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INFORMED CONSENT AND THE MENTAL PATIENT: CALIFORNIA RECOGNIZES A MENTAL PATIENT'S RIGHT TO REFUSE PSYCHOSURGERY AND SHOCK TREATMENT

*The processes of life, the make-up of the human organism, who can fully understand these miracles? . . . What is happening to you now is what should happen to any normal healthy human organism contemplating the actions of the forces of evil, the working of the principle of destruction. You are being made sane, you are being made healthy.*¹

I. INTRODUCTION

While great attention has been focused over the past twenty years on protecting the rights of previously neglected groups such as criminal suspects,² black schoolchildren,³ juvenile offenders⁴ and consumers,⁵ courts and legislatures are just beginning to recognize the basic constitutional and procedural rights of the mentally ill.⁶ One right that is now being extended to mental patients is the right to refuse treatment.⁷ Unlike other medical practitioners, psychiatrists have long possessed the legal power to force treatment on institutionalized mental patients.⁸ Some of the more drastic forms of treatment which have been used on mental patients without their consent include psychosurgery and shock treatment. Psychosurgery is the removal or destruction of healthy brain tissue for the purpose of affecting behavior.⁹ Shock treat-

1. A. BURGESS, *A CLOCKWORK ORANGE* 110 (2d ed. 1972).

2. See, e.g., *Miranda v. Arizona*, 384 U.S. 436 (1966).

3. See, e.g., *Brown v. Board of Educ.*, 347 U.S. 483 (1954).

4. See, e.g., *In re Gault*, 387 U.S. 1 (1967).

5. See, e.g., *Vasquez v. Superior Court*, 4 Cal. 3d 800, 484 P.2d 964, 94 Cal. Rptr. 796 (1971).

6. See, e.g., *Jackson v. Indiana*, 406 U.S. 715 (1972); *Baxtrom v. Herald*, 383 U.S. 107 (1966).

7. R. SLOVENKO, *PSYCHIATRY AND THE LAW* 243 (1973) [hereinafter cited as SLOVENKO]. See Mich. Stats. (1974), P.A. 258, § 716, at 638 (West Legislative Service 1974), amending MICH. COMP. LAWS ANNOT. § 330.1716. For an analysis of Congressional activity and recently issued executive guidelines on the use of psychosurgery, see Spoonhour, *Psychosurgery and Informed Consent*, 26 U. FLA. L. REV. 432, 449-50 (1974) [hereinafter cited as Spoonhour].

8. SLOVENKO, *supra* note 7, at 243.

9. *Id.* at 248. It is estimated that some 500 psychosurgical operations are performed annually in the United States. Offir, *Psychosurgery and the Law—The Movement to Pull Out the Electrodes*, 7 PSYCHOLOGY TODAY, May, 1974, at 69.

ment is the use of drugs, hormones, or electric shock to induce convulsions in patients as a means of treating certain mental disorders.¹⁰

In response to the need for regulating the use of dangerous and controversial treatments on patients without their consent, the California legislature adopted AB 4481 on September 27, 1974.¹¹ The new law, which became effective on January 1, 1975, provides that mental patients have the right to choose whether to submit to psychosurgery or shock treatment in California mental institutions.¹²

The bill has been criticized by some members of the medical community as an unwarranted intrusion on the psychiatrist's right to determine the most appropriate treatment for a patient.¹³ Supporters of the bill consider it a major breakthrough in the recognition of basic civil rights for mental patients.¹⁴ As a result of the controversy over AB 4481, the use of psychosurgery and shock treatment has been suspended at various hospitals,¹⁵ a law suit has been instituted to enjoin enforcement of the new consent law,¹⁶ and an emotional public debate over the value of

10. Krouner, *Shock Therapy and Psychiatric Malpractice: The Legal Accommodation to a Controversial Procedure*, J. FOR. MED. 397, 398 (1973) [hereinafter cited as Krouner]. The number of shock treatments administered annually in California is hard to determine because no statewide records are kept. However, one hospital in San Francisco alone conducted over 1000 electro-shock treatments in 1974. Letter from Orville Booth, Executive Vice-President, Saint Francis Memorial Hospital, to the San Francisco Mental Health Advisory Board, Jan. 17, 1975 [on file with SANTA CLARA LAWYER].

11. Cal. Stats. (1974), ch. 1534, at 4328 (West Legislative Service).

12. *Id.* at 4328.

