Psychiatrist, Dr C / Clinical Psychologist, Ms D / Public Hospital

A Report by the

Health and Disability Commissioner

(Case 00HDC07173)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Complaint

The Commissioner received a complaint from Ms A about the treatment provided to her husband, Mr B, by a Public Hospital. The complaint was that:

- *Mr B should not have received electro-convulsive therapy (ECT) treatment on an outpatient basis.*
- *Mr B's ECT treatments should have spanned less than three working weeks but took nearly two months to complete. On occasions, at short notice, treatment did not proceed on some of the appointed days despite being told by a community mental health service (the Community Service) that it would.*
- *While Mr B was receiving ECT he continued to take Tegretol and lithium. Neither of these drugs should be taken while undergoing ECT and may have affected the expected outcome/benefit of the treatment, or contributed to his current condition.*
- *The Community Service advised Mr B that the situation regarding his drugs was so serious they were going to hold an internal inquiry to determine why it had happened. Mr B was not told whether an inquiry took place and, if so, what the outcome was.*

Investigation process

The complaint was received on 13 July 2000 and an investigation was commenced on 21 September 2000. Information was obtained from:

Mr B	Consumer
Ms A	Complainant / Consumer's wife
Dr C	Provider / Psychiatrist
Ms D	Provider / Clinical Psychologist
Dr E	Clinical Leader Mental Health Services, Public Hospital

Relevant clinical records were obtained and viewed. Expert advice was obtained from Professor Pete Ellis, an independent psychiatrist.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information gathered during investigation

Background
Mr B first saw Dr F, a psychiatrist, on 20 October 1995. On 27 October 1995 Dr F wrote to Mr B's general practitioner, Dr G, advising:

> "[Mr B] came to see me at his own initiative on 20 October together with his partner. He gave a history of recurrent chronic depression since 1987. He complained of feeling 'lousy and rotten' and very low. He denied any suicidal ideation. He said he could not care about anything and was often tearful. He was tense and anxious and described himself as obsessional and very orderly by nature. He complained of being uncommunicative and lethargic. He also complained of poor concentration, very low libido and absent interest. He could not remember when he last felt well and he had generalised anhedonia [lack of enjoyment in life].
>
> He said that he was diagnosed as suffering from ME in the early 1980s, but in retrospect felt that he was probably depressed. In 1987 he was treated with Prothiaden 50 [a tricyclic antidepressant] – 150mgs and he took that intermittently until 1983 when he saw [Dr H] and was started on Fluoxetine [an antidepressant/SSRI (selective serotonin reuptake inhibitor)]. At the time I saw him he was taking Fluoxetine 60mgs daily, Prothiaden 75mgs nocte and Renitec [for hypertension] 5mgs daily.
>
> There was no family history of depression. …
>
> On examination he was a pleasant, articulate man whose thought form was normal and the content was significantly depressed. His affect was restricted and his mood appeared seriously depressed. I felt that he was suffering from a recurrent chronic Major Depressive Disorder [a mood disorder characterised by the occurrence of one or more major depressive episodes and the absence of any history of manic, mixed or hypomanic episodes] and I decreased the Fluoxetine to 40mgs per day, continued the Prothiaden at 75mgs and added Lithium Carbonate [an antipsychotic] 250mgs mane [morning] and 500mgs nocte [night]. I arranged for him to have a lithium level and thyroid and renal function tests.
>
> I saw [Mr B] again on 26 October and he had noticed a distinct improvement in his mood. He said he was finding it easier to communicate and he felt more relaxed and under less pressure. His concentration had also improved. He had some postural hypotension and I decreased the Prothiaden to 50mgs nocte [night] and continued the Lithium and Prozac. I have arranged to review him again in two weeks' time.
>
> I will keep you informed of his progress. I would be grateful if you could please send me information you have on file from [Dr H]."

Dr F wrote to Dr G on 29 November 1995 advising:

> "I have continued to see [Mr B] and he has not made a lot of progress. His mood has remained significantly depressed and he lacks motivation and energy and complains of terrible concentration. This is despite taking 40mgs of Fluoxetine, 50mgs of

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> Nortriptyline [a tricyclic antidepressant], 750mgs of Lithium and 600mgs of Carbamazepine [Tegretol, an anticonvulsant]. I have therefore stopped the Nortriptyline and Fluoxetine and will give him a two week wash out period and then start him on Moclobemide [an antidepressant/MAO inhibitor]. There is a risk that he may deteriorate further in the next two weeks and I have discussed the option of ECT [electro-convulsive therapy – the use of electro-convulsive shock as a therapeutic procedure for psychiatric disorders. The technique consists of applying weak electric current to the tempero-frontal region of the skull until a grand mal seizure results] with him, which he would probably be agreeable to if necessary, but at this stage has opted to see if he can make it through until the Moclobemide can be started. I will see him regularly during this time."

Mr B continued to see Dr F throughout 1996. By November of that year she recorded that his mood was "much improved". Dr F noted, in December 1997, that Mr B had "essentially been very well this year". In April 1999 she recorded that he had noticed a "relapse" and "some depressive symptoms".

Dr F wrote to Dr G on 20 January 2000 advising:

> "I saw [Mr B] on 19 January. He has experienced a relapse of his recurrent Major Depressive Disorder which had its onset before Christmas. Currently he complains of feeling sad and low, lethargic and experiences no pleasure in his activities. He has no motivation, poor concentration and poor short term memory. He is sleeping all right but cannot face the day. He is not suicidal. He has absent libido.
>
> He has been taking Venlafaxine 112.5mg daily and I have increased the dose to 225mg per day and have arranged to review him again in two weeks' time.
>
> I will keep you informed of his progress."

Dr F referred Mr B to the Community Service (a community mental health service administered by the Public Hospital) for urgent consideration of ECT on 2 February 2000. Her referral letter stated:

> "Diagnosis: Major Depressive disorder, recurrent unipolar [the qualifier unipolar is used for cases in which the depressive episodes recur without the appearance of the manic phase that is observed in the classic form of bipolar disorder].
>
> I would be grateful if you could please see [Mr B] urgently and take over his management. He has treatment resistant depression and is a candidate for ECT to which he is agreeable. He is currently taking 225mg Venlafaxine, (which he imports from Switzerland), Carbamazepine CR 600mg daily and LiC03 1000mg nocte.
>
> He has previously not responded to adequate trials of tricyclic, SSRI [selective seratonin reuptake inhibitors] and MAOIs [MAO inhibitors] in various combinations.

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> Currently mood is low, variable suicidal ideation, frequent waking during the night, no appetite, no motivation, anhedonia, absent libido, no energy. He feels hopeless and at the end of his tether.
>
> I have arranged for him to have a lithium level today."

The Community Service

Mr B saw Dr C, a psychiatrist at the Community Service, on 9 February 2000. Ms A and Ms D, a clinical psychologist, were also present. Dr C advised:

> "… [Mr B] presented as superficially reasonably together, but his voice was very flat and he showed little emotional responsiveness. He complained of feeling almost totally hopeless and empty of feelings. His sleeping pattern was distorted with often little sleep. He was irritable and reckless. He was contemplating leaving his job, which he loved. He had thought of suicide, but had no serious plans. I did not feel that he was a high risk for suicide at that time.
>
> I told him that I would recommend that we go ahead with a trial of ECT as an outpatient. He knew quite a lot about ECT and had looked it up on the Internet. I have had considerable experience with using ECT for depression and reassured him that the risks would be minimal, the main concern being the anaesthetic. Some memory loss might be apparent soon after the course, but would rapidly improve. I tried to emphasise that a good result could not be guaranteed but could reasonably be expected.
>
> …
>
> My plan was to go ahead with a course of ECT as an outpatient. I understood this was available through the [Acute Mental Health Unit] at [the Public Hospital] [("the Outpatient Service")]. I did not see that there was any indication for admitting him to hospital. He and his wife were intelligent, capable people with good accommodation. He was not acutely suicidal and was physically well.
>
> …"

Dr E, the Clinical Leader Mental Health Services at the Public Hospital, advised:

> "At a team discussion the next week it was questioned whether psychotherapy might be still an option although he had had some previous counselling. On 18 February his partner advocated strongly that ECT was their preferred choice. Their next appointment with Psychiatrist [Dr C] was cancelled as the client was in Melbourne. He met with [Dr C] and [Ms D], a psychologist, on 9 March. The pros and cons of ECT were discussed and the client seemed well informed having looked at material on the Internet. It was decided to proceed with ECT as an outpatient."

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Outpatient treatment
Mr B and Ms A were concerned that Mr B should not have received ECT on an outpatient basis.

Dr E advised:

> "The great majority of ECT at [the Public Hospital] is given in the inpatient setting. This is primarily because the great majority of patients receiving ECT are so severely depressed that they require inpatient therapy in any case. While ECT is a recognised treatment for resistant depression it has been much less common in […] to administer ECT to patients well enough to be outpatients. There is considerable variation in ECT practice around the world. In some centres outpatient ECT is fairly common while in other parts of the world ECT may be used very little or even may be illegal.
>
> The disadvantages of inpatient admission ECT are that the majority of patients on the inpatient unit would be extremely unwell and this is therefore not an ideal environment for people well enough to cope as outpatients. There is also great pressure on inpatient beds with priority being given to emergency admissions. On the other hand outpatient ECT has the disadvantage of potential communication problems between the referring clinician in the community and the team administering ECT. This can affect practical details such as scheduling, as in this case, and potentially clinical decision making as the inpatient staff administering ECT do not have overall clinical responsibility for the client."

Practical arrangements

Policies
The Public Hospital's policy on 'practical arrangements for arranging ECT' states:

> "The patient must have had a recent physical examination and special investigation appropriate to their physical state. They must be fit for general anaesthetic. If there is any doubt about this, it should be discussed with the anaesthetist scheduled to give the anaesthetic.
>
> Current health, medical history and ECT history are to be recorded on the ECT Record Form by treating medical staff. Cognitive testing (and, where indicated, CT scan) should be performed pre ECT. The patient should be assessed for laterality to and discussions regarding unilateral and bilateral treatment.
>
> Medication must be reviewed prior to ECT, and adjusted as necessary."

The Public Hospital's outpatient ECT policy states:

> "ECT will ordinarily be administered by the treating psychiatrist or registrar (if trained). Occasionally it may be arranged that the registrar or psychiatrist from the corresponding inpatient team administers the treatment. This arrangement will be discussed and agreed between the medical staff."

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The Royal Australian and New Zealand College of Psychiatrists' statement on electro-convulsive therapy states:

> "5.2.1 It is inadvisable to prescribe a pre-determined number of treatments. The patient must be reviewed after each ECT treatment by a medical officer, who should assess the efficacy of treatment and any adverse events, especially delirium. …"

Process

Dr C telephoned Dr I, consultant psychiatrist, whom she understood was a "key figure in organising the [ECT] process". Dr C said Dr I "listed for me the key processes needed, and Mr B's keyworker and myself proceeded to get things under way".

