Is ECT an Ethical Treatment?

March 01, 2004 | Electroconvulsive Therapy [1], Major Depressive Disorder [2], Mania [3], Schizophrenia [4]  
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Although there are many social impediments to the use of ECT, it appears to meet the four ethical principles of health care.

Although electroconvulsive therapy is widely considered a controversial therapy, it has survived for 70 years and usage has even increased. In Scandinavian countries, ECT is given on an equal footing with drugs and psychotherapy to psychiatric patients, while in the United States and some other European countries, there are social impediments to its use. As a consequence, patient suffering is prolonged, the cost of psychiatric care is increased and avoidable tragic deaths occur.

**Reasons for Controversy**

Three reasons are given for the aversion: 1) ECT is considered old-fashioned and politically incorrect; 2) it is forced on the patient; and 3) the memory disturbances are so severe and persistent that no rational human being would undergo this procedure, no matter how well-intended.

Electroconvulsive therapy is the oldest psychiatric treatment now in use, but modern practice is very different from that of early years. The technique of stimulation has been refined, and superficial anesthesia with muscular relaxation and oxygenation are in wide use. These changes contribute to a more lenient procedure.

The popular perception of ECT as forced upon an unwilling patient as pictured in the film *One Flew Over the Cuckoo's Nest* is no longer a feature of modern treatment. Treatments are now given with patients' individual consent. Only when patients are incompetent by reason of a severe psychiatric disturbance is ECT proposed without patients' individual consent. At such times, the laws of the state for the application of life-saving procedures may be invoked and the patient treated.

Immediate confusion accompanies ECT, but it is not persistent. Loss of personal memories is often described but is persistent in only a few patients. In the overall picture of the thousands of patients treated with ECT each year, the memory effects are a nuisance rather than an unassailable obstacle to its use.

**Ethical Analysis**

An ethical analysis of our practice may lead us out of the present impasse. An upsurge in interest in the application of ethical principles to medical care followed World War II, leading to the declarations and codes of the United Nations and scientific and professional communities. Four principles of health care--beneficence (doing good), non-maleficence (not doing harm), respect for personal autonomy and justice (equality of opportunity)--are widely accepted since their proposal by the philosophers at Georgetown University (Beauchamp and Childress, 2001). In practice, all principles are to be respected in all instances. When such is not possible, an analysis of the alternatives and their consequences in both the short and long term is made, and the least harmful alternative is accepted.

**The Principles of Ethics**

Many randomized clinical trials crystallize the indications for ECT where its efficacy is unsurpassed by other treatments. The effective indications are major depression, especially its psychotic form (Petrides et al., 2001; UK ECT Review Group, 2003), and catatonia, especially its malignant form (Fink and Taylor, 2003). Electroconvulsive therapy also relieves severe mania (Mukherjee et al., 1994) and some forms of schizophrenia (Fink and Sackeim, 1996). The risk of suicide decreases after ECT (Prudic and Sackeim, 1999). In these conditions, ECT complies with the principle of beneficence. With modern techniques of administration in ECT, the risks of death, fractures and tardive seizures, once commonplace, are now alleviated. Gaps in memory for the times of treatment, especially impaired recollection of personal and public events, increase with age and with the number of treatments but disappear within a few weeks after the completion of treatment. Many patients even experience improved memory compared to the difficulties associated with the illness. Prolonged disturbance is rare, and should it occur, the role of ECT is uncertain. Since most patients experience their memory impairment as a small nuisance in comparison with the relief of their
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psychiatric disability, the treatment is consistent with the ethical principle of non-maleficence. Informed consent is a feature and, indeed, a requirement, for health care, except in instances considered an emergency. The same attitude that is a feature of systemic health care applies to psychiatry and particularly to ECT. Before treatment, patients are told why the treatment is recommended and the anticipated benefits and risks. In the United States, a written consent is signed by the patient in the presence of a witness, usually a family member. When patients are considered incapable of giving an informed and voluntary consent by reason of their mental illness, they may be treated after legal authorization, following the laws of the community in which the patient resides. Nowadays, nearly all patients give voluntary consent to ECT after being informed of the benefits and risks. The few who are incapable to consent--1% to 2% of patients treated with ECT--may be treated with judicial consent when the illness is life-threatening and the treatment life-saving (Kramer, 1999; Reid et al., 1998). Given the choice of treating or not treating a patient with a severe psychiatric illness, the principle of beneficence is given priority over respect for autonomy. Modern ECT practice complies with the principle of respect for autonomy.