13. Margolis, *San Francisco Chronicle*, Feb. 26, 1974, at 44, col. 2 (letter to the editor).

14. Statement by Wade Hudson, member of Network Against Psychiatric Assault, before the San Francisco Mental Health Advisory Board, Jan. 20, 1975, at 4 [on file with SANTA CLARA LAWYER] [hereinafter cited as Hudson Statement].

15. Letter from Richard H. Trapnell, Chairman, Psychiatric Committee at Saint Francis Memorial Hospital, to all members of the medical staff, Nov. 21, 1974, [on file with SANTA CLARA LAWYER] [hereinafter cited as Trapnell letter].

16. *Doe v. Younger*, Civil No. 361769 (San Diego County Super. Ct., filed Dec. 30, 1974). *Doe* was filed by two physicians and a mental patient receiving shock treatment, who are seeking to enjoin enforcement of AB 4481 on a variety of grounds. The complainants have alleged, *inter alia*, that:

- 1) the establishment of a committee to review all shock treatment and psychosurgery proposals as required under AB 4481 constitutes an invasion of a patient's right to privacy (*Doe* complaint at 5);
- 2) such reviews impinge on patient-physician confidentiality (*Id.*);
- 3) provisions of AB 4481 which allow governmental officials to review patient records violate a patient's right to privacy (*Id.* at 3);
- 4) the harsh penalty provisions of the bill are vague and unconstitutionally discriminate against psychiatrists and neurosurgeons (*Id.* at 7).

A temporary restraining order enjoining the enforcement of AB 4481 was issued by Judge Charles W. Froehlich of the San Diego Superior Court on De-

these treatments has surfaced.¹⁷

AB 4481 makes three significant changes in current California law. First, the word "lobotomy" is deleted from section 5325 of the Welfare and Institutions Code and replaced by the word "psychosurgery."¹⁸ In addition to offering a definition of psychosurgery, the bill recognizes the absolute right of mental patients to refuse such treatment.¹⁹ Second, AB 4481 guarantees a patient who is deemed capable of giving informed consent the right to refuse shock treatment.²⁰ Prior to AB 4481, California law permitted the director of a mental facility to authorize shock treatment, in spite of a patient's objections, upon a showing of good cause.²¹ Under the new law, a patient's refusal to submit to shock treatment must be respected.²² Third, the statute provides that a physician who violates it may be fined up to \$10,000 and have his license to practice medicine revoked.²³

This comment will examine AB 4481 by first considering the concept of informed consent and its usual application in the practice of medicine. The analysis will then focus upon the concept of informed consent as applied by AB 4481 to the treatment of mental illness. Turning next to a discussion of psychosurgery and its historical development as a means of modifying human behavior, the comment will examine closely the provisions of AB 4481 which require mental institutions to obtain informed consent before psychosurgery is performed. In the discussion of psychosurgery, the comment will undertake an analysis of a recent Michigan Circuit Court decision, *Kaimowitz v. Department of Mental Health*,²⁴ the only case thus far which has dealt with the issue of informed consent to psychosurgery. *Kaimowitz* is significant because it recognizes that the inherently coercive environment of the mental

ember 30, 1974. Petitioners have filed a petition for a writ of mandate in the Fourth District Court of Appeals (Civil No. 4-14407).

17. *Psychiatry Is No Legislative Area*, Editorial, San Francisco Chronicle, Feb. 26, 1975, at 44, col. 1; San Francisco Chronicle, Jan. 21, 1975, at 3, col. 1; San Francisco Sunday Examiner & Chronicle, Jan. 19, 1975, § A, at 4, col. 1; The Daily California, July 15, 1974, at 3, col. 1; TIME, Jan. 20, 1975, at 56, col. 3.

18. CAL. WELF. & INST'NS CODE § 5325(g) (West Supp. 1975).

19. *Id.*

20. *Id.* § 5326.4(g).

21. *Id.* § 5326 (West 1972), *as amended*, Cal. Stats. (1974), ch. 1534, at 4329.

22. CAL. WELF. & INST'NS CODE § 5326.4(g) (West Supp. 1975).

23. *Id.* § 5326.5(a).

24. Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973). *Kaimowitz* is extensively discussed in Spoonhour, *supra* note 7, and Comment, *Kaimowitz v. Department of Mental Health: A Right to be Free From Experimental Psychosurgery?*, 54 B.U.L. REV. 301 (1974).

institution precludes a patient who has been confined for a substantial period of time from rendering informed consent.

Next, the comment will outline the history and nature of shock treatment, with consideration given to AB 4481's requirement that informed consent be obtained prior to the administration of shock treatment. Finally, the comment will examine the new law's third party consent requirements with regard to shock treatment.

