

Can ECT be "clinically indicated"?

A "clinical indication" is just what the prevailing medical standards say it is. It is an attempt to impose some sort of order on daily practice, as in: "If conditions A, B and C prevail then, all things being equal, current mainstream opinion is that treatment K should be followed." Most emphatically, it does not shift the decision to use a treatment from the practitioner to the clinical picture, which is the impression the expression gives: ultimately, the practitioner is responsible. Needless to say, two psychiatrists can look at the same patient and come to radically different conclusions about the best form of management. ECT, like all other forms of treatment, is indicated just when the psychiatrist says it is. In practice, Point 7.2 of the Position Statement now reads:

> ECT ... should be available to all patients *if the psychiatrist decides to use it*...

This imparts quite a different significance.

If the notion of "clinical indication" has any objective standing, it is difficult to explain how there could be such enormous variation between, say, rural areas in Belgium and their main

cities (TPR respectively 2.0 and 10.0), or the American figures quoted by Eranti and McLoughlin (2003). More pertinently, it is necessary to explain New Zealand's relatively low rate compared to Australia. Since the populations are so similar on all genetic, socio-economic and cultural parameters, and psychiatrists in both countries are trained to the same curriculum, it is not possible to say that "clinical indication" can account for the 600% difference in utilisation of ECT. A potential explanation is buried in the paper by Leiknes et al: in New Zealand, ECT is not given in private facilities.

In practice, it is the psychiatrist's decision whether or not to use ECT but this has immediate impact on the concept of informed consent. Ideally, all patients advised to have ECT should be told that while their psychiatrist advises it, other psychiatrists in the same town would not while, in some countries, it is so severely restricted that the question would not arise. As will be shown later, the clinical outcome of ECT vs. no ECT is about the same so, whether patients get ECT or not is not a matter of science, it is a matter of the psychiatrist's personal predilection, i.e. chance.

There are further grounds to suspect the value of attributing ECT to "clinical indications." In Australia, use of ECT in private settings increased very dramatically in the decade from 2007, as shown by Medicare rebates for ECT in the private sector:

State	2007	2016	Increase %
New South Wales	4936	8039	63
Victoria	4895	8639	76
Queensland	4852	9274	91
South Australia	1163	2487	114
Western Australia	1457	4242	191
National totals	18183	33641	85

Nationally, the "clinically-indicated" use of ECT in private practice increased nearly six times faster than population growth in that decade (15%). The dramatic rise of 190% in Western Australia cannot be explained on any reasonable clinical grounds. In Queensland (population 4.8million), ECT usage in both public and private sectors jumped from 16,602 episodes in 2013-14, to 19,365 episodes the following year, i.e. 16.5% increase. By way of comparison, Davis and Duncan (2017) noted that in 2015-16 in England (population 53million), NHS trusts reported about 22,500 episodes of ECT, meaning Queensland uses ECT approximately 1000% more than England.

A similar pattern is seen in the US, where ECT is largely reserved to the private sector:

> A typical ECT patient in the United States was said to be an elderly white female paying for treatment with insurance or private funds (Leiknes et al, 2012).

Sackeim (2007) reached the same conclusion:

> ...ECT recipients are older, more often white, more likely to have private insurance, and more likely to live in more affluent areas. Contrary to its portrayal as a treatment inflicted on the poor or destitute, ECT is disproportionately administered to those more well-off.

After a most extensive review, Read and Arnold (2017) commented:

> We should, meanwhile, remain cognizant of the fact that the archetypal ECT recipient remains, as it has for decades, a distressed woman more than 50 years old.

This raises another question, the allocation of ECT.

Is ECT properly allocated by clinical indications?

Using figures taken from the website of the Australian National Depression Initiative (Beyond Blue.org), in any year, about one million Australians will suffer a depressive episode. Some, of course, will suffer several, so the total figure is quite a lot higher. In 2015, 3027 deaths by suicide were recorded, of which a certain proportion were not associated with depression, say one quarter. This yields 2270 suicides among one million plus cases of depression, where the risk for men is 3.4 times greater than for women.

Accepting Beyond Blue's figures that two thirds of cases of depression are female, the annual risk of suicide among depressed women is approximately 545 deaths in 670,000 cases p.a., or 81 suicides per 100,000 cases per annum (one suicide per 1,234 cases of depression). The equivalent risk for men is 525 per 100,000 cases of depression (one death per 190 cases of depression), 650% greater, but women get 80% of the ECT in this country. Clearly, this constitutes a grave misallocation of resources. Equally clearly, it would not be feasible to try to prevent all suicides by admitting all depressed people to hospital and giving them ECT.

