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Abstract

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MEDICAL, ETHICAL AND LEGAL CONSIDERATIONS OF ELECTROCONVULSIVE THERAPY

BY R. PETER MACDONALD*

How can it be determined whether a patient has consented to electroconvulsive therapy? Under what circumstances should therapy be given against a patient's will? Peter MacDonald addresses these questions from a medical, ethical and legal perspective.

The mind is its own place, and in itself
Can make a heaven of hell, and a hell of heaven.¹

I. INTRODUCTION

Mental illness, by definition, postulates an infirmity of the mind. However, the objective determination of this infirmity can never be certain if one believes that individual perception reflects a subjective "amalgam of reality and delusion."² This inherent uncertainty, although presupposed in every medical diagnosis, makes the validity of a given psychiatric diagnosis difficult to assess; not only is there "no general agreement on the irreducible minimum of symptoms required for each diagnosis, . . . [but] the symptoms are often so vague and subjective that it is impossible to measure the correspondence between an ephemeral symptom and the diagnostic category."³

It is with this observation in mind that one must address the medical, legal and ethical issues of intrusive psychiatric treatment. Electroconvulsive therapy (or ECT) is arguably of this description⁴ and has recently inspired much public scrutiny. The notion of passing electrical current through the brain to induce convulsions is alarming and

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* Member of the 1985 graduating class of Osgoode Hall Law School. The author wishes to thank Professor R. J. Gray of Osgoode Hall Law School and Dr. J. D. Carlisle for their helpful suggestions regarding an earlier draft of this paper.

¹ Milton, *John Milton: Complete Poems and Major Prose* (1980).

² Korenberg & Korenberg, *Psychiatry: The Lost Horizon: The Erosion of Human Rights* (1981), 5 *Legal Med. Q.* 79 at 79.

³ *Id.* at 84.

⁴ Its intrusive nature is self-evident with respect to involuntary treatment. The suspect capacity of a psychiatric patient to consent to such treatment in an informed manner may also render voluntary ECT intrusive. See *infra*, text "The Right to Refuse Treatment".

"evokes Frankenstein images of torture and coercion."⁵ However, available medical literature⁶ suggests that ECT fosters minimal risk and its effectiveness is comparable to, or better than, many major surgical procedures. Despite substantial medical consensus⁷ regarding the clinical indications and effects of ECT, the neurophysiological and biochemical mechanisms of the treatment remain essentially unexplained. In fact, patrons of ECT are indecisive over which method of treatment to employ.⁸

Because the symptoms associated with acute psychotic disorders are difficult to appreciate within an objective framework, the potential abuse of ECT is a justified concern. This concern prevails despite the precarious ethical considerations attending the "appropriate" use of ECT. These ethical questions arise from a patient's desire to receive treatment which conflicts with a physician's reluctance to administer ECT; or from a patient's refusal to ECT despite a physician's advice to the contrary. Finally, one must assess the proposition that the "psychiatrist knows best"⁹ in light of the patient's rights to autonomy, inviolability and privacy.¹⁰

Thorough examination of these ethical problems requires consideration of certain underlying legal concepts including: the notions of civil commitment; incompetency; guardianship; and informed consent.

Provincial legislation plays an important role in the regulation of psychiatric treatment. Some psychiatrists¹¹ believe that the Ontario *Mental Health Act* strips mental patients of their rights as individuals. This concern raises several ancillary questions. Should such legislation provide definitive guidelines to be followed by psychiatrists in informing their patients? Should ECT be legislatively supported in the case of non-consenting involuntary patients? Finally, should ECT be acknowledged as a form of restraint (as opposed to treatment) within the enabling legislative provisions?

Although "that which is legal may not be ethical and that which is ethical is not necessarily codified into law,"¹² moral attitudes often underlie legislative and judicial norms, including the laws governing med-

⁵ O'Connell, *A Review of the Use of Electroconvulsive Therapy* (1982), 33 *Hosp. & Comm. Psych.* 469 at 473.

⁶ For example, see *id.* at 473.

⁷ See, text accompanying *infra* notes 14-23, 38-46.

⁸ Bailey, *ECT or not ECT: That is the Question* (1983), 79 *Nursing Times* 12 at 12.

⁹ Salzman, *ECT and Ethical Psychiatry* (1977), 134 *Amer. J. Psych.* 1006 at 1007.

¹⁰ Can., *Consent to Medical Care* (1980) at 5.

¹¹ *Supra* note 2, at 85.

¹² Nulman, *Morality, Law and ECT* (1983), 13 *The Hastings Center Report* 44 at 44.

ical decision-making. Hence, a conscientious inquiry into the therapeutic use of ECT must not divorce the various clinical, ethical and legal considerations involved; it is only for the sake of convenience that this paper addresses the issues categorically.

II. THE MEDICAL PERSPECTIVE

ECT was introduced in Europe and North America in the late 1930s. It was quickly endorsed "as it filled a therapeutic void for the treatment of major psychoses."¹³ Unfortunately, its early use was marred by error experimentation, and "moral considerations became secondary to the quest for technical perfection."¹⁴ As with many new medical therapies, the popularity of ECT fluctuated "from extremes of enthusiasm and overuse to skepticism and restricted use."¹⁵ The therapeutic utility of the treatment was evident, but its clinical application was often psychologically and physically traumatic. With the advent of anaesthesia and muscle relaxants, however, the traumatic effects of ECT became less substantial.

The use of ECT decreased dramatically in the late 1950s and early 1960s due to advances in psychopharmacology. Antidepressants, antipsychotics and lithium became increasingly effective in the treatment, and prevention, of many types of depressions, acute schizophrenias and manic illnesses.

Although the idea of an induced epileptic convulsion by ECT has triggered negative social response,¹⁶ psychiatrists now believe that "patients who do not respond to drug [therapy] remain inadequately treated in the absence of alternative ECT treatment."¹⁷

A. *Current Use of ECT*

In 1976, a comprehensive survey¹⁸ of metropolitan New York psychiatric institutions indicates that ECT was used in eighty-three per cent of the thirty-six hospitals surveyed. Practices and procedures were "remarkably uniform," including staff training programmes which were minimal and unplanned. One exception to the uniformity, how-

¹³ *Supra* note 5, at 469.

¹⁴ *Supra* note 8, at 12.

¹⁵ *Supra* note 5, at 469.

¹⁶ This response is due, in part, to recent distorted press and media presentations such as the film "One Flew Over the Cuckoo's Nest."

¹⁷ *Supra* note 5, at 469.

¹⁸ Asnis, Fink & Saferstein, *ECT in Metropolitan New York: A Survey in Practice* (1978), 135 *Amer. J. Psych.* 479.

ever, was that less than seventeen per cent of the units used "unilateral ECT" (a clinical procedure whereby electrodes are placed on only one of the cerebral hemispheres).

Although only three to five per cent of the psychiatric inpatients in the United States received ECT during the calendar year of 1978,¹⁹ an American Psychiatric Association survey²⁰ conducted in the same year revealed that eighty-three per cent of the 3,000 psychiatrists interviewed felt that a well-equipped psychiatric institution should be prepared to provide ECT. In that same survey, seventy-two per cent of the psychiatrists questioned believed that there were many patients for whom ECT, either as full or partial treatment, was the safest, least expensive and most effective form of treatment. However, only twenty-two percent of those surveyed had actually administered ECT. In addition, seven per cent considered ECT to be an "obsolete" form of treatment, and sixteen per cent felt that it should be "discontinued or at least curtailed."²¹

One psychiatrist attributed the variation in actual patterns of ECT use to non-scientific factors.²² O'Connell proposed that the administration of ECT had become suppressed as a result of "theoretical biases passed on during training, political and legal influences, differential malpractice rates, and misconceptions about risks and side-effects."²³ O'Connell also suggested that increased use of ECT may reflect the fact ECT is one of the few technical procedures available in psychiatry. As such, its administration can contribute generously to the income of an attending physician.

