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### Symposium 3:

# Consent, competency and ECT: a psychiatrist's view

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## Editor's note

*Dr Taylor, an English psychiatrist, considers the issue of the symposium in the context of the Mental Health (Amendment) Act 1982. This, she says, gives little guidance on how judgment of a patient's competency or capability to consent to treatment should be made, although it specifies that unless compulsorily detained patients competently consent to ECT a special second medical opinion is required. Although some guidelines from the Department of Health may be offered before implementation of the Act in September 1983 all those working with psychiatric patients will have to consider the issues. After discussing her criteria for informed consent, some practical approaches for obtaining it and problems arising from these, and problems of surrogate consent, Dr Taylor concludes that there is no single or simple solution to the dilemma. She ends by asking: 'Can refusal of ECT for severe depression ever be a competent decision?'*

It is no accident that the paper by Culver *et al* (1) prompting this discussion about the competency of patients to consent to ECT comes from the USA. For some time Americans have been faced with more legal challenges to their practice of psychiatry than have been experienced in Britain. Analysis and re-evaluation of time-honoured procedures from within the profession are most responsible reactions to the introduction of external controls. The issues are, however, rightly of concern beyond medical disciplines and it is invaluable to have the benefit of insight from philosophers too. Professor Sherlock's questioning of some of the issues raised by Culver *et al*'s paper and then further elaboration by Dr Lesser is peculiarly timely for psychiatrists practising in England and Wales. Here, for the first time, new legislation, effective from September 1983, addresses the issue of consent to specific treatments, including ECT.

Psychiatrists in England and Wales are not unfamiliar with issues of competency of the mentally ill.

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## Key words

Medical ethics; consent; autonomy; impaired autonomy; depression and consent; paternalism; Mental Health (Amendment) Act.

Questions may be raised in the criminal or civil courts. The psychiatrist may be asked to present evidence about a patient's mental state so that a court may decide whether his will is valid, whether he is fit to stand trial on a criminal charge, whether he was responsible for his behaviour in committing a criminal offence or whether he is fit to manage his personal affairs. On questions relating to a patient's need for medical attention the Mental Health Act 1959 left the burden of the decision more directly with the doctors. Patients could be detained in hospital against their wishes on the strength of medical certification, in conjunction with an application by a relative or social worker, stating that detention was necessary and why it was necessary. Some sections of the Act specifically empowered detention for treatment but consent to individual treatments was not considered as a separate issue. The Mental Health (Amendment) Act 1982 changes that. It recognises three categories of treatment: those which require consent *and* a second opinion; those which require consent *or* a second opinion; and those which do not require consent. The new mental health law thus reflects clinical practice only in part, when, except in occasional emergency or lifesaving situations treatment only proceeds with the consent of the patient. Failure to follow this course could, especially with a treatment such as ECT, be dealt with under common law as an assault, but not under special mental health laws.

The first most stringent category applies to any patient and covers psychosurgery and use of hormone implants for control of libido. The second category applies only to compulsorily detained patients and covers long-term (more than three months) medication and ECT. The use of ECT for informal (voluntary) patients thus remains a matter to be decided entirely between the patient and his or her doctor. For ECT to proceed in the case of a detained patient, however, the patient must first consent and then his consultant certify in writing that he is 'capable of understanding its nature, purpose and likely effects and has consented to it'. If either of these conditions cannot be met then a new controlling body, The Mental Health Act Commission, must be approached to appoint an independent doctor. If this doctor certifies that the patient is not capable of consenting, or has not consented, but

requires ECT the treatment may then take place. Although the Act gives clear instructions about the procedure which must be followed if the patient's consent is in doubt, it gives no guidelines about how the judgment of competency, or capability, should be made. It thus implies that it will be a simple matter with which all consultant psychiatrists and medical and lay appointees of the Mental Health Act Commission will be familiar. Professor Sherlock and Dr Lesser disabuse us of any tendency to think along similar lines.

There seems to be one fundamental point on which there is absolutely no disagreement between the Culver group, Professor Sherlock, Dr Lesser and myself; that in the context of undergoing treatment consent must mean more than simple agreement. How much more and the conditions under which disagreement may be overruled provide the debate. My criteria on the surface would appear much tougher than those discussed by Sherlock. I suggest that valid consent should be a free, informed, reasoned, rational, committed decision to undergo treatment. In practical terms for ECT this involves progressing through a four-stage process: the giving *and* receiving of information; an assessment of the competency to consent; the signing of a consent form, and actual compliance with the procedure.

