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Voices of people who have received ECT

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Abstract

Electroconvulsive therapy (ECT) is controversial but widely practised in India. We elicited perspectives, using qualitative interviews, from patients who received ECT and their relatives. Ethical issues related to personal autonomy, right to information, competence, informed consent and consent by proxy are discussed. We suggest strategies to ensure a basic minimum standard for obtaining informed consent for ECT in India.

Introduction

Electroconvulsive Therapy (ECT) is widely practised in India to treat severe psychiatric disorders. However, ECT is one of the most controversial treatments in medicine and opinions regarding it are often polarised (1). Recent debates have focussed on the choice of ECT without anaesthesia (2), the practice of maintenance ECT and the clinical indications of ECT following the guidelines published by National Institute of Clinical Excellence (NICE) (3). Practitioners of ECT have always been challenged by sceptical arguments against its safety and efficacy. Perspectives on ECT have ranged from considering that it is probably ineffective and causes brain damage (4) to thinking it is the most effective treatment available in psychiatry and is completely safe. Systematic reviews of available efficacy studies conclude that ECT is an effective short-term treatment for depression, and is probably more effective than drug therapy. They acknowledge the propensity to cause short-term memory deficits, which are more common with bilateral supra-threshold ECT (5). However, systematic reviews of patients' perspectives of ECT claim that at least one-third of patients suffer from persistent memory deficits (6). They suggest that a similar proportion of patients perceived that they were coerced into giving consent for the treatment and they were not given enough information about ECT (7).

Despite these disputes and the dearth of data regarding its long-term adverse effects, the use of ECT is relatively common in India due to its clinical efficacy, the relative absence of negative perceptions and cost effectiveness. A recent Indian survey reported that 52 per cent of institutions still use ECT without anaesthesia and only eight institutions have facilities for routine electro-encephalography monitoring (8). Continuation and maintenance ECT are also widely in use. Those favouring direct ECT claim that facilities for anaesthesia are neither available nor affordable in many settings (2). Institutions in India also differ in their standards of practice and technical specifications while delivering ECT (9). Recent Indian studies have predominately focussed on clinical efficacy of ECT (10). There have also been legal attempts to ban direct ECT in India (11). Though opinions and controversies about ECT are often vociferously expressed and debated, systematic research on such perspectives in India is sparse. We describe a qualitative investigation into perspectives about ECT among patients and relatives.

Methods

The department of psychiatry, Christian Medical College, Vellore, is a tertiary referral centre rendering mental health services for patients from many parts of India. The 122-bed hospital provides short-term care for patients with organic disorders, substance abuse-related disorders, psychoses, mood disorders, anxiety disorders and adjustment problems. Patients and members of the family stay in independent cottages during the period of hospitalisation, which often ranges from three to six weeks. The emphasis is on a multi-disciplinary approach and eclectic care using a wide variety of pharmacological and psychotherapeutic approaches. The outpatient clinic serves 20-25 new and 350-400 review patients per day. It employs 15 consultant psychiatrists, 20 psychiatric residents, and 30 psychiatric nurses in addition to clinical psychologists, social workers, occupational therapists, speech therapists and special education teachers. ECT is administered twice a week under general anaesthesia. Ten to 15 patients receive ECT per session and the number of ECTs given per patient ranges from eight to 12.

We conducted qualitative interviews with 104 people: 52 consecutive patients who received ECT, and their relatives. The details of the study are described elsewhere (12). All respondents were interviewed individually after the completion of their course of ECT using a modified version of the Short Explanatory Model Interview (13), specially adapted to elicit perspectives related to ECT. We selected 10 more articulate patients for the in-depth interviews. A discussion guide was developed based on eight major issues raised in the literature (6, 14). They were: (i) fear of ECT, (ii) perceived adequacy of information provided about ECT, (iii) the process of informed consent, (iv) perceived coercion, (v) perceived benefits of ECT, (vi) attribution of cognitive deficits to ECT, (vii) suggestions from patients and (viii) whether they would accept ECT as treatment for future episodes of illness. At the end of the interview, information was provided regarding ECT and support services available for people with severe psychiatric

illnesses and their caregivers. One investigator (APR) conducted all interviews in Tamil. These lasted for 45 to 60 minutes with an additional 15 minutes for informal conversation. The interviews were audiotaped, with the consent of each participant, and transcribed verbatim.