B. *Clinical Indications for ECT*

ECT is widely used for relief from, and treatment of, certain acute affective psychoses. Severe depression is a primary indication for ECT. In treating serious depressive disorders, ECT seems to be at least as effective as antidepressant medications. In a recent study conducted at the American National Institute of Mental Health, psychiatrists administered ECT to a group of seriously depressed patients with life-threatening symptoms such as "severe and persistent suicidal preoccupa-

¹⁹ Weiner, *The Psychiatric Use of Electrically Induced Seizures* (1979), 136 *Amer. J. Psych.* 1507.

²⁰ *Amer. Psych. Assoc., Electroconvulsive Therapy* (1978), Task Force Report 14.

²¹ *Id.*

²² *Supra* note 5, at 470.

²³ *Id.*

pation or cessation of food intake with dehydration.”²⁴ These patients had not previously responded to carefully monitored trials of antidepressant medications. Eight of the nine patients studied over an eight year period showed relatively dramatic and rapid improvement following ECT. Only one subject, a “cycling manic-depressive who continued to cycle despite numerous forms of therapy,” relapsed shortly after ECT treatment. All others were free from depression for at least one year following treatment.

Another advantage of employing ECT to treat severely depressed patients is its faster onset over antidepressants. This consideration is particularly significant in the treatment of suicidal or markedly agitated depressions. It is important to note that, presently, researchers are generally better able to predict therapeutic serum levels for antidepressants than amounts of shock to administer to patients. However, one can assume that with the continued use of ECT, doctors will become equally familiar with administering ECT as they are with prescribing doses of antidepressants.

ECT is also used as an initial treatment for delusional depressive disorders. Glassman, Kantor and Shostak compared the efficacy of tricyclic antidepressants with ECT in the treatment of delusional depressive patients and recommended ECT as the “therapy of choice” for these patients.²⁵ Because delusional patients, unlike non-delusional patients, do not respond to tricyclics as frequently as they do to ECT, “to treat delusional depressive patients with tricyclic antidepressants may well prolong their suffering, lengthen the period at risk for suicide, and expose them unnecessarily to the toxicity of tricyclic drugs.”²⁶

ECT is also effective in treating acute manic disorders. However, ECT is not employed frequently to treat manic disorders because of the availability of appropriate pharmacological therapy (including lithium and antipsychotic medication). Nevertheless, O’Connell suggests that if the severity of the affective state requires immediate treatment, ECT should be an alternative to medication.²⁷

For schizophrenic patients, ECT appears to be less effective than a combination of antipsychotic medication and psychotherapy.²⁸ Psychotherapy advocates claim that psychotherapeutic remedies are prefera-

²⁴ Paul *et al.*, *Use of ECT with Treatment — Resistant Depressed Patients at the National Institute of Mental Health* (1981), 138 *Amer. J. Psych.* 486.

²⁵ Glassman, Kantor & Shostak, *Depression, Delusions and Drug Response* (1975), 132 *Amer. J. Psych.* 716.

²⁶ *Id.* at 718.

²⁷ *Supra* note 5, at 470.

²⁸ Squire, *ECT and Memory Loss* (1977), 134 *Amer. J. Psych.* 997.

ble to ECT and independent drug therapies since these may only suppress the cause of illness and not prevent its ultimate recurrence. It is better to confront and eradicate the personality characteristics that give rise to the patient's disabling symptoms.²⁹ Although an appropriate combination of psychotherapy and antipsychotics is likely to prevent the recurrence of a schizophrenic disorder, such treatment is time-consuming and difficult to monitor successfully. Certain schizophrenic conditions such as severe catatonia (characterized by mental stupor, muscular rigidity and alternate seizures of panic and hallucination) or unsuccessful responses to a combination of medication and psychotherapy may render ECT a necessary alternative for schizophrenic patients under critical clinical conditions.

Paradoxically, some of the most severely depressed patients (as evidence by life-threatening symptoms and resistance to conventional antidepressant treatment) have shown the most dramatic response to ECT.³⁰ For depression and acutely suicidal psychoses, ECT is clearly indicated as primary treatment. For other psychiatric disorders (including most schizophrenic conditions), where the efficiency of ECT is poorly defined due to complex outcome criteria and limited studies, ECT may be less effective than other therapies. However, in treating any unresolved illness of this kind, O'Connell suggests that "the risk of chronicity outweighs any risk of side-effects induced by ECT."³¹

C. *Contraindications*

Aside from obvious conditions such as intracranial lesions, there appear to be no absolute contraindications for ECT. Generally, a prudent physician should not administer ECT until the patient's "acute medical conditions" (including recent myocardial infarct, aneurysms and late stages of pregnancy) have stabilized.³² "Severe osteoporosis or a significant history of major cardiac arrhythmias may [also] render a patient unsuitable for ECT treatment."³³

Each clinical decision must ultimately encompass a careful assessment of the given risk-to-reward ratio. "When money, medical insurance, or time is limited, the physician and patient may opt for the most

²⁹ Fink, *Myths of Shock Therapy* (1977), 134 *Amer. J. Psych.* 991.

³⁰ *Supra* note 24, at 488.

³¹ *Supra* note 5, at 470.

³² *Id.* at 471.

³³ Beresford, *Legal Issues Relating to Electroconvulsive Therapy* (1971), 25 *Arch. Gen. Psych.* 100 at 100.

effective treatment in the least amount of time."³⁴ Appropriate medical care, therefore, cannot be accurately determined until the precise circumstantial boundaries of each case are evident and carefully considered.

D. *Mechanism of Action*

Numerous neurophysiological theories have been adduced in an attempt to explain the operative mechanism of ECT. In the early days, some scientists believed that "convulsions altered the level of arousal in the central nervous system, either increasing the level (as desired in depression), or decreasing it (as desired in mania)."³⁵ Another theory was that ECT produced the desired level of arousal by mysteriously altering "the balance of the 'mood-regulating' system."³⁶

Modern theorists argue that ECT "shocks the recipient into altered behaviour in much the same way as patients were shocked by sudden immersion into cold baths."³⁷ Goffman suggests that the amount of "personalized care and treatment" received by a patient is responsible for the efficacy of ECT.³⁸ Another view is that the sudden loss of consciousness is the main factor. In short, today's psychiatric community appears to be no closer to a precise understanding of the treatment's operative mechanism than it was forty years ago.

Several incidental advances have been substantiated in recent years. It is presently known that "cerebral seizure" is either the therapeutic event itself (its length being related to clinical efficacy) or a direct reflection of it, and that neither shock nor convulsion is central to the therapeutic process.³⁹ Today, ECT is administered to patients who are asleep following receipt of intravenous barbituate. The patient experiences neither fear, anxiety nor pain during treatment. Because ECT is effectively administered in conjunction with muscle relaxants resulting in complete muscle paralysis, it is believed that the motor and autonomic aspects of convulsion contribute minimally to the therapy. Although cerebral seizure may be produced chemically, electric induction seems to be the simplest method.

The amnesic effect of ECT is largely related to the shock aspect of the treatment (as a direct result of the electric induction), rather than

³⁴ *Supra* note 5, at 470.

³⁵ *Supra* note 8, at 12.

³⁶ *Id.*

³⁷ *Id.* at 14.

