REVIEW ARTICLE

What are the ethical dilemmas in the decision-making processes of nursing people given electroconvulsive therapy? A critical realist review of qualitative evidence

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Accessible Summary

What is known on the subject? ECT is a treatment which has a long and complicated history. There is no consensus on its effectiveness and there is a great deal of polarized debate as to whether it should be used. MHNs are asked to work with people who are receiving ECT as part of their duties.

What the paper adds to existing knowledge? The paper seeks to move beyond the polarized arguments and to consider how MHNs can work with people where ECT is being considered or administered as part of their treatment in a manner which satisfies their professional obligations.

Implications for practice MHNs may need to broaden their understanding of ethics beyond the traditional biomedical ethics model of beneficence, non-maleficence, justice and autonomy, as well as improving their understanding of social and political factors which may have an unseen effect of the use of ECT as a treatment in order to meet their professional obligations when working with people being administered ECT.

Abstract

Introduction: Electroconvulsive therapy (ECT) has a complex and contentious place in psychiatric care. Mental health nurses (MHNs) are of obligated to be part of this practice despite ethical concerns.

Aim: To consider the ethical dilemmas and decision-making processes facing MHNs involved in the administration of ECT.

Method: A critical realist review of the literature surrounding ethical considerations and ECT was undertaken using thematic analysis.

Findings: Four key themes emerged: the MHN as an advocate and conflict in their role, issues surrounding consent, questionable efficacy and unknown method of action, side effects, and legal issues and clinical guidelines.

Discussion: Using a critical realist framework for understanding, the decision-making process and ethical considerations are viewed as part of the empirical and actual
parts of reality, while the potential for other, unseen causal powers to be at play is acknowledged. **Implications for practice:** MHNs need to ensure they have an adequate ethical underpinning to their practice to enable them to navigate contentious areas of practice such as ECT to practice effectively and preserve safety. This may require moving beyond the traditional biomedical model of ethics. Developing an appreciation of unseen causal factors is also an essential part of MHNs’ developing professional competency.

**KEYWORDS**
acute mental health, decision-making, ethics, professional development

**1 | BACKGROUND**

Electroconvulsive therapy (ECT) has a complex history, mired in controversy and ethical dilemmas which go to the very heart of some of psychiatry’s most fundamental and often bitterly disputed principles. ECT as we think of it today was first used in April 1938 by Cerletti and Bini, two Italian psychiatrists (Sadowsky, 2017), although there are accounts of electric shocks being used to treat mental illness much earlier, including one from 1752 when Benjamin Franklin reported having used it to cure a woman of hysterical fits (Newnes, 2018). The results reported from the early use of ECT were promising, apparently curing many patients who were previously considered incurable or hopeless, and its use became widespread internationally (Sadowsky, 2017; Shorter & Healy, 2012). Early forms of ECT were unmodified, meaning it was given without anaesthesia and the sinusoidal current was administered bilaterally, which resulted in uncontrolled convulsions that could cause fractures, as well as causing memory problems and confusion (Kiloh et al., 1988). As the treatment became more refined, modifications were made to the type of current used, the placement of the electrodes, and anaesthesia was introduced (Sadowsky, 2017). Memory impairment associated with the procedure was originally viewed as a success of the treatment, as it was thought that it might be the removal of negative memories which caused the improved mental health of the recipients. They had no recollection of the process (particularly in the days before anaesthesia was administered), so they were generally not reluctant to undergo the process again (Sadowsky, 2017). As the process was refined, it became apparent that it was people who had a diagnosis of depressive illnesses, rather than schizophrenia, who appeared to receive the most benefit from ECT (Sadowsky, 2017).

The depiction of ECT in the media and resulting public perception has been noted as controversial. The first notable depiction was by Mary Ward in her novel The Snake Pit (1948) and the subsequent film adaptation followed by the treatment received by the character Randle McMurphy in One Flew Over the Cuckoo’s Nest (Kasey, 1962). In these, and many other depictions through the decades, ECT is shown as a device for punishing or controlling patients, almost always shown in its unmodified form (Shorter & Healy, 2012; Torreblanca et al., 2011). Its use appears to have been profound as it dropped significantly from the 1950s through to the 1970s (Shorter & Healy, 2012). ECT saw a resurgence in the latter part of the 20th century (Sadowsky, 2017), and the most recent figures available for England, Wales, ROI and NI indicate that more than 1682 people were given over 1821 courses of ECT in 2016/17 (Royal College of Psychiatrists [RCP], 2017). The data are limited as there is no requirement for clinics to sign up to the RCP accreditation scheme and not all clinics who are signed up report their data; in fact, for the 2016/17 only 74% of accredited clinics submitted data (RCP, 2017).

The question of whether, and to what extent, ECT is effective in alleviating symptoms of serious mental illness has been demonstrated in reviews of efficacy (e.g. Chan et al., 2019; Kawoos et al., 2018; Palma et al., 2016), and the RCP report that 42.6% of those treated in their accredited clinics who submitted data demonstrated improvement (RCP, 2017). However, in a more recent review, Read et al. (2019) explored the quality of 11 ECT studies measuring the efficacy of ECT treatment in relation to depression. They reported issues with the quality of the studies in relation to methodology and with the limited range of variables they are measuring, which does not include quality of life, and call for quality randomized controlled trials (RCTs) to be established. ECT is sometimes used before other treatment options have been explored, particularly psychological interventions, and it has been suggested it is oversused in women and older people (Read et al., 2018). Other researchers have also called for more robust RCT analysis in order to be assured of the evidence base (Leroy et al., 2018) and for a more candid approach when discussing efficacy with potential recipients of the treatment (Blease, 2013). Also of great concern are the number of people who describe themselves as ECT survivors through support groups on social media and websites such as ECT Justice, who report debilitating side effects as a direct result of ECT treatment.

