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Legal Issues Relating to Electroconvulsive Therapy

H. Richard Beresford
Cornell Law School

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H. Richard Beresford, MD, JD, Denver

A survey of 54 psychiatric units disclosed that 49 (91%) were using electroconvulsive (ECT), principally for major depressive illnesses. During the five-year period 1964 to 1968, fractures and other complications of ECT were uncommon. Sudden death was reported in seven cases. During this period, none of the respondents or their affiliated physicians had been involved in lawsuits relating to the use of ECT. In general, suits for injuries occasioned by the use of ECT seem to be declining. Possible remaining problem areas are the performance of ECT without the prior consent of the patient; the failure to have facilities and personnel available for managing cardiorespiratory emergencies occurring during ECT; failure to diagnose or treat an ECT-related injury; and perhaps the failure to use ECT where the indications are compelling.

SUITS against psychiatrists or psychiatric hospitals occasionally arise from the use of electroconvulsive therapy (ECT). At one time, some professional liability insurers apparently thought that the risk of injury from ECT was so great that they were reluctant to insure physicians or others who administered ECT.[1] The current incidence of these suits is difficult to ascertain. It seems reasonably certain that the incidence has declined as the use of effective muscle relaxants has become more widespread.[2] While few such cases reached the state appeals courts in 1968 and 1969,[3-6] it is unclear whether they accurately reflect the extent of litigation in this area. Most professional liability cases are settled before trial and only a small fraction ever go as far as a state appeals court. Professional liability insurers are reluctant to release information about the number and type of cases they settle out of court. My conversations with counsel for companies which write malpractice insurance policies indicate that suits against psychiatrists for injuries arising from ECT are uncommon. Even though suits relating to ECT are probably waning, it is still predictable that occasional patients who incur injury during or after ECT will bring suits against allegedly culpable physicians or hospitals.

This study surveys the recent experience with ECT in a loosely selected group of psychiatric units, and, against this background, raises and briefly discusses some of the legal issues relating to ECT.

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From the Division of Neurology, University of Colorado School of Medicine, and Denver General Hospital, Denver. Dr. Beresford is currently at the Department of Neurology, Cornell University Medical College, New York.

Reprint requests to Cornell University Medical College, 1300 York St, New York 10021 (Dr. Beresford).

Survey

Methods.—A questionnaire was sent to the directors of 90 psychiatric units, approximately equally divided between large state hospitals and hospitals or services associated with university medical centers. The questionnaire posed several inquiries with respect to the use of ECT in these units, including questions relating to any legal actions arising from the use of ECT. Replies were received from 54 directors of units, the average daily census of which ranged from 15 to 9,000 patients (mean 1,028). Thirty responses were from state hospitals and 24 were from university hospital psychiatric units.

Results.—Forty-nine of the respondents were using ECT at the time of the survey in late 1969 and early 1970, or 91%. In this group of 49, use of ECT in 1968 (the most recent year for which full records were available) had increased over previous years in five units, decreased in 30 units, and had not changed substantially in 14 units. During 1968 alone, over 9,000 patients had received ECT at the reporting units. Depressive psychoses (especially involutional depressions) were the principal indications for the use of ECT in all the units. In several units, ECT was used in treating catatonic reactions or extreme agitation in schizophrenics. ECT was rarely used in other types of cases, such as agitated organic dementias or severe neuroses. All respondents using ECT regarded it as a highly effective or superior form of treatment for major depressive illnesses. Of the five units not using ECT, one was a small university psychiatric service treating mainly adolescent patients. Four were large state hospitals. The director of one of these indicated that his unit had stopped using ECT in 1962 and had not resumed its use because other satisfactory treatments were available. All the units employing ECT at the time of this survey plan to continue its use in the foreseeable future.

In the matter of obtaining consent for the use of ECT, 36 of the respondents had governing regulations requiring that they obtain before treatment a consent to ECT from each patient or his legal representative. Three units had rules which permitted them to perform ECT without the consent of patients or their legal representatives only if the patients were under involuntary commitment orders. Ten units had no rules requiring advance consent to ECT, but most of these customarily sought such consent. However, during 1968 eight units did use ECT in a few cases without the consent of patient or his legal representative.