On 13 March 2000 Dr C completed an 'Electro-convulsive Treatment Record' form requesting "six to eight" bilateral ECT treatments. She noted that Mr B had been diagnosed with major depressive disorder and that his medications were Efexor 75mg three times per day, Tegretol 200mgs twice per day, lithium 250mg x 4 in the evening and Accupril 10mg.

On 16 March 2000 Mr B signed a consent for ECT. The form stated:

> "I … give consent to a course of Electroconvulsive Therapy (ECT) of up to 8 treatments to be performed on myself.
>
> I agree my doctor has fully explained the reasons this course of ECT is necessary, what the treatment procedure involves and the expected effects it will have.
>
> I understand these effects may include memory impairment for events immediately preceding and following the treatment and possibly limited memory impairment for a few days after each treatment.
>
> I agree not to take any food or drinks within 6 hours of each treatment except when my doctor or nurse advises me to do so.
>
> I agree not to drive a motor vehicle for 24 hours after each treatment because the effects of the anaesthetic or other drugs which have been given may impair my ability to drive."

Ms A signed the consent form as witness, on 16 March 2000. Dr C had previously signed the form, as the responsible clinician, on 13 March 2000.

Mr B was required to undergo a physical examination prior to commencing ECT. Clinical notes recorded that an ECG was performed on 16 March 2000, and that it was abnormal. Dr C postponed the first ECT "to check out ECG and procedural issues".

Dr C advised:

> "We had hoped to start ECT by the end of March but the need to check out his heart function delayed this. The ECG was followed up with an echo-cardiogram. The results were checked by the anaesthetist and he was cleared for ECT."

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Dr C saw Mr B at the Community Service on 23 March 2000. Mr B was disappointed at the one week delay "but understood the necessity". Dr C said Mr B's level of depression was "much as before".

Mr B underwent an echocardiogram at a private hospital on 24 March 2000. Dr J, an interventional cardiologist at the private hospital, wrote to Dr G on the same date advising that the report showed:

> "… left ventricular hypertrophy. It is otherwise normal."

Mr B was cleared to have ECT.

On 28 March 2000 a respite nurse was arranged to stay with Mr B in theatre, accompany him home afterwards, and remain with him "until he made a good recovery".

Clinical notes recorded that a respite nurse was requested for 28, 29 and 30 March, and 3, 5, 7, 10 and 12 April 2000.

ECT
The Public Hospital's policy states:

> "Administration of ECT must be by, or under the supervision of, a Psychiatrist experienced in administration of ECT with the equipment being used, and credentialled for this purpose.
>
> Registrars may administer ECT only after receiving satisfactory training in the administration of ECT with the equipment being used, from a Psychiatrist credentialled for this purpose (administration of ECT)."

Dr E advised:

> "At present [the Public Hospital] is in the process of credentialling procedures by Department. Psychiatric practices are due to be credentialled later in the year. Currently all ECT is administered by or under the direct supervision of a Royal Australian & New Zealand College of Psychiatry (RANZCP) approved supervisor who themselves must have experience in ECT practice, theory and administration.
>
> Under the current rostered system four different registrars (approved trainees of the RANZCP) administered ECT to [Mr B] with one of three consultant psychiatrist supervisors present at each session. I understand all anaesthetics were administered by Anaesthetists approved for the purpose under the aegis of the Australian and New Zealand College of Anaesthetists."

Mr B received his first ECT treatment at the Public Hospital on 29 March 2000. Dr E advised:

> "As is usual practice he was started on a lower dosage of electric charge recorded as 20% on the ECT machine being used. As there was no sign of a convulsion either visibly or through EEG monitoring he was given further shocks at 30% and 40% with

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no resulting definite convulsion. As is common practice, further shocks were not given that day."

Mr B underwent a second ECT on 31 March 2000. Dr E advised:

"On 31 March at a dose of 45% [Mr B] had a convulsion lasting 19 seconds on the EEG monitor. The aim is to cause convulsions of more than 25 seconds, timed on the EEG, ideally."

Mr B underwent a third ECT on 3 April 2000. He received a 55% dosage, which resulted in a convulsion lasting 12 seconds. A repeat shock at 65% resulted in no recorded convulsion.

Mr B underwent a fourth ECT on 5 April 2000. He received a 75% dosage, which resulted in a convulsion lasting 23 seconds. He received further shocks at 75% and 80%, which produced only one convulsion of 8 seconds' duration.

Mr B underwent a fifth ECT on 7 April 2000. He received an 85% dosage, which resulted in a 20 second convulsion.

Mr B underwent a sixth ECT on 10 April 2000. He received a 100% dosage, which resulted in a 12 second convulsion.

Mr B underwent a seventh ECT on 26 April 2000. He received an 85% dosage, which resulted in a 23 second convulsion.

Mr B underwent an eighth and final ECT on 28 April 2000. He received an 85% dosage, which resulted in a 48 second convulsion.

Contemporaneous drug therapy
Mr B and Ms A were concerned that Mr B remained on Tegretol and lithium carbonate while receiving ECT.

The Public Hospital's ECT policy states:

"All patients undergoing ECT must have a Psychiatrist clearly identified as responsible for their care.

The Psychiatrist responsible for the care of the patient must supervise the course of treatment (in conjunction with the credentialled Psychiatrist if necessary), including reviewing progress, any adverse effects, duration of therapy, etc."

The Royal Australian and New Zealand College of Psychiatrists' statement on electro-convulsive therapy states:

"6.2.3 **Mood Stabilisers**
Both carbamazepine [Tegretol] and sodium valproate increase seizure threshold, although it may be appropriate to continue these drugs during ECT if they are used for mood stabilisation. Similarly, patients with epilepsy should continue to receive their

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> anti-epileptic medication, and consultation with a neurologist is recommended. In both instances, the dose of anti-convulsants may require temporary reduction. Lithium prolongs the neuromuscular blockade of succinylcholine and has been reported to increase the risk of post-ECT delirium. Although concomitant administration is not a contraindication to ECT, it is generally advisable to withdraw lithium prior to the commencement of ECT. For certain bipolar patients who are well controlled on lithium, the risk of ECT-induced mania may outweigh the risk of delirium, in which case lithium should be continued during ECT."

Dr C saw Mr B on 30 March and 6 April 2000. She observed that he "seemed to be coping well".

A clinical note by Ms D, psychologist, on 10 April 2000 recorded:

> "...
> Phone call from [Mr B] concerning hospital not wanting to do ECT this morning due to lack of clear instruction concerning this. Informed [Mr B] re need for further assessment following six treatments and that therefore treatment on Wednesday may be delayed – I will advise him tomorrow after consulting with [Dr C].
> Plan: [I am] to phone [Mr B] tomorrow."

Dr C advised that on 11 April 2000 she was contacted by Mr B's keyworker and advised that the ECT team had "just discovered" that he was still taking Tegretol. Dr C was told that this should be stopped. She contacted the pharmacist at a second public hospital "to get advice on safe and fast reduction". She then contacted the keyworker "and a plan of reduction of dose was put in place".

A clinical note by Ms D on 11 April 2000 recorded that Dr C would:

> "… talk to [the Outpatient Service] about delaying next ECT to Friday. [Ms D] to phone [Mr B] to discontinue Tegretol from today and not have ECT tomorrow (Wednesday). Is coming on Thursday to see [Dr C]. Probable ECT Friday."

A further entry by Ms D, at 4.30pm on 11 April 2000, recorded:

> "Phone call from [Dr C] – advised me to tell [Mr B] to not take night dose of Tegretol but to take it in the morning as he needs to be discontinued slowly."

The next entry by Ms D, at 4.45pm on 11 April 2000, recorded:

> "Phone call to [Mr B]. Instructed not to take night dose of Tegretol. He informed me that he took two Tegretol at night. I am not sure [Dr C] is aware of this."

An entry by Ms D at 5.00pm recorded:

> "Discussion with CTT [community treatment team] re Tegretol. Phone call to [a second community mental health service] to contact [Dr C] to clarify whether [Mr B] should cut dose of Tegretol from two tablets to zero or one tablet. [Dr C] asked to call CTT to clarify.

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> Plan: If [Mr B] needs to only cut one tablet rather than entire dose of Tegretol he will need to be contacted tonight."

A further entry dated 11 April 2000 recorded:

> "Paged by [Dr C]. Advised regarding above. [Dr C] instructed that [Mr B] take one Tegretol tonight. No Tegretol tomorrow am and one Tegretol tomorrow night. He is to take no further Tegretol after that and has appointment on Thursday with [Dr C].
> Phone call to [Mr B]. Answerservice on. Message left detailing above instructions. ([Ms K] checked verbal message from [Dr C] as per protocol.)"

Clinical entries by Ms D on 12 April 2000 recorded:

> "Phone call to [the Outpatient Service]. Unable to locate file at [the Outpatient Service]."

> "Significant Events Form completed and given to manager, [Ms L]."

The 'Significant Event Form' completed by Ms D on 12 April 2000 stated:

> "Description of Occurrence:
> This patient has had 6 treatments of ECT as an outpatient commencing 29.3.00. He was referred to [the Community Service] for the purposes of ECT by [Dr F] who had also prescribed his medication. He was seen at [the Community Service] first by [Ms D] and [Dr M] and then [Ms D] and [Dr C]. No medication chart was filled in. At [the Outpatient Service] the psychiatrists who administered ECT, the house officer who booked ECT, the anaesthesiologist, all had the chart and did not note the patient's current medications. His current medications include Tegretol, an anticonvulsant. The patient did not have the effects expected on ECT. The patient also has a known heart problem and high blood pressure.
>
> The patient is due to have a review of his treatment on Thursday, 13 April 2000. I rang [the Outpatient Service] and medical records and his chart [from the Community Service] is missing."

Dr C saw Mr B on 13 April 2000. She told him that he should have been taken off the Tegretol prior to commencing ECT because "it would have been interfering with efficacy" of the ECT.

Dr C advised that Mr B "was experiencing considerable confusion but some lightening of mood". She said she felt "no alarm".

Mr B's last Tegretol dose was taken on the evening of 13 April 2000.

