

Only very rarely will electroshock be given to patients suffering from life-threatening depression without their consent. But do we have sufficient knowledge of the quality of this consent in situations where the patient has acquiesced?

## Therapy without consent

Receiving health care is a voluntary matter. The preconditions are that the patient understands why this help is provided, what it consists of, and the consequences of providing it. Accordingly, consent by the patient will be required as a rule. A valid consent can be tacit, oral or written, depending on the nature of the procedure or the service, and may range from a nod at the start of a physical examination to a time-consuming conversation that will test the doctor's respect for the autonomy of the patient.

In this issue of the Journal of the Norwegian Medical Association, Kjell Martin Moksnes addresses issues of consent related to electroconvulsive therapy (ECT) (1). During this procedure, electric current is sent through the patient's head for periods of 2–4 seconds. This stimulates the brain, and is accompanied by muscular contractions that may last for up to 60 seconds. A more common designation among laypeople – but also among health personnel – is electroshock. The term «shock» dates from the time when the procedure was undertaken without anaesthetic and could produce severe spasms and even skeletal injuries, and therefore fell into disrepute. The film *One Flew over the Cuckoo's Nest*, with its outstanding performance by Jack Nicholson, also helped sustain this negative reputation. Media pundits with no medical expertise continue to describe the procedure in the same terms as lobotomy in spite of its numerous technical modifications, such as the use of short-term narcosis, muscle relaxants that reduce the convulsions and improvements in the way in which the electric current is applied. These modifications have drastically reduced the adverse effects (2).

Seventy-five years have passed since electroconvulsive therapy was first used to treat mental disorders. The method was applied uncritically during the initial years, which must be seen in light of the absence of other effective therapies. Today, there is widespread consensus on its benefits in the case of life-threatening depression in instances where other therapies have failed (3). Its use on this indication is maintained, in spite of documentation of long-term effects on certain neuropsychological functions (4). The fact that we still fail to understand how the treatment works ought also to call for caution. We may also pay heed to some voices that are clearly critical of its use in cases of severe depression (5).

When the situation is critical and the best discretionary judgement indicates that treatment must be initiated, the patient's possible refusal must be weighed against the obligation of health personnel to provide help. Coercion may be an option, but must invariably be applied in accordance with the law. Most frequently, this is done pursuant to the Mental Health Act, the Patients' and Users' Rights Act and the Health Personnel Act. The former, however, does not authorise electroconvulsive therapy, which is regarded as a considerable encroachment on the patient's autonomy. The final resort is the section on plea of necessity in the General Civil Penal Code. If the treatment is administered on this basis, the law requires that the condition cannot be relieved by any other means, and that the risk to be averted must be significantly greater than the damage that may be inflicted by the intervention.

Practices, results and consequences involved in providing treatment against the patient's wish are highly important matters to discuss in any society ruled by law. Moksnes has concentrated on seven patients who were given the treatment in spite of documented evidence of their refusal. The author convincingly argues that these seven ful-

filled the formal criteria required by the doctor to enter a plea of necessity. They quickly improved – their median lifespan after the treatment was nine years. But what can Moksnes' material reveal about the willingness to undergo ECT treatment with regard to the remaining 234 series administered to 134 patients? A large degree of uncertainty prevails in this area, which is openly acknowledged by Moksnes.

We do not know how many were requested to provide consent. Only in 1984 did the health authorities underscore that the patient's consent to ECT treatment should be obtained. Moksnes' material dates back to the 1960s, and we have reason to believe that in former times, doctors were less likely to assume that they needed the patient's explicit acquiescence. Second, Moksnes has only been able to assess the patients' opinion in those cases where the doctor noted in the records whether the patient had been asked or not. As a matter of fact, no written registration of the response has been required until recent decades, and then explicitly only in cases where the therapy is provided without consent. The total material may therefore encompass a considerably larger number of patients who received electroconvulsive therapy in spite of their refusal. An indication of the scope is obtained from the information that five of the 18 patients who received the first series of treatments on a vital indication consented, no information on consent exists for six patients, while the remaining seven refused, as we have seen. If we assume that those patients whose status is unclear were not significantly different from the seven who have been documented, presumably few censurable acts have been committed, but strictly speaking we really cannot tell.

The most critical question remains unanswered. Was the consent informed, voluntary and explicit? Was the information provided in a manner adapted to the patient, so that he/she could understand what was about to happen? How real was their opportunity to refuse, and how often and to what extent was persuasion applied? Moksnes is concerned with this issue, and judiciously notes that in the first series of 141 patients altogether 21 initially refused, «but later provided consent after having received more information and repeated recommendations». How many of them were able to provide consent? Moksnes notes examples of statements from patients that leave the impression that drawing conclusions as to their ability to provide consent must have been extremely complicated. All things considered, it is hard to exclude the possibility that among those who consented, many received electroconvulsive therapy on an uncertain or an unfounded indication – or perhaps prematurely?

With such a number of unanswered questions, this important study ought to trigger a broad, prospective investigation of the indication for electroconvulsive therapy as well of the quality of the consent that is obtained – and of the further clinical pathway.

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