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Regulation of Electroconvulsive Therapy

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Electroconvulsive therapy (ECT)\(^1\) is a psychiatric procedure that induces a convulsive seizure in the patient in order to treat severe depression.\(^2\) Recently, courts,\(^3\) legislatures,\(^4\) and the medical profession\(^5\) have paid increasing attention to the regulation of ECT. Their interest has been stimulated by the growing recognition of the rights of mental patients,\(^6\) the developing role of consent in medical \(^1\)For an extensive analysis of legislative involvement in this area, see Note, Legislative Control of Shock Treatment, 9 U.S.F.L. Rev. 738 (1975). Electroconvulsive therapy has in the past commonly been referred to as “shock treatment.” While insulin coma therapy and other convulsion-inducing therapies may still be occasionally used by a few practitioners, by far the most widespread form is electroconvulsive therapy. The term “convulsive” rather than “shock” therapy is preferred by the medical profession because the convulsion itself is the common element in these treatments and because “shock treatment” has negative connotations. Such connotations are regarded as unfortunate by advocates of treatment, see, e.g., L. Cammer, Up from Depression 153 (1969) (“a disquieting misnomer for an excellent and highly beneficial treatment method”), but opponents have deliberately emphasized them to discredit treatment, see, e.g., Adams, You’re in for the Shock of Your Life, Madness Network News Reader 84 (Frank ed. 1974) (pointing to one practitioner who favors term “electric/shock torture”).


5. Psychiatrists are now actively involved in ECT research, see note 8 infra, regulation of ECT through professional organizations, see California Area Branches Draft ECT Guidelines, Psychiatric News, Feb. 6, 1976, at 1, 22-23, and debate over the merits of the treatment, see Convulsive Therapy Bull. (1976).

transactions, and the results of recent scientific research on the efficacy and consequences of ECT.

Regulation of ECT has generally focused on whether the patient or his representative effectively consented to the treatment. The highly intrusive nature of ECT and the unique circumstances of those patients who are likely to receive it create particularly difficult legal issues concerning the validity of the patient's consent. This Note will examine the various methods that are available to protect the rights of patients for whom ECT is proposed. After briefly explaining the nature of the therapy, the Note will discuss the efficacy of judicial remedies with respect to both competent and incompetent patients. It will argue that, because of the peculiar nature of ECT, special procedures that ensure the existence of consent to state-administered ECT may be constitutionally required. It will then address specific procedures legislatively enacted by several states for the regulation of ECT and will assess their constitutional limitations, with emphasis upon the problem that a regulatory scheme, in its effort to protect patients from unconsented therapy,


9. Note that in cases of total incompetency, a guardian, state-approved review panel, or other representative may be allowed to consent for the patient. This substituted consent is discussed in text at note 143 infra. When the term “patient” is used in this Note, it includes those persons or bodies qualified to give substituted consent.

10. See text at notes 81-82 infra.

11. See text at notes 109-30 infra.

12. See note 4 supra.

13. It should be pointed out that, while this Note focuses particularly on ECT, the interest of mental patients in being free from unwanted psychiatric treatment extends to other forms of therapy as well. An analysis of ECT regulation may serve as a model for regulation of other psychiatric treatments. For example, increasing attention is being given to the use and effects of psychotropic medications. See Marker, Phenothiazines and the Mentally Retarded: Institutional Drug-Abuse?, in Mental Health Law Project, Summary of Activities 1 (March 1975). The value of ECT as a model treatment is more apparent when one compares public reactions to “shock” and “chemo” therapy. Our culture is so accustomed to the frequency, ease, and acceptability of taking drugs that the misuse of drugs may seem a less serious area for mental health regulation. Yet by different physiological mechanisms, ECT and psychotropic drugs appear to present similar potential harms to patients. See Bomstein, The Forcible Administration of Drugs to Prisoners and Mental Patients, 9 Clearinghouse Rev. 379 (1975); Note, Mental Health—The Right to Refuse Drug Therapy Under Emergency Restraint Statutes, 11 New Eng. L. Rev. 509 (1976).
may interfere with the right of patients to consent to privately administered ECT.

I. THE ADMINISTRATION, PURPOSES, AND EFFECTS OF ECT

ECT is the term generally used to describe several types of psychiatric treatment, all of which involve inducing in the patient a convulsive seizure similar to a grand mal epileptic attack. The patient does not eat for four hours prior to the convulsion. Sedatives may be provided before treatment, but usually no drug therapy occurs. One-half hour before the convulsion, atropine, a preanesthetic medication that reduces the risk of suffocation by decreasing the production of saliva, is furnished. A fast-acting barbiturate anesthetic is then injected so that the patient will feel neither the muscle contractions that precede muscle relaxation nor the unpleasant sensation of respiratory arrest. Electrodes are attached to the patient's temples and a current that ranges between seventy and 130 volts is administered for 0.1 to 0.5 seconds.

14. These are pharmacological shock or convulsive therapy, insulin coma treatment, and electroconvulsive therapy. See Krouner, Shock Therapy and Psychiatric Malpractice: The Legal Accommodation to a Controversial Treatment, 2 FOR. SCI. 397, 423 nn.11 & 12 (1973). See also L. Kalinowsky & H. Hippius, Pharmacological Convulsive and Other Somatic Treatments in Psychiatry 269 n.3 (1969).


16. See Krouner, supra note 14, at 402.

18. To increase conductivity and prevent burns, graphite jelly is applied to the temples. See Kalinowsky, supra note 15, at 1279.

19. In unilateral ECT, electric current is applied by placement of one electrode to the nondominant hemisphere of the brain. Bilateral ECT employs two electrodes, one on each temple. The distinction is significant. Unilateral treatment results in a lessening of posttreatment memory loss and confusion. See Karliner, Present Status of Unilateral Shock Treatments, 4 BEHAVIORAL NEUROPSYCH. 2-4, 12 (1973); Abrams, Recent Clinical Studies of ECT, 4 SEMINARS IN PSYCH. 3-5 (1972); Dombush, Memory and Induced ECT Convulsions, 4 SEMINARS IN PSYCH. 47-49 (1972). However, a greater number of unilateral treatments than bilateral is necessary to achieve therapeutic benefit. See CLEARINGHOUSE PAMPHLET, supra note 2, at 9. For example, unilateral treatments may be given daily but bilateral is rarely administered more than three times a week. See MASS. TASK FORCE, supra note 2, at 4. Unilateral ECT may involve a trade-off of reduced memory impairment for the other risks implicit in a greater number of treatments. One psychiatrist reports preference for bilateral placement despite its lessened clinical effectiveness because the patient is spared the additional anesthetic risks of the more frequent unilateral treatments. See Gabriel, ECT as the Treatment of Choice, WORLD MED. NEWS REV., Nov. 1974, at 68. Electrode placement may thus determine the degree or nature of posttreatment impairment. This may make especially significant the physician's disclosure of dangers to the patient and the patient's participation in choosing which risks he may prefer to accept.

seizure, the therapeutic agent, lasts between thirty and fifty seconds. The patient remains totally unconscious for a few minutes after the convulsion; full consciousness is regained in five to thirty minutes.

This procedure is most widely used to treat severe depression and schizophrenia. Although there is evidence, albeit disputed, that it has at least some positive effect, there is little agreement as to the process by which ECT ameliorates these conditions. One theory posits that ECT works by producing a regression of behavior to infantile levels, which enables the patient's personality to be restructured. Other explanations are that it causes amnesia which helps repress stressful and unpleasant experiences, that it induces fear in the patient, or that it makes the patient feel he is being punished, thereby assuaging his conscience, or that it stimulates certain chemicals in the brain. None of these theories, how-

21. The seizure or convulsion consists of the body shaking and twitching and of a transient apnea or loss of breath. D. McCarthy & K. Borrin, Medical Treatment of Mental Disease: The Toxic and Organic Basis of Psychiatry 593-96 (1955). When muscle relaxants are used, however, the violent shaking of the body is not experienced by the patient; the only observable motion during convulsion may be a twitching of the toes. See T. Detre & H. Jarecki, Modern Psychiatric Treatment 639 (1971).


23. The medical illness for which ECT is most widely recognized as appropriate is involuntional melancholia, the depressed phase of manic-depressive illness, sometimes called psychotic depressive reaction. See E. Rosen, R. Fox & I. Gregory, Abnormal Psychology 433 (2d ed. 1972). As emphasized by the Massachusetts Task Force Report, "the use of the term 'depressed' by the patient should not immediately be construed to imply the presence of an affective disorder. Descriptive phrases such as 'non-functional' or 'depressed person' are insufficient to justify the use of ECT." Mass. Task Force Report, supra note 2, at 19.

24. Sullivan, Treatment of Acute Schizophrenia: The Place of ECT, 35 Diseases of the Nervous System 467-69 (1974). Although agreement exists that ECT is effective in treating wildly destructive or catatonic patients by controlling behavior so that other treatments (psychotropic drugs and psychotherapy) can be used, there is no consensus on any other role for ECT in the treatment of schizophrenia. See Mass. Task Force Report, supra note 2, at 19.


29. See Miller, supra note 27, at 303.

30. See id. at 304-05.

31. See L. Kalinowsky & H. Hippius, supra note 14, at 375.

32. See Abrams & Taylor, Electroconvulsive Therapy and the Diencephalon: A
ever, has been widely accepted.35 This inability to discern the manner in which ECT works makes it difficult for physicians to predict accurately which patients will benefit from the treatment.36

A major problem with ECT therapy is that physical complications can result from the convulsion. Bone fractures and dislocations have been a frequent consequence of the violent seizure.38 Although muscle relaxants are now often administered before the convulsion to reduce the risk of fractures,37 it is still accepted medical practice to administer ECT without them.38 Respiratory and cardiovascular complications have also occurred.39 However, careful pretreatment investigation for physical weaknesses,40 and the


34. See T. DEPRE & H. JARECKI, supra note 21, at 641-42.

35. Id. at 645. But see Mendels, The Prediction of Response to Electroconvulsive Therapy, 124 AM. J. PSYCH. 153 (1967).

36. See Krouner, supra note 14, at 402-03.

37. See id. at 403.

38. See Pettis v. State Dept. of Hosps., — La. App. —, 336 So. 2d 521, 528 (1976); Foxiger v. State, 23 Misc. 2d 933, 934, 203 N.Y.S.2d 985, 986 (Sup. Ct. 1960). In these cases the plaintiffs suffered fractures following the administration of unmodified ECT. No negligence was found on the part of the treating physicians because the absence of muscle relaxants was an accepted medical technique of ECT administration. Practitioners who give ECT without muscle relaxants argue that their use entails too many independent risks.

39. See Krouner, supra note 14, at 402. Other negative consequences include amenorrhea, see Michael, The Menstrual Cycle and Recovery During Shock Treatment, 15 DISEASES OF THE NERVOUS SYSTEM 342 (1954), permanent epileptic disorders, see Assael, Centrencephalic Epilepsy Induced by Electro Convulsive Treatment, 23 ELECTROENCEPHALIC CLINICAL NEUROPHYSIOLOGY 193 (1967), aggravation of preexisting lung disease, see Krouner, supra note 14, at 402-03 n.129, and sexual disturbances, see Weinstein, Sexual Disturbances After Brain Injury, 8 MEDICAL ASPECTS OF HUMAN SEXUALITY 10 (1974).

40. Osteoporosis, old age liver disease, recent cerebral hemorrhage, severe debilitating illness, and recent heart or lung disease have been cited as physical weaknesses that make ECT administration particularly dangerous. See MASS. TASK FORCE REPORT, supra note 2, at 11. One study, however, has indicated that ECT can be safely administered to patients with a history of heart trouble. See Ballenger, Electroconvulsive Therapy and Cardiac Pacemakers, 14 PSYCHOSOMATIC 233-34 (1973). Pretreatment screening should also include considerations of the interaction between other medications the patient may have taken and drugs administered as part of the ECT procedure. See Chessen, Geha & Salzman, ECT, Glaucoma, and Prolonged Apnea, 35 DISEASES OF THE NERVOUS SYSTEM 152 (1974). See also Unrecognized Adult Phenylketonuria, 289 NEW ENG. J. MED. 395, 397 (1973) (two women inappropriately given ECT when ferric chloride test would have revealed an undiscovered metabolic disorder).
use of muscle relaxants, barbiturate anesthetics, and oxygen have greatly reduced these complications.\(^1\)

Of far greater concern are the mental complications of ECT—particularly disorientation and loss of memory. Disorientation may be so complete that the patient will not remember the names of people around him and, in rare cases, his occupation.\(^2\) Such confusion has been reported to persist for as long as six months after treatment.\(^3\) This effect may actually be a necessary part of the therapy, for some clinicians believe that the extent of the treatment's eventual success is directly proportional to the amount of temporary disorientation.\(^4\) That loss of memory is also a frequent result of ECT is not seriously questioned. However, the scope and length of the loss is a subject of vigorous debate within the psychiatric profession.\(^5\) Total amnesia typically occurs throughout the entire course of a series of treatments.\(^6\) Some authorities state that memory usually returns within a few weeks of the final treatment;\(^7\) however, there are also

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41. See Krouner, supra note 14, at 402.
42. T. Detre & H. Jarecki, supra note 21, at 641-42. Kalinowsky suggests that, because of the problem presented by the patient's increasing confusion during the course of treatment, physicians should "warn the relatives most carefully to keep the patient away not only from friends (who, seeing him in this confused state, might draw wrong conclusions as to his mental capacities) but from his business, where he might do much harm without realizing it." L. KALINOWSKY & H. HIPPIUS, supra note 14, at 184.
44. Robitscher, A Duty to Desist in Informed Consent: When Can It Be Withdrawn?, 2 HASTINGS REPORT 10, 11 (1972).
45. Zamora & Kaelbling, Memory and Electroconvulsive Therapy, 12 AM. J. PSYCH. 546 (1965). The accounts of psychiatrists and patients concerning memory loss differ. For example, Kalinowsky states: "Neurotics with hypochondriacal tendencies complain more often than other patients of not remembering names and places, of difficulty in concentrating or of forgetting more easily. All patients who remain unimproved after ECT are inclined to complain bitterly of their memory difficulties." L. KALINOWSKY & P. HOCH, SHOCK TREATMENTS, PSYCHOSURGERY AND OTHER SOMATIC TREATMENTS IN PSYCHIATRY 139 (1952). See L. Cammer, supra note 1, at 157.