### The giving and receiving of information

Perhaps the stage on which I would put most weight is that of information exchange. Culver *et al* propose the most minimal of criteria, which Sherlock accepts, namely that the patient should know:

- 1) The physician believes that he (the patient) is ill (although the patient may not agree).
- 2) That the physician believes that the particular treatment may help.
- 3) That he is being called on to make a decision.

Roth and colleagues (2) studied 57 patients, mainly with primary depressive illness and all prescribed ECT for depression. They found that failure to recall information about the disorder and the proposed treatment was significantly associated with refusal of treatment. Many decisions labelled as irrational are held because the individual holding them does not have sufficient information with which to progress to a more considered judgment. Sherlock suggests that the patient who refuses ECT because 'nobody is going to put electricity in my brain' had irrational fears. That, however, was precisely what the doctors were proposing to do, ie put electricity in the patient's brain. It is not clear what Sherlock means by attempts 'to dissuade him' but almost certainly the emphasis should have been placed on attempts to provide clear truthful information to the patient about the proposed treatment.

Informing patients is not easy, either in terms of deciding how much to tell, or in the process of telling. The first essential to be grasped is that, strictly, the

information can be given in probabilities only. This immediately raises problems. The doctor's confidence in the treatment often enhances its effects so should this confidence be withheld in favour of mere statistics? At what level of statistical frequency does it become necessary to mention risk to a patient? Does the presentation of all risks in itself constitute a risk? With those cautions in mind most people would concede that the patient needs to know something about his illness and the treatment. Rarely mentioned, perhaps because it is more difficult to achieve, is that he ought also to be informed about the skills, knowledge and biases of his doctor.

When the treatment in question is ECT the patient is most likely to be suffering from a severe depression. If the patient is to be well informed of his illness he will need to know that spontaneous recovery occurs, but often only after months or years, and that the risk of death if he is untreated is high. There is an approximately one in ten chance that he will die by suicide (3) and a greatly increased risk over his non-depressed peer that he will die from superficially unrelated conditions such as heart disease (4). If he does not recover quickly he already has experience of the kind of suffering he must endure and must weigh the consequent risks that this will precipitate against any risks of treatment. He is likely to be inefficient in his work and may lose his job; personal relationships may deteriorate to the extent that his family reject him, or he may be driven to uncharacteristic confused or despairing behaviours such as shoplifting, leading to loss of social status. Information about the proposed treatment would include simple practical details of what it entails, in this case the giving of an anaesthetic, the passage of an electric current, information about what he will experience during treatment, the length of time the treatment will take, and so on. The expected benefits and their timing must be described, as should possible side-effects such as headache or confusion for a short time after treatment. A realistic appraisal of the risks must be attempted. There is a risk of death which is possibly about the same as that for patients undergoing dental surgery under anaesthesia (5). The risk that gives rise to most concern, however, is that of brain damage. Wide-ranging studies have failed to reveal more than the slightest objective evidence of brain damage or lasting cerebral dysfunction after a course of treatment given under modern conditions with anaesthesia, muscle relaxant and oxygen (6); the nagging doubts remain that our tests for damage may not be sophisticated enough or that in unusual situations like the giving of large numbers of treatments our knowledge is inadequate. Finally, because it is least important to the issue of consent, and could reasonably be omitted, the mechanism of action of ECT could be discussed.

The information just listed represents a mere skeleton of the data available but it is nevertheless a great deal of new material for any average man or woman with no medical background. Can it be ab-

sorbed? Fully informed consent is unlikely for any but the expert. The patient who first demands an expert and then an honest answer from him or her to the question 'If you were in my position would you have this treatment?' may come the closest to making an informed decision and this is perhaps why Sherlock so readily accepts the Culver *et al* position about being adequately informed. The doctor should not, however, be relieved of the responsibility to try and inform, although the number of research reports in this area suggests that he has little interest in his success in doing so. There is nevertheless some evidence to suggest that things are far from hopeless. One study, for example, (7) suggested that a group of psychiatric patients while not well informed about their diagnosis – in this case schizophrenia – and the positive aspects of their medication, were very likely to know of the side-effects and risks involved. A demographically matched group of medical patients were significantly less well informed about risks. Roth and his colleagues in America (2) addressed themselves more specifically to the question of ECT. Over half of their series of 57 patients, described above, understood at least two thirds of the information on a consent form. Failure to recall the information was significantly associated with severity of illness and demographic factors such as low educational levels. The finding, already mentioned, that it was also significantly associated with refusal of treatment should be a powerful stimulus to perseverance with patient education. In contrast the patients in a British sample (8) had gained their knowledge of ECT in an ordinary clinical setting without any research-based, information-giving procedure. A similar proportion of, again, mainly depressed patients nevertheless had grasped what the treatment involved. One third failed to gain any understanding. Roth and his colleagues further addressed themselves to how the information was best conveyed. The number of subjects was small but they found that of the 11 patients with extremely low scores for retaining information from the consent form, five were able to learn to a satisfactory level from interview.

