THE ROLE OF CRITICISM IN SCIENCE: ECT, AND THE DUTY TO SPEAK.

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Abstract: On request, the author gave an interview to a reporter who wanted opinions on ECT. The author does not use ECT. Five months later, a committee of the RANZCP lodged a complaint against the author, that his reported comments had "denigrated and disrespected" the profession of psychiatry. This article is based on some of the material used in the author's response, rejecting the complaint. It concludes that ECT is unnecessary, hugely expensive and has no justification in a formal model of mental disorder. ECT should be severely restricted, if not banned.

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In November, 2016, an article appeared in the weekend newspaper in Brisbane, Qld, on the place of ECT in psychiatry (link to article). *The Courier Mail* is a Murdoch paper and is not renowned for its temperance but the reporter had gone to considerable efforts to obtain a balanced view. The medical director of a large private psychiatric hospital in Brisbane, which uses ECT extensively, was reported as lauding ECT as safe and a "healthy alternative to medication." My views were that it is dangerous and unnecessary, and the very high rate of ECT usage in this country is probably financially-driven as it could not be for clinical reasons.

Five months later, I received a complaint from the Qld branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), of which I have been a member for just on 40yrs, alleging that my comments were likely to "denigrate and disrespect" psychiatrists who use it, to bring the profession into disrepute, and to spread "anxiety, stress and fear" among patients and their relatives. There were other objections, that I said detained psychiatric patients in this state have fewer rights than prisoners; that they are detained in what is essentially a prison; that I would never give ECT to a child; that I failed to provide suitable references to the scientific literature which claims that ECT is "effective in relieving severe clinical depression"; that I did not clarify that my views were not mainstream; and that it is inappropriate to air such views in the mainstream media (MSM).

To expand on the process, the complainant is "anonymous" and therefore cannot be cross-examined; I have seen only the small parts of the complaint quoted by the committee and cannot see the whole document; I had no say in choosing the committee; and only one member of the committee has been identified. Of course, the committee had the authority to reject the complaints *ab initio* but did not do so.

By way of background, I graduated in medicine in 1971 and in psychiatry in 1977. Since then, I have worked in prisons, in veterans' hospitals, in security wards in general hospitals, in private practice and in community practice; in cities, suburbs and in one of the most isolated parts of in the Anglophone world. I have extensive experience in military and forensic psychiatry, isolated and Aboriginal psychiatry, and in the mental health of immigrants, refugees and injured workers. Throughout this time, I have published extensively, including five books, mainly theoretical works on the application of the philosophy of science to psychiatry. My extensively argued conclusion is that modern psychiatry is at best a proto-science and, at worst, mere pseudoscience.

Today, in Brisbane, I work part-time in a declining middle class suburb with a surprisingly high rate of struggling younger families, and the rest in a working class suburb with many immigrants, pensioners and unemployed people. My offices are situated in busy shop-front general practices, which provide most of my referrals. My fees are paid by the national insurer, Medicare, meaning patients pay nothing for private care. Thus, I see the sorts of patients who would normally have to attend public services. Some of them have been to public services and are keen to change. Under the Medicare agreement, I cannot charge full private rates, which are about 300% higher than the rates the government pays me.

In short, I've always worked at the tough end of psychiatry, including six years as the world's most isolated psychiatrist [1]. While in the North, it happened several times that I went as long as two years without seeing or speaking to another psychiatrist. In four decades, I've had one complaint against me and two notifications of disputed decisions, all of which were fully investigated and dismissed. I would like to think that I practice a tough but fair psychiatry; in the alternative, nobody would ever accuse me of being a gracious psychiatrist.

As I read the process and contents of this complaint, there are three questions to consider:

1. Do individual psychiatrists have the right to give opinions to MSM? Should I have provided references for my opinions?

2. Is it factually correct that ECT is unnecessary, seriously overused and dangerous; that psychiatric patients in Qld are treated worse than prisoners while held in prison-like surroundings; etc.

3. Does the RANZCP have the right to object to a member criticising psychiatry?

We can look at each of these in turn.

1. Do individual psychiatrists have the right to give opinions to MSM? Should I have provided references for my opinions?

Psychiatrists talk to MSM all the time. Mostly, it is the same half dozen well-known figures who are contacted by reporters for an opinion on some topical matter, just because they always take calls. They can also be relied upon to present a serving from the same old stew that psychiatry is making huge advances; it stands on the brink of major biological discoveries that will free us of the scourge of mental disorder; that psychiatric treatments exist for all manner of old and new illnesses; that those treatments are amazingly safe, effective and free of side-effects, and will get you playing the piano, ice hockey or loving grandma in a jiffy; that treatment is readily available, just ask your doctor; and that we psychiatrists need lots more money for more buildings, research, professors, seminars and the like. They *never* provide references for this.