Yet descriptions by patients suggest that memory loss is real. As one patient has stated: "I'd lost the body of knowledge that constituted my professional skill . . . . I'd lost my experience, my knowing. But it was worse than that. I felt that I'd lost myself." Roueche, Annals of Medicine: As Empty as Eve, The NEW YORKER, Sept. 9, 1974, at 96. Ernest Hemingway is reported to have commented after receiving a series of ECT treatments at the Mayo Clinic: "Well, what is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lose the patient . . . ." A. HOTCHNER, PAPA HEMINGWAY: A PERSONAL MEMOIR 308 (1966).

Whether memory loss can be traced to physiological or psychological causes may have greater scientific than legal significance. In any case, physicians should be required to warn the patient of the risk of amnesia as part of obtaining informed consent. See text at note 118 infra.
47. See T. Detre & H. Jarecki, supra note 19, at 642-43.
reports of permanent memory impairment.\textsuperscript{48} Memory loss may extend to events occurring before\textsuperscript{49} or after\textsuperscript{50} the treatment. Although other serious mental complications of ECT are not thoroughly documented, there is some evidence indicating that ECT may cause brain damage\textsuperscript{51} and impairment of learning ability.\textsuperscript{52}

II. JUDICIAL REGULATION OF ELECTROCONVULSIVE THERAPY

Although some states have comprehensive legislation that controls

\textsuperscript{48} See Roueche, supra note 45, at 84; Goldman, Gomer & Templar, Long Term Effects of Electroconvulsive Therapy Upon Memory and Perceptual-Motor Performance, 28 J. CLINICAL PSYCH. 33. Studies indicate that the placement of electrodes can significantly affect the duration and type of memory loss that occurs. See d’Elia, Memory Studies in Electroconvulsive Therapy with Different Electrode Placements, 37 BRAIN RESEARCH 364 (1972); note 19 supra.

\textsuperscript{49} This is called retrograde amnesia. See Squires, Slater & Chace, Retrograde Amnesia: Temporal Gradient in Very Long Term Memory Following Electroconvulsive Therapy, 187 SCIENCE 77-79 (1975).

\textsuperscript{50} This is called anterograde amnesia. Dornbush & Williams, Memory and ECT, in PSYCHOBIOLOGY OF CONVULSIVE THERAPY 199, 201 (M. Fink, S. Ketty, J. McGaugh & T. Williams eds. 1974). Anterograde amnesia may be classified not as memory loss but as an impairment of the ability to learn. See note 76 infra.

\textsuperscript{51} The relation between ECT and brain damage is uncertain. The Massachusetts Task Force on Electroconvulsive Therapy reported:

Despite the assertions of some authors that ECT may produce a subtle form of brain damage, and that they have seen several patients with histories of excellent educational achievements demonstrate subnormal intelligence quotients after multiple courses of ECT, most authors do not believe that permanent brain damage occurs when a reasonable number of treatments are properly administered with sufficient oxygen. It is apparent, however, that a definitive answer is not available regarding the likelihood of permanent brain damage resulting from an unusually large number of treatments. Mass. Task Force Report, supra note 2, at 5. One study nonetheless suggests that, because ECT may have a local effect on the brain structure immediately under the electrodes, electrodes should be placed over cortical areas not directly related to crucial mental functions and that placement should be individualized depending on the patient’s occupation: “For example for a carpenter who must earn his living by skeletomuscular activities, i.e., nonverbal activities, unilateral electrode placement over the dominant hemisphere may be optimal, even though that particular placement carries a greater risk of loss of verbal memory function.” McGaugh & Williams, Neurophysiological and Behavioral Effects of Convulsive Phenomena, in THE PSYCHOBIOLOGY OF CONVULSIVE THERAPY 279, 282 (M. Fink, S. Ketty, J. McGaugh & T. Williams eds. 1974). Serious questions are raised by the repeated admonitions in psychiatric literature concerning the relationship between electrode placement and patient occupation. Just as manual capabilities of a carpenter should be preserved, “one should also be cautious with the man who uses a highly trained memory in the exercise of his profession.” W. Sargant & E. Slater, AN INTRODUCTION TO PHYSICAL METHODS OF TREATMENT IN PSYCHIATRY 73 (1972); Memory Disturbances After ECT—A Major or Minor Side Effect?, 134 INTERNATIONAL CONGRESS Ser. 161 (1967) (Academy of Psychosomatic Medicine).

\textsuperscript{52} Some interference with the ability to store information received by the patient after treatment has been reported. See Squire & Miller, Diminution of Anterograde Amnesia Following Electroconvulsive Therapy, 125 BRIT. J. PSYCH. 490, 490-95 (1974). Again, the placement of the electrodes seems related to the nature of the learning impairment which can follow treatment. Berent, Cohen & Silverman,
the administration of ECT,\textsuperscript{53} most patients must still rely on the courts for protection. Because ECT is a form of medical treatment that involves a physical invasion of the patient's body, traditional tort doctrines, which are adequately discussed elsewhere,\textsuperscript{54} apply: If the patient does not consent to the treatment, or if he is not fully advised of its risks, an action for damages is available. It is being increasingly recognized, however, that a patient who receives ECT without his consent is not limited to remedies in tort; such medical practices may violate the patient's constitutional rights as well.

With the exception of those cases where ECT is administered in private settings on an inpatient or outpatient basis, the state is usually sufficiently involved with the administration of ECT to satisfy the Constitution's state action requirement.\textsuperscript{55} This section of the Note contends that the administration of ECT by the state to a nonconsenting patient\textsuperscript{56} violates several of his constitutional rights.\textsuperscript{67} In order to give such treatment, the state therefore must show either that the patient has effectively consented to the medical care, thereby waiving his right to the constitutional protections violated by the forcible medical intervention, or that it possesses a sufficiently strong

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\textit{Changes in Verbal and Nonverbal Learnings Following a Single Left or Right Unilateral Electroconvulsive Treatment}, 10 Biological Psych. 95, 95-100 (1975).

53. See statutes cited note 4 supra.


55. It is recognized that the state action requirement limits the class of protected patients. Three levels of state involvement can be discerned by categorizing patients according to admission status and place of treatment. Arguably in the case of involuntarily committed patients, whether to a public or private hospital, the state has been sufficiently active in bringing about the individual's status as a patient to meet the fourteenth amendment standard. The next level would be patients voluntarily hospitalized in state institutions. The state's involvement is not in securing the hospitalization but in actually administering the therapy, a degree of activity sufficient to come within requirements for state action. The third group of patients are those who receive ECT in private hospitals or clinics, either on an in- or out-patient basis. It can be argued that a private hospital that receives state or federal funding to a significant degree or operates under governmental regulation may fall within the parameters of state action. See Note, Judicial Review of Private Hospital Activities, 75 Mich. L. Rev. 445 (1976); Note, State Action in the Health Field, 1975 Wis. L. Rev. 1188.

56. This section focuses on the validity of the consent of patients who are competent. Of course, many patients are legally incompetent and incapable of giving consent. In these situations, representatives of the patient—relative, guardian, or a medical, state-sanctioned panel—must give consent. The implications of so-called substituted consent is discussed at note 208 infra. Substituted consent must also satisfy the constitutional standards for waiver when the treatment is administered by the state; of course, if the patient is competent, there is no reason to look to substituted consent.

57. It is well settled that the competent individual has a right to refuse to submit to certain actions being performed upon his body. As stated by Justice Cardozo, "every human being of adult years and sound mind has a right to determine what shall be done with his own body ..." Shloendorff v. Society of the N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). See Sibbach v. Wilson & Co., 312 U.S. 1, 17 (1941) (Frankfurter, J., dissenting).
interest that justifies treating a nonconsenting patient. It is argued that no sufficient state interest is adequately served by forcing ECT upon patients who are competent to make a rational choice about treatment. However, special problems exist concerning the knowledge and voluntariness of these patients—that is, whether they have, in fact, given consent. The state should thus be obligated to provide some mechanism to verify that the purported consent satisfies the constitutional standards for waiver. This Note further maintains that the state, in many instances, will possess a sufficient interest in treating incompetent patients who lack the capacity to consent to ECT. It is suggested, however, that a review mechanism is also necessary in these instances to ensure that the intrusion upon the patients and the risk of harm are justified by the treatment’s benefits.

A. Constitutional Implications of State Administration of ECT to Nonconsenting Patients

The right to refuse unwanted ECT is derived primarily from the constitutional rights of free speech and privacy. Additional support for the right to refuse treatment can be found in the first amendment’s protection of religious exercise. In Winters v. Miller, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971), the Second Circuit held that, absent a judicial finding of incompetence, the forced treatment in a mental institution over the objections of the patient, a Christian Scientist, unconstitutionally interfered with her religious beliefs. The Court could find no compelling state interest to override Winter’s first amendment right of freedom of religion. The applicability of this holding to the nonconsensual administration of ECT seems clear: A patient whose religious beliefs prevent medical intervention should be allowed to refuse medical or somatic psychiatric treatment. There are, however, both limitations and extensions of the right to refuse treatment when based on the right of freedom of religion. See text at notes 87-89 infra. It has been suggested that the right to refuse treatment based on religious protection should apply not only to those patients who belong to an organized religion but also to any person who has a sincere and deeply felt opposition to psychiatric drugs. See Bomstein, The Forcible Administration of Drugs to Prisoners and Mental Patients, 9 CLEARINGHOUSE REV. 379, 385 (1975).

Another potential constitutional basis for regulation of ECT is the eighth amendment prohibition against cruel and unusual punishment. If a treatment were given solely for punitive reasons, the requirements of the eighth amendment would most certainly apply. It is very probable that this amendment is relevant only in those cases where the treatment is used illegitimately. It is nonetheless noteworthy that the mere characterization of a procedure as treatment or rehabilitation has been held not to insulate it from eighth amendment scrutiny. See Knecht v. Gillman, 488 F.2d 1136, 1139 (8th Cir. 1973); Inmates of Boys’ Training School v. Affleck, 346 F. Supp. 1354 (D.R.I. 1972). Courts have found eighth amendment violations in the use of vomit-inducing and tranquilizing drugs outside a psychotherapeutic setting. See Knecht v. Gillman, 488 F.2d 1136, 1139-40 (8th Cir. 1973); Nelson v. Heyne, 355 F. Supp. 451, 455 (N.D. Ind. 1972), affd., 491 F.2d 352 (7th Cir.), cert. denied, 417 U.S. 976 (1974).

Recently, the Minnesota Supreme Court rejected a plaintiff’s claim that the ECT he had received was cruel and unusual punishment. The court found that “the decision to administer electroshock therapy was not triggered by any single incident nor did it involve an isolated treatment, both of which would be more characteristic of punishment,” thus acknowledging in dicta circumstances under which an eighth
Freedom of expression as protected by the first amendment encompasses the right of an individual to communicate. Similarly, thought, or the action or process of thinking, has also been protected under that amendment. Both communication and thought would not occur without a "logically prior antecedent," which is widely referred to as the process of mentation. Mentation has been defined as "a person's power to generate thought, ideas, and mental activity." It describes the mental activity that precedes thought and refers to the mental process itself. Extending the scope of amendment claim might succeed. Price v. Sheppard, — Minn. —, 239 N.W.2d 905, 909 (1976).

There is little question that electroconvulsive therapy has been used inappropriately. See Abse & Ewing, Transference and Countertransference in Somatic Therapies, 123 J. NERVOUS & MENTAL DISEASE 32, 38 (1956) ("It is, of course, the frequent experience of a physician in a state hospital to be approached by a nurse who suggests a 'few shocks' for a patient because he has been fighting, resistive, uncooperative or even merely obscene in his talk."). The possibility of a perhaps unconsciously retributive aspect to ECT administration is suggested by one study which found that those patients chosen for ECT were highest on a doctor-patient tension level scale given to the administering psychiatrist. Rabiner, Reiser, Silverberg, Schacht & Granick, Method of Assessing Doctor-Patient Tensions: Its Application in Assessing the Role of Those Tensions in the Choice of Electroshock, 4 ARCHIVES GEN. PSYCH. 553, 560 (1961).

Finally, ECT may occasionally be used not solely as punishment but as punishment for the purposes of treatment. See Opton, Psychiatric Violence Against Prisoners: When Therapy is Punishment, 45 MISS. L.J. 605, 644 (1974). For example, ECT could be used in a program of aversive conditioning, a technique of behavior modification involving forms of punishment to discourage negative behavior. For an extensive bibliography on recent legal and medical studies on behavior modification, see 13 AM. CRIM. L. REV. 101-11 (1975).

There are reports suggesting that ECT has been used both for behavior modification and for control purposes without supplementary psychiatric treatment. For example, unmodified ECT was given by an American psychiatrist to 120 patients in a Vietnamese mental hospital who refused to work. "Gradually there began to be evident improvement in the behavior of the patients ... and [in] the number of patients volunteering for work. This latter was a result of ECT's alleviating schizophrenic or depressive thinking and effect with some. With others it was simply a result of their dislike or fear of ECT." Cotter, Operant Conditioning In a Vietnamese Mental Hospital, 124 AM. J. PSYCH. 24-25 (1967). Because such use of ECT has an element of both punishment and treatment, it has been suggested that the treatment element controls making the eighth amendment inapplicable. See, e.g., Peck v. Accone, 369 F. Supp. 97 (W.D. Mo. 1974) (dismissing petitioners' cruel and unusual punishment claim based on the forceful administration of thorazine because the officers "were not attempting to punish or harm the petitioners"). Others have urged that the courts should extend full constitutional rights when therapy is used as punishment. See Opton, supra, at 644. See also Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973).

61. Shapiro, supra note 59, at 258-59.
62. Id. at 255-56.
63. The distinction between control of thought and mentation is suggested by the California Court of Appeal in its description of the effect of the bill regulating ECT: "Here the state has sought to control neither what is thought by mental patients, nor...
first amendment protection to include mentation simply recognizes that each step in the sequence of producing a communication is necessary and should therefore be protected under the first amendment's right of expression.

This was precisely the conclusion in *Kaimowitz v. Department of Mental Health*, in which a Michigan circuit court prevented experimental psychosurgery on a mental patient who was incapable of giving consent. The court reasoned that "if the First Amendment protects the freedom to express ideas, it necessarily follows that it must protect the freedom to generate ideas. Without the latter protection, the former is meaningless." The interference with the patient's mental process that accompanies ECT treatment is substantial. As with psychosurgery, the very purpose of the treatment is to change the nature of mental activity by organic means. Mental disorientation and loss of memory are frequent consequences. Thus ECT—as well as similar treatments—should be considered violative of the first amendment's right of free expression when it is administered to a nonconsenting patient.

The right to refuse unwanted medical treatment is also protected by the constitutional right of privacy. This right was deemed "fundamental" in *Griswold v. Connecticut*, in which the Court invalidated how they think. Rather, the state is attempting to regulate the use of procedures which touch upon thought processes in significant ways . . . ." *Aden v. Younger*, 57 Cal. App. 3d 662, 679, 129 Cal. Rptr. 535, 546 (1976).


