XXX" the word dement to describe a patient suffering from dementia is no different from the terms arthritic, cardiac, schizophrenic, and depressive, and bears no comparison with abusive descriptions like "schizos" and "psychos" as suggested by Dr Manchip. The use of a term to describe a group of patients should not be taken as "dehumanising and derogatory" but tells us much more about the attitudes of those who object.

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GMSC guidance to GPs

Sir: The General Medical Services Committee (GMSC) has recently issued guidance to general practitioners (GPs) in respect of their responsibilities for the assessment and continuing care of patients with mental disorders (*British Medical Journal*, 1996). The guidance implies that GPs have fulfilled their obligations after having assessed and referred a patient to specialist psychiatric services. The latter are then expected to assume responsibility for prescribing and administering of any psychiatric medication, with the GP remaining responsible for prescribing for conditions unrelated to mental illness.

We agree that, in most cases, it is not appropriate for a GP to act as a keyworker under the care programme approach, but their involvement in such cases is nonetheless invaluable. This has traditionally included not only monitoring the patients' mental state and prescribing drugs but also, for example, providing emotional support to their families and administering depot neuroleptics. The removal of prescribing responsibility would inevitably lead to an eventual withdrawal of these "psychiatric primary care services", to the detriment of a particularly vulnerable group of patients.

GPs prescribe on FP10s on the recommendation of consultants from other disciplines. They may disagree with the specialist advice received but presumably, in most cases, are content to comply with it, whilst retaining some overall clinical responsibility for the patient. GPs would also expect to monitor their patients' progress between hospital appointments. We question why psychiatry has been singled out to be the exception; psychiatric management should be no different in this respect and the fact that the GP would not be the key worker is surely irrevelant.

We believe that the GMSC guidance is potentially divisive. It does nothing to encourage the notion of shared care between primary and specialist care and has significant resource implications for over-stretched hospital or community trusts. An increase of referrals to specialist care may be expected as fund-holding practices seek to transfer the financial burden of prescribing. In response, psychiatrists may feel compelled to discharge patients prematurely back to their GP.

BRITISH MEDICAL JOURNAL (1996) Medico-Political Digest. *BMJ*, **312**, 583.

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The Patient's Charter for Mental Health Services

Sir: The Patient's Charter for Mental Health Services is currently a draft edition for consultation. It is a 22 page booklet, informing patients how "the rights and standards in the Patient's Charter apply to people using NHS adult mental health services".

We have serious concerns about the Charter. We understand that it was written in consultation with users of the service. We see little evidence of consultation with mental health professionals in its preparation.

There appears to be a great disparity between what the Charter offers and what, in our experience, is currently available. One striking example is the expectation that a mental health nurse will visit within four hours if a patient is referred as urgent, and within two working days if the referral is non-urgent. The description of a referral as urgent is not clarified, raising the question of what is urgent – a panic attack or florid psychotic episode? Moreover, who will identify a referral as urgent? This will be a source of potential conflict between the patient, the GP and the mental health team. Further conflict may stem from exploitation of the Charter. In the hands of a manipulative patient it could jeopardise genuine therapeutic strategies such as boundary setting.

We find the document inconsistent in both its attention to detail and its philosophy. Some standards are specific, some are vague. We quote from the draft edition of the Charter by way of example: "You can expect a home visit within a two-hour time band" yet "You can expect to be told what treatments are available other than medication". Turning to the philosophy of the Charter, there is a curious mix of paternalism and user empowerment. Again, quoting from the Charter: "Prior to discharge . . . you will be told what to do, and who to contact in the event of problems" whereas "You have the right to be referred to a consultant acceptable to you". Statements such as these have far reaching implications.

The proposed Charter will have a profound influence on the psychiatric service. On the positive side, it may lead to an improved out-of-hours service. However, by making unrealistic promises, this Charter is setting up the service for failure. Our most serious concern is that by reinforcing the bias of service provision to those who 'shout loudest' the Charter will further marginalise the seriously mentally ill: would a reclusive psychotic ask for an appointment on a specific day, giving 48 hours notice?

The draft edition of the Charter invited comments before 26 April 1996. We have written to Mr Tony Day of the NHS Executive requesting that the publication of the Charter is delayed until there has been consultation with a wide group of mental health care professionals.

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Propofol and ECT

Propofol was introduced as an induction agent for ECT in our hospital last year but, after four months of its use, it was discontinued as seizures were often described by the medical officer giving the ECT as brief or inadequate. Also, the ECT machine had to be set at a higher than average setting using a higher dose of electricity. In the Royal College of Psychiatrists' guidelines (1995) propofol is specifically not recommended for ECT.

It was decided, as an audit topic, to look retrospectively at the last 53 patients who had ECT under either propofol or methohexitone. Clinical outcome after the course of ECT was obtained from case notes. Recorded clinical improvement was rated as marked, moderate or none, based on what was stated in the case notes after the last administered ECT application. The sample included 31 patients who received ECT under methohexitone and 22 patients under propofol.

Duration of seizures was significantly longer with a mean of 25 seconds with methohexitone compared with 18 seconds with propofol ($P<0.01$). The mean setting of the ECT machine was 226 mQ for ECT given with methohexitone compared with 269 mQ with propofol ($P<0.01$). There was no evidence to suggest that patients who received ECT under propofol, and despite the significantly shorter seizure duration compared with methohexitone, required additional ECT applications. The mean number of ECTs were 5.1 and 4.8 for methohexitone and propofol induced ECT respectively ($P=6$). The recorded clinical outcome following the ECT course given under either agent was not significantly different ($P>0.05$).

This may imply that ECT under either anaesthetic was equally effective. Also the similar clinical outcome after ECT given under either agent may suggest that the reduced, visible, seizure duration may be misleading and should not be taken to indicate poor therapeutic effect of ECT. However the retrospective nature of data collection, with non-randomisation, also the possibility that in some cases, the number of ECTs may have been determined in advance by some consultants are flaws of this review which may limit any conclusion that can be made.

ROYAL COLLEGE of PSYCHIATRISTS (1995) *The ECT Handbook*. London: RCPsych.

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Information of interest

The medical director and representatives of the Association of British Pharmaceutical Industries (ABPI) and representatives of the RCPsych held their second 9-monthly meeting on 29 September 1995. We felt it would be worthwhile to inform members of various points which arose during the meeting concerning patient prescribing and clinical trials.

The pharmaceutical industry will be introducing a procedure to put a leaflet with prescriptions which inform patients about the drugs that are being dispensed under prescription, including their actions and side-effects. The industry will also continue its practice of supporting Continuing Professional Development, medical education, postgraduate meetings and scientific meetings of interest to the profession.

The ABPI has produced a draft contract for pharmaceutical companies to indemnify Trusts and patients who participate in clinical trials. A survey carried out over the past 5 years with the intention of recording the requirement for indemnity payments found that there were only 20 cases out of 415 000 patients who participated in clinical trials during the survey period, an incidence of 0.005%. Three-quarters of these came from one clinical trial and there were no court proceedings.

The ABPI can provide any one who is interested with a list of standards they have established for training for both industry funded and non-industry funded research projects involving the treatment of patients. The public should be