AUTHORIZING A GUARDIAN TO CONSENT TO ELECTROCONVULSIVE THERAPY

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Electroconvulsive therapy ("ECT") is the most controversial treatment in psychiatry. *Electroconvulsive Therapy, NIH Consensus Statement Online* 1985 June 10-12; 5(11);1-23 (hereinafter cited as "NIH Consensus Statement"). ECT involves passing electrical currents through the brain in order to induce convulsions. The therapeutic effects of ECT are generally believed to be obtained by the seizure produced by the stimulation of the central nervous system. Beale, et. al, *Recent Developments in Electroconvulsive Therapy*, 91 JOURNAL OF SOUTH CAROLINA MEDICAL SOCIETY 93, 96, March 1, 1995.

In the early days of ECT mortality was a significant problem, and complications included vertebral compression fractures from the convulsions. *NIH Consensus Statement*. Today, the risks attending the administration of such treatment have been greatly reduced by the use of muscle relaxants and general anesthetics. In fact, the medical literature suggests that the administration of ECT has been refined to the point where it can be safely administered with an acceptable side effect profile. Beale et al. at 96. Prior to the administration of ECT, medications are given to the patient intravenously, including a drug that prevents cardiac irregularity, a light general anesthetic and a muscle relaxant. Thereafter, stimulus electrodes are placed on the patient's scalp and a seizure is produced by the administration of electric stimulus. Treatments are usually given three times per week in a course of six to twelve treatments, depending upon patient response. *Id.* at 95.

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The most common side effects of ECT today include disturbances in intellectual orientation (i.e., confusion) and/or memory loss.[2] *Id.* Headaches, nausea and muscle pain are also common, but typically respond to symptomatic treatment. Moreover, because a general anesthetic is used during the procedure, the typical risks associated with general anesthesia are present.

ECT was first administered in the 1940's and 1950's to severely disturbed patients residing in large mental institutions. *NIH Consensus Statement*; Abrams, *The Treatment That Will Not Die*, PSYCHIATRIC CLINICS OF NORTH AMERICA, Vol. 17, No. 3, 525, 528 September 1994. The NIH Consensus Statement notes:

> Although ECT has been in use for more than 45 years, there is continuing controversy concerning the mental disorders for which ECT is indicated, its efficacy in their treatment, the optimal methods of administration, possible complications, and the extent of its usage in various settings. These issues have contributed to concerns about the potential for misuse and abuse of ECT and desires to ensure the protection of patient's rights. At the same time, there is concern that the curtailment of ECT use in response to public opinion and regulation may deprive certain patients of a potentially effective treatment.

Unlike other treatment modalities developed at about the same time, ECT remains widely used to this day, particularly with patients suffering from major depression. A March 1993 editorial in the *New England Journal of Medicine* noted that ECT "is more firmly established than ever as an important method of treating certain severe forms of depression." *The New England Journal of Medicine*, Vol. 328, No. 12, March 25, 1993, at 882. Moreover, the Pennsylvania Department of Public Welfare noted ECT's importance in its Mental Health

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[2] Because many patients for whom ECT is recommended also suffer from some degree of cognitive impairment it is important to evaluate orientation and cognitive functioning prior to administration of ECT in order to establish a baseline level of functioning. America Psychiatric Association, THE PRACTICE OF ELECTROCONVULSIVE THERAPY: RECOMMENDATIONS FOR TREATMENT, TRAINING AND PRIVILEGING § 12.2 (hereinafter cited as "APA at ____".).

Bulletin *Guidelines for the Use of Electroconvulsive Therapy (ECT)*, No. 99-86-06, March 5, 1985:

> ECT is a valuable treatment modality for patients with certain forms of mental illness or in situations involving life-threatening symptoms or behavior. Particularly responsive to ECT are patients with severe depressions with serious suicidal intent, and some with severe mania and catatonia. Although ECT is most often considered after more traditional psychotherapies have been tried and found ineffective, there is evidence that certain patients respond only to ECT and that for others, particularly depressed patients, ECT is the best initial treatment. It is likely that substantial numbers of suicides have been averted through the use of ECT.