Is ECT "irreplaceable"?

To paraphrase the RANZCP submission to the FDA, ECT is absolutely essential as an emergency measure to treat severe mental disorders and their associated morbidity and mortality. This applies especially to severe depression, which is becoming more problematic due to the rise of "treatment resistant depression." In a recent review of ECT, Kolar (2017) stated:

> ...acute ECT has an essential role when the urgency of the clinical situation (an increased risk of suicide, treatment resistant catatonia, malnutrition, etc) demands a treatment with a rapid onset of therapeutic action.

However, in Norway, ECT is restricted and it is reported (Leinkes et al, 2012) that, at centres authorised to use ECT, waiting lists of up to eight weeks are not uncommon. In Italy, 91 centres are authorised to use ECT but, in 2014, only fourteen did so. That is, about 85% of the population of some 63million did not have access to ECT. There is no evidence that they were any worse off. There is no doubt that, if there were a discrepancy in suicide rates between areas where ECT is available and those where it is not, advocates of ECT would seize upon it eagerly. There is no such evidence.

Despite the recent rapid increase in use of ECT in Australia, the suicide rate has recently peaked at 12.6 per 100,000 p.a. (ABS 2016) For men, the figure is 19.2, about 340% of the rate for women, but since most patients receiving ECT in Australia are female, it is clear that ECT is misallocated:

> ...100 female psychiatrists performed 109 ECTs with equal numbers of male and female patients, but 100 male psychiatrists performed 345 ECTs and there were four females for every male patient. These results are reflected in the national data. Male psychiatrists perform 93.5% of ECTs... (Quadrio 2001).

Those patients who receive ECT, essentially meaning older white women who can afford to be managed in private hospitals, are among the least likely to attempt suicide. The population at gravest risk of suicide is younger, male, unemployed, often with drug and alcohol problems,

possible criminal history, recent major losses etc. That is, they show exactly the profile of my own practice. Needless to say, this group cannot afford private hospitals, and would be unlikely to cooperate in any event. It would not be unfair to conclude that the allocation of ECT in Australia is determined by some factor other than "the urgency of the clinical situation." ECT therefore appears to be very replaceable, dependent entirely on the patient's socio-demographic factors, otherwise known as finances.

A psychiatrist who says to a depressed patient "You must have ECT, it is irreplaceable in your case," is saying only one of three things:

1. "I am firmly committed to the concept of depression as a genetically-determined, biological disease of the brain and, as such, I believe that physical methods of management are irreplaceable."

If so, that psychiatrist is adopting a position which has been shown to be ideological, not scientific, and which is probably wrong anyway (McLaren 2013).

2. "I have tried everything I can but I have reached the limit of my skill set. I don't know what else to do."

That psychiatrist should request a second opinion from a colleague who is able to practice without ECT, or hardly uses it.

3. "It pays well."

There are other, doctrinaire positions but they are outside the scope of this paper.

ECT is never irreplaceable, but people who use it routinely will never discover that. It is only when it is *not* available that valid alternatives become obvious. Essentially, the decision to use ECT should be taken from individual psychiatrists and handed to an impartial committee, including critics of ECT. In order to remove the financial incentive as a confounding factor, it would be reasonable to argue that all ECT should be given in public facilities, as in Norway, or that private psychiatrists can give it but cannot charge.

Who believes ECT is best?

From the RANZCP Submission to the FDA:

> The RANZCP strongly supports the use of ECT ... The RANZCP is strongly of the view that ECT remains ... the RANCZP believes very firmly...

This is a category error (Ryle 1949). The organisation known as RANZCP is not the type of entity that can hold beliefs or opinions, etc, nor can it "strongly support" anything because it doesn't have mental properties. Its members do, but that is a different matter. As it stands, the submission is highly misleading. It should have said something like this:

> A small proportion of the membership of the RANZCP, all of whom use ECT, strongly support the use of ECT, etc., but they didn't survey the full membership, nor did they include critics of ECT in their deliberations.

Is ECT harmless?

From the RANZCP Submission to the FDA:

> There is further evidence that ECT does not cause brain damage or personality change, and a lack of evidence or rational reason to suggest or expect any long term ill-effects... much of the opposition to ECT is based on fear and irrational thinking, not science.