65. 2 Prison L. Rptr. at 478. That interference with mentation triggers constitutional protections was also recognized in *Mackey v. Procunier*, 477 F.2d at 877 (9th Cir. 1973). There, the Ninth Circuit found that the administration of a "fright drug" as part of a behavior modification program to which the patient had not consented could raise "serious constitutional questions respecting . . . impermissible tinkering with the mental processes." 477 F.2d at 878.

66. See text at notes 42-52 infra. One characteristic of psychosurgery seen by the *Kaimowitz* court as impairment of the power to generate ideas was "the deadening of memory." 2 Prison L. Rptr. at 478. As the court in *Aden v. Younger* acknowledged regarding ECT, "[t]he extent of memory loss and the risk of permanent memory loss are not fully known or agreed upon, but the fact of memory loss is not questioned." 57 Cal. App. 3d 662, 672, 129 Cal. Rptr. 535, 541 (1976).

67. One might argue that an incompetent patient—one who lacks the capacity to express his thoughts—cannot take advantage of constitutional protections, since his thoughts are not significant enough to warrant protection. This argument, however, suffers from several fundamental weaknesses. First, an incompetent patient may well have mentation or thoughts, though he is unable to express them. Second, the decision that one is incompetent itself deserves constitutional protection; otherwise, a fully competent patient may have his rights infringed when he is erroneously deemed incompetent and consequently treated against his will. To give this decision constitutional significance is tantamount to saying that a mental patient has a right not to be presumed incompetent. Thus, it is appropriate to recognize that all mental patients—even though some are wholly incompetent—enjoy the constitutional rights discussed in this section.

68. 381 U.S. 479 (1965).
a state statute proscribing the use of contraceptives by married persons. Since Griswold, recognition of the right of privacy has sustained the use of contraceptives by unmarried persons,\textsuperscript{60} the possession of obscene materials in one's own home,\textsuperscript{70} and the obtaining of an abortion within the first trimester of pregnancy.\textsuperscript{71} Although it is difficult to discern a precise rationale that controls all of these cases,\textsuperscript{72} it is nonetheless apparent that their underlying values would seem to compel a finding that the state's administration of ECT to nonconsenting patients violates the right of privacy.

The fundamental value that the Court apparently considers to be supportive of the privacy right is the interest in individual autonomy, or the “right to be left alone.”\textsuperscript{73} The “dignitary quality” of each individual requires that he have spheres of activity free from governmental intrusion.\textsuperscript{74} Generally, the Court finds a right of privacy in areas traditionally considered “personal.” For example, the fourth amendment has been held to protect those areas for which the person has a “reasonable expectation of privacy.”\textsuperscript{75} Justice Douglas has argued for “the autonomous control over the development and expression of one's intellect, interest, tastes and personality”\textsuperscript{76} and “the freedom to care for one's health and person.”\textsuperscript{77}

It is difficult to imagine an aspect of the human condition more personal and more deserving of protection than an individual's mental processes. The court in Kaimowitz reached this conclusion:

There is no privacy more deserving of constitutional protection than that of one's mind . . . . If one is not protected in his thoughts, behavior, personality and identity, then the right of privacy becomes meaningless. (In the hierarchy of values, it is more important to

\textsuperscript{69} See Baird v. Eisenstadt, 405 U.S. 438 (1972).
\textsuperscript{72} Professor Kurland notes that, because the constitutional concept of privacy is undefined, it is consequently confused with “a great many other notions that are related but should not be identified with it, because such identification both distorts and demeans it.” Kurland, The Private I: Some Reflections on Privacy and the Constitution, 10 U. Chi. REc. 107, 117 (1976). The Supreme Court itself has noted that its privacy decisions, “while defying categorical description, deal generally with substantive aspects of the Fourteenth Amendment.” Paul v. Davis, 424 U.S. 693, 713 (1976) (no privacy right invaded by distribution to local merchants of a flyer containing a mugshot of the plaintiff under the heading “Active Shoplifters”).
\textsuperscript{73} Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).
\textsuperscript{77} 410 U.S. at 213.
Electroconvulsive Therapy

...protect one's mental processes than to protect even the privacy of the marital bed.78

Recently, the Minnesota Supreme Court also stated that the administration of ECT to a nonconsenting patient infringes that person's privacy: "At the core of the [U.S. Supreme Court's] privacy decisions in our judgment, is the concept of personal autonomy—the notion that the Constitution reserves to the individual, free of governmental intrusion, certain fundamental decisions about how he or she will conduct his or her life."79 The court characterized the impact of a decision to receive ECT as "unquestionably great, for the result is the alteration of the patient's personality."80

The characteristic of ECT and other similar treatments that courts evaluate to determine whether the privacy right has been violated is "intrusiveness."81 In essence, intrusiveness measures the extent to which a treatment alters the behavior and thought processes of the patient. Because ECT can result in disorientation, memory loss or impairment of cognitive abilities,82 it is not surprising that such treatment has been characterized by one court as "one of the most intrusive forms of treatment."83 Thus, the effectiveness of consent to a highly intrusive treatment such as ECT must be more critically scrutinized than consent to other kinds of medical interventions since

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78. 2 Prison L. Rptr. at 477-78.
80. — Minn. at —, 239 N.W.2d at 911.
81. See Aden v. Younger, 57 Cal. App. 3d 662, 673, 129 Cal. Rptr. 535, 543 (1976); Kaimowitz v. Department of Mental Health, 2 Prison L. Rptr. at 478; Price v. Sheppard, — Minn. at —, 239 N.W.2d at 910-11. It is useful to examine the meaning of "intrusive" or at least to ascertain what constitutes an intrusive treatment. Intrusiveness in the psychiatric sense involves a physical interference with the patient for the purpose of altering his thought or behavior processes. As the term has been used, both physical and psychological invasion appear to be necessary for a treatment to qualify as being intrusive. Shapiro offers six criteria which make up the concept of intrusiveness:
   (i) the extent to which the effects of the therapy upon mentation are reversible;
   (ii) the extent to which the resulting psychic state is "foreign," "abnormal," or "unnatural" for the person in question, rather than simply a restoration of his prior psychic state (this is closely related to the "magnitude" or "intensity" of the change);
   (iii) the rapidity with which the effects occur;
   (iv) the scope of the change in the total "ecology" of the mind's functions;
   (v) the extent to which one can resist acting in ways impelled by the psychic effects of the therapy; and
   (vi) the duration of the change.
Shapiro, supra note 59, at 262. The alteration of mental process or "intrusion into one's intellect" triggers the protection of privacy. But one's mental processes can be altered by countless nonintrusive stimuli every day. Hence the physical component is necessary to distinguish volitional and nonorganic changings of the mind from those that will occur organically as a result of treatment administered without regard to the patient's desire. Id. See also id. at 257 n.53.
82. See notes 42-51 supra and accompanying text.
the effect of the bodily invasion is to reorder, subdue, alter, or blunt the individual's mental process. The California Court of Appeal recently recognized this facet of mind-altering treatment: "[W]e need not decide whether the decision to undergo medical treatment is deserving of constitutional protection in and of itself . . . because the right to privacy so clearly includes privacy of the mind." 84 Although the future course of the scope of the privacy right appears uncertain, 85 it appears that the right is sufficiently broad to protect nonconsenting patients from state-administered ECT. 86

85. For example, the Supreme Court recently upheld a Virginia statute criminalizing homosexual relations between consenting adult males. Doe v. Commonwealth's Attorney, 425 U.S. 901 (1976). The district court opinion characterized homosexuality as being "obviously no portion of marriage, home or family life." 403 F. Supp. 1199, 1202 (E.D. Va. 1975).
86. An alternative constitutional basis for finding a right to be free from unwanted medical treatment that is closely related to the privacy-right analysis is substantive due process. The close relationship between the two rationales is suggested in Justice Stewart's concurrence in Roe v. Wade:

"The Griswold decision can be rationally understood only as a holding that the Connecticut statute substantively invaded the "liberty" that is protected by the Due Process Clause of the Fourteenth Amendment. As so understood, Griswold stands as one in a long line of cases under the doctrine of substantive due process, and I now accept it as such." 410 U.S. 113, 168 (1973).

In the first third of this century, under the doctrine of substantive due process, the Supreme Court held unconstitutional state statutes that it characterized as "mere meddlesome interferences with the rights of individuals." Lochner v. New York, 198 U.S. 45, 61 (1905). The legislation invalidated under this application of the fourteenth amendment protection of life, liberty and property was primarily in the areas of economic and labor regulation. The theory of these decisions was that certain rights, specifically the freedom of contract and the right of private property, could not be intruded upon by legislative enactments passed under the state's police power. See Brown, Due Process of Law, Police Power, and the Supreme Court, 40 HARV. L. REV. 943 (1927). The Court seemed simply to substitute its own judgment about the wisdom of regulating certain subjects for that of the legislature.

Although the use of the theory declined in the late 1930s, see Olsen v. Nebraska ex rel. Western Reference & Bond Assn., 313 U.S. 236 (1941); Nebbia v. New York, 291 U.S. 502 (1934), the doctrine has been revived in several recent decisions. It has, for example, been used by the Supreme Court to invalidate the confinement of a mentally retarded person because of his incompetency to stand trial, see Jackson v. Indiana, 406 U.S. 715, 736-38 (1972), and the custodial confinement of persons not dangerous to themselves or others, see O'Connor v. Donaldson, 422 U.S. 563, 573-76 (1975). Lower courts have relied on substantive due process theory to protect institutionalized retarded persons from involuntary sterilizations, see Wyatt v. Adenholt, 368 F. Supp. 1583 (M.D. Ala. 1974), and to establish a right to treatment for civilly committed patients, see, e.g., Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), supplemental decisions, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 387 (M.D. Ala. 1972), affd. in part, remanded in part and rev'd. in part sub nom. Wyatt v.
B. State Administration of ECT to Competent Patients

1. The Strength of the State Interest in Forcibly Administering ECT to Nonconsenting Competent Patients

Although state administration of ECT to a nonconsenting competent patient infringes that individual's constitutional rights, the state may proceed if it can demonstrate a sufficient interest in treating the patient. The interference by government with certain personal rights normally requires only a rational relationship between the state's purpose and the state's act. However, if the right infringed has been deemed "fundamental," the state's action will not be sustained unless it can demonstrate a compelling or qualitatively greater interest. Under this approach, therefore, it is initially necessary to determine whether a patient's right to refuse electroconvulsive therapy is a "right" or a "fundamental right."

There appear to be no objective standards by which to judge whether a particular right is fundamental. Nevertheless, freedom of speech has been consistently declared fundamental. Moreover, the privacy guarantee extends only to those personal rights that have already been deemed fundamental. Since the right to refuse ECT is derived from these two rights, it is necessarily fundamental.

A recent decision of the Minnesota supreme court effectively demonstrates this method of constitutional analysis. In *Price v. Sheppard,* the court held that the state's administration of ECT to a fourteen-year-old patient without his consent and over the

Aderholt, 503 F.2d 1305 (5th Cir. 1974); Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974).

Substantive due process analysis is appropriate if the state's administration of ECT intrudes upon a property or liberty interest of the patient. It is conceivable that an individual may be deemed to possess a property right in the integrity of his mind. It is more likely, however, that a patient might be found to possess a liberty interest in his mental process. The Court held in *Grosjean v. American Press Co.* that "[the] word 'liberty' contained in [the fourteenth] amendment embraces not only the right of a person to be free from physical restraint, but the right to be free in the enjoyment of all his faculties as well." 297 U.S. 233, 244 (1936).

Justice Powell has stated that "the key to discovering whether education is 'fundamental' . . . lies in assessing whether there is a right to education explicitly or implicitly guaranteed by the Constitution." *San Antonio Indep. School Dist. v. Rodriguez,* 411 U.S. 1, 33 (1973). The usefulness of that standard was questioned by Justice Marshall who asked, "I would like to know where the Constitution guarantees the right to procreate, or the right to vote in state elections, or the right to an appeal from a criminal conviction." 411 U.S. 1, 100 (1973) (Marshall, J., dissenting) (citations omitted). It would seem that the classification actually derives from a prior judicial balancing of the importance of the individual's interest against the countervailing assertions of state authority.


90. — Minn. —, 239 N.W.2d 905 (1976).
objection of his mother violated the patient's right of privacy. The court said that, before forcing an unwilling patient to undergo ECT, the state must "demonstrate a legitimate and important state interest." It further stated:

[The right of privacy] is not an absolute one and must give way to certain interests of the state, the balance turning on the impact of the decision on the life of the individual. As the impact increases, so must the importance of the state's interest. Some decisions, we assume, will be of little consequence to the individual and a showing of legitimate state interest will justify its intrusion; other decisions, on the other hand, will be of such major consequence that only the most compelling state interest will justify the intrusion.

The court did not reach the question whether the administration of ECT to the plaintiff satisfied a sufficient state interest. It nevertheless expressed deep concern over the highly intrusive nature of this therapy. To prevent further intrusive treatments to nonconsenting patients, the court articulated a procedure that would henceforth require judicial determination of the necessity and reasonableness of nonconsensual ECT treatments.

It is submitted, however, that had the court in *Sheppard* reached the question of the strength of the state interest, it would have decided that state administration of ECT to nonconsenting competent patients fulfills no legitimate or sufficiently strong state interest. The only Supreme Court case that considers whether medical

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91. — Minn. at --, 239 N.W.2d at 911.
92. — Minn. at --, 239 N.W.2d at 910.
93. Citing *O'Connor v. Donaldson*, 422 U.S. 563 (1975), the court found for the defendant, arguing that "given the vagueness of the constitutional right of privacy, ... the defendant could not reasonably have known that the administration of electroshock treatments to [the plaintiff] violated a 'clearly established' constitutional right." — Minn. at --, 239 N.W.2d at 912.
94. The court adopted the following procedure:
   (1) If the patient is incompetent to give consent or refuses consent or his guardian other than persons responsible for his commitment also refuses his consent, before more intrusive forms of treatment may be utilized, the medical director of the state hospital must petition the probate division of the county court in the county in which the hospital is located for an order authorizing the prescribed treatment;
   (2) the court shall appoint a guardian ad litem to represent the interests of the patient;
   (3) in an adversary proceeding, pursuant to the petition, the court shall determine the necessity and reasonableness of the prescribed treatment.
   — Minn. at --, 239 N.W.2d at 913.
In making that determination, the court should balance the patient's need for treatment against the intrusiveness of the prescribed treatment. Factors which should be considered are:
   (1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment, (2) the risk of adverse side effects, (3) the experimental nature of the treatment, (4) its acceptance by the medical community of this state, (5) the extent of intrusion into the patient's body and the pain connected with the treatment, and (6) the patient's ability to competently determine for himself whether the treatment is desirable.
   — Minn. at --, 239 N.W.2d at 913 (footnote omitted).
treatment may be given to unwilling competent patients is Jacobson v. Massachusetts. In that case, the Court sustained a Massachusetts statute that required citizens to receive smallpox vaccinations. It was held that "the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand." In Jacobson, the public possessed a valid interest in reducing the risk of smallpox. No similar state interest is fulfilled by forcing ECT upon competent patients. The refusal to receive the treatment affects only the patient; there is no threat of a contagious disease that might endanger the public health. Thus, the conclusion reached in New York City Health and Hospital Corporation v. Stein is sound:

It does not matter whether this court would agree with her judgment [to refuse ECT]; it is enough that she is capable of making a decision, however unfortunate that decision may prove to be. It is her own well being that is at stake, and, giving effect to the spirit of [the statute], she must be permitted to consent or withhold her consent.