The articles are usually accompanied by pictures of remarkably untroubled and elegantly-coiffed, radiantly-smiling young people seated in new armchairs in pleasant offices, talking to preternaturally handsome and attentive mature people or to vivacious young people with three rows of teeth, with not a stud, tattoo, black eye, tear, missing tooth or gob of snot in sight. To complete the surreal picture, they don't even have boxes of tissues on the coffee table.
In addition, as every reporter knows, there are one or two psychiatrists in most towns who regularly ring or email their opinions on all manner of matters and complain to the Press Council when they aren't published. Finally, there is always at least one who can be trusted to say that if a psychiatric patient dies on the ward or commits some dread crime, it wasn't the fault of the hospital or the government because the matter has been fully investigated by an internal committee composed of the psychiatrist's friends who found nobody was to blame so the matter is now closed and we should all move on.

Clearly, the complaints committee has no problem with psychiatrists talking to MSM. What they meant was that they don't want *contrary* opinions expressed in the MSM. They do not want anybody casting doubt on their "same old stew" as it may cause people to look more closely at what psychiatrists are doing or, heaven forbid, lead to an enquiry. They rely on controlling the narrative that psychiatry is good for you. They do not want anybody to say that antidepressants normally lead to 30, 60, or even 100% gain in weight. They do not want young men to know that antidepressants wreck your sex life; or parents to know that they are highly addictive and junior probably will never be free of them; or anybody to know that they are toxic and regularly cause manic reactions and/or homicidal and/or suicidal ideas and/or impulses, and that practically all mass murderers over the past 25yrs were taking them at the time of their crimes. That's exactly what they *don't* want publicised because it would interfere with the cash flow.

Years ago, in response to something or other, I challenged the then-president of the RANZCP to a public debate. His team would consist of himself, the editor of the RANZCP journal, the *Australian and New Zealand Journal of Psychiatry* (*ANZJP*), and the chairman of the college education and examinations board. The topic would be: *That mainstream modern psychiatry is not a science as it does not have a model of mental disorder*. My team would consist of myself alone.

Predictably, he declined, but on the remarkable basis that it was "inappropriate to discuss such matters in public." Instead, he said, such debates should take place in the pages of the college journal. However, he was on very safe ground as he knew perfectly well his good friend, the editor, could be relied upon *not* to publish anything contentious. Evidence? Certainly.

My survey of the *ANZJP* from January 1996 to December 2005 showed 1154 original papers, editorials, commentaries etc (not including correspondence, obituaries, political comments etc). Of these, only ten (0.87%) could be considered in any way critical of mainstream psychiatric theories or practice. Six of these were minor gripes or just trivial, although one author opined that psychiatrists should pay more attention to their patients' religious views. Only three papers

(0.26%) in the ten years were significantly critical of some aspect or other of psychiatry. Two of these (0.18%) were by overseas authors (not NZ). The remaining paper, comprising a minuscule 0.09% of the journal's output for the decade, was my critical review of the biopsychosocial model [2]. That is, the total critical output of Australasian psychiatry for ten whole years consisted of a little over 4,000 words, amounting to somewhat less than one tenth of one word of critical material per psychiatrist per year. For a field that claims to be scientific, that is a little underwhelming.

Readers may think the RANZCP might like to award me a prize for my effort but far from it; twenty years later, I still have psychiatrists sneering at me for that paper. They do not want anybody to threaten their studiously-crafted narrative of psychiatrists as terribly nice, caring "clinical brain scientists" who will help you look into your soul to sort out your woes. We will return to this point under Q.3.

In the article, a psychiatrist who uses ECT extensively said: “A vast majority of people that I treat for ECT ask for it as it’s a healthy alternative to medications.” What can we make of his comment?

Firstly, I don't believe it. In forty years, I can recall only one person actually saying to me that ECT was necessary. This person had had at least 135 episodes of ECT during twenty admissions in a fifteen-year career as a mental patient and was in the habit of going to hospital to have ECT when the misbehaviour got too much. Second, as science, his comments are valueless as they are mere anecdote. Anecdotes do not add up to a general truth - which he knows perfectly well.

Third, I expect there probably are people who would like ECT. So what? There are people who swear by moxibustion; some swoon for candling; others love their feng shui or worship their elimination diets; still more would die for Reiki or kill for colonic irrigation. Who cares? The point is not that some people like some things some of the time, because that only attests to human gullibility and Veblen consumption, but whether the procedure will, in the "vast majority" of cases (his words), safely and reliably induce an improvement that would not otherwise have ensued and which outweighs the risks. Clearly, ECT won't meet that standard because plenty of psychiatrists get the same results without using it.

Finally, yes, I'm sure there are people who like ECT. They love it and go back for more. It gets them out of the house, out of work, out of the firing line, into a nice private hospital where they can be waited on hand and foot by lovely nurses in between pleasant conversations with caring and understanding psychologists while waiting to see that brilliant and personable young doctor who will give them... oblivion. Because that's what ECT does. It doesn't resolve anything, it just obliterates it.

Believe it or not, there are actually people who like oblivion, even many who prefer it to reality. These days, with our highly advanced civilisation, people can choose from a range of industries offering oblivion. There is the very large alcohol industry, very popular among the leisured classes who all agree they can stop when they want. Then we have the huge illegal drugs industry, also well-regarded by the monied classes (denizens of Sydney's exclusive suburb of Woollhara use cocaine at twelve times the state rate, meaning 25 times the national rate).

