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Time to acknowledge the bias of some ECT researchers and defenders

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As authors of the article[1] misreported by Gergel and colleagues,[2] we wish to respond. Our article[1] did not conclude, as claimed,[2] that 'electroconvulsive therapy should be abandoned'. The lead author (JR) has, however, concluded, in a comprehensive literature review, that ECT 'should be immediately suspended until a series of well designed, randomized, placebo-controlled studies have investigated whether there really are any significant benefits against which the proven significant risks can be weighed?.[3] The study cited by Gergel and colleagues was an audit of 'usage, demographics and adherence to guidelines and legislation'.[1] Sadly, Gergel and colleagues have nothing to say about the safety and monitoring problems identified. What we actually concluded was: 'Given the apparent failure of current monitoring and accrediting of ECT clinics in England by the Royal College of Psychiatrists' ECT Accreditation Service (ECTAS), an independent government sponsored review is urgently needed'.[1] One example of this failure is the fact that 23% of ECT clinics in England are currently unaccredited with ECTAS, including, as of Jan 5, 2022, the clinic at which one of Gergel's co-authors, Robert Howard, is the lead consultant.

Gergel and colleagues rely primarily on two articles to argue that ECT is safe. The first[4] was a well-designed propensity score-matched, retrospective cohort study, but, like virtually all ECT research, it lacked a placebo control group (the last placebo study was in 1985[3]). It generated data that could test the oft-made claim that ECT saves lives. It found no difference between the ECT and non-ECT groups for 'medical hospitalisations and non-suicide deaths'. Rather than concluding that their finding confirmed previous findings that ECT does not save lives, it was presented, instead, as showing that in this study (unlike many others[3]) ECT did not endanger people's lives. Kaster and colleagues[4] then conducted a secondary analysis, on suicide. Unlike most other studies[3] they did find a difference in favour of ECT, of 0.1% vs 0.2%.

The second paper was an important systematic review covering studies involving over 100,000 ECT recipients by Duma and colleagues.[5] Gergel and colleagues accused us of 'sophistry', because we cited this review as an example of our safety concerns.[1] To support their accusation they quoted Duma and colleagues' conclusion that 'major adverse cardiac events after ECT are infrequent'.[5] But Gergel and colleagues omitted the next eight words: '…and occur in about 1 of 50 patients'. Even that alarming number is inaccurate, because Duma and colleagues actually found major adverse cardiac events in 25.8 per 1,000 patients—one in 39. So, both Gergel and colleagues and Duma and colleagues[5] argue that this very high rate of major cardiac events somehow renders ECT a safe procedure. It does not. We are equally concerned about the repeated minimisation of the persistent memory

loss reported by between 12% and 55% of recipients,[3] which is inadequately monitored by many ECT clinics.[1]

Gergel and colleagues portray research findings that are contrary to their opinions as somehow stigmatising ECT. They assert that ECT is not only safe but is 'the most effective of psychiatric treatments', in the absence of a single study, after 80 years, showing superiority to placebo beyond the end of treatment.[3] If their claim were true, what would that say about psychiatry's other treatments? If ECT is so very effective and so very safe, why is it used only by a tiny and dwindling number of psychiatrists?

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Competing interests declaration:

JR has received royalties for: Read J, Dillon J (eds) (2013) 'Models of Madness: Psychological, Social and Biological Approaches to Psychosis', Routledge, which includes a chapter on ECT. In 2021 he received a fee from a law firm, as an expert witness on an ECT case.

CH and JG have no conflicts of interest.

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