Editorial

Mental Health Care Bill and Electroconvulsive Therapy: Anesthetic Modification

In the recently introduced Mental Health Care bill, electroconvulsive therapy (ECT) practice figures with a caution. The bill allows the use of ECT only under anesthesia (modification). In other words, if the bill is passed and implemented, the unmodified (direct) ECT cannot be practiced. Concerns have been raised by some well-meaning psychiatrist colleagues. The cost of ECT would increase, thus taxing the poor patients. Anesthesiologists to provide modification are fewer. In "emergency" ECT situations, depending on anesthesiologists would pose challenges in that crucial eleventh hour. The position in the bill and the arguments for or against the unmodified ECT are examples of the issues to be faced by psychiatrists in the days to come. How are we prepared?

In its first move, the Indian Psychiatric Society produced the position paper on unmodified ECT.[1] It did endorse the benefits of modification in ECT and also conceded that such a procedure should be the contemporary standard. At the same time, the group recorded the concerns of denying ECT on the grounds of unavailability of resources to support modification. The position of the society is to allow use of unmodified ECT only in "exceptional" circumstances.

Unmodified ECT has been a matter of concern and debate since many years. As early as in 1980, *Lancet* published several views for and against following a report of use of unmodified ECT in Broadmoor (UK). Arguing for unmodified ECT, Crammer[2] also stated that some patients actually preferred ECT without injections (unmodified). Another supporter of this procedure stated that withholding ECT when modification is not possible amounts to unethical practice. Situations of failing to get a vein for intravenous injections (repeated injections in previous ECT sessions can result in such a difficulty) is one such circumstance when unmodified ECT may be the option.[3] On the other hand, nearly 40 other psychiatrists wrote against unmodified ECT, terming it as "anachronistic" and "indefensible."[4] They also opined that unavailability of anesthesiologist does not condone use of unmodified ECT. It may be noted that some psychiatry textbooks from the West have altogether dropped information on unmodified ECT in their recent editions. There is no doubt that modified ECT should remain the current standard of ECT practice.

In reality, however, unmodified ECT is in vogue in many parts of the world,[5] China,[6] Pakistan,[7] and India.[8] Together, this would account for the largest ECT population in the world. In our country itself, a recent survey indicated that over 50% of ECTs are unmodified.[9] Clearly, the bill would affect the majority in this regard. This majority would, therefore, not get the benefits of ECT as unmodified ECT would be disallowed. Even if supported by the position adopted by the Indian Psychiatric Society, most, barring the "exceptional" ones, would be denied ECT. Psychiatrists may also be tempted to adopt different definitions of this "exceptional" indication. For example, a social reason was an urgent indication for ECT.[10] It is true that earlier users of unmodified ECT had recognized adverse events such as fractures and even rupture of bladder,[11] apart from others, that discouraged them from using unmodified ECT. In this context, Indian reports have reassured, though not convincingly, that unmodified ECT is not as unsafe as has been projected.[12,13] Benzodiazepine as a muscle relaxant has been suggested as an alternative to modification.[14,15] It is arguable, however, as an anticonvulsant this drug may interfere with seizure induction. Suggestions have also been advanced if psychiatrists can be trained in ECT-related anesthesia procedures.[16] This issue surely deserves consideration for debate and consensus.

In this background, we need to be also alert to the concerns of patients and their kin. One report noted that most patients received unmodified ECT without serious adverse events. However, the same study observed that most patients were poorly informed.[17] It is here that the Mental Health Care bill's issue of mandating modification for ECT deserves attention.

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As noted by Crammer,[2] would patients actually prefer unmodified ECT (sans injections)? Should they be informed about both ECT procedures with their pros and cons? Would the patients or their kin have a choice? For example, unmodified ECT, being less expensive and less invasive (no injections), may be a choice that some patients would make. The bill has also introduced the concept of advanced directive. Psychiatric disorders, being episodic and recurrent, can make some patients foresee the need for ECT in the next admission with an advanced directive to receive ECT with modification only. In such a situation, the treating psychiatrist's options are limited when faced with a patient who has relapsed into stupor.

Lastly, extending the arguments of informing the patients, should psychiatric facilities have levels of accreditation? For example, at level A, the facility will provide modified ECT with EEG monitoring; at level B, modified ECT without EEG monitoring; and at level C, only unmodified ECT. Patients can make an informed choice of the level of care they prefer or can afford. The society should also consider setting up accreditation systems for select treatment facilities, ECT in particular. We must build into our system the scope for education to patients. This will help optimal exploitation of the bill in the interest of the psychiatric patient.

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