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95. 197 U.S. 11 (1905).
96. 197 U.S. at 29.
97. 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972).
98. 70 Misc. 2d at 947, 335 N.Y.S.2d at 465. See Cantor, A Patient's Decision To Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 Rutgers L. Rev. 228, 263 (1973).

The right to refuse medical treatment has been upheld in decisions that declined to order lifesaving blood transfusions for Jehovah's Witnesses who refused them. In In re Brooks, the Illinois supreme court held that the free exercise of religion could be restricted by the state only "where such exercise endangers, clearly and presently, the public health, welfare or morals." 32 Ill. 2d 361, 372, 205 N.E.2d 435, 441 (1965). The court refused to intervene even though it acknowledged that the patient's decision might be regarded as "unwise, foolish or ridiculous." 32 Ill. 2d at 373, 205 N.E.2d at 442. Also, in In re Osborne, 294 A.2d 372 (D.C. Ct. App. 1972), the District of Columbia Court of Appeals found no compelling reason to override the refusal of a transfusion by a religiously motivated patient. The Brooks and Osborne result was reached in Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962), but on different grounds: the patient's refusal of a transfusion was respected on the grounds of individual autonomy and not religious belief. The court stated: "[i]t is the individual who is the subject of a medical decision who has the final say . . . . [t]his must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires." 44 Misc. 2d at 28, 252 N.Y.S.2d at 706.


For the most part, those cases in which the patient's decision was overridden were
The Supreme Court has acknowledged in other contexts as well that the discretion to exercise certain personal rights must rest upon the individual alone. In *Farretta v. California,*[99] for example, the Court held that a criminal defendant could proceed *in propria persona* so long as his waiver of the sixth amendment right to counsel was made knowingly and intelligently. Although the Court agreed

emergency situations where the patient was not competent at the time the treatment was required to save his life. See, e.g., Application of President & Directors of Georgetown College, Inc., 331 F.2d at 1008. Arguably, these cases should be analogized to ECT and incompetents, see text at notes 131-43 infra, in which context it is argued that the state may have a sufficient interest in ordering the treatment. Usually, where the patient is fully competent and is making a voluntary and knowing decision, and no third party—such as a child-dependent—will unduly suffer, the patient's wishes are respected. These latter cases support the conclusion that competent patients should be allowed to refuse ECT.

It should be noted, however, that the desire of a patient who, though incompetent at the time of transfusion, had previously indicated by means of a release card carried in the wallet, or the testimony of his family, that no blood was ever to be administered to him, has not always been treated as having expressed his will. See *Paris,* supra, at 3. This argument assumes that an individual who has given such a "prior refusal" would, if competent, revoke it when actually confronting imminent death. However, the commentators and courts that adopt this view have been subject to increasing attack. See, e.g., *Cantor,* supra, at 242-54. Cantor does acknowledge that the patient's refusal could be overridden if the result were to inflict "legally cognizable harm" on third persons but finds the traditionally protected harms to others (grief of family, economic loss to relatives, economic burden on state, stress to physicians) not sufficient. *Id.* at 249-54.

Finally, even if one accepts the view that the state can require blood transfusions in any case, notwithstanding the patient's refusal, it does not necessarily follow that the state may override a patient's refusal in the ECT context. Unlike the need for blood, for which there is rarely a less drastic alternative, ECT is rarely required immediately. The American Psychological Association has stated that

most psychiatric emergencies . . . can usually either be anticipated or initially handled without the use of somatic treatments such as electro-convulsive treatment. For example, homicidal or suicidal patients may be well handled in protected settings for brief periods of time via, if necessary, physical isolation techniques which deny the patient access to any potential weapons.


Thus, the blood transfusion case most analogous to the ECT problem is *In re Green,* 448 Pa. 338, 292 A.2d 387 (1972), where the court respected the religious beliefs of the parents, and refused to order a transfusion for a minor child in a situation not involving an imminent threat to life. That analysis is the more appropriate one for the ECT context. One could, of course, argue that *Green* is incorrect. In that case, the surgery that the parents did not allow their child to receive would have probably allowed him to walk again; postponing the surgery would risk rendering him permanently bedridden. Arguably, the state has a sufficient interest in the well-being of its citizens to override such a parental choice. However, even if *Green* were so decided, the situation of ECT can be easily distinguished.

Unlike the surgery contemplated in *Green*—and unlike the medical treatment contemplated in all of the transfusion cases—there is no assurance that ECT will benefit the patient and there is a substantial risk of complications. Because there is not nearly the expected benefit from such treatment, the state arguably lacks a substantial enough interest to compel ECT.

that a defendant would usually receive a better defense with the
guidance of counsel, it nevertheless concluded:

Personal liberties are not rooted in the law of averages. The right
to defend is personal. The defendant, and not his lawyer or the
State, will bear the personal consequences of a conviction. It is the
defendant, therefore, who must be free personally to decide whether
in his particular case counsel is to his advantage. And although he
may conduct his own defense ultimately to his own detriment, his
choice must be honored out of "that respect for the individual which
is the lifeblood of the law."100

2. Consent as Waiver of Constitutional Rights

Medical treatment administered without the consent of the patient
is likely to constitute a battery.101 With regard to state adminis-
tration of ECT, the consent must, in addition to making an otherwise
impermissible touching privileged, amount to a waiver of the
patient's constitutional rights. Without such a waiver, the treatment,
in the absence of a sufficient state interest, is unconstitutional.

The standard for waiver of constitutional rights has received the
greatest attention in the context of the criminal law. In 1938, the
Supreme Court, when sustaining the waiver of counsel in a federal
trial, defined waiver as "an intentional relinquishment or abandon-
ment of a known right."102 Since then, the Court has upheld the
criminal defendant's waiver of rights in a variety of contexts.103
Because of the importance of these rights, the Court has insisted that
certain requirements be met to ensure the validity of the waiver. In
Brady v. United States, the Court declared that "[w]aivers of con-
stitutional rights not only must be voluntary but must be knowing,
intelligent acts done with sufficient awareness of the relevant cir-
cumstances and likely consequences."104

Thus, the three elements of a valid waiver appear to be competence,
knowledge and voluntariness. It is apparent that informed

100. 422 U.S. at 834 (citations omitted, emphasis added).
101. Consent is the mechanism by which the patient grants the physician permission
to invade his person for the purpose of treatment. W. Prosser, supra note 54, at 101. Thus, informed consent distinguishes legally permissible medical interventions from those that would subject a doctor to liability on either a battery or negligence theory. See, e.g., Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); Bonner v. Moran, 126 F.2d 121, 122-23 (D.C. Cir. 1941); Waltz & Scheuneman, Informed Consent to Therapy, 64 NW. U.L. REV. 628 (1969); Note, Informed Consent in Medical Malpractice, 55 CALIF. L. REV. 1396, 1399-400 (1967); Note, Restructuring Informed Consent, 79 YALE L.J. 1533, 1538 n.4 (1970).
consent and waiver involve "essentially comparable standards"; accordingly, if a patient's consent to ECT is informed, it constitutes a valid waiver of the constitutional rights that nonconsensual treatment would violate. In most medical procedures, the process of giving or withholding consent is "private"—that is, the attending physician, based on his consultation with the patient, determines whether the patient consents to proposed treatment. The physician's judgment is questioned only if the patient or his representative later sues him, alleging that a necessary element of informed consent was absent. In the context of state administration of ECT, the unique situation of the institutionalized mental patient makes it extremely unlikely that truly informed consent will be given. Yet the manner in which the existence of informed consent of institutionalized mental patients is currently ascertained poses the danger that consent will nevertheless be proclaimed by persons administering ECT. Consequently, further safeguards of patients' constitutional rights must be developed.

Competence, the first of the three elements of informed consent, is "the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information." The tendency of some individuals—particularly medical professionals—to consider all mental patients legally incompetent reflects a gross misunderstanding; indeed, it is well settled that a person should not be deemed incompetent solely because he is hospitalized or is receiving psychiatric treatment. This principle has been codified by several states, and courts have specifically recognized that a person who has been civilly committed is not incapable of making decisions in all areas of his life. For example, one court held unconstitutional a Connecticut statute that made the state commissioner of finance conservator of the funds of all residents of

106. See Shapiro, supra note 59, at 280-81.
107. For example, a patient who is left unexpectedly paralyzed following surgery might sue his physician for nondisclosure of a risk of the procedure, alleging that had he been more fully informed he would not have consented. See Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).
108. Difficulties presented by the physician's control over major aspects of a patient's consent may not be confined solely to the setting of psychiatric treatment. A strong argument has been made that, in most current medical transactions, physicians have become "increasingly susceptible to pressures which may conflict with the interests of [their] immediate patients" so that a profession-wide system of underdisclosure has developed. Schneyer, supra note 7, at 127.
109. Kaimowitz v. Department of Mental Health, 2 Prison L. Rptr. at 476.
mental institutions whose assets totalled less than $5000. The court considered this procedure violative of the patient's due process rights because no hearing had been held to determine whether the patient was capable of managing his own financial affairs.¹¹²

Thus, some patients will be sufficiently competent to form their own judgment about whether to consent to ECT. Many others, however, will indeed be incapable of giving informed consent. A number of psychiatric disorders prevent the patient either from understanding the nature of any treatment or, because of the patient's confusion or agitation, from articulating a choice about whether to receive it. In fact, one court has identified institutionalization itself as a factor that impairs the patient's competence, on the theory that involuntary institutional confinement strips him of the sense of his own mental integrity and self worth.¹¹³ Surely such patients should not be deemed competent to give informed consent to ECT.

A difficult problem that threatens the efficacy of constitutional waiver requirements, however, is the inability of the treating physician to make an unbiased determination of the patient's competence. In most kinds of medical treatment, the physician himself decides whether the patient is competent and thereby capable of giving consent. When the physician who recommends ECT is an ardent believer in the utility of that type of therapy, he may be more inclined to find the patient competent because that result would allow him to pursue the course of treatment he deems best for the patient.¹¹⁴ Since a competent patient can consent to and then undergo intrusive mental treatments, some sort of review mechanism is necessary to ensure that the patient whom the physician declares capable of giving consent is actually competent.

The second element of informed consent is knowledge. For consent to be effective, it must be given knowingly; "uninformed consent" is tantamount to no consent at all.¹¹⁵ However, the extent to which a physician must disclose the nature and risks of a proposed treatment has been vigorously debated. Many jurisdictions have adopted the rule that a doctor has the duty to reveal such information as would be disclosed by a doctor in good standing within the medi-


¹¹³ See Kaimowitz v. Department of Mental Health, 2 Prison L. Rptr. at 433. But see Murphy, Total Institutions and the Possibility of Consent to Organic Therapies, 5 HUMAN RIGHTS 25 (1977) (institutionalization per se should not bar the inmate's ability to consent).


This standard has been severely questioned and has been rejected in several states. Most of these states have embraced the standard that a doctor has a duty to disclose what the reasonable patient needs to know to make an intelligent decision about whether to undergo treatment. As the California supreme court held in *Cobbs v. Grant*:  

"The patient's right of self-decision . . . can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communication to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision."  

This approach rejects the so-called therapeutic privilege that allows the physician to withhold information if he believes its disclosure would be medically or psychologically harmful to the patient. The privilege is based on the assumption that revealing certain risks to the patient might unnecessarily frighten him and cause needed treatment to be refused. Persuasive evidence exists, however, that a majority of patients want to know what complications should be expected and that the risk of overdisclosure is exaggerated.

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119. 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).
122. One psychiatrist states that the profession is unduly concerned with alarming patients by overdisclosure: "We regularly see our neurotic and even psychotic patients rise to the occasion when confronted with reality stress and exercise remarkably sound judgment. Neuroses are born of irrational anxieties, not reality based fears." Modlin, *Informed Consent: Mandate or Myth*, MEDICAL INSIGHT REPRINT (May 1972). In fact, one study reports that patients with clear ideas about the nature of the treatment show greater improvement than uninformed patients. See Park, Covi & Uhlenhuth, *Effects of Informed Consent on Research Patients and..."
Both the nature of the information disclosed and the method of disclosure have traditionally been left to the discretion of the treating physician. Although strong pressures for underdisclosure exist in medical practices generally, these pressures are particularly acute in the context of ECT and other mental treatments. These medical practitioners assume that their patients need mental treatments and are therefore particularly reluctant to disclose information that may cause the patient to refuse it. Where the "community standard" rule for disclosure is in effect, underdisclosure to mental patients is, unfortunately, a protected practice. Even under the Cobbs rule, however, it appears that additional safeguards may be necessary to ensure adequate disclosure.

Of the three elements of informed consent, voluntariness is perhaps the most problematic from the point of view of protecting patients' rights. Many commentators have observed that a certain amount of coercion is inherent in any doctor-patient relationship. The superior knowledge, expertise, and authority of the physician places him in an advantageous position in dealing with his patient. Moreover, the patient may be psychologically dependent on the physician and therefore unable to weigh the risks and benefits of a proposed treatment. These factors tend to impede the voluntariness of the patient's consent.

Study Results, 145 J. NERVOUS & MENTAL DISEASE 349, 349-57 (1967). Fuller disclosure may also inure to the patient's physical as well as psychological well-being. Schneyer points out that a patient often possesses information relevant to treatment decisions of the physician and that the patient may be unaware of the importance of such information for a treatment decision until the physician has disclosed certain data. See Schneyer, supra note 7, at 134.

