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ECT during COVID-19: An Essential Medical Procedure – Maintaining Service Viability and Accessibility

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Editorial

"I have no idea what's awaiting me, or what will happen when this all ends. For the moment I know this: there are sick people and they need curing."

— Albert Camus, The Plague

With the advent of the COVID-19 plague, we are in unprecedented times (see Tor et al., *ECT in a Time of Covid*-19; McLoughlin et al., Images in Clinical ECT: Immediate impact of COVID-19 on ECT Practice; both this issue).(1,2) The last pandemic of similar scope, the Spanish flu of 1918, occurred before the advent of modern medicine: before the use of insulin in diabetes, before the discovery of penicillin, and before the discovery of electroconvulsive therapy (ECT) for serious psychiatric disorders. The world we knew last week is not the one we know now and what becomes the new normal remains to be determined. Yet, amidst this uncertainty and peril, we, as practicing Psychiatrists and mental health clinicians, are tasked to continue to provide help, care, and hope. Over the past weeks, beginning first in Asia and marching now through every corner of the world, the strain on healthcare systems has exposed fragilities and gaps impacting our ability to care for our patients.(2-5) While the focus has been on directly confronting and containing the coronavirus pandemic through public health measures, there remains a need to deliver care for everyone else, including those with serious mental illness requiring ECT, an often essential and life-saving treatment. However, ECT has been traditionally viewed as an elective procedure, and in this pandemic, elective procedures are deemed non-essential or non-urgent, creating much angst for providers and especially for patients who depend on this treatment.(6) Notwithstanding the lack of clear consensus within

the medical field on what uniformly constitutes an elective procedure, its potential absence or severe limits on access necessitates a reevaluation of this label and new appreciation of its place among medical procedures. Clearly, for some patients ECT will be urgently needed and life-saving. For others, ECT will remain essential because of clinical acuity or the lack of available options. For another group (mostly maintenance ECT patients and those presenting with less urgent clinical situations), and dependent on available staffing and resources, ECT may have to be postponed. During this time, it will behoove the ECT practitioner, with guidance from ISEN and the APA, to develop a framework on which to determine a hierarchy of need commensurate with local resources to perform ECT in the necessary and safest manner.

Unfortunately, whether during pandemics or, more commonly, in everyday situations, the needs of all patients may not be equally or dispassionately considered, and consequently guidelines and policies may be suboptimal at best and discriminatory at worst.(7) It is an all too familiar story for persons with psychiatric illnesses.(8-10) While many arguments for rationing precious resources (hospital beds, ventilators, personal protective equipment (PPE), etc.), are sound and laudable, these choices and policies often exclude the unique and challenging needs of persons with mental disorders or disabilities. Further, policies developed without the input or knowledge of ECT Psychiatrists and mental health providers at the front lines may result in care processes or resource allocation decisions with adverse consequences due to the lack of complete understanding or deep appreciation of the unique role of ECT and the tremendous value of restoring function, maintaining quality of life, and, as we all can attest, saving a patient's life.(11)

Notably, on the International Society for ECT and Neurostimulation (ISEN) listserv, a resource for ECT practitioners, several recent comments reveal a disturbing trend. These fall into several categories and reflect the lack of consensus at the healthcare system level, in general, and among some of our Anesthesiology colleagues, specifically, about the role and place of ECT in psychiatric medical practice. The categories comprise processes of care, resource allocation, treatment modifications, and patient and staff safety. While the majority of comments and recommendations reflect what is known about contact precautions informed by public health and infectious disease management principles, a few at the extreme reveal a disheartening lack of understanding about the ECT procedure from a safety standpoint and lack of appreciation for what makes ECT such an essential treatment. Consequently, when considered from the latter perspectives, the viability of this procedure, by maintaining sufficient access and providing necessary support and resources thereof, is threatened. It would appear then that some basic education could be a first step to confronting this bias.

Any modifications needed to keep an ECT service viable will understandably vary at the local level, given the differences in country or setting where ECT is performed, available resources and staffing, number and types of program (private, public, or academic, university-affiliated) in the area, clinical service size, inter alia.(2) Logistical changes are important but the **process** by which these changes are undertaken is equally important. Communication (and education) early on is essential and identification of key stakeholders will support the recognition of the importance of access to ECT and what it will take to keep the service open.

Recently, on a senior hospital administration call the question posed was how many current or pending ECT patients were cancelling out of fear of contamination. There had been none, and in fact, patient calls increased to request treatment out of fear that ECT would not be available. Realistically though, necessary steps to conserve both personnel and hospital resources may include limiting new acute courses of ECT to the most urgently ill, and spreading out the time between maintenance treatments as much as feasible.

Psychiatric patients often get second class treatment during normal times in healthcare systems, perhaps largely due to stigma and the lingering belief that psychiatric illness is somehow not as "real" or serious as other types of medical illness. Now is a crucial time for us to stand up for our patients' right to continued access to ECT as an urgent treatment, at the same time recognizing the need for the healthcare system to adapt to the current crisis, conserve resources, and protect staff and patients from infection. ECT will need to be more limited for the time being, rationed like other resources, but it should not be stopped completely, in a discriminatory fashion. Clearly, amidst precious resources, ECT is a lifesaving gem.

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