We used a framework approach to data collection and analysis of the in-depth interviews (15). The framework approach has been used for applied or policy-relevant qualitative research in which the objectives of the investigation are typically set in advance. Although the framework approach reflects original accounts and observations, it starts deductively from our preset aims and objectives. We employed thematic analysis for the assessment of the themes that emerged during in-depth interviews. We identified themes which recurred with high frequency and themes with high emotional load. The analysis was designed so that it could be viewed and assessed by people other than the primary analysts (APR, BS). We generated notes and open codes, organised them manually, and grouped similar codes into categories. We discussed any disagreements regularly to reach consensus regarding coding. Though we did not enhance rigour by multiple coding, the analysis was improved by constant comparison with the transcripts. We identified and discussed a hierarchical scheme of specific themes, issues, and problems that emerged from the qualitative data. The information was translated into English after the analysis.

Results

The majority of the patients were women (29; 56.8 per cent), younger adults (mean age 32.1; SD 9.9 years), married (33; 73.5 per cent), literate (46; 88.5 per cent), employed (35; 67.3 per cent) and from rural backgrounds (32; 61.5 per cent). They had affective illness (30; 57.7 per cent) or schizophrenia (22; 42.3 per cent) with high suicidal risk (25; 48.1 per cent) and with an average duration of illness of about four years. A quarter of the patients (13; 25 per cent) had received ECT in the past. The semi-quantitative data are presented elsewhere (12). Five men and five women who were more eloquent participated in the in-depth interviews within a week after the completion of their course of ECT. Details of the qualitative data are presented here.

The voices of people who have received ECT are discussed under the following heads:

Fear of ECT

Fears about general anaesthesia, the ECT procedure, possible brain damage and memory impairment and the stigma related to ECT were mentioned during the interviews.

"When I thought of what would happen during ECT, my body was trembling in fear."

"I feared that my brain would be damaged by this. I worried whether I would become useless and unable to do any work."

An unmarried woman added, "I feared that I would be unable to do household work or to marry."

Patients also reported hitherto unaddressed fears about the anaesthesia. "I knew about anaesthesia right from my school days. We used to anaesthetise frogs with chloroform during our dissection. I thought that I was in the place of that frog."

Another patient reported that her fear of ECT was short-lived. "I felt the difference after the first ECT. My fear had gone away. I developed the confidence that I could work."

Perceived adequacy of information provided about ECT

Many patients were unaware of the ECT procedure, its purpose, and possible risks and benefits even after completing their course of ECT.

"I went inside, they made me lie down. They stuck a needle in my hand. I thought that they were taking a blood sample."

"I did not know what was happening inside the room. But I did not have the courage to ask questions."

Patients wanted their psychiatrists to provide more information about ECT as evidenced by the following views:

"No one explained the details to me. I would stand in the queue to pay for and then receive the ECT. They also gave me a prescription for medicines..."

"They should provide some more information. They should at least tell the patient that they are getting 'shock treatment'."

Patients, especially those from the rural areas, the less educated and the poor were hesitant to talk to their doctors and to clarify their doubts.

"I do not have the courage to talk to the doctors. I will tell you the truth: I am really fearful when I am talking to any doctor. I hold the doctors in high esteem. How can I ask them questions?"

Other patients had implicit faith in the doctor's judgment.

"Doctors are the people who are going to treat me. They are equal to God. I have not seen God. I am seeing God in them. How can things go wrong?"

Some of them felt that the information provided was adequate:

"I think that the information they provide now is enough. Of course they are giving ECT first and only then are they telling patients that they have been given ECT. The patients are getting cured, so we cannot say that this is wrong."