³⁸ Goffman, *Asylums* (1961).

³⁹ *Supra* note 5, at 471.

the seizure or accompanying biochemical events.⁴⁰ This phenomenon is evidenced by the fact that some depressed patients improve after several seizures without any indication of memory loss. Moreover, upon the administration of "unilateral ECT," the therapeutic response is sustained but memory loss is reduced.⁴¹

Fink points out the superficial similarities between current neurophysiological understanding of ECT and that of psychotropic drugs in the late 1950s and early 1960s.⁴² At that time, scientists found distinctions amongst antipsychotic drugs related to clinical diagnosis and psychopathological response rather than the chemical structures of various agents. Since ECT is one of the most effective treatments for depression, a detailed understanding of its active mechanism would contribute tremendously to the knowledge of affective disorders; however, "if lack of understanding of the mode of action was sufficient basis for withdrawal of medical therapy, we would have to discard not only ECT but all therapies used in psychiatry, including psychotherapy, drug therapies and behaviour therapies."⁴³

E. *Clinical Procedure*

An effective dosage of ECT usually requires about two hundred and ten "seizure-seconds" of treatment. Clinical application is generally administered over seven sessions at a rate of three sessions per week.⁴⁴ The patient is usually anaesthetized with a short acting barbituate and oxygenated until spontaneous respiration returns. A "mouth gag" or "rubber-bite block" is used to prevent damage from jaw muscle contracture during treatment.

For patients having rapidly recurring depressions that cannot be treated pharmacologically, maintenance ECT is generally entertained. In such cases, one session per month may be prophylactic.

Prior to the practice of administering adequate muscle relaxants in conjunction with the shock treatment, broken teeth, compression spinal fractures and dislocations were common results of treatment. Today, if a patient's medical history or physical examination indicates possible complications, the appropriate thoracic spinal x-rays are considered prior to treatment and acted upon accordingly.

Effective ECT requires an electrical stimulus "sufficient to over-

⁴⁰ *Supra* note 29, at 992.

⁴¹ See text accompanying *infra* notes 46 & 48.

⁴² *Supra* note 29, at 994.

⁴³ *Id.*

⁴⁴ *Supra* note 5, at 471.

come resistance of the skin, skull and dura, and to induce [cerebral seizure]."⁴⁵ Excessive stimulus, however, may increase memory loss and postictal confusion without any therapeutic advantage. Consequently, the course and duration of seizure must be carefully monitored; references to EEG and blood-pressure cuff indications (where the motor component of seizure can be seen in the non-paralyzed extremity because muscle relaxant is prevented from reaching the periphery) are helpful in this regard.

Although "positive response to ECT can be expected among eighty-five per cent to ninety-five per cent of severely depressed patients,"⁴⁶ it is common to give antidepressants before initiating treatment in an attempt to circumvent possible amnesic effects and avoid the need for general anaesthetic. Several studies have also suggested that placing the electrodes on the non-dominant hemisphere (right unilateral ECT) triggers relatively optimal amnesic complications.⁴⁷ All other things being equal, bilateral ECT generally produces more extensive anterograde memory loss than right unilateral ECT, and greater retrograde amnesia than left unilateral ECT (involving stimulation of the dominant hemisphere). Presuming that a patient's anterograde memory function is most vital to his capacity for new learning, right unilateral ECT seems to be the preferable method of treatment. However, these considerations must be viewed in the light of the patient's particular needs in order to provide a basis for clinical judgment.

Notwithstanding significant academic support for a preferred clinical procedure, methods of administration vary substantially in practice.⁴⁸ Many experienced physicians believe that unilateral ECT is less effective than bilateral ECT and requires prolonged treatment as a result.⁴⁹ A more unified clinical methodology based on comprehensive research would undoubtedly benefit physicians, patients and all others concerned. Surely, one must entertain the experience of these clinicians and weigh the health costs of prolonged unilateral treatment against the problem of increased memory loss in considering the appropriate clinical procedure.

F. *Complication and Side-Effects*

Many patients experience headaches, confusion and anxiety imme-

⁴⁵ *Id.* at 472.

⁴⁶ *Id.* at 470.

⁴⁷ *Supra* note 28, at 1000.

⁴⁸ *Supra* note 8, at 12.

⁴⁹ *Supra* note 5, at 471.

diately after a session of ECT. Cardiac arrhythmia is the most significant complication among elderly patients and those with cardiac disease. Cardiac problems can be reduced by: appropriate medical evaluation prior to treatment; adequate ventilation and oxygenation during the procedure; and the avoidance of anticholinergic medication in certain clinical circumstances.⁵⁰

The mortality rate of shock therapy has been compared to that of dental surgery performed with anaesthesia.⁵¹ However, Fink reports an incidence of death in ECT that is significantly inconsistent with this comparison.⁵² O'Connell's figures support those of Hesche and Roeder.⁵³ In reviewing this matter, it would be hasty to conclusively ascribe these statistics to the treatment of ECT itself, as opposed to the general vulnerability of the treated population. Moreover, "the agitation, poor sleep and poor nutrition that accompany depression may also contribute to morbidity and mortality."⁵⁴ To view the mortality associated with ECT in the proper perspective, one must remember that depressed patients treated with ECT show a significantly lower mortality rate than do those with untreated depression.⁵⁵

Memory loss and the possibility of brain damage appear to be the most controversial side-effects of ECT. Both anterograde and retrograde amnesia are common side-effects⁵⁶ that increase with the number of treatments. Although amnesia is known to be reversible, some patients complain of persistent memory loss. One patient, who received over one hundred treatments in a period of five weeks, now has neither "recollection of the birth of her first five children, nor of the first twenty-five years of her life."⁵⁷ She has recently decided to have a sixth child so that she can "rediscover motherhood."⁵⁸

Recent studies indicate that no neuropathological evidence of

⁵⁰ *Id.*

⁵¹ Hesche, *Electroconvulsive Therapy in Denmark* (1976), 128 *Brit. J. Psych.* 241. The incidence of death in dental surgery with anaesthesia is approximately one death per every 100,000 procedures.

⁵² *Supra* note 29, at 993. Here, the mortality rate reportedly varies from 0.0% to 0.8% of the patients treated with ECT.

⁵³ *Supra* note 5, at 471.

⁵⁴ *Id.*

⁵⁵ Avery & Winokur, *Mortality in Depressed Patients Treated with Electroconvulsive Therapy and Antidepressants* (1976), 33 *Arch. Gen. Psych.* 1029.

⁵⁶ The degree and occurrence of specific types of amnesic effect seem to be strongly correlated to clinical procedure. See text accompanying *supra* note 46.

⁵⁷ *The Globe and Mail* (Toronto), January 20, 1984 at N-4.

⁵⁸ *Id.*

brain damage secondary to ECT has been shown,⁵⁹ and that "the bulk of evidence fails to reveal more than the slightest objective indication of lasting cerebral dysfunction."⁶⁰ Others believe, however, that "ECT is a method of producing amnesia by selectively damaging the temporal lobes and structures within them."⁶¹ If one defines brain damage by pathological study, scientific confirmation of ECT-oriented brain damage is tempered by the time-lapse between treatment and death. Because there is no truly objective measurement of cognitive function, one cannot discard the possibility of "subclinical memory impairment"⁶² as a further cause of statistical ambiguity. In light of these factors, the current inquiry into ECT associated brain damage seems to be relatively unsophisticated.