Historically, convulsive techniques were developed, initially by Ladislas Meduna in the 1920s, explicitly for the purpose of inducing diffuse, low-grade brain damage as evidenced by gliosis. There is now a substantial body of literature showing that ECT can cause long-lasting damage to memory, to other cognitive functions, and to the sense of self. For example, the American Psychiatric Association (APA) committee on ECT (2001) left no room for doubt:

> In some patients the recovery from retrograde amnesia will be incomplete, and evidence has shown that ECT can result in persistent or permanent memory loss.

A few years later, Rose and colleagues (2003) were perfectly blunt:

> The current statement for patients from the Royal College of Psychiatrists that over 80% of patients are satisfied with electroconvulsive therapy and that memory loss is not clinically important is unfounded.

Similarly, in a well-planned, multi-centre study of 347 patients receiving ECT, Sackeim et al (2007) concluded:

> ...this study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings.

MacQueen et al (2007) conducted a detailed neuropsychological study of post-ECT patients and found:

> Compared with healthy subjects, patients had verbal learning and memory deficits. Subjects who had received remote ECT had further impairment on a variety of learning and memory tests when compared with patients with no past ECT. This degree of impairment could not be accounted for by illness state at the time of assessment or by differential past illness burden between patient groups.

Similarly, after an extensive review, Read and Bentall (2010) concluded:

> Given the strong evidence of persistent and, for some, permanent brain dysfunction, primarily evidenced in the form of retrograde and anterograde amnesia, and the evidence of a slight but significant increased risk of death, the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified.

More recently, the Royal College of Psychiatrists appears to have had second thoughts, as their current patient leaflet explains:

> Memory problems can be a longer-term side effect (of ECT). Surveys conducted by doctors and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10.* Patient-led surveys have found much more, maybe in half of those having ECT.... Some memory problems are probably present in everyone receiving ECT. ... some people do complain that their memory has been permanently affected, that their memories never come back. ...It is not clear how much of this is due to the ECT, and how much is due to the depressive illness or other factors.** Some people have complained of more distressing experiences, such as feeling that their personalities have changed, that they have lost skills or that they are no longer the person they were before ECT. They say that they have never got over the experience and feel permanently harmed. What seems to be generally agreed is that the more ECT someone is given, the more it is likely to affect their memory.... Between 30% and 50% of patients complained of difficulties with memory after ECT (RCPsych, undated)

* A 10% rate of "severe" side effects is hardly "low level."

** This isn't clear, as they had already said the depression had resolved; now they are saying persisting memory defects must be due to persisting depression, for which the treatment, presumably, is more ECT. In any event, since it isn't clear how much is due to ECT and how much to "other factors," and since alternative treatments are available, it would be reasonable to stop using ECT.

In a presentation to the US FDA enquiry on the reclassification of ECT machines, and speaking as a member of the FDA's research and assessment staff, Como (2011) stated:

> ....self-reported memory loss tends to be more persistent than the deficits that can be measured on formal neuropsychological testing. However, for those patients who do experience memory or cognitive impairment, they consider this to be a considerable source of distress for themselves and their families.

Breggin (2010) prepared a review for the same FDA enquiry, concluding:

> Electroconvulsive therapy (ECT) and the machines that deliver it have never been tested for safety and efficacy in order to receive approval from the FDA. The APA and ECT advocates protested when the FDA took steps to classify the machines as posing “an unreasonable risk of illness or injury”, which would have required their testing before approval. Without requiring this testing, the FDA is now preparing to classify the treatment and the machines as safe... ECT is very harmful to the brain and mind... the FDA should demand the usual testing, starting with animals, that is required before psychiatric treatments and machines are approved for marketing and use.

Breggin (2017) maintains a website with over 150 citations, dating from 1942-2012, showing that ECT can cause lasting damage. It is worth noting that medical attitudes to cognitive impairment have changed over the years. For example, a detailed research paper from 1951 found considerable levels of impairment of memory, but this was seen as evidence for the efficacy of ECT as "...facilitat(ing) the selective forgetting or repression of emotionally disturbing material" (Janis and Astrachan 1951). This view is generally not shared by patients. The amnestic effects of ECT are addressed poignantly in a widely-cited, first-person account by Donahue (2000) and in another by Ian McPhee, a Sydney anaesthetist (2009). In a section entitled *The Disaster of ECT*, McPhee said:

> The consequences (of ECT) were dire. Retrograde memory loss was profound. I was devastated and searched for answers where my treating doctors could give none.... I was left then to claw back a life only half remembered.

