討 論

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Is Patient's Preference Valid for Electroconvulsive Therapy Indications?

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［Aim］This study aimed to examine the validity of including the patient's preference as an indication for the primary use of acute electroconvulsive therapy（ECT）.

［Methods］We compared the guidelines of various countries and organizations（Australia, New Zealand, Canada, Germany, Japan, Spain, the UK, the USA, and the World Federation of Societies of Biological Psychiatry）. Since the question of whether the patient's preference should be included in the medical indications is ethical, we referred to clinical ethics.

［Results］The relationship between the patient's preference and indications for the primary use of acute ECT is divided into four categories：（ⅰ）the patient's preference is included in the indications,（ⅱ）the patient's preference is included only when the patient is depressed,（ⅲ）the patient's preference is included only when the patient is severely depressed, and（ⅳ）the patient's preference is not included. From the perspective of clinical ethics, a distinction should be made between patient preference and medical indications.

［Conclusion］Guidelines for acute ECT should distinguish the patient's preference from medical indications, and the patient's preference should not be included in the indications for the primary use of ECT. If a competent patient prefers ECT despite the lack of medical indications, the patient's preference should be confirmed, and the medical indications should be reconsidered. If a patient is not competent and their family members or other proxies prefer ECT despite the lack of medical presentations, careful discussion with them is necessary.

Keywords　clinical ethics, electroconvulsive therapy, guideline, medical indication, patient preference

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Introduction

Electroconvulsive therapy（ECT）is a valuable treatment for several severe psychiatric illnesses, particularly when a rapid response is critical and when other treatments have failed[5]. The Japanese Society of Psychiatry and Neurology（JSPN）[8,12]has developed guidelines for ECT. The guidelines provide indications for acute ECT for treating acute episodes of psychiatric disorders, continuation ECT for preventing relapse after remission for six months or less, and maintenance ECT for preventing relapse for six months or longer. The indications for acute ECT are based on a combination of "diagnostic indications for ECT" and "clinical indications for ECT". The former lists major depression, mania, and schizophrenia as the principal and other diagnoses. The latter includes situations in which ECT is considered the primary treatment prior to pharmacotherapy and situations in which ECT is regarded as a secondary treatment after standard treatment, such as pharmacotherapy.

Table 1 shows the clinical manifestations of the primary use of ECT in the guideline of JSPN[8,12]. According to the guidelines, if a diagnosis of psychiatric disorders meets the indications for ECT and if the patient prefers it, the indications for acute ECT are considered met. Patient preference is considered paramount, even when there is little need for a rapid response or when the risk of other treatments is low. To investigate whether it is appropriate to include the patient's preference in the indications, this paper examines the validity of including patients' preferences as an indication for the primary use of ECT.

Ⅰ. Methods

We compared the guidelines that have already been discussed in Japan regarding ECT indications[8,13]：American Psychiatric Association（APA）[1], Canadian Network for Mood and Anxiety Treatments（CANMAT）[11], Japanese Society of Mood Disorders（JSMD）[7], Japanese Society of Psychiatry and Neurology（JSPN）[8,12], National Institute for Health and Care Excellence（NICE）[14,15], Royal Australian and New Zealand College of Psychiatrists（RANZCP）[10], Royal College of Psychiatrists（RCPsych）[6], and World Federation of Societies of Biological Psychiatry（WFSBP）[2]. We also compared German Association for Psychiatry, Psychotherapy and Psychosomatics（DGPPN）[4] and Spanish National Health System（SNS）[16] as guidelines of countries which are referenced in the WFSBP[2] guidelines but not adequately discussed in Japan. We also referred to clinical ethics because the question of whether ECT should be indicated based on the patient's preference is ethical when their diagnosis is indicated for acute ECT, but whose mental and physical condition suggests a low need for ECT.