Generally speaking, the medical foreground of ECT highlights clinical benefits in the treatment of certain illnesses, as well as the intrusive and possibly hazardous character of that treatment. With so many contradictory and confusing theories and techniques in existence, ECT must remain open to debate, argument and mistrust. However, the consequential risks of not treating severely depressed patients in need of ECT are very real; there is a ten per cent chance that they will die of suicide and a greatly increased risk that they will die from "superficially unrelated conditions such as a heart disease."⁶³ By abandoning such patients to their fate and administering time as their only therapy, the untreated individual who does not recover quickly must endure suffering and a despondent world of mental infirmity.

III. AN ETHICAL INQUIRY WITHIN A LEGAL FRAMEWORK

John Stuart Mill, the nineteenth-century British philosopher, captured the unconstrained essence of an individual's right to decide his own destiny:

Consideration to aid his judgment, exhortations to strengthen his will, may be offered to him, even obtruded on him by others; but he, himself is the final judge. All errors which he is likely to commit against advice and warning are far outweighed by the evil of allowing others to constrain him to what they deem his

⁵⁹ Freeman & Kendell, *ECT I: Patient's Experiences and Attitudes* (1980), 137 Brit. J. Psych. 8.

⁶⁰ Taylor, *Consent, Competency and ECT: A Psychiatrist's View* (1983), 9 J. Med. Ethics 146 at 147.

⁶¹ Friedburg, *Shock Treatment, Brain Damage and Memory Loss: A Neurological Perspective* (1977), 134 Amer. J. Psych. 1010 at 1010.

⁶² *Supra* note 24, at 488.

⁶³ *Supra* note 60, at 147.

good . . . But neither one person, nor any number of persons, is warranted in saying to another human creature of ripe years, that he shall not do with his life for his own benefit what he chooses to do with it. He is the person most interested in his own well-being: the interest which any other person, except in cases of strong personal attachment, can have in it, is trifling . . .⁶⁴

Mill's philosophy must be put in the context of psychiatric care. Mental patients' abilities to make rational decisions regarding their treatments and, hence, their personal well-being, may be seriously compromised by the nature of the illness for which treatment is indicated. In particular, the administration of ECT to an involuntarily institutionalized patient without the consent of that patient is ethically delicate and complex.

On the one hand, one must consider the Hippocratic Oath which demands that "any regimen adopted by a physician shall be for the benefit of those who consult him."⁶⁵ On the other hand, one must be aware of the patient's fundamental rights to self-determination and privacy, and the question as to whether a physician's authority to violate these rights should be prescribed or denied under the appropriate legislation.

Patients' right to refuse ECT may be dampened by special considerations of competency and informed consent; their right to receive treatment may be complicated depending upon their status as a voluntary or involuntary patient. A comprehensive discussion of these issues must entail appropriate reference to various common law principles, current legislation and possible statutory amendment.

A. *The Right to Receive Treatment*

The question of whether a physician has the ethical right to withhold an effective treatment, such as ECT, may be considered within a bipolar framework: at one pole, one may take into account a voluntarily admitted patient requesting the use of ECT over circumstantially appropriate drug therapy; at the other pole, one may acknowledge an involuntarily confined patient consenting to and in desperate clinical need of ECT.

The ethics of withholding ECT are particularly significant for a patient who has previously not responded to other forms of therapy, or who, because of certain clinical contraindications, cannot safely consume therapeutic doses of available antidepressant medication. In the

⁶⁴ Cohen, *The Philosophy of John Stuart Mill* (1961) at 488.

⁶⁵ Frankel, *Current Perspectives on ECT: A Discussion* (1977), 134 *Amer. J. Psych.* 1014 at 1018.

case of a voluntary patient preferring ECT over alternative treatment, the physician's decision may be slightly less precarious. If, for example, the clinical history of the particular patient reveals rapid relief and no memory impairment with ECT, the accompanying ethical dilemma may merely reflect the physician's personal and non-clinical views on the subject. In this instance, the patient might seek the services of a more accommodating physician, and render the ethical problem effectively evasible.

One physician suggests that

if [one] accept[s] the available data that ECT is useful treatment for certain forms of affective illness and that it is often less hazardous than doing nothing or using antidepressant drugs, psychotherapy or long-term hospitalization, it would seem an ethical necessity to offer ECT to a consenting voluntary patient.⁶⁶

This may be a reasonable suggestion within the narrow context of pure medical ethics.

A more pragmatic inquiry must undoubtedly encompass certain social and economic considerations. In particular, the administration of ongoing "maintenance ECT"⁶⁷ where results are temporary and relatively unsuccessful may not effect the most efficient allocation of limited resources. Hospital beds, physicians, equipment and funding are relatively scarce resources and must be utilized in such a way that optimum medical care can be apportioned appropriately among the vast number of patients in need. Consequently, a voluntarily admitted mental patient receiving relatively non-productive "maintenance ECT" on a regular basis might indirectly deny another patient of such treatment; if one patient is tolerant of drug therapy and the other is not, "preferred" treatment (on the part of the drug-tolerant patient) acquires a circumstantially trivial significance.

The right to receive treatment is most often associated with the opposite extreme of the bipolar inquiry. Under sub-section 1(c) of the Ontario *Mental Health Act*,⁶⁸ an "involuntary patient" is defined as "a person who is detained by a psychiatric facility under a certificate of involuntary admission or a certificate of renewal." Sub-section 14(5) of the Act prescribes the conditions precedent to the administration of a certificate of involuntary admission or a certificate of renewal: the attending physician must be of the opinion

that the patient is suffering from mental disorder of a nature or quality that likely will result in . . . serious bodily harm to the patient, . . . serious bodily

⁶⁶ *Supra* note 9, at 50.

⁶⁷ See *supra*. text "Clinical Procedure".

⁶⁸ R.S.O. 1980, c. 262.

harm to another person, or . . . imminent and serious physical impairment of the patient, unless the patient remains in the custody of the psychiatric facility . . .

Sub-section 14(1)(a) augments sub-section 14(5) by providing that the attending physician

shall release the [patient] from the psychiatric facility if [he or she] is of the opinion that the patient is not in need of the treatment provided by that psychiatric facility.

By implication, then, it would appear that a patient cannot be involuntarily detained at a given psychiatric institution unless that institution can offer the appropriate medical treatment to that patient.⁶⁹ Because the patient's release from involuntary hospitalization may result in serious bodily harm to the patient and to others, the administration of ECT where a consenting involuntary patient is in resolved clinical need of such treatment seems virtually unavoidable; indeed, the physician's ethical right to withhold treatment under such circumstances becomes effectively insignificant.

In addition to the legislative condition of civil commitment, one must consider the prospective possibility of civil litigation as a result of the physician's failure to administer treatment. Beresford has suggested that "[i]nvoluntary patients who are not offered ECT for their psychotic depression may later contend that the hospital [or the attending physician] was negligent in omitting this medically indicated and highly effective treatment."⁷⁰

In short, the physician's ethical right to withhold clinically indicated ECT from a consenting involuntary patient seems substantially unjustified; a physician's decision to refuse the use of ECT on a voluntary patient requesting such treatment on the basis of personal preference may be ethically more palatable.

B. The Right to Refuse Treatment

The vast majority of patients do consent to the use of ECT when it is clinically recommended.⁷¹ At first glance, then, there may appear to be little reason to question the validity of such consent.⁷² However, the principle of consent goes further; it suggests the corollary right to re-

⁶⁹ Although this particular matter has not been addressed by the Canadian courts to date, the American courts have held that mental patients have the right to be released from involuntary hospitalization if they cannot be offered the appropriate psychiatric treatment. See *Wyatt v. Stickney*, 344 F. Supp. 387 (U.S.D.C. 1972).