Dr C advised:

> "[Mr B's] current medication was Efexol (Wyeth) a modern antidepressant imported from overseas at a cost of $400 a month – 225mg daily, carbamazepine (mood stabiliser) 600mg daily and lithium carbonate (mood stabiliser) 1000mg daily. Because he had

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> been on medication solidly for some five years, I did not want to leave him without medication, or with reduced medication, until it was clear that the ECT was lifting his mood.
>
> However, I should have discontinued carbamazepine before ECT started, because it is an anticonvulsant, and ECT is the process of producing a seizure with an electrical impulse. This was an oversight on my part, for which I apologise. However, while it presents problems for the people administering ECT, it should not have any ill-effects for the patient.
>
> After the course of ECT was over comments were made that I should have also discontinued the lithium carbonate. It is usual nowadays to stop lithium prior to ECT when geriatric patients are being treated. Lithium is believed to worsen the confusion that may happen after ECT, but not to have lasting ill-effects.
>
> However, [Mr B] was 50, not geriatric. I continue to believe that it was reasonable to leave him with some medication cover.
>
> I recorded the medication he was on in the body of the notes. The actual tablets he was taking were prescribed by [Dr F]. I usually record medication being taken in both the case notes and on the medication card. I cannot be sure now that I did that, and the only medications recorded on the medication card are those I prescribed myself after the ECT was stopped. If the only record of current medication was in the case notes, the staff administering the ECT may have missed it."

Dr E advised that the consent form prepared by Dr C "clearly listed the medications [Mr B] was taking (Carbamazepine and Lithium)" and that the information was known to the doctors who administered the ECT.

Dr E advised that "[t]here are relative contra-indications to both these drugs being taken during ECT treatment which would need to be balanced against the benefits of remaining on them". He noted that "[Dr C] was concerned that [Mr B] might deteriorate if his medications, which he had been on for some time, were stopped. However this consideration was not documented." He also noted that Tegretol would "increase seizure threshold and be likely to increase the amount of electric charge necessary to induce a convulsion and/or reduce the length of the convulsion". Also, when Tegretol was stopped, one of the convulsions Mr B experienced was of 48 seconds' duration, which "might suggest that [Tegretol] had had some effect on reducing convulsion length".

Dr E further commented:

> "Lithium is relatively contra-indicated as it may increase confusion immediately after ECT administration. The charted ECT records do not record any unusual level of confusion or post-ECT problems on the eight occasions when it was administered. All the post-anaesthetic recovery scores recorded were normal, though on a couple of occasions this was not recorded but recovery was said to be uneventful.

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> Some degree of memory loss is quite common with ECT as experienced between treatments and sometimes for a few days or a week afterwards. Post ECT confusion is common when convulsions are prolonged, which was not the case here. Longer term memory or cognitive problems are otherwise uncommon as are effects on intellectual ability. Where memory problems are marked or persisting, or there are difficulties with work or other functioning, as in [Mr B's] case, then other possible causes must be considered including effects of continuing depression, ongoing medication and undiagnosed physical illness. These are being considered and investigated by [Dr N].
>
> Lithium is the probable cause of the tremor experienced by [Mr B] and Lithium discontinuation was attempted for this reason when the ECT had been completed. However, he experienced some deterioration in mood and the Lithium was restarted. This underlines that there would have been some risk to discontinuing Lithium before ECT treatment was started though this is commonly done."

Mr B advised me, in response:

> "The Lithium was discontinued after my first consultation with [Dr N] as he believed this to be the most probable cause for the tremor. After a short time it was restarted at 500mg nightly (50% of original dose). This provided the best balance as it assisted with the improvement of my mood but the serious tremor was eliminated."

Treatment delays

Mr B and Ms A were concerned that Mr B's ECT treatments should have spanned less than three working weeks but took nearly two months to complete. They complained that on occasions, at short notice, treatment did not proceed on some of the appointed days despite being told by the Community Service that it would.

Dr C advised:

> "On 14 April [the Outpatient Service] w[as] notified that he would be ready for ECT on Monday. Unfortunately the theatre was fully booked. We were told the next dates were 19 and 20 April. On 18 April we were told no further ECT were possible until after Easter. I saw [Mr B] on 20 April and he expressed his anger at the further postponement. We also planned reducing the Efexol because he seemed to be making good progress.
>
> That afternoon we were rung to say that ECT could be done on 26 and 28 April. These went smoothly.
>
> If this recital of events sounds confusing, I can assure you it was confusing at the time.
>
> Altogether the eight ECT took from 29 March to 28 April.
>
> There were some minor but annoying hiccups. The file was meant to accompany [Mr B] to the theatre for the treatment and return to [the Community Service] afterwards. It went missing at least twice. Eventually the main file was left at [the Outpatient Service] and [the Community Service] kept notes in a folder. Presumably

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> this is why some of the notes are out of sequence. I had no direct contact from the ECT team though I was available on the phone all the week if not always at [the Community Service]. On 12 April the keyworker filled in a Significant Event form and forwarded it to [the Community Service] manager. I was informed of this later."

A clinical entry by Ms D on 18 April 2000 recorded:

> "Phone call from [Dr C] – message left on my voicemail to contact [Mr B] re ECT tomorrow that he is to have ECT tomorrow morning."

A second clinical entry by Ms D on 18 April 2000 recorded:

> "Message left from [Dr O], house surgeon, saying [Dr P, consultant psychiatrist] has reviewed ECT list and felt that for consistency [Mr B] should wait for next ECT to after Easter.
>
> Phone call to [the Outpatient Service] – spoke to [Dr O] confirming above.
>
> Phone call to [Mr B] – detailed message left on answerphone cancelling tomorrow's ECT. Phone call to CTT asking to cancel bureau nurse for tomorrow."

A clinical entry by Dr C at 3.15pm on 20 April 2000 recorded:

> "Seen and situation discussed. More alert but not surprisingly somewhat angry.
>
> Medication discussed – Venlafaxen – at present taking 3 75mg tablets in 24 hours. To reduce and discontinue over the next 1 to 2 weeks.
>
> To see me next Thursday.
>
> Other medication: Tegretol has been discontinued – last dose on 12/4/00.
>
> Lithium Carbonate 250mg tablets – still taking 4 tablets a day.
>
> 4.00pm Phone call from [the Outpatient Service] ([Dr O]) – one patient on list has been cancelled, so ECT now on Wednesday and Friday.
>
> * Crisis Team to notify [Ms A and Mr B] tonight, and organise nurse, file etc for Wednesday."

Mr B received his final two ECT treatments on 26 and 28 April 2000. Dr E admitted that the delay between the sixth and seventh ECT treatments, from 10 to 26 April, was "regrettable" and that the two week gap was "far from ideal". Dr E stated that the cancellation was due to "more ill inpatients being prioritised and the scheduling problems at [the public hospital], which were unfortunately at very short notice".

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Treatment outcome
Mr B and Ms A were concerned that the expected outcome/benefit of ECT may have been affected by the fact that Mr B continued to take Tegretol and lithium carbonate while undergoing the treatment.

Dr C advised:

> "On 4 April [Mr B] rang to say he was feeling very depressed again. He was visited at home by a nurse from the crisis team who reported that he was concerned about his memory, his failure to improve and some odd physical symptoms.
>
> I saw him the next day [5 April 2000]. He had had a difficult week with a number of stresses including pressure from work. He complained of odd rushing sensations in his neck. He was anxious about his memory. He was tearful when talking about events of the week, but for all that, talked with good voice modulation, good facial mobility and managed a few jokes and laughed at them. I checked his possible suicidality and was not concerned for his safety.
>
> I was then informed that [Dr N] had been asked to see him for a second opinion. Though I would have preferred to have it discussed with me beforehand, I felt it to be a good idea. I was beginning to be concerned that I might have missed some concomitant physical illness."

Mr B advised me, in response:

> "The second opinion was at my request as I had lost confidence in [Dr C] and felt that I was not receiving the level of care that I was entitled to and expected. This had been discussed by me with [Ms D] and she supported my request to be placed under the care of [Dr N]."

Dr C stated:

> I saw [Mr B] again on 25 May. His mood showed some improvement. He was now taking nortriptyline 150mg nocte and lithium 1000mg daily. His odd physical symptoms had abated and he was managing a reasonable pattern of work and recreation.

Mr B advised me, in response:

> "Neither the tremor nor the head rushes had abated. The tremor did not cease until the Lithium dose rate was reduced by [Dr N]. [Dr C] did not appear to believe that I had a tremor and this was one of my areas of concern regarding the level of care I received from her.
>
> At this stage I had to resign from my executive role as General Manager (due to the problems experienced following ECT). I had just commenced a part time position as building manager/cleaner in the apartment block that we lived in, in an effort to try and survive financially. Even this light work proved extremely difficult and our recreational and social activity was non-existent. I was struggling with extreme

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fatigue, unable to make basic decisions and required assistance with most aspects of daily living."

Dr C stated:

"[Dr N] saw [Mr B] on 9 June, made no changes in management but planned to investigate the memory loss further.

I was told about a week later that [Mr B] wanted to change psychiatrists. I had one further interview with him, on 22 June. He outlined three reasons why he did not want to continue as my patient, none related to ECT. We parted amicably."

Mr B advised me, in response:

"My meeting with [Dr C] was to provide reasons why I had requested that I be transferred to [Dr N]. I wrote down 5 reasons (so I wouldn't forget them) and while these were not the only incidents, they were sufficient to enable me to feel that I could convey to [Dr C] why I had concerns over the care I was receiving from her. The reasons were:

a) She did not believe that I had a tremor and twice commented that she had watched me carry a cup of water and that she saw no evidence of a tremor – therefore it did not exist. Given that I was having difficulty even writing, I found this to be very distressing.

b) [Dr C] had not requested that I have any blood tests for Lithium levels until I suggested that I was well overdue. Due to the dose rate of Lithium, these had always been done in the past on a regular basis as a precaution against kidney damage.

c) [Dr C] had started me on Nortriptyline following the ECT. At no stage had she arranged for me to have blood level tests taken to ascertain if the dose rate she had placed me on fell within the therapeutic range for this drug.

d) Both Tegretol and Lithium could have affected and/or compromised the outcome of the ECT but there had been no discussion of this prior to the ECT commencing.

e) [Dr C] wanted to give me a prescription for medication as her records showed she had previously only given me one month's supply. She had in fact given me three months' supply but incorrectly recorded this.

We had a short discussion regarding the above and [Dr C] said she did not agree with any of the points I raised. One of the reasons related directly to the ECT treatment while the tremor had only appeared following ECT.

I would term our parting as 'civilised' rather than amicable as I was not intent on anything other than removing myself from [Dr C's] care."

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Dr C advised me that she did not have any further contact with Mr B after 22 June 2000. She said she was not notified of the results of any enquiry. She left the Community Service at the end of August 2000.

