AN OPEN LETER TO HAROLD SACKHEIM

Dear Dr. Sackheim,

As you are undoubtedly aware, electroconvulsive therapy (commonly called ECT, or by its older designation, electroshock) is not universally accepted as a benign and useful medical intervention. In the eyes of certain neurologists, psychologists and psychiatrists such as John Breeding and Peter Breggin,it is not a respectable medical treatment, and many patients who have had it claim to have been harmed by it. In your own 2006 study you admitted that it does not leave the brain unscathed, and you have now recommended that involuntary ECT treatments (which are more likely to use the older, more invasive technologies) be discontinued. You are certainly to be commended for not “spinning” away unpleasant evidence unearthed in your momentous New York study, and making recommendations based upon science, not the short term interests of ECT providers.

Having been touched by this controversy quite by accident, I would like to say that nothing else has had quite an impact on my life. An ethicist by profession, I put a lot of thought into this subject, and can now see the controversy from both the side of medicine and the side of the aggrieved patients. Please allow me to share some of my conclusions with you.

It is my feeling that ECT currently faces three grave ethical challenges. If it could meet those three criticisms (and I will suggest how it might), ECT would become a mainline, respected treatment, requiring no duplicity or obfuscation to sell it to an ignorant public, and no dishonesty or false professions of ignorance (“no one knows how it works”) in explaining how it works to members of the medical profession.

Make no mistake. The way ECT is marketed now belies a product that no one wants to call by its right name, and which must be sold by fraud and force. I was illegally strongarmed into a 30-day ECT program, and bullied with scare tactics (e.g. “there’s no hope for you”) so that I would accept it over my explicit verbal objections and the refusal of my psychiatrist to sign the consent form. The newly hired electroshock doctor had a “bud” of his sign the second-opinion consent form required by law, and ignored the fact that I had repeatedly turned it down. He was supposedly intending to anesthetize me first, and get some kind of coerced consent later. (Lucky for him another physician intervened and struck me off the list, or I would have been forced to sue to stop the juggernaut). Can you imagine those kind of tactics being used to market kidney dialysis?

No. This is because kidney dialysis is an accepted, respectable, mainline medical treatment for identifiable conditions and diseases.

If ECT could meet the three serious ethical challenges it faces, it, too, could join the class of such uncontroversial medical interventions. Right now it cannot pass ethical muster.

The first problem has already been hinted at: *dishonesty* in marketing. The APA specifically directs those who design consent forms to avoid the words “brain damage.” Wouldn’t want patients to be discouraged from having this life-saving treatment by fear of damage to their brains! Yet that is exactly what your own study revealed. The APA apparently has decided to deal with this unpleasant reality by not telling them. It isn’t true that “no one knows how ECT works.” Anyone who has taken a course in how to deal with severe head injuries, including nurses, medical techs, even boy scouts and girl scouts, knows that memory loss, flattened affect and euphoria are signs of brain damage. I’ve seen euphoria myself in ECT patients. (“You get to see a whole different side of Dr ---when you’re one of his special patients” a patent chirped. “You find out he’s got a soul after all!” he continued, inadvertently revealing a lot about patient/doctor relations on the ward). Similar to hitting a patient on the head with a baseball bat so she can hear the tweety birds, we are marketing the numbness and euphoria due to brain damage as a palliative for depression

The most shockingly dishonest aspect to marketing ECT is teaching patients to misdescribe their own experience. Instead of telling them the truth—that the "feeling no pain" period is a window of opportunity that will wear off as brain lesions heal and normal thought processes return—patients are taught that the returning depression is their "illness coming back," so they need MORE "helpful treatments" to prolong the euphoria &/or numbness. I would ask here: just how much "maintenance" can sensitive human brain tissue sustain?

But this dishonesty is not necessary. Patients could be told honestly that "feeling no pain" is caused by mild brain damage, which would probably reduce the number of instances where patients would agree to have it. But is this a bad thing? That is necessarily undesirable only if providers are thinking primarily of how much they are getting paid per treatment, not of benefit to the patient. (Did I mention that we have a "broken health care system"? That in my case, my insurance fully covered ECT? That statistically, the one characteristic shared by ECT patients besides age and female gender is insurance coverage?)