Table 1　Clinical indications for the primary use of ECT by JSPN[8,12]

- A need for a rapid, definitive response（high suicidal risk, physical deterioration due to compromised eating, or malnutrition or dehydration, stupor, confusion, excitement, severe psychosis with agitation, etc.）
- When the risk of other treatments outweighs the risk of ECT（the elderly, during pregnancy, and physical complications）
- History of poor medication response or good ECT response in one or more episodes of illness
- Patient preferences

Ⅱ. Results

In the guidelines, we focused on whether the patient's preference is included in the indications. When included, we compared whether there was a distinction based on the diagnosis or severity of the symptoms. The consideration for the patient's preference in the indications for the primary use of ECT, as suggested in the guidelines can be divided as follows：（ⅰ）the patient's preference is included in the indications,（ⅱ）the patient's preference is included only when the patient is depressed,（ⅲ）the patient's preference is included only when the patient is severely depressed, and（ⅳ）the patient's preference is not included.

The first position is that of APA[1] and JSPN[8,12], which considers the patient's preference for the primary use of ECT. The indications for the primary use of ECT by APA[1] are listed in Table 2, and APA[1] includes the patient's pref-

Table 2 The primary use of ECT by APA[1)]

Situations in which ECT may be used prior to a trial of psychotropic medication include, but are not limited to, any of the following：
- A need for rapid, definitive response because of the severity of a psychiatric or medical condition
- When the risks of other treatments outweigh the risks of ECT
- A history of poor medication response or good ECT response in one or more previous episodes of illness
- The patient's preference

Table 3 Clinical indications for ECT as a first-line treatment for major depressive disorder by CANMAT[11)]

- Acute suicidal ideation
- Psychotic features
- Treatment-resistant depression
- Repeated medication intolerance
- Catatonic features
- Prior favourable response to ECT
- Rapidly deteriorating physical status
- During pregnancy, for any of the above indications
- Patient preference

Table 4 First-line indications for ECT for major depressive disorder by RANZCP[10)]

- Severe melancholic depression, especially when the patient is refusing to eat/drink
- High risk of suicide
- High levels of distress
- Psychotic depression or catatonia
- Previous response, patient choice

Table 5 First-line indications for ECT for depression by RCPsych[6)]

ECT as a first-line treatment for patients (including the elderly)：
- Where a rapid definitive response for the emergency treatment of depression is needed
- With high suicidal risk
- With severe psychomotor retardation and associated problems of compromised eating and drinking and/or physical deterioration
- Who suffer from treatment-resistant depression that has responded to ECT in a previous episode of illness
- Who are pregnant with severe depression and whose physical health or that of the foetus is at serious risk
- Who prefer this form of treatment

Table 6 First-line indications for ECT for major depressive disorder by WFSBP[2)]

ECT as a first-line treatment：
- Severe major depression with psychotic features
- Severe major depression with psychomotor retardation
- "True" treatment-resistant major depression
- Refusal of food intake or in other special situations when rapid relief from depression is required (e. g., in severe suicidality)
- Medication contraindicated (e. g., in pregnancy)

ECT as a first-line approach may also be indicated in patients
- Who have experienced a previous positive response to ECT
- Who prefer ECT for a specific reason

erence as one of the situations in which ECT may be used before a trial of psychotropic medication. As noted above, JSPN[8,12)] lists the patient's preference as one of the indications for the primary use of ECT.

The second position is that of CANMAT[11)], RANZCP[10)], RCPsych[6)], and WFSBP[2)], which considers the patient's preference for the primary use of ECT in depression. The indications for the primary use of ECT in the CANMAT[11)] guidelines for managing adults with major depressive disorder are listed in Table 3. Patient preference is listed as an indication, but the level of evidence is expert opinion/consensus, which is the lowest among the four levels[11)]. The indications for the primary use of ECT in the RANZCP[10)] guidelines for mood disorders are listed in Table 4. Patient choice is listed as an indication for first-line treatment of ECT[10)]. The indications for the primary use of ECT in the RCPsych[6)] guideline for depression are listed in Table 5. ECT is recommended as a first-line treatment for patients who prefer this form of treatment[6)]. The indications for the primary use of ECT in the WFSBP[2)] guideline for the biological treatment of unipolar depressive disorders are listed in Table 6. ECT as a first-line approach may be indicated in patients who prefer ECT for a specific reason[2)].