On 10 July 2000 Mr B underwent testing by Ms D on the Wechsler Memory Scale – Revised. Results indicated that Mr B had significantly lower verbal than non-verbal memory. Ms D's report stated:

> "**Reason for testing:** [Mr B] has a history of longstanding drug resistant depression. He received a course of 8 ECTs between 29/3/00 and 28/4/00. The Wechsler Memory Scale-revised was administered in order to establish a baseline measure of memory so that any changes can be tracked.
>
> Since the ECT [Mr B] has complained of severe memory problems particularly involving medium term (last 2-3 years) and short term memory. The medium term memory loss particularly involves discrete gaps in memory for significant events eg cannot remember his wedding, did not remember that his daughter's cat had died.
>
> **Date of administration:** 20/6/00 and 26/6/00
>
> **Test results:**
>
> Wechsler Memory Scale – Revised
>
> | Indexes | |
> |---|---|
> | Verbal memory | 84 |
> | Visual Memory | 119 |
> | General Memory | 93 |
> | Attention/Concentration | 129 |
> | Delayed recall | 105 |
>
> **Conclusions:**
> Results indicate that [Mr B's] verbal memory is functioning at a significantly lower level than his non verbal memory. These results are consistent with his reported memory loss. It is difficult to determine the amount of deterioration as no pre ECT measures were taken. The discrepancies in scores would indicate the need to investigate further to rule out other causes particularly in the light of the almost three month time delay since the end of the course of ECT with no reported improvements. It is difficult to determine the extent of the loss attributable to depression or to ECT or other organic source. These results are indicative of the need for a more in-depth investigation. I strongly recommend a neurological referral."

The Community Service inquiry
Mr B and Ms A were concerned that, although Ms D told them the situation regarding the drugs was so serious there would be an internal inquiry to determine why it happened, Mr B was not told whether an inquiry took place and, if so, what the outcome was.

Ms D advised:

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"During [Mr B's] ECT treatment issues regarding procedures for Outpatient ECT were raised. I discussed this in the Central Team Meeting on 11 April. I filled in a [Public Hospital] incident form on 12 April 2000 in which I outlined my concerns at the time, these were centred mainly on procedures for Outpatient ECT. I informed [Mr B] that I had done this. I do not recall telling him that an 'internal inquiry' was taking place.

I had a meeting between myself and both [Mr B] and [Ms A] on 8 May in which we discussed how things were going particularly the changes in his memory that he had noticed.

I had as I recall two meetings with [Ms L], the Manager at [the Community Service], where we discussed the issues raised by my incident form and they were raised at management level. My understanding is that, as a result, protocols are being developed by [the Outpatient Service] clearly setting out guidelines for Outpatient ECT. My recollection is that I did inform [Mr B] that that had happened."

Mr B advised:

"It was [Ms D] who advised us that an internal inquiry was to be held.

1. I am quite certain that it was [Ms D] that told [Ms A] and I of this and that it was unprompted by us.

2. It was prior to our making the formal complaint.

3. I asked [Ms D] on more than one occasion after she had made that comment what progress was being made or if there was an outcome. She was always going to follow up.

4. It was in fact the initial reason that caused us to feel that something inappropriate or untoward had happened and that my condition was not a normal response to the treatment.

5. The lack of action on [the Community Service's] part prompted us to make the formal complaint.

…"

Neuropsychiatric referral

Mr B was subsequently referred to Dr N, consultant psychiatrist at the Public Hospital, who advised:

"From memory, [Mr B] and his partner described a significant decline in his memory, particularly long term memory after his ECT course. This was evident in a cursory memory test that I did. If I am not mistaken, the neuropsychological tests also revealed something similar.

The memory impairment appeared quite severe to me, as he cannot even recall significant details of the recent years like his wedding as well as the Rugby World Cup.

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It appears that it has reached a point where [Mr B's] functioning was severely reduced after the ECT.

Because of the complexity of the case, as well as the impairment, I sought the second opinion of a neuropsychiatrist, [Dr Q]. I have not received any reports from [Dr Q] as of yet.

[Mr B] is still quite disabled. I am not expert on cognitive/memory disorders so I cannot comment on his long-term prognosis re: his memory.

Because of the strong temporal relationship between his ECT and his memory impairment, I strongly suspect that 1) the ECT or 2) having ECT while on Tegretol and lithium or 3) the anaesthetic process or 4) combination of the above resulted in his memory dysfunction."

Dr N referred Mr B to Dr Q, a neuropsychiatrist at a private specialist centre. Dr Q's report dated 15 December 2000 stated:

"Referral or Identifying Data

[Mr B] was referred by [Dr N] for an opinion on cognitive dysfunction acquired since a course of ECT in March to April 2000. Specifically, the main questions were:

1. What is the likely cause of the memory impairment?
2. Are further investigations required?
3. Are there relevant treatment options?

The GP is [Dr G]. He was seen, together with his partner [Ms A], for about one hour on 6 September 2000.

…

Functional Enquiry

Possible symptoms of acquired brain injury
His senses of smell and taste were reduced following the injury and have not appreciably improved. He used to suffer cluster headaches prior to the ECT but has only had one since, a reduction in headache frequency. There was one episode of vertigo following ECT but he was discontinuing an antidepressant at the time.

There has been no hearing loss or tinnitus [ringing in ears], no impairment of vision, and no photosensitivity [sensitivity to light] or phonosensitivity [sensitivity to sound].

He has been more irritable, with a pattern congruent with the effects of brain injury namely a very short fuse with rapid rise to anger. This is different to his prior pattern of 'bottling things up' (though of course lithium can have an effect on irritability independent of its effect on mood and the lithium was discontinued at one point). He remains more easily fatigued than prior to the ECT; this is not typical for the effects of

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brain injury alone, since he wakes feeling tired then this persists all day. He is now less tolerant of physical exercise.

His concentration and memory are slowly improving but not yet back to normal.

He describes mild high level expressive language dysfunction, describing paraphasia [the habitual inappropriate use of words in speech] especially. He has not suffered any blackouts.

…

Examination

A well dressed and groomed right handed adult Caucasian male, making adequate rapport and with no obvious psychomotor retardation, distractibility, impulsivity or irritability. He did obviously fatigue over the course of the interview but did not develop dysarthria [impaired ability to articulate] or a headache.

He was oriented to time place and person. He could tell me the months of the year backwards quickly and fluently. There was an obvious memory deficit on bedside testing; he could only recall two of four coloured objects at three minutes. Verbal fluency was reduced, with 8 words beginning with 'c' and seven with 't' in respective 60 second intervals.

Tandem gait was normal and static and dynamic balance seemed unimpaired. An exaggerated physiological tremor was present with no abnormalities of tone, power or co-ordination in the upper limbs. Rapid alternating movements were unimpaired. No primitive reflexes were present and his sense of smell was objectively intact. Smooth pursuit eye movements were slightly jerky, but saccades were normal and there was a full range of eye movement with no nystagmus [type of eye movements, the presence and/or absence of which is used in diagnosing a variety of visual and neurological disorders].

There were no psychotic features; his mood was depressed but with reactive affect, and there was no current suicidal ideation or intent.

Opinion

[Mr B] describes memory impairment following ECT. The course of ECT was unusual in that he was left on a significant dose of a psychotropic anticonvulsant for the first six applications and as a result larger than usual doses of electrical stimulus were applied with a less adequate result (in terms of induced seizure activity) than usual.

The amnesia is apparent on simple memory testing and is not contingent on poor concentration as would be likely to be the case if the cognitive impairment were due to depression. There are other symptoms suggestive of, though not diagnostic of, diffuse brain injury. The reduced verbal fluency is clinically in keeping with brain injury rather than depression.

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Recommendations

As will be seen, I did not perform any tests which a neuropsychologist might wish to administer. Neuropsychological testing should be carried out by a clinician familiar with the assessment of patients following acquired brain injury, possibly focusing especially on tests with good ecological validity. Tests of motivation should be included to demonstrate that a motivational deficit is not present. Once this has occurred, specific strategies to compensate for residual memory deficits could be advised, with their use being monitored and tailored over at least several months by an experienced neuropsychologist.

There is no current history suggestive of ongoing seizure activity so electroencephalography is not expected to be contributory, though should be undertaken if seizure-like phenomena occur. Structural brain imaging, namely an MRI, would be reassuring to rule out possible complications such as subcortical changes typical for anoxic insult, or indeed to rule out other unrelated (coincidental) structural brain disease as a cause for his symptoms.

In addition to clinical advice from a neuropsychologist, it would be possible to trial stimulant medication such as methylphenidate which might improve attention to the point that some of his memory dysfunction can be minimised."

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Mr B was assessed by Mr R, clinical psychologist/neuropsychologist, on 12 April 2001. Mr R's report noted:

"**Referral/Identifying information**
The referral sought to assess [Mr B's] neuropsychological status, in order to determine his current profile of strengths and limitations. Advice was requested on an appropriate rehabilitation plan together with information on a likely prognosis.

…

Psychometric assessment
Tests Administered

Wechsler Adult Intelligence Scale – Revised (WAIS-R) subtests
Wechsler Adult Intelligence Scale III (WAIS III) subtests
Wechsler Memory Scale (WMS) subtest
Rey Auditory Verbal Learning Test (RAVLT)
Speed and Capacity of Language processing Test (SCOLPT)
Controlled Oral Word Association (COWA)
National Adult Reading Test (NART)
Rey Complex Figure (RCF)
Trail Making Tests A&B (TMT)
Behavioural Assessment of Dysexecutive Syndrome (BADS) subtests
Wisconsin Card Sorting Test (WCST)
Beck Depression Inventory (BDI)
TOMM Test

Results:

I have no reason to suspect [Mr B] did not put his full effort into completing the tests to the best of his ability. Testing was also carried out in the morning, when he was more likely to be rested and alert.

Premorbid intellectual ability
Subtests generally regarded as providing reliable estimations of premorbid intellectual ability place [Mr B's] ability in the high average range.

General intellectual ability
Whilst a full scale assessment was not carried out, the profile of subtest results obtained from the WAIS-R and WAIS-III suggest there has been no change in intellectual ability resulting from changes brought about through events last year.

Verbal abilities and reasoning skills
There was no evidence of receptive language difficulties. There was however, as noted above, observed difficulty in word finding ability, and [Mr B's] speech was sometimes slow and halting as he concentrated on recalling certain words by which to express himself. That said, he did not demonstrate any difficulties in comprehending

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sometimes complex instructions for carrying the testing procedures. Neither did he have any difficulty in reasoning ability or with abstractions.

Visuospatial and constructional skills/visuospatial perception
[Mr B's] ability to 'make sense' of and perceive the overall gestalt of visual information is intact and he did not demonstrate any difficulties in manipulating visual images in order to complete complex tasks.

Verbal memory and learning
Testing in this domain yielded mixed results. A test of verbal memory involving a logical and meaningful sequence of information produced results for 'immediate recall' and '30 minute delayed recall' that landed within the normal range for individuals of [Mr B's] age group. However, it is likely his ability was in the high average range previously, and these scores probably represent a decline from his premorbid ability.

