# Electroconvulsive therapy without consent

**BACKGROUND** In principle, electroconvulsive therapy (ECT) can only be administered to patients who consent to the treatment. If the patient does not consent, the treatment can be given in exceptional cases, in situations where a plea of necessity can be made. The purpose of this study was to investigate whether the issue of consent was documented in the patient records at Dikemark Hospital in the period 1960–95, and to study the outcomes for patients who were given ECT treatment without having consented.

**MATERIAL AND METHOD** The article is based on a review of the ECT protocols and the records of patients who were given this treatment during the period 1960–95 in three psychiatric wards at Dikemark Hospital. We registered whether the issue of consent had been documented, and if so, whether consent had been provided or not. The material encompasses 241 ECT series administered to 141 patients.

**RESULTS** The issue of consent had been documented for 107 of a total of the 241 series. Seven patients were given the therapy against their wishes. The median age of these seven was 68 years (range 56–82 years). All of them had been diagnosed with depressive psychosis and were given electroconvulsive therapy on a vital indication under a plea of necessity. Insufficient intake of nourishment was described as the main reason for the vital indication in all the seven patients. According to their records, they showed signs of improvement on the day after the first treatment. Their lifespan after the treatment varied from three to 19 years.

**INTERPRETATION** On the basis of the records in which it was documented that the patient had not provided consent, electroconvulsive therapy was administered exclusively as a life-saving intervention.

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**MAN MESSAGE**

**Consent for electroconvulsive therapy at Dikemark Hospital was inadequately documented in the patient records during the period 1960–95.**

**Documentation practice improved during the 1980s and 1990s.**

**In those few cases where it had been documented that consent had not been provided, the treatment was administered under a plea of necessity.**

**According to the patient records, the ECT treatment had a positive effect in all those who did not consent.**

Electroconvulsive therapy (ECT) has been used for more than 70 years to treat severe depression as well as rare conditions such as catatonia and manic delirium. The treatment is provided under short-term anaesthesia two or three times per week, frequently in a total of eight treatments in a series. In the case of relapse or a new episode, a further series is frequently provided.

Today, informed consent is a key topic in all clinical practice, and as a main rule, health care should only be provided with the patient's consent (1). The Mental Health Act of 1961 made no reference to the non-provision of consent, and in the years after 1961, the prevailing conception of justice was that people who had been forcibly committed with serious mental disorders should be provided with adequate and professionally appropriate psychiatric treatment, even when no consent had been given (2). Requirements for consent to electroconvulsive therapy were specified in 1984 (3). During the last 30 years, large changes have occurred with regard to perspectives on self-determination, and requirements for consent, record-keeping and assessment of the patient's ability to provide consent have been tightened in the applicable laws and regulations. Today, consent should preferably be provided in writing and appended to the patient records. In addition, the doctor should assess and document whether the patient is able to provide consent, and state the grounds for this decision (1, 4).

If the patient does not consent, electroconvulsive therapy can be provided in exceptional cases in specific situations of vital necessity, pursuant to Section 47 of the General Civil Penal Code (5, 6). The preconditions for entering a plea of vital necessity include an inevitable threat to the patient's life or a serious health risk. The risk must be material, and the prevailing risk must not be avertable in any other, less invasive manner. Treatment justified by vital necessity can only be initiated to avert immediate risk (5).

To my knowledge, no studies have yet described consent to electroconvulsive therapy in Norwegian psychiatric hospitals. In a previous article, we have described the treatment method, its effects, its adverse effects and relapses at Dikemark Hospital during the period 1960–95 (7–9). In this study, the same material is used to investigate the extent to which consent to ECT treatment was documented and how the patients fared after having received the treatment, but without having provided consent.

