suspending DNR status during ECT treatments
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To all:
Glenn Prentice has brought up the issue of suspending DNR during ECT treatment on patients. After some discussion with JA and myself, we feel that it is the appropriate policy to implement with this population. Ordinarily we would have a discussion with DNR patients and their families about perioperative suspension of DNR when obtaining our anesthesia consent, and leave the choice up to the patient. However, as Glenn has outlined below, ECT patients present a unique set of problems. Going forward, when you are obtaining the q 6 month anesthesia consent for ECT, please advise the consenter that this is our policy. Thank you.

-NB

From Dr. Prentice:

Treating DNR patients with ECT presents unique problems:

A) It is not clear the risks of not treating a DNR patient with dementia outweighs the risks of not treating them.
   1) We are not treating a patient who is likely to die if we don’t treat them, and might live if we do.
   2) There is no research showing whether ECT is helpful for dementia patients with behavioral problems. We lack a validated instrument to measure improvement quantitatively, and we have no standards as to what meaningful improvement is. We lack the basis needed for risk/benefit analysis when we make decisions about whether to treat, or continue to treat, these patients.

B) Even if we could be certain that ECT significantly helps every patient, we still need to consider the risks of treating DNR patients:
   1) ECT has to be done repeatedly. The risks it involves are ongoing, these are not one-time treatments.
   2) Having no life-threatening event during an ECT treatment does not eliminate the risk of such an event each time it is repeated.
   3) Patients who benefit need ongoing ECT indefinitely, or the benefits are lost. Over time, as the patient’s health status deteriorates with continued aging, the risk of each treatment goes up.
   4) Families often accept the risk of death from ECT as preferable to the patient living in the state they are in. From that point of view there is no risk, only hope.

C) There is substantial risk for the ECT treatment team. If the treatment they do induces a condition that will kill the patient if they don’t intervene, and they are required to do nothing and watch that patient die, they are at risk for suffering potentially severe, potentially lasting, emotional injury. Such an event also puts them at risk of being stigmatized as a healthcare practitioners.

D) Even one bad outcome could result in very few practitioners agreeing to be involved in such treatment, which, would reduce or eliminate the possibility that these patients could continue to get ECT.*

E) There is an alternative. We can require the consenter to sign a special consent that suspends the DNR status of the patient during ECT treatments. If we succeeded in keeping the patient alive, ECT could be discontinued because it is too dangerous to continue. Treatment could shift to palliative care and/or hospice care if the family felt that was preferable to the patient living in the state they are in.