If that palls, there is always the gambling industry, where people can sit for hours in front of flashing lights and switch off; there's meditation and hypnosis for those who like their trance states; there's mystical religion if you: and we mustn't overlook cruise ships, hair-dressing salons, business trips with your secretary, academic conferences and... food. Yes, gorging is a very popular way of avoiding the messy business of normal life. Clearly, ECT is just one starter among a very crowded field (soma, anyone?) but it has the nifty advantage of making other people pay for it and it also brings lots of sympathy.

So is ECT "a healthy alternative to medications”? Well, yes, because wait until you see what the drugs do.

2. Is it factually correct that ECT is unnecessary; it is seriously overused, probably for financial reasons; and it is dangerous; that psychiatric patients in Qld are treated worse than prisoners while held in prison-like surroundings, etc?

(i) "ECT is unnecessary."

The RANZCP Position Statement on ECT, No 74, issued March 2014, states at Pt 7.2:

> ...ECT remains a useful and essential treatment option that should be available to all patients in whom its use is clinically indicated...

Let's unpack this claim, which is widely quoted in courts and in mental health tribunals as the scientific justification for ECT. The word 'useful' is wholly a value judgement, an insubstantial claim based on the shifting grounds of opinion. It has no place in a scientific document. The term 'clinically indicated' means nothing more than that the psychiatrist thinks it should be used, i.e. whimsy. Two psychiatrists seeing the same patient can reach opposite conclusions, which means the expression reflects no more than pre-existing opinion, otherwise known as 'prejudice.' For purists, the expression 'clinically indicated' is valueless because it cannot be operationally defined.
The claim that ECT is an "essential treatment option" could be seen as a value judgement but it has the merit that the word 'essential' also has an empirical meaning:

> Essential adj. (1) vitally important; absolutely necessary. (2) basic; fundamental. (3) completely realised; absolute; perfect.... (8) something fundamental or indispensable.

Here, we are on solid ground: there is no wriggle room, as they say. Indispensable has only one meaning. Thus, if anybody can show that ECT is not "vitally important; absolutely necessary; something fundamental or indispensable" to psychiatric practice, then the RANZCP has made a very serious *scientific* error in making that claim. And that is exactly what my forty years of rough and tumble psychiatric practice in some of the harshest parts of the English-speaking world has shown. I do not use ECT, and never have. Therefore it is not essential. QED.

Of the more than 15,000 consecutive, unselected public patients I have seen over that period, not one has received ECT. I would say that I have seen and personally managed practically everything that psychiatry can throw (would you like to hear of the time I diagnosed a cerebral abscess in a man sheltered from the rain under the wing of the Flying Doctor plane? I was wrong. He had eight cerebral abscesses, due to melioiodosis. Needless to say, he died. He had previously shown Ganser's syndrome).

Both times I was head of public hospital psychiatry departments, one for veterans, one a security unit in a general hospital, ECT had been in use prior to my appointment. It stopped for the duration of my stay, and was restarted some time after I left. In both hospitals, the admission rate went down, the mean duration of stay in hospital went down, and the mean bed occupancy rate went down. As soon as I left, those statistics began to revert to their previous norms. While I was Regional Psychiatrist, Kimberley Health Region, in the far north of Western Australia, from 1987-93, patients who had previously been flown south (at enormous expense) to have ECT were managed in the region, very often at home, without resort to ECT.

That is to say, psychiatrists seeing exactly the same patient profile as I had and, in some cases, even the same patients, were electing to use ECT in precisely the circumstances where I had not. Any claim, by any psychiatrist anywhere, that ECT is "essential for psychiatric practice" is empirically false.

There is, however, one tiny wormhole that allows some psychiatrists to wriggle around "indispensable." The prevailing narrative about ECT is that it is a very positive thing, that the unhappy patient is lucky to have chanced upon a psychiatrist who knows how to use it. Without ECT, he is likely to have months or much longer of severe mental disorder, if not end up as a statistic. That, however, is the reversal of the true case. A psychiatrist who, free of any financial incentive, uses ECT is saying only one thing: "I don't know what else to do." This is because modern psychiatry has no real understanding of mental disorder, due to its lack of an accepted model of mental disorder [26].

Faced with a very distressed patient who doesn't respond to the usual approach, the psychiatrist reaches for the electrodes just because he has no options, he has reached the limits of his skill set. So for psychiatrists who don't know what to do, it is probably true that ECT is "indispensable" but that is hardly a justification.

(ii) "ECT is seriously over-used."

This is easy to confirm. A quick glance at the psychiatric literature shows that rates of usage of ECT vary dramatically from one country to the next, and from one region (state, county) to the next within the same country, even from one hospital to the next in the same town. Some psychiatrists use ECT a great deal, others hardly at all. One of Quadrio's respondents in Sydney [4] was a male psychiatrist in his fifth decade:

> ...he works 55 hours and spends up to 20 percent of his time doing ECT.... He rated his work as moderately satisfying and minimally stressful. (Added: 11hrs a week at $500 an hour yields about $250,000 a year, which is more than can be earned working full-time in a bulk-billing psychiatric practice in Australia).