The Nobel Prize-winning author, Ernest Hemingway, committed suicide shortly after completing a course of 20 ECT. Just before he shot himself, Hemingway said bitterly:

> What these shock doctors don't know is about writers...and what they do to them...What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient.

However, the question of the risks of ECT is not the point: if it is *unnecessary*, then questions of safety do not arise. As for the suggestion that opponents of ECT are necessarily "irrational, anti-scientific," the burden of proof rests with those who use it. As it happens, ECT has no rational basis in an articulated model of mental disorder (McLaren 2013). It should be recalled that in the debate over Italy's Basaglia Law (1978), which severely restricted ECT to the point where it is hardly used today, psychiatrists aimed just these criticisms at proponents of the law.

They were shown to be wrong: the mental health of Italians did not deteriorate measurably and, forty years later, they appear to be coping admirably without it.

Is ECT effective?

ECT is widely held to be highly effective for treating depression and other major mental disorders. In fact, it is less effective than its supporters claim. In a study of 290 patients, Sackeim's group found that only 159 remitted (55%). Moreover, the remission is generally not maintained:

> Our study indicates that without active treatment, virtually all remitted patients relapse within 6 months of stopping ECT (Sackeim 2001).

That is, ECT is at best a temporary alleviation of symptoms, not a cure. Similarly, a study of 531 patients as part of the Consortium for Research on ECT revealed a remission rate of just 64% (Kellner 2007). This is not much better than most drug trials claim. The RANZCP Position statement explicitly acknowledges this:

> 5.6: The use of evidence based pharmacotherapy and other strategies to prevent relapse after improvement from ECT is essential for obtaining a lasting improvement.

Indeed, the very notion of "maintenance ECT" indicates clearly that any benefit is likely to be transient. Read and Arnold (2017) were equally skeptical:

> By 2010, there had only been ten such studies (placebo-controlled randomized trials) for ECT and depression, and none since 1985. Those ten had produced minimal evidence of some temporary benefits, for a minority, during the treatment period, and no evidence at all of benefits beyond the end of the treatment period.

Does ECT require special skills?

In public practice in many countries, it is normal for ECT to be administered by the most junior hospital doctors. In Norway, 6% of ECT is administered by nurses (Leiknes et al 2012) while I have seen it administered by medical students. In the UK and in the Netherlands, ECT is now being given by GPs and by geriatricians. Their view is that they can diagnose depression sufficiently reliably to prescribe antidepressants, and ECT is just another minor procedure to them. There are reports that ECT is now being administered to treat Parkinson's syndrome, and in early dementia. These are not psychiatric diagnoses and are therefore outside the scope of this paper, but I doubt the physicians regard ECT as demanding special skills only possessed by psychiatrists.

Is ECT cost-effective?

As noted several times above, ECT is more likely to be given to people who can afford it. Despite any claims to the contrary, ECT is an expensive form of management. In Australia, the current Medicare rebate for ECT, MBS Item 14224, is $70.35. In 1974-6, while in training in Perth, WA, assisted by an anaesthetist, I routinely gave four to six modified ECT per hour (55 minutes of which was spent standing around watching). The bulk-billing fee for a one hour consultation for the purpose of treatment, Item 306, is $156.15. Bearing in mind that very few private psychiatrists charge the base fee for ECT, more likely double or treble, it is clear that giving ECT to a severely depressed patient is much more profitable and requires very much less effort than psychotherapy with the same patient. Moreover, in Australia, private office psychotherapy funded by Medicare is capped at fifty sessions per year, which is not a lot for a seriously-disturbed patient, whereas for a patient admitted to hospital, there are no restrictions. A psychiatrist could administer ECT three times a week and see the patient every other day and still charge full fees.

Assume a day in a dedicated private psychiatric bed costs something of the order of $1500, plus the psychiatric and other fees. ECT will cost of the order $500 per episode, roughly one third to each of the psychiatrist, the anaesthetist and the hospital's theatre fees (in Brisbane, the actual figure is quite a lot higher). The cost of a five week admission to hospital for twelve ECT will start at about $58,500.00. Ten weeks of psychotherapy which, in qualified hands, will produce about the same result, will cost at most $1600.00, 97% less, more likely about half that (psychotherapy does not include CBT, DBT, Mindfulness, ACT etc).

CONCLUSION.