## Material and method

The study is based on a review of ECT protocols (and the records of all patients for whom an ECT protocol existed) for the period 1960–95 from three wards at Dikemark Hospital. Altogether 141 persons were

**Table 1** The patients' views of the initial and subsequent ECT series at Dikemark Hospital during the period 1960–95, as reported in patient records

| | Initial series[1] (n = 141) | | Subsequent series[1] (n = 100) | |
|---|---|---|---|---|
| | Number | (%) | Number | (%) |
| Requested ECT treatment upon admission | 6 | (4) | 10 | (10) |
| Consented after recommendation | 39 | (28) | 20 | (20) |
| Consented after refusal | 21 | (15) | 4 | (4) |
| Did not consent | 7 | (5) | 0 | (0) |
| Not noted in the records | 68 | (48) | 66 | (66) |
| **Total** | **141** | **(100)** | **100** | **(100)** |

[1] Of a total of 241 series, 11 were provided before 1960, five initial and six subsequent series

**Table 2** Documentation of consent in the patient records for ECT series at Dikemark Hospital during the period 1960–95

| Year | Total no. of series | Consent entered in the records | Non-consent entered in the records | No information on consent | Issue of consent noted in the records | |
|---|---|---|---|---|---|---|
| | | | | | Number | (%) |
| 1960–69 | 22 | 7 | 0 | 15 | 7 | (32) |
| 1970–79 | 29 | 3 | 0 | 26 | 3 | (10) |
| 1980–89 | 93 | 38 | 4 | 51 | 42 | (45) |
| 1990–95 | 86 | 49 | 3 | 34 | 52 | (60) |
| **Total** | **230[1]** | **97** | **7** | **126** | **104** | **(45)** |

[1] 11 series of the total material of 241 series were administered prior to 1960, and are not included in the table

provided with a total of 241 series and 1 960 individual treatments. Five of those 141 patients who were treated during the period 1960–95 had received a total of 11 ECT series during the years 1952–59. These series have also been included in the material. The material has been described in detail in previous articles (7–9).

The patient records have been systematically reviewed to identify documentation of whether the treatment was provided with or without consent. The author registered the diagnoses (re-diagnosed according to ICD-10) and adverse effects, as well as a scored effect of the therapy on the basis of information in the patient records. A random sample of 22 records was drawn and reviewed by an independent assessor. There was a satisfactory correspondence, measured in kappa values, for the diagnoses, adverse effects and effect scores (7).

The effects of the treatment were classified as follows:

- *Much improved:* Re-establishment of the pre-morbid level of functioning with full remission of symptoms, permitting the patient to be discharged from the hospital within four weeks.
- *Improved:* Improvement of symptoms and level of functioning, although with some residual symptoms that did not allow the patient to be discharged within the next four weeks.

*Ethics*

The study has been approved by the Data Protection Officer at Oslo University Hospital.

## Results

*Description of consent in the patient records*

The issue of consent was described in the records for 107 of 241 treatment series (Table 1). There was a tendency for the issue of consent to be documented in a higher number of records in the latter part of the period (Table 2). In the three wards, consent was described in 41 %, 47 % and 74 % of the records, respectively. The patient's ability to provide consent was not referred to in any of the records.

For the initial ECT series administered to the 141 patients at Dikemark Hospital, the issue of consent had been documented in 73 cases. Six patients requested the treatment. Another 39 patients consented after the doctor had recommended ECT treatment, and 21 patients initially refused consent, but later provided consent after having received more information and repeated recommendations (Table 1). Despite repeated recommendations and information, seven patients did not provide consent, but nevertheless were given ECT treatment (see more detailed description below). For 18 patients, the records state that electroconvulsive therapy was administered on a vital indication. Of these, five had consented to the treatment and provision of consent was not documented for another six. The remaining seven patients were those who did not consent.

The issue of consent was documented for 34 of the 100 ensuing series. In ten of these, the patient requested ECT treatment, 20 consented after recommendations, and four consented after first having refused the therapy. No treatments undertaken without consent were noted (Table 1). For four of the 100 series, the ECT treatment was administered on vital indications – two patients consented, but no information on the two others was noted in the records.