The continuing controversy concerning ECT has reached the courts in several recent, high profile cases where ECT was authorized over an allegedly incompetent person's objection. Recently, the Cumberland County Orphans' Court refused to authorize an emergency guardian of an incapacitated person to consent to ECT. In *In The Matter of Cheryl I. Dyarman*, 21 Fiduc. Rep. 2d 227 (O.C. Cumb. 2001), Ms. Dyarman was suffering from a debilitating and progressive physical illness known as demyelinating disease. Because of the depression arising from the demyelinating disease, the solicitor for the Mental Health and Mental Retardation Unit of Cumberland County sought both a commitment pursuant to the Mental Health Procedures Act and the appointment of an emergency guardian with authority to consent to ECT. The Orphans' Court denied the commitment and, although it appointed an emergency guardian of the person, it refused to authorize ECT treatments. On exceptions, the Orphans' Court *en banc* affirmed the decision refusing to authorize ECT. Although there is no extended discussion of what standards were applied in evaluating the request for ECT, the Orphans' Court *en banc* held that Ms. Dyarman's depression "related to a hopeless and progressively debilitating physical illness that had almost reached the point of total paralysis." Given the dearth of law on this topic, the

question arises what standards an Orphans' Court should apply when considering a request by a guardian to authorize ECT.[3]

Any analysis must necessarily start with fundamental principle that an individual has a right to refuse medical treatment, which right does not cease upon his or her incapacitation. *In re: Fiori*, 543 Pa. 592, 601, 673 A.2d 905, 910 (1996). Thus, the first and most significant issue to be addressed is whether the individual, although incapacitated, nevertheless has capacity to refuse ECT. Also considered at this threshold level are any living wills or advance medical directives expressing the individual's wishes in such a situation.

Under Section 5521(d)(1) of the Probate, Estates and Fiduciaries ("PEF") Code, 20 Pa. C.S.A. § 5521(d)(1), the Court, after making specific findings of fact, may authorize a guardian to consent on behalf of the incapacitated person to electroconvulsive therapy. Although no reported Pennsylvania decision has specifically the applicable standards, the elements and burden of proof, and the appropriate considerations for the Court, can be analogized to other "special" powers that may be granted to a guardian under Section 5521(d), and by reference to reported decisions of other jurisdictions.

There can be no doubt that the burden of proof rests with the petitioner, as with all guardianship proceedings, to establish by "clear and convincing evidence" that the proposed ECT is in the "best interests" of the alleged incapacitated person. *Cf.* PEF Code Section 5511 ("upon presentation of clear and convincing evidence"); PEF Code Section 5512.2 ("the burden of proof, by clear and convincing evidence, shall be on the party advocating the continuation of [the] guardianship or expansion of areas of incapacity"); *Estate of C.W.*, 433 Pa. Super. 167, 169, 640 A.2d 427, 428 (1994) (noting that a guardian seeking authorization to consent to sterilization, another "special power" enumerated in PEF Code Section 5521(d), has the burden of proof to show that sterilization is in the patient's "best interests", and that the standard of proof is "clear

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[3] Needless to say, the Court should always appoint counsel for the incapacitated person where authorization for ECT is recommended. *See* PEF Code Section 5511(a).

and convincing evidence") (citing *Matter of Terwilliger*, 304 Pa. Super. 553, 450 A.2d 1376 (1982)). However, exactly what factors the Court should consider in making the determination that ECT is in the "best interests" of the alleged incapacitated person have never been defined by a Pennsylvania appellate court.

In *In re: M.K.M.*, 765 P.2d 1075 (Colo. Ct. App. 1988), the court held that the standards applicable to the forced administration of anti-psychotic medication would also have to be met before ECT is authorized, and therefore it must be established by clear and convincing evidence that:

> (1) the patient is incompetent to participate effectively in the treatment decision; (2) the treatment requested is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition or to prevent the likelihood of the patient causing serious harm to himself or others in the institution; (3) a less intrusive treatment alternative is not available; and (4) the patient's need for treatment by . . . [ECT] is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment.

765 P.2d at 1075. The court in *M.K.M.* also noted that when it is asked to substitute its judgment for that of an incompetent patient, the court must have the same information that would be conveyed to obtain an informed consent. 765 P.2d at 1076.

In *In re: Schuoler*, 723 P.2d 1103, 106 Wash.2d 500 (Wash. 1986), the Washington Supreme Court held that when a court is asked to make a substantive medical treatment decision for an incompetent individual, it must attempt to decide as that individual would if competent. The court noted:

> A court asked to order ECT for a nonconsenting patient must consider the patient's desires before entering an order. The court should consider previous and current statements of the patient, religious and moral values of the patient regarding medical treatment and electroconvulsive therapy, and views of individuals that might influence the patient's decision. If the patient is unable to understand fully the nature of the ECT hearing -- as severely

> mentally ill patients often are -- the court should make a "substituted judgment" for the patient that is analogous to the medical treatment decision made for an incompetent person. Finally, the court should enter a finding on the nature of the patient's desires.

723 P.2d at 1108, 106 Wash.2d at 507 (citations omitted).

The court in *Schuoler* also noted that "before a court orders ECT it must consider and set forth findings on (1) the desires of the patient or the substituted judgement by the court, (2) the state's interest in the treatment, and (3) the necessity for and effectiveness of the treatment." 723 P.2d at 1110, 106 Wash.2d at 511.