AB 4481 requires that a determination of a patient's capacity to consent be made before either psychosurgery or shock treatment is administered.²⁵ Since it is commonly assumed that persons undergoing treatment for mental illness are somehow incapable of exercising the judgment necessary to render informed consent, the question of a mental patient's *capacity* to consent is crucial in analyzing the new statute. Both the law and modern psychiatric practice recognize that mental incompetence and mental illness are entirely separate concepts.²⁶ Unless found to be incompetent by a court of law, the mental patient should retain the right to consent to such dangerous and controversial forms of treatment.

Determining mental competency has traditionally been reserved to the courts and the legal system.²⁷ AB 4481, however, breaks with this tradition and allows a reviewing committee, composed of physicians, to judge whether a mental patient has the necessary mental capacity to make an informed consent to either form of treatment covered by the law.²⁸ It is the thesis of this comment that such a critical and—in the case of psychosurgery—

25. CAL. WELF. & INST'NS CODE §§ 5326.3(e), 5326.4(e) (West Supp. 1975).

26. See *id.* § 5331, which states:

[n]o person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder. . . .

In *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971), the court noted:

a finding of mental illness, even by a judge or jury, does not raise even a presumption that a patient is "incompetent" or unable adequately to manage his own affairs. Absent a specific finding of incompetence, the mental patient retains the right to sue or defend in his own name, to sell or dispose of his property, to marry, draft a will, and, in general to manage his own affairs.

Id. at 68.

Fortunately a list of proposed amendments to AB 4481 prepared by Assemblyman Vasconcellos's office includes such language:

A person confined shall not be deemed incapable of informed consent solely by virtue of being diagnosed as a mentally ill, disordered, abnormal or mentally defective person.

Amendments to 4481, prepared by the office of Assemblyman John Vasconcellos (Dem.—24th Dist.), at 3, Jan. 28, 1975, [on file with SANTA CLARA LAWYER] [hereinafter cited as Amendments]; SLOVENKO, *supra* note 7, at 208.

27. See text accompanying notes 182-84 *infra*.

28. CAL. WELF. & INST'NS CODE §§ 5326.3(e), 5326.4(e) (West Supp. 1975). But see text accompanying note 202 *infra*.

irreversible decision affecting a person's welfare demands the objective scrutiny of a court, which is singularly equipped to insure adherence to the basic rights of due process and fundamental fairness.

II. INFORMED CONSENT

A. Background

AB 4481 is designed to guarantee a mental patient the right to refuse psychosurgery or shock treatment.²⁹ Thus, before a physician can administer these procedures, the patient must "knowingly and intelligently, without duress or coercion, manifest consent to the treatment."³⁰ The statute then sets forth what a physician must explain to a patient before seeking consent. The explanation must include:

1. an explanation of the procedures used in performing the treatment;
2. an explanation of the nature and seriousness of the patient's disorder;
3. an explanation of the patient's right to revoke consent before or during the procedure;
4. an explanation of reasonable alternative therapies;
5. an explanation of uncertainties associated with the treatment; and
6. an explanation of the hazards associated with the procedures.³¹

To avoid the new law's stringent penalty provisions³² or a

29. Cal. Stats. (1974), ch. 1534, at 4328 (West Legislative Service).

30. CAL. WELF. & INST'NS CODE § 5326.3 (West Supp. 1975).

31. *Id.*

32. AB 4481 adds a strong penalty and enforcement provision to sections 5325 and 5326 of the Welfare and Institutions Code. The new law provides that a physician who violates the informed consent provisions of AB 4481 may suffer a civil penalty of not more than \$10,000 for each violation. CAL. WELF. & INST'NS CODE § 5326.5(a) (West Supp. 1975). The physician may also have his or her license to practice medicine revoked. *Id.* Further, AB 4481 preserves the right of an individual whose physician has violated the consent requirements of the law to bring a civil cause of action in superior court. *Id.* § 5326.5(b). In addition, the court is empowered to exact from the defendant reasonable attorney's fees and court costs for the benefit of the plaintiff. *Id.*

