

Electroconvulsive therapy: the importance of informed consent and 'placebo literacy'

Charlotte Blease

I thank Julie Hersh for her thoughtful and valuable comments on the use of electroconvulsive therapy (ECT).¹ Discussions with those who have experience of treatments (such as ECT) is of the utmost importance when debating issues such as informed consent. I am therefore very pleased to be given this opportunity to respond. Hersh offers three main criticisms of my paper but I hope to show that the tenets of the paper are not undermined by her commentary.

Hersh's first criticism stems from her personal experience: she claims that, 'The results of ECT for me were miraculous'. She argues that ECT 'works' and we have '70 years of remarkably positive experience' to support this fact. In response, I agree that there are certainly patients who believe that ECT has been a highly effective intervention: but equally, there are others who have experienced intolerable side effects as a result.² ECT is a controversial treatment precisely because of the serious long-term risk of memory loss.^{3 4} If we are to strive for the best healthcare possible, we cannot base our conclusions merely on positive cases: we need to consider *all* cases (and this is why providing information on side effects is extremely important for this form of treatment). Thus, I reject her conclusion that ECT is 'remarkably positive' for all patients: studies do not unequivocally support Hersh's fortunate experiences. In addition, I must also challenge the assumption that ECT 'works'. Counterintuitive as it may sound, no patient can make assumptions about *whether* her course of ECT treatment actually 'works': this includes assumptions about *how* a treatment may work. For example, it might be that the individual patient would undergo remission anyway. In addition, patients cannot infer the causal mechanisms of a treatment: in the case of ECT, we need to ask: (i) *whether* there is evidence that it does work, and (ii) if it does work, *why*: what is the curative component? This

information is not intuitively accessible to human consciousness: as individuals we may 'tell more than we know',⁵ but it is the job of scientific researchers to answer these questions. None of this undermines the point that patients' subjective reports about treatments are important but it does emphasise that anecdotal cases are never enough to reach conclusions about the efficacy of a treatment.

Hersh's second complaint regards the hypothesis that ECT may work as a placebo and what this means for patients. Hersh is concerned that if patients are advised that ECT works as a placebo then this will 'belittle' the treatment. She cautions against informing patients that there is an 'unproven hint of a placebo effect' since this will 'denigrate the procedure'. There are two serious problems with this analysis. First, there is an underlying assumption that if ECT works as a placebo this means it is a 'non-effect'. As I argued in the paper, there continues to be controversy over whether ECT is effective; and, in addition, if it is effective, whether this is due to the placebo effect. I also noted that ECT may still prove to be a significant intervention for depression even if it is placeboogenic. Indeed, Hersh is quite right—the idea of electricity in the brain is good theatre—but the point is, it may be this very theatricality that plays a key role in inducing the placebo effect.⁶ In summary, the placebo effect can be a *specific* effect for certain disorders, and one that may prove very important in certain treatments. Indeed, whether she realises it or not (and whether this rankles or not), the medical community regards it as a plausible hypothesis that the placebo effect *might* have been effective in Hersh's own case.

Second, I would gauge that most patients implicitly assume that when high-voltage electricity is passed through the brain causing a seizure that the medical community has a sound explanation as to why such a procedure works. It is certainly of relevant interest to patients that the medical community does not yet understand how ECT works and that it may work as a placebo effect. Moreover, in the paper I noted that *as a matter of fact*, physicians in the USA (where Hersh

received her treatment) are expressly forbidden to use placebos without patient consent.⁷ It is an empirical matter whether we can provide 'non-deceptive placebos' to patients: as I mentioned in the paper, it may even be the case that we can inform patients that they are receiving a placebo and for the treatment still to prove effective.^{8 9} Once again, however, we require more empirical research on these issues.

This brings me to Hersh's third criticism: this is the claim that informing patients that ECT may work as placebo enforces a 'dogged approach' that may 'cause more harm than good' and render patients 'more likely to refuse the procedure'. In response, I reiterate that intuitions are no substitute for empirical research. It is an open, empirical matter whether informing patients that a treatment may work as a placebo will dissuade patients from undergoing ECT. If full and accurate information is provided on placebos, it might be the case that patients will not be dissuaded from this form of treatment: that is to say, if physicians are 'placebo literate' then patients may be better informed about the placebo effect as a treatment for depression being not insignificant (indeed, that it *may* save their life).¹⁰

Second, there are serious ethical issues that Hersh has glossed that Hersh has glossed over. Advocating a paternalistic policy of not providing full or relevant information is risky: it is one that assumes that patients cannot handle information or are not equipped to make their own medical decisions. Perhaps Hersh is suggesting this when she declares that one can be 'overly informed'. I agree that the issue of capacity to make decisions is a significant concern. It is one that I did not have the space to discuss in the paper. Nonetheless, in Hersh's own case it appears that information on potential side effects ultimately did not impede her own decision to go ahead and complete the treatment. More broadly, therapeutic privilege is a move that the medical community has sought to relinquish.¹¹ The author alludes to this herself when she objects that many seriously depressed people have contacted her with the complaint that they have been denied the treatment because, in her words '*their psychiatrists* have ruled out ECT because of the fear of side effects'. It is surely right that each patient decides, weighs up the information and makes an informed choice about her treatment, just as Hersh had the opportunity to do.

I would like to respond to two further, minor criticisms. Hersh imputes to me support for the signing of consent forms before *every* treatment of ECT. I did not discuss this aspect of the informed

Correspondence to Dr Charlotte Rosalind Blease, School of Politics, International Studies and Philosophy, Queen's University Belfast, 25 University Square, Belfast BT7 1PB, Northern Ireland, UK; cblease02@qub.ac.uk

consent procedure in detail. Second, Hersh claims that neuroimaging would be a better method of ‘proving’ the efficacy of ECT. I am less sanguine about the possibility of what can be proved by neuroimaging both in the short term, and as a long-term goal in ‘vindicating’ treatments.

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