There is tension between a treatment which is reportedly safe and effective, but which is consistently controversial to where it has become a stock trope, depicting a power-hungry, socially repressive psychiatry (Ottoson & Fink, 2004; Sadowsky, 2017; Shorter & Healy, 2012). ECT is iconic due to the negative portrayal in the media and arguably misunderstood, but also administered on a contentious evidence base which has led to narrative experiences not captured through traditional quantitative reporting.
2 | RATIONALE

One gap in research is that of how nurses experience their role within this ethically contentious provision of ECT. Balancing the demands of professional and legal obligations is complicated. ECT is fraught with unique challenges, which may impact on MHNs' psychological well-being when there is a disparity between moral theory and practical application (Christodoulou-Fella et al., 2017; Wojtowicz et al., 2014). Biomedical ethical principles (Beauchamp & Childress, 2019) may provide some guidance; however, the UK’s National Institute for Health and Care Excellence (NICE) guidelines for the use of ECT (2009) recognize the evidence base for the use of ECT is mixed at best and make cautious and confusing recommendations about its use. Therefore, it is challenging to fully appreciate how nurse’s might experience non-maleficence, justice, autonomy or beneficence (Beauchamp & Childress, 2019) in relation to ECT.

3 | AIM

This review seeks to critically review literature exploring biomedical ethical decision-making and ECT, with a view to synthesize this into meaningful findings which MHNs can utilize as part of their reflective practice and decision-making when working with people who have ECT.

4 | METHODOLOGY

A critical realist review approach provided the underlying philosophy and theoretical framework for this study, allowing under-explored phenomenon to be exposed with an overview of the factors which may influence individual actions and perceptions (Aveyard et al., 2016). By taking an integrative approach, a range of different studies was included which allowed consideration beyond whether ECT “works” and towards what the experience of ECT might mean for those involved (Aveyard et al., 2016; Pawson et al., 2005). Critical realism can provide a novel approach to exploring multifaceted interventions, such as ECT, which take place in open systems [health care] which are subject to numerous different influences (Coleman, 2019a, 2019b; Edgley et al., 2016). Due to its comparative freedom in allowing a blending of methodology, philosophy and theory, critical realism allows a deeper understanding of phenomena to evolve, along with promoting creative solutions to complex problems, in line with the arena MHN’s practice (Angus & Clark, 2012).

Bhaskar popularized the theory of critical realism in the 1970s with his thesis for transcendental realism (Bhaskar, 1975). Critical realism distinguishes between that which cannot be observed (the Real); mechanisms which may be unknown to humans, and the resulting observable events (the Actual) which may arise because of these unseen mechanics (Hawke, 2017). From these events, interpretations are made and data extracted (the Empirical). These interpretations are influenced by the observer’s own uniqueness (Hawke, 2017). The epistemological, that which can be known or understood, is separate from the ontological, that which is real. This study considers the mechanisms behind the observable events for MHNs.

Critical realism strives for enhanced reflexivity and transformative practice, so while there would not be an expectation of formulating a decisive model or theory for MHNs engaged in caring for people receiving ECT, it would support the development of deeper levels of understanding and explanation in relation to ethical decision-making given that ECT occurs and MHNs are expected to be a part of this process (Coleman, 2019a, 2019b). The use of critical realism in nursing research supports bridging the gap between theory and practice (McEvoy & Richards, 2003) as well as negating some of the tensions between positivism and interpretivism, allowing MHNs to transition fluidly between different positions without being beholden to either quantitative data, or experiential, qualitative reports (Ryan, 2019).

While the extraction of the themes from the literature reviewed takes the form of a familiar thematic analysis (e.g. Aveyard, 2019; Lobiondo-Wood & Haber, 2018; Williamson & Whittaker, 2020), it is the interpretation of these results following the conventions of critical realism and the stratified ontology underpinning it; the domains of the empirical, actual and real (Bhaskar, 1975; Danermark et al., 2019; Emmel et al., 2018), which sets this apart from a more traditional, standard literature review.

4.1 | Search strategy

A search strategy was employed utilizing standard Boolean operators: ‘electroconvulsive therapy’ or ‘ECT’ or ‘shock therapy’ or ‘electroshock therapy’ or ‘electroshock’ and ‘ethical’. CINAHL returned 50 results, Medline returned 53, and PsychINFO/Psychnline returned 30. A supplemental search was undertaken on Google Scholar, which returned one result. Abstracts were read of the returned documents, and in some cases, the full text was reviewed to ascertain relevance, and duplicates were removed (Appendix 1: Figure A1). The full text of the remaining 28 documents which met the selection criteria was reviewed, and after an appraisal of their relevance to the study, nine texts were selected to form the basis of the review, as documented in the summary table (Appendix 2).

4.2 | Inclusion and exclusion criteria

Results were limited to those in English due to a lack of resources for translation. A date range to within the last 10 years was adopted to ensure relevance and to limit results due to limited resources for review and thematic analysis. Results where the full text was not available were excluded as the quality of the text could not be assessed. Texts behind a paywall were not excluded, although no results of this nature were returned. The review took a qualitative approach but did not exclude mixed methods data. Any studies
which raised ethical concerns were excluded. Grey literature such as letters and editorials were not excluded. Woods et al. (2020) found in a review of the bibliographies of nursing journals that the citation of grey literature was substantial, while Adams et al. (2016) suggest that including grey literature in literature reviews is essential in some circumstances as the information may only be present in grey literature. Due to the critical realist philosophy underpinning this research and the potential to add meaningful data in the attempt to interpret the stratified reality, the search results were not limited to academic journals, and where possible, grey literature was included.

### 4.3 Critical appraisal

A hierarchy of evidence was adopted as suggested by Noyes (2010) which suggests that moving beyond the traditional hierarchy of evidence (e.g., Williamson & Whittaker, 2020) which places the randomized control trail as the gold standard. For qualitative reviews which are concerned with rich, deep data, this type of approach is unhelpful and undermines the premise and ontological approach of this research (Noyes, 2010). A variety of methodologies were considered in terms of limitations using the Critical Appraisal Skills Programme (CASP) checklists (2020). A summary of key strengths and limitations is included in Table A2 (Appendix 3).