In *Price v. Sheppard*, 239 N.W.2d 905, 307 Minn. 250 (Minn. 1976), the Minnesota Supreme Court held that in making a decision to authorize ECT treatments for an involuntarily committed minor, the following factors should be considered:

> In making that determination the court should balance the patient's need for treatment against the intrusiveness of the prescribed treatment. Factors which should be considered are (1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment, (2) the risks of adverse side effects, (3) the experimental nature of the treatment, (4) its acceptance by the medical community of this state, (5) the extent of the intrusion into the patient's body and the pain connected with the treatment, and (6) the patient's ability to competently determine for himself whether the treatment is desirable.

239 N.W.2d at 913, 307 Minn. at 262-63.

Although not addressing ECT specifically, Pennsylvania cases authorizing a guardian to consent to the incapacitated person's sterilization provide somewhat analogous considerations for the Court in applying the "best interests" standard. In *Terwilliger* and *Estate of C.W., supra*, and consistent with *Fiori*, the courts required a preliminary determination that the individual lacked capacity to make a decision about the proposed sterilization. Such a determination certainly is required where the guardian proposes ECT. Thus, the threshold determination must be whether the petitioner has proven by clear and convincing evidence that

the incapacitated person lacks capacity to make a decision about ECT. The fact that a person is "incapacitated" does not mean that his or her preferences can be totally ignored. *See Terwilliger, supra*, 304 Pa. Super. at 566, 450 A.2d at 1383; PEF Code Section 5521(a) ("Expressed wishes and preferences of the incapacitated person shall be respected to the greatest possible extent.").

After making a preliminary determination that the individual lacks capacity, the Court must consider whether ECT is a "necessary treatment." In this regard, the Court must determine whether, under the circumstances, there are any less restrictive alternatives that are appropriate. *Cf.* PEF Code Section 5518 (petitioner must present evidence "why no less restrictive alternatives would be appropriate"); *Estate of C.W.*, 433 Pa. Super. at 171, 640 A.2d at 429 ("detailed medical testimony must show that the . . . procedure requested is the least significant intrusion necessary to protect the interests of the individual. ") (citing *Terwilliger*). In particular, the petitioner should present evidence regarding other treatments that were attempted and deemed unsuccessful, including pharmacological and psychotherapeutic treatments. While some medical literature suggests that ECT is the preferred treatment for particular conditions such as severe depression, where a Court is asked to authorize ECT, especially over an incapacitated person's objection, the Court must be clearly convinced that other less restrictive treatments have been exhausted.

The Court must be clearly convinced that the likely benefits of ECT outweigh the known possible risks and likely side effects.[4] As part of this consideration, the Court should make specific factual findings concerning:

- The discomfort, side effects and risks of ECT, including any special conditions of the individual that may be effected or exacerbated by ECT;
- The likely consequences if ECT is not authorized[5]; and

[4] The Court may also wish to appoint an independent physician with requisite expertise to evaluate the incapacitated person and opine on the appropriateness of ECT as a treatment modality. *See* PEF Code Section 5511(d).

- The likely consequences if ECT is authorized, and in particular whether the individual's condition is one which is likely to favorably respond to the ECT.

If the Court authorizes ECT pursuant to Section 5521(d)(1), the Court should be careful to delineate the type of ECT to be administered (bilateral or unilateral) and the number and frequency of treatments. As noted above, ECT is typically administered three times per week in a course of six to twelve treatments, depending upon patient response. Unless compelling circumstances exist for the authorization of twelve treatments, it would seem that no more than six treatments should be authorized initially, and then additional testimony received concerning the individual's response to the treatment and any perceived side effects.

Conclusion

ECT remains an important treatment for certain psychiatric conditions, including severe depression. Regardless, the controversy concerning ECT continues, and the public debate can become extremely contentious when the Court is asked to authorize ECT over an incapacitated person's objection. Before doing so, the Court must be clearly convinced that the individual lacks capacity to make their own decision regarding ECT, and that the treatment is necessary and in the individual's best interests, after considering all of the attendant risks and likely benefits.

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[5] The Court should receive testimony and make specific findings on the electrode placement. ECT is administered bilaterally or unilaterally. In bilateral ECT, the shock is administered to both hemispheres of the brain. In unilateral ECT, the shock is administered on only one side, typically the right hemisphere. Although unilateral ECT has been associated with shorter confusion periods and fewer memory deficits, bilateral ECT may be more effective in certain patients or conditions. *NIH Consensus Statements, APA at § 11.5.3.*