Process of informed consent

All consent forms for ECT were signed by the relatives and some were also signed by patients. Even the patients who signed their consent forms were unable to recall the details about the consent process.

"I signed without knowing what form it was."

"I do not remember anything. I cannot recall who talked with me, what they said and whether they got my signature.

I remember standing in the reception of the ECT room... I also remember lying down on the bed. Otherwise, I do not remember anything else. Now, the doctors are saying that I opted for ECT. I do not remember ..."

"My daughter signed the form. She is quite ignorant. She does not know anything about this treatment."

"My brother told me that we were going to the hospital. His decision was final and cannot be disputed. So I agreed and came to this hospital. I did not know that he was bringing me for this."

However, one patient summarised the process as follows:

"I could have been cured or I could have died. Both could have happened. So they got my signature. I told them that I would not die and then I signed the form."

Perceived coercion

Some patients felt coerced into agreeing to undergo ECT. However, many stated that other treatment choices were given and that they were not unhappy with the ECT. One patient said:

"No, ECT was the only option given..."

Many patients were passive and admitted that their doctors made the decision.

"It was my doctor's decision. He said that I would be alright after this treatment."

A mother of a patient (she was present during the interview with the patient) said:

"My daughter will be cured only if she accepts ECT. How can we leave her if she does not want this? We should make her get the treatment with compulsion."

Others were aware of alternative treatments. "Yes. I got a choice. My doctor gave me ECT after getting my consent."

Perceived benefits of ECT

Many patients admitted to positive experiences and benefits due to ECT. However, patients assessed benefits of ECT in global terms with particular emphasis on recovering functional ability, rather than mere recovery from clinical symptoms.

"My condition was so bad. Now there is a definite change... My health is better now."

"There is good improvement after ECT. I am able to go to work now."

"I can enjoy my life to some extent. This was not possible earlier. You know, when you are depressed, the mood and the way of thinking are completely different. I was like that. I can control that unnecessary thinking now... I was thinking about a lot of unwanted things. I thought of committing suicide. I do not have those thoughts now."

Attribution of cognitive deficits to ECT

Many patients spontaneously reported cognitive deficits.

"I am unable to remember anything. Who will bear that? It is really unfair. I do not remember anything about my uncle's visit to the hospital. I do not remember even a millisecond of that."

Patients are more concerned about the functional limitations caused by their cognitive deficits.

"My memory is becoming dull. After ECT, I cannot find any job. That is my first concern."

"...I do not remember what I talked about with my doctor. I have forgotten my doctor's name... I wonder why ... I used to have a good memory. Now I am very forgetful. This affects my life very much. I am unable to go to work. I have difficulty in managing my household work."

Other patients felt differently:

"I would rather be forgetful than be depressed."

"It is fine. There is a price for everything... There is no treatment without side effects. I have forgetfulness. I cannot deny that, but can I get any treatment without adverse effects?"

Patients' suggestions

Most of the patients were surprised when they were asked to provide suggestions to improve the treatment procedure. Many acknowledged that they had never been presented an opportunity to share their views.

"I feel it's OK. What has been done is good enough."

Patients suggested that they should have been provided at least the minimum information regarding ECT.

"Doctors prescribe ECT to patients who may be severely ill. So they need not explain all the details about the ECT at that time. It will be better if they explain when they improve."

One patient aptly suggested that psychiatrists do more research in this area to enlighten people regarding ECT:

"You should do more research. You should know all the good and bad things about ECT. Only if you know them all can you do any good for people like us."

Whether they would undergo ECT again

Four of the 10 patients who participated in the in-depth interviews stated that they would accept ECT as treatment for future episodes of illness. Many who refused to accept ECT in the future mentioned their concern about cognitive deficits.

"I am forgetting too many things. If I am asked to undergo ECT again, I will not agree..."

"I would not like to have ECT anymore... I will negotiate with the doctors not to get ECT."

One patient, a surgeon by training, strongly resisted the option of ECT.

"I will not accept ECT. They need my consent. I have read psychiatry books saying ECT is a good treatment... But I cannot find anything good in ECT. I did not find any benefit from ECT."