ECT usage in Qld jumped from 16,602 episodes in 2013-14, to 19,365 episodes the following year. There is no conceivable clinical explanation for a 16.5% increase in one year. Commenting on an even more dramatic spike in ECT in young women in NSW, Jonathon Phillips, former president of RANZCP, said:

> In a way 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... [5].

A large survey by Leiknes et al showed that worldwide, there are very substantial variations in ECT usage [6]. For example, Poland uses it only 0.11 times per 10,000 population per annum; Germany, 0.26; Spain 0.41; Ireland 2.7; and USA up to 5.2 treatments per 10,000 population pa, or 5000% more than Poland. Down here in the antipodes, New Zealand gives 0.7 treatments per 10,000 pa but just across the Tasman Sea, Australian rates vary from 2.4 to 4.4 depending on the state. A 640% variation among more or less identical populations is not explicable on clinical grounds.

On regional variations, O'Brien [5] noted:

> The Medicare (national) 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.

NSW psychiatrists apparently did not return his calls so the reason remains a mystery. In the UK, ECT is enjoying something of a patchy comeback:

> Exclusive data covering four-fifths of NHS mental health trusts in England shows that more than 22,600 individual ECT treatments were carried out in 2015-16, a rise of 11% from four years ago, when about 20,400 were carried out.... While the number of treatments carried out by Mersey Care NHS trust, for example, has remained fairly constant over the last four years, the figures for Lincolnshire... show a 75% increase in treatments [7].

At present, the state of Qld (population 4.8million) gives almost as much ECT per year as the entire English National Health Service (population 53million), where ECT usage had dropped by about 50% over the past 15 years. Among others, Finland, Japan and Italy, where it was invented, hardly use it. In the most recent figures available from Italy, 91 centres in the country are licensed to use ECT although only 14 actually use it. In 2015, about 500 Italians received it, at an average of 8 episodes each, meaning 4000 per year for a country of 61.5million. Using Qld rates, it should be about 250,000. That is, Qld uses ECT 62.5 times (6250%) more than this large and highly sophisticated European country.

The province of Pavia, in the north of Italy, has a population of 550,000. In the last 20yrs, only four (4) people received ECT, meaning the rate of ECT per year is 0.3 episodes/100,000 population. In 2014-15, Qld used ECT at the rate of 403.5 episodes/100,000 population/yr., or a spectacular 135,000% more than Pavia. It would not be sustainable to argue that Qld's rate of severe mental disorder is over 100,000% of that in northern Italy (it may be sustainable to a Lombard, I'm not sure).

In the most recent review of ECT available (May 4th 2017), Kolar 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 [7].

However, in Norway, ECT is restricted and Leinkes et al [6] report that, at centres authorised to use ECT, waiting lists of up to eight weeks are not uncommon. This vitiates the claim that it is an emergency life-saving measure which cannot possibly be delayed. Did Norwegian suicide rates spike as a result of the delay? In fact, they did not. What this does show is that the apparent urgency with which ECT is administered, certainly in Australia, is wholly spurious. It's the old waiting list trick: if you make people wait for a treatment, they often find they didn't need it.

I submit that, by international standards, ECT is seriously over-used in this country. This is also true of Britain and the US. Can we conclude from this that Anglophone psychiatrists simply aren't as good as their overseas counterparts? We will come back to this question but first, we need to ask why it is being overused. My series of over 15,000 cases shows that overuse of ECT does not derive from clinical needs. If I could manage depression without using ECT, say in an Aboriginal man with practically no Western education who struggled with English, in a tiny settlement on the edge of the Tanami Desert, then so too can all these terribly clever professors or smooth society psychiatrists in their

luxuriously furnished suites in huge, lavishly-equipped hospitals in the middle of giant cities. No, my claim is that ECT is overused for financial reasons. Here is the evidence.

In Australia, private psychiatric patients treated as out-patients (office or community clinics) are restricted to fifty consultations a year. After that, the fee rebate halves. This can be difficult as, during a period of increased distress, a patient may need to be seen two or three times a week. However, patients who are admitted to hospital can have their entire costs covered by insurance, with no limits to the numbers of consultations. It therefore makes good economic sense for a psychiatrist to admit a fee-paying patient to hospital, at $1000-1500 per day, as all costs are covered. That is, there is a perverse financial incentive built into the insurance scheme which encourages over-treatment and over-billing, at the same time as it penalises frugal treatment.

As a procedure, ECT also makes very good economic sense. The current rebate under Medicare is $73.20 per episode but private psychiatrists normally charge much more than this, often $150-190.00 per episode. When I was training in psychiatry in Perth in the mid-1970s, we were required to learn how to give ECT. Assisted by an anaesthetist, we could easily give four to six in an hour. With two anaesthetists, this became eight to ten in an hour.