⁷⁰ *Supra* note 33, at 102.

⁷¹ Culver, Ferrel & Green, *ECT and Special Problems of Informed Consent* (1980), 137 *Amer. J. Psych.* 586 at 590.

⁷² *Id.*

fuse medical therapy. Although it is this corollary right that has raised much controversy, a thorough review of the matter requires fundamental consideration of psychiatric patients' consent in the broadest sense.

Ultimately, the question is whether a severely depressed (or otherwise impaired) mental patient can validly consent to the administration of ECT; indeed, "whether anyone should be asked to consent to a treatment that some have held as disabling and beyond the range of rational choice."⁷³

A recent study paper for the Law Reform Commission of Canada illustrates consent as "a legal concept and a factual reality."⁷⁴ It is essential that the intrinsic uncertainties of psychiatric care be emphasized in the light of "factual reality." The patient's capacity to comprehend the medical treatment proposed; the degree of information imparted to him or her by the attending physician; and the questionable nature of the patient's "voluntary" response are pertinent factors to be considered in assessing a patient's refusal of ECT.

1. Special Problems of "Informed Consent"

Informed consent is of paramount significance to the legality of medical treatment and therapeutic intervention. Under the present law,⁷⁵ a physician must consider the patient's individual circumstances before applying standard medical procedures; must volunteer information regarding material risks attending the recommended treatment; and must answer all specific questions asked by the patient.⁷⁶ For practical purposes, a patient is entitled to any medical information reasonably consistent with the patient's ability to cope with that information and desire to have it.⁷⁷

Although it is clear that informed consent is an essential prerequisite to ECT, the amount of information necessary for a patient to make an informed decision is not clear. Two distinct dilemmas contribute to the ambiguity of informed consent. First, one must consider how much information can be fully appreciated by a patient with "disordered cognitive functioning."⁷⁸ Psychotically depressed patients, for example,

⁷³ *Id.* at 586. This was stated in an editorial introduction to the article.

⁷⁴ *Supra* note 10, at 1.

⁷⁵ *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.

⁷⁶ In *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, the Supreme Court of Canada held that a risk carrying serious consequences (such as paralysis or death) should be regarded as a material risk requiring disclosure, even if the occurrence of that risk is only a mere possibility.

⁷⁷ Harrison, *Informed Consent: The New Spectre in Litigation* (1984), 3 Ont. Med. 5 at 5.

⁷⁸ *Supra* note 9, at 1008.

may be incapable, to varying degrees, of comprehending what they are being told and, consequently, making the appropriate decision based on such information. Second, one must recognize the delicate task of ensuring that consent is "informed" without frightening the patient away. As Salzman points out,

[i]t is hard to imagine that any patient who has been fully informed of the [remote] possibility of permanent near-total memory loss would consent to such a procedure. If patients who might benefit from ECT are frightened away, have we done them a service?⁷⁹

Generally, American courts have had great difficulty in deciding how much information is helpful to a patient facing ECT. Decisions have ranged from no requisite informed consent to the requirement that a patient be informed of all reasonable and recognizable risks associated with the treatment.

Guidelines for determining the amount of information actually perceived and retained by the patient would be helpful in formulating a "test" for informed consent. Perhaps physicians should examine patients on their comprehension of the matter. If so, one might ask whether the capacity to regurgitate information would be sufficient or whether the patient should also be required to show the capacity to "formulate the issues and ask himself the relevant questions."⁸⁰ In light of the fact that the failure to recall information appears to be significantly associated with the severity of a patient's illness as well as various demographic factors (such as low educational levels),⁸¹ it would seem reasonable that requisite standards of comprehension be relatively independent of a patient's recall ability.

Taylor points out that only the expert is likely to enjoy fully informed consent:

the patient who first demands an expert, and then an honest answer to the question 'if you were in my position would you have this treatment' may come closest to making an informed decision.⁸²

Ultimately, one must recognize that information concerning medical risk can only be conveyed with reference to probabilities. Even if determinative criteria for informed consent were available, the particular skills, knowledge and biases of the attending physician would subjectively influence his or her diagnosis, communicative approach

⁷⁹ *Id.*

⁸⁰ *Supra* note 60, at 149.

⁸¹ Roth *et al.*, *Competency to Decide about Treatment or Research — An Overview of Some Empirical Data* (1982), 5 *Int'l. J. Law Psych.* 29.

⁸² *Supra* note 60, at 148.

and treatment methodology. If the psychiatrist conscientiously explains the rationale for ECT under the given clinical circumstances, the procedure involved and the material side-effects and complications associated with the treatment; allows ample time for questioning and consideration; and advises the patient (and family members, where appropriate) to obtain further medical consultation where doubts about the treatment arise, it would seem that diligent efforts were made to "adequately" inform the patient of recommended medical care.

2. Competency

Individual competence to consent to treatment raises two related questions: is the individual competent to decide on treatment; and who should determine whether such competence exists at the time the treatment decision is to be made?

In Ontario, there is no set standard upon which one may measure competence; institutionalization is not necessarily conclusive of either legal or factual incompetence.⁸³ At common law, an individual's general legal incompetence was traditionally assessed in relation to managing an estate.⁸⁴ Clearly, the capacity to direct one's estate may be factually independent of an individual's capacity to protect his or her person. It follows that the subjective evaluation of those providing medical care for a psychiatric patient should be the basis (apart from considerations of the estate) from which to determine the patient's factual competence in relation to treatment decisions. Because factual incompetence imputes legal incompetence within this limited context, one must further investigate the parameters of a physician's subjective evaluation.

A clinical definition of competency may be helpful. It has been suggested that

a patient should be regarded as competent to reject or accept medical treatment if he knows the doctor believes he is ill and in need of treatment, knows the doctor believes the treatment may help his illness, and knows he is expected to decide whether or not to have the treatment.⁸⁵

The rationale behind this position is that others should not make deci-

⁸³ S. 14(5) of the *Mental Health Act* provides that dangerousness to oneself or others may be criteria for involuntary admission to a mental hospital; this criteria does not, of itself, connote factual incompetence. In addition, s. 36(4) of the Act denies the presumption of legal incompetence by requiring a medical examination after admission on the basis of which a certificate of incompetence may be issued. Note that in California, the presumption against legal and factual incompetence has been legislated: see *California Penal Code* (Supp 1975), § 2672(b) & (c).

⁸⁴ *Supra* note 10, at 90.

⁸⁵ *Supra* note 71, at 587.

sions for a patient unless it is evident that the patient is unable to do so.

Many have challenged the narrow scope of this rationale. Although patients may "meet the cognitive standards of [the test] and manifest impeccable logical reasoning ability, because of their seriously distorted perception of the world, [they may] base much of their reasoning on false premises."⁸⁶ In short, the decision may be well reasoned but irrational. If the patient "knows" guns are being pointed at him, for example, it makes "good sense" for him to run away; similarly, if the patient perceives ECT as a "form of execution," it follows that the patient will avoid it.⁸⁷ Korenburg and Korenburg point out that "in order to claim irrationality, it is necessary to be rational; if one were truly irrational, it would be impossible for the individual to recognize his state."⁸⁸

A patient's choice of medical care is not necessarily unreasonable merely because it does not coincide with that of the attending physician. Patients may have detailed knowledge of their own particular circumstances that they are unable to articulate fully. In a sense, it may be irrational to trust the patient's "gut reaction" over expert advice, but expert advice is not infallible and does not conclusively warrant absolute trust.⁸⁹

Apart from the fundamental distinction between "reasonable" and "rational", some academics⁹⁰ criticise the above definition on the ground that "voluntariness" is an essential component of informed consent and must therefore be a part of the recommended cognitive criteria. Accordingly, one must take account of circumstantial realities. A patient who sits in a corner and says, "I really don't know what I should do" or "I have more important things to think about," and lapses into depressive ruminations, may display strict cognitive complacency, but suffers a "grossly impaired volition."⁹¹ Sherlock, a professor of theology, points out a correlation between the mental patient's impaired volition and the concept of phobia.⁹² He asserts that a patient

⁸⁶ Editorial, *Impaired Autonomy and Rejection of Treatment* (1983), 9 J. Med. Ethics 131 at 131.