Pressure from the medical community to modify the stiff penalty provisions of AB 4481 has been intense. *Editorial*, San Francisco Chronicle, Feb. 26, 1975, at 44, col. 1. Physicians claim that the fine and license revocation provisions of the new law are so harsh that they constitute "the taking of their property without due process of law, and are discriminatory against a single specialty in the practice of medicine." Complaint at 7, *Doe v. Younger*, Civil No. 361769 (San Diego Super. Ct., filed Dec. 30, 1974). Drs. Fisher and Rosen of the Langley-Porter Neuropsychiatric Institute have proposed that the penalty provisions of AB 4481 be amended to provide that a physician who violates the new law be reported to the State Board of Medical Examiners and investigated. Fisher &

possible malpractice suit,³³ the psychiatrist who wishes to perform psychosurgery or administer shock treatment in California will have to make a complete disclosure to the patient of the risks and hazards associated with the procedure. The question of how much information the psychiatrist must disclose is crucial. Since the requirement of informed consent to psychiatric treatment is such a new subject, there is little case law on it. However, psychiatrists will be able to draw useful guidelines from the standards of disclosure courts have imposed on physicians in other areas of medical practice.

B. *Limited vs. Full Disclosure*

The recognition of a physician's duty to obtain informed consent before administering medical treatment has been a relatively new development in American law.³⁴ Although informed consent

Rosen, Suggested Amendments to AB 4481, at 3, Nov. 20, 1974, [on file with SANTA CLARA LAWYER]. The Fisher-Rosen amendment would subject a physician to "whatever penalty, if any, the Board feels to be warranted." *Id.* This amendment has been criticized by commentators on the ground that it would eliminate the enforcement function of the state Attorney General's office. Supporters of AB 4481's penalty provisions argue that the enforcement of the law must remain independent of the mental institution administering the treatment. Roth, Analysis of AB 4481, at 10, Dec. 28, 1974, [on file with SANTA CLARA LAWYER]. Removing the enforcement power presently vested in the Attorney General's office would take the teeth out of the new law.

In response to the medical community's demand for a modification of AB 4481's penalty provisions, Assemblyman Vasconcellos has proposed an amendment to AB 4481 which would reduce the maximum penalty to \$5,000 and provide for an investigation of alleged violations by the State Board of Medical Examiners. Amendments, *supra* note 26, at 6. The investigation could lead to possible license revocation. Vasconcellos's amendment would retain the enforcement power in the office of the Attorney General. *Id.*

33. See, e.g., Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965), and Mitchell v. Robinson, 334 S.W.2d 11 (Mo. 1960), in which the Missouri court recognized the duty of physicians to obtain informed consent before administering shock treatment.

34. The modern concept of informed consent developed after the turn of the century in the well-known case of Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918). The plaintiff in *Burroughs* sued his doctor to recover for burns he sustained as a result of X-ray treatments used to treat a skin disorder. The suit was based on two grounds: (1) that the doctor was allegedly negligent for breaching his duty to inform the patient of the possible risks which were involved in the X-ray treatment, and (2) that the treatment had been negligently administered. *Id.* at —, 96 S.E. at 362-63. The court held that the evidence was insufficient to sustain a finding of negligent treatment. *Id.* at —, 96 S.E. at 371. However, the court analyzed the concept of informed consent and approved plaintiff's contention that "it is the duty of a physician in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy." *Id.* at —, 96 S.E. at 366. In effect, the court found that the "defendant had misled plaintiff by not only not giving him the warning aforesaid, but by affirmatively assuring him that if the treatment was applied, plaintiff's condition would be cured." *Id.* at —, 96 S.E. at 366-67.

Failure to obtain informed consent was first recognized as a possible basis of recovery in a 1957 California case, Salgo v. Leland Stanford, Jr. Univ. Bd. of

is a requirement in all jurisdictions,³⁵ courts are divided on what constitutes sufficient disclosure by a physician before a patient can render meaningful consent. Most courts have applied a limited disclosure standard which requires a physician to provide as much information concerning the procedure as would ordinarily be provided by competent doctors in the community who administer the same treatment.³⁶ Other courts, including the California Supreme Court, have applied a full disclosure standard under which a physician must consider what information concerning a proposed treatment is necessary to afford the opportunity to give meaningful consent.³⁷

Under the full disclosure standard, liability is founded on a physician's failure to provide the patient with sufficient information to make a meaningful choice between the risks inherent in the treatment and the consequences of forgoing such treatment.³⁸ In an action by a patient against the physician for failure to render informed consent, the basic issue for consideration by the trier of fact is whether the physician has disclosed all the risks that would be deemed material by a reasonable person confronted with the decision whether to undergo the proposed treatment.³⁹

The limited disclosure standard favors the physician in a malpractice suit, because the plaintiff must establish that the physician not only failed to inform him of the risks involved, but also that

Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957). The plaintiff in *Salgo* had become paralyzed allegedly as a result of a negligently performed injection into his spinal cord. Although the *Salgo* court reversed the plaintiff's lower court judgment, it suggested that full disclosure of all risks would be required when a physician seeks to obtain consent to surgery from a patient. The court found that beyond certain bounds of discretion, a doctor was in breach of duty to a patient if he did not fully reveal all the facts the patient needed to render a meaningful consent. *Id.* at 578, 317 P.2d at 181.