However, those who were willing to accept ECT in the future approved of it as a useful treatment.

"Yes, definitely, if someone has experienced ECT once, they will never say no to it later, because there is much improvement."

More than half of the patients were not aware of the details of ECT even at the end of the course but were not unhappy about receiving ECT. An analysis of the semi-quantitative data gathered in interviews of patients and their relatives (12) revealed the following: The majority of relatives felt that enough information was provided about the treatment. They knew of its benefits and risks and felt that they were offered a choice of treatment but also admitted to feeling coerced. Patients and relatives assessed benefits and risks of ECT in global terms with an emphasis on recovering functional ability rather than merely recovering from clinical symptoms. Individual patients and relatives differed in their willingness to receive more information, the perceived adequacy of their knowledge about ECT, their ability to recall the details, and their belief systems. All relatives had signed the consent forms while a minority of patients had also given their signed consent. Even patients who had signed their consent forms were unable to recall the details about the consent process.

Discussion

This study was part of a broad-based qualitative investigation on the perspectives of patients who received ECT, and those of their relatives (12). Qualitative research methods were chosen to explore attitudes and perceptions in detail. The need for more information on subjective perceptions of ECT and the need for new insights into this issue justify the choice of qualitative research. While 52 consecutive patients were enrolled for the study, in-depth interviews were conducted on a small and selected sample of patients who were verbal, communicative and cooperative. The other methodological limitations include the short interval between treatment and interview and the setting of the interview. The short follow-up after the course of ECT does not allow for views on its long-term effects. Medical personnel in the hospital conducted the interviews and this might have influenced the views of patients. The lack of multiple coding for the in-depth interviews was overcome by constantly comparing with the transcripts and with available research in this field. The personal bias of the researchers was minimised by avoiding directive questions to elicit cognitive side effects, by allowing discussions to develop naturally, and by reporting the wide range of perspectives.

We recognise that qualitative research has its own limitations, notably limited generalisability due to the recruitment of a small convenient sample. The concept of transferability, introduced as an alternative to generalisability, is probably better suited for such research. It implies that the onus is on the reader to evaluate the methods, setting, and results and decide if these are transferable to their own situation. We believe that the findings of this study can be transferred to other settings, not only in India but also elsewhere.

The perspectives and opinions expressed by those interviewed for this study highlight the complex nature of the issues faced by people with psychiatric illness, by their relatives and by the treating team. The ethics of informed consent for medical procedures is a complex subject. There are many reasons for the polarisation of views on, for example, informed consent in ECT. We have chosen here to discuss five ethical issues related to ECT, using the qualitative data presented here and the semi-quantitative data from the same study published elsewhere (12). We leave it to readers to arrive at their own conclusions.

1. Standards for informed consent

The two criteria commonly employed as standards for consent are individual freedom (and the patient's right to refuse treatment) and society's right (and its right to impose therapy), which are mutually exclusive. The western world favours individual rights when the patient's competence is intact; society may take over decision-making when this faculty is considered to be impaired. The actual decision depends on the clinical situation and represents a compromise between these two rights. Similar ethical dilemmas exist in many clinical situations in the care of people with severe mental illness, including compulsory admission and the use of parenteral medication in acutely disturbed patients.

With the increasing value placed on personal autonomy in many cultures, many patients and societies have demanded that the individual be given the legal right to decide on medical procedures and treatments. However, in many countries including India such legal requirements are often met if the individual signs an informed consent form for a medical procedure or treatment. This practice may violate the spirit of informed consent, as even educated patients may not fully understand medical jargon; also there is a certain amount of doubt and uncertainty in medicine. Similar issues regarding the validity of informed consent during the conduct of randomised controlled trials are being debated (16). In reality, the ethical choices related to informed consent are complex and difficult to make.