The third position is that of DGPPN[4)] and NICE[14,15)], which considers the patient's preference for the primary use of ECT in severe depression. The indications for the primary use of ECT in the DGPPN[4)] guidelines for unipolar depression are listed in Table 7. ECT is primarily used

Table 7 The primary use of ECT for severe depressive episodes by DGPPN[4)]

- Other treatments are contraindicated and involve a higher risk or more severe side effects
- There is a particularly urgent condition (e. g., life-threatening or severe suicidality)
- The patient explicitly prefers the treatment
- A good response to ECT is expected (experience from previous ECT treatments or prognostic indications, such as psychotic symptoms or psychomotor retardation)

Table 8 Indications for ECT for severe depression by NICE[15)]

Consider ECT for the treatment of severe depression if:

- The person chooses ECT in preference to other treatments based on their past experience of ECT and what has previously worked for them
- A rapid response is needed (for example, if the depression is life-threatening because the person is not eating or drinking)
- Other treatments have been unsuccessful

Table 9 Patient's preference in the indications for the primary use of acute ECT[1,2,4,6-8,10-12,15,16)]

	Included			Not Included
		only in depression	only in severe depression	
Guidelines	APA	CANMAT	DGPPN*	JSMD
	JSPN	RANZCP	NICE*	SNS
		RCPsych		
		WFSBP*		

* Patient's preference is included when it is explicit.

for severe depressive episodes when the patient explicitly prefers the treatment[4)]. The indications for the primary use of ECT in the NICE[15)] guidelines for depression in adults are listed in Table 8. ECT is considered for the treatment of severe depression if the person chooses ECT over other treatments based on their experience with ECT and what has previously worked for them[15)]. Guidance on the use of ECT by NICE[14)] states that valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent and that the decision to use ECT should be made jointly by the individual and the clinician (s) responsible for treatment, but there is no mention of making the patient's preference an indication for the primary use of ECT.

The fourth position is that of JSMD[7)] and SNS[16)], which does not list the patient's preference as an indication for the primary use of ECT. The JSMD guidelines[7)] list situations in which ECT is needed for moderate or severe depression, such as when there is an imminent risk of suicide, a life-threatening malnutrition situation, or when the depression is accompanied by psychotic symptoms or is resistant to pharmacotherapy, but do not list the patient's preference as an indication for the primary use of ECT. According to the SNS[16)] guidelines, ECT should be considered a therapeutic option in patients with severe depression; mainly if there is a need for a rapid response due to high suicidal intent, severe physical damage or when other treatments have failed. The decision to use ECT should be made jointly with the patient and/or family, by taking into account factors such as patient preference.

From the perspective of clinical ethics, Jonsen, A. R., et al.[9)] proposed four topics for organizing ethical reasoning: medical indications, patient preferences, QoL, and contextual features. These topics should provide a pattern for collecting, sorting, and ordering the facts of a clinical ethical problem. Medical indications are facts and their interpretations about the patient's physical and/or psychological condition that provide a reasonable basis for the physician's clinical judgments. Patients' preferences are the choices people make when facing health and medical treatment decisions.

III. Discussion

Considering the differences among guidelines, there are four problems, including the patient's preference in the indications for the primary use of acute ECT.

First, consideration of the severity of the diagnosis is inadequate. Only the DGPPN[4] and NICE[15] guidelines include the patient's preference and the severity of the diagnosis in the indications. The lack of mention of the severity of the diagnosis may mean that even mild cases are indicated for acute ECT if the patient prefers it ; however, it may be necessary to consider whether mild cases should be indicated for acute ECT.

Second, suppose the patient's preference indicates the primary use of ECT only for depression, as in the case of CANMAT[11]. In that case, it is unclear why other diagnoses for which ECT is indicated are excluded. If the patient's preference is not an indication for diagnoses other than depression, such as schizophrenia or bipolar disorder, a rational reason is needed.

