

Symposium 1:

Consent, competency and ECT: some critical suggestions

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Editor's note

Should the 'irrational' refusal to consent to ECT of a depressed patient who knows he is thought to be ill, knows that his doctor believes ECT will help him and knows that he is being asked to decide, be respected or overridden? The author of the first paper, an American bioethicist argues that the refusal should be overridden in the interests of fostering the autonomy of the patient by overcoming the impediment to that autonomy which major depression represents. A philosopher and a psychiatrist respond and an editorial discusses the issues.

Most of the conclusions reached by Drs Culver, Ferrell and Green in their discussion of special problems concerning informed consent for electroconvulsive therapy (ECT) in psychiatric medicine (1) are well taken and should be kept in mind by any serious clinician. However, in one subset of cases I believe that their conclusions are morally and clinically questionable. Furthermore, they seem to be at variance with the senior author's own previously published work on medical paternalism (2). I briefly discuss these matters here hoping to stimulate further discussion on this important issue.

Culver and his co-authors describe three sets of cases in which consent may be sought for ECT. First are those in which an individual is competent to decide this question for himself, even though he or she may be very depressed. In this case the authors decide, correctly in my judgment, that the wishes of the individual must be respected. Secondly, are those cases in which an individual is clearly incompetent to decide. Here the consent of a family member should be obtained for he or she will usually be in the best position to know what the patient would want or have wanted. For the purposes of these cases the authors determine competency very minimally to mean that the patient knows he is ill (9), knows that the physician believes this treatment will help him and knows that he is being called upon to decide this question.

These first two sets of cases are handled in un-

problematic fashion. It is the third set of cases in which the authors' discussion is seriously flawed. The subset of cases to which I refer are those that are classified by the authors as 'competently made irrational decisions' i.e. patients who completely irrationally refuse ECT. With reference to these cases the authors assert that a clinician will not err morally by respecting such choices even where continued suffering results. The only case in which they would consider overriding a patient's refusal of ECT is in the rare situation where death is likely without it, (for example, a depressed patient who refuses to eat).

This policy seems to me to be very dubious. What it means is that even in cases where the likelihood of therapeutic relief is high we should prefer, morally, continued suffering merely because a patient 'tells' us he wants it that way. If we accept the authors' view of the efficacy and low risks of ECT then the acceptability of this position seems to me to vanish (3). We are then permitting a demonstrably irrational choice to override all other clinical and moral considerations in favour of treatment that would, in all likelihood, relieve a condition of real human suffering. This is hardly a very attractive morality.

In reply it may be asserted that we are thereby preserving the very great good of the patient's autonomy by respecting his decision. This, however, is also a questionable claim. Surely a limited autonomy is being preserved by such a policy. But how much autonomy does the acutely depressed patient really have? A person with insomnia, anorexia, anhedonia, psychomotor retardation, feelings of helplessness and hopelessness, etc, is simply not in a position to be autonomous in any recognisably valuable sense. He cannot really choose what he wishes to do with his life. He cannot freely decide to go on a vacation, to go to work in the morning, to get a good night's sleep, or to engage in countless other activities that autonomous individuals engage in and the freedom for which we zealously protect. If we do value autonomy we ought to pursue it in its fullest possible form, not in the truncated, one-dimensional case of refusal of ECT. If autonomy is a good then I submit that the morally appropriate course of action is to foster the autonomy of patients by relieving to the best of our abilities the impediments to autonomy such as major depression (4).

Key words

Medical ethics; consent; autonomy; impaired autonomy; depression and consent; paternalism; competency.

Competency

Furthermore, it seems to me entirely inappropriate, in many cases, to consider these individuals competent in any useful sense of that term. To illustrate this point consider a case that is similar to one presented by Culver and his associates:

Mr B, a 50-year-old man came to the hospital with complaints from him and his wife that he had been depressed for several months. On admission he was markedly depressed with insomnia, weight loss (30lbs in three months), complaints of the hopelessness of his own life and his powerlessness to change it. He had even had suicidal ideation but had never acted on these thoughts and did not appear inclined to do so.

Because of severe urinary inhibition on even small doses of tricyclics, ECT was suggested as the treatment of choice. The patient, however, refused: 'Nobody is going to put electricity in my brain'. Even after repeated attempts to dissuade him he maintained an essentially irrational and compelling fear of ECT.

In contrast to Dr Culver's extremely limited concept of competency, it seems to me entirely unreasonable to consider this patient as competent to give informed consent regarding ECT. Informed consent involves two central elements, without which one has no consent: 1) an informational component, and 2) a voluntariness component (5). The former is the only one given attention by the authors. It requires that the patient have sufficient information in order to render a 'knowing' consent to therapy or a refusal to consent: i.e. Does the patient 'know what he is doing?'. Typically we would wish to ensure that the patient knows the nature, effects and risks of a proposed treatment. The second component, voluntariness, refers to a patient's being able to render an uncoerced consent. Is he, in other words, free to consent? For example, a prisoner who is offered a pardon in exchange for participation in a potentially lethal experiment is not really free to make a choice on this question and few would suggest that such a 'consent' be honoured.

