

Electroconvulsive Therapy: Administrative Codes, Legislation, and Professional Recommendations

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Government regulatory involvement in electroconvulsive therapy (ECT) is due to several factors, including patient advocate groups, prior abuse by psychiatrists, and a general trend of state authority to move into areas traditionally governed by medical authorities. Regardless of the specific reasons, ECT is both highly effective in the treatment of many psychiatric disorders and heavily regulated by state administrative codes and legislation. The purpose of this article is to conduct a systematic review of the state administrative codes and legislation for the 50 states, the District of Columbia, and Puerto Rico and to compare the findings with professional recommendations for the administration of ECT.

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Electroconvulsive therapy (ECT), while highly effective in the treatment of many psychiatric disorders, is heavily regulated by state administrative codes and legislation.^{1–3} Some have suggested that the regulatory influence has been motivated by patient advocate and special interest groups, and therefore differ in each state.¹ Others have suggested that “. . . progressive intrusion of state authority into areas traditionally held to lie in the domain of medical judgment. . .” and “. . . comprehensive safeguards promulgated by the psychiatric community [for the use of ECT]. . .” existed before statutory regulation (Ref. 2, p 1349). Finally, some believe that the legal regulation of ECT is a phenomenon related to its overuse when first available as a therapeutic treatment modality in the late 1930s.³ Regardless of the reasons, it is clear that ECT is one of the most regulated psychiatric treatments currently available.

The American Psychiatric Association’s (APA) guidelines for the treatment of moderate-severe major depression, recommends ECT as the treatment modality when medications are intolerable or ineffective.⁴ Further, the APA guidelines for the treatment of bipolar disorder state that ECT is indicated as a treatment for medication-resistant acute mania.⁵

ECT has also been recommended for psychotic depression in the context of bipolar disorder.⁶ Moreover, it is a first-line treatment for the following: acute mania in pregnancy, psychosis in the context of neuroleptic malignant syndrome, catatonia, and severe affective disorders in the context of general medical conditions that preclude the use of standard pharmacologic agents.^{7,8}

Although there is agreement in the professional literature concerning the target syndromes or illnesses for which ECT is indicated, there appears to be disagreement concerning contemporary standards of care before the onset of treatments. Specifically, the matters of consent by an individual with an acute mental illness and consultation or evaluation by a second psychiatrist (referred to as the psychiatrist with ECT privileges) remain debatable.^{2,8,9} In essence, there is agreement that the person granting or withholding consent must be competent, informed, free of coercion, and of legal age¹⁰ to consent to ECT. Generally, it is acknowledged that competency may be affected by the underlying symptoms of mental illness. In cases where consent or refusal is based on thinking that is indicative of, or seriously impaired by, mental illness, psychiatrists are urged to consider the patient incompetent to consent.^{10,11} However, there exists no widely accepted, validated, replicated, and standardized test for competency in the context of ECT.¹⁰ As with involuntary adminis-

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tration of neuroleptics, involuntary use of ECT as a treatment modality adds another layer of complexity to the process.

Consultation with a second psychiatrist before the initiation of voluntary ECT is a variable practice. The APA clearly recommends evaluation and concurrence by the psychiatrist with ECT privileges,⁷ in a manner similar to evaluation and concurrence by a general surgeon when a primary care physician recommends a cholecystectomy. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) reiterates the APA recommendations.⁹ However, some states have incorporated these recommendations into administrative codes and legislation; others have not.

The purpose of this article is to provide a systematic review of the applicable laws and administrative codes among the 50 states, the District of Columbia, and Puerto Rico concerning ECT and adults. At issue is uniformity among the judicial and statutory regulation with the professional recommendations concerning ECT in the United States.

Methods

Applicable laws and administrative codes among the 50 states, the District of Columbia, and Puerto Rico were reviewed. The legal research engine, LexisNexis was used to access laws and administrative codes. In addition, both the psychological and psychiatric literature were reviewed, using PsychInfo and PubMed, respectively. In the PsychInfo search engine, 2281 articles were generated from 1972 to April 2006, using the search words “electroconvulsive therapy” and “shock therapy.” When the word “standard\$” was added, and the search was restricted to English articles concerned with humans, published after 2000, 32 articles were selected. The abstracts for these articles were reviewed for appropriateness. The keywords “electroconvulsive therapy and standards” were entered into the PubMed search engine on April 22, 2006, yielding 258 articles. When the search was limited to “published in the last 10 years,” English language, concerned with humans, in a “core clinical journal,” and concerned with adults older than 18 years, one article was retrieved. The content of the articles, the administrative codes, and statutory laws were compared with guidelines offered by the American Psychiatric Association (APA)⁷ and requirements by JCAHO.⁹