The claims made on behalf of ECT are that it is "useful," "essential," "irreplaceable," "effective," "valuable," "clinically indicated," "important and necessary," and harmless, while opposition to it is "irrational," out-dated and not scientific. This brief survey shows that these claims are not sustainable. ECT is most certainly not essential; it is not irreplaceable as alternatives are readily available; it is not based in a model of mind or of mental disorder so it has no rational or scientific basis; it is expensive; it carries significant risks which psychiatrists usually don't ask about; and it is effective in the short-term only. Suggestions that it is "useful, valuable and clinically-indicated" are personal judgements only, devoid of any empirical content.

By international standards, Australia uses ECT at a grossly excessive rate (e.g. 600% more than New Zealand, 4400% more than Poland), yet its use is increasing far more rapidly than any demographic factors can justify. It is thus reasonable to conclude that a major impetus for its use in this country is the perverse financial incentive built into the Medical Benefits Schedule of the national Health Insurance Commission. Bearing in mind that the remission rates of ECT-treated depression are quite poor, and that relapse is common, "...the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified" (Read and Bentall 2010). However, psychiatrists who use it, and their closely-associated private hospitals, represent an enormously influential lobby which governments show no signs of resisting. c.f. Upton Sinclair:

> It's difficult to get a man to understand something when his salary depends on his not understanding it.

Remarkably, insurers show practically no signs of interest in the notion that we can dispense with ECT and get the same results at a tiny fraction of the cost of ECT.

Note 1: The RANZCP made a submission to a foreign government agency because "...any decision by the FDA that leads to a restriction in the availability of ECT devices will have an impact on Australia and New Zealand as countries reliant on US manufacturers." ECT devices were in Class III but, for historical reasons, they had never been tested properly. When the FDA asked manufacturers to meet the standards of that class, they demurred on the basis of cost. They then asked to have the devices regraded to Class II so that they did not have to comply, which led to the hearings.

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ADDENDUM:
As an example of the failure of psychiatrists to justify their use of ECT, [redacted]
I promptly submitted a letter which was rejected in short order on the basis that I didn't provide enough figures to justify my case. Bearing in mind that letters are limited to 500 words, and the only figures in the originating article were wrong, there were, in fact, more figures in my letter than in the original article. I have objected to the rejection but expect that will be rejected too. My letter follows:

HOLLOW CHEERS FOR ECT.

In a brief review of ECT in Australia, [redacted] announced:
[redacted]

A full critique of this buoyant piece would take pages; I shall focus on two points. First, the figures he quoted for usage of ECT in Australia are actually rebatable episodes of ECT funded under Medicare, meaning private cases only. When public usage is added, as shown in a recent paper [2], Australia's use of ECT puts us among the leaders in the world. For example, Victoria uses ECT 600% more than New Zealand. Queensland uses it 1000% more than the UK; 5000% more than Poland; 6250% more than Italy, where it was invented; a remarkable 135,000% more than the northern Italian province of Pavia; and infinitely more than Slovenia, where it is banned. Despite the dire predictions of its proponents, these places seem to manage quite well with little or no ECT.

Even in Australia, there are huge regional differences in usage, but the most remarkable finding is the recent surge in private ECT. For example, from 2007 to 2016, rebatable ECT in Western Australia jumped by an astounding 191% [2]. What possible clinical indication can account for these figures? I don't believe there is any such indication; the only conceivable explanation is that private use of ECT, mostly for distressed middle-aged, middle class women, the group with the lowest rate of suicide in the community, is motivated primarily for financial reasons, not clinical.

Second, in the forty years since I graduated in psychiatry, I have worked in public general and mental hospitals, in private hospitals; in remote regions and depressed urban areas; in prisons, military and forensic settings; among the indigenous, migrants and refugees, from every religion and every continent. In my solo, bulk-billing practice in a working class area in Brisbane, I see well in excess of 250 new cases a year, the great majority of them severely disturbed by any estimate. During my career, I estimate I have personally assessed and managed between 12,000 and 15,000 patients yet not one of them has received ECT.

Speaking as an expert in ECT, [redacted] has determined what he believes my responsibility to be. My response is that I am also an expert in ECT: an expert on how to practice psychiatry without using it. If I can practice forty years at the rough end of psychiatry without ever once resorting to ECT, so too can every psychiatrist in this country. It is his responsibility is to face this unpalatable truth: ECT doesn't need a centenary.

Refernces:
[redacted]

2. McLaren N. Electroconvulsive Therapy: A Critical Perspective. *Ethical Hum Psychol Psychiat* 2018 19: 91-104

454 words.