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Liability and Electroshock Therapy

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ABSTRACT: The malpractice status of the use of electroshock therapy (electroencephalotherapy) has been reviewed. In about 40 years, there have been relatively few reported cases dealing with EST (EET) and professional liability. Few cases have been won, and those generally for modest amounts. However, future successful claims are expected to reflect current inflation. Certainly the limited volume of litigation would seem to raise a question as to the justification for the extent of the surcharges charged for psychiatric malpractice insurance for the administration of EST. Potential liability for EST continues to be a significant threat to the psychiatric practitioner, although drug matters, suicide, and conformance with legal standards seem a more significant area for current litigation. Those who use EST (EET) can minimize liability exposure by (1) obtaining an informed consent from the patient, (2) describing the method of treatment and possible complications to the family or patient and so noting, (3) ensuring legal authority to treat the patient who is incompetent to give consent or for whom special procedures are required, (4) treating in accordance with accepted procedures, (5) avoiding outpatient EST, if possible, (6) paying close attention to patient complaints, (7) keeping good records, and (8) not promising perfection.

KEY WORDS: psychiatry, litigation, electroconvulsive therapy

In view of the rapid evolution of the development of somatic treatments over the last several decades, electroshock therapy (EST) has become, by virtue of the changing times, the "granddaddy" of such therapies. With the disappearance of Metrazol®-, insulin-, and Indoklon®-precipitated convulsive therapy, EST has continued to hold a unique position in the psychiatric armamentarium of therapies. Other older somatic therapies for diseases such as general paresis (malaria, hyperthermia) faded out as the diseases themselves were both prevented and treated by antibiotic therapies; nutritional or dietary discoveries and changes have minimized the occurrence of vitamin deficiency psychoses.

In the last 20 years, the biochemical revolution has opened the door to a multiplicity of pharmacologic regimens for the two common psychotic disorders—manic-depressive illness and schizophrenia. Despite these advances, EST has continued to be utilized—primarily for severe depression, occasionally for nonresponsive mania and schizophrenia. The American Psychiatric Association (APA) [*1*] has recently reviewed the efficacy, method, and place of EST as a psychiatric treatment modality.

Concurrently, EST has been the target of massive assault, both from psychiatrists who question its merit and laymen who have attacked EST as ineffectual, inappropriate, abusive, and destructive. The politics of EST has become a major legislative issue in many states, particularly but not exclusively directed at governmental institutions. Unfortunately,

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EST has become the symbol and rallying-point for attacks on psychiatry and the medical profession. Because of the semantic problems involved in the very name itself, the word *electroencephalotherapy* (EET) has been suggested as a more satisfactory alternative to electroshock or electroconvulsive therapy [2].

Another issue involving EST has been the widely trumpeted potential liability for EST use. Insurance companies have charged much higher malpractice premiums for those who administer EST. Many psychiatrists have declined to use such therapies because of the administrative burdens and costs and the potential legal hazards.

Insurance Experience

As of May 1976, the 5626 policies in the APA malpractice plan included 710 that covered EST (or approximately 12%). Such policies were charged a 50% supplemental premium. The New York Medical Society plan (1975) showed a pay-out ratio 161% higher for those psychiatrists using EST as compared to those not using EST (the latter including neurologists). The Medical Society of New Jersey plan showed an even greater disparity—465%. The Insurance Service Office, a national insurance rating organization, estimated that a 75% surcharge would be appropriate. Although purportedly as low as 5% of claims have involved EST, the high surcharge has been justified on the basis that psychiatrists who use EST seem to be involved in more legal claims; it may be that this reflects the greater legal vulnerability to this point for those who use somatic therapies compared to those who use psychotherapy and other verbal or milieu techniques. Those who use EST are also likely to be heavy users of medication; they also undoubtedly deal with a sicker population.

Incidence of Reported Legal Cases

Bellamy [3] in 1962 reviewed appellate cases over a 15-year period and reported 18 malpractice cases involving psychiatrists; six involved EST and one, insulin shock. In a subsequent article [4], he reported that 8 of 28 cases involved EST. Morse [5] in 1967 reported only 6 cases involving EST out of 36 cases, several of which were nonpsychiatric. Beresford in 1972 [6] reported 12 cases and in 1973 [7], 17 cases, including one that involved alleged failure to give any treatment other than milieu therapy and did not directly involve EST. He discussed both the method of EST administration and complications and noted that suits for EST seemed to be declining. Perr [8] minimized the current importance of EST as a cause for suit. Dawidoff [9] reports only a few scattered cases in his not very adequate book, *The Malpractice of Psychiatrists,* which dealt primarily with other issues [10]. Similarly, Messinger [11] in 1975 mentioned only a few cases and did not even list the potential legal problems of EST as an identified problem meriting a special section.

Of the first 90 cases reported to the insurers of the APA malpractice plan, only 2 dealt with EST.