Another important case that dealt with the issue of informed consent was *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960). The plaintiff in *Natanson* alleged that her physician had been negligent in administering radiation therapy to treat breast cancer. In reversing a judgment for the defendant for an erroneous instruction on negligence, the Kansas Supreme Court commented that a physician violates his duty to his patient and subjects himself to liability for malpractice . . . if he makes no disclosure of significant facts within his knowledge which are necessary to form the basis of an intelligent consent.

Id. at —, 350 P.2d 1095 (1960).

35. HEALTH LAW CENTER, PROBLEMS IN HOSPITAL LAW 68 (2d ed. 1974) [hereinafter cited as PROBLEMS IN HOSPITAL LAW].

36. *Id.*

37. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962). For an excellent discussion of the informed consent issue, see *Waltz & Scheuneman, Informed Consent Therapy*, 64 Nw. U.L. REV. 628 (1969).

38. PROBLEMS IN HOSPITAL LAW, *supra* note 35, at 70.

39. *Id.*

the failure to inform constituted a deviation from the procedure normally employed by other physicians practicing in the community.⁴⁰ Such "deviations" from community practice must be proved by the use of expert testimony.⁴¹ Without expert testimony, the plaintiff's case will be dismissed despite its merits.⁴²

Although the limited disclosure standard is clearly the majority position in the United States today, there is a distinct trend towards the full disclosure approach.⁴³ In a series of well-reasoned opinions, California,⁴⁴ New Mexico,⁴⁵ and the Court of Appeals for the District of Columbia⁴⁶ have each adopted the full disclosure standard.

C. California's Informed Consent Standard

In adopting the full disclosure standard, the California Supreme Court, in *Cobbs v. Grant*, criticized the limited disclosure approach:

Even if there can be said to be a medical community standard as to the disclosure requirement, it appears so nebulous that doctors become, in effect, vested with absolute discretion. . . . Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowingly consents to be subjected.⁴⁷

The *Cobbs* court enunciated certain disclosure guidelines based on whether a proposed procedure was "complicated" or "simple."⁴⁸ A different standard applies to each type of procedure. For instance, if a proposed treatment is "simple," the doctor does not have to describe remote risks.⁴⁹ On the other hand,

40. Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. REV. 548, 551 (1973).

41. *Id.* at 551-52. See, e.g., *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962); *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963); *Govin v. Hunter*, 374 P.2d 421 (Wyo. 1962).

42. *Kessenick & Mankin, Medical Malpractice: The Right to be Informed*, 8 U.S.F.L. REV. 261, 270 (1973) [hereinafter cited as *Kessenick & Mankin*]; Note, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834, 835-37 (1966); Comment, *Res Ipsa Loquitur: Its Place in Medical Malpractice Litigation*, 8 U.S.F.L. REV. 343, 355 (1973). But see *Fox, Should Medical Reports be Obtained from the Plaintiff's Expert in Malpractice Cases?*, 1 L.A. TRIAL LAW. ASS'N ADVOCATE, Nov. 1973, at 1, wherein the author contends that it is much easier to obtain expert testimony against a doctor today than it once was.

43. *Kessenick & Mankin, supra* note 42, at 270.

44. *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

45. *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962).

46. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

47. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

48. *Id.* at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

49. *Id.*

if the procedure is "complicated," the physician is obligated to describe all possible risks, regardless of how remote.⁵⁰ The *Cobbs* court felt that a patient should be informed of all the important facts regarding the treatment and then be allowed to weigh his or her subjective fears and hopes against the disclosed risks before deciding whether to consent.⁵¹ This position is founded upon the notion that since consent does not require a medical evaluation, it should be reserved to the patient alone.⁵²

The *Cobbs* court recognized that the full disclosure concept does not apply in those emergency situations where a patient is unconscious and in need of immediate attention,⁵³ or where a physician is dealing with a minor or a mental incompetent.⁵⁴ As a general rule, a minor's consent is considered ineffective and a physician is required to obtain permission from the minor's parents or guardians before administering any medical treatment. The same rule applies if a person has been properly judged mentally incompetent.⁵⁵ If an adult is conscious and competent, he or she usually has an absolute right to refuse medical treatment or surgery, and a physician will be liable for battery if treatment is administered without consent.⁵⁶

Cobbs v. Grant involved the disclosure requirement for informed consent to which a physician must adhere before he or

50. *Id.* In requiring a full disclosure standard, the *Cobbs* court held that the physician is not required to render a

lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required; the patient is concerned with the risk of death or bodily harm, and the problems of recuperation.