Third, it is necessary to evaluate the patient's capacity for autonomous choice carefully. As symptoms become severe, the patients' capacity is expected to decrease ; therefore, it is necessary to consider whether they are capable of adequate decision-making when they express their preferences.

Fourth, the problem is whether the patient's preference should be included in the medical indications. Medical indications and patient preferences may be different factors in determining the treatment plan. First, we examined the fourth problem, which is considered the most fundamental.

Based on the four topics by Jonsen, et al.[9], patients' preferences and medical indications were distinguished. If a patient has the capacity for autonomous choice, there is no problem in providing treatment when it is medically indicated and a patient prefers it. On the other hand, even if treatment is medically indicated, it should not be administered when a patient does not prefer it. In case a patient prefers treatment despite the lack of medical indications, it is necessary to ascertain the patient's preference and level of understanding and reconsider the decision that the treatment is not medically indicated. Treatment should not be based solely on medical indications or the patient's preference.

The problem with the guidelines for acute ECT is that the patient's preference is confused with medical indications. For example, according to JSPN[8,12], the first to third criteria of clinical indications for ECT are facts about the patient's mental and physical condition, but the fourth is the patient's preference ; thus, medical indications and the patient's preference are confused. Therefore, if the patient prefers ECT, its primary use is indicated without medical indication. To prevent this, it is necessary to consider the first to third of the four clinical indications as indications for treatment and to distinguish the patient's preference. In other words, if the patient has the capacity for autonomous choice, acute ECT should be used if any of the first to third indications is met and the patient prefers it. Still, acute ECT should not be used if the indication is met, but the patient does not prefer it. Acute ECT should not be used if there are no indications and the patient does not prefer it. However, acute ECT should not be used immediately if there is no indication, but if the patient prefers it. It is necessary to confirm the reason why the patient prefers it, ensure the patient's level of understanding of their medical condition and ECT, and reconsider the medical professional's decision that there is no medical indication. The significance of the distinction between a patient's preference and medical indications is to prevent the patient's preference from being confused with medical indications and to clarify the conflict between them. This distinction enables us to address the three problems mentioned above.

Regarding the first problem, even mild cases are indicated for acute ECT if the patient prefers it ; the patient is no longer indicated for the primary use of acute ECT because medical indications are not met. Mild cases are exceptionally indicated if they meet medical indications, such as a high risk of other treatments, poor medication response in previous episodes, or good ECT response in previous episodes.

Regarding the second problem about including the patient's preference in the indications only for depression, depression is no longer the only exception because the

patient's preference is not included in the indications for the primary use of ECT in any diagnosis. In case a patient whose diagnosis is indicated for acute ECT has the capacity for autonomous choice, acute ECT is used when the medical indications are met, and the patient prefers it.

Regarding the third problem, careful evaluation of the patient's capacity for autonomous choice is needed ; different procedures are needed depending on whether the patient has the capacity for autonomous choice. If the patient does not have the capacity for autonomous choice, surrogates make the decision. Traditionally, next of kin have been considered the natural surrogates, and clinicians have turned to family members for permission to treat the patient[9]. Beauchamp, T. L., et al. [3] proposed three general standards for use by surrogate decision-makers : substituted judgment, which is sometimes presented as an autonomy-based standard ; pure autonomy ; and the patient's best interests. The standard of substituted judgment holds that decisions about proper treatment belong to incompetent or non-autonomous patients. The surrogate is to make the decision that the incompetent person would have made if competent. Surrogates should have a sufficiently deep familiarity with the patient that the particular judgment reflects the patient's views and values. The pure autonomy standard applies exclusively to formerly autonomous, now-incompetent patients who, when autonomous, expressed a relevant treatment preference. The principle of respect for autonomy morally compels us to respect clear preferences. Without explicit instructions, a surrogate decision-maker might select from the patient's life history values that accord with the surrogate's values and then use only those values to reach decisions. The surrogate might also base their findings on the patient's values, which are only distantly relevant to the immediate decision. Often a relevant autonomous preferences of patients cannot be determined. Under the best interests standard, a surrogate decision-maker must then determine the highest probable net benefit among the available options, assigning different weights to the patient's interests in each option balanced against their inherent risks, burdens, or costs. Previously, competent patients who autonomously expressed clear preferences in an oral or written advance directive should be treated under the pure autonomy standard. However, if the previously competent person left no reliable trace of their preferences—or if the individual was never competent—surrogate decision-makers should adhere to the best interests standard.