### 4.4 Reflexivity

The researcher is not immune to the possible effects of the controversy surrounding ECT, and it is acknowledged this may have influenced the reading of themes and interpretation of results. The research also has its own clinical experiences of being involved in the care of people given ECT under a variety of circumstances, which is impossible to untangle from the researcher’s theoretical knowledge of the procedure.

The researcher did engage in discussion of the results during supervision with peers, and also through using the information gathered throughout the process as the basis for a number of teaching sessions for undergraduate student MHNS, which took a collaborative learning approach (Biggs & Tang, 2011) that in turn stimulated discussion and prompted a variety of different viewpoints which were reflected on and incorporated into the researcher’s experiences and wider understanding.

### 4.5 Synthesis

Themes were synthesized through reading of the full text of the nine included papers. After consolidating the initial data unearthed during thematic synthesis, five core themes emerged; see Table A3 (Appendix 4) for detail of strengths of each theme.

## 5 FINDINGS

### 5.1 The nurse as advocate and conflict in the MHN’s role

The role of healthcare professionals and nursing staff generally was discussed in several of the papers. The idea of shared decision-making as part of the process within the multi-disciplinary team (MDT) and the disparity in perceptions of this process between professionals was evident. The decision to administer ECT was that of the psychiatrist as responsible clinician, with psychiatrists expressing the belief that the rest of the team agreed with the decision made (Clarke et al., 2018), while other evidence suggested this was not the feeling of the whole team (Duxbury et al., 2018) and that MHN felt it better to keep their opinions to themselves to avoid disputes within the team (Flanigan, 2010).

The role of the MHN in relation to supporting the psychiatrist was something they felt was a professional obligation, which was sometimes at odds with their own values and beliefs (Clarke et al., 2018; Duxbury et al., 2018) with MHN’s role being an advocate for their ECT recipient (Flanigan, 2010). There was a fine line between the MHN utilizing their therapeutic relationship to offer reassurance to the ECT recipient about the procedure in order to enhance understanding and decision-making ability, and the possibility of the MHN using their position to persuade the ECT recipient to have the treatment (Clarke et al., 2018; Duxbury et al., 2018; Ejaredar & Hagen, 2014; Flanigan, 2010). A further issue with an MDT approach was that the psychiatrist’s decision whether to administer ECT was led by their personal disposition towards it, based on experience and personal values (Duxbury et al., 2018; Stefanazzi, 2013).

The concept of paternalism in relation to healthcare professionals was also repeated throughout the literature, with the feeling from many people who were prescribed ECT that clinicians involved took the view that they knew what was best for the ECT recipient, often contrary to the ECT recipient’s own views (Clarke et al., 2018; Duxbury et al., 2018; Ejaredar & Hagen, 2014; Flanigan, 2010; Stefanazzi, 2013).

### 5.2 The multifaceted issue of consent

A core aspect of being a MHN is to explain and consent people for different treatments. The issue of consent was a theme throughout. For those ECT recipients who were not able to consent, the pathways were in some ways more straightforward then for capacious individuals; however, issues still remained in relation to themes such as efficacy, side effects, legal issues and clinical guidelines (Duxbury et al., 2018; Flanigan, 2010; Stefanazzi, 2013). Several papers noted that individuals had technically given consent for ECT treatment to take place, but due to one or several factors such as perceived / real pressure from clinical staff, lack of understanding about the procedure and/or its possible side effects, power imbalances or mental state impeding comprehension, on reflection they felt that this had
Finally, within this broader theme, was the sub-theme of the placebo effect and ECT. It was not clear whether any perceived positive effect in reduction of symptoms by ECT could be due to the [un-]
known] mechanism of action of the procedure, therefore cementing its validity (Hersh, 2013; Torrance, 2015), or whether the placebo ef-
fect of such a medicalized procedure was the more important factor
at play in terms of any perceived recover (Blease, 2013; Stefanazzi,
2013).

5.4 | The short- and long-term side effects

There was acknowledgement that the perception of the severity
of side effects differed significantly between MHNs and other
clinicians, and recipients, with recipients finding them to be more
harmful than they had been led to believe (Blease, 2013; Clarke
et al., 2018; Ejaredar & Hagen, 2014; Flanigan, 2010; Seniuk,
2018; Stefanazzi, 2013). Other authors contradicted this, indicat-
ing the side effects were significantly less harmful than not treat-
ing the recipients with ECT (Hersh, 2013; Torrance, 2015). There
was general agreement that short-term side effects (for example,
confusion, headache, nausea and short-term memory loss) were
not significantly problematic when considering the treatment and
these were generally routinely disclosed to recipients (Blease,
2013; Clarke et al., 2018; Ejaredar & Hagen, 2014; Flanigan, 2010;
Hersh, 2013; Seniuk, 2018; Stefanazzi, 2013; Torrance, 2015). It
was noted that the information given in terms of the short-term
side effects was variable and at times downplayed the short-term
side effects (Clarke et al., 2018; Ejaredar & Hagen, 2014; Seniuk,
2018).

The discussion of longer-term side effects focussed on the
lasting effects of ECT on memory, particularly autobiographi-
cal memory (Ejaredar & Hagen, 2014; Seniuk, 2018; Stefanazzi,
2013). Hersh (2013) notes memory problems are a temporary side
effect, or something which only occurs in a very small number of
ECT recipients. Following on from alterations to systems relating
to memory, some literature considered how this might impact the
ECT recipient's own sense of self and identity, arguing for a deeper
understanding of the harm such fundamental changes to a person's
sense of self might cause in terms of recovery and future well-
being, which subsequent implications for MHNs in terms of their
own professional responsibilities (Clarke et al., 2018; Ejaredar &
Hagen, 2014; Seniuk, 2018).

Due to the invasive nature of ECT, some of the literature con-
sidered the potential for ECT to cause psychological harm, based
on the reported experiences of ECT recipients (Clarke et al., 2018;
Duxbury et al., 2018; Ejaredar & Hagen, 2014; Seniuk, 2018). The
potential to cause psychological harm was recognized by some
MHNs and other clinicians as well (Duxbury et al., 2018). Other
authors considered the potential psychological harm of withholding
ECT treatment or disclosing a plethora of information that recipi-
ents might not be equipped to comprehend (Duxbury et al., 2018;
Hersh, 2013).