For an excellent analysis of *Cobbs*, see Kessenick & Mankin, *supra* note 42.

51. 8 Cal. 3d at 243, 502 P.2d at 11, 104 Cal. Rptr. at 514.

52. *Id.*

53. *Id.* This exception is recognized in all jurisdictions. See PROBLEMS IN HOSPITAL LAW, *supra* note 35, at 88-89. The so-called "emergency" exception to the informed consent requirement is often confused with the notion of implied consent. Implied consent exists when particular words or acts of a patient manifest his willingness to consent to the procedure. The emergency exception applies only when, due to dire circumstances, neither the patient nor one authorized to consent for the patient is able to give consent, permitting the physician to perform the necessary surgery to which consent undoubtedly would have been given had the patient been competent and able to comprehend the situation. *Id.* at 70. See W. PROSSER, LAW OF TORTS 101, 103 (4th ed. 1971).

54. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. "Mental incompetent" here refers to those persons adjudicated incompetent in a judicial incompetency proceeding. The term does not apply to persons receiving treatment for mental illness.

55. PROBLEMS IN HOSPITAL LAW, *supra* note 35, at 82 (minor), 86 (mental incompetent).

56. *Id.* at 90. The following cases support the assertion that a medical operation or treatment without consent constitutes a battery: *Berkey v. Anderson*, 1 Cal. App. 3d 790, 803, 82 Cal. Rptr. 67, 76-77 (1970); *Pedesty v. Bleiberg*, 251 Cal. App. 2d 119, 123, 59 Cal. Rptr. 294, 297 (1967); see also Comment, *Consent to Surgery—A Dilemma*, 37 ALBANY L. REV. 591 (1973).

she can administer conventional medical treatment. Because AB 4481 requires that the same informed consent be obtained from mental patients, the full disclosure standard enunciated in *Cobbs* should apply to the use of psychosurgery and shock treatment as well. Both these techniques are "complicated" procedures which involve a risk of death or serious injury. Therefore, under *Cobbs*, the psychiatrist would seem to be obligated to disclose the potentially lethal nature of the treatment, "the available choices with respect to the proposed therapy [and] . . . the damages inherently and potentially involved in each," before seeking a mental patient's consent to either treatment.⁵⁷

III. AB 4481 AND PSYCHOSURGERY

A. Background

Since lobotomies are rarely performed anymore in the United States,⁵⁸ the California Legislature has substituted the word "psychosurgery" for "lobotomy" in the Welfare and Institutions Code.⁵⁹ Psychosurgery refers to the removal or destruction of

57. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. The physician's duty to disclose all known risks with respect to complicated medical procedures raises the question of whether this duty includes risks not known to the physician, but discoverable by referring to medical literature.

58. Mark, *Psychosurgery versus Anti-psychiatry*, 54 B.U.L. REV. 217, 218 (1975) [hereinafter cited as Mark].

59. CAL. WELF. & INST'NS CODE § 5325(g) (West Supp. 1975). AB 4481 includes within its definition of psychosurgery "those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery" if the surgery is performed for "modification or control of thoughts, feelings, actions, or behavior." *Id.*

Other definitions of psychosurgery include:

[1] Brain surgery, the primary purpose of which is to seek the alteration of thoughts, patterns of social behavior, various personality characteristics, or emotional relations.

Chorover, *Psychosurgery: A Neurological Perspective*, 54 B.U.L. REV. 231 (1974) [hereinafter cited as Chorover].

[2] Surgery on the frontal lobes or their connections in the brain to treat the symptoms of intractable depression, agitation, compulsion, delusion, hallucination and ideas of reference in patients with no known brain disease.

Mark, *supra* note 58, at 217.

