

## Old people and ECT: what difficulties are encountered in obtaining anaesthetics for the elderly?

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Since developing an interest in the use of electroconvulsive therapy (ECT) in late life, I have received correspondence from psychiatrists describing difficulties in obtaining anaesthetics for elderly patients who are perceived as frail or physically unwell. Nevertheless, Pippard & Ellam (1981) found in their survey of the use of ECT in 1980 that 37% of courses were given to people aged 60 years and over. I decided to survey old age psychiatrists' views on ECT, and to look at difficulties encountered in obtaining anaesthetics. Old age psychiatrists specialise in the care of mentally ill elderly people and are dealing with patients who are particularly likely to have physical problems in addition to mental illnesses. Their experience of ECT is therefore of wider relevance to all who prescribe ECT for elderly or physically ill people.

### *The study*

A survey of psychogeriatricians' views on electroconvulsive therapy (ECT) was carried out in 1989; 205 practising old age psychiatrists returned a postal questionnaire (Benbow, in press).

### *Findings*

Sixty-three (30.7%) respondents replied that they had encountered difficulty in obtaining anaesthetics for elderly people requiring ECT and many responded to the invitation to comment further; 15 other doctors appended comments, despite having encountered no difficulty in obtaining anaesthetics. In total, there were 104 comments which fell into seven categories.

#### **Problem patients or particular physical problems**

Twenty-three accounts (22% of the total) fell into this category. Problems were often related to severe physical and mental illness combined. One respondent wrote "in patients with depressive illness and severe medical problems, (it is) sometimes difficult to persuade anaesthetists that treatment of mood disorder is important". A recurrent theme was concern about cardio-respiratory status, particularly in the very elderly, those with pace-makers and following myocardial infarction.

Sometimes respondents reported that treatment had not proceeded: a typical case might be a depressed '80-year-old with refusal of food and fluid' who was refused treatment by the anaesthetist. On other occasions treatment might be delayed by anxiety about the patient's physical health: one doctor described how "ECT (was) delayed in a very depressed lady of 89 years because anaesthetist felt she was 'too old' and 'too frail'. Discussion with senior anaesthetist led to treatment being given on the grounds that she had failed to respond to all other treatment and would die without intervention. Patient received six treatments . . . (and) recovered completely".

#### **Reluctance or over-caution on behalf of anaesthetists**

Twenty respondents (19% of comments) described experiences in this category.

Some old age psychiatrists commented mildly on this, describing anaesthetists as "unduly cautious about the presence of doubtful physical illness" while others clearly felt quite strongly about it: "anaesthetists tend to be over-cautious and fuss about nothing!". Why might this be? – "... some anaesthetists appear to regard ECT as punitive and of no benefit . . .", "One senior consultant anaesthetist is absolutely opposed to ECT for patients of any age . . .". Other doctors implied that anaesthetists questioned the need for ECT.

#### **Seniority of anaesthetists**

Ten comments (10% of total) drew attention to the experience or seniority of the anaesthetists involved: over-caution was seen as more frequent when dealing with junior anaesthetic staff and was sometimes shown by an anaesthetist giving apparently spurious grounds for failing to anaesthetise a patient for ECT.

Perhaps not unreasonably, "less experienced anaesthetists often defer the first treatment until a senior colleague is available". Reluctance was thought to vary "with grade of anaesthetist and strength of psychiatric indication" and might be "due to ignorance of procedure and type of anaesthesia required".

### Helpful suggestions

Twenty doctors (19% of comments) offered suggestions on dealing with reluctant anaesthetists or severely ill patients. The need for discussion prior to treatment was emphasised. "Explanation and good communication usually works." Perhaps one doctor described the ideal practice: "Our anaesthetists discuss with us the degree of risk in giving/withholding ECT and we come to a joint decision". Supportive medical colleagues were seen as important, as were full physical investigations. Some problems are readily avoidable, e.g. non-availability of test results. Sometimes the procedure can be changed by using theatre, transferring to geriatric beds or using the intensive care unit for recovery.

### Technical problems in administering ECT

Fifteen respondents (14% of total) described technical difficulties in organising treatment sessions or in the practical administration of treatment. Practical problems included "difficulty in getting access to veins", "long recovery period after ECT" and "teeth problems". Problems in organising ECT sessions included staffing, funding and availability of sessions. Anaesthetists, like psychiatrists can have different views: "... a course of ECT can suddenly be interrupted by a new anaesthetist suddenly rejecting the patient as being 'too much of an anaesthetic risk'".

### Positive comments

A number of positive comments provided evidence that good working relationships can be achieved (12 comments: 12% of total). Nine respondents commented on how helpful, co-operative, interested or 'agreeable' they found their anaesthetic colleagues. One respondent wrote, "Our anaesthetist is pretty committed to positive response to ECT and even in pretty frail cases will try".

### Failure to recognise the risk of untreated depression

Four doctors (4% of total) commented that anaesthetists failed to recognise the life-threatening nature of severe depression. One wrote simply "anaesthetists don't understand that depression kills". Another commented "(anaesthetist) somehow fail to make the connection between severe depression and increased mortality".

### Comments

The relationship between anaesthetist and psychiatrist, their respective roles and differing views have attracted little attention. Freeman and colleagues (1989) in *The Practical Administration of ECT* refer briefly to the anaesthetist's role.

This survey highlights the need for clear communication between psychiatrists and anaesthetists. It is helpful for policies to be developed jointly and to anticipate potential problems before they arise. Pippard (1988) emphasised the importance of appointing a psychiatrist with responsibility for the ECT clinic. The active involvement of senior anaesthetists is also seen as useful by old age psychiatrists, and may be as important. Where both anaesthetist and psychiatrist respect the other's skills and role in treatment, good working relationships can be developed. If psychiatrists do not value the anaesthetists' role in treating patients with ECT, anaesthetists are unlikely to recognise their own importance and it is perhaps understandable then if they seem to undervalue the role of ECT itself in the treatment of severely ill people.

### Acknowledgement

This study was supported by a grant from the North West Regional Health Authority. I am grateful to all the old age psychiatrists who completed the questionnaires.

### References

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