

## *Virtual Mentor*

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### **VIEWPOINT**

#### **Ethical Considerations with Electroconvulsive Therapy**

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Electroconvulsive therapy (ECT) is a treatment modality which is primarily provided to individuals with very severe episodes of major depression, usually when multiple attempts to utilize treatment alternatives (psychotropic medications and psychotherapy) are either ineffective or poorly tolerated. In a minority of situations, where there is a high degree of urgency or when ECT has proven necessary in earlier episodes, ECT is administered prior to failure of these treatment alternatives.

It has been clearly established that ECT is the most rapid and effective way to induce a clinical remission in individuals with major depression.<sup>1</sup> It is also the case that severe depressive episodes often include clinical features, such as psychosis, suicidal intent, and medical debilitation, which are accompanied by substantial risk in the short term if not successfully treated. Given this situation, the efficacy and safety of ECT must be considered in a relative, rather than absolute, sense; ie, are risk-benefit considerations at a given time in a specific patient more auspicious with ECT than if ECT is not utilized?

There are no truly "safe" treatments in medicine. As noted, even no treatment at all is associated with the risks inherent with the disease process itself; in this case, the risks are considerable. The risks of ECT are several-fold. First, there are relatively common side effects, including transient headaches, muscle pain, and nausea, which tend to be mild and easily managed. Second, some degree of amnesia often develops over the ECT course. In a majority of individuals receiving ECT, this amnesia is temporary, except for a difficulty in remembering items from the recent past, ie, days, weeks, and months prior to the start of the ECT course.

A smaller fraction of ECT recipients, however, report that their difficulty in recalling information prior to ECT (termed retrograde amnesia) is more pervasive, even though such deficits have not been corroborated by research studies utilizing formal memory testing. Still, amnesia with ECT remains a concern to clinicians and patients alike and has raised the question of possible structural brain damage. Contemporary research, however, has not supported such a possibility.

A third type of risk with ECT involves the occurrence of more serious medical adverse effects, including myocardial infarction, stroke, and death. Except for

individuals already predisposed to these risks on the basis of certain preexisting medical illnesses, such serious adverse outcomes are extremely rare.

### **Ethics of consent**

Because of its nature, administration of ECT requires informed consent. The hallmarks of informed consent are the delivery of comprehensive and accurate information to the consentor and the ability of the consentor to understand, process, and act upon this information. In the great majority of situations, the patient him- or herself serves as the consentor. In this regard, the presence of psychosis or other irrational thought patterns does not in itself militate against capacity to consent.

There are, however, situations where capacity to consent is lacking. In these cases, the manner in which consent should be obtained is covered by state law. Depending on the state, the applicable regulations range from surrogate consent by the primary significant other to a judicial determination of a guardian specifically appointed to provide consent for ECT.

The process of informed consent raises several ethical questions. First, when does a recommendation for ECT by a clinician constitute coercion? While it is the physician's duty to make a recommendation as to treatment, this recommendation should be accompanied by a rationale for why it was chosen over alternative treatments. In the process of doing so, the physician should not put pressure on the patient to accede to the treatment, nor should he or she threaten the patient with any form of adverse action if the recommendation is not followed.

The second question pertains to how and by whom capacity for consent is determined. While this determination is sometimes specified under state law, more often, as with all other clinical procedures, it is left to the clinical team. In such situations, the determination of capacity should be based upon the patient's ability: (1) to understand that he or she has an illness for which the treatment is being recommended, (2) to comprehend consent-related material which is provided, and (3) to process this information in a manner by which a reasoned decision can be made. Importantly, this determination should also be independent of the desires of the physician or of significant others.

The third ethical question deals with whether and in what manner the wishes of a patient who lacks capacity should be incorporated into the decision-making process (something which is often not prescribed under state law). It is incumbent upon a surrogate consentor to take such wishes into consideration, while at the same time also acting in the patient's best interest. Such patient wishes encompass not only presently stated views, but include in addition any known views on the matter from the past.

The decision regarding whether to administer ECT reflects, in many ways, a balance between the right to have a treatment and the right not to have a treatment. It is the physician's role to allow the patient the opportunity to have a clinically

indicated treatment which is relatively safe and effective. At the same time, this role also subsumes the need to help ensure that the informed consent process is meaningful and there is the opportunity to decline treatment. The American Psychiatric Association has recently published comprehensive practice recommendations which cover these issues and help set a standard for the practice of ECT throughout this country.<sup>2</sup>

Severe clinical depression is a debilitating and deadly illness. ECT represents an effective treatment option, which, with proper ethical safeguards, should remain available for use.

### References

1. Avery DH, Lubrano A. Depression treated with imipramine and ECT: the DeCarolis study reconsidered. *Am J Psychiatry*. 1979;136:559-62.
2. American Psychiatric Association. *The Practice Of Electroconvulsive Therapy: Recommendations For Treatment, Training And Privileging*. 2nd ed. Arlington, VA: American Psychiatric Publishing Inc; 2001.

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