5.3 | Questionable efficacy & an unknown
mechanism of action

It was acknowledged that there is significant disagreement about
the efficacy of ECT and there was significant discussion around how
best to manage this fact and all of the literature reviewed mentioned
efficacy to some extent. There is a tension between those who be-
lieve in the biomedical/biochemical roots of mental ill health, where
ECT is viewed as something which can medically correct this fault
in an individual's biology, and those who take a more psychosocial
approach who are concerned by the potential disruption to less
tangible elements of the person (Blease, 2013; Clarke et al., 2018;
Duxbury et al., 2018; Ejaredar & Hagen, 2014; Seniuk, 2018). For
MHN's involved in the process, there was an indication that they
themselves felt that they had a lack of knowledge about the procedure,
relying instead on instinct and being required to make individ-
ual judgements in relation to their own beliefs and ethical positions
(Duxbury et al., 2018; Flanigan, 2010).

Frustration by MHNs and other clinicians at the continued por-
trayal of ECT in media in a manner which is considered as outdated
and playing to negative stereotypes and contributing to the stigma
around the procedure was noted; it was felt that this may unduly
influence MHNs and potential recipients in deciding whether to use
the treatment, as well as their experience of it (Duxbury et al., 2018;
Hersh, 2013; Seniuk, 2018; Torrance, 2015).

For ECT recipients who did not legally lack capacity to consent,
the situation was more complex. One viewpoint called for full dis-
closure of the limited evidence base and controversial nature of ECT
within psychiatry, arguing that only if people were presented with all
available information could they be said to be truly informed in terms
of authentic or fully informed consent (Blease, 2013; Clarke et al.,
2018; Duxbury et al., 2018; Ejaredar & Hagen, 2014).

A second viewpoint argued that this was unnecessary and made
links with other treatment options, such as psychotropic medication,
where there is limited understanding around efficacy and mecha-
nisms of action; however, it is still prescribed routinely with little
debate. There was caution against over informed consent, which
might deter people from having what was sometimes viewed as a
life-saving treatment if they felt the treatment was no more than a
placebo, or which might stop the treatment working if it is in fact due
to placebo effect (Hersh, 2013; Torrance, 2015).

A final viewpoint suggested a responsive or spontaneous ap-
proach of MHNs to consent and that rather than providing rigid
guidance or expectations, the burden was on clinicians to review
the autonomy of each prospective ECT recipient on a person-by-
person basis and to make an informed professional judgement as to
the amount of information to discuss with that person (Seniuk, 2018;
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the treatment, as well as their experience of it (Duxbury et al., 2018;
Hersh, 2013; Seniuk, 2018; Torrance, 2015).
5.5 | Legal issues and clinical guidelines

Legal capacity and the ability to consent were consistent themes. Several authors linked their discussion of capacity to the legislative processes which guide clinicians in determining whether the proposed ECT recipient could be considered able to consent to such treatment, indicating that these processes were complex and that capacity to consent was not a clear-cut issue (Duxbury et al., 2018; Flanigan, 2010; Hersh, 2013). This was echoed by the discussions around policy and guidance, which were open to interpretation and could be used to support the nurse or medic’s own views and preferences when deciding whether to administer ECT (Blease, 2013; Duxbury et al., 2018).

Flanigan (2010) considered the impact of advance statements, which are not legally binding but are intended to support in the application of person-centred care and are made when the prospective ECT recipient was considered capacitous but reported that these are often disregarded by clinicians. Stefanazzi (2013) reported that the legal mechanisms in place served to protect the clinicians, rather than those receiving treatment. Thus, nurse’s may be in a role of tension—between the patient they advocate for best interest’s and the treatment the person has been prescribed.

MHNs frequently employ complex decision-making skills as part of their role as well as being expected to take a patient-centred approach, but the ability to engage in shared decision-making with those under their care may be hindered by different priorities. This is evident when considering consent and capacity, where the MHNs in the literature viewed it is their professional obligation to encourage potential ECT recipients to have the treatment and to convince them that it was the best option, often ignoring or dismissing concerns, or downplaying the potential for side effects (Blease, 2013; Clarke et al., 2018; Duxbury et al., 2018; Ejaredar & Hagen, 2014).

6 | DISCUSSION

By developing their understanding of the connection between the observable actions (the Actual) related to ECT and improving their knowledge of the unobserved (the Real) mechanisms at work which are driving these events, MHNs can hope to become more aware of the complexity of their role in relation to people receiving ECT and how their actions relate to the experience for that individual. The Real in this situation would be considered the dilemmas the MHN faces; borne out in the themes generated by the review, such as how consent is defined and obtained, the uncertain mechanism of action of ECT, short and long-term possible side effects, legal and ethical issues, and ultimately the MHN’s own professional values and obligations. A richer understanding of these factors in relation to ECT would then be applied to the Actual, which would be the clinical decision-making process, care planning and delivery, and the person-centred nature of any therapeutic interaction.

There was indication that some MHNs were themselves not adequately informed about ECT, and while it would not be reasonable to expect a scholarly level of understanding for everyone involved in the administration of ECT, it would be reasonable to expect an awareness and understanding of the key issues and debates in an area of practice, as part of professional requirements (NMC, 2018a, 2018b). Research suggests that despite the professional obligation, nurses are not always aware of the evidence base for a treatment and the move towards an evidence-based professional identity has been a slow one (Crawford et al., 2002; Lobiondo-Wood & Haber, 2018) and that efforts to implement evidence-based practice will face more resistance in some areas than others (Rye et al., 2019). Further to this, it may be that relying on evidence-based practice for guidance, which has at its heart a positivist, quantitative approach to managing needs, may not be fit for purpose when making decisions which are rooted in social complexities and personal experience (Lines, 2001; Reynolds & Trinder, 2000).