#### Figure: Guidelines for informing patients

**I**nformed psychiatrist  
**N**on-technical presentation  
**F**amiliarity with patient  
**O**ther potential informants  
**R**epetition of information  
**M**oral obligations

The Roth group's confirmation that time spent in direct contact with the patient is fruitful, leads to the suggestion of some guidelines which I personally have found maximise the amount of information gained and retained by the patient. The Figure summarises these. The first is to be informed oneself, and the second to be able to convey that information in non-technical language. Doctors tend to talk in technical jargon and

the detailed consent forms now provided in many American institutions represent an extreme of this tendency. Morrow (9) evaluated a number of consent forms by their 'readability scores'. He found that their language was the equivalent of that found in a number of standard medical journals, such as the *Journal of the American Medical Association*, and that they fell well below the standard of such publications as local newspapers, *Better Homes and Gardens* or, the most readable of all, *The Adventures of Spiderman*. A third requirement is that the doctor informing is familiar to the patient and in turn the patient familiar to the doctor, which inevitably means making time available to be with the patient and allowing him the freedom to ask questions. This is probably more valuable than any number of lectures. Fourthly, it is useful if another person, preferably of the patient's choice, is present at a session when information is conveyed. This gives the advantage of allowing the patient 'an ally' which not only increases his confidence in questioning the doctor but may also facilitate translation from technical to simple language. The husband or wife, or even a nurse who spends more time with the patient than the doctor, may know better the manner of explanation likely to be most meaningful to the patient. Fifthly, it is essential to repeat the information at regular intervals. New information is rarely absorbed in its entirety on one occasion even by the most competent individuals and possibly emotive information creates extra problems. A depressed patient may, as indicated earlier, have impaired concentration and therefore be less likely to register new material, let alone recall it. When ECT is the treatment in question, given the impairment of short-term memory which it sometimes causes, information may have to be repeated after each treatment. Involving others in the initial session allows almost unlimited possibilities for repetition. Finally, there are the moral issues. The patient should be as free as possible to make his choice, so unreasonable pressures should not be a part of the information-conveying. It is unfortunately not a myth that a few patients have been told that they will be 'put on an order' i.e. compulsorily detained and/or locked up if they refuse to sign the consent form.

#### Assessment of competency to consent

The most difficult part of the whole process of obtaining consent to a treatment is the judgment of whether the patient's decision about it is valid. A fundamental requirement is that he should show evidence of being able to make a free decision of any kind. A few depressed patients are all too obviously in a state of distressed ambivalence and cannot even pass this first hurdle. 'I really don't know what I should do' is a not uncommon response to requests for a decision about treatment or anything else. Alternatively they may say that they 'have much more important things to think about' and lapse into their depressive ruminations, or they may say nothing at all and remain in the corner, wringing their hands. There are patients too,

however, who say 'my wife will decide' or 'whatever you say doctor'. Are these remarks adequate evidence of free choice? Sherlock points out that for some depressives irrational or false beliefs may also curtail freedom of choice. To give my own example: the patient who 'knows' that he is wicked may feel that he must not accept treatment as his guilt can only be assuaged by suffering.

A more sophisticated element in the evaluation of consent is whether the choice is informed. The process of information-giving has been discussed and it can be fairly simply evaluated in itself but what of the process of information-receiving? Should a short examination of the patient's knowledge take place? If so, at what criterion of success in regurgitating information is he to be regarded as informed? If it can at least be established that he is informed, is the capacity to repeat alone sufficient? Should the patient also show powers of formulating the issues and himself asking relevant questions? This would be asking for very high standards indeed. I agree with Sherlock and Lesser's misrepresentation of Culver *et al*'s criterion of competence. The patient should know that he is ill and I would add that he should know the consequences of his illness if untreated. He should indeed know that the doctor believes that the treatment will help but he should also be given a realistic appraisal of its benefits and risks.