⁸⁷ *Supra* note 60, at 149.

⁸⁸ *Supra* note 2, at 82.

⁸⁹ Lesser, *Consent, Competency and ECT: A Philosopher's Comment* (1983), 9 J. Med. Ethics 144.

⁹⁰ *Supra* note 86, at 132.

⁹¹ *Id.*

⁹² Sherlock, *Consent, Competency and ECT: Some Critical Suggestions* (1983), 9 J. of Med. Ethics 141 at 142. The American Psychiatric Association defines phobia as "a persistent and irrational fear of a specific object, activity or situation that results in a compelling desire to avoid

who maintains a fundamentally irrational and compelling fear of ECT, despite repeated efforts of dissuasion, cannot enter into an open-minded process of reasoning about the recommended treatment; "[such a patient] is no more free to decide vis-à-vis the dreaded object than he would be were he faced with severe hardship for failure to comply with a command to consent."⁹³ Some commentators⁹⁴ suggest, however, that it may be contentious to classify a patient's refusal of ECT as a "phobia" because a close-minded process of reasoning is not necessarily reflective of persistent and irrational fear.

In retrospect, a more comprehensive outline of factual incompetence is called for; perhaps, the inability to give a reason for one's decision (as distinct from refusing to give a reason, or giving an eccentric one) and the clinical presence of pathological indecisiveness or phobia resulting in impaired volition should be directly assessed in determining the competency of an ECT candidate. Without the capacity "for a reasonable 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."⁹⁵

On the question of who should ultimately determine a patient's legal capacity to make treatment decisions, most commentators prefer at least partial third-party intervention. One writer⁹⁶ firmly believes that any serious doubt about a patient's ability to understand the nature and complexities of the proposed treatment, whether the patient has been hospitalized voluntarily or involuntarily, should be decided by the courts. Although a third-party decision-maker, such as a judge, is more likely to ensure the patient's civil liberties than legal guardians, relatives, psychiatric committees or other physicians not on the hospital staff, the real dilemma concerns the degree to which the courts should be involved in the clinical determination of a patient's factual competency. Because factual incompetence connotes legal incompetence, the subjective evaluation of the attending physician is of utmost importance in the final analysis. This is easily justified with regard to the "means" of determination, since it is the attending physician who has carefully observed the patient's clinical condition over time from a distinguished perspective of medical expertise and experience. It is questionable, however, whether a doctor should indirectly determine the patient's le-

the dreaded object."

⁹³ *Id.* at 142.

⁹⁴ *Supra* note 86, at 132.

⁹⁵ *Supra* note 92, at 142.

⁹⁶ Stone, *Mental Health and Law: A System in Transition* (1975).

gal status and, ultimately, the patient's choice concerning a course of treatment.

Since it is somewhat artificial to segregate the "means" and the "effect" of any determination, a co-operative effort between physicians and judges would undoubtedly render the most appropriate outcome. The question is a difficult one and goes beyond the scope of this paper.

3. "Paternalistic" Intervention

Sub-section 35(4) of the Ontario *Mental Health Act* provides that the attending physician, upon notice to the patient or nearest relative, as the case requires, may apply to the regional review board for an order authorizing the provision of a recommended course of psychiatric treatment. Two preconditions to the application are set forth: treatment refusal must be effected by an involuntary patient or the nearest relative (as the case requires), or it must be unavailable (as in the case of a mentally incompetent involuntary patient with no relative from whom consent may be requested). A psychiatrist who is not a member of the psychiatric facility in which the patient is detained, as well as the attending physician and a staff psychiatrist, must each state that he or she has examined the patient and is of the opinion that the patient is likely to improve substantially with (and not likely to improve without) the recommended treatment. According to sub-section 30(2) of the Act, a review board of three or five members shall be composed of a least one psychiatrist, one lawyer and one person whom is neither a psychiatrist nor a lawyer. Sub-section 35(5) further provides that the review board may authorize the provision of psychiatric treatment where it is satisfied that only such treatment is likely to render substantial medical improvement; the board must issue its decision within seven days after the completed hearing.

As a preliminary matter, one might note the potential weaknesses associated with the vehicle by which psychiatric treatment may be administered to a non-consenting involuntary patient. First, the provision of effective treatment may be urgently needed prior to the outcome (indeed, possibly the commencement) of the prescribed proceedings; for example, in the case of an acutely depressed patient who refuses to eat and does not respond to alternative forms of therapy the immediate administration of ECT may be a life-saving necessity. Second, the board's authorization of the treatment in question appears to be based essentially upon the merits of clinical diagnosis. Like the procedural dilemmas associated with the determination of a patient's compe-

tency,⁹⁷ it is difficult to evaluate the extent to which a “non-medical” member of the board should participate in the substantive review of a medical opinion.

The underlying moral and ethical questions raised by the provision of section 35 deserve particular emphasis. Should an individual’s rights of autonomy and self-determination be violated with the view to fostering mental health? Is such violation more appropriate with regard to involuntary hospitalization, or should voluntarily admitted patients be subjected to the same “paternalistic intervention”? To what extent should “surrogate consent”, given by a relative or legal guardian of the incompetent patient, affect the administration of intrusive psychiatric treatment?

Two fundamental principles are juxtaposed within the moral context of these questions. Beneficence is presumably the motivating force behind the caring professions; and respect for an individual’s autonomy and acknowledgement of a person’s right to make his or her own deliberated decision according to personal preference, as long as it does not hurt others, is a vital constituent of democratic freedom. Normally, these two principles do not conflict because people consult physicians to ameliorate their medical problems by restoring integrity to the body and mind. As Sherlock points out, however, “restrictions on individual autonomy are a necessary but significant result of hospitalization.”⁹⁸ Institutionalized mental patients, it would seem, suffer impaired autonomy in an extraordinary sense; sustained indecisiveness, depression and psychotic delusion may affect their capacity for autonomous choice in addition to the inherent restrictions of hospitalization.

The ultimate question, then, is whether continued hospitalization and affective illness (as a result of the patient’s wishes) will increase a patient’s autonomy significantly, or whether ECT should be intrusively administered in an attempt to actively foster that autonomy, since autonomy itself is a function of psychiatric health. Sherlock argues that an acutely depressed patient is not in a position to be autonomous in “any recognizably valuable sense” because such patients cannot choose what to do with their lives, or freely engage in countless activities that autonomous individuals enjoy. Hence, “if we do value autonomy, we ought to pursue it to its fullest possible form, not in the truncated one-dimensional sense of refusal of ECT . . . ; [we should promote] the

⁹⁷ See text accompanying *supra* note 96.