Another issue that has an impact on informed consent is the value systems of people. Many people in rural India continue to value health over personal autonomy and often request the doctor to decide about treatment options. In India the doctor-patient relationship is often viewed as similar to a *guru- sishya* or teacher-disciple relationship. The fiduciary nature of the doctor-patient relationship allows doctors to make decisions on their patients' behalf, when their patients permit them to do so. In such contexts, the ethical decision would be dependent on the physician and would be part of the burden of caring for patients. However, doctors need to assess the patient's value system. Treatment choices and basic information should be offered to all patients and discussed in detail for patients (and relatives when they have to give consent) who value individual

autonomy. Treatment decisions can be made for patients when they permit doctors to decide on their treatment. The psychiatrist should recognise that the *guru- sishya* relationship not only empowers the *guru* to decide but also enforces more responsibility on him/her to respect the welfare of the patient. Accountability is the other side of the coin of autonomy. When a psychiatrist transgresses autonomy because of the context, he or she is expected to accept the added accountability.

2. Patient competence

Competence encompasses the cognitive capacity essential for therapeutic decision-making. It is fundamental to the process of informed consent. When this faculty is considered to be impaired, society devalues personal autonomy and takes over the individual's rights to decide on treatment options. Every adult is considered competent unless it is proved otherwise and psychiatric illness per se does not infer the lack of competence. For example, many patients with severe depression have been found to have adequate decisional capacity to consent for ECT (17).

Nevertheless, the assessment of competence often hinges on clinical judgement. Psychiatrists have demonstrated poor inter rater reliability (with kappa values as low as 0.31) for their clinical judgement on competence (18). Competent refusals of ECT may be confused with lack of competence, and the acceptance of ECT in people who lack competence may be misinterpreted as informed consent. In the context of the fiduciary nature of the doctor-patient relationship, the treating team and doctor often have the last word.

The study clearly demonstrates that informed consent was not obtained from the majority of patients and was obtained from their relatives instead. In addition, many subjects who signed consent were not able to recall the details of the process. The results of the semi-quantitative investigation (12) reveal that patients who were admitted and received ECT "voluntarily" differed from those who were admitted as involuntary patients. Those who were admitted to the hospital as voluntary patients held medical causal explanations, agreed that an alternative treatment option was given, felt that adequate information was provided, perceived more benefits, were aware of possible memory problems and gave personal consent for the procedure. Those who were admitted to the hospital as involuntary patients held nonmedical causal explanations, were unaware of alternative treatment options, felt that information provided was inadequate, perceived fewer benefits and were unaware of possible memory problems. Their relatives provided the consent for the procedure (12).

The minimum requirements for competence include understanding that ECT is offered, consciously deciding on whether or not to undergo ECT after considering its risks and benefits, and having the ability to communicate one's decision. The need for a standardised assessment of competence is increasingly being recognised. Instruments such as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) can assess an individual's competence to consent for ECT, but they have not yet become routinely used in clinical practice (19). The instrument consists of four domains: understanding information relevant to one's illness and the recommended treatment, reasoning about the potential risks and benefits of the choices presented, appreciating the nature of one's situation and the consequences of one's choices, and expressing a choice. When a psychiatrist doubts a patient's competence, he or she must clearly document the rationale for this opinion. It is also desirable to call for further detailed assessment and an independent second opinion regarding competence. The assessment that a patient lacks competence affects only the right to decide on treatment; it does not take away basic human rights of safety, dignity and good quality medical care. Hence, doctors should take additional effort to ensure the care and rights of those patients whom they declare to lack competence.

3. Consent by proxy

When an acutely or severely ill patient is judged to lack competence to consent for ECT and is at risk to him/herself or others, psychiatrists seek surrogate consent or consent by proxy from the patient's legal representatives. In this study, all consent forms had space for the relative's signature and the relatives were asked to give consent on behalf of those patients who were considered to lack competence. Many relatives mentioned their responsibility to ensure the best possible care for their ill relatives and many stated that they would seriously consider forcing their ill relatives to get ECT if it benefited them. Women who participated in in-depth interviews reported that they had to abide by the decisions made by their male relatives.