Administering ECT requires no special skills which explains why, in Australia, Denmark, New Zealand, Norway, the UK and many other places, ECT is normally given by the most junior hospital doctors. In Norway, 6% of ECTs are administered by nurses and in the Netherlands sometimes by geriatricians or physicians. It is also the case that in the UK at least, geriatricians and general practitioners are beginning to use ECT [6]. Entirely plausibly, they argue that there is nothing intrinsically psychiatric to it, it is just another minor procedure; if they can prescribe antidepressants, they can give ECT.

Thus, by giving ECT in private hospitals, a psychiatrist can easily earn from $500 an hour upwards for a procedure which requires about the same intellectual effort as opening a can of beer. I maintain that this is the cause of the huge discrepancies in ECT usage in clinical practice. No alternative explanation suggests itself.

Similarly, private psychiatric hospitals are heavily dependent on the ECT trade. Without it, as I have shown, most of their patients would not need to be in hospital. In fact, it is the act of giving ECT which renders them in such a state that they need to be in hospital. Granted, it was used on an outpatient basis in many countries but that requires a lot more support at home than is normally available in the nuclear family. Certainly, elderly people living alone could not have ECT as an outpatient. So who is the median ECT patient?

> In contrast to Asia, the typical ECT patient in the United States is said to be an elderly white female paying for treatment with insurance or private funds [6].

Elderly, wealthy, white, female. In western countries, women comprise about 70% of patients receiving ECT, and 75% of ECT is administered by male psychiatrists [6]. These discrepancies are more extreme in Australia, as Quadrio found in her extensive study:

> ...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... [4].

In Australia, the US and UK, ECT is something that male psychiatrists do to female patients. If ECT were given rationally, this would not happen.

Without ECT, the private psychiatric hospital industry would struggle to survive, if not fail altogether. I argue that this is a gross misallocation of limited resources. It diverts funds away from young, poor, uneducated, unemployed and minority patients who are forced to use public facilities, favouring wealthy, educated and well-supported patients in private hospitals who mostly don't need to be there. However, public hospitals and community clinics the world over are themselves quite grotesquely inefficient. Some years ago, I stood in the psychiatric unit in Detroit Receiving Center, watching the almost medieval way patients were admitted and assessed.

"This must be costing a lot of money," I told the director, a charming, foreign-trained psychiatrist. "It must be about $1000 for every patient who comes through the door."

"It's $1132 per patient," he replied briskly.

"Really? Based on my figures, I could do it for you for under $250."

"Not here you couldn't," he retorted. "Nothing can change due to institutionalised inefficiency and corruption."

At a community clinic barely 500m from my office, patients are seen by a range of junior trainee psychiatrists, nurses, psychologists and social workers, at a cost to the government of $275.00 per half hour consultation. In my practice, patients are seen by a senior consultant (me) at a cost to the government of $73.50 for half an hour. That is, giving ECT, which takes about one minute, earns the same as seeing a patient for half an hour of psychotherapy (I do not mean CBT or any other simplistic technology. 50% of my patients express suicidal ideas at their first consultation but they are still managed as out-patients).

This amounts to a prima facie case that ECT is grossly overused in this country, the reason being financial, not clinical.

(iii) "ECT is dangerous."

The literature is crystal clear: ECT causes significant memory and other cognitive impairments, and these adverse reactions effects are wholly due to the physical effects induced by the treatment itself (i.e. the memory impairment is not psychological in nature). For example, in 2001, the APA committee on ECT [9] 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 [10] were equally 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 [11] 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 [12] studied 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.

After an extensive review, Read and Bentall [13] 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.

6.6. More recently, the Royal College of Psychiatrists [14] 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.

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

** This isn't clear, as they had already said the depression resolves with ECT; 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, surely the answer would be 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 [15] 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 [16] 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 American Psychiatric Association 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.

His website, ectresources.org [17], includes a list of some 150 citations extending from 1942 to the present. This evidence leaves no doubt that, quite apart from unexpected catastrophes including anaesthetic deaths, brain damage follows ECT in a dose-related fashion.

In a more recent study, Kirov et al [18] found:

> Repeated courses of ECT do not lead to cumulative cognitive deficits.

This appears to be so completely at variance with patients' accounts and with majority opinion that it cannot be taken as settling the matter. It is an easy matter to find accounts which completely contradict this group's findings (e.g. Grant [19]: "ECT completely wipes out 30yrs of memory"). It is of interest that Kirov's group did not cite the results of Sackeim's group's prospective study. This is very typical in the psychiatric literature: adverse results are simply ignored.

However, the most recent review available, by Kolar [7], contradicts Kirov's group's findings:

> Cognitive side effects of ECT are sometimes underestimated and may last much longer after completed treatment than it is usually expected. These cognitive impairments associated with ECT may cause significant functional difficulties and prevent patients returning to work.

Two things were quite clear in this review. Firstly, in view of their figures, the expression "sometimes underestimated" is excessively cautious. Second, the reason cognitive side effects are "sometimes underestimated" is because the great majority of studies are inadequate to the task (i.e. substandard):

> Neuropsychological assessment should be an essential part of a good clinical practice in ECT services.... Cognitive assessment during ECT treatment is usually not comprehensive enough and is limited to bedside assessment. A more proactive approach to careful neuropsychological assessment (is) essential.