⁹⁸ Sherlock & Haykal, *Saying ‘No’ to Electroshock* (1982), 12 *The Hastings Centre Report* 18 at 18.

patient's autonomy . . . by relieving the impediments to [it]."⁹⁹

Alternatively, civil libertarians claim that autonomy must be recognized in relative terms. Autonomy is not an absolute; it may vary with individuals, time and circumstances. One writer suggests that

[i]f mere evidence of impairment of autonomy (or even serious impairment) is to be used to justify compulsory intervention by others in order to increase a person's autonomy, all standard concepts of respect for autonomy and respect of individual liberty will take on a new, and to many, somewhat sinister meaning.¹⁰⁰

Eventually, moral inclination in this regard must influence the approach to the question of whether "paternalistic" intervention should vary according to a patient's admission status. If one accepts the proposition that individual liberty must succumb to the merits of fostered autonomy and assume that an involuntary patient has been institutionalized on the basis of dangerous behaviour,¹⁰¹ it seems reasonable that an involuntary patient, who is in dire need of ECT, but refuses to accept treatment, should undergo compulsive therapy.

However, administering ECT to a non-consenting voluntary patient may encompass a more intrusive violation of the patient's rights. Most authorities agree that once the competency of the patient and truly voluntary nature of the consent are determined, the patient's wishes should be respected.¹⁰² ECT is, by nature, physically invasive and patients may be circumstantially justified in valuing the present state over the potentially therapeutic effect of treatment.

The Court of Appeal of California has acknowledged the fact that "voluntary and involuntary labels do not always indicate the voluntariness of a specific patient,"¹⁰³ and that "the voluntary label is a creation of the Legislature, and often only means the patient did not formally protest hospitalization."¹⁰⁴ In cases where voluntary patients are unable to care for themselves outside of the hospital, discharging them because they refuse clinically indicated treatment would undoubtedly show cruel disrespect for their welfare. However, leaving them in their present condition of illness and hospitalization may be equally as cruel and "shortsighted". Under these circumstances, it may be best to inform individuals of their inevitable committal as involuntary patients and of

⁹⁹ *Supra* note 92, at 141.

¹⁰⁰ *Supra* note 86, at 132.

¹⁰¹ This assumption is based on the statutory criteria for involuntary admission, as provided in s. 14(5) of the *Mental Health Act*. See *supra* note 86.

¹⁰² *Supra* note 86, at 131.

¹⁰³ *Aden v. Younger*, 57 Cal. App. 3d 662 at 679, 129 Cal. R. 535 at 547 (C.A. 4th Dist. Div. 1976).

¹⁰⁴ *Id.* at 674.

the possibility of compulsive therapy following this committal; the imparted realization may alter the patient's outlook on the matter and facilitate the administration of clinically-indicated treatment without undue delay.

Finally, one must consider the question of "surrogate consent". To what extent should the decision of a relative or guardian, on behalf of an incompetent patient, facilitate or deny the administration of ECT? There is a general consensus that the patient's relatives, where possible, should make such decisions because they are in the best position to know what the patient would have decided autonomously.¹⁰⁵ This proposition warrants careful scrutiny in two respects. First, although relational proximity may allow relatives to genuinely ponder the patient's hypothetical behaviour, special care is needed in assuming a harmony of interest between the decision-maker and the patient. Second, it is questionable whether the patient's hypothetically autonomous decision should be honoured in the event that it is not consistent with the patient's "best medical interests".¹⁰⁶

Although,

the doctrine of substituted judgment . . . has been used [historically] to provide for needy dependents from incompetent's estates, it is another matter to use it as a justification to invade one's bodily integrity, especially when it is much easier to be altruistic on behalf of [another] rather than oneself.¹⁰⁷

Ultimately, the notion of "surrogate consent" raises as many ethical issues as it purports to resolve. If one takes into account the degree to which the patient is factually incapacitated and the assent of the patient sought, to the extent that this is possible, a moral assessment of such consent may be effected with relative conviction.

In summary, a patient's right to refuse ECT is, not surprisingly, a complex matter. The legal parameters of capacity, voluntariness and information are suspect with mental patients, and effectively serve to highlight the ethical dilemma associated with such treatment.

Ultimately, the right to refuse treatment reflects a delicate balance of civil liberties (encompassing the principles of self-determination, inviolability of the body and autonomy of the person) and state interests (including the maintenance of societal and individual health, welfare and safety). Perhaps the cost of anguish to the family and community,

¹⁰⁵ *Supra* note 86, at 131.

¹⁰⁶ In such a situation, one might argue that the "surrogate", in his or her capacity as a fiduciary, must act in a way that can be objectively described as "in the best interests of" the principal (the incompetent patient), and thereby consent to whatever "sensible" medical opinion suggests.

¹⁰⁷ *Supra* note 10, at 92.

as a result of a patient's declining health, should be a part of the ethical decision to be made by the attending physician. In the final analysis, however, the utter irrationality of a patient's decision to refuse ECT varies according to the propensity of therapeutic effect;¹⁰⁸ as a matter of logic, then, refusal must be assessed circumstantially.

III. LEGISLATIVE REGULATION: A NEED FOR REFORM?

Current parliamentary debate in Ontario reflects the controversial nature of various psychiatric treatments. Recently, the Toronto Board of Health has asked for a moratorium on the use of involuntary ECT pending the results of a public inquiry.¹⁰⁹ Several issues are involved. Should the Ontario legislature enact regulations to specifically control the practice of ECT? If so, should these regulations define the content of "informed consent" within the limited context of such treatment? Should the legislature acknowledge the use of ECT as a form of "restraint" under certain clinical circumstances?

The underlying question of legislative intervention may be approached from different perspectives. Frankel believes that statutes should have no place in the practice of medicine because they are "subject to the bargaining process of the political arena and become rigid in the light of newly discovered scientific knowledge."¹¹⁰ Others claim that such regulations are useful and proper: it would relieve physicians of doubt as to the legal implication associated with the prescribed course of treatment; and may prevent clinical "abuse" as a result of liberal access to the procedure before its efficacy and safety have been conclusively established.¹¹¹

Sub-section 35(5) of the Ontario *Mental Health Act* presently gives a regional review board the power to authorize non-consensual psychiatric treatment for involuntary patients, except here such treatment constitutes "psychosurgery". According to sub-section 35(1), psychosurgery is

any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of historically normal brain tissue, or inserts indwelling electrodes . . . for the purpose of altering behaviour or treating psychiatric illness.

The Ontario High Court of Justice, in *Re T and Board of Review*

¹⁰⁸ *Supra* 92, at 142.

¹⁰⁹ *The Globe and Mail* (Toronto), January 18, 1984 at 4.

¹¹⁰ *Supra* note 65, at 1018.

¹¹¹ *Supra* note 98, at 19.

for the Western Region,¹¹² has recently decided that ECT is not a form of "psychosurgery" within the meaning of the Act. In that case, Madame Justice Van Camp accepted expert testimony purporting that properly administered ECT has no permanent effect on the continuity of normal brain tissue apart from very rare instances of complications. She held that the use of ECT on involuntary psychiatric patients is legal. The outcome of the case seems to be significantly influenced by the fact that available medical information is fraught with speculation and uncertainty: "[a] collection of uncertain possibilities does not lead to a positive conclusion"¹¹³ and therefore "[t]he possibility of complications must be weighed against what will happen to the patient if treatment is not given."¹¹⁴ Ultimately, the court emphasized the need for further scientific study.

The chairman of the Canadian Psychiatric Association's Board of Directors was supportive of the ruling in *Re T*; "it clarifies the law on the subject, and makes it easier for psychiatrists to administer treatment which may be the last resort when medication fails to alleviate severe depression."¹¹⁵ Regarding the consequential possibility that ECT may be misused, the chairman asserted that psychiatrists are collectively conservative and therefore not likely to effect such abuse. This latter proposition clearly lacks conviction. Most significantly, the *Re T* decision reduces the patient's civil rights with regard to medically controversial psychiatric treatment. Medical literature shows that permanent memory loss and intellectual impairment are possible side-effects of ECT.¹¹⁶ Although these adverse effects could be functional in nature (and not due to "brain damage," as such), the court's narrow reading of sub-section 35(1) effectively denies an involuntary patient the automatic protection that may have been intended against compulsive treatment of an intrusive and potentially hazardous nature.