Findings

The APA notes that the conceptual requirements for informed consent for ECT, as proposed by the 1978 APA Task Force on ECT, are still applicable and include: (1) provision of adequate information; (2) the patient must be capable of understanding and acting reasonably on such information; and (3) consent must occur in the absence of coercion.⁷ It is noted that a hallmark of informed consent is the quality of the interactions between the patient and the physician—especially as consent for ECT is an ongoing process. While JCAHO requires written informed consent for a series of ECT, there are no specific recommendations as to the content of the consent.¹⁰

General reviews of matters concerning informed consent as they relate to ECT can be found in the literature.^{11–13} Capacity for consent and the use of ECT in incompetent or involuntary patients has been historically addressed in the literature. More recent references covering these subjects can also be found.^{12,14–18}

The APA recommends specific topics for inclusion in an informed-consent document for ECT. The recommendations include: “. . . a discussion of the relative merits and risks of different types of stimulus electrode placement and the specific choice that has been made for the patient. . .” and “. . . the name(s) of the individual(s) who can be contacted [at any time] with questions.”⁷

Notably, both the APA and JCAHO recommend an evaluation by a physician who has privileges to administer ECT before the initiation of treatments. The evaluation includes documentation of the indications for ECT, the risks, suggested additional evaluative procedures, alterations in ongoing medications, and/or any necessary modifications needed to the ECT technique.

Table 1 summarizes the legislative and administrative codes concerning ECT in the 50 states, the District of Columbia, Puerto Rico, and Virgin Islands.^{19–83} The practice concerning consultation with a psychiatrist familiar with ECT in Alaska is governed by the ruling in *Wyatt v. Hardin*.^{2,84} The ruling determined that two psychiatrists experienced with ECT must make the decision, and the hospital director must concur. The court asserted that it was “not undertaking to determine which forms of treatment are appropriate to particular situations,” and the court stated that it did not intend to practice

Electroconvulsive Therapy

Table 1 Statutory Laws and Administrative Codes Concerned with ECT and Adults

State	Voluntary ECT	Involuntary Patients	Involuntary ECT	Comments
Arkansas ^{22,23}	Nothing included	Treatment restrictions outlined	Probate court; clear and convincing evidence	
California ²⁴	Requirements by treating physician articulated; must have three appointed physicians (two board-certified) who agree that patient has capacity to consent	“. . . common knowledge mentally ill persons are more likely to lack the ability to understand the nature of a medical procedure and appreciate its risks. The special regulation of ECT is also a reasonable classification because procedures associated with mental illness, present a great danger of violating the patient's rights."		
Colorado ²⁵	Requirements by treating physician articulated	Must include written information regarding "that there is a difference of opinion within the medical profession on the use of electroconvulsive treatment"		
Connecticut ²⁶	Requires written consent that is valid for 30 days	Nothing concerning involuntary patients. If patient is incompetent to consent: head of hospital, two physicians, and Court of Probate must agree that patient is incompetent and there is no other "reasonable alternative procedure."		
Delaware ²⁷	Requires written informed consent for voluntary ECT. Nothing in statutory laws or administrative codes about involuntary patients or involuntary ECT			
Illinois ³³⁻³⁷	Voluntary ECT not covered in legislation	Involuntary ECT does not require written notice of risks and benefits		
Minnesota ⁴⁷	Nothing concerning voluntary ECT	Involuntary ECT requires that the person be found incompetent to make medical decisions. Court has ultimate decision-making capacity.		
Missouri ⁴⁹	Voluntary ECT requires verbal and written informed consent	Involuntary ECT requires court order after full evidentiary hearing		
Montana ⁵⁰	Consent to voluntary ECT must involve consent from patient and ". . . counsel, the legal guardian, if any, the friend of the respondent appointed by the court, and any other interested party of the patient's choice. . ."			
Nebraska ⁵¹	Only requirements for licensed physician (psychiatrist) specified to perform ECT			
New York ⁵⁶⁻⁵⁹	Detailed guidelines regarding voluntary administration of ECT	Person must be found incompetent by the court for involuntary ECT to be administered		
North Carolina ⁶⁰	Written, informed consent required for treatment			
Ohio ⁶²	"No patient shall be subjected to [convulsive therapy]. . . until both the patient's informed, intelligent, and knowing consent and the approval of the court have been obtained, except that court approval is not required for a legally competent and voluntary patient in a nonpublic hospital."			
Oregon ⁶⁴	Nothing in statutory laws or administrative codes about ECT and adults	Involuntary patients specifically are not subject to ECT		
Pennsylvania ⁶⁵	Nothing concerning voluntary ECT	Powers and duties only granted by court includes consent for involuntary ECT		
South Dakota ^{69,70}	Written informed consent required for voluntary ECT	". . . court finds that the person is incapable of consenting to such treatment because the person's judgement is so affected by the mental illness that the person lacks the capacity to make a competent, voluntary and knowing decision concerning such treatment, the court may exercise a substituted judgment on the administration. . ."		
Texas ⁷²⁻⁷⁵	Extensive requirements directed towards facilities (including registering the ECT machine) and physicians concerning informed consent. Two physicians are required to state that the procedure is medically necessary if the individual is older than 65 years.			
Vermont ⁷⁷	Established a commissioner to oversee the use of ECT.			
Virginia ⁷⁹	Nothing specific concerning voluntary ECT	Court may authorize ECT; clear and convincing evidence is the standard.		
Washington ⁸⁰	Mental health directive may include provisions for ECT. Nothing specific about voluntary/ECT evaluation and consent process			
Alabama ¹⁹ ; Alaska ²⁰ ; Arizona ²¹ ; District of Columbia ²⁸ ; Florida ²⁹ ; Georgia ³⁰ ; Hawaii ³¹ ; Idaho ³² ; Indiana ³⁸ ; Iowa ³⁹ ; Kansas ⁴⁰ ; Kentucky ⁴¹ ; Louisiana ⁴² ; Maine ⁴³ ; Maryland ⁴⁴ ; Massachusetts ⁴⁵ ; Michigan ⁴⁶ ; Mississippi ⁴⁸ ; Nevada ⁵² ; New Hampshire ⁵³ ; New Jersey ⁵⁴ ; New Mexico ⁵⁵ ; North Dakota ⁶¹ ; Oklahoma ⁶³ ; Puerto Rico ⁶⁶ ; Rhode Island ⁶⁷ ; South Carolina ⁶⁸ ; Tennessee ⁷¹ ; Utah ⁷⁶ ; Virgin Islands ⁷⁸ ; West Virginia ⁸¹ ; Wisconsin ⁸² ; Wyoming ⁸³	Nothing in statutory laws or administrative codes about ECT and adults			