123. Tensions within the doctor-patient relationship may result in significant underdisclosure of medical risks and alternatives. See Schneyer, supra note 7, at 136-41. In addition, increased third-party payment of medical bills has "blunted patients' pecuniary bias against costly treatment alternatives." Id. at 138-40. That such tensions may result in a decision-making bias toward underdisclosure has been explained in part by two aspects of the provision of medical services:

First, the physician traditionally functions both as the manager of the patient's case who determines or at least recommends what mix of goods and services would best serve the patient's needs, and as a supplier who stands to benefit from the provision of only some of these inputs. Second, the inherently uncertain outcomes of alternative treatments may afford the physician a number of recommendations that can be made in good faith. Therefore, biases, pecuniary or otherwise, could influence treatment recommendations. Id. at 136-37. Such biases may affect not only the amount of disclosure but also the method and timing of disclosure. See Capron, supra note 7, at 379. If disclosure occurs immediately before the treatment, it may suggest to the patient and to the hospital staff itself that obtaining consent is something of a formality—that there can be little expectation of refusal since so much preparation for the surgery has already occurred. California tries to reduce these effects by requiring 24 hours between the physician's disclosures and the signing of consent. See CAL. WELF. & INST. CODE. § 5326.3(d) (West Supp. 1976).


125. See Capron, supra note 7, at 386.
No one seriously contends, of course, that the existence of these factors is sufficient by itself to render consent ineffective in the usual doctor-patient relationship. The difficulty in the context of ECT and similar intrusive treatments, however, is that these pressures are particularly acute. The nature of the coercion may be so intense that no involuntarily confined patient may truly be able to give informed consent. As observed by the court in *Kaimowitz v. Department of Mental Health*:

The involuntarily detained mental patient is in an inherently coercive atmosphere even though no direct pressures may be placed on him. He finds himself stripped of the customary amenities and defenses. Free movement is restricted. He becomes a part of communal living subject to the control of the institutional authorities. . . . Indirect and subtle psychological coercion has a profound effect upon the patient population. Involuntarily confined patients cannot reason as equals over whether they should undergo psychosurgery. They are not able to voluntarily give informed consent because of the inherent inequality in their position.129

Further, it is by no means certain that voluntarily hospitalized patients are immune from the pressures placed on involuntary patients. Studies have shown that mental patients are sometimes classified as “voluntary” for merely failing to protest hospitalization.127 Moreover, the classification may hide various forms of familial and official coercion.128 Once hospitalized, the patient is subjected to the same kinds of institutional pressures that face the involuntary patient.129 Even though a patient is considered to have been voluntarily committed, this does not assure that his consent to mental treatments is always voluntarily given.130

C. State Administration of ECT to Incompetent Patients: The Strength of the State Interest

Although it is true that many patients in mental institutions have

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126. 2 Prison L. Rptr. at 477. For a discussion of the inability of institutionalized patients to consent voluntarily, see Burt, *Why We Should Keep Prisoners from Doctors*, 5 HASTINGS CENTER REPORT 25, 27 (1975).


128. See Ellis, supra note 127; Gilboy & Schmidt, supra note 127.


130. The court in *Aden v. Younger* found that the classification of mental patients, both voluntary and involuntary, was rationally related to the law’s objective of insuring that certain medical procedures not be performed on unwilling patients. 57 Cal. App. 3d at 673, 129 Cal. Rptr. at 542.
the capacity to make rational decisions for themselves concerning whether to undergo intrusive treatments, many other patients—perhaps a majority—do not possess that capability. The predicament of these patients poses problems distinct from those that occur when a competent patient is involved.

As discussed earlier, in order to infringe a fundamental constitutional right, the state must demonstrate a compelling state interest. An early Supreme Court case that directly addressed the question whether the state could unilaterally administer medical procedures to incompetent patients was *Buck v. Bell*. The Court found "[t]he principle that sustains compulsory vaccination [to be] broad enough to cover cutting the Fallopian tubes," and therefore upheld a Virginia statute that provided for the sterilization of incompetents. Protecting the public welfare was considered to justify sterilization: Society would benefit financially because many sterilized incompetents could be released from the state hospital, thereby saving the state the cost of their care. Justice Holmes delivered the Court's opinion:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence.

Yet it is not self-evident that the state possesses what would now be considered a substantial interest in treating incompetent patients. The monetary considerations approved in *Buck* have been undercut by *Shapiro v. Thompson*:

In order to demonstrate a compelling interest, the state must "do more than show denying welfare benefits to new residents saves money." Since the rights infringed by ECT are of a fundamental stature, the possible savings engendered by curing patients is not by itself sufficient to justify the intrusion. Similarly,
the desire to rid society of incompetence has little strength. In *O'Connor v. Donaldson*, the Court framed the issue as follows:

May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.138

If the state cannot incarcerate to limit the number of incompetents in society, it follows that the state may neither sterilize nor impose other treatments upon mental patients for the same purpose.

Thus, the interests articulated in *Buck* that sustained a forcible medical intervention upon an incompetent patient are no longer thought to have substantial weight and would probably not sustain administration of ECT upon an incompetent individual. However, the sterilization procedure approved in *Buck* can be distinguished from ECT in an important regard. Sterilization is not a "curative" treatment, while ECT is intended to improve the mental well-being of the patient. That the state has a valid interest in providing care and assistance to protect the health, welfare, and safety of its citizens under the *parens patriae* doctrine is well settled.139 This interest may well be strong enough to justify requiring ECT for certain patients. In fact, this was the holding of *Price v. Sheppard*:

The state's interest in assuming the decision [whether a patient receives ECT] is in acting as *parens patriae*, fulfilling its duty to protect the well-being of its citizens who are incapable of so acting for themselves. Under the circumstances of this case, that interest can be articulated as the need for the state to assume the decision-making role regarding the psychiatric treatment for one who, presumptively, based on the fact of commitment on the ground of mental illness, is unable to *rationally* do so for himself. If that interest of the state is sufficiently important to deprive an individual of his physical liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision. We hold that it is.140

The rationale for this holding is relatively simple: The state acting as *parens patriae* may commit an individual who lacks the capacity to make a rational decision about whether to undergo hospitalization. Inherent in this determination is the judgment that such an individual can be forced to accept treatments. Otherwise, the individual could frustrate the state's purpose in hospitalizing him.141

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139. 422 U.S. at 574.
140. — Minn. at —, 239 N.W.2d at 911 (footnote omitted, emphasis original).
The difficulty with this position is that it presumes a mental patient, who has been incarcerated through the legal process, to be unable to make virtually any decision for himself. As a general rule, the state may not incarcerate an individual for custodial purposes only; hence, all involuntarily committed patients are presumed to need some form of treatment. It does not follow, however, that such patients are in need of highly intrusive treatments. In many cases, for example, counselling may be wholly sufficient. The fact of incarceration should not create a presumption that the patient loses all of his rights. A better approach, the nature of which is explained below, would recognize that an adjudicatory hearing is required before ECT may be administered to an incompetent patient. Yet with the primary conclusion of the court in Sheppard there can be little dispute: The state has a valid interest in the health of its citizens and may infringe certain rights of the individual in order to preserve or attain their well-being.

Because incompetent patients lack the capacity to give informed consent, which is a prerequisite of medical treatment, many states have passed legislation specifying how substitute consent may be given. Sometimes “consent” is given by personal representatives of the patient, such as a relative or guardian, but more often it is provided by the state, through a doctor in a state institution or some other mental health authority who prescribes the treatment for the patient. Yet it should be clear that the state cannot waive or take away certain rights of its citizens without due process. Hence an adjudicatory hearing, after which a court may approve treatment, is the appropriate means of establishing substitute consent. The next portion of this Note will argue that this procedure, which is not always followed, is actually required by the Constitution.

D. Pretreatment Review of the Decision to Administer ECT

In the case of incompetent patients, there is no effective check on the discretion of medical practitioners, in the absence of legislation, to decide whether a particular treatment is the least drastic alternative or even whether it is necessary at all. It is also apparent that the present method of securing a competent patient’s consent does

142. The Court expressed its holding in O’Connor v. Donaldson as follows: “In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.” 422 U.S. at 575. Thus, the Court left open the possibility that a competent person might be confined for custodial purposes in certain circumstances, such as if he cannot survive by himself and has no one to lend him assistance. For example, the state may commit an aged individual with no means of support even though that person is legally competent.

143. See notes 166-67 infra and accompanying text.
not adequately ensure that the consent is knowingly and voluntarily given. Medical practitioners, often unable to give an objective evaluation, usually have complete discretion to decide whether a patient is competent to refuse treatment; it is all too likely that competent patients will be treated as incompetents and will receive intrusive treatments without their consent. Although prohibiting ECT altogether has some proponents, such an approach ignores the needs of those patients for whom ECT is the last treatment alternative. Instead, given the significance of the constitutional rights involved, the magnitude of the dangers posed by ECT, the existence of several factors that impair the ability of a competent person to withhold consent, and the peculiar circumstances of incompetent patients, ECT should not be administered by the state without the approval of a review panel. In the absence of legislation, some courts have promulgated such a safeguard.

1. Review of the Decisions of Competent Patients

In the context of the treatment of competent patients, such an approach would have several advantages. It would help prevent patients whose "consent" has been coerced, either directly or indirectly, from receiving treatment. It would relieve the administering physician of the power to make decisions in those cases where he has a conflicting interest that urges him to declare incompetency. By providing a check on unilateral treatment decisions by the physician, a review mechanism might, in a few cases, even diminish the impact of the numerous coercive forces affecting the patient that render informed consent an inadequate safeguard of the patient's rights. Still, the mechanism's principal advantage is that it would prevent ECT in some situations where the coercive factors are so strong that consent cannot be freely given.

Because all medical treatment is to some degree a physical and psychological intrusion upon an individual, and because there are potential problems with competency, knowledge, and voluntariness in any doctor-patient relationship, it could be argued that a review mechanism is necessary before any person can receive any medical treatment. See T. DETRE & H. JARECKI, supra note 21, at 636. It is, on the other hand, not sensible to abandon the informed consent requirement completely. Allowing the doctor to do whatever good medical practices dictate when the patient is incapable of consenting has been characterized as confusing "medical procedures for the benefit of the patient's health (which the medical profession is capable of assessing) with the patient's interest in the integrity of person or personality (which is a question of liberty and is not susceptible to medical judgment)." Jacob, The Right of a Mental Patient to His Psychosis, 39 Mod. L. Rev. 17, 36 (1976).

144. See text at notes 125-26 supra.
treatment. Even if such an approach were thought desirable, only a few kinds of treatment—such as ECT or psychosurgery—are so intrusive that constitutional rights are invaded. Moreover, mental patients deserve special protection not needed by other patients for several additional reasons. First, the problem of obtaining informed consent is greater with institutionalized patients than with noninstitutionalized individuals. It is far more likely that patients incarcerated for mental problems are legally incompetent. Patients are generally less familiar with the risks of ECT and other mental treatments than with the risks of treatments for nonmental illnesses and, as noted earlier, institutionalized persons are more susceptible to coercion. Second, mental patients are more likely to receive medical treatment without their consent being solicited than are physically ill patients. This results in part from the mistaken view that a patient who is unable to make a rational judgment about whether to be hospitalized, and who must therefore be involuntarily committed, is not capable of making treatment decisions for himself. Finally, the inadequacy of tort remedies makes a pre-treatment review mechanism desirable. Although it is certainly not easy to compensate a patient for a physical injury such as an unauthorized tonsillectomy, it would be even more difficult to compensate a person for permanent memory loss or serious impairment of his mind. Where damage remedies are hopelessly inadequate, courts have fashioned other mechanisms—often procedural—to protect constitutional rights. Yet injunctive remedies are not realistic safeguards. Mental patients almost invariably lack quick access to a lawyer when treatment is proposed. Some patients may not even be competent. Others who desire the treatment will likely not sue even though their consent was directly or indirectly coerced.

The suggestion that a protective mechanism is constitutionally required because certain factors prevent an individual from knowingly and voluntarily waiving his rights is not a novel legal

146. The scope of such constitutional protection would probably depend on the scope, heretofore undefined, of the privacy right. It is conceivable that any touching could be protected by such a right, although such an interpretation seems unlikely.

147. See notes 125-26 supra and accompanying text.

148. The Minnesota Supreme Court has fallen into this trap: "The interest can be articulated as the need for the state to assume the decision-making role regarding the psychiatric treatment for one who, presumptively, based on the fact of commitment on the ground of mental illness, is unable to rationally do so for himself." Price v. Sheppard, — Minn. —, 239 N.W.2d 905, 911 (1976) (footnote omitted, emphasis original). See R. Rubenstein & H. Lasswell, The Sharing of Power in a Psychiatric Hospital (1966).

149. For example, the inadequacy of civil suits to protect against unreasonable searches led to the exclusionary rule. See Mapp v. Ohio, 367 U.S. 643, 651-52 (1961).

argument. Particularly in the criminal law setting, courts have often ordered the creation of special safeguards when constitutional rights are endangered. In at least two situations—in-custody police interrogation and the assertion of a guilty plea—the Supreme Court has found mechanisms that ensure voluntary consent to be constitutionally required.

In *Miranda v. Arizona*, the Court concluded that the pressures surrounding in-custody interrogation can very easily overbear the will of the suspect. Finding such compulsion to be inconsistent with the suspect's fifth amendment right against self-incrimination, the Court reasoned that adequate protective devices were necessary to dispel the compulsion, and therefore held that all statements obtained during in-custody interrogation were inadmissible unless certain procedural safeguards were followed. These constitutionally required safeguards included the *Miranda* warnings, which provided the suspect with both the knowledge of his rights and the opportunity to have counsel present. Through this procedure, the Court sought to assure the voluntariness of any waiver of fifth amendment rights.

A similar situation exists in the context of intrusive mental treatments. A review committee is necessary both to give the subject knowledge of the risks involved with ECT and of his right to refuse it, and to provide a third party who will help dispel the inherent coerciveness of the institutional environment. Using the *Miranda* rationale, no invasion of rights should be allowed and no consent recognized unless the procedural safeguard of submission to a review committee is followed.

One difficulty with this analogy is that the suspect in *Miranda* was merely given the opportunity to consult with the third party. The Court did not find the in-custody atmosphere so coercive that the the suspect could not knowingly waive his rights. Thus, a literal application of *Miranda* to intrusive mental treatments would require only that the physician inform the patient of the risks of ECT, of his right to refuse consent, and of his right to speak with the review committee. However, such a procedure is not sufficient to protect the constitutional rights of a mental patient. A person who challenges the validity of his consent to in-custody interrogation is able to do so before he is sentenced to prison and hence before the

152. 384 U.S. at 469.
154. 384 U.S. at 458.
155. 384 U.S. at 444-45.
full weight of the constitutional deprivation is felt. In contrast, a
patient cannot challenge the validity of his consent to ECT until
after he has received the treatment and his constitutional right (not
to have any mental alteration) has been irrevocably infringed. Thus,
the decision to receive ECT arguably deserves even greater scrutiny
than the decision to consent to in-custody interrogation. Moreover, whether the person who is waiving his rights is actually compe-
tent to do so is more often a problem with mental patients than with
criminal suspects.