It's difficult to find a person who has had ECT who looks back on it as a helpful intervention (According to one Massachusetts study, 84% are seriously depressed a year later)—the two responses one tends to get to inquiries about whether ECT "did you any good" after several months are: "I wish I had never met that SOB!" (regret) and "it worked for me—but my illness came back" (resignation). If a physician wants to get that glowing testimonial, s/he'd better grab it during or just after the treatments! (The very patient who was sent into my room to talk it up and convince me to have it—who raved about it—was surprisingly negative five months later when I bumped into her at a social affair: "No you DON'T know how I feel about ECT. I've changed my mind," she declared bitterly).

One could easily survey 1000 ex-patients and find that *not a single one* thinks she or he was permanently helped by ECT. But there are such people. Kitty Dukakis, for instance, wrote a glowing testimonial to modern psychiatric intervention, and insists that her electroshock, including single maintenance treatments (with the "kinder, gentler" technologies) has been a lifesaver for her. We need to figure out why rare individuals actually say they are helped, and in what way, by ECT. In Kitty Dukakis' case, I think we can see that what was different in her case was that her several-month long stretch of "not suffering" (not due to alcohol or other self-medication) gave her the opportunity to reach out and "grab the brass ring", so to speak. She took advantage of opportunities in her life to build up a plan that worked. She obtained the tools to solve her life problems, thus ending her emotional suffering. Therefore we could say that in some sense the treatment which helped rouse her from a debilitating depression "worked." But of course, most of us do not have Kitty Dukakis' life opportunities available to us. Feeling less depressed after ECT, typical patients may get out of bed, and as the old song says, get "all dressed up" and find themselves with "nowhere to go." And of course, eventually, that freshly scrubbed and dressed up patient lapses back into anomie.

This leads to the second ethical problem: how to distinguish ECT from the claims of cocaine pushers—how to justify using temporary euphoria as a cure for depression. Any graduate of Alcoholics Anonymous can tell you that countering depression with temporary fixes of euphoria is a recipe for disaster. So ECT, which does provide a period of time (ideally, at least) of "no pain," needs to be supplemented with social and behavioral supports that allow the patient to take advantage of available opportunities, much as Kitty Dukakis used her “happy time” to get her life in order. What is needed is something like a personal social worker and a bevy of counselors who can help the patient construct a practical life plan and acquire the skills to follow it. Shocking patients and sending them back to the same oppressive relationships, the same joblessness, the same grief, lack of support and reminders of social worthlessness is the same as selling them some potent white powder and assuring them it will “fix them up”—and wondering why they are back in a few months after attempted suicides and other signs of severe distress. And make no mistake, our society IS currently sending them back to the same depressing situations after “ECT treatment,” not lifting them out of those situations—or, I should say, not helping them to lift themselves. (One psychiatrist actually told me “I’m not here to help you fix your life.” Presumably, she meant she was there to oversee drug treatment, not to do social work. But that illustrates my point. How does that differ from what illegal drug pushers do?)

And the third ethical problem has to do with the physician’s oath, “first, do no harm.” If ECT results in measurable brain damage, then as doctors pledged to produce health, shouldn’t ECT providers be concerned with the health of brain tissue? Shouldn’t brain health be a priority after ECT? A regimen of brain health might do a lot to help mitigate some of the effects caused by exposing delicate brain tissue to electrical current. In addition, applying insights from today’s burgeoning field of brain health (I’m thinking here of Frank Lawliss at the Lawliss and Peavey Centers for Psychoneurological Change in Texas and other such people) to ECT patients would work to undo some of the damage inflicted by alcohol, psychiatric drugs, over-and-under-the-counter drugs, and even by the depression itself. The patient may emerge from such a regimen with manifestly better brain health than when s/he first entered treatment.

But of course, a patient dealt with honestly, provided with a personal social worker, a brain health “coach,” guided into appropriate support systems, therapies, groups and classes might decide against taking a brief detour into brain damage before setting out upon a regimen of brain health. Why not aim for brain health in the first place?

We are faced with a striking conclusion: any changes to the ECT regimen added in order to make ECT ethically acceptable render it medically superfluous.

Yours Truly,
Jay Gallagher, Ph.D.