Review of 34 Cases

An effort was made to ferret out reported cases involving EST; 34 such cases were studied in an attempt to clarify the legal issues involved in EST (not all involved EST; some involved consent and others issues somewhat related to EST problems). Almost all were appellate cases; therefore, those cases settled before trial or not appealed are not represented. The number of such cases cannot be determined by this type of survey. Many of the cases were against hospitals as well as physicians or solely against hospitals. However, they are lumped together as EST issues; the reader should keep in mind that the treating psychiatrist will not ordinarily be liable for hospital staff negligence. Because

many of the issues in a given case involve multiple principles of law or multifold possible grounds for liability, the number of legal issues raised is greater than the number of cases. The cases are listed in the Appendix in rough chronological order, reflecting the relationship of EST suits to time.

Almost every ground for medical litigation has been involved in EST lawsuits except breach of confidentiality and sexual relations with a patient.

Review of the cases reveals a general lack of pattern. Most significant is the lack of current litigation based on the mere occurrence of fracture. While most cases were in favor of the defense, the disposition of many were not clear as they were sent back for retrial.

A total of 57 issues were noted in the 34 cases, as shown in Table 1. Only one successful case dealing with failure to use relaxant medication was noted. Nor were consent issues generally a successful ground for suit. Various activist groups have designated EST as an intrusive or hazardous treatment; this has not been adopted by courts in malpractice litigation, although the *Mental Disability Law Reporter* in its ongoing classification lists Section 404, "Right to refuse treatment ... C. Unusual or hazardous procedures (including ECT)." Many states now have clearly defined procedures governing consent for EST.

Res ipsa loquitur or liability based on the mere occurrence of a fracture is historically not a successful ground for suit.

An interesting case not dealing with the issue of liability per se is that of *Aden v. Younger* [*12*], in which an initial attempt to control the use of EST arbitrarily by law in California was declared unconstitutional. Subsequent California rules delineated the procedures in a slightly less restrictive manner.

The details of these cases will not be elaborated in this report. The review does reflect

TABLE 1—*Legal issues addressed in 34 cases.*

Issue	Number of Cases
Negligent follow-up and care of patients	19
Falls	6
Lack of bed rails	5
Inadequate treatment or radiologic review subsequent to treatment	3
Subsequent treatment of fracture	2
Burn	1
Drowning	1
Failure to ask about pain	1
Lack of consent or inadequate consent	10
Consent by spouse or patient	8
Presumed consent	1
Withdrawal of consent	1
Lack of informed consent	7
Lack of informed consent per se	6
Capacity to refuse	1
Res ipsa loquitur	6
Negligent administration of EST	6
Adequate relaxation and medication	3
Method	2
Osteoporosis	1
Breach of warranty or guarantee	3
Captain of ship and role of referring doctor	2
Punitive damage	1
Role of state doctors	1
Commitment giving the right to treat	1
Cruel and inhuman punishment and invasion of right to privacy	1

both a continuing possible vulnerability and a relatively small number of reported cases over the years. Attention to consent issues [*13*] will minimize vulnerability, as will good hospital supervision.

Analysis of Outcomes

Cases that have been appealed show a general tendency, but not highly significant, for a verdict in favor of the defense. Not all of the cases dealt with narrow EST issues; some involved insulin therapy. In some cases, a hospital was held potentially liable (for EST aftercare) while the physician was not. As best as could be determined from the appellate rulings, verdicts for the plaintiff were upheld in three cases and for the defense in eight cases. Nine cases were reversed in favor of the defendant and eight in favor of the plaintiff. Some of the reversals were due to procedural errors, for example, not allowing an internist to testify in a case involving both EST and medication [Cit. 24].

Cases where plaintiffs were affirmed or had adverse rulings reversed included these:

(1) negligence in the treatment of a fracture, not the occurrence per se [Cit. 3];

(2) a fall after EST with negligent treatment for the resulting fractures of the vertebrae [Cit. 7];

(3) a question of warranty of treatment being "perfectly safe" [Cit. 9];

(4) limiting voir dire as to a juror's connection with an insurance company and defective testimony governing informed consent [Cit. 20];

(5) a fall on leaving a hospital after outpatient EST; the ruling was against the hospital, and the defendant doctor was not held responsible [Cit. 25];

(6) a decision that there was no negligence in not using muscle relaxant but there was negligence in not following up a complaint of pain [Cit. 33];

(7) an award but no punitive damages for not using muscle relaxant [Cit. 32];

(8) a fall out of bed after EST [Cit. 12]; and

(9) continued treatment after alleged fracture with first treatment, no X-rays, and increased voltage [Cit. 18].

One of the more exotic cases was a suit against an attorney for failing to file within the period defined by the statute of limitations. The plaintiff had to establish medical malpractice in order to recover from the attorney [Cit. 26].