If the patient has passed these tests how can his choice be judged as reasoned or reasonable? I think there is a distinction between the unreasonable and the irrational and this would seem to have parallels with Dr Lesser's view that there are two elements to the term irrationality as used by Professor Sherlock. One time honoured criterion for reasonable choice is whether it is the same as the doctor's. It may, however, be that a patient even when depressed has evaluated all the information presented and then, taking it in conjunction with his more detailed knowledge of his own circumstances, presented a perfectly well reasoned decision which is at variance with the doctor's. Sometimes this will be a truly reasonable decision. In practice if patients have been able to express a clear choice about treatment, when this is a refusal they almost invariably give some kind of reason. One is rarely faced with the inability or reluctance to do so which concerns Dr Lesser. The medical fear, which is occasionally justified, is that although the reasoning of the depressive may be sound, the premises of his argument, for example that the future is hopeless, may not be. The decision may be well reasoned but irrational. There are other ways too in which the decision may be irrational. The treatment may be seen as punitive and threatening, for example, the preliminary blood test as drawing the life away, the chest x-ray as giving a lethal dose of radiation, drugs used as a form of poison, and the ECT as a form of execution. Sherlock and Lesser mainly concern themselves with irrational refusal. One problem they do not consider is that occasionally patients may give irrational consent. Many

psychotic depressives, that is those who have substantially lost touch with reality believe that they are evil or wicked and fit only for the most dreadful punishment. Some of these view ECT as a punishment and consent only because it is what they believe they deserve. Acceptance of such a consent perhaps makes clinical management easier but ethically should it be so readily accepted?

### The signing of the consent form

For ECT written consent is always required. It is now a treatment for which the patient is first rendered unconscious with an anaesthetic, and so must give clear advance consent, not only for the treatment itself but for anything necessary to sustain life in the unlikely event of complications. The obtaining of a signature on a consent form should be merely a confirmation of the informed and rational consent already obtained. It is largely for the benefit of the doctor rather than the patient and developments in the structure of the consent forms in the more litigious parts of the world tend to reinforce this idea. In this country in the '60s it was common for there to be special consent forms for ECT. They were likely to contain a brief, rather positively biased summary of the treatment, and space was provided for the patient alone to sign his agreement. More recently in this country the form has been brought into line with general medical and surgical standards as have most elements of mental health care. If anything the risks are emphasised by including consent to 'other measures if necessary' but the advantage is that the patient has to read only the simplest of statements and should be in no doubt that if he signs he is agreeing to two main things: firstly to have the treatment and secondly that it has been explained to him to his satisfaction. The doctor, too, has to commit himself in writing to confirm that he has informed the patient. Similar forms are available if relatives' consent is sought. Many American units, in parallel with the increasingly restrictive legislation covering ECT in a number of states, have developed very much more complicated consent forms. They detail the nature of the mental disorder, the treatment, its benefits, side-effects and risks, and patients' rights. I have little knowledge of how these forms are used in practice but I suspect that they have been taken to imply the invalid suggestion that 'here is all the necessary information' and, worse, that the doctor is thereby relieved of the necessity to struggle with attempts to instruct the patient personally. Reference has already been made to Roth's work (2) which demonstrated well that some patients who failed to inform themselves from a detailed consent form were capable of grasping the information at interview.

### Compliance with the procedure

The three processes already discussed represent the formalities of the decision-making. The patient who has consented on paper may demonstrate his independence in decision-making in a more practical

way. He may simply fail to comply with the procedure. This is the stage too when the patient who has been judged incompetent and either had the decision made on his behalf, or his own decision overruled, demonstrates and/or enforces his choice at least for a time. A few patients 'forget' that they must take no food or drink for at least four hours before the treatment. There is some genuine confusion and forgetting but many who 'forget' on more than one occasion are very aware that treatment cannot proceed. A few others disappear or abscond on the ECT morning. The anaesthetist is usually a visiting doctor and a morning away from the unit is therefore quite sufficient to sabotage treatment for the day. Rarely there is the much more distasteful scene of a distressed patient fighting those who attempt to take him for treatment and restrain him on the bed for the anaesthetist. Sedation and extra observations can be and are used for a few hours prior to the treatment for such patients if treatment is judged to be life-saving, or essential for some very special reason. In other cases, each of these situations if repeated indicates refusal or withdrawal of consent so strongly that whether or not the patient consented in the first instance and whether or not he was judged competent, his behaviourally demonstrated view probably ought to be respected.