The present need for legislative review in Ontario is evident. In England, the legislature has recently addressed the issue of consent for specific psychiatric treatments including ECT.¹¹⁷ The use of ECT on a voluntary patient in England must now be decided entirely between the patient and doctor. With regard to involuntary patients, ECT shall not

¹¹² (1983), 44 O.R. (2d) 153, 3 D.L.R. (4th) 442 (H.C.).

¹¹³ These are the words of Madame Justice Van Camp in her reasons for judgment at 162 (O.R.), 451 (D.L.R.).

¹¹⁴ *Id.* at 157 (O.R.), 446 (D.L.R.).

¹¹⁵ Goldman, *Can Treatment be Compulsory* (1984), 130 Cdn. Med. Assoc. 451 at 453.

¹¹⁶ See text accompanying *supra* notes 57-63.

¹¹⁷ In fact, amendment to the British *Mental Health Act* (in this regard) was proclaimed in September, 1983; *Mental Health (Amendment) (Scotland) Act* 1983 c. 39.

be administered unless the consenting patient is competent and "fully informed" of the nature, purpose and likely effects of therapy; failing this, an appointed¹¹⁸ independent physician must certify the patient's incompetence and the clinical need for ECT, prior to the administration of treatment. Similarly, the California legislature has concurrently regulated the administration of psychosurgery and ECT in an effort to protect the patient's civil liberties whenever clinically feasible. The Court of Appeal of California has suggested that the protection of these rights must be viewed as more than the mere regulation of medical procedure for public health and safety.¹¹⁹

Certain provisions in the California *Welfare and Institutions Code*¹²⁰ even provide a list of itemized information that must be generally explained to an ECT candidate in order to effect validly informed consent. Although the state's judiciary appears to endorse this procedure on the premise that it ensures the competency, voluntariness and informational requirements of valid consent within a definitive framework,¹²¹ it is difficult to assess the merit of such a scheme because each patient will undoubtedly require a "unique" degree of information according to his particular capacity and circumstances. In the end, to attempt an exhaustive definition of informed consent seems to usurp the very essence of medical care.

Incidentally, one must entertain the question of whether ECT should be considered a form of clinical "restraint" within the legislative framework. In recent years, the "restraint" of an agitated and uncontrollably violent mentally ill patient may have been effected through various chemical or physical means, including the use of "wet packs", "dry packs" and "strait jackets". Under sub-section 14(4) of the Ontario *Mental Health Act*, "[a]n involuntary patient may be detained, restrained, observed and examined in a psychiatric facility. . . ." According to sub-section 1(t), "restrain" means "keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient." The application of these provisions is relatively clear in relation to chemical and mechanical forms of restraint, but the use of ECT in this regard remains controversial.

¹¹⁸ Such an appointment must be made by the Mental Health Act Commission (as prescribed by the Act, *id*)

¹¹⁹ *Supra* note 102, at 673 (Cal. App.)

¹²⁰ See West's *Annotated Welfare and Institutions Code* at § 5326.

¹²¹ *Supra* note 102, at 680 (Cal. App.)

In 1978, an American Psychiatric Association report¹²² concluded that "ECT should not be used to control behaviour in the absence of severe, intractable, dangerous conduct occurring in the context of a major psychosis." Although this position does not address alternative forms of restraint in a relative manner, it is inferred that ECT might reasonably be used as a restraint technique under critical circumstances. As illustrated by Jeffries¹²³, some patients are not settled with mechanical or chemical agents; furthermore, heavy doses of sedative increase the risk of respiratory and cardiac arrest. In certain cases, then, ECT may be considered the "restraint of choice."¹²⁴

Due to the fact that this particular method of restraint is not currently referred to in the Ontario *Mental Health Act*, physicians may be unwilling to use such an approach. While "ECT used to [conveniently] restrain difficult [patients] constitutes a misuse of effective medical treatment,"¹²⁵ it may be administered in a humane effort to protect the patient, and others, from grave damage. Where there is convincing clinical evidence to support such action, legislative maintenance would facilitate an uninhibited and reasonable approach to the clinical problem.

In retrospect, the need for legislative attention regarding the administration of ECT in Ontario is clear. The ultimate extent to which Parliament should regulate clinical decisions regarding treatment and "restraint" and define the boundaries of consent, however, is debatable. The fact that the word "electroencephalotherapy" (EET) has been suggested as an alternative to the term "electroconvulsive therapy" in an attempt to relieve semantic problems associated with prospective legislation¹²⁶ highlights the degree to which legislative draftsmen must strive to prevent the potential misconstruction of statutory intervention. Accordingly, if "the input of experienced and well-informed clinicians is to remain the pivotal point of the clinical decision,"¹²⁷ Parliament must exercise its legislative influence with extreme care.

V. CONCLUSION

The medical use of ECT presents an integrated spectrum of clinical, ethical and legal problems. Neurophysiological knowledge is in

¹²² *Supra* note 20.

¹²³ Jeffries & Rakoff, *ECT as Form of Restraint* (1981), 28 Cdn. J. Psych. 661 at 662.

¹²⁴ *Id.* at 662.

¹²⁵ *Id.* at 663.

¹²⁶ Perr, *Liability and Electroshock Therapy* (1980), 25 J. For. Sci. 508 at 508.

¹²⁷ *Supra* note 65, at 1018.

its infancy regarding the treatment's precise mechanism of action; psychiatrists and civil libertarians disagree fundamentally as to the moral foundation upon which the notion of "paternalistic intervention" should be assessed; and legislative regulation of the controversial therapy varies from a limited observation of non-consensual psychiatric treatment (in Ontario) to an extensive and definitive statement of ECT governance (in California).

Due to the fact that ECT remains an essentially empirical procedure (rather than a theoretically rational one), resolution of the underlying ethical and legal debate must ultimately depend on a thorough evaluation of the treatment's therapeutic disposition in relation to its hazardous potential. By relinquishing the myths of "shock therapy" and refining clinical attitudes, one can "reduce the call for legal prescriptions and encourage controlled medical research"¹²⁸ in a productive manner.

Ultimately, one must realize that to deny a clinically useful therapy may be worse than applying a speculatively detrimental one. Prospective statutory amendment providing for the designation of a specific committee to effect the regular review of ECT patients might allow, in time, to determine the relative wisdom of objective intrusion between the patient and the physicians.

An astute trial lawyer once contrasted medical thought to that of the legal mind:

If a doctor were called upon to treat typhoid fever, he would probably try to find out what kind of milk or water the patient drank, and perhaps clean out the well so that no one else could get typhoid from the same source. But if a lawyer were called on to treat a typhoid patient, he might give the patient thirty days in jail and think that nobody else would dare to take typhoid. . . .¹²⁹

Such an anecdote is certainly not comprehensive, but it does emphasize the fact that a legalistic construction of a medical problem is not independently appropriate. If one endorses this proposition, increased cooperation among psychiatrists, legislative draftsmen and civil libertarians can only foster a more integrated appreciation of the task at hand — the resolve of ECT's operative role in modern psychiatry.

¹²⁸ *Supra* note 29, at 995.

¹²⁹ *Supra* note 2, at 87. This colourful observation was phrased by Clarence Darrow in the midst of a renowned murder trial.