Different types of psychosurgery include:

1. *cingulumotomy*—most prevalent type of psychosurgery. Not performed to treat disorders thought to be connected with violent behavior, but rather to alleviate symptoms of neuro-psychiatric illnesses like depression, anxiety, and other untreatable neuroses.
2. *thalamotomy*—used to treat Parkinson's disease. Dr. O.J. Andy at the University of Mississippi uses the thalamotomy to treat what he calls "hyper-responsive syndrome" which he believes is the cause of violent, unmanageable behavior in some patients.
3. *amygdalotomy*—originally used to treat epilepsy; some theorize this is the portion of the brain which is the source of violent behavior in some people.

healthy brain tissue to affect or modify behavior. Brain surgery, on the other hand, involves the removal of diseased brain cells to relieve organic disorders such as tumors.⁶⁰ The new statute recognizes this important distinction when it speaks of psychosurgery as surgery to modify thoughts or behavior, as opposed to the treatment of "known and diagnosed physical disease[s] of the brain."⁶¹

B. *History of Psychosurgery*

The history of psychosurgery can be traced to the 18th century phrenologists who believed that certain relationships existed between portions of the brain and human behavior.⁶² Phrenologists employed complicated schematic diagrams and intricate measuring devices to study these relationships. Their simplistic and unsubstantiated claims have been discredited in the scientific community today, but critics of psychosurgery compare modern advocates of surgery to modify behavior with the early phrenologists.⁶³ These critics feel that psychosurgery advocates are wrong in assuming that specific brain structures can be correlated to specific patterns of behavior.⁶⁴

Brain surgery designed to modify human behavior can be traced to the 1890's when Dr. G. Burkhardt, a Swiss psychiatrist, began removing portions of patients' brains to control their behavior. Although Burkhardt was successful in controlling his patients' violent behavior, he discontinued his activities because of pressure from colleagues in the medical community who were disturbed by the ethical implications of using brain surgery to control behavior.⁶⁵

Further development of psychosurgery was delayed until 1935 when a Portuguese scientist, Egas Moniz, and a colleague conducted a series of experiments to determine whether the behavior of disturbed patients could be controlled.⁶⁶ At first, Moniz tried cutting a small round hole in the skull near the temple and inserting alcohol to coagulate the fiber tracts between the frontal lobes

Holden, *Psychosurgery: Legitimate Therapy or Laundered Lobotomy?*, 179 SCIENCE 1109 (1973) [hereinafter cited as Holden].

60. SLOVENKO, *supra* note 7, at 248.

61. CAL. WELF. & INST'NS CODE § 5325(g)(1) (West Supp. 1975).

62. Chorover, *supra* note 59, at 232. Phrenology is the study of skull configurations as an indicator of mental faculties and traits. For an interesting perspective on the history of psychosurgery see *id.* at 232-35.

63. *Id.* at 232.

64. *Id.*; SLOVENKO, *supra* note 7, at 246.

65. N. KITTRIE, THE RIGHT TO BE DIFFERENT 305 (1971) [hereinafter cited as KITTRIE].

66. Chorover, *supra* note 59, at 234.

and other parts of the brain.⁶⁷ The alcohol coagulation did not work well, so Moniz began cutting the fibers with a special knife called a leucotome.⁶⁸ After twenty such operations, the Portuguese government forced Muniz to stop.⁶⁹

The lobotomy procedure nevertheless attracted world-wide attention, and from the late 1930's to the early 1960's, frontal lobotomies were hailed as an important breakthrough in the treatment of severely disturbed mental patients.⁷⁰ Approximately 50,000 were performed in the United States between 1940 and 1960.⁷¹ Unfortunately, enthusiastic lobotomy advocates underplayed the fact that this "great breakthrough" often left patients apathetic, asocial, and intellectually blunted.⁷² The use of lobotomies virtually disappeared in the United States with the development of powerful drugs called phenothiazines, by which the effects of a lobotomy could be achieved without surgery.⁷³

Doctors in recent years have developed a surgical technique which utilizes electrodes composed of fine wires to penetrate the brain.⁷⁴ Using a complicated coordinate system, a surgeon can implant the electrodes inside the brain and, by applying varying degrees of electrical shock, stimulate or destroy desired portions of brain tissue.⁷⁵ This technique, called stereotaxic surgery, is far superior to the earlier forms of brain surgery which required the surgeon manually to cut through or remove portions of the brain in order to reach areas under the skull.⁷⁶

67. KITTRIE, *supra* note 65, at 305; Chorover, *supra* note 59, at 234.

68. Chorover, *supra* note 59, at 234.

69. SLOVENKO, *supra* note 7, at 244.

70. Drs. W. Freeman and J. Watts performed the first lobotomies in the United States in 1936. KITTRIE, *supra* note 65, at 305.