But what is the difference between this situation and that of the patient above, who has what amounts to a phobia in standard psychiatric terminology i.e. 'a persistent and irrational fear of a specific object, activity or situation that results in a compelling desire to avoid the dreaded object' (6). Such a patient cannot choose to undertake the activity in question; generally he cannot even enter into a process of reasoning about it, at least not in any open-minded fashion. He is no more free to decide *vis a vis* the dreaded object than he would be were he faced with severe hardship for failure to comply with a command to consent.

It seems to me, therefore, that patients who maintain a continuous irrational fear of ECT ought, in many cases, to be considered incompetent to render informed consent since one of the major components of consent is lacking. Without the capacity for a reasonably uncoerced choice there can be no true consent,

only mere acquiescence in the dictates of another or in the sub-rational drives of one's own psyche (7). I suggest that we would be just as morally remiss in treating a patient as capable of consent when he is not as vice versa.

Paternalism

My final point is that I find Dr Culver's actual practice on this matter to be at variance with his previously published work on medical paternalism. In those papers it was held that paternalistic intrusions on the liberty of another human being were justified only if three conditions were met: 1) one person believed that his paternalistic actions would be for the benefit of another, 2) 'The evils that would be prevented to the person are so much greater than the evils, if any, that would be caused by the rule (against paternalism) that it would be irrational for B not to want to have the rule violated with regard to himself', and 3) one must be able 'universally [to] allow the violation of the rule in these circumstances' (8).

For these purposes the crucial criterion is the second. In explaining it the authors have recourse to the concept of a 'rational ranking' of value preferences. One may not impose one's own rational ranking on the equally plausible rankings of others. Only when it is completely irrational to choose one course over another may we interfere with the actions of one who makes such a choice.

If this is accepted then there is no reason not to act paternalistically in such cases as that above, or those presented by Culver and his associates. For a patient in effect to 'choose' the prolonged suffering of a major affective disorder over accepted and effective therapy is surely not rational, not even minimally so. Furthermore, when this choice is dictated not by any previously held religious or quasi-religious beliefs but by a persistent and compelling fear its distance from any conceivable 'rational ranking' ought to be acknowledged. The alternative would be to make the meaning of rational ranking purely subjective. At this point however, its usefulness for the purposes of sorting out justified and unjustified paternalism in the medical context would vanish.

Possible abuse

The position I am maintaining certainly opens up the possibility of abuse. But while real, this may be an exaggerated fear. There are clear indications for the use of ECT as a standard mode of treatment, i.e. conditions for which little doubt exists that it is an effective therapy with few proven risks. In such cases, and only in such cases, it is reasonable to suggest that a patient's decision against ECT may be completely irrational and not simply based on an idiosyncratic view of how he would prefer to live his life. In such cases the decision of the patient need not be respected. However, where the therapeutic possibilities of ECT diminish so too does the utter irrationality of a patient's decision to refuse it, and his refusal must be respected accordingly.

Thus there are clear criteria for the use of ECT over the objections of a patient. The existence of such criteria means that while there might be abuses, as there might be with any therapy, such abuses would not be the result of the policy I am proposing. In this sense I think that the view I am suggesting will meet Culver's third condition for justified paternalism, namely, a willingness to adopt a practice as a general policy. We can clearly specify those conditions in which a refusal of ECT is completely irrational and given the alternative of continued suffering and possible confinement I would not hesitate to adopt as a general policy the practice defended here.

Conclusion

I conclude, therefore, that where the likelihood of therapeutic benefit is high and the alternatives non-existent or very doubtful a physician may have a moral obligation to use ECT, even without the consent of the patient. In such a situation a patient's preferring prolonged suffering to reasonable treatment may be so much the product of a compelling fear that it is not proper to speak of the patient as competent to render informed consent. In such cases paternalism is justified by the complete 'irrationality' of the 'decision' of the patient which suggests his incompetence and leads to the responsibility of the clinician to act for his welfare when he cannot.

References and notes

- (1) Culver C M, Ferrell R B, Green R M. ECT and special problems of informed consent. *American journal of psychiatry* 1980; 137: 586–591.
- (2) Gert B, Culver C. Paternalistic behavior. *Philosophy and public affairs* 1976; 6: 45–57; Gert B, Culver C. The justification of paternalism. *Ethics* 1979; 89: 199–200.
- (3) They cite Fink M. Myths of shock therapy. *American journal of psychiatry* 1977; 134: 991–996 and Frankel F. Current perspectives on ECT. *American journal of psychiatry* 1977; 134: 1014–1019.
- (4) Dworkin G. Autonomy and behavior control. *Hastings Center report* 1976; 6, 1: 23–28.
- (5) Freedman B. A moral theory of informed consent. *Hastings Center report* 1975; 5, 4: 32–39.
- (6) American Psychiatric Association. *Diagnostic and statistical manual* 1979; 3rd ed.
- (7) I would also call attention to the fact that indecisiveness is often part of the clinical picture of major depression. In that sense the individual is unable to offer true consent as a result of the pathological process itself, just as much as if he were rendered unconscious by a brain lesion. It is not true to say in such cases that the patient merely does not want to consent; his ability to 'want', to desire anything, has been severely impaired.
- (8) See reference (2) Gert B, Culver C. The justification of paternalism.
- (9) Strictly speaking Culver and his co-authors require that the patient knows that the doctor believes him to be ill – not that the patient knows he is ill. Both commentators discuss this distinction. Editor.