Informed Consent for Electroconvulsive Therapy

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Despite the controversy surrounding the procedure, electroconvulsive therapy (ECT) remains a very effective treatment for certain mental disorders among the elderly.

Certain issues must be considered and dealt with effectively to ensure proper treatment and optimum results for patients.

By Richard E. Finlayson

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Informed Consent for Electroconvulsive Therapy

I have been discussing the general topics of cognition and competency in my column. Our attention will now turn to a specific clinical issue. Electroconvulsive therapy (ECT) has become a highly controversial topic in the arena of public discussion and public policy. In the International Journal of Technology Assessment in Health Care, E. Heitman from the University of Texas–Houston School of Public Health discussed the impact of lay participation in the regulation of health care. Heitman emphasizes the importance of outcomes assessment in the shaping of health policy. In the case of ECT, there is widespread professional acceptance of the method contrasted with very vocal opposition to ECT by groups of persons having received psychiatric treatment, often with ECT. Many persons are surprised that it is “still used,” under the assumption that it is an archaic method, replaced by the wonder drugs of psychiatry. The fact is that ECT remains a very effective treatment for certain mental disorders. The progress in drug therapy has reduced the need for ECT overall, but certain circumstances do exist in which it can be lifesaving. One of the problems with antidepressant therapy, for example, is the delay experienced before a positive effect is noted. The period is usually from two to three weeks but sometimes up to six weeks. Severely depressed and suicidal patients, or those in whom the depression has complicated their medical status, can be treated with ECT and generally be on the road to recovery within days.

Neuroleptic (antipsychotic) medication is an example of a treatment that has probably reduced the need for ECT, but its use has also become more regulated by law than it was in the past. In Right to Refuse Treatment, Janus et al. stated the following concerning Minnesota law, the state in which I practice: “The law defines intrusive treatment as including electroconvulsive therapy, and neuroleptic medication. Minnesota statutory law governs the nonconsensual administration of neuroleptic medication. The procedures for
administering nonconsensual ECT are not spelled out in the statute. Case law suggests that the ECT procedures are similar to the medication procedure."

ECT is used to treat acute schizophrenia, other forms of psychosis, mania, and depression. The usual indication for ECT in the elderly is depression. Not infrequently, the older person has cognitive problems as well. The latter may be secondary to Alzheimer’s disease, vascular dementia, or alcoholism. Depression itself may lead to cognitive problems, sometimes referred to as “pseudodementia.” About one-third of those suffering from Alzheimer’s develop a major depression. I recall the case of a surgeon’s wife, residing in a nursing home, who had advanced Alzheimer’s and was severely depressed. Various antidepressants had been tried without notable benefit. Her appetite remained poor and weight loss was marked. She was in a persistent state of agitation. The potential benefit of ECT was discussed with the family and they opted to go ahead with the treatment. The patient received a course of approximately 10 widely spaced treatments and was greatly benefited by them. Although her cognitive deficits were not greatly affected, she began to eat again and was much less anxious. She lived for another six months and the family was grateful for the improvement in her quality of life.

During my years of nursing home practice, I was impressed with how grateful families and the nursing staffs were if any improvement could be obtained in the quality of life of these older persons who suffered with a variety of mental conditions. I refer not only to ECT but also to drug therapy and psychotherapy. These treatment modalities may, however, be accompanied by side effects or complications. Memory loss is the most common complaint of persons who have received ECT. The loss of memory is typically temporary. According to research, persistent complaints may be due to multiple factors and not necessarily the ECT itself. There is extensive scientific literature dealing with this topic, and any substantive discussion of it is beyond the scope of this particular column. If there is interest among the readership of Elder’s Advisor Journal for a more in-depth discussion of this topic—that is, the research dealing with side effects and complications—I will devote a future column to it.

The short-term administration of neuroleptic medication may produce muscle rigidity, difficulty swallowing, and tremors. The most serious complication of long-term therapy, most common in elderly women on neuroleptics, is a condition named “tardive dyskinesia.” It involves involuntary movements, usually of the head and neck, and sometimes the trunk. It is a disfiguring condition manifested by uncoordinated movements of the lips, tongue, facial muscles, and so on. Fortunately, it usually develops only after months or years of treatment. There is evidence that some of the newer neuroleptic medications, known as the “atypical antipsychotics,” have a reduced capacity for producing these side effects.