The “doctor’s handmaiden” perception of nurses has been a damaging one to the profession (Summers, 2010), and it is concerning to see that the literature appears to indicate MHNs still position themselves as peripheral to and decisions that were made, instead indicating that it was the psychiatrist who took responsibility for all decisions made. In their analysis of the data from focus groups with nurses and consultant psychiatrists, Felton and Stacey (2018) reported that much of the interplay between doctors and nurses was not much changed from the 1970s. They indicated a clear, hierarchical approach to the relationship, where the opinion of the consultant was considered superior to that of the nurse.

Problems existed in relation to the use of ECT within all four of Beauchamp and Childress’ (2019) ethical principles. Those receiving ECT expressed concerns in relation to respect for autonomy. A tension between providing enough evidence to elicit effective self-determination and providing so much evidence it might overwhelm the prospective ECT recipient was evident. Informed consent was described in several different ways, but broadly fell into three categories: those who felt there was already adequate information provided; those who felt the information was significantly lacking; and those who felt that the onus was on the healthcare professionals involved to make an individual judgement as to what level of information would best suit the potential ECT recipient, based on open dialogue and therapeutic relationship.

Several authors recognize that the level of information which needs to be shared in order to facilitate informed consent (assuming the proposed recipient has capacity) is a matter for debate; however, the overarching notions of understanding the broad principles of what they are consenting to as well as being able to make the decision to consent freely are fundamental to the process (Chadwick & Gallagher, 2016; Morgan et al., 2016). Usher and Arthur (1998) make the case for “process consent” as an adjunct to informed consent and suggest that consent should be a continuous process based on shared understanding. When considering informed consent specifically in relation to ECT, Ottosson and Fink (2004) support the notion that the amount of information provided should not be to such a degree that it frightens the prospective recipient into refusing consent. Other authors argue that this it is precisely the information that must be shared (Barker, 2011; Read et al., 2018).
Another threat to autonomy was the possibility of advocacy for ECT as a treatment option crossing the line into coercion, with multiple ECT recipients feeling they did not truly have the option to decline the treatment, thus invalidating their sense of autonomy. This practice could be described as informal coercion (Andersson et al., 2020; Pelto-Piri et al., 2019; Valenti et al., 2015). Taking an international perspective on informal coercion, Valenti et al conducted focus groups with mental health professionals residing in ten different countries. They reported that although there was a feeling informal coercion could be effective in eliciting the desired behaviour, the use of it cause feelings of conflict and there was a disconnect between attitudes and actions in relation to the frequency with which it was used. This is evidenced in the literature reviewed, as many nurses struggled to reconcile this dissonance.

Paternalism was a consistent theme throughout the literature. The use of paternalistic practices to control people’s responses to ill mental health, even with the best of beneficent intentions, is still paternalism. Cody (2003) considers the question of paternalism in nursing and health care and concludes that only by appreciating the diversity of human experience and committing to continued professional development, can MHNs move beyond this approach. More recently, Jorgensen et al. (2018) found that implantation of ethical care was challenged by the biomedical and paternalistic structures underpinning mental health services.

Further to their links with self-determination, the concepts of consent and capacity, which are enshrined in law, relate to the ethical principle of justice. There were occasions within the review though where ECT recipients expressed the belief that despite having been considered capacious, upon reflection, they did not agree that they were. There appears to be a grey area here, supported by the notion that despite its legal underpinning, capacity assessment is a complex task (Jayes et al., 2017). MHNs need to ensure they are adequately applying the principles of legally defined capacity to practice and are allowing those potential ECT recipients the time and space to consider whether they can truly comprehend what it is they are asking to consent to.

Also related to the principle of justice is the access, or not, that people have to ECT. There was a clear discrepancy reported, with personal preference for or against the treatment by individual clinicians often cited as the main deciding factor as to whether ECT would be considered as a treatment option or not. In the UK, NICE guidelines for ECT (2009) do not support consistency in the use of ECT, as they make conflicting statements regarding its use and evidence base. They have also not been updated in over ten years. An audit of data on ECT use in England found significant differences in its use across different regions of the country (Read et al., 2018).

Many of the recipients of ECT within the review reported distressing and disabling side effects from their ECT treat, including significant memory loss and changes to their concept of self, as well as experiencing the whole process as a trauma in and of itself. The concept of non-maleficeence is thrown into sharp focus when considering these experiences. ECT is often posited as a last resort and a life-saving treatment, although the RCP position statement (2017) suggests it could be used more habitually, although does also indicate that the risks around cognitive impairment should be discussed. At the heart of much of the debate about whether ECT should be used, is the belief that mental health services have not been open and transparent about the true extent of harm ECT may cause on recipients, through poor auditing, oversight and flawed research (Read, Cunliffe et al., 2019; Read, Kirsch et al., 2019; Read et al., 2018). Due to the reliance on “gold standard,” positivist research, the experience of those who have suffered lasting disability as a result of ECT have been marginalized.

Reviewing Beauchamp and Childress’ (2019) ethical principles in relation to ECT, it is apparent that while they provide guidance for MHNs, these biomedical principles do not sufficiently cover all factors. Radden (2015) has suggested the use of virtue ethics as a way to bring balance to clinical decisions and to include social facets, which are a fundamental part of mental health nursing. Expanding the discourse around ethics beyond the biomedical to consider personal virtues rather than professional duties may strengthen wisdom and insight for healthcare professionals and improve the experience of those being cared for (Hawking et al., 2020; Roque et al., 2020).

The decision-making processes and ethical considerations of the MHN in relation to ECT would be considered as parts of the empirical and actual parts of reality under critical realist philosophy. What remains to consider are the significant, if unseen, causal powers at play. These causal powers form the structures and frameworks on which the discussions around ECT are built, influencing and directing their ebb and flow (Danemark et al., 2019). While it may not be truly possible to “know” with any certainty which of these is at play, attempting to understand that these mechanisms exist and the context in which ECT resides, will provide a depth of understanding in relation to human experience, as well as the potential to influence and direct discourse and policy, to the MHN (Coleman, 2019a, 2019b; Nairn, 2012; Ryan, 2019).