A possible explanation of the "outlying" figures in Kirov et al [18] is that patient surveys invariably find much higher incidences of memory and cognitive dysfunctions than researchers do. This is addressed poignantly in a widely-cited, first-person account by Anne Donahue [20] and in another by Ian McPhee, a Sydney anaesthetist [21]. In a section entitled *The Disaster of ECT*, McPhee commented:

> 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.

Historically, of course, Ernest Hemingway and Sylvia Plath killed themselves shortly after ECT. Just before he shot himself, a few days after a course of 20 ECT, 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.

In the past two years, I have managed three patients complaining of major memory loss after ECT. One, a professional writer, had had only three episodes of ECT, while the other was taking anticonvulsants at the time of the ECT and initially did not develop seizures. He was therefore given much more powerful shocks, then bilateral ECT, so this may be a little unusual but it is still ECT. The case of Garth Daniels, who, as an involuntary patient, was given in excess of 100 ECT over a 34wk period, is well known [22]. He constantly complains of memory loss. Tellingly, the ECT was administered as a "matter of life and death," yet his behaviour during and after it remains exactly the same as before. As a form of treatment of his alleged "brittle psychosis," it was absolutely useless.

This brief survey indicates that ECT can have severe and long-lasting, if not permanent, effects on memory and cognitive function, and that this damage is physical in nature. Anybody who claims that ECT has no significant side effects should try it himself.

When this information is so readily available (I am accessing this material from my home computer), why do most psychiatrists not know this? The answer is very simple. Psychiatrists are not trained to think critically. As trainees, they are given reading lists and as graduates, they simply follow the pattern of reading whatever reinforces their opinions. They don't like to be challenged or shocked, and react badly to criticism.

(iv) "In the state of Queensland, prisoners are treated better than psychiatric patients."

I can't imagine why anybody would dispute this, perhaps a total lack of any knowledge of the laws as they stand. A person who is arrested on a criminal charge is given a caution, then he is interviewed by two officers, with his solicitor if he has one. The interview is recorded and the offender is given a copy. He has full access to any material used as evidence against him and has the right to challenge it and to cross-examine witnesses. Unless his guilt is found to be "beyond reasonable doubt," he must be freed. If found guilty, he is given a determinate sentence and cannot be mistreated or humiliated, or forced to do anything unusual or to take treatment against his will.
Psychiatric patients, on the other hand, can simply be snatched off the street or out of their houses on the authority of a justice examination order. These are issued in camera, on secret depositions which the patient will most likely never see, by people he can't know or cross-examine. Very commonly, he will be interviewed by a nurse, then briefly by a junior psychiatric trainee who will sign a detention order before calling a psychiatrist who will confirm the order over the phone.

Some days later, the patient will appear before a mental health tribunal consisting of a lawyer, a psychiatrist and a lay person. Only 4% of patients in Qld have legal representation at a process which can deny them most of their human rights. It is exceedingly rare for the hospital's application to be denied by the tribunal. The outcomes are so predictable that many patients don't even bother attending. Very few patients can afford a second opinion, or would even know they can do so, or how to obtain one. However, that is generally a waste of time as the psychiatrists on the panel were trained in the same system as the hospital staff, generally know them well and are all convinced of the same "truths." That is, they firmly believe that mental disorder is biological and therefore demands biological treatments, including drugs and ECT, regardless of the patient's or his relatives' wishes.

A person who refuses ECT can be detained simply on the basis of "unreasonably refusing treatment." Nobody, however, has ever defined "reasonable refusal of treatment": by default, all refusal is unreasonable. If the patient resists treatment, he will be wrestled to the ground, injected and locked in an isolation room, generally without his clothes or bedding. If he complains, e.g. of side effects, he will be given more drugs. If he expresses hostility or resentment toward the hospital or staff, he will be deemed "lacking in insight" and his detention can be extended indefinitely on the basis that he is likely to be non-compliant with treatment. People can be detained and forcibly subjected to mind-altering drugs and ECT simply for swearing at staff and demanding to be released. Of course, psychiatric patients aren't allowed to smoke.

The president of the Qld Mental Health Tribunal, a lawyer, was recently dismissed after it was found that one of the lawyers he had approved, who sat on the tribunal for eleven years, was not in fact qualified [24]. Qld's unicameral parliament rushed through an amendment to the Mental Health Act retroactively ratifying eleven thousand detention orders in order to prevent thousands of law suits alleging unlawful detention and assault against dozens of hospitals and many thousands of staff. This did not address the inherent bias of the tribunals, which is that people appearing before them cannot get a fair hearing just because all the officials involved firmly believe that mental disorder is

biological in nature; that patients must be treated to reduce risk (which mainly means to society) whether they want it or not; that mental patients can't possibly know their own minds; and that psychiatrists can do no wrong.