A second area where the Court has created safeguards against the
uninformed waiver of rights involves the guilty plea. Since the
assertion of a guilty plea waives the privilege against self-incrimi-
nation, the right to trial by jury, and the right to confront one's accusers, the plea must be made voluntarily and with full under-
standing of its significance. However, as the Supreme Court has
noted, "ignorance, incomprehension, coercion, terror, inducements,
[or] subtle or blatant threats" may prevent the defendant's waiver
from being effective. Thus, the Court has required that judges
make certain inquiries to determine whether the waiver has, in fact,
been voluntarily made. Moreover, to provide further protection
against involuntary waivers, the Court has decided that certain
"prophylactic procedures" must be followed before a person's guilty plea is considered valid: The record must disclose the facts
that caused the trial judge to conclude that the defendant entered
his plea voluntarily and with understanding. Thus, the Court has
given an individual who may lack the ability to make a knowing and
intelligent decision about whether to plead guilty the benefit of
various mechanisms that help prevent the involuntary waiver of
important constitutional rights.

157. Usually the patient who contests consent will do so in a tort action following
the administration of ECT. Thus, the analogy to Miranda would be complete only if
a criminal defendant could not challenge a police claim of consent except in a tort action after he had been convicted, sentenced, and served his time.


159. 395 U.S. at 242-43.


162. 395 U.S. at 244.

163. Similarly, the right to counsel at lineups can be seen as a constitutionally mandated mechanism to "preserve the defendant's basic right to a fair trial as affected by his right meaningfully to cross-examine the witnesses against him." United States v. Wade, 388 U.S. 218, 227 (1967). See Grano, Kirby, Biggers and Ash: Do Any Constitutional Safeguards Remain Against the Danger of Convicting the Innocent?, 72 Mich. L. Rev. 719, 755-59 (1974). In addition, in Johnson v. Avery, 393 U.S. 483 (1969), the Supreme Court prohibited the states from barring inmates from providing assistance to one another in the preparation of post-conviction relief petitions unless the state provided a reasonable alternative to assist in the preparation.
While requiring certain procedures to safeguard constitutional rights, the Court has not insisted that any specific measures be used. For example, the Court in *Miranda* stated that the procedural safeguards elucidated therein were required unless other fully effective means are devised to inform accused persons of their right of silence and to assure a continuous opportunity to exercise it. Thus, it is not suggested here that any particular type of procedure for evaluating consent to ECT must be adopted; review mechanisms for other medical treatments vary widely in form. At the very least, however, some effective review mechanism appears to be constitutionally required.

2. **Review of the Decision to Administer ECT to an Incompetent Patient**

In the context of the treatment of incompetent patients, a review mechanism possesses compelling advantages. It was previously noted that the holding in *Price v. Sheppard*—that an individual who is committed is not capable of making a decision about whether to undergo treatment—could cause patients who do possess such a capacity to undergo intrusive treatments against their will. A separate adjudicatory hearing on the question of treatment would prevent this result.

For purposes of economy, this decision could be made during the commitment hearing, but the decision to impose intrusive treatments must be considered apart from the commitment decision itself. Such an approach would effectively protect the constitutional rights of the patient: The hearing that decides whether the state may commit considers the individual's liberty interests, and the hearing that decides whether to impose intrusive treatment considers the individual's free expression and privacy rights. It might be argued that the tenuousness of the distinction between intrusive and nonintrusive treatment will hinder this approach by making it difficult to know whether the second hearing is required. This is not, however, a problem for the regulation of ECT. Its certain risks of harm and its profound impact on the mental process render it highly intrusive; thus, the state should be required to show a compelling interest before administering ECT to an incompetent.

In addition to determining whether the patient is incapable of deciding whether to undergo such treatment, the second hearing

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164. 384 U.S. at 467.
165. "Effective" review might preclude determinations by the treating physician himself or by a colleague. "Effective" might require that determinations and supporting data be recorded.
166. *See* note 148 *supra*. 
ensures that the treatment is actually necessary and that all less intrusive alternatives have been considered. The court would not evaluate the therapeutic value of the treatment itself; rather, the court would balance the seriousness of the patient's condition against the treatment's intrusiveness, thereby ensuring that ECT is the least drastic alternative.

Although the holding of the Minnesota Supreme Court in *Price v. Sheppard* is subject to criticism, the practical effect of the decision is wholly consistent with the analysis above. At the conclusion of the opinion, in response to its concern over the broad discretion of treating physicians in ordering therapy for nonconsenting patients, the court outlined a procedure that would, in fact, determine whether the patient was competent and whether the treatment was necessary. The court specified that, in the future, the medical director of the state hospital must petition the probate division of the county court for an order authorizing treatment. The court would then appoint a guardian ad litem to represent the patient, and, in an adversary proceeding, the court would determine the necessity and reasonableness of the prescribed treatment. Such an approach is desirable to determine whether the state has a sufficient interest to justify imposing ECT, a very drastic treatment, upon the patient.

3. Summary

Pretreatment review of the decision of the state to administer ECT to a patient would most likely be sought in the same manner in which most mental health rights have been secured. A patient-plaintiff or his representative, perhaps representing a class, would sue a particular governmental entity, such as a state department of health, for violation of his constitutional rights. In addition to granting the plaintiff individual relief, the court could order the state, as it did in *Sheppard*, to obtain consent prior to the administration of ECT and to establish a review mechanism to ensure the validity of the consent of a competent patient or the necessity of giving the treatment to an incompetent patient.

The effectiveness of this approach is, of course, not without limitations. Mental patients are generally not litigious; their awareness of their legal rights is often minimal and their access to legal services is often negligible. Moreover, the class of mental patients protected when the court's order is based on constitutional grounds is restricted by the state action requirement; voluntary patients in private hospitals would be excluded. Finally, any judicially

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167. — Minn. at —, 239 N.W.2d at 913.
169. See note 55 supra.
ordered protections may well be minimal in scope. Such safeguards in the field of mental health are often difficult to implement and enforce.\textsuperscript{170} Court supervision is time-consuming and burdensome, and the sanction of contempt may be inadequate to ensure compliance.\textsuperscript{171}

While litigation will probably result in the establishment of certain basic safeguards, a broader strategy may be needed for more comprehensive protection of patient rights. Legislative regulation of ECT is advantageous since statutory requirements and standards are not restricted by the state action limitation. Also, legislation can be more comprehensive in scope than case-by-case adjudication. It is to this type of regulation of ECT that this Note now turns.

III. LEGISLATIVE REGULATION OF ECT

It is well recognized that the power of a state to protect the health and safety of its citizens is vested in the legislature.\textsuperscript{172} This "police power" has been described as extending "to the protection of the lives, limbs, health, comfort, and quiet of all persons."\textsuperscript{173} In accordance with this power, states have licensed physicians,\textsuperscript{174} have regulated the administration of drugs by medical practitioners,\textsuperscript{175} and have regulated conditions in which medical and psychiatric treatments are provided.\textsuperscript{176} Legislatures in several states have also enacted statutes that monitor the administration of ECT.\textsuperscript{177} It is appropriate now to explore the constitutionality and desirability of these statutes.


\textsuperscript{171} See Wyatt v. Hardin, No. 3195-N (M.D. Ala., Feb. 28, 1975) (contempt proceedings unsuccessfully brought against three physicians and the hospital director).

\textsuperscript{172} For a discussion of the exercise of police power in areas where the state seeks to protect the citizen from himself, see Cantor, supra note 98, at 246-49 (1973), and Note, Motorcycle Helmets and the Constitutionality of Self-Protective Legislation, 30 Ohio St. L.J. 355 (1969).

\textsuperscript{173} Thorpe v. Rutland & Burlington R.R., 27 Vt. 140, 149 (1854).


\textsuperscript{175} Blinder v. State Dept. of Justice, 25 Cal. App. 3d 174, 181-82, 101 Cal. Rptr. 635, 640 (1972). In United States v. Moore, 423 U.S. 122 (1975), the Supreme Court held that a physician registered under the Controlled Substances Act, 21 U.S.C. §§ 801-904 (1970), as amended by 21 U.S.C. §§ 801-904 (Supp. V 1975), could be prosecuted under the Act if his activities fell outside the usual course of professional practice. The Court found that the doctor had acted as a large-scale pusher by dispensing methadone without adequate examination of the patient and by graduating his fees according to the number of pills prescribed rather than medical services provided.

\textsuperscript{176} See, e.g., CAL. HEALTH & SAFETY CODE §§ 1203-1554 (West Supp. 1976).

\textsuperscript{177} See note 4 supra.
A. The Nature of Legislative Regulations

Several states have enacted statutes that control the administration of intrusive mental treatments. Not surprisingly, the statutes are varied in format and purpose. Some have recognized an absolute right to refuse ECT; unless the informed consent of the patient, his guardian, or a next-of-kin is obtained, these statutes—though several suffer from drafting problems—appear to forbid intrusive treatments. Others require the written consent of the patient or his guardian but also provide a procedure for the state to provide treatment without such consent in certain circumstances.

The most comprehensive statute regulating administration of ECT and other intrusive mental treatments was recently adopted in California. Assembly Bill 1032, which was signed into law on September 20, 1976, recognizes the mental patient's right to refuse convulsive treatment including ECT. Two principal provisions regulate the treatment. The first establishes several prerequisites to the administration of ECT to an involuntary patient: (a) the treating physician must document reasons for the treatment and certify that it is the least drastic alternative; (b) a review committee composed of two other physicians must agree with the opinion of the treating physician; (c) a full disclosure of the reasons for, and the nature and risks of, the treatment must be made to a relative or a guardian of the patient, unless the patient decides to dispense with this requirement; (d) the patient must give written informed consent, which must be reviewed every thirty days and can be revoked at any time; (e) the patient's attorney—or a court-appointed one—must agree to the patient's capacity or incapacity to give written informed consent; (f) if the treating physician or the attorney believes the patient lacks the capacity to give consent, then an evi-

178. See DEL. CODE ANN. tit. 16, § 5161(2)(d) (Supp. 1975) (written informed consent by the patient or his guardian is required for surgery, ECT, etc.). Accord, UTAH CODE ANN. § 26-17-18.5 (1969). See also FLA. STAT. ANN. § 394.459(3)(b) (1975) (though unclear whether statute requiring written permission applies to surgery and ECT, or surgery requiring an anesthetic or ECT); IOWA CODE ANN. Senate File 499, § 23(2) (West's Leg. Serv. 1975 No. 2, at 182, 192) (right to refuse treatment by shock therapy or chemotherapy, although statute does not say that consent is necessary).

179. See CONN. GEN. STAT. ANN. § 17-206(d) (1975) (No ECT may be administered without the written informed consent of patient. If he is incompetent, no ECT may be given without the informed consent of a guardian, a next-of-kin, or a physician appointed by the judge of the probate court.); MICH. COMP. LAWS ANN. § 330.1716 (1975) (ECT may not be administered without (1) the consent of the patient if competent, or (2) the consent of a guardian of the incompetent. If neither kind of consent is possible, then a probate court may consent to the procedure in lieu of the person eligible to give it.). Cf. KY. REV. STAT. 202A.180(7) (Supp. 1976) (empowering the Secretary of Human Resources to promulgate regulations to protect patient rights).

The second principal provision regulates all other administrations of ECT, including those to voluntary patients in a state institution or to anyone receiving treatment in a physician's office, clinic, or private home: (a) requirements (a), (c), and (d) for involuntary patients must be met; (b) instead of a review committee, one other physician must certify the patient's capacity to give informed consent; and (c) if the other physician will not verify the patient's capacity, or if the patient lacks capacity, requirements (b) (e), (f), (g), and (h) for involuntary patients must be satisfied.\(^{182}\)

The statute also provides that any patient, whether voluntarily or involuntarily committed, who is capable of giving informed consent and refuses to do so may not receive convulsive treatment.\(^{183}\) Individuals over sixteen years of age are subject to the general provisions of the act.\(^{184}\) Treatment is prohibited on children under twelve years of age and is allowed in only limited circumstances on children between twelve and sixteen years of age.

The California statute, in effect, accepts the constitutional analysis presented earlier.\(^{185}\) It recognizes that a patient may be incapable of making a rational decision about hospitalization yet fully capable of deciding whether to submit to intrusive treatments. A review mechanism is provided to ensure proper characterization of the patient's competence to make the treatment decision. The patient is given a representative to protect his rights in the adversary hearing. If the patient is deemed incapable of giving consent, safeguards are provided to ensure that the treatment is not given unnecessarily and that it is the least drastic alternative.\(^{186}\) The Cali-

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185. Recognizing the danger of a violation of a mental patient's constitutional right to privacy, the Legislature intends by this enactment to assure that the integrity and free choice of every such patient is fully recognized and protected. Because those who are emotionally disturbed are vulnerable to being unduly influenced, the Legislature believes the protection of their rights requires a careful process of informing and consenting in order to assure the protection and vindication of their rights. Cal. Assembly Bill No. 1032, § 1 (1976) (WELF. & INST. CODE).
186. It is not likely that a state could require all other forms of treatment to be exhausted before allowing administration of ECT. The potential benefit of an ECT treatment given immediately may outweigh the benefits of proceeding with a six-
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The California statute could very well become the model for legislation in other states.

B. Constitutional Limitations

The traditional test for evaluating the constitutionality of a statute enacted pursuant to the police power has been to determine whether there is a reasonable relationship between the purpose of the legislation and the means used to accomplish it. If, as noted above, a state interferes with a fundamental right of an individual, mere rationality is no longer sufficient; in such cases, the compelling state interest test is employed. Once it is shown that a state’s interference with a fundamental right fulfills a sufficient state interest, however, the judicial inquiry is not concluded. At that point, the state must show that its enactments are “narrowly drawn.” In other words, to ensure that the interference with a fundamental right is minimized, the state is required to choose the “least drastic means” to accomplish its purpose.