The presentation of ECT in the media, be that print of film, and the potential impact of this should not be underestimated. In an area where undisputed facts are scarce, presentation and perception are important. Andre (2009) claims to expose the tactics used by ECT proponents to promote ECT through encouraging the media to promote a positive picture. Others have suggested that the presentation of ECT in the media is consistently unfair, stigmatizing and outdated (Shorter & Healy, 2012; Sienaert, 2016; Torreblanca et al., 2011). The presentation of mental health and invasive practices in a salacious manner is unlikely to end while people continue to be entertained and intrigued by such content. While the impact of the way ECT is presented in the media is unclear, it is also undeniably something which will inform individual perceptions of ECT, and something which should be borne in mind.

Themes appeared to be consistent no matter where geographically the literature was from. All the pieces of literature reviewed were from what is generally referred to as “Western” cultures, and there is a possibility that there might be differences in understanding of ECT and ethical considerations in other parts of the world. A brief review of research from places such as India and China would
indicate similar discussions around consent, legal issues, provision of information about ECT and public perception (e.g. Duffy et al., 2017; Li et al., 2016; Zong et al., 2020). There is a broad spectrum of approaches towards ECT internationally, with some countries completely banning its use feeling it is too dangerous and invasive to use, while other countries utilize ECT at nearly every psychiatric unit, with some of those countries still practising unmodified forms of the treatment (Gazdag et al., 2017). This scaled-up international view would suggest the wider debates and themes remain the same, whether at a local, national or international level, and whether ECT is used in Westernized countries or other parts of the world.

There was a strong tendency in the literature towards considering only the female experience of ECT. ECT has been viewed by many as something which is used disproportionately on women as a means of punishment and control as part of a wider systemic pattern of paternalism and/or misogyny (Appignanesi, 2008; Newnes, 2018; Sadowsky, 2017). There does not appear to be any academic literature examining male experience specifically. There are studies which consider the experiences of mixed cohorts of ECT recipients (e.g. Koopowitz et al., 2003; Kring et al., 2018), which do not appear to show any significant gender differences in terms of perceptions and experience of ECT. There are also narrative accounts from men who describe themselves as survivors of ECT that can be found hosted on various forums online, as well as accounts from men who have had more positive or mixed experiences (e.g. ECT Justice!, 2020; Healthtalk.org, 2020; Mad in America, 2020), suggesting that many of the themes persist across gender.

7 | LIMITATIONS

The empirical studies included all contained small sample sizes, which may limit generalizability. Themes were consistent throughout the literature selected, and they were in keeping with the wider literature considering ECT. The underlying philosophy of a critical realist approach could be considered problematic. There is significant debate amongst scholars about the myriad of different philosophical viewpoints underpinning research in the social sciences, and this is just as true of critical realism as of any other (Coleman, 2019a, 2019b; Nairn, 2012; Ryan, 2019). This review intended to offer a multidimensional view of the processes and structures governing the use and administration of ECT, and how these relate to the role of the MHN as both a professional and a human, when involved in this. With critical realism, there is the possibility of the researcher making leaps which may not be grounded in the available evidence (McEvoy & Richards, 2003). Attempts have been made to mitigate this by providing a transparent methodology and reflexive account. It is accepted that the researcher will bring to this review their own experience, values and beliefs, just as the reader will bring their own reality, and that these will act as a filter over all information provided, creating different realities from reading the same information.

8 | IMPLICATIONS FOR PRACTICE

Negotiating the interplay between legal and ethical issues is a difficult task which can result in internal conflict as well as conflict between individuals. MHNs need to have excellent comprehension of ethical principles and self-awareness as to how these fit alongside their own values, beliefs and professional identity in order to manage conflict which might arise. This may result in better outcomes for those receiving mental health care, as well as improved satisfaction and reduced stress for the MHN. Embracing a virtue ethics approach in addition to the traditional biomedical model of ethics would provide additional opportunity for continued reflection and personal growth as it would allow the MHN value wisdom and personal character, rather than relying solely on professional duty.

When considering the guidelines and information surrounding the use of ECT, it is essential that different groups are engaged with so that as true a picture of the procedure and its possible outcomes can be provided as possible. This should include those who consider themselves survivors of ECT and who advocate for its discontinuation as a treatment, as well as those at the other end of the spectrum who view it as a life-saving and under-used treatment option.

Finally, it is essential that all those involved in the treatment of individuals with ECT consider this within the wider context of societal factors. MHNs need to ensure they are sensitive to the fact that wider causational mechanisms will be at play, rather than simply accepting what is visible as the “truth.” An element of social and political awareness is integral to making sense of the unseen issues such as health inequalities, the critical- and anti-psychiatry movements, cultural representations of psychiatry and mental health, neoliberalism and globalization.

9 | RELEVANCE STATEMENT

MHNs are involved in the care of people receiving ECT. Due to the contentious nature of ECT treatment and the complex ethical issues, they may be placed in situations which are professionally tricky to navigate. MHNs may need to broaden their ethical framework beyond the biomedical model and to improve their understanding of unseen causal factors at play to meet their professional obligations in relation to practising effectively and preserving safety.

CONFLICT OF INTEREST
No conflict of interest to declare.

ETHICAL APPROVAL
Ethical approval was gained via Sheffield Hallam’s ethics process. No ethics committee approval was required as this was a review of existing literature.

