

# Medico-Legal Challenges with Consent in Electroconvulsive Therapy: Urgently Needed Legal Reform

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 The authors of this poster have no actual or potential conflicts of interest in relation to this poster.



## BACKGROUND

Despite demonstration of electroconvulsive therapy (ECT) as a highly efficacious treatment, particularly for severe or refractory mental illness, *medico-legal challenges related to informed consent* for the procedure in patients who may not have capacity to give consent result its *underutilization*. For a patient that is *non-voluntary*, most states require *court approval* to be obtained, after which a *legally appointed guardian* may provide consent for treatment. The *variability between state regulations* is marked with regards to provisions in the setting of an emergency, restrictions for special populations, and whether it is permissible for a patient admitted to the hospital involuntarily. The bulk of the *regulatory framework for ECT is without basis in the scientific or medical literature* and in many cases is not in alignment with the American Psychiatric Association recommendations. The literature abounds with reports of poor patient outcomes including deaths due to these legal obstacles to ECT.

It is also worth acknowledging that these statutes contribute to *discrimination*, wherein individuals with limited support structures or from historically medically mistreated populations are far less likely to obtain ECT. Middle and upper socioeconomic groups are disproportionately able to navigate these legal barriers. African American, Latino, Asian, Native American, and Native Hawaiian patients are significantly less likely to receive ECT than Caucasian patients across all spectrums of diagnosis, age, and treatment settings.

Per Luccarelli et al, Caucasian patients are overrepresented among ECT recipients:

breakdown of ECT recipients by race compared to the demographics of the state as of the 2010 American Community Survey. White patients are overrepresented among ECT recipients, while all other races received treatments at a lower rate than their share of the population.

State	Years	White	Black	Hispanic	Asian	Native American	Other/Ch.	Misling
CA	2008-2017	ECT Recipients: 31438 80.4%	3145 8.0%	1332 3.4%	1930 4.9%	128 0.3%	1151 2.9%	0 0.0%
		State overall: 40.0%	37.7%	12.9%	0.8%	0.8%	2.8%	
IL	2006-7; 2013-18	ECT Recipients: 18245 84.9%	851 4.6%	964 4.9%	218 1.0%	62 0.3%	379 1.8%	775 3.6%
		State overall: 63.6%	15.9%	14.7%	4.4%	0.1%	1.5%	

## CASE #1

- 42-year-old Southeast Asian woman
- Catatonic presentation (Bush-Francis Score 23)
- Elevated creatine kinase, autonomic instability, immobile, poor oral intake
- Refractory to first-line treatment of catatonia including high doses of Lorazepam, Memantine, and Zolpidem
- Developed a *malignant form of catatonia*, for which mortality rate is very high
- CL team recommended ECT as standard of care
- Given the patient’s rate of decline, *the codified means of acquiring consent for a nonvoluntary patient through Arkansas statute would not result in treatment being received in a necessary time frame*
- The team drew upon the *Emergency Medical Treatment Act* => This allowed for expedited first ECT treatment with the consent of the patient’s husband
- ECT changed the patient’s clinical course* and she stabilized to a point of appropriateness for transfer to the inpatient psychiatric unit, and to discharge from the hospital on day 22 *with resolution of catatonia*
- The only adverse effect incurred by patient was transient difficulty with short-term memory

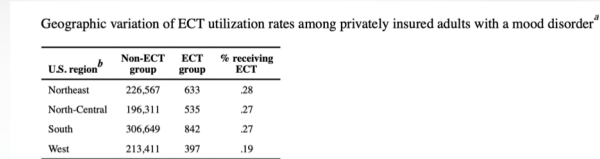
## CASE #2

- 66-year-old Caucasian woman
- Catatonic presentation in the setting of *worsening major depressive episode*
- Rapid cognitive and physical decline with poor oral intake
- Loss of more than 50 pounds* down to 72 pounds
- Mirtazapine was initiated given historical positive response
- Benzodiazepine treatment initially impactful though less effective with time and not tolerated* to necessary doses
- Patient was evaluated *not to have capacity with regards to ECT and sister was identified as her surrogate decision maker*
- Drawing upon the *above mandated pathway*, the *Emergency Medical Treatment Act* was utilized thus circumventing the court process
- Patient was able to receive *ECT on hospital day 3* with approval of her surrogate decision maker
- On hospital day 9, ECT had restored patient’s decision-making capacity; she agreed to continue with ECT

