

welcome Ms Andre's full disclosure of her financial support from CTIP, and disclosure of the source of funding for CTIP since its website states that dues are not a requirement for membership.

Second, she claims that those in our study had an average Mini-Mental State Examination (MMSE) score of 18 at baseline. In fact, the mean baseline MMSE score was 27.4, as shown in Table 2 (McCall *et al*, 2004: p.407). The minimum MMSE score for inclusion was 18.

Third, Ms Andre takes us to task for not citing Rose *et al* (2003). The Rose *et al* paper has merit, but has no direct bearing on our work. Those authors 'aimed to... assess the debated distinction between efficacy, effectiveness, and satisfaction'; the focus of our paper is quality of life (QOL) and function, not 'satisfaction'. As reviewed by Asadi-Lari *et al* (2004) satisfaction and QOL are discrete, non-overlapping ideas.

Fourth, Ms Andre asserts that memory effects of ECT must necessarily affect QOL. Ms Andre is changing the definition of terms to suit her purposes, or else remains unfamiliar with the field. QOL research is '... widely regarded as a robust measure of outcome assessment...' and is defined as '... the patient's perspective of their own health status' (Asadi-Lari *et al*, 2004). It is a violation of the concept for anyone, including Ms Andre, to define a patient's QOL for them.

Fifth, Ms Andre belittles our work for showing that ECT is associated with significant improvement in activities of daily living and instrumental activities of daily living. She does not recognise that impairment of instrumental activity of daily living may be the deciding factor in referring patients for ECT (McCall *et al*, 1999) and that ECT is superior to medication in improving instrumental activities of daily living over 1 year of follow-up (McCall *et al*, 2001).

We do share one goal with Ms Andre – a desire for truth in psychiatry. We choose to reveal truth through the scientific method as opposed to rhetoric.

Asadi-Lari, M., Tamburini, M., & Gray, D. (2004) Patients' needs, satisfaction, and health related quality of life: towards a comprehensive model. *Health and Quality of Life Outcomes*, **2**, 1–15.

Council on Ethical and Judicial Affairs (1997) *Code of Medical Ethics*. Chicago, IL: American Medical Association.

McCall, W.V., Cohen, W., Reboussin, B., et al (1999) Pretreatment differences in specific symptoms and quality of life among depressed inpatients who do and do not receive electroconvulsive therapy: a hypothesis regarding why the elderly are more likely to receive ECT. *Journal of ECT*, **15**, 193–201.

McCall, W.V., Reboussin, B. A., Cohen, W., et al (2001) Electroconvulsive therapy is associated with superior symptomatic and functional change in depressed patients after psychiatric hospitalization. *Journal of Affective Disorders*, **63**, 17–25.

McCall, W.V., Dunn, A. & Rosenquist, P. B. (2004) Quality of life and function after ECT. *British Journal of Psychiatry*, **185**, 405–409.

Rose, D., Wykes, T., Leese, M., et al (2003) Patients' perspectives on electroconvulsive therapy: systematic review. *BMJ*, **326**, 1363.

W.V. McCall Department of Psychiatry and Behavioral Medicine, Wake Forest University Health Sciences, Medical Center Boulevard, Winston-Salem, NC 27157-1071, USA. E-mail: vmccall@wfubmc.edu

Author's reply: Dr McCall responds to my letter but does not answer it. I get very tired of explaining to ECT proponents that the Committee for Truth in Psychiatry is not an 'anti-ECT' group, but no matter how many times and in how many contexts I do so, that false statement continues to be made. More about CTIP later, since I cannot leave Dr McCall's claims unrefuted. But much more important are the still unaddressed concerns about the methodology and validity of the McCall *et al* study.

My point about building assumptions about the longevity of ECT's adverse effects into the research design by including persons who had recently had ECT was not addressed.

Nor was any evidence presented to show that the rating scales chosen by McCall *et al* are relevant to the types of deficits reported by former ECT patients and illustrated so well in the SURE report. (Nor has there been evidence, which I requested privately from the author, to show that the study participants, who for some reason scored so poorly on both the MMSE and the IADL prior to this course of treatment, are representative of ECT patients as a whole.)

McCall's point that ex-patients and only ex-patients define what quality of life is and by what standard it should be measured is exactly my own: no ECT survivor or ex-patient ever has or ever would define 'quality of life' or 'functioning' in the terms Dr McCall uses. He says, 'It is a violation of the concept for anyone to define a patient's QOL for them', yet that's exactly what he has done. Had he asked patients themselves, an approach taken by the Rose *et al* group, he would have set off in a productive direction instead of down a blind alley.

His attempt to selectively redefine the work of Rose *et al* as research on

'satisfaction', not relevant to work on quality of life, is without foundation, as a reading of the actual study will show. It was he who brought up the work ongoing in Britain as relevant, by his reference in his first sentence to the National Institute for Clinical Excellence guidelines which came out concurrently with, and used some of the same evidence base as, the report of the Rose group at the SURE.

There is a wide literature on non-financial conflicts of interest, best described as 'an individual occupying dual roles which should not be performed simultaneously' (Fava, 2001). Those include treatment researcher and editor of a journal promoting the treatment under study.

If you yourself read what CTIP says, and not what others say about us, you will begin to wonder where the 'anti-ECT' claim comes from. We are an international organisation made up entirely of persons who have received ECT. We represent the spectrum of outcomes, from persons who feel ECT is beneficial and have had it more than once, to persons whose lives were ruined by it. None of us was truthfully informed of the risks of ECT before consenting to it, and no one liked being lied to. Our organisation exists for one purpose only: to advocate truthful informed consent for prospective ECT patients. Thus, it makes no sense to say that 'any information that supports the use of ECT threatens the position of CTIP'.

Whether you are of the opinion that being in favour of truthful and informed consent somehow makes you anti-ECT depends on whether you believe that patients have the right to full disclosure of ECT's risks – and the right to make a decision for themselves based on that information – or whether you believe that ECT's risks are such that full disclosure would result in patients en bloc deciding to forego the treatment. That Dr McCall and colleagues are in the latter camp speaks much more eloquently than their article as to what they really believe about ECT's effects on quality of life.

CTIP, founded in 1984, has never received funding of any kind.

Fava, G. A. (2001) Conflict of interest and special interest groups. *Psychotherapy and Psychosomatics*, **70**, 1–5.

L. Andre PO Box 1214, New York, NY 10003, USA. E-mail: ctip@erols.com

Editor's note: This correspondence is now closed.