If the patient does not have the capacity for autonomous choice and the primary use of acute ECT is considered by surrogate decision-making, the problem arises when there is an indication for treatment. Still, the surrogate opposes it, or when there is no indication, but the surrogate prefers it. In both cases, it is necessary to ascertain whether the surrogate's decision is based on the patient's treatment preference when the patient was autonomous or whether it is consistent with the patient's decision if competent. If the patient's preferences cannot be determined, it is necessary to consider whether the decision maximizes the patient's benefit. In case there is a conflict between the indications for treatment and surrogate decision-making, deep deliberation is required to ensure that the final treatment plan is not mentally or physically detrimental to the patient.

Including the patient's preference in the indications for acute ECT in the guidelines may be a criticism of the old-style ECT, which was used without informed consent. Medical indications are objective interpretations of a patient's condition and should not be used to impose medical professionals' opinions on the patient. For example, the JSPN guidelines[8,12] explain the informed consent procedure and state that ECT should be based on information disclosure to the patient and consent by the patient if the patient has the capacity for autonomous choice. However, there is a difference between giving treatment based on the patient's consent and giving treatment that is not medically indicated based on the patient's preference. Following medical indications can reduce the risk of side effects and increase the effectiveness of treatment ; however, deviating from medical indications increases the risk of side effects and ineffectiveness. Giving treatment, which is not medically indicated based solely on the patient's preference, is likely to result in the patient's disadvantage.

In actual clinical practice, challenging situations that cannot be solved simply using the guidelines are likely to arise. For example, there may be disputes regarding wheth-

er the patient's condition meets medical indications for the primary use of ECT, the patient may have hesitations, or the reasons for the patient's preference may be unclear. To consider the issues that arise in each case, it is necessary to have a sufficient discussion among the patients, their relatives, and medical professionals. It is also essential to share the process of reaching a decision with the patients and their relatives, and trying to reach a rational one. If the patient has the capacity for autonomous choice, it is necessary to focus on the context of the patient's words to prevent misunderstandings between them. If the patient does not have this capacity, careful discussion with relatives or other surrogates is necessary. In the primary use of acute ECT, a distinction should be made between patient preferences and medical indications, and ECT should be considered only with a medical rationale.

Conclusions

Guidelines for acute ECT should distinguish between medical indications and the patient's preference and should not include the patient's preference in indications for the primary use of ECT. For any diagnostic indication, the patient's preference should be excluded from the indications for primary treatment, and acute ECT should not be used based solely on the patient's preference. If there is a conflict between a patient's preference and medical indications, it is crucial to examine the cause. To prevent conflict, patients must have accurate medical knowledge of ECT. The more knowledge about ECT is disseminated in society ; the more patients may express their preferences for ECT in advance to prepare for the acute phase of mental disorders, when the capacity for autonomous choice is decreased. Dissemination of accurate knowledge about ECT is necessary to dispel the excessive expectations of ECT and mistrust based on misinformation. In addition, when the guidelines are revised, opinions of patients and their families should be adequately reflected to disseminate the guidelines more widely in society.

Previous presentation

Some of the results described in this paper have been presented at the 118th Annual Meeting of the Japanese Society of Psychiatry and Neurology, Fukuoka, Japan（June 16–18, 2022）.

Conflicts of interest

The authors declare no conflict of interest.

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Author Contributions

A. N. and M. N. conceived and designed the study. A.N., M.N., K.O., T.K., N.T. and K. O. contributed to data acquisition and analysis. A.N. contributed to writing the manuscript. H.H., T.M. and H.S. supervised the study, conception and design of the study, analysis of data, and writing and revising the manuscript. All the authors reviewed the article and approved its submission.

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