A variety of state statutes that single out certain medical areas for regulation have been found constitutional. For example, controlled drug classifications have been upheld as being designed to promote a permissible state purpose: “The legislative purpose [to prevent drug abuse] in making the differentiation [among various drugs] being thus permissible, indeed laudable, the courts will not assume the task, for which they are conspicuously unfitted, of inquiring whether every drug was properly placed by the Legislature in one schedule rather than another.” The Supreme Court echoed this

month drug treatment or a two-year consultation program, at the conclusion of which ECT may still be needed. A California court of appeal, however, upheld an exhaustion-of-all-other-appropriate modalities requirement from an attack of vagueness by construing appropriate modalities to mean “any forms of treatment medically appropriate for a particular patient with a particular condition.” Aden v. Younger, 47 Cal. App. 3d 662, 677, 129 Cal. Rptr. 535, 544-45 (1976) (emphasis original). Thus the court concluded that “[e]very possible form of therapy need not actually be used on a patient, because not all forms will be considered appropriate for that patient. This is a purely medical determination, which is within a doctor’s professional judgment.” 57 Cal. App. 3d at 677, 129 Cal. Rptr. at 545. Nevertheless, the new California bill requires only that “all reasonable treatment modalities have been carefully considered.” Cal. Assembly Bill No. 1032, § 5326.7(a) (1976), (WELF. & INST. CODE).

187. See text at note 87 supra.
189. This was recognized in Price v. Sheppard: “But once justified, the extent of the state’s intrusion is not unlimited. It must also appear that the means utilized to serve the state’s interest are necessary and reasonable, or, in other words, in light of alternative means, the least intrusive.” — Minn. at —, 239 N.W.2d at 910 (footnote omitted).
language in upholding a state requirement that informed consent be
given prior to an abortion:

We could not say that a requirement imposed by the State that a prior
written consent for any surgery would be unconstitutional. As a con-
sequence, we see no constitutional defect in requiring it only for some
types of surgery as, for example, an intracardiac procedure, or where
the surgical risk is elevated above a specified mortality level, or, for
that matter, for abortions. 191

It is therefore not surprising that state regulation of ECT has
recently been upheld. In Aden v. Younger, a new, important case
in this area, a California court of appeal held that regulation of
intrusive and possibly hazardous forms of medical treatment is a
proper and legitimate exercise of the state’s police power. 192

Legislation regulating ECT is not likely to be challenged success-
fully on the ground that the treatment is not a proper subject of state
regulation. However, many of the specific functions of the review
mechanisms established by state statutes may encounter greater
difficulty. These constitutional issues require more detailed con-
sideration.

1. Certification of Consent of Competent Patients

One of the most important functions of a pretreatment review
mechanism is to determine whether a patient who consents to ECT
is competent to make such a decision and whether his consent was
knowingly and voluntarily given. However, the authority of the state
to regulate ECT through procedures that review patient consent is
not unlimited, for such regulation may actually interfere impermissibly
with the patient’s right to privacy. As discussed earlier, the right
of privacy protects the individual by preventing compulsory adminis-
tration of ECT on nonconsenting patients. However, the right of
privacy may also protect the right of the individual to receive treat-
ment without undue governmental interference. In this instance, the
right of privacy may be asserted to preserve the sanctity of the doctor-
patient relationship. Indeed, as suggested by the recent Supreme
Court abortion decisions, a statute that either prohibits a medical
procedure or conditions its execution upon the consent of a review
committee may impermissibly interfere with the right of privacy en-
compased in the doctor-patient relationship.

omitted).

192. 57 Cal. App. 3d 662, 673, 129 Cal. Rptr. 535, 542. Yet a statute that regu-
lates “ECT,” “shock treatment,” or “intrusive treatments” might be challenged as being
so vague that the statute cannot be constitutionally enforced. However, ECT and
shock treatment have precise technical meanings and can easily be defined in precise
statutory language. 57 Cal. App. 3d at 676, 129 Cal. Rptr. at 544.
The Supreme Court held in *Roe v. Wade*\(^{193}\) and *Doe v. Bolton*\(^{194}\) that the right of privacy protected a woman's decision to consent to an abortion. In *Roe*, the Court held that a woman's decision whether to have an abortion was protected by the right of privacy and that no compelling state interest justified overriding her right during the first trimester. In *Doe*, the Court held a Georgia statute that prohibited a physician from performing an abortion without the concurrence of two other physicians and a hospital committee to be unconstitutional.\(^{195}\)

Although both cases recognized that a woman has a privacy interest in the doctor-patient relationship, the Court declined to remove all aspects of that relationship from the scope of permissible legislative regulation. The decisions prohibited state regulation of abortions during the first trimester because no compelling state interest was served by such regulation. Criminal abortion laws were originally intended in part to protect women from the hazards of artificial termination of pregnancies. The Court noted in *Roe* that "[m]odern medical techniques have altered this situation . . . . Consequently, any interest of the State in protecting the woman from an inherently hazardous procedure . . . has largely disappeared."\(^{196}\) After the first trimester, however, the Court found two compelling state interests that justified state regulation of abortions: "preserving and protecting the health of the pregnant woman"\(^{197}\) and "protecting the potentiality of human life."\(^{198}\)

If the Court's method of analysis in the abortion cases is applied to ECT, it appears that state regulation would be allowed. ECT can be easily distinguished from abortion in the first trimester, which the state is not allowed to control. First, such abortions are relatively safe; on the other hand, ECT, due to the possibility of rather severe complications, may threaten the health and safety of the patient and, accordingly, is an appropriate subject of state regulation. Second, while the abortion of a pregnancy is irreversible, it does not affect the woman's ability to become pregnant again. By contrast, ECT

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195. The Court stated:
Review by a committee once removed from diagnosis is basically redundant. We are not cited to any other surgical procedure made subject to committee approval as a matter of state criminal law. The woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it are substantially limited by this statutorily imposed overview. . . . We conclude that the imposition of the hospital abortion committee is unduly restrictive of the patient's rights and needs that, at this point, have already been medically delineated and substantiated by her personal physician.

410 U.S. at 197-98.
196. 410 U.S. at 149.
197. 410 U.S. at 162.
198. 410 U.S. at 162.
is known to have lasting effects on the mental processes of some patients. Consequently, the state has a greater interest in ensuring the patient's consent. Third, unlike ECT patients, women who obtain abortions are usually fully able to give informed consent. The competence, voluntariness, or knowledge of women seeking abortions are not likely to be contested. Finally, the function of the review committee that was struck down in \textit{Doe} is distinguishable from the role of a pretreatment review mechanism that certifies consent. In \textit{Doe}, the physician review committee was designed to override the decisions of women, who were almost invariably capable of giving informed consent, to have abortions. A pretreatment review mechanism for ECT seems less intrusive since it simply certifies that individuals, whose ability to give informed consent may be impaired, have knowingly and voluntarily given consent.

It is unreasonable to read the abortion decisions as creating an absolute privacy right in the doctor-patient relationship. As declared in \textit{Roe}, "a state may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life . . . . The privacy right involved, therefore, cannot be said to be absolute." Thus, if the state can demonstrate that the health, safety, or welfare of its citizens is sufficiently threatened, as is most certainly the case with the administration of ECT, the state may establish a review mechanism to ensure that the patient has manifested an effective consent.

2. Disclosure Requirements

To guarantee that the consent of a patient is informed, state statutes and regulations sometimes specify what information must be included in the physician's disclosure to the patient. Although mandatory disclosure requirements have been challenged as impermissible intrusions into the privacy of the doctor-patient relationship, courts have upheld them as a reasonable method of ensuring the adequacy of consent.

\textit{In Planned Parenthood Association v. Fitzpatrick}, a federal
district court upheld a state requirement that a doctor make certain disclosures to a woman before performing an abortion. The state's regulation was deemed not to interfere improperly with the doctor-patient relationship.\textsuperscript{203} The court found a sufficient state interest in the disclosure requirements in part because

the [abortion] procedures, perhaps routine for those performing them, will probably be totally unlike any others theretofore undergone by the patient. In addition . . . the woman may well be experiencing considerable emotional anxiety . . . .

The state under such circumstances might understandably wish to be certain that each woman be given the facts regarding her condition, her options, the abortion procedure to be performed, and the possible future consequences of the choice she makes. Like the licensing of facilities, the regulations, and the record-keeping provisions, the informed consent requirement may well be an attempt by the state to monitor the quality of medical care received by women procuring abortions.\textsuperscript{204}

The reasoning in \textit{Fitzpatrick} is equally persuasive when applied to pre-ECT disclosure requirements. Mental patients for whom ECT is proposed are more likely to be unaware of the treatment's procedures or effects than are women who seek abortions. Thus, the California court of appeal has held that the California statute, which required certain information about ECT to be disclosed to the patient, constituted only a minimal invasion of privacy. The court said that the statute's purpose—ensuring that consent is given in a knowing and intelligent manner—"could not be accomplished by any means short of such disclosure, and the procedure is constitutional."\textsuperscript{205}

Some statutes, in addition to requiring that particular information be disclosed to the patient by the physician,\textsuperscript{206} also require that the same disclosure be made to certain relatives of the patient before ECT can be administered.\textsuperscript{207} If the patient has been found to lack the capacity to give informed consent and the relative has been accorded the authority to give consent for the patient, disclosure to the relative is justified. Otherwise, the relative could not give

\textsuperscript{203} 401 F. Supp. at 587 (Adams, J., concurring in part & dissenting in part).
\textsuperscript{204} 401 F. Supp. at 587 (Adams, J., concurring in part & dissenting in part).
\textsuperscript{206} See text at note 201 supra.
\textsuperscript{207} See, e.g., CAL. WELF. & INST. CODE § 5326.3 (West Supp. 1976).
informed consent. Similarly, if the legislature allows a relative to challenge the decision of a court or medical panel to administer ECT to the patient, then disclosure would be appropriate. It would be incongruous to conclude that a state may authorize such an appeal but may not authorize the necessary disclosure to render it effective. 208

However, if the patient is competent, it appears that his privacy would be unjustifiably infringed by mandatory disclosure to a relative. It might be argued that disclosure to the relatives of a competent patient fulfills a significant state interest: The state might assert an interest in encouraging informal counseling among family members when intrusive treatments are being contemplated. 209 Such a conclusion, however, does not necessitate requiring disclosure. If the state desires to promote consultation among family members prior to ECT treatment, it should encourage rather than require the patient

208. A more difficult question arises when the patient is incompetent and the relative, usually a parent, has been excluded from the substitute decision-making process. It is arguable that because the relative has no role in the treatment decision, any disclosure would be unjustified invasion of the patient's privacy. One court has accepted this view:

The disclosure of the nature and seriousness of the patient's disorder is a clear infringement of the patient's right of privacy and no countervailing state interest is apparent. Because no standing to assert the patient's rights is granted to the relative, it is doubtful this disclosure furthers the protection of patients' rights or prevents unnecessary treatment.


Although the court may be correct, it seems unwise that any statute should prevent substitute consent or involvement of relatives in the first instance. To exclude the parent or child of the incompetent, not only from participating in the patient's treatment decision but also from discussion of the question and even from all information about the treatment, may be insensitive to their interests and may not be legally compelled. Since family members may help care for the patient following hospitalization and treatment, they can more ably understand the patient's needs if they have knowledge about his treatment. Also families that are ignorant about the procedure might withdraw the patient from the institution if they fear the proposed treatment. Therefore, the state could justifiably authorize disclosure to certain relatives as part of advancing the patient's best interests. The revised California legislation follows this approach. A responsible relative of an involuntary patient's choosing is to be given an oral explanation by the attending physician unless the patient desires that the relative not be informed or unless the relative is unavailable.

Cal. Assembly Bill No. 1032, § 5262.7(c) (1976) (WELF. & INST. CODE). This provision is particularly admirable because the relative to be informed is chosen by the patient himself; the intended benefit of the disclosure, consultation with the patient, is thereby made more likely. The provision also defers to patient privacy by allowing the patient to dispense with the requirement.

209. The efficacy of consultation was recognized in Poe v. Gerstein, 517 F.2d 787 (5th Cir. 1975), which was decided before Danforth. The Poe court examined a statute that required parental consent before a competent minor could obtain an abortion. It found that the purpose of parental approval was to help the minor make a reasonable decision. The court nevertheless held the statute unconstitutional: "At the very least, the statute would more narrowly achieve the state's result if it called for parental 'consultation' rather than permission prior to abortion." 517 F.2d at 793. Because Danforth does not address the question of counseling, its impact on the validity of such a mechanism is uncertain.
to disclose the information himself. A patient who is sufficiently competent to decide whether to submit to ECT is capable of deciding whether consulting his relatives would be beneficial. Compulsory disclosure of personal information infringes the patient's privacy; it also threatens individual autonomy by subjecting the patient to family pressures he may wish to avoid. Compulsory disclosure does not serve a compelling state interest when the patient is competent; encouraging disclosure should be preferred, since no individual rights are infringed.

3. Overriding the Decision of a Competent Patient

Any statute that makes it too difficult for a competent patient to receive treatment may be overbroad. For example, assume an individual seeks medical assistance for depression and the physician prescribes ECT. The physician indicates that the patient, after being fully informed of the nature and risks of the treatment, knowingly and voluntarily consented. It is proper for the state at that point to intervene and review the patient's consent. If the review committee finds either that the patient was competent but did not give consent, or that the patient was incompetent, treatment can and should be prevented. However, if the committee finds that the patient was competent and did give consent, the question remains whether the treatment can be denied, or, in other words, whether the state can override the consent of a competent patient.

Some states have statutes that require, in addition to the patient's consent, the approval of another person or a committee before any

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210. This is what the California statute does. See Cal. Assembly Bill No. 1032, § 5326.7(c) (1976) (WELF. & INST. CODE). Problems may arise when information is disclosed to public officials about the receipt and conditions of treatment. The state has a strong interest in assuring that its laws concerning ECT are not violated. To uncover violations, inspection of individual patient records may be necessary. In Aden v. Younger, the court held that the establishment of a reporting system seeking to control possible abuses of patients' rights would be a clear invasion of the patients' privacy if their identities were disclosed; thus, a patient's report could only be disclosed through a code that would refer to the patient's treatment records. 57 Cal. App. 3d at 681, 129 Cal. Rptr. at 547-48. See Roe v. Ingraham, 403 F. Supp. 931 (S.D.N.Y. 1975), application for stay denied sub nom. Whalen v. New York, 423 U.S. 1313 (1975), probable jurisdiction noted, 96 S. Ct. 1100 (1976). Comment, The Right to Privacy: New York Statute Interfering with Constitutionally Protected Doctor-Patient Relationship Invalidated—Roe v. Ingraham, 50 N.Y.U.L. Rev. 1149 (1975).