A more demanding verbal memory test using unrelated information (RAVLT) demonstrated a normal rate of acquisition over the 5 learning trials. There was some loss of newly learned material following a distraction, and his score there was at the lower end of the normal range. However, the recall of that same newly learned material after 20 minutes was poor, and the score there was 2 standard deviations below the norm. Cued recall did not assist in retrieving information and there again scores were low and at least 2 sd below the normative range.

Other tests that rely on short term memory ability for success (as well as intact attention/concentration ability) did not pose any difficulty for [Mr B].

Non-verbal memory
Testing here did not find [Mr B] having any difficulties.

Attention/concentration abilities
Tests designed to assess the ability to focus, sustain, or divide attention gave results that all landed well within or above the normal range. As noted above, some of those tests also rely on short-term memory ability for success.

Speed of information processing
Results from tests designed to assess speed of information processing produced results that landed firmly in the normal range for individuals in [Mr B's] age group.

Executive and problem solving abilities
Executive functioning refers to a range of abilities including being able to benefit from feedback and learn from mistakes; to think abstractly or laterally; to direct and switch attention; plan and organise information or activities, and to initiate activity; to generate ideas; and to regulate behaviour and emotional response. It is important to note that compromised ability in one attribute does not necessarily mean other features associated with executive functioning will be compromised also.

Subtests from the BADS placed demands on [Mr B's] ability to think laterally but posed no difficulties for him.

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The WCST is a test of abstract reasoning but it also assesses difficulties with inefficient initial conceptualisation, failure to maintain cognitive set, perseveration, and inefficient learning across stages of the test.

Oral word fluency, the ability to spontaneously generate words starting with a given letter within a time limit (COWA), is also regarded as a measure of executive functioning.

[Mr B's] performance on the WCST produced results that point to significant difficulties in 'stitching information together'. Consequently, whilst [Mr B] was able to name the sorting principles, he was not able to put that information into practice so as to consistently follow through with or apply the concept necessary for success on that task.

Similarly, results from COWA were below the 10th percentile and also pointed to difficulties in organising and linking bits of information together so as to retrieve information held in long-term memory. In addition, there was a marked decline in words generated after 30 seconds which also points to dysexecutive functioning.

I suspect dysexecutive functioning probably accounts for the deficits in [Mr B's] verbal memory functions. There were intrusions from List A into List B on the cued recall trial of the RAVLT which point to difficulties in organising and structuring information to be learned and then stored or retrieved. Poor overall results obtained from the cued recall trial of the RAVLT tend to confirm that conclusion.

Summary and comment
Results from the BDI landed on the cusp of the mild–moderate ranges of depression. As such it is unlikely that depression exerted a negative effect on test results obtained in this assessment. Recent research findings demonstrated that severe depression, but not mild–moderate had such an effect on psychometric test results. The profile of test results obtained here reflect deficits in specific domains, and not generally across all domains as one might expect if depression were exerting a negative influence.

Formal testing confirmed [Mr B's] report of his having difficulties in the area of verbal memory functioning. [Mr B] has no difficulty in processing new information and retaining that in short term memory store (cognitive neuroscience describes this process as taking place within 'reverberating neural loops').

However, the route by which newly learned information is then stored in long-term memory involves an organising/structuring process in which specific memory associations are formed at a neural level. That same process also facilitates retrieval of information from long-term memory. It is likely deficits in neural organising/structuring processes lie at the base of [Mr B's] verbal memory problems.

Executive functions are not mediated solely through the frontal lobes, although [Mr B's] difficulties in multitasking, word-finding, coping with changes to his routine, and in regulating emotional response (controlling anger or aggressive outbursts) tend to suggest some degree of compromised frontal lobe functioning. However, it is also

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possible that lesions or area of attenuation in the hippocampus or closely connected diencephalic structures may be implicated here. Results from MRI may provide more information in this line of enquiry.

In brief, the profile of test results obtained in this assessment found the following –

Strengths: No significant change in intellectual ability from estimated premorbid level.
Intact verbal abilities and reasoning skills.
Intact visuospatial perception and construction skills.
Intact non-verbal memory ability.
Normal or above normal range ability to focus, sustain, or divide attention also reflected in above average short-term memory ability.
Speed of information processing within the normal range.
Average verbal memory ability for logical or 'meaningful' information.
Intact ability to think laterally or in abstract terms.

Limitations: Significantly reduced ability to retain more complex or unrelated (verbal) information in long-term memory.
Compromised executive functioning surrounding the ability to organise and structure information – leading to linking or 'stitching' information together.

To conclude, the evidence obtained here, together with reported difficulties in multi-tasking, word-finding, coping with changes to his routine, undue fatigue, regulating emotional response (controlling anger or aggressive outbursts), and phonosensitivity point to acquired brain injury as the likely cause.

…"

In January 2001 ACC accepted that Mr B's memory impairment was caused by the ECT and that it was a rare and severe consequence of treatment, qualifying Mr B for cover on the basis of a "medical mishap".

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Independent advice to Commissioner

The following expert advice was obtained from Professor Pete Ellis, an independent consultant psychiatrist:

"**What are the specific standards that apply and were they followed?**
Specific standards
There are no nationally mandated, documented, specific standards that apply to the administration of ECT (other than under the provisions of the Mental Health Act). I am not aware of any specific requirements set by the Health Funding Authority in its contract with [the Public Hospital].

I note the internal clinical procedure document dated September 1998.[1] This covers a number of procedural matters, but does not address in any clear way what is meant by the term 'credentialling' and does not clarify the respective responsibilities of medical staff prescribing and administering ECT, nor does it prescribe or advise against any specific medication in conjunction with ECT. There appears to be a separate ECT treatment record that requires treatment to be documented.

There are a number of guidelines available in relation to ECT. These include those prepared by the Royal College of Psychiatrists (UK) (RCPsych), the American Psychiatric Association and the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The latter organisation has recently revised their guidelines, which have now been substantially extended. They were released subsequent to [Mr B's] treatment.

While I would expect clinicians to be familiar with the broad issues in these guidelines, they are not treatment protocols and there is no reference in the material from [the Public Hospital] to imply that they have been adopted in their service. To try and put this in context, car drivers in New Zealand have the opportunity to attend defensive driving courses that espouse a number of undeniably valuable driving techniques. Few drivers actually take up these opportunities or are familiar with the relevant material in detail, although most responsible drivers try and abide by these principles. Similarly, those producing these guidelines hope they will influence but not dictate practice, mindful that there are specific circumstances that may require different solutions.

Were the standards followed?
The matters raised by the complainant are not specifically addressed by the Clinical Procedure document on ECT.

They are addressed to some extent in the various guidelines. In brief, relying on the RANZCP clinical guideline (that is dated 1999 but to my personal knowledge was not released until mid 2000), it appears that ECT was indicated for [Mr B], there were no

[1] As a minor matter, I note there are a series of significant typographical errors in the document that raise concerns about the extent of its review before adoption (eg 'Nurse Surgeons' when I suspect 'house surgeons' was intended; 'impulsive patients' when I suspect 'compulsory patients' was intended; 'preformed' instead of 'performed'; 'insight' instead of 'in sight', etc).

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clear contraindications to the treatment and his pre-treatment medical assessment was satisfactory. Prescription of a series of treatments at a time is no longer recommended, mostly in order to ensure that patient's progress is reviewed regularly. However, this objective appears to have been met as [Dr C] reviewed [Mr B] after at least his first, fourth, sixth, seventh and eighth treatments, although it is a little difficult to follow the exact intervals from the notes, for the reasons explained by [Dr C]. It is recommended that treatment be reviewed at 'appropriate intervals' by the RANZCP guidelines. In my opinion [Dr C's] practice was consistent with that usual in New Zealand. I note the significant contact between other members of [the Community Service] staff and [Mr B] over this period.

I will address issues regarding concurrent medication below. The facilities for the treatment, as far as I can ascertain from the limited information available to me, were probably satisfactory. In particular, the recommended stimulus dosing approach was followed and monitoring included EEG monitoring. Re-stimulation following an inadequate seizure appears to have followed recommended practice. I am not clear whether the suggested ECT Committee is established at [the public hospital], but note this is a recommendation that did not become available until after the incidents under consideration.

I note that the ECT treatment record for [Mr B], signed by [Dr C], indicates clearly that he was continuing to take Efexor, Tegretol, Lithium and Accupril, stating specific doses. It is clear therefore that both [Dr C] and the administering psychiatrist had details of the medication being taken by [Mr B]. The clinical procedure document does not state whether the administering psychiatrist is also expected to exercise judgement in relation to information in this record. I would expect this to be the case.

Was [Dr C's] decision to refer [Mr B] for ECT on an outpatient basis reasonable in the circumstances?
In my opinion this was an appropriate decision. I note that there were unanticipated procedural difficulties in providing treatment in this way. However, outpatient ECT treatment is currently regarded as a mainstream practice.

What risks are associated with ECT?
What side effects are associated with ECT?
The risks associated with ECT are principally those of the anaesthetic and of memory disturbance. The latter is usually limited to the period immediately surrounding treatment. In rare and largely unpredictable circumstances it may be more persistent, lasting for six months or more.

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More detailed accounts of risks/side effects are given in the RANZCP guidelines, which state:

10.1 A number of immediate side effects such as headache, myalgia, nausea and drowsiness are benign and should respond to symptomatic or supportive therapy.

10.2 The cognitive side effects of ECT are of most concern to clinicians and to patients. It should be noted that evidence for much of this is based on older studies which used ECT machines with sine wave stimulus and bilateral electrode placement. It should also be noted that severe depressive illness per se is associated with cognitive impairment, and that this may improve as the depression responds.

10.3 The features of an acute post-ECT delirium may vary from impaired comprehension and disorientation, which is not unexpected in most patients and for which close nursing supervision and support is adequate, to severe psychomotor restlessness, which may require the administration of intravenous psychotropics. A persistent post-ECT delirium may be observed in a small proportion of patients, in which case physical investigations should be considered. Techniques which may minimise the extent of delirium include the use of unilateral ECT in association with moderate suprathreshold electrical dosage, reduction in the frequency of treatment and minimisation of concurrent psychotropic medications.

10.4 Unilateral ECT using modern brief-pulse machines is associated with minimal anterograde amnesia (inability to learn new information) and minimal retrograde amnesia (memory loss for events or information before ECT); complete resolution by six months after treatment is expected. However, bilateral ECT is associated with greater levels of amnesia, which may be more persistent, although new learning, judgement and reasoning are not affected. Retrograde memory problems, especially for autobiographical events for up to six months before ECT, may continue to be noted. In some cases, persistent subjective complaints of memory disturbance after ECT seem to show greater correlation with residual depression, rather than with any objective evidence.