The World Medical Association (WMA) allows consent by proxy but emphasises that the patient must be involved in therapeutic decisionmaking to the fullest extent allowed by his or her capacity. The WMA also empowers the physician to act in the patient's best interest in situations of emergency (20). In the West, such situations are mostly handled by advance directives, substituted consent of the court, and consent by proxy by institutional ethics committees, treatment review panels or a team of psychiatrists. The situation in India is different. The cost of treatment and the burden on the family play a major role in deciding on the choice of treatment here. Unlike in the West, the cost of treatment in India is not paid for by insurance or by the government health service; it is borne by patients and their families. The absence of a state-sponsored social security net and the responsibility on the family to provide care and treatment make the family responsible for providing consent by proxy. When a psychiatrist seeks consent by proxy from a patient's relative, the dyad (psychiatrist and relative) is governed by all the issues related to autonomy, right to information and informed consent.

4. Personal autonomy and perceived coercion

The study shows that all relatives signed consents; many reported that the details of ECT were discussed with them and alternative treatments offered and they were happy with

the outcome. Yet many relatives also perceived that they were forced to provide their consent. Even the minority of patients who signed the consent form could not recall the details of the procedure. Many patients also reported coercion. It suggests a power differential between doctors and patients. Such unequal power balances within the doctor-patient relationship exist even in the West. The West sanctions the devaluing of personal autonomy when there is a threat to society, possible harm to others, a need for partner notification of an HIV positive person, and a conflict with the physician's own moral standards (21). Personal autonomy in the context of Islamic society has also been evaluated and it is concluded that a universal declaration of biomedical ethics may not be possible (22). In psychiatric settings, personal autonomy is frequently challenged in clinical situations such as compulsory involuntary admission and the use of parenteral medication while caring for the acutely and severely ill. Often such decisions contain elements of subtle and even overt coercion (23).

5. Right to information

In this study more than half the patients interviewed were unaware that they had received ECT and the majority reported that they were not given essential information regarding the procedure while their relatives admitted to having received information about the treatment. The patients in this study expected their psychiatrists to provide more information about ECT but many of their relatives considered that providing more information could do more harm than good (12).

The WMA asserts that every patient has the right to receive all information about his or her medical treatment. Such information should be provided in a culturally appropriate way that ensures adequate comprehension. The World Health Organization (WHO) has discussed the three general models for providing information: non-disclosure, full disclosure and individualised disclosure (24). The non-disclosure model provides false hope and denies the patient an opportunity to come to terms with the treatment. It also undermines the doctor-patient relationship, precludes patients' and relatives' participation in their treatment and creates barriers within family units. It also leads to information gathering from uninformed sources. The full disclosure model is based on revealing all available information to patients. This too is paternalistic, as the provider decides on when to provide information. It is culturally insensitive in a culturally heterogenous society because the provider does not consider the needs of the individual patient. The individualised disclosure model suggests that information should be provided according to patients' needs: how they will cope, and the amount of information they want. Such a model may not provide complete information to everyone but will attempt to convey information appropriate to each person. For this reason, the individualised disclosure model has received wide support.

ECT has a special status among psychiatric treatments and requires specific written informed consent. The term "informed consent" implies that a person understands the facts, benefits and risks of ECT and then voluntarily indicates willingness to receive ECT. Such complete understanding and true voluntarism are rarely attained in actual practice. In the context of a dependent therapeutic relationship, informed consent almost always contains an element of coercion (25). In India, the process is complicated by a reduced emphasis on personal autonomy and a lack of awareness of human rights, with roots in illiteracy and poverty. Submission to authority is often considered appropriate. In this situation the patient voluntarily yields to the physician's authority. Informed consent becomes a mere formality, given in order to maintain harmony in the doctor-patient relationship. It is difficult to ensure the spirit of informed consent.

Suggestions to improve the practice of ECT in India

The difficult issues related to informed consent must be addressed in routine clinical practice. A protocol needs to be in place, employed religiously and audited regularly.