Public psychiatric wards in Queensland are all locked, including voluntary wards, even though this is illegal under Australian law. Security wards at The Park Security Unit in the Brisbane suburb of Wacol have ordinary steel-barred cell doors and high steel fences which cannot be climbed. Patients are locked in their rooms at night and can be strip-searched at any time. Even though there have been patients on that site for over 150 years (it was once Australia's biggest mental hospital), there are practically no occupational therapy facilities. Patients pace up and down or loll in front of the TV. Obesity is a major problem among chronic psychiatric patients, partly due to the drugs and partly to inactivity. Patients on forensic orders (found not guilty on the grounds of mental impairment) are mixed with ordinary patients as young as eighteen.

All of this should be seen in the context that Australians who take long-term psychiatric drugs will die, on average, 19 years younger than their undrugged peers. In the US, that figure is 25yrs [24, 25]. In the US in the period 2000-14, the rate of "serious outcomes" from drugs used to treat depression rose 226% while fatalities themselves rose 132% [25; population growth was about 15%]. Was suicide so common before antidepressants and other psychotropic drugs became freely available? In fact, it wasn't.

I should point out that none of this evokes the slightest concern among politicians, psychiatrists, lawyers or the general public.

It has always seemed to me that, in respect of private hospitals for voluntary patients and public for involuntary, we have our priorities reversed. People who, without committing an offence, are locked up and drugged against their will should have the nice hospitals with carpets, en suites, pleasant gardens, soothing music and group therapy rooms where they can emote. People who generally don't need to be in hospital should get the concrete floors, communal bathrooms, noisy and smelly dining rooms with the tables and chairs bolted to the floor, and staff who gossip and play radios loudly all night. That might encourage them in the idea that they really aren't doing so badly after all.

More tellingly, the excessive use of ECT in private hospitals diverts the limited funds from people who need them to those who don't (Note 1). It is impossible to get temporary home care for out-patients, or respite care for their children, short-term domestic services or suitable training programs just because so much money is poured into keeping people in hospitals for a form of treatment that at least 98% of them don't need. Instead of home care in working class suburbs, we have luxurious private hospitals staffed by psychiatrists who drive expensive imported cars to visit their wineries or spend their weekends sailing their yachts near their beach houses.

3. Does the RANZCP have the right to object to a member criticising psychiatry?

For anybody who knows anything about the philosophy of science, this question is risible. Any person who claims to work in a scientific field of any sort is under the transcendent obligation to criticise the status quo, just because that is how science progresses. Anybody who tries to suppress criticism is not a scientist but a charlatan. That's point one. Point two is this:

If I, as a citizen, believe that something very bad is happening, I have the ineluctable duty to bring the matter to public attention. The people who organised this complaint (for I have a pretty good idea who they are) make very large sums of money from ECT, for very much less effort than I put into my patients. As it happens, I make no money from ECT. My income from my bulk-billing practice is about one third of what they make, but that's my choice. But I don't like public money being drained into the purses of the wealthy for no good purpose, just because they can get away with it. I don't like mentally disturbed people being subjected to gross abuse based on a false narrative about the nature of mental disorder [26]. That's not science, that's a shameful abuse of a trusted position by highly educated and privileged people who ought to know better [27].

This raises the question of why psychiatrists don't know better.

Point three:

> If liberty means anything at all, it means the right to tell people what they do not want to hear (Orwell).

Conclusion:

What does this add up to? First, I firmly believe, and my long and diverse practice proves, that ECT is completely

unnecessary. There is absolutely no evidence that any psychiatrist can put before a neutral observer that could prove this assertion wrong. The only possible exception is in the case of psychiatrists who lack the competence to deal with complex psychiatric disorders in the psychological mode, because they haven't been trained to do so. But, of course, orthodox psychiatrists don't believe in "the psychological mode." As a matter of ideology [26], they firmly believe that all mental disorder is biological in nature, and therefore requires physical treatments. This even applies to that most quintessential of psychological disorders, the acquired anxiety state or what is now known as PTSD. Because they don't believe that mental disorders can have prior mental causes, they lack the requisite skills to deal with it and are forced to use inappropriate physical methods of "treatment."

Second, it is indubitable that ECT is highly lucrative to psychiatrists and to private hospitals. These hospitals are very dependent on the ECT trade and since their investors have billions of dollars tied up, they have the very strongest incentive to convince the general public that ECT is safe, effective and has next to no side effects - and, above all, indispensable. The corollary to this is that this industry will fight bitterly any suggestion that they are misusing public funds. They are, of course, powerfully connected to the medical and financial establishments, and thence to the political establishment. Private medical bodies are highly adept at seeing off challenges to their business model. We have reached the point where this matter can only be investigated by a high-level national enquiry, completely independent of psychiatric influence. Psychiatrists should be restricted to giving public evidence only with no say in or influence over the composition or the outcome of the enquiry.

Third, psychiatrists like ECT because it gives them a status as "specialists" among medical practitioners. Without it, what do they have? Modern psychiatrists have next to no training in psychotherapy, and general practitioners can and do prescribe psychiatric drugs freely. 88% of prescriptions for antidepressants in Australia are initiated and prescribed by general practitioners; 6% by other specialists and only 6% by psychiatrists. Compounding this, modern psychiatrists generally cannot take a full psychiatric history, just because they are in the habit of leaving it to nurses armed with checklists.