10.5 There is no evidence that ECT causes any structural cerebral damage.'

An alternative formulation of risks follows:

POTENTIAL RISKS

Exacerbation of pre-existing medical, physical or psychiatric disorder by the physiological events associated with ECT and anaesthetic administration, viz:

- a physical response to the administration of anaesthetic and muscle relaxation agents
- activation of the autonomic nervous system
- increase of intracranial, intraocular and intra abdominal pressures

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- a cerebral and motor tonic clonic seizure.

Serious risks include:

- airway obstruction leading to hypoxia and possible death (risk <1 in 100,000)
- respiratory depression leading to hypoxia and possible death
- regurgitation leading to obstruction, aspiration pneumonitis and possible death
- cardiovascular instability leading to myocardial infarction, heart failure, stroke and possible death
- allergic/anaphylactic reactions leading to possible death
- serious injury
- enduring memory disturbances
- spontaneous seizures

Less serious adverse effects include:

- headache and muscle pain
- nausea and vomiting
- weakness and tiredness
- incontinence
- temporary memory disturbances

Other risks are the same as with any anaesthetic and include breathing difficulties, aspiration (the breathing into the lungs of saliva or vomit) leading to pneumonia and allergic reactions to the anaesthetic drugs or equipment. People with existing cardiac problems or high blood pressure will be carefully monitored and medications such as antihypertensives, may be given with the anaesthetic to prevent stress on the heart.'

What should someone contemplating ECT be told about the treatment?

I am aware that the Commissioner has previously considered issues of informed consent. A person should be informed of the risks of the procedure and the extent of these risks, and its potential benefits. There is merit in documenting these in writing as a standard list, as has become the usual practice in surgery, but I am not aware that this is yet common practice in the administration of ECT. There may be merit in such an expectation.

However the drawback of such documentation is that it may become a substitute for more detailed personal discussion tailored to the level of concentration, depression and prior knowledge of the person considering ECT and their significant others. I note that [Mr B] was noted to have gone to some efforts to gather information about ECT himself and [Dr C] considered him to be well informed about the treatment.

The following is one statement of information available to people considering ECT. In my opinion such information should be available as an adjunct to detailed personal discussion, but this is not yet usual practice in New Zealand and the following was not prepared until late in 2000.

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'**WHAT ARE THE MAIN SIDE EFFECTS OF ECT?**

The most commonly reported side effects are varying degrees of confusion and memory loss shortly after and during the course of ECT. On awakening from ECT it is usual to experience some confusion. This usually clears within 5-30 minutes and consumer/tangata whaiora say that it is not distressing, just puzzling.

*Many consumer/tangata whaiora will find their memories are somewhat hazy for the time that they were ill. Depressed, manic and psychotic consumer/tangata whaiora who do not receive ECT frequently experience the same problem.

During the treatment course, memory for recent events, dates, public events, addresses, telephone numbers, account and pin numbers may not be as good as usual. This memory disturbance generally goes away within a few days or weeks after completing the index ECT course. Sometimes it can continue in a mild nonspecific manner for a period of months or longer. Though rare, enduring 'patchy' memory loss can occur mostly in people with pre-existing memory problems (either from psychiatric illness itself, medical conditions, drug and illicit substance abuse, head injury etc). This can also happen if ECT is not administered according to clinical guidelines and recommended parameters. Memory disturbances are not necessary for ECT to work, and your doctor will endeavour to tailor your treatment to minimise any effects on memory.

Other side effects:

Headaches, muscle pain, tiredness, weakness and nausea. They could result from a combination of the anaesthesia and/or ECT. These can generally be relieved with rest, fluids and medications such as panadol. Every effort is made to minimise these side effects by individually tailoring the treatment protocols.'

What length of time should ECT span?
There is evidence to suggest that ECT can be given twice or thrice a week with similar benefit. The key variable associated with a good outcome is an adequate total duration of seizures.

Was the length of time taken to complete [Mr B's] ECT reasonable in the circumstances?
The length of time taken for the initial six treatments was satisfactory (although the duration of seizures elicited by these treatments were generally unsatisfactory).

The delay in the further treatments was unsatisfactory and appears to reflect the pressure on [the public hospital]. The process by which priorities are assigned to different patients in the rationing of healthcare as a result is beyond the terms of your instructions to me.

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What effect, if any, would the treatment delays have had on [Mr B's] prognosis?
I doubt that it is possible to provide an evidence-based response to this question. It is probably of more importance that he did not receive an adequate course of ECT. The delays may have reduced the degree of initial confusion.

What effect would the taking of Tegretol during ECT have had on [Mr B's] treatment?
In my opinion, it would have been likely to mean that a greater dose of electricity was necessary to induce seizures of adequate duration to be clinically effective. The increased dose of electricity may have increased the risk of post treatment memory impairment. This view is consistent with the opinion (unreferenced) in the RANZCP guidelines that:

> '6.2 It is recognised that many patients receiving ECT will be administered concurrent psychotropic medications with the potential to alter significantly seizure propagation, and therefore impact negatively on the efficacy of ECT.'

[And later in this section, discussing specific medications]

> '6.2.3 Mood Stabilisers
> Both carbamazepine and sodium valproate increase seizure threshold, although it may be appropriate to continue these drugs during ECT if they are used for mood stabilisation. Similarly, patients with epilepsy should continue to receive their anti-epileptic medication, and consultation with a neurologist is recommended. In both instances, the dose of anti-convulsants may require temporary reduction.' [Continues to discuss lithium – see below.]

Similarly, I note that the American Psychiatric Press Textbook of Psychopharmacology, 2nd Edition, states:

> 'In general, patients with epilepsy should continue taking their anticonvulsants during ECT. If difficulty arises in eliciting seizures, a decrease in dose of the anticonvulsant can be considered.'

This suggests that it is recognised that when indicated (as in epilepsy) it is not mandatory to discontinue anticonvulsants. [Dr C] clearly considered that it was important to continue [Mr B's] Tegretol for fear of a relapse pending the hoped for benefits of ECT. I note also the RANZCP guidelines indication that 'many patients receiving ECT will be administered concurrent psychotropic medications'.

In my opinion it would have been desirable to discontinue [Mr B's] carbamazepine prior to treatment, or failing this, at an earlier stage of his ECT treatment when it became clear that it was proving difficult to elicit adequate seizures. In my opinion this is a matter which should have been discussed between the treating psychiatrist and the psychiatrist responsible for administration of ECT, preferably before the first treatment. [Dr C] effectively acknowledges this in her reply to the Commissioner.

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What effect would the taking of Lithium Carbonate during ECT have had on [Mr B's] treatment?
The American Psychiatric Press Textbook of Psychopharmacology, 2nd Edition, states:

> 'Lithium is also usually discontinued at least 48 hours before ECT because of a potentially increased risk of delirium during ECT.'

The RANZCP guidelines are less restrictive, recommending:

> '6.2.3 Mood Stabilisers
> Both carbamazepine and sodium valproate [etc]. Lithium prolongs the neuromuscular blockage of succinylcholine and has been reported to increase the risk of post-ECT delirium. Although concomitant administration is not a contraindication to ECT it is generally advisable to withdraw lithium prior to the commencement of ECT. For certain bipolar patients who are well controlled on lithium, the risk of ECT-induced mania may outweigh the risk of delirium, in which case lithium should be continued during ECT.'

In my opinion, the decision to continue lithium was a balance between the risk of relapse pending the hoped for benefits of ECT as against the possible risk of exacerbating any ECT related delirium. It would not in itself have affected the seizure activity. I note the later deterioration in [Mr B's] mood when the dose of lithium was reduced.

What effect, if any, did the continuation of drug therapy during ECT have on the outcome [Mr B] experienced?
The continued use of antidepressants is not associated with significant effects on the benefits of ECT.

The specific effects of carbamazepine and lithium have been addressed above.

In your opinion was [Dr C's] decision not to stop either of these drugs prior to ECT reasonable in the circumstances?
[Dr C] has acknowledged that it would have been desirable to discontinue the carbamazepine. The decision as to whether to stop lithium is less clear cut and would be a matter of opinion, in my view, dependent on the prior treatment response to this agent. In this regard I note a clinical deterioration when this was reduced post ECT.

Were the amounts of electric charge given to [Mr B] during ECT within the usual treatment range?
Yes. The maximum dose administered was 504 mC, which is regarded as within the normal treatment range. The references to a percentage value refer to the proportion of this dose administered at any one time. It is usual for the dose to increase during treatment, especially when an adequate seizure is not elicited at lower doses.

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Was the ECT treatment provided between 29 March and 10 April 2000 reasonable in the circumstances?
Please see comments above. It would clearly have been desirable to complete the treatment course without interruption but this was constrained by external factors beyond the control of the treating clinicians. It would have been desirable for earlier identification of the difficulty in eliciting adequate seizures and review of his medication, or to have withdrawn carbamazepine prior to treatment.

In your opinion what relationship, if any, is there between the ECT treatment received by [Mr B] and his subsequent memory loss?
In my opinion this relationship is at least probable. However, it is somewhat unusual for the memory difficulties not to have been more evident immediately following treatment although the exploration of these was not formalised. I presume that the investigations suggested by Dr Q have now been undertaken and that other sources of his memory difficulties have been excluded. If this were so, it would then seem likely that the course of ECT was the cause of his memory disturbance.

To what do you attribute his hand tremors?
I note they were not present to a significant extent prior to ECT, but decreased following reduction in his lithium dose post ECT and were not exacerbated when this was later increased again. While lithium may well have played a part, it is not possible to make a definite comment without a neurological opinion.

In your opinion what are [Mr B's] prospects for recovery?
Depression
[Mr B] has suffered from a long period of depression that has been relatively resistant to a wide range of treatments. The ECT treatment he received was of, at best, only limited and transient benefit to his mood, despite reasonable grounds to hope otherwise at the time of its initiation. While the natural history of depression is ultimate recovery, this can be long delayed and I expect that he will require ongoing psychiatric and psychological treatment pending this.

Cognitive impairment
Assuming that the further investigations do not reveal other causes, I would presume that he can expect substantial improvement over a period of months to a year or more, but the literature on delayed recovery is scant and provides little assistance in predicting prognosis. I note that the last file note was October 2000 and that further neuropsychological testing was planned at that time. The degree of improvement between successive such tests would be a more accurate predictor of his rate of cognitive recovery.

Are there any other matters you consider relevant in relation to the standard of care provided to [Mr B]?
It is not clear how the procedural difficulties associated with outpatient ECT have been overcome and whether the other aspects of establishing clinical responsibility in the provision of ECT have been addressed."