DATA AVAILABILITY STATEMENT
Data sharing not applicable to this article as no data sets were generated or analysed during the current study.
health settings. *International Journal of Mental Health Nursing*, 3, 257. https://doi.org/10.1111/inm.12043

Woods, S., Phillips, K., & Dudash, A. (2020). Grey literature citations in top nursing journals: A bibliometric study. *Journal of the Medical Library Association*, 108(2), 262–269. https://doi.org/10.5195/jmla.2020.760

Zong, Q.-Q., Qi, H., Wang, Y.-Y., Zhang, C., Balbuena, L., Ungvari, G. S., An, F.-R., & Xiang, Y.-T. (2020). Knowledge and attitudes of adolescents with psychiatric disorders and their caregivers towards electroconvulsive therapy in China. *Asian Journal of Psychiatry*, 49, 101968. https://doi.org/10.1016/j.ajp.2020.101968

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APPENDIX 1

![Figure A1 Records reviewed](image-url)
### TABLE A1 Full texts screened

| Author | Study design or evidence type | Sample size | Comments/key findings | Include/Exclude |
|--------|-------------------------------|-------------|-----------------------|-----------------|
| 1 Bennett, D., Perrin, J., Currie, J., Blacklaw, L., Kuriskose, J., Rao, A., and Reid, I. (2011). A comparison of ECT dosing methods using a clinical sample. *Journal of Affective Disorders* 141 (2012) 222–226 | A sample of quantitative data from ECT recipients was analysed. Patients had undergone one of three different types of ECT | 63 | Results looked at efficacy of different treatments in inducing seizures | Exclude due to focus of the study which compared different treatment types and was not concerned with ethics beyond those relating to research |
| 2 Blease, R. (2012). Electroconvulsive therapy, the placebo effect and informed consent. *Journal of Medical Ethics* 2013; 39:166–170 | Paper considering ECT and informed consent | N/A | In order to promote autonomy, patient should be provided with a fuller description of ECT | Include |
| 3 Blease, C. (2012). Electroconvulsive Therapy: the importance of informed consent and ‘placebo literacy’. *Journal of Medical Ethics*. https://doi.org/10.1136/medethics-2012-101201 | Commentary—response to | N/A | Response to letter critiquing her paper above. Considers ethical issues such as being “overly informed” | Exclude does not add any additional information not already contained in previous correspondence |
| 4 Chiu, N., Lee, Y., and Lee, W. (2012). Electroconvulsive therapy without consent from patients: One-year follow-up study. *Asia-Pacific Psychiatry*. https://doi.org/10.1111/j.1758-5872.2012.002.03.x | Retrospective cohort study | 29 | ECT can be administered to patients without capacity without fear of lawsuits | Exclude. Very limited discussion on ethics. Focus on litigation potential for clinicians |
| 5 Clarke, K. A., Barnes, M., and Dyann, R. (2018). I had no other option: Women, electroconvulsive therapy, and informed consent. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/inm.12420 | Feminist narrative enquiry | 7 | Some women make decisions about ECT without full information or preparation | Include |
| 6 Collins, J., Halder, N., and Chaudhry, N. (2012). Use of ECT in patients with an intellectual disability: review. *The Psychiatrist*. https://doi.org/10.1192/pb.bp.110.033811 | Literature review | NA | ECT is a valuable treatment in this group but there are obstacles in its use such as diagnosis, legal and ethical issues | Exclude—about LD rather than MH |
| 7 Dhossche, D. (2014). Decalogue of catatonia in autism spectrum disorders. *Frontiers in psychiatry*. https://doi.org/10.3389/fpsyt.2014.00157 | Opinion article | NA | ECT should be used to treat catatonia in ASD | Exclude—very niche area of discussion |
| 8 Electroconvulsive therapy and brain plasticity | Quasi-experimental comparison study | 55 | Underlying brain pathology has an effect on the effect of ECT | Exclude—data heavy and lacking in ethical discussion |
| 9 Duxbury, A., Smith, I., Mair-Edwards, B., Bennison, G., Irving, K., Hodge, S., Anderson, I., and Weatherhead, S. (2018). What is the process by which a decision to administer electroconvulsive therapy (ECT) or not is made? A grounded theory informed study of the multi-disciplinary professionals involved. *Social psychiatry and psychiatric epidemiology*, 53(8), 785–793. https://doi.org/10.1007/s00127-018-1541-y | Grounded theory-informed model | 10 | There are many layers to the decision-making process | Include |
| Author | Study design or evidence type | Sample size | Comments/key findings | Include/Exclude |
|--------|-----------------------------|-------------|-----------------------|----------------|
| 10     | Narrative interviewing       | 9           | Generally experiences of ECT were negative and participants felt they lacked power and knowledge | Include         |
| 11     | Case study                  | 1           | There is conflict between ethical considerations for the MHN involved in ECT | Include         |
| 12     | Prospective analytical descriptive study | 621 | Headaches after ECT are more common than myalgia | Exclude—limited discussion of ethical considerations |
| 13     | Systematic literature review | N/A         | Not all people have equal access to mental health care in low- and middle-income countries | Exclude—Irrelevant subject matter |
| 14     | Lived experience narrative   | N/A         | Personal reflection on positive effects of ECT and ethical issues | Include         |
| 15     | Retrospective chart review   | 8           | ECT is a viable treatment for DVT | Exclude—irrelevant core subject material |
| 16     | Randomized, double-blind, placebo-controlled trial | 63 | Preemptively administering paracetamol reduced the incidence and severity of headaches after ECT | Exclude—irrelevant core subject material |
| 17     | Retrospective review of patient records | 100 | There was no difference in relapse rate between unipolar and bipolar depression | Exclude—irrelevant core subject material |
| Author | Study design or evidence type | Sample size | Comments/key findings | Include/Exclude |
|--------|-------------------------------|-------------|-----------------------|-----------------|
| Jewell M, Delva NJ, Graf P, Chan P, Enns M, Gosselin C, Gilron I, Lawson JS, Martin B, Milev R, Patsy S, Bonifacio M. | A National Survey on Nursing in Canadian ECT Departments. Arch Psychiatr Nurs. 2017;31(3):302–305. | 107 | A review of nursing practices and duties in relation to ECT | Exclude—considers operational factors rather than ethical complexities of administering ECT |
| Kellner, C., and Fink, M. | Electroconvulsive therapy versus pharmacotherapy for bipolar depression. American Journal of Psychiatry, 172:3 | Letter | N/A | Agreeing with previous article which shows ECT to be more effective than pharmacological approaches | Exclude—no significant mention of ethical considerations |
| Mughal, F., and Menezes, S. B. | Severe Depression with Cotard’s Phenomenon: Treatment of a Capacitated Patient Within the United Kingdom’s Mental Health Act 2007. Mental Illness, 5(1), e3. | Case report | 1 | ECT with consent was successful in this individual case | Exclude—very specific illness and application |
| Rogers, S. | Letter to the Editor. Mental Health Weekly. Letter | N/A | Discusses the risk of ECT she feels were neglected in a previous article | Exclude—too brief to add meaningful data |
| Seniuk P. | I'm shocked: informed consent in ECT and the phenomenological-self. Life Sciences, Society and Policy, 14(1), 5. | Paper discussing phenomenological insights | N/A | True informed consent would acknowledge potential changes to a persons' sense of "self" | Include |
| Stefanazzi M. | Is electroconvulsive therapy (ECT) ever ethically justified? If so, under what circumstances. HEC Forum: An Interdisciplinary Journal on Hospitals’ Ethical and Legal Issues, 25(1), 79–94. | Paper discussing ECT in relation to ethical principals | N/A | Consent to ECT should be fully informed | Include |
| Torrance R. | Informed consent and ECT: how much information should be provided? Journal of Medical Ethics. 41(5), 371–374. | Essay | N/A | Considers informed consent and possible double standards of continuing to use pharmacological interventions which may cause harm | Include |
| Wachtel, L. E., Dhossche, D. M., Fink, M., Jaffe, R., Kellner, C. H., Weeks, H., and Shorter, E. | ECT for developmental disability and severe mental illness. The American Journal of Psychiatry, 170(2), 1498-1499. | Letter | NA | Discussing the use of ECT in children | Exclude—children are outside the scope of this review |
| Wilhelmy, Saskia and Rojes, Vanja and Grözinger, Michael and Un, Uz and Schoettle, Sabrina and Gross, Dominik. | Knowledge and Attitudes on Electroconvulsive Therapy in Germany: A Web based Survey. Psychiatry Research. 262, 407–412. | Web-based population survey | 1000 | ECT is not well known and viewed negatively in the German population. Raising awareness would be beneficial | Exclude—mainly about raising awareness to expand treatment rather than considering ethical implications |
| Zisselman, M. H., and Jaffe, R. L. | ECT in the treatment of a patient with catatonia: consent and complications. The American Journal of Psychiatry, 167(2), 127-132. | Clinical case conference | 1 | Comprehensive case study which includes significant discussion on consent in ECT when the patient is unable to consent | Exclude—limited discussion of ethics; overly procedural |
### APPENDIX 3