The principle of justice calls for ECT to be available to all the psychiatrically ill who need it, regardless of age, gender, social and financial status, or nation, hospital or catchment area. The decisive factor is the need for the treatment. Worldwide, the adherence to this principle is spotty, and even within a nation the availability is uneven. In the United States, ECT is available at academic hospitals, but hardly at state, municipal or Veterans Affairs hospitals (Hermann et al., 1995). Training in ECT is limited, so that only 8% of American Psychiatric Association members used or were confident in administering it (Hermann et al., 1998). Laws in some U.S. states so restrict the use of ECT that psychiatrists cannot give appropriate care. Treatment algorithms offered by expert committees recommend trial after trial of medication before ECT, which is considered the last resort, and encourage prolonged suffering in depressed patients (Crismon et al., 1999). Similar injustice has been reported in European countries (Benadhira and Teles, 2001; Koukopoulos, 1993; Philpot et al., 2002). In Sweden, the conditions are different, as evidenced by a psychiatrist who was admonished in 1996 by the National Responsibility Board for not giving ECT to a patient with depression who subsequently committed suicide. Regretfully, it must be concluded that the practice of ECT in many countries does not comply with the principle of justice.

Discussion

Electroconvulsive therapy can be administered in accordance with the principles of ethics, especially in the presence of confident patient-psychiatrist relationships. For many patients, their own experience with ECT or witnessing the benefits in other patients has sufficed to encourage its use and their voluntary consent. By personal experience, they are unhappy with the limited benefits of medications. After previous ECT, they experienced only transient problems with their memory. Informed consent is either given orally or written. All patients are treated equally.

Respect for patient autonomy is a central maxim of ECT, as it is of all medical interventions. There are occasions, however, when there is an obvious need for ECT in a non-consenting patient. When the consequences of withholding treatment may be life-threatening, the principle of beneficence achieves priority over respect for autonomy, and a paternalistic position is adopted to ensure treatment. Physicians have the obligation to save lives even if it means overriding a patient's wishes. Just as competent patients have the right to accept, abstain or discontinue an offered treatment; incompetent patients have the right to receive the most effective treatment, including ECT. Paternalism must not be totally rejected because it is sometimes confused with authoritarianism--the latter reflects insensitiveness, disrespect for patient autonomy and integrity, and desire for power. Just as it is valuable for children to have good parents, a paternal (or maternal) physician can be valuable to the psychotic patient. Psychiatrists who refrain from ECT when the indications are satisfied may be regarded as morally, even if not legally, negligent (Merskey, 1999). Paternalism neither justifies nor encourages coercive methods to accomplish treatment. If a good interpersonal relationship has been established between the patient and the professional staff and sufficient time is devoted to educate the patient and family members, even the most severely disturbed psychotic patients may come to understand that the recommended treatment is aimed at alleviating their distress. With a confident patient-psychiatrist relationship, even delusional patients may accept a proposed intervention.

Many efforts are being made to find a more elegant and less distressing treatment, and it may not be long before ECT is replaced by an equally effective and less controversial treatment. As long as ECT has an evidence-based superiority over other treatments, however, it should be utilized for the benefit of patients. Proper use not only assures patients of an effective treatment but is considerate of health care costs. The widespread noncompliance with the principle of justice in the practice of
ECT means a violation of the U.N. Declaration of Human Rights, which states that human beings are equal in dignity and rights.

**References:**

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