*Non-provision of consent*

In seven cases, the records documented that the patient had not consented to ECT treatment. These seven patients had a median age of 68 years (range 56–82 years). These ECT series were provided during the period 1981–94. According to their records, all these seven patients suffered from depression of a psychotic nature, in the form of a serious bipolar depression, recurrent serious depression or a serious first-time depression (Box 1). All seven of them were provided with the treatment on a vital indication under a plea of necessity, since it was considered that the patient's life would be at serious risk if no ECT treatment were provided. The patients were in a poor general condition, with a median weight of 47 kg (range 44–57 kg). Insufficient intake of nourishment was described as the main reason for the vital indication in all seven patients. In all cases, the next of kin were informed and provided consent to administering electroconvulsive therapy.

According to the records, all seven patients showed signs of improvement on the very first day after the treatment. All of them were classified as improved, six of whom were

much improved. Adverse effects were described for three of the seven, in the form of intermittent forgetfulness/brief spells of confusion. Their median life span after the treatment was nine years (range 3–19 years).

The ECT therapy was undertaken in the standard manner. The hospital's specialist in internal medicine assessed the patients continuously, they were informed about these assessments and were given the opportunity to voice their concerns. The supervisory authorities were informed during the process and after the treatment was completed. According to the records, the patients did not physically or otherwise resist once the decision had been made, and some of them appeared to be content that the therapy had been prescribed by others. The records do not state whether the patients were asked again for each new treatment session. According to the records, all patients were grateful for their treatment, and some had stated that they wished to receive repeated electroconvulsive therapy in case of a relapse. Four of the seven patients relapsed and consented to subsequent ECT series.

## Discussion

The documents show that over a period of 36 years, seven patients at Dikemark Hospital received ECT treatment without having provided consent. All had deep depression of a psychotic nature, and they appeared to have insufficient insight into their disease (Box 1). Awareness of entering the issue of consent in the patient records appears to have increased during the 1980s and 1990s.

In Scotland, The National Audit of ECT showed that approximately 1 000 patients received this treatment annually, and that 82 % of them provided consent. The remaining patients received the treatment pursuant to safety regulations under the Mental Health Act of 1984 (10). In a Canadian study, altogether 6 % of the voluntarily and 36 % of the involuntarily committed patients who received electroconvulsive therapy were deemed unable to provide consent (11).

### *Patient autonomy and ability to provide consent*

Providing help to those who need it and respecting the patient's autonomy are two fundamental principles in contemporary medical practice. Occasionally, these two principles come into conflict. The patient has the right to refuse treatment (1). This situation is especially complicated when the patient is extremely ill and refuses treatment, and this appears to be irrational.

The patients' ability to provide consent was not referred to in any of the records. Requirements for such assessment were not added until later. The Patients' Rights Act now distinguishes between patients who are able to provide consent and those who are unable to do so (1). The ability to provide consent or to make decisions requires mental capacity to understand, assess, decide rationally and voice an opinion. Section 4–3 of the Patients' Rights Act points out some issues that must be reviewed to decide whether the patient is able to provide consent (1). If the patient suffers from physical or mental disorders, senile dementia or developmental disability, this may impair the ability to make competent choices. The grounds for the assessment of the ability to provide consent should be recorded in writing and should be submitted to the patient and his or her next of kin immediately (1).

Previous studies indicate that as a rule, severely depressed patients are able to provide valid consent to or rejection of an offer of electroconvulsive therapy (12), while patients with psychotic depression may have an impaired capacity to make decisions because of cognitive impairment, insufficient understanding or delusions (13).

This raises a number of dilemmas. What about patients who are able to provide consent, but consent or refuse on irrational grounds? How should we relate to such irrational grounds? For example: «I refuse ECT, because no treatment can help me.» Some authors claim that the patient's right to self-determination should be respected regardless of the irrationality of his or her ideas, unless the patient's life is at risk (14). So what about patients who are unable to provide consent, but accept the treatment on irrational grounds? «Give me the treatment, because I'm a bad person and deserve to die.» Some would accept this as a valid consent, but is it legitimate?

The study cannot indicate how many consented for irrational reasons or how many were recommended ECT treatment, but refused and were not treated. Refusing treatment is far from synonymous with having insufficient insight. There are numerous examples of patients who do not want electroconvulsive therapy, but prefer conversation therapy, drug-assisted treatment and other measures.