## DISCUSSION

It is hoped this above pathway may be replicated by other physicians to avoid delays in access to what could be life-saving and functionality-preserving care to patients. These cases also serve as a means of raising awareness for the unique legal barriers to ECT which stand in stark contrast to other medical treatments with regards to lack of uniformity across states and misalignment between the degree of access restriction and risk-benefit ratio of the treatment.

Per Wilkinson et al, ECT utilization rates have been demonstrated to be directly correlated with stringency of statute statutes:



<sup>a</sup>Source: 2014 MarketScan database. ECT, electroconvulsive therapy

<sup>b</sup>Of the data, 2.5% were missing.

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Region	State	Reporting	Consent for ECT	Process for Nonvoluntary/Involuntary ECT
Mid-Atlantic/Northeast	Connecticut	Not Mandated	Requires review of capacity and clinical necessity by two physicians (one must be a psychiatrist). Consent is valid for 90 days	Court authorization required
	Delaware	Not Mandated	Written informed consent	Not addressed in state legislation
	Maryland	Not Mandated	No specific state legislation for adults aside from prohibition in pregnant or gravely ill patients (247 years of age)	Not addressed in state legislation
	Maryland	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
	Massachusetts	Mandated	No specific state legislation for adults	No specific state legislation for adults
	New Hampshire	Not Mandated	For patients 65 years of age or older, two physicians must complete documentation for procedure as medically necessary and provide this to the patient or guardian. Patient or guardian must also be informed of any known medical condition that may increase the possibility of death or injury	Not permitted unless a legal guardian consents
	New Jersey	Not Mandated	For patients 65 years of age or older, written proposal must be submitted to the Division of Mental Health and Hospitals, who then can provide written approval	Court authorization required
	New York	Mandated	In addition to the treating physician, a licensed psychologist who is not an employee of the facility will provide a written opinion regarding the patient's capacity to consent to ECT	Court authorization required
	Pennsylvania	Mandated	Developed standard informed consent form. For patients 65 years of age or older, two physicians must document treatment is medically necessary and the patient or guardian needs to be informed of any known current medical condition of the patient that may increase the possibility of injury or death as a result of ECT	Court authorization required
	Rhode Island	Not Mandated	Formal evaluation necessary to protect individuals from physical injury to themselves or others and is after alternative treatments have been utilized	Not addressed in state legislation
Northeast	Vermont	Mandated	State Commissioner has established specific informed consent guidelines. Repeat informed consent must occur every 12 months or if a medical condition occurs	Guardian may give consent for patient to receive ECT. If patient refuses treatment, court approval is needed to override their objection
	Washington, D.C.	Not Mandated	No specific legislation for adults	No specific legislation for adults
	Illinois	Mandated	Written informed consent	Court authorization required along with a written physician's order. Emergency provisions as stated
	Indiana	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
	Iowa	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
	Kansas	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
	Michigan	Not Mandated	Consent must be obtained from patient or guardian. If from guardian, two physicians must document concurrence with decision	Court authorization required
	Minnesota	Not Mandated	Written informed consent	Court authorization of consent of guardian required. May treat based on physician's advance directive
	Missouri	Mandated	Written informed consent. Prohibited in patients diagnosed solely as intellectually disabled	Court authorization required
	Nebraska	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
South	North Dakota	Not Mandated	Written informed consent	Guardian may give consent for patient to receive ECT
	Ohio	Not Mandated	Written informed consent	Court authorization required
	South Dakota	Not Mandated	Written informed consent	Emergency provisions if the attending physician and one other physician determine that administration of treatment is necessary to prevent significant deterioration of the person's severe mental illness and that the person's potential for improvement would be significantly impaired if such treatment is not provided
	Wisconsin	Not Mandated	Written informed consent	Not addressed in state legislation
	Alabama	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