medicine. However, the court specifically addressed procedural safeguards and “. . .the court proceeded to forbid some uses of ECT and established 14 rules that severely restricted its use” (Ref 2, p 1350). The required rules ranged from due process and consent to the qualifications of the physicians who might recommend ECT and the conditions under which ECT can be provided. The *Hardin* decision represented the addition of the third arm to the approaches to ECT: professional recommendations or medical approach as embodied by the APA; legislative or administrative approaches; and, finally, the legal approach.

It has been suggested that the three different approaches to the regulation of ECT have different goals.² Findings in *Hardin* attempt to prevent ECT from being provided without “. . .assurance of genuine, responsible, and even independent consent” (Ref. 2, p 1350). As is shown in Table 1, state statutes and regulations range from non-existent to a minimal goal of specific consent required for the procedure, to attempts to control virtually every aspect of the treatment. In general, areas of concern among professional recommendations and judicial and legislative codes are: (1) practice of medicine, (2) documentation; (3) competency and consent; and (4) due process before and during the series of treatments.

Including the District of Columbia and Puerto Rico, there are 33 geographical jurisdictions where the state laws and administrative codes do not comment on the use of ECT. In states where there is no statutory law or administrative code concerning ECT and adults, a determination by only one physician is therefore needed to offer ECT to a patient. Arkansas codes outline treatment restrictions for involuntary patients and require that the probate court find clear and convincing evidence that ECT is needed. Illinois, Pennsylvania, South Dakota, and Virginia all require a court hearing and clear and convincing evidence as the standard of proof and employ substituted judgment a petition is made that a patient receive involuntary treatment.^{33-37,65,69,70,79}

California's specific legislative requirement that three consenting physicians agree to the treatment and agree that the individual is competent to consent to ECT arises from the court's opinion in *Aden v. Younger*.²⁴ The Colorado Revised Statutes, the Texas Health and Safety laws, and the New York Office of Mental Health are very specific with respect to the

requirements of the treating physician.^{25,56-59,72-75} In California, these requirements include providing the patient with written information that specifically states “. . .that there is a difference of opinion within the medical profession on the use of [ECT].”²⁴

In summary, the medical recommendations for ECT as proffered by the APA, have been reiterated by JCAHO. Therefore, all hospitals across the country, in the District of Columbia, and in Puerto Rico that accept Medicare payments should be following these minimal recommendations. The majority of states do not have administrative codes or legislation that addresses ECT, and so providers would theoretically follow the APA/JCAHO recommendations. There are three states (California, New York, and Texas) where the legislative requirements are more stringent than the APA recommendations.

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Electroconvulsive Therapy

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Harris

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