Pursuant to current legislation, electroconvulsive therapy can only be administered on the basis of valid consent or on a plea of necessity (2). It could be an ethical problem, however, that patients who are unable to provide consent fail to receive this treatment until a situation that justifies a plea of necessity occurs.

### *Plea of necessity*

The seven patients who did not consent did not suffer from any acute disorders, but a gradual deterioration that extended over several weeks. The therapists had remained in daily contact with the patients over an extended period to establish cooperation on the further course of treatment. The review of the patient records clearly shows that the arguments put forward by the health personnel were not understood. According to the regulations at Dikemark Hospital, the patient's next of kin were invariably informed about his or her treatment. When an emergency situation occurred and the patient did not consent, the therapists would generally prefer to elicit a written confirmation from the next of kin, stating that they accepted the treatment. Following consultations in the monitoring commission, the hospital's practice after 1984 was that the senior consultant who was responsible for the decision would inform the Chief County Medical Officer and the monitoring commission in writing that electroconvulsive therapy would be provided if a life-threatening situation should occur.

In all of the seven patients, the emergency situation arose because of life-threatening

BOX 1

**Seven patients were provided with ECT treatment without having consented**

All of these patients had been repeatedly admitted to the psychiatric ward for long periods. Attempts had been made with conversation therapy, treatment with more than three different antidepressants and at least one or two different psychotropic drugs. They had all been depressed for several months and were marked by serious symptoms of depression and apathy, discouragement, restiveness, suicidal thoughts, dehydration and a high degree of refusal of nourishment, which caused a life-threatening situation with electrolytic disturbances and rapid weight loss. Some were bedridden or could walk only with difficulty. These are some examples of psychotic symptoms and manifestations that could not be corrected:

- «I will never recover. All treatment is wasted. The world will come to an end.»
- Insomnia, distress, anxiety, confusion and psychosis.
- Isolation, major weight loss over a short period, negative attitude.
- Long latency period, death wish, lack of energy.
- Bodily delusions.
- Excessive, disordered, crying frequently, tormented, rigid, staring.
- Violent, anorectic, wish to die.
- «Nothing helps. I'm not ill, just a bad person, no doctor can help me.»

refusal of nourishment. They were in a state of starvation with rapid weight loss and electrolytic disturbances, but they were not yet unconscious. Other available treatment options had been attempted. Most likely, none of them would have survived without ECT treatment. The Norwegian Board of Health Inspection has stated that life-preserving measures can be defended in such situations when the risk cannot be averted through any other legal interventions (5). However, the plea of necessity can be entered only in the case of immediate risk. In the cases concerned, this will correspond to a few days until the patients improved and started to eat and drink, but the records do not report whether the patients were asked again about subsequent treatment sessions in the series.

*Strengths and weaknesses*

The weakness of the study is its retrospective design and that information on consent had been entered in only half of the patient records. The circumstances surrounding treatment without consent were so extraordinary that there is a high likelihood that these treatment series were meticulously recorded, and after 1980 the monitoring commission supervised these situations with great care. We may therefore well assume that electroconvulsive therapy without consent was more frequently entered in the records than in the cases in which the patient consented and the treatment could be provided in the ordinary manner. However, there were eight instances of ECT treatment provided on a vital indication without any reference to consent having been entered in the records, and we cannot exclude the possibility that in addition to these seven, further patients did not consent to the treatment.

The seven patients who did not consent were all assessed as having benefited from the treatment. The issue remains, however, that the therapists may have overestimated the results, since the treatment was administered on a plea of necessity. Most likely, it was important for them to document positive effects and the appropriateness of having used electroconvulsive therapy.

The strength of the study is its naturalism, that all patients who received ECT therapy during these 36 years have been included and that their lifespan could be documented.

## Summary

The patients' view of electroconvulsive therapy seems to be documented increasingly during the 1980s and 1990s, in particular the initial series. Seven patients suffering from severe psychotic depression and life-threatening refusal of nourishment received the treatment without having consented. According to the patient records, all seven patients benefited from the treatment.

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The author has completed the ICMJE form and declares no conflicts of interest.

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