	Arkansas	Not Mandated	No specific state legislation for adults	Court authorization required
	Florida	Not Mandated	Written informed consent. Another physician not involved in patient's care must agree with treating physician and document in record	Court authorization or consent of guardian required
	Georgia	Mandated	Written informed consent	Not addressed in state legislation
	Kentucky	Not Mandated	No specific state legislation for adults	No specific state legislation for adults
	Louisiana	Not Mandated	No specific state legislation for adults	Court authorization required. Emergency provisions if the director of the facility and two physicians determine the patient's condition is life-threatening
Southwest	Mississippi	Not Mandated	Written informed consent	Not addressed in state legislation. Emergency provisions if the director of the facility and two physicians determine the patient's condition is life-threatening
	North Carolina	Mandated	Written informed consent. Two licensed physicians must document indication for treatment, methods for measuring efficacy, and indications for discontinuation	Legal guardianship procedure outlined
	Oklahoma	Not Mandated	Written informed consent	May not be administered "against [patient's] will"
	South Carolina	Not Mandated	No specific state legislation for adults	If patient determined by physician to lack capacity to give consent for treatment, decision for treatment may be made by multiple others (in state "hold" or a designated order/guardian appointed by the court, durable power of attorney, spouse, adult child, parent, sibling)
	Tennessee	Mandated	Written informed consent	Not addressed in state legislation
	Texas	Mandated	Written informed consent. Two physicians must agree treatment is medically necessary if the patient is >65 years old	Court authorization required
	Vermont	Not Mandated	No specific state legislation for adults	Court authorization required
	West Virginia	Not Mandated	Written informed consent	Not addressed in state legislation
	Alaska	Not Mandated	No specific state legislation for adults	Court approval required. Surgeon may give consent for patient to receive ECT
	West	Arizona	Not Mandated	Written informed consent
California		Mandated	If any patient offered treatment and patient must be given at least 24 hours with the paperwork before signing. Consent must be received after a limited number of treatments or 30 days. A witness must be present for the consent process. A psychiatrist or neurologist who is not the treating physician must assess the patient as being capable of and having given consent to treatment. All facilities providing ECT must have a committee to review all treatments and to make sure they are necessary. This is a public record. Treatment may not exceed a period of ECT months or a total months within a year	Not addressed in state legislation. May not be administered to ECT recipients, may not be given ECT. Consent or guardian can provide consent on behalf of patient only so long as they lack capacity to give consent. For a patient 65 years of age or older, two physicians must sign a form documenting the reason ECT is the recommended treatment, two physicians must examine the patient, and patient's attorney must give the doctor that patient is able to provide consent and has given this for ECT
Colorado		Not Mandated	Written informed consent. Two or more psychiatrists must determine ECT is the most preferred form of treatment for the patient	Not addressed in state legislation
Illinois		Not Mandated	No specific state legislation for adults	No specific state legislation for adults
Indiana		Not Mandated	No specific state legislation for adults	No specific state legislation for adults
Iowa		Not Mandated	No specific state legislation for adults	No specific state legislation for adults
Nebraska		Not Mandated	No specific state legislation for adults	No specific state legislation for adults
New Mexico		Not Mandated	No specific state legislation for adults	No specific state legislation for adults
Nevada		Not Mandated	Not addressed in state legislation	Not addressed in state legislation. Involuntarily admitted patients though with reference to "procedures" generally with no state laws
Utah		Mandated	Written informed consent. ECT prohibited in pregnant women. For a patient 65 years of age or older, two physicians must sign a form indicating the treatment is medically necessary and inform the patient of any known current medical condition that may increase the possibility of injury or death as a result of the treatment	May not provide treatment without written consent
Washington	Not Mandated	Written informed consent with at least one documented witness	Not addressed in state legislation	
	Not Mandated	No specific state legislation for adults	No specific state legislation for adults	