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Responses to Provisional Opinion

Dr C
Dr S, Medico-legal Advisor, Medical Protection Society, responded on behalf of Dr C as follows:

> "I write on behalf of [Dr C] in response to your provisional opinion in this matter.
>
> In essence, [Dr C] accepts the opinion as to breach. The submission she wishes me to make on her behalf concerns the detail of that opinion.
>
> [Dr C] does not dispute the evidence in front of you in relation to the discontinuance of Tegretol prior to or during the course of ECT. Her submissions relate more to their interpretation.
>
> [Dr C] believes she made a valid clinical decision, which was open to her reasonably to make, that there was a risk, should the Tegretol (and other medications) be stopped prior to ECT, of deterioration in [Mr B's] depression prior to the commencement of that treatment. She feels it was reasonable for her to rely upon the obligation of the team who were to institute ECT to assess the appropriateness of these medications prior to commencing ECT. As part of their clinical management protocol, it could be contended that they should have determined prior to ECT what medications [Mr B] was taking for his depression and that they would then have been in a position to determine whether the continuance of Tegretol was detrimental to the efficacy of ECT and to discontinue it at any time. Indeed, once it was known to them that [Mr B] was on Tegretol, they did choose to discontinue it.
>
> In relation to the continuance of Lithium treatment, [Dr C] accepts the RANZCP recommendation that it is 'generally advisable to withdraw lithium prior to commencement of ECT'. This expression, it is submitted, stops well short of mandating discontinuance of Lithium. It is a reasonable interpretation that the expression means that the Psychiatrist should put their mind to whether the treatment should be stopped, should on balance stop it, but that it is open to clinical conclusion that there may be reasons for continuing it. [Dr C] did consider this, as indicated in her evidence, but came to the conclusion that there were clinically valid reasons for continuing such treatment. An alternative interpretation of the College statement would be that it is best practice to cease Lithium prior to ECT. However, with respect, it is difficult to reconcile their statement with an opinion that it is invariably a breach of the standard of care if Lithium is not ceased prior to treatment, regardless of any clinical reason for not ceasing it.
>
> It is therefore [Dr C's] submission that she was not under an obligation to cease these medications prior to referral for ECT when it is the obligation of those providing ECT to determine the appropriateness of current medication. Furthermore, it is reasonable for [Dr C] to rely upon their determination in that regard."

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Public Hospital
The Public Hospital advised me that it and Mental Health staff were satisfied with the provisional opinion.

Ministry of Health
Dr T, Director-General (Mental Health) of the Ministry of Health, responded to my provisional opinion as follows:

> "Thank you for your letter of 15 January 2002 seeking comment on a provisional Health and Disability Commissioner opinion about the treatment provided to [Mr B], by [the Public Hospital].
>
> You state that the case appears to highlight a lack of clear guidelines for the safe and effective delivery of Electro-convulsive Therapy (ECT). The Ministry of Health disagrees with this statement.
>
> The Royal Australian and New Zealand College of Psychiatrists (RANZCP) have had in place clinical guidelines for ECT since 1982. These guidelines are reviewed every five years and were in the process of being reviewed during the time that [Mr B] was receiving ECT. It is clear from your provisional opinion that despite the existence of guidelines the failure to discontinue anti-convulsive medication was an oversight admitted by the psychiatrist responsible for his care.
>
> Some recent research by Dr U, Clinical Director, Mental Health Services for Older People, [a second Public Hospital], involved surveying the clinical practice of ECT by New Zealand psychiatrists by questionnaire (*The Royal College of Psychiatrists, Psychiatric Bulletin (2001) 25: 467-470*). The survey found that the United Kingdom's Royal College of Psychiatrists' *ECT Handbook* was the most nominated source of information on ECT in New Zealand. Most (87%) respondents were aware of at least one set of ECT guidelines.
>
> Regarding your recommendation that the Ministry of Health develop guidelines for ECT, it is the Ministry's view that developing such guidelines would add, at most, marginal value to the recently reviewed RANZCP guidelines on ECT.
>
> Nevertheless, clinical practice guidelines are only valuable if they are implemented by services. To help facilitate better implementation of the RANZCP guidelines for ECT the Ministry will:
>
> 1. Write to the College seeking to circulate their ECT guidelines to District Health Boards with a letter from the Director of Mental Health, indicating that it is expected that their clinical governance arrangements will ensure compliance with the Guidelines. The College will also be asked if their information sheet for people considering ECT could be circulated to DHBs and for that information to be made freely available to mental health consumers.
>
> 2. Request that the College place their ECT guidelines on an open part of their website. (Presently, only College members can assess the guidelines via the

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Internet. However, the public can access the information sheet for people considering ECT from the College's website.)

3. Include the RANZCP guidelines within the Ministry of Health's *Nationwide Mental Health Service Statement* currently under development. This will create an expectation that the guidelines must be adhered to by DHBs and any other publicly funded services which administer ECT.

You are also considering making the recommendation that the Ministry of Health undertake a national review of the administration of ECT. It is our view that such a formal review is not necessary at this time. Indeed it would be very unusual to conduct such a review on the basis of a single case of poor practice.

ECT continues to be an important tool for the treatment of certain major mental disorders. There is a considerable body of evidence for its effectiveness and safety in treatment of severe, often life-threatening depression, and of certain other severe mental disorders. It would be unfortunate for public perceptions of this sometimes lifesaving treatment to be further undermined by the suggestion that its administration is conducted unprofessionally around the country. This inference would, I believe, be drawn from the recommendation you are considering.

You may wish to consider an alternative recommendation directed to DHB medical credentialing committees. Particular attention could be paid to credentialing psychiatrists and other medical practitioners for the prescription and administration of ECT. It would be appropriate for credentialing committees to be advised by the RANZCP during the credentialing process.

In conclusion, I confirm that the Ministry does have an interest in the safety and quality of ECT treatment, as well as other treatments provided by mental health services. You may be aware that a national special interest group of clinicians involved with ECT treatment has recently been established. The Deputy Director of Mental Health is a member of this group and has been pleased to report their activities, including their intention to survey the use of ECT throughout New Zealand. The Ministry will continue to encourage the activities of this group."

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Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

...

3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

...

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive ....*

Opinion: Breach – Dr C

In my opinion Dr C breached Right 4(1) of the Code by not reviewing and discontinuing Mr B's Tegretol and lithium treatment prior to, or at an earlier point during, the course of his ECT treatment.

Right 4(1)

Tegretol
The purpose of ECT is to induce seizure activity in the brain. Tegretol is an anti-convulsant medication that prevents this seizure activity. Dr C was aware that Mr B was taking Tegretol prior to starting ECT. Although she was concerned about discontinuing Mr B's medication until it was clear that the ECT was "lifting his mood", Dr C acknowledged that her failure to discontinue Tegretol prior to the commencement of ECT was an "oversight" for which she apologised.

I accept that, according to RANZCP guidelines, it may be appropriate to continue taking Tegretol if it is used for mood stabilisation. However, I do not accept that it was appropriate for Dr C to continue this drug therapy until 11 April 2000, given that adequate seizures had not been elicited in six treatments, and despite electricity doses rising to 100%. The Public Hospital's policy on ECT requires that the psychiatrist responsible for the care of the patient must supervise the course of treatment, which includes reviewing progress

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and any adverse effects. By continuing to take Tegretol Mr B was subjected to higher than average doses in an attempt to induce seizures of an adequate duration. This appears to have impacted on the post treatment memory impairment that he continues to experience.

My psychiatric advisor commented:

> "In my opinion it would have been desirable to discontinue [Mr B's] carbamazepine prior to treatment, or failing this, at an earlier stage of his ECT treatment when it became clear that it was proving difficult to elicit adequate seizures. In my opinion this is a matter which should have been discussed between the treating psychiatrist and the psychiatrist responsible for administration of ECT, preferably before the first treatment. [Dr C] effectively acknowledges this in her reply to the Commissioner."

My advisor also commented that the outcome for Mr B was that he "did not receive an adequate course of ECT" and that this was because the duration of seizures was generally unsatisfactory. Dr C, as the responsible clinician, should have discontinued Mr B's Tegretol, if not prior to treatment, certainly when it became clear that it was proving difficult to elicit adequate seizures. I accept Dr C's point (made in the submission on her behalf by Dr S) that the Public Hospital team who were to institute ECT "should have determined prior to ECT what medications [Mr B] was taking for his depression". The team would then have been in a position to determine how the medication would impact on the ECT. Dr C was let down by the Public Hospital's mental health service team responsible for the administration of ECT. However, that does not excuse her responsibility as the responsible clinician for Mr B. Accordingly, in my opinion Dr C did not exercise reasonable care and skill and breached Right 4(1) of the Code.

Lithium

Lithium may increase confusion immediately after ECT administration. Dr C chose not to discontinue it prior to commencing ECT because "it is usual nowadays to stop Lithium prior to ECT when geriatric patients are being treated". She concluded that Mr B was, at age 50, not geriatric and she wanted to leave him with some medication cover. However, Dr E noted that lithium is commonly discontinued before ECT is started.

My psychiatric advisor stated that "the decision to continue lithium was a balance between the risk of relapse pending the hoped for benefits of ECT as against the possible risk of exacerbating any ECT related delirium".

I also note the RANZCP guidelines, which state:

> "Although concomitant administration is not a contraindication to ECT it is generally advisable to withdraw lithium prior to the commencement of ECT. For certain bipolar patients who are well controlled on lithium, the risk of ECT-induced mania may outweigh the risk of delirium, in which case lithium should be continued during ECT."

Dr C commented (through Dr S) that the College statement meant that it was "best practice" to cease lithium prior to ECT, but that "it is difficult to reconcile their statement with an opinion that it is invariably a breach of the standard of care if Lithium is not stopped prior to treatment, regardless of any clinical reason for not using it". Dr C did

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consider cessation, "but came to the conclusion that there were clinically valid reasons for continuing such treatment".

I accept that the College statement is a guideline only. However, if Dr C had reviewed Mr B's medication, rather than simply documenting it, prior to commencing him on ECT, her oversight in forgetting to discontinue his Tegretol would not have occurred. It seems probable that, had a review occurred, the lithium would also have been discontinued. The College recommends lithium cessation for ECT patients, unless the patient is well controlled on the drug and has a bipolar affective disorder. Mr B did not have a bipolar affective disorder. Although Mr B's mood did deteriorate when the lithium was later reduced, this could have been addressed as part of his ongoing monitoring, while he was receiving ECT.

I am not satisfied that it was reasonable for Dr C to continue Mr B on lithium while he was receiving ECT. In my opinion Dr C did not exercise reasonable care and skill and breached Right 4(1) of the Code.

Opinion: No breach – Dr C and the Public Hospital

In my opinion Dr C did not breach Right 4(1) of the Code by referring Mr B for outpatient ECT.