211. As discussed above, see note 180 supra, and as recognized by the California court of appeal, "[V]oluntary patients . . . are susceptible to many of the pressures placed on involuntary patients." 57 Cal. App. 3d at 674, 129 Cal. Rptr. at 542-43. If the pressures on all institutionalized patients are acknowledged as being equal, then it would seem that involuntary and voluntary patients possess undifferentiated interests in having their competently rendered decisions respected. The revised California legislation recognizes that the refusal of a competent patient, whether voluntary or involuntary, must be respected. Cal. Assembly Bill No. 1032, § 5326.85 (1976) (WELF. & INST. CODE).
treatment can be given. With respect to competent patients, these mandatory "second consent" provisions have been declared unconstitutional for both abortion and ECT. In *Planned Parenthood v. Danforth*, the Supreme Court invalidated a Missouri statute that required the consent of a woman's husband, or, if she were unmarried and under 18, her parent, for an abortion within the first twelve weeks of pregnancy. The right of a competent patient to make his own decision about whether to undergo ECT was recently upheld in *Aden v. Younger*. The California law in question did not permit ECT unless a three-physician committee unanimously agreed that ECT was "critically needed for the welfare of the patient." The court held:

> [O]nce the competency of a voluntary patient has been confirmed, and the truly voluntary nature of his consent is determined, the state has little excuse to invoke the substitute decision-making process. . . . [T]here is no justification for infringing upon the patient's right to privacy in selecting and consenting to the treatment.

The court did not state that a committee could not prevent or even prescribe ECT for an incompetent, or that a committee could force a competent patient to receive it. It simply held that the committee could not prevent a competent patient who desires ECT from receiving such treatment when at least one physician is willing to administer it.

The state may nevertheless be able to justify "second consent" provisions on another rationale. Because a large proportion of health services are provided by state funds, the state has a valid interest in ensuring that health resources are not wasted. More importantly, the state has a valid interest in the health, safety, and welfare of its citizens; to the extent that citizens undergo inherently risky medical treatments that are unnecessary, this interest is impaired. The issue, then, is whether the interest is sufficiently compelling to override a competent patient's decision to receive ECT.

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212. 96 Sup. Ct. 2831 (1976). Developing its holding in *Roe v. Wade*, the Court concluded: "[W]e cannot hold that the State has the constitutional authority to give the spouse unilaterally the ability to prohibit the wife from terminating her pregnancy, when the State itself lacks that right." 96 Sup. Ct. at 2841 (citation omitted). And in striking down required parental approval the Court explained:

> Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights. . . .

Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

214. 57 Cal. App. 3d at 677, 129 Cal. Rptr. at 544.
This question was posed in a different context in Planned Parenthood Association v. Fitzpatrick,\(^{217}\) which involved a challenge to the constitutionality of a Pennsylvania statute that required a determination of pregnancy prior to the performance of an abortion.\(^{218}\) The requirement precluded the use of one technique of abortion, menstrual extraction, which is most effective when performed prior to the time that many widely used tests can detect a pregnancy. Even though menstrual extraction is performed during the first trimester of pregnancy, which Roe v. Wade immunized from state regulation, the constitutionality of the provision was upheld: "[W]e do not believe that Roe precludes the state from requiring a positive determination of pregnancy prior to the performance of an abortion procedure in furtherance of its interest in protecting nonpregnant females from undergoing unneeded abortion procedures."\(^{219}\) If this reasoning were applied to ECT, "second consent" statutes would seemingly be constitutional, so long as overriding the patient's consent was intended to help the patient. Given the high risks of ECT, the state may well be able to assert this interest and prevail.

Although a state may prohibit unnecessary administrations of ECT, the standard that draws the demarcation between necessary and unnecessary treatment must be carefully articulated. For example, the former California standard—that ECT be "critically needed for the welfare of the patient"—was declared void for vagueness.\(^{220}\) The recently adopted California statute attempts to improve this language. Under the new act, treatment may not be given unless it "is definitely indicated and is the least drastic alternative for this patient at this time."\(^{221}\) If even greater specificity is desired, a


\(^{218}\) In Fitzpatrick, patients in Philadelphia County could obtain an effective test to determine pregnancy at an early stage, but this procedure was not available outside the county. 401 F. Supp. at 573-74.

\(^{219}\) 401 F. Supp. at 574. A related case is Association of American Physician & Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill.), aff'd. without opinion, 423 U.S. 975 (1975), where the court rejected a challenge to the professional standards review organizations. These committees were established by Congress to ensure that payment for medical services under Medicare and Medicaid would be made only when those services were medically necessary and could not be provided as effectively on a less expensive out-patient basis. The court upheld the power of the committees because of the legitimate interest of government in controlling the rapidly rising costs of its health care delivery systems. The organizations, however, did not actually function as a "second consent" mechanism. A patient could still get treatment; the government would simply not pay for it.


\(^{221}\) Cal. Assembly Bill No. 1032, § 5326.7(a) (1976) (WELF. & INST. CODE).

Because special knowledge is required to evaluate a medical recommendation, the committee checking the quality of informed consent may not be able to make this second determination unless it is composed of physicians. Another possibility is
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statute could list those illnesses—such as acute schizophrenia and indogenous depression—for which ECT is appropriate.222

C. Incompetent Patients and Substitute Consent

As discussed earlier, if any one of the three elements of informed consent—competence, knowledge or voluntariness—is absent, the consent is not effective. Yet incompetent patients, who may well need treatment most, cannot give informed consent and the concomitant waiver of constitutional rights. Most states, therefore, have adopted legislation that establishes procedures for “substitute consent.”223 Usually, a relative, guardian, conservator, committee of physicians, or court is empowered to perform this function.224

suggested by the new standard 9 in Wyatt v. Hardin, Civ. Action No. 3195-N (M.D. Ala., Feb. 28, 1975). There, no ECT can be given unless the recommendation for treatment has been made by a qualified mental health professional, concurred in by a second qualified mental health professional, and approved by the hospital director. Whether the determination is to be made by a physician as part of the informed consent determination of the committee or prior to the patient’s consent is surely within the legislative prerogative. The only requirements should be that those persons approving the medical appropriateness of the recommendation are qualified to evaluate the information and that their approval is not a pro forma exercise. To prevent concurrence in the treating physician’s recommendation from being automatically approved by a colleague, the legislature could require the recommendation, the reasons given for it, and the approval to be in writing to minimize the potential for such a concurrence. Other possibilities might include requiring the concurrence of two doctors or the impartial appointment and rotation of a physician or physicians to serve in this capacity.

222. But the federal district court in Wyatt has stated:
It must be emphasized at the outset of this order that, in setting forth the minimum constitutional requirements for the employment of certain extraordinary or potentially hazardous modes of treatment, the court is not undertaking to determine which forms of treatment are appropriate in particular situations. Such a diagnostic decision is a medical judgment and is not within the province, jurisdiction or expertise of this Court. . . . But the determination of what procedural safeguards must accompany the use of extraordinary or potentially hazardous modes of treatment on patients in the state’s mental institutions is a fundamentally legal question . . . .


223. See, e.g., Cal. Assembly Bill No. 1032, § 5326.7(g) (1976) (WELF. & INST. CODE). California provides no guidelines to help the surrogate make his decision to consent for the incompetent patient.

The Wyatt v. Hardin standard, on the other hand, provides that the determination made by the substitute decision-maker, here the Extraordinary Treatment Committee, should be based upon a review of pertinent medical, psychiatric, psychological and social information concerning the patient; an interview with the patient, his family or others who could contribute relevant information; and the recommendation of a mental health professional recommending treatment. The standard also provides that “great weight” shall be given to any expression of the patient of a desire not to be subjected to ECT. Wyatt v. Hardin, Civ. Action No. 3195-N (M.D. Ala., Feb. 28, 1975). The inclusion of some legislative, or, as in Wyatt, a judicial, expression of what criteria should make up a best-interests determination is preferred.

consent of the representative must be informed; indeed, to be a valid waiver of constitutional rights, the consent must be knowingly and voluntarily given.

If some method of substitute consent is not made available the alternative is to ban ECT altogether for incompetents. Such a position is not implausible. It might be argued that a state cannot constitutionally authorize a third party to consent to ECT for an incompetent because the potential consequences of ECT are so severe and its intrusion on the mental process is so great that only the patient himself should be able to give consent. Although a proponent of this view must concede that a state acting as *parens patriae* may authorize certain treatments for incompetent patients, such as nonpsychiatric or nonintrusive interventions, he would argue that the purpose of, and risks inherent in, ECT are qualitatively different. Thus, the state should not be able to provide substitute consent: If the state lacks a sufficient interest to force competent persons to receive ECT, it likewise does not have a sufficient interest to "impose" ECT upon nonconsenting incompetents.

On at least two occasions, courts have agreed with this position and have prevented the administration of intrusive treatments to incompetents. The first decision that embraced this view was *Wyatt v. Stickney*. Although the court would eventually change its position, it initially decided that the requirement of informed consent forbade treatment of incompetents:

Patients have a right not to be subjected to treatment procedures such as lobotomy, electroconvulsive treatment, aversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice.

This position was also adopted in *Kaimowitz v. Department of Mental Health*. After deciding that institutionalization diminished the patient's capacity to consent to irreversible experimental psychosurgery, the court rejected the possibility of substitute consent: "Although guardian or parental consent may be legally adequate

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225. See text at notes 87-97 supra.


227. "After a thorough consideration of [the] written requests and responses [of the parties and amici curiae] and the Court's further study of Bryce and Searcy hospitals' experiences in operating under Standard 9, the Court's of the opinion that a substantial revision of the present Standard 9 is in order." Wyatt v. Hardin, Civ. Action No. 3195-N (M.D. Ala., Feb. 28, 1973). The revised standard 9 provided that patients incompetent to consent could receive ECT after several procedural requirements, including the determination by the Extraordinary Treatment Committee that treatment is in the patient's best interest.

228. 344 F. Supp. at 380.
when arising out of traditional circumstances, it is legally ineffective in the psychosurgery situation."

However, total prohibition of ECT for incompetents is undesirable. Although a state does not have a sufficiently compelling interest to force ECT upon a competent patient, it does not follow that the state lacks a sufficient interest to provide a mechanism whereby an incompetent can obtain treatment. Technically, the incompetent person cannot refuse treatment because he is incapable of making a decision. When a representative of the patient makes the decision to proceed with treatment, the patient's wishes are not overruled. The representative, in effect, is attempting to approximate the choice the patient would make if he were competent. Under this view, substitute consent is not compulsion but rather a mechanism that makes treatment available and thus is an appropriate device for the state to utilize.

Moreover, ECT is not a treatment that courts should classify as being so hazardous that it cannot be administered to incompetents under any circumstance. There are patients for whom no less drastic treatment could be effective and for whom ECT offers a chance of better health. Three years after the court in Wyatt v. Stickney declared that incompetents could not receive ECT, it took notice of these arguments and established a substitute consent mechanism for incompetent patients. Its rationale should sustain statutory substitute consent.

Once it is determined that the state may provide for substitute consent for treatment, the difficult problem of what kind of mechanism best represents the patient's interests remains. A relative of

229. 2 Prison L. Rptr. 433, 476 (1976). It may be significant that both cases involved psychosurgery and not ECT. Psychosurgery may be deemed more intrusive than ECT, and substituted consent may be allowed for ECT but not surgery. For example, California's new legislation requires consent from the patient himself for psychosurgery and provides no mechanism for substituted consent so that an incompetent patient can receive it. Cal. Assembly Bill No. 1032, § 5326.6 (1976) (Welf. & Inst. Code). However, a substituted consent mechanism is provided for ECT.

230. This position is reflected in the California requirement that ECT be used only after all other treatment modalities had been considered. See Cal. Assembly Bill No. 1032, §§ 5326.7(a) & 5326.75(a) (1976) (Welf. & Inst. Code).

231. See note 227 supra. The Wyatt v. Hardin procedure is similar to that promulgated in Price v. Sheppard. Attempting to respect the integrity of the patient without denying him potentially beneficial treatment, the Wyatt court established the Extraordinary Treatment Committee and empowered it to make best interest determinations for incompetents. It also imposed three conditions on the committee's ability to order treatment. First, the patient must be represented by counsel at all proceedings and deliberations. Second, all doubts about the wisdom of ECT must be resolved against authorizing the treatment. Finally, if the committee does conclude that ECT should be administered, the patient or a relative can appeal the decision. A legislature might also require that there be additional verification that ECT is medically indicated and that the person(s) exercising the consent are subject to the consent requirements imposed on competent persons. See, e.g., Cal. Assembly Bill No. 1032, § 5326.7(g) (1976) (Welf. & Inst. Code).
the patient has traditionally been recognized as an appropriate surrogate. However, several commentators have recently observed that a relative—particularly a close one—may not be the person best qualified to make a judgment for the patient. The Minnesota Supreme Court, cognizant of this problem, has concluded that those individuals responsible for the patient's commitment—frequently relatives—cannot represent the patient's interests in the adjudicatory hearing where the decision whether to administer ECT is made. If a relative is allowed to substitute his consent for that of the patient, the relative's decision should be subjected to the same scrutiny as the consent of a competent patient. Whatever disclosures would have been made to a competent patient should also be made to the relative. Just as an inquiry is made into whether a physician is coercing a patient's consent, the same inquiry should be made into whether the physician is pressuring the relative to give consent by, for example, conditioning or threatening to condition the patient's release upon their consent. If no relative is available, some statutes allow a court to designate a representative who may be able either to give consent himself or to ask the court for an order authorizing treatment. Some statutes allow such a representative even though a relative is available. This procedure may be unwise; a relative should at least be allowed to challenge the decision of the court-appointed representative in an adjudicatory hearing.

D. Summary

When the decision-making process for the administration of ECT has been challenged in court, courts have typically devised methods to protect the rights of mental patients. They have frequently concluded that a pretreatment review mechanism is the best means of helping to ensure both the validity of a competent patient's consent and the desirability of treating an incompetent patient. Not

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232. W. Prosser, supra note 54 at 102-03.
233. In particular, conflicts of interest have been recognized in parental decision-making for children. Ellis, Volunteering Children: Parental Commitment of Minors to Mental Institutions, 62 CALIF. L. REV. 840, 850-51, 857-59 (1974).
234. Price v. Sheppard, Minn. at —, 239 N.W.2d at 913 n.11. California avoids a conflict of interest by providing that no one serving on a review committee can be otherwise personally involved in the treatment of the patient whose case he is reviewing. Cal. Assembly Bill No. 1032, § 5326.55 (1976) (WELF. & INST. CODE). Similarly, a recent Tennessee statute provides for a lawyer to represent minors who need ECT but prohibits the appointment of any lawyer who has advised the party seeking authorization of ECT for the minor, who has advised the minor's parents, or who is connected with a parent's business. Tennessee Public Act of 1976, ch. 489, § 1(c).
surprisingly, a number of states have adopted legislation that requires for all cases of ECT administration many of the same procedures already developed by the courts. These statutes raise many questions, the most crucial of which have been analyzed above. Undoubtedly, other questions will eventually be raised as legislatures seek to devise new ways to protect the rights of mental patients. Nevertheless, much of the analysis of the issues presented by current statutes may well be useful in resolving these developing, but related, questions.