Forty-five of the 49 units employing ECT currently use paralytic agents (eg, succinylcholine) to achieve muscular relaxation during induced seizures. Twenty-eight use some form of general anesthe-

sia, most frequently a short-acting barbiturate (eg, methohexital [Brevital, Britan]). Many use atropine. At all units, a licensed physician is present during the induced seizures. In most units where general anesthesia is employed, anesthesiologists administer it.

During the five-year period 1964-1968, inclusive, vertebral fractures were the most common complication of ECT. The respondents reported 35 of these in a total of several thousand treatments (exact figures not ascertainable from data provided). Only one hip fracture was recorded. Cardiac arrhythmias occurred in 13 patients, and in three cases led to death of the patients. Sudden death occurred in four other patients, but the causes were not stated. Slight burns occurred in seven patients, and a variety of other complications occurred in one or two patients, including a dislocated shoulder, a mandibular dislocation, broken teeth, and aspiration pneumonia.

None of the units reported that, during the period 1964-1968, any lawsuit had been filed against it or any of its affiliated physicians in connection with any injury incurred during ECT. In addition, none of the respondents or affiliated physicians suffered an adverse court judgment or reached an out-of-court settlement with any claimant in connection with such an injury. However, these findings do not necessarily imply that the units which did not respond to the questionnaire had had such a favorable experience with respect to litigation or settlements. Moreover, since several of the responding units were agencies of their respective states, many were immune from suits in any event.

Legal Issues

There are several legal grounds on which a patient may rely in pressing a suit relating to ECT.

ECT Not Indicated.—If a patient sustains an injury during ECT, the indication for which was not a generally accepted one, he might possibly prevail in a suit against the physician who ordered the treatment. For example, one who receives ECT for an anxiety neurosis might later contend that he was negligently submitted to the risk of his resulting hip fracture. There was, however, no reported cases in which a plaintiff has won a suit on this ground.

ECT Too Risky.—A patient may submit that his preexisting medical status made ECT a prohibitive risk for him. For example, in a recent Pennsylvania case,[5] an elderly woman asserted that a psychiatrist's negligence in failing to diagnose her osteoporosis before ECT entitled her to recover from him when ECT produced bilateral hip fractures. After hearing testimony of physicians, the court decided that her particular form of osteoporosis was not a contraindication to ECT and that, although the psychiatrist's failure to diagnose it before ECT was an error, this error did not directly cause her hip fractures. Despite this decision, it seems obvious that a cautious approach is indicated respecting the use of ECT in a patient with severe osteoporosis. Similarly, a patient with a history of major cardiac arrhythmias may not be a suitable subject for ECT.

No Consent to ECT.—One who does not consent in advance to ECT may contend that a resulting injury is in effect an assault and battery.[7] In a few cases, plaintiffs have raised this argument, but the courts and other legal authorities have generally rejected it.[8,9] One reason given has been that the potential therapeutic benefits of ECT and its low morbidity justify granting psychiatrists the discretion to use it without the consent of the patient in cases where it is clearly indicated.[8] Another is that the patient's voluntary submission to ECT constitutes implied consent.[7] However, it seems unwise to assume that courts in states which have not yet faced this issue will necessarily sanction the use of ECT without a patient's consent or that of his legal representative.

A patient who consents to ECT may, after an ECT-related injury, assert his consent was not "informed" and therefore was invalid.[10] To recover on this theory, he must show that the risk of which he was not advised was so significant that his physician violated a duty to him by not informing him.[12,13] Occasionally courts are willing to dispense with the requirement that consent be informed if there is evidence that informing the patient of risks will substantially worsen his psychological state.[13]

ECT Negligently Performed.—Before the near-routine use of muscle relaxants with ECT, several suits were brought by persons who sustained fractures and other injuries during ECT.[13-17] The usual allegation was that the patient was negligently managed during ECT. The courts generally took the view that fractures and dislocations were accepted or inevitable risks of ECT and that, if proper indications for the use of ECT were present and standard precautions were taken, the injured person had no grounds for recovery. Moreover, the courts in ECT cases have been unwilling to apply the doctrine of *res ipsa loquitor*,[15,16] a rule which permits a plaintiff's case to go to the jury even though the plaintiff does not introduce expert testimony relating to a defendant's alleged negligence.