### **Resolving conflicting decisions**

This process of obtaining consent, which results in three independent ways in which the patient may express his decision, i.e. orally, in writing, and by his actions, itself offers a check on the patient's capacity for decision-making. Ideally his consent should be consistent throughout for treatment to proceed. Some of even the most severely depressed patients can pass all the tests described and be consistent in their consenting. When this occurs the resulting course is simple. When inconsistencies arise, either in the patient's presentation of his views or between doctor and patient in their decision about management, then the difficulties arise. The patient should expect a range of rights but the focus of attention in an issue such as this invariably seems to be on the 'right to refuse treatment', often, and not always correctly, equated with the right to integrity of body and mind or, in Professor Sherlock's terms, autonomy. A right which is at least as important is the right to health, which is likely to be much closer to the position of personal and bodily integrity than the pre-treatment state. Ironically this equates with being restored to a condition in which fully competent consent becomes possible.

One of the consequences of judging that an acceptable decision on the part of the depressed patient is always possible will be that in a few cases patients will receive treatment on the basis of a consent that was an insane response or mere blind compliance. For a few more, it will be that refusal, whether irrational or not, must be respected with, quite literally, potentially fatal results. Both Sherlock and Lesser are ready to overrule irrational decisions if the patient's life is in immediate

danger and Sherlock believes that it is more generally justifiable to relieve suffering. They concede that there might be abuses of this 'paternalism' but Sherlock sees it as the responsibility of the clinician to act in this way. The clinicians when polled tend to agree (10). Even so they concede that they would generally request a second opinion or some form of surrogate consent, for example from a relative, before proceeding with treatment. As with many fundamentally good ideas there have been pressures to over-extend the application of surrogate consent. It has been suggested that it should be obtained for all patients offered ECT, in other words that it be assumed none of them can give consent. Formal proposals for the reform of the Mental Health Act by a previous Government suggested that the decision about treatment with ECT should be made by a multidisciplinary committee. Early proposals by the Government which brought in the Mental Health (Amendment) Act were not dissimilar but following vigorous professional representations these were substantially modified to a more helpful position. Under the Act a second opinion must be sought from a doctor appointed by the Mental Health Act Commission before ECT can proceed for a detained patient who is incompetent or who refuses it. The present position with regard to informal (voluntary) patients will remain unchanged. Legally, ECT given against the wishes of such a patient would constitute an assault.

Surrogate consent, however, raises as many ethical dilemmas as it solves. At best it will delay treatment by days, perhaps even by weeks, if committees, or worse, courts make the decision. The American psychiatric literature (11) provides ample testimony of the tragic delays caused by the need to invoke a court decision. At worst, and this effect is not measurable, it may prevent patients from getting appropriate treatment at all, not because the committees or courts rule inadequately but because doctors will not be prepared to spend time and money on costly and lengthy procedures which if successful contribute to the assistance of only one patient and in any event deprive others of the resources that have been expended on this form of bureaucracy. Lesser rightly highlights the resources problem in a slightly different context. Another important problem to which surrogate consent gives rise is the very same problem it is supposed to redress, that of the threat to the patient's integrity. A major source of distress to many patients, is the supposed shame of having a psychiatric disorder and the intense fear that their very personal agonies will be exposed to others in their world. While in law patients have no absolute right of medical confidentiality, most patients and their doctors believe that this is a moral right and in practice the expectation that things revealed to the medical team will go no further is respected as far as possible. If the consent to treatment is to be decided by someone other than the patient, clearly that person will need to be informed in some detail of the patient's mental state and circumstances as well as the nature of the treatment. The patient might reasonably wish to withhold

consent to discussion of his case with relatives and still more to discussion with an unknown multidisciplinary team. If the depressed patient were willing to allow his illness to be discussed in a formal court session, it would probably be because the nature of his illness led him to believe that to be on trial for his wickedness was appropriate.

There is no single or simple solution to the dilemmas raised by the concept of competency to consent to treatment or to the particular question of whether the severely depressed patient is capable of consenting to ECT. However, psychiatrists in England and Wales have to act as if there is from September 1983. Most are keen to debate the issues, particularly with those such as Sherlock and Lesser who can focus understanding and planning on the medical anxiety most often raised by the rare cases in which there is conflict between the doctor's advice and the patient's choice. In relation to ECT for severe depression the essence of this anxiety is as follows: given that, firstly severe depression is an unpleasant and dangerous condition, secondly that ECT is in many cases the most effective form of treatment and in some the only effective form, and thirdly, that ECT is one of the safer and best studied treatments we have, can refusal of ECT for severe depression ever be a competent decision?

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