As one can readily imagine, the question of whether an elderly person is able to give informed consent to receive ECT arises commonly. It is difficult to discuss the legal aspects of the matter for one not trained in the law. It is my understanding, however, that legal standards relating to competency and informed consent may be difficult to interpret even within a given state. Some standards may, for example, be written with a state hospital population in mind while others may refer to ambulatory populations. The issues become even more complex across state lines. The complexity of obtaining informed consent in the elderly population is also increased because of the multiple medical problems of old age. As an aside, I have objected to the separation of the concepts of “psychiatric” and “medical” because psychiatrists are physicians who employ medical treatments. This dichotomy has, however, become a common feature of the lay and scientific literature and I will bear with it for now. In The Woman Who Wanted Electroconvulsive Therapy and Do-Not-Resuscitate Status: Questions of Competence on a Medical-Psychiatric Unit, Dr. Sullivan describes the case of an elderly woman suffering concurrently from serious psychiatric and medical illnesses. She requested ECT and do-not-resuscitate (DNR) status. The case illustrates a conflict between medical and psychiatric treatment goals and ethical traditions, which, as the author notes, will become more common as psychiatrists treat older and more medically ill patients.
The kind of information that is typically provided to patients for whom ECT is being considered or recommended is shown in Table 1. In this table, Dr. Robert I. Simmon summarizes the recommendations of the task force convened by the American Psychiatric Association in 1990 to assess the practice of electroconvulsive therapy.

Table 1. Recommended Information to Be Provided to Patients Being Considered for ECT

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<tbody>
<tr>
<td>1.</td>
<td>Description of ECT procedures, including</td>
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<td></td>
<td>a. When, where, and by whom they will be performed.</td>
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<td></td>
<td>b. Range of number of treatments.</td>
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<td></td>
<td>c. Brief overview of ECT technique.</td>
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<td>2.</td>
<td>Reason for recommendation of ECT; reasonable treatment alternatives.</td>
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<td>3.</td>
<td>Therapeutic benefits, including possible transitory ones.</td>
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<td>4.</td>
<td>Likelihood and severity of risks associated with anesthesia, muscular relaxation, and seizure induction.</td>
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<tr>
<td>5.</td>
<td>Nature of consent for ECT, including implications of consent to perform appropriate emergency interventions, if necessary.</td>
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<tr>
<td>6.</td>
<td>Voluntariness of consent, which can be revoked at any time.</td>
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<td>7.</td>
<td>When questions about ECT may be asked (at any time); whom to contact.</td>
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<tr>
<td>8.</td>
<td>Restrictions on patient behavior prior to, during, and following ECT.</td>
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An assessment of how well the elderly person understands this information, once provided, should help to determine competency.

Clarification of some of the points mentioned in the table may be helpful. A description of the procedure of ECT is very important because of the manner in which the media tends to dramatize it. Item 2 may be difficult for a depressed person to understand because of inherent ambiguities. Usually, medications have been tried before ECT is considered. There is no agreement as to how many trials should be given before ECT is recommended, which is for the better because the age, general condition, past history of depression, financial circumstances, and social circumstances of the patient must be considered. For example, if the patient must remain in the hospital for his or her safety, repeated medication trials can extend therapy for weeks and even months. If the depressed person is the caretaker of another, perhaps a frail spouse, medication as an alternative can mean a longer hospital stay with all the negative implications for the needy spouse.

The last item of the recommended information to provide to patients—restrictions on patient behavior (number 8)—requires some clarification also. Although the overall risk from ECT is small, a certain amount of patient compliance is necessary to maintain that safety. The procedure requires a brief general anesthetic and therefore the usual pre-anesthetic precautions, such as not eating or drinking beforehand, must be observed. In addition, cooperation with the procedure itself is necessary.

Last, immediately following the procedure, the patient must remain in a recovery area just as he or she would if a major surgical procedure had been performed. Even if the procedure is done on an outpatient basis, which is common, a reliable adult must accompany the patient and supervise the patient's behavior, usually for the remainder of that day. To illustrate, the patient should be given a ride home after the treatment because confusion may result from anesthesia and the treatment itself.

I discussed the problems in assessing competency in my last column. Speaking from the point of view of the clinician, delay in administering treatment is a serious problem in the elderly, especially the frail elderly. Malnutrition, neglect of medical problems, general deconditioning, accidents, and suicidal thinking commonly afflict these elderly people. In some states, circumstances may permit involuntary treatment for an "emergency" as defined in that state's statutes. Unfortunately, some cases do not qualify as an emergency but the patients may still need psychiatric treatment. Permission to involuntarily treat a person refusing treatment may be very difficult to obtain if there is no apparent threat to life. I recall a nursing home case in which the court had denied involuntary treatment. An elderly woman had a paranoid psychosis. She was in a constant dread that the Internal Revenue Service would arrest her for unpaid back taxes. There seemed to be no basis for
this concern. Valid or not, her concern could not be modified by argument or persuasion. Medication trials had failed. ECT had been recommended but refused by the patient. The resident lived for several years, tormented by paranoid delusions. This resident did not suffer from malnutrition or fluid restriction. She was not suicidal or threatening the life of others, but she was irritable and very suspicious.

This issue's column deals with one of the most difficult areas of mental competence. It will likely remain so for the foreseeable future.

Endnotes