Techniques to enhance the transfer of information use a graded stepwise approach. Information is provided after obtaining a clear signal to proceed with the details. Discussion should be held within the context of an empathetic, supportive therapeutic relationship. There should be no intimidation or curb on clarifications. Patients should be provided enough time to absorb the information. It is also important to discuss the patient's feelings.

The specific components of the transfer of information include: (i) finding out what the patient already knows, (ii) assessing and bridging the gap between patient understanding, expectation and reality, (iii) providing details that the patient wants to have, (iv) stating the issues in simple language, (v) allowing time to absorb the information, (vi) encouraging patients to express their feelings (vii) clarifying doubts, misconceptions as well as fears and (viii) being available for further clarification.

A minimum standard for the practice of ECT in India should include the following strategies regarding informed consent and competence assessment:

(i) Adoption of the individualised disclosure model to provide information. Patients should repeatedly be given information about ECT using the techniques described above to maximise comprehension.

(ii) Informed consent is not an event but a process. Patients and their relatives have difficulty assimilating details on ECT in a single interview. The psychiatrist should provide regular appointments for education and clarification of doubts. Patients should be facilitated to ask more questions.

(iii) If the psychiatrist believes that it is inappropriate for certain information to be provided to the patient at a particular time or context, this should be documented in the medical records. The justification for those concerns should be reviewed periodically during the course of ECT.

(iv) Written information in the form of fact sheets on ECT should be provided to patients and their relatives. Fact sheets cannot replace verbal discussion but they can act as efficient

adjuvants. They serve as reminders for discussed information and as templates for framing further questions. They should be written in simple language devoid of technical jargon. They need to be provided in the patient's mother tongue. Institutions can develop their own fact sheets keeping in mind the cultural and contextual specifications of their patient population. Ensuring accuracy and maintaining a neutral perspective are desirable but arduous while formulating a fact sheet. Even the Royal College of Psychiatry had to withdraw its fact sheet following controversies related to NICE guidelines (3). Hence, an honest attempt to maximise quality may fail to produce the ideal fact sheet on ECT but will result in the construction of one that is sufficient to strengthen prevailing practice. Liberal support to ask further questions should also be offered. (A basic framework for the topics to be covered in a fact sheet is presented as supporting online material in the journal website.)

(v) Written informed consent should be obtained from patients who are competent or from the legal representatives of patients who lack such competence. When a patient is judged to lack competence, his/her decision-making capacity should be reassessed during the course of ECT. If the faculty of competence is restored, specific consent should be obtained from the patient to proceed with further ECT.

(vi) Patients' comprehension of conveyed information regarding ECT, its risks and benefits should be assessed independently by a medical or non-medical professional who is not involved in the treating team.

(vii) A checklist should be formulated to ensure that treating psychiatrists have attended to essential elements of the informed consent process. The routine use of such checklists will help subsequent audit of the informed consent process. (An example of such a checklist is also provided as supporting online material in the journal website.)

These strategies, when employed in the context of the grossly unequal power equations of doctor-patient relationships, will not result in equality for patients; nor will they remove all coercion. However, we hope that they will improve the current practice of ECT in India and move it towards the ideal.

Conclusion

ECT remains as a controversial treatment but is widely practised in India. The current practice of ECT in India has many lacunae due to complex sociocultural factors. The application of a universal bioethical model and the use of arguments on ethical standards of ECT have not produced any tangible progress. Hence, we favour a holistic approach to understand the ethical quandaries related to the use of ECT and have devised feasible strategies to ensure a basic minimum standard to obtain informed consent for ECT. Future research on patient perspectives, long-term cognitive adverse effects and the effectiveness of differing models of educational interventions on ECT is desirable.

Conflict of interest: *The authors employ ECT in their clinical practice.*

Acknowledgement: *The study was supported by a research grant from Christian Medical College, Vellore. The authors would like to thank all those who took part in the study. The authors have modified the informed consent procedure for ECT after the study, and have introduced a detailed fact sheet clearly stating the issues related to usefulness, the procedure, memory deficits, consent and its implications. They have also implemented procedures to provide information in a graded stepwise manner and a checklist to document the process of obtaining consent.*

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