It may be that a patient who incurs a skeletal injury during ECT in a facility where muscle relaxants are not used would prevail in a lawsuit on the theory that he was negligently denied the protective benefit of these agents. In other words, since the generally accepted practice is to use muscle relaxants, deviation from this practice is arguably a negligent omission.

Another facet of the liability problem relates to the use of muscle relaxants and anesthetic agents. These increase the risk of cardiac arrhythmias, hypotension, and aspiration pneumonia. Although such risks are often not preventable, an occasional case may arise where a person who sustains anoxic tissue damage during ECT will assert that a physician's or hospital's negligence was the root cause.

Negligent Management After ECT.—Injured patients have occasionally prevailed in suits where they have established negligence on the part of those caring for them during the period when they were confused after ECT.[3,17-19] In a recent Louisiana case,[3] the court found that a hospital was negli-

gent when a patient who had undergone ECT fell while being led downstairs by a nurse's aide about one hour after ECT. There was conflicting evidence about the state of the patient's mental function at the time of the accident, but the court accepted the testimony of a physician that she probably was not "lucid" when she fell. This emphasizes the importance of close supervision of patients during their postictal confusional states.

Negligent Failure to Diagnose ECT-Related Injury.—Even if an injury is deemed an accepted risk of ECT, an injured patient may nevertheless recover from a physician who negligently fails to diagnose his injury. Ordinarily, the injured person must introduce testimony of other physicians to establish the defendant's negligence. But in a recent North Carolina case,[20] the court indicated that a psychiatrist's failure to diagnose a patient's ECT-related vertebral fracture was negligent, even though the patient did not introduce physician testimony. The patient did, however, establish that the standards for ECT prepared by the American Psychiatric Association stated that a patient who complains of pain after ECT should receive a physical examination and x-ray. The psychiatrist did neither.

Negligent Failure to Administer ECT.—Whatever the legal risks of administering ECT, there may be situations where *not* using it will raise legal problems. There are recent cases which suggest the possibility of future suits against psychiatrists or hospitals for failing to administer ECT. In a District of Columbia case,[21] an involuntarily committed patient obtained release from a mental hospital on the grounds that it had not afforded him any treatment other than milieu therapy. In a New York case,[22] a former patient recovered $300,000 from the state for its negligent failure to give him proper psychiatric treatment during the 14-year period he was involuntarily committed to a state hospital. These cases together emphasize that psychiatric hospitals have a duty to treat their patients and the failure to treat may give rise to a lawsuit. Thus, a patient who is involuntarily hospitalized for psychotic depression, and who does not receive ECT might later contend that the hospital negligently omitted a medically indicated and highly effective treatment. It is speculative how a court would receive this contention. But a general impression exists that many large psychiatric hospitals have afforded their patients no treatment or inadequate treatment.[21] In this setting, some courts may be receptive.

Comment

The hospital survey discloses that ECT is widely used, that it has few major complications, and that lawsuits relating to its use are uncommon. In projecting about future litigation arising from the use of ECT, certain factors suggest that the legal risks of administering ECT are not substantial. First, the effectiveness of ECT as a treatment for major depressive illnesses no longer seems arguable. Second, ECT-related skeletal injuries are becoming rare as muscle relaxants are more widely used.[2] Third, standardized procedures have been developed for performing ECT, which include the participation of anesthesiologists and the availability of resuscitative equipment. Fourth, given the efficacy and safety of ECT, courts will probably continue to regard ECT as a standard form of treatment for psychiatric disease rather than an exceptional therapy which they must scrutinize with scepticism.

Possible problem areas remain. In those states where the laws or court decisions do not provide clear sanction, administering ECT without a patient's prior consent raises the possibility of liability for unauthorized treatment. Where general anesthesia or muscle relaxants are in use, the ready availability of physicians and equipment for managing cardiorespiratory emergencies is essential. The liability of a hospital which fails to have this type of support on call is predictable if a patient dies or suffers tissue injury because of this omission. Where a patient suffers an injury during or after ECT, a basis for liability would exist if reasonable steps were not taken to prevent, diagnose, or treat the injury.[3,5,17-20] Finally, because ECT has been such an effective treatment, there is the possibility that not employing it where indications are present may give rise to legal action.[22]

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