**TABLE A2** Summary of key strengths, limitations, methodology and sampling

| Paper                  | Methodology                                | Sampling                                    | Strengths                                                                 | Limitations                                                                                     |
|------------------------|--------------------------------------------|---------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Blease (2013)          | Paper considering ECT and informed consent | N/A                                         | Good evidence base, peer reviewed                                         | Paper rather than research—arguably one sided, response from Hersh (2013) is included in the review for balance. US based |
| Clarke et al. (2018)   | Feminist narrative enquiry                  | 7 female recipients of ECT                  | Appropriate methodology, in depth discussion of rich data, clear themes with evidence | Small sample size. Research took place in Australia                                            |
| Duxbury et al. (2018)  | Grounded theory-informed model              | 10 NHS professionals involved in the decision-making process of whether to administer ECT or not, including nursing and medical staff | Evident reflexivity. Synthesizes symptom based and experience-based research. Focussed on clinicians | Small sample size. Mixture of professionals rather than just MHNs                               |
| Ejaredar and Hagen (2014)| Narrative interviewing                      | 9 women who had previously received ECT    | In depth discussion of data collected from interviews. Clear themes with evidence | Focussed on women, data may not apply to men                                                  |
| Flanigan (2010)        | Case study                                 | 1 female recipient of ECT                  | Very deep, considered reflection which competently explores the complex ethical issues around using ECT | Reflective piece. May be limited to author’s own experiences, limited generalizability. Authored in New Zealand so some information is specific to their legal system |
| Hersh (2013)           | Lived experience narrative                 | N/A                                         | Lived experience narrative paper. Author is someone who has been treated using ECT so provides a unique perspective | Lived experience narrative in response to Blease (2013). Author provides alternative viewpoint to this paper. Arguably one sided. US based |
| Seniuk (2018)          | Paper discussing phenomenological insights  | N/A                                         | Rich and deep discussion in relation to informed consent and ideas of self | Limited area of discussion; focus on informed consent and ideas of self which the author acknowledges may be difficult to apply as these are complex philosophical areas. Single author |
| Stefanazzi (2013)      | Paper discussing ECT in relation to ethical principals | N/A                                         | ECT considered from a range of ethical positions which demonstrates complex interplay of these | Literature is based in Ireland and makes specific reference to legal issues there, although these are underpinned by commonly accepted ethical principles. Single author |
| Torrance (2015)        | Essay                                      | N/A                                         | Clear and thorough review and discussion around informed consent and the different approaches to this. Thoughtful and persuasive arguments | Essay with single author                                                                     |
TABLE A3  Key themes present in each included article

| Paper                        | MHN as advocate | Consent | Efficacy | Side effects | Legal issues and clinical guidelines |
|------------------------------|-----------------|---------|----------|--------------|-------------------------------------|
| Blease (2013)                | x               | x       | x        | x            | x                                   |
| Clarke et al. (2018)         |                 | x       | x        | x            |                                     |
| Duxbury et al. (2018)        | x               | x       | x        | x            | x                                   |
| Ejaredar and Hagen (2014)    | x               | x       | x        | x            | x                                   |
| Flanigan (2010)              | x               | x       | x        | x            | x                                   |
| Hersh (2013)                 | x               | x       | x        | x            | x                                   |
| Seniuk (2018)                | x               | x       | x        |              |                                     |
| Stefanazzi (2013)            | x               | x       | x        | x            | x                                   |
| Torrance (2015)              | x               |         | x        |              |                                     |