Fourth, ECT justifies psychiatric authority under the mental health act. Essentially, it is a source of power and status in the rigidly hierarchical public health system. A psychiatrist's decision to use ECT on a patient overrides any opinions from nursing staff, psychologists etc.

I conclude that the widespread use of ECT has no clinical justification whatsoever. I see it as a social phenomenon deriving from the false narrative concerning the biological nature of mental disorder, driven by pecuniary interests and maintained by a profession that knows it has a very great deal to lose. In short, it is a racket, but like all the best rackets, it is hidden in plain sight. Psychiatrists have convinced the various political, legal and social authorities, and the general public, that there is only one conceivable model of mental disorder, which just happens to be theirs.

In socio-historical terms, as an institution, the selling of ECT isn't far removed from the sale of indulgences during the Middle Ages. That is, a powerful and priviliged minority, which has worked its way to the centres of power, has convinced the secular authorities and the general public that they must pay for something vital when, in fact, it is both misleading and unnecessary. Is this therefore just a straight-out fraud, like the Libor or robot-signing frauds of the GFC? I don't think so. To paraphrase the Nobel laureate immunologist, Peter Medawar:

> Psychiatrists can be excused of dishonesty only on the grounds that, before deceiving others, they have taken great pains to deceive themselves [28]

How can this be changed? I believe change will be very difficult to achieve, not least because of the enormous, covert influence of the business and professional interests involved. We can't appeal to the principles of ethics, because nobody cares about psychiatric patients. The history of psychiatry is so bad, so indescribably brutal [29-31], that medical students and trainees in psychiatry are simply not taught it. Governments certainly don't care. They know they can't win votes by being nice to psychiatric patients, they can only lose votes if something goes wrong. Hence the decision of the former government of Qld to lock voluntary wards, to head off embarrassing headlines in the morning papers. Nobody cared that it was illegal, and certainly not the psychiatrists.

We can't appeal to a sense of fair play because, as it is today, so many people are making so much money from psychiatry (and we haven't even mentioned the drug companies) that they will fight fiercely to preserve their privileged position. Remember that the more people have, the more they believe they are entitled to have, and the more strenuously they resist attempts to challenge those entitlements.

We can't expect psychiatrists to lead the way to change, partly because they make so much money and partly because they have painted themselves so far into the biological corner that they don't actually have anything left. Even

academic psychiatrists, who may not use or make much money from ECT, have staked their all on the biological "model" of psychiatry. If that collapses, as it should, they will be out of their jobs. But they trained the psychiatrists who use ECT anyway. Moreover, we know that major change rarely if ever comes from within a conservative profession (and psychiatry is *very* conservative). It has to be forced on them under threat of losing their privileged status.

Finally, psychiatrists don't actually believe in morality, because morality is a psychological construct. Psychological constructs play no part in psychiatry because psychiatrists don't have a model of mind. They have no model of mind, no model of a disordered mind, no model of personality and no model of personality disorder. Psychiatry is a sham science, which is a great tragedy, because mental disorder is a very, very real thing. Just ask the sufferers.

Note 1:

Assume that a private hospital has 100 beds. Each occupied bed earns about $1,250 per day, or $8750 per week. A patient who has a course of twelve ECT, at three per week, will be in hospital a minimum of five weeks, for a basic cost of $43,750. There are invariably additional costs, such as group therapy, individual counselling etc, say $500 per week, or $2,500 for five weeks. If each bed is occupied 50 weeks a year, it will earn $462,500 per annum, and the hospital's income will be $46,250,000 for the hundred beds per year.

The costs of ECT are of the order $500 per episode, comprising psychiatrist's fee, anaesthetst's fee and the hospital theatre fee (I assume one third each). At twelve sessions, that is $6,000 in five weeks, $60,000 a year generated by each bed or $6,000,000 a year for the hundred beds. This gives a total cost of $52,250 for each five-week admission for twelve ECT, which is 1.1% of the hospital charge. This figure should be compared with $575.00 for managing the same patient as an outpatient and, overwhelmingly, getting the same or better outcome (remember that ECT is not curative; it does not deal with the underlying psychological problem although mainstream psychiatry's ideology says there is no such thing as an underlying psychological problem).

The psychiatrist will also have other fees from the patient, probably billed as two half hour sessions per week at about $175 per session, with unlimited claims per year. For a patient in a private hospital, the psychiatrist will earn three ECT fees and two consultations, or about $800 per week, for what could only be described as minimal intellectual effort.

At $500 per episode, and one hundred per week, private ECT in Qld generates something like $7,500,000 per year. This is in addition to the hospital fees of approximately $46million for this state alone.

It will be clear that private psychiatric hospitals, in which ECT plays a large part, are a very large and highly lucrative industry. If there are 2,500 private psychiatric beds in the country, which amounts to about $1.16billion per year, plus at least $30million to the specialists, the sums of money involved are very, very large. If my argument is correct, 97% of this money is wasted. This is why mainstream psychiatrists attack with such ferocious passion even the slightest hint of an argument against ECT.

Niall McLaren is an Australian psychiatrist, author and critic, although not necessarily in that order.

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