Right 4(1)

Outpatient ECT
Most of the ECT performed at the public hospital is on an inpatient basis. This is because most of the patients receiving it are severely depressed and need to be admitted. However, outpatient treatment is available. I note the advice of my independent expert that outpatient ECT is regarded as mainstream practice in New Zealand. I also note that Dr C did not consider there were clinical indicators for admitting Mr B for inpatient ECT. This was because "he and his wife were intelligent, capable people with good accommodation. He was not acutely suicidal and was physically well."

In these circumstances I consider that Dr C and the Public Hospital provided services with reasonable care and skill by referring Mr B for outpatient ECT and did not breach Right 4(1) of the Code.

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Opinion: No breach – Ms D

In my opinion Ms D did not breach Right 6(1) of the Code.

Right 6(1)

Internal inquiry
Mr B and Ms A believed that the Community Service was to hold an internal inquiry to determine why the situation regarding his drugs had arisen, but were not advised of the outcome. Ms D denied saying that an "internal inquiry" would take place. She said she completed an incident form on 12 April 2000 expressing concerns about procedures for outpatient ECT, and related this to Mr B.

Mr B would have been entitled to know the results of an internal inquiry, had such an inquiry taken place. It did not. I am unable to conclude that Ms D misinformed Mr B. In the circumstances I conclude that Ms D did not breach Right 6(1) of the Code.

Opinion: Breach – Public Hospital

Right 4(3)

In my opinion the Public Hospital breached Right 4(3) of the Code by the delays in administering ECT to Mr B.

Treatment delay
Mr B's treatment did not take nearly two months to complete, as alleged in the letter of complaint. Although it was initially delayed, reasonably and unavoidably, because of the abnormal ECG, Mr B received his first treatment on 29 March 2000. Six treatments followed, at two or three day intervals, ending on 10 April. Mr B then had a 16 day break before receiving the seventh treatment on 26 April. The eighth and final treatment was performed on 28 April 2000.

I accept the advice of my psychiatric advisor that, although the treatment delay was less influential on the outcome than the lack of seizure activity, it was nevertheless unsatisfactory. The break in treatment occurred because it was discovered, on 10 April 2000, that Mr B was still taking Tegretol. His ECT appointment, scheduled for 12 April, had to be abandoned while the drug was withdrawn. I consider that the break in treatment, necessary so that Mr B could be withdrawn from Tegretol, was appropriate in the circumstances.

The scheduling difficulties that resulted were frustrating for Mr B and unsatisfactory in terms of overall treatment. In my opinion, having initially assessed Mr B as suitable for outpatient ECT, and commenced him on a course of treatment, the Public Hospital had an obligation to ensure that the treatment programme was completed in a timely fashion. A

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16 day delay between treatments was too long, as Dr E, Clinical Leader for the Public Hospital's Mental Health Services, admitted.

ECT is a major and invasive treatment for mental illness. A provider should not commence a course of treatment unless it is assured that the course can be completed in a timely fashion, consistent with the needs of the patient undergoing ECT.

In my opinion the Public Hospital did not provide services consistent with Mr B's needs as a patient undergoing ECT. Quite apart from the possibly diminished effectiveness of a delayed course of treatment, Mr B was understandably upset by the delays. By failing to ensure that Mr B's treatment was concluded in a reasonable timeframe, the Public Hospital breached Right 4(3) of the Code.

Rights 4(1) and 4(5)

In my opinion the Public Hospital breached Rights 4(1) and 4(5) of the Code by failing to have appropriate policies and procedures in place for the administration of ECT in March/April 2000.

Clinical procedures for ECT
The Public Hospital's clinical procedure document, dated September 1998, covers a number of procedural matters in relation to ECT. These include, amongst other things, issues of clinical responsibility, credentialling, facilities staff, ECT management, communication and consent. However, I note the advice of my psychiatric advisor that:

> "This [document] … does not address in any clear way what is meant by the term 'credentialling' and does not clarify the respective responsibilities of medical staff prescribing and administering ECT, nor does it prescribe or advise against any specific medication in conjunction with ECT. There appears to be a separate ECT treatment record that requires treatment to be documented."

I also note the Public Hospital's response (provided by Dr E) in light of Mr B's experiences:

> "In the light of [Mr B's] experiences and some concerns from clinicians in other circumstances with regard to the difficulties of setting up ECT as an outpatient, we shall be implementing a tighter protocol for outpatient ECT. We will facilitate better co-ordination and communication to reduce any delays in treatment. Secondly there will be agreed clinical guidelines for ECT prescription which will be expected to be followed by the psychiatrists in the community initiating ECT and also checked by a psychiatrist co-ordinating ECT administration. At present the administration of ECT is co-ordinated from a practical and clerical point of view but this does not include clinical surveillance of clinical issues such as the number and timing of treatments and medication etc. An ECT co-ordinator will be identified to have this role. ECT is not an exact science and there is variation in practice across different countries and different psychiatrists. However there is sufficient knowledge for guidelines to be available and followed."

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In my opinion the Public Hospital's policies and protocols in relation to outpatient ECT were inadequate. No clinician was appointed as care co-ordinator with overall responsibility for clinical surveillance of Mr B's course of ECT. It is the responsibility of the Public Hospital's mental health team that is to administer ECT to assess the appropriateness of the patient's current medications before commencing ECT. The lack of adequate oversight — notably the failure to review and alter his current medications — adversely affected Mr B and reflected a lack of organisational care and skill by the Public Hospital in administering a highly potent treatment, ECT, to outpatients. In these circumstances the Public Hospital breached Right 4(1) of the Code.

Where a patient is receiving treatment in the community and as an outpatient at a hospital campus, it is essential that there is proper co-ordination between the community and hospital providers. Dr C admitted that on at least two occasions Mr B's file was mislaid between the Community Service and the Outpatient Service. The lack of co-ordination between the branches of the Public Hospital's Mental Health Services compromised the quality of care received by Mr B, and amounted to a breach of Right 4(5) of the Code.

Action

I recommend that Dr C and the Public Hospital take the following action:

- Apologise in writing to Mr B for their breaches of the Code. The apologies are to be sent to the Commissioner and will be forwarded to Mr B.

I recommend that the Director of Mental Health circulate a copy of this opinion, with personal identifying features removed, to all District Health Board Mental Health Managers, and Chief Medical Advisors, for quality improvement purposes and for use by credentialling committees. I suggest that DHB committees credentialling psychiatrists and other medical practitioners for the prescription and administration of ECT seek advice from the Royal Australian and New Zealand College of Psychiatrists during the credentialling process.

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Other actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.

- A copy of this opinion, with personal identifying features removed, will be sent to the Deputy Director-General (Mental Health) and the Director of Mental Health. I recommend that the Ministry of Health facilitate better implementation of the RANZCP guidelines for ECT by:

  1. writing to the College seeking to circulate their ECT guidelines to District Health Boards, with a letter from the Director of Mental Health indicating that it is expected that their clinical governance arrangements will ensure compliance with the Guidelines. The College should also be asked to send DHBs their information sheet for people considering ECT, and to make that information freely available to mental health consumers.

  2. requesting that the College place their ECT guidelines on an open part of their website.

  3. including the RANZCP guidelines within the Ministry of Health's *Nationwide Mental Health Service Statement* currently under development. This should create an expectation that the guidelines must be adhered to by DHBs and any other publicly funded services that administer ECT.

- A copy of this opinion, with personal identifying features removed, will be sent to the Mental Health Commission and the Royal Australian and New Zealand College of Psychiatrists, for educational purposes.

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Addendum

This opinion was issued on 12 March 2002. On 10 May 2002 I received the following information from the Co-ordinator of Psychiatric Registrar Training, Auckland:

> "I do not think that there is yet any real acknowledgement in any of Auckland's DHBs (or most other DHBs in New Zealand) that ECT co-ordination and training is extremely time-consuming and requires the credentialled ECT co-ordinator to be physically present 2 or 3 mornings weekly, every week of the year, for up to 2 hours each morning when ECT occurs (if the ECT list is long). In addition, an ECT co-ordinator needs to ensure that their DHB has an adequate and updated ECT protocol, modern and well-maintained ECT equipment, and needs to liase with the anaesthetic department regularly, and with all referring psychiatrists, both inpatient and out-patient based. Registrars administering ECT are frequently rostered to do so on an intermittent basis, so they often do not have any real ability to keep a close eye on the progression of a patient's care during a course of ECT.
>
> There is thus an absolute need for an ECT co-ordinator to be present and for referring psychiatrists to provide close monitoring of patients undergoing ECT, with close communication between the referring psychiatrist and the ECT co-ordinator at least weekly during the course. It is a great assistance to such a co-ordinator to have a skilled ECT nurse also present to oversee the practicalities of ECT administration, but to my knowledge only one Auckland DHB (Counties Manukau, Middlemore Hospital) has such a nurse funded by the DHB's Mental Health Services. The resourcing and organisation of ECT services is thus frankly inadequate in many DHBs. I am not aware that any Auckland DHB has resourced a skilled psychiatrist with specific tenths weekly protected so as to carry out ECT co-ordination; such nominated 'co-ordinators' do exist but they carry out these tasks among all their other duties without assistance with the resource issues to manage this.
>
> The logistics of out-patient (OP) ECT are very complex (arranging transport and a nursing escort, a special ECT file, medical assessment pre-ECT, completion of all referral forms pre-ECT, at least weekly psychiatrist reviews during ECT, at least weekly liaison with the ECT service to book treatments and discuss progress and any problems, arranging a place for the patient to recover before being driven home, etc). I believe however that OP ECT should be an option available to all patients who are clinically well enough for this to be safe, as an unnecessary acute psychiatric admission is very stressful and is frankly impossible in today's climate of serious admission-bed shortages. However, OP ECT needs very careful organisation and few out-patient psychiatrists have the experience to manage the logistics properly. An ECT co-ordinator is essential to ensure that all the necessary steps are attended to, as is a detailed protocol with clear practical steps to guide community psychiatrists who will only rarely have to organise OP ECT thus will not be familiar with the logistics from common practice.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

It may interest you to know that training in ECT administration and prescription/monitoring becomes compulsory with a pending change in the RANZCP By-laws for Training, from December 2002. The College had been keen to make this compulsory earlier but it has taken time to encourage HHSs/DHBs to improve their equipment and ECT systems to allow this to be provided on a mandatory basis.

I intend to encourage and arrange further CME in Auckland for psychiatrists regarding prescription of ECT and monitoring of patients undergoing ECT courses. Credentialling is needed not only for the few experts who administer ECT and do hands-on training of the registrars, but (regarding slightly different matters) for all inpatient psychiatrists and all OP psychiatrists who may refer their patients for ECT but who still need to remain the responsible treating psychiatrist during the course. This needs discussion and support by the RANZCP and the DHBs."

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