Cases supporting defense contentions included these:

(1) a negative answer to the question Was absence of an X-ray a proximate cause of the injury? [Cit. 6];

(2) wife's consent was sufficient [Cit. 8];

(3) no res ipsa loquitur [Cit. 1 and 3];

(4) a fall from bed 24 h after EST [Cit. 13];

(5) false imprisonment [Cit. 14];

(6) alleged warranty and claim of traumatic deafness without medical testimony [Cit. 6];

(7) use of restraints after EST [Cit. 22];

(8) consent presumed by voluntary submission to treatment, no proof of damages [Cit. 19];

(9) physician not a guarantor against fracture, referring doctor not responsible, use of X-rays [Cit. 21];

(10) EST not cruel and inhuman punishment, role of guardian and guardian ad litem in case of minor [Cit. 34];

(11) claim of coercion [Cit. 30];

(12) no use of relaxant medication [Cit. 10]; and

(13) fractures but no negligent administration [Cit. 23].

APPENDIX—Legal Citations

1. *Quinley v. Cocke,* 183 Tenn. 428, 192 S.W.2d 992 (1946).
2. *Kaplan v. New York,* 198 Misc. 62, 95 N.Y.S.2d 890, *aff'd* 777 A.D. 1065, 100 N.Y.S.2d 693, *lv. to appeal denied,* 302 N.Y. 949 (1950).
3. *Farber v. Olkon,* 40 Cal. App. 2d 503, 254 P.2d 520 (1953).
4. *O'Rourke v. Holcyon Rest.,* 281 A.D. 838, 118 N.Y.S.2d 693, *aff'd* 306 N.Y. 692, 117 N.E.2d 639 (1953).
5. *Adams v. Ricks,* 91 Ga. App. 494, 86 S.E.2d 329 (1955).
6. *Eisele v. Malone,* 2 A.D. 550, 157 N.Y.S.2d 155 (1956), *denied* 158 N.Y.S.2d 761 (1957).
7. *Brown v. Moore,* 143 F. Supp. 816 (D.C., Pa. 1956), *aff'd* 247 F.2d 711 (3rd Cir., 1957).
8. *Lester v. Aetna Cas & Sur. Co.,* 240 F.2d 676 (5th Cir., La., 1957).
9. *Johnston v. Rodis,* 102 App. D.C. 209, 251 F.2d 917 (1958).
10. *Foxluger v. New York,* 23 Misc. 2d 933, 203 N.Y.S.2d 985 (1960).
11. *Mitchell v. Robinson,* 334 S.W.2d 11 (Mo., 1960).
12. *Quick v. Benedictine Sisters Hosp. Ass'n.,* 257 Minn. 470, 102 N.W.2d 36 (1960).
13. *Roth v. Havens,* 56 Wash. 2d 393, 353 P.2d 159 (1960).
14. *Maben v. Rankin,* 55 Cal. 2d 139, 358 P.2d 681 (1961).
15. *Howe v. New York,* 33 Misc. 2d 147, 226 N.Y.S.2d 933 (1962).
16. *Woods v. Brumlop,* 71 N.M. 221, 377 P.2d 520 (1962).
17. *Anon. v. State,* 17 App. Div. 2d 495 (3d Dep't., Ky., 1963).
18. *Stone v. Proctor,* 259 N.C. 633, 131 S.E.2d 297 (1963).
19. *Wilson v. Lehman,* 379 S.W.2d 478 (Ky., 1964).
20. *Aiken v. Clary,* 396 S.W.2d 668 (Mo., 1965).
21. *Collins v. Hand,* 431 Pa. 378, 246 A.2d 398 (1968).
22. *Constant v. Howe,* 436 S.W.2d 115 (Tex., 1968).
23. *Howe v. Citizens Memorial Hosp. of Victoria County,* 426 S.W.2d 882, 436 S.W.2d 115 (Tex., 1968), *rev'd,* see Cit. 22 above.
24. *Kosberg v. Washington Hosp. Center,* 394 F.2d 947 (D.C. Cir., 1968).
25. *Meynier v. DePaul Hosp.,* 218 So. 2d 98 (La., 1969).
26. *Christy v. Saliterman,* 288 Minn. 144, 179 N.W.2d 288 (1970).
27. *New York City Health and Hospitals Corp. v. Stein,* 335 N.Y.S.2d 461 (N.Y., 1972).
28. *Stowers v. Wolodzko,* 386 Mich. 119, 191 N.W.2d 355 (1972).
29. *Dunwoody v. Trapnell,* 120 Cal. Rptr. 859 (Cal. Ct. of App., 1975).
30. *Rice v. Mercy Hosp.,* 318 So.2d 436 (Fla., 1975).
31. *Travis v. Tellecare Corp.,* Cal. Super. Ct., Alameda Co., Docket No. 438328 (June, 1975).
32. *McDonald v. Moore,* 323 So. 2d 635 (Fla., 1976).
33. *Pettis v. State,* 336 So. 2d 521 (La., 1976).
34. *Price v. Sheppard,* 239 N.W.2d 905 (Minn., 1976).

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