71. Statement by Dr. Bertram S. Brown, Director of the National Institute of Mental Health, in *Hearings on S. 974, S. 878 and S.J. Res. 71 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare*, 93d Cong., 1st Sess., pt. 2, at 340 (1973).

Early statistics revealed that lobotomies produced serious consequences. One study indicated that out of 624 lobotomies performed during a certain period, 3.6 percent resulted in death and 51.5 percent resulted in undesirable side effects such as partial paralysis, bladder control problems, and convulsions. Lobotomies also frequently produced in a patient listlessness, lack of ambition, and a diminished capacity to form abstract thought or react to conscience. In addition, lobotomies were often resorted to—unfortunately—to control and subdue patients deemed to be disciplinary problems. KITTRIE, *supra* note 65, at 305-06.

72. KITTRIE, *supra* note 65, at 305-06.

73. Holden, *supra* note 59, at 1109.

74. Chorover, *supra* note 59, at 236.

75. *Id.*

76. *Id.* For discussions of recent developments in the field of stereotaxic surgery, see Chorover, *supra* note 59, at 236-37 (implantation of wireless telemetry components); I. COOPER, *THE VICTIM IS ALWAYS THE SAME* (1974) (freezing portions of the brain through cryosurgery); and Holden, *supra* note 59, at 1112 (curing *anorexia nervosa*—self-induced starvation).

Very little research has been conducted to determine the effects of psychosurgery on human behavior. Experiments have demonstrated, however, that psychosurgery can cause dramatic changes in the social behavior of monkeys.⁷⁷ Marked decreases in aggressive behavior have been observed in connection with the removal of a monkey's amygdala, a portion of the brain which acts as a "relay center" for sexual and aggressive impulses.⁷⁸ Amygdalectomized monkeys were found to be incapable of engaging in basic social interaction with other monkeys, assuming instead an attitude of fearful confusion when confronted by others of their species.⁷⁹ Researchers found that when these monkeys were returned to their previous troop (in a free-ranging colony habitat) they were ostracized by members of their species and eventually starved or were killed by predators.⁸⁰ Considerable controversy has developed in the scientific community over both the ethical and medical problems involved with psychosurgery.⁸¹ The controversy has focused largely on the work of three doctors who strongly support psychosurgery as a means of correcting brain dysfunctions, which they claim cause violent behavior in certain people.⁸² Critics argue that because there is little research or conclusive evidence demonstrating the benefits of psychosurgery on humans, experiments of this type should be carefully controlled or limited strictly to animals.⁸³

C. *Informed Consent and Psychosurgery*

California's new legislation establishes the *right* of a mental patient to refuse psychosurgery, but it does not recognize that institutional coercion may impair a patient's *ability* to consent to psychosurgery. The notion of institutional coercion raises questions about any legislation which permits a patient to consent to such a

77. Kling, *Effects of Amygdalectomy on Social-Affective Behavior in Non-Human Primates*, in *THE NEUROBIOLOGY OF THE AMYGDALA* 511 (B. Eleftheriou ed. 1972), cited in Chorover, *supra* note 59, at 238-39.

78. *Id.*

79. *Id.*

80. *Id.*

81. See, e.g., V. MARK & F. ERVIN, *VIOLENCE AND THE BRAIN* (1970); Annas & Glantz, *Psychosurgery: The Law's Response*, 54 B.U.L. REV. 249 (1974); Chorover, *Big Brother and Psychotechnology II: The Pacification of the Brain*, 7 *PSYCHOLOGY TODAY*, May, 1974, at 59; Lowinger, *The Detroit Case-Psychosurgery*, 170 *THE NEW REPUBLIC*, Apr. 13, 1974, at 17 [hereinafter cited as Lowinger]; Spoonhour, *supra* note 7.

82. The three doctors are William Sweet, Chief of Neurosurgery at the Massachusetts General Hospital; Vernon Mark, Chief of Neurosurgery at Boston City Hospital; and Frank Ervin, a psychiatrist and neurologist at U.C.L.A.. Holden, *supra* note 59, at 1104.

83. Lowinger, *supra* note 81, at 19; Chorover, *supra* note 59, at 232.

drastic and irreversible form of treatment.⁸⁴ The effect of coercion becomes especially acute with patients who have been involuntarily hospitalized for a substantial period of time. Because the only case which has dealt with the issue of informed consent to psychosurgery involved a mental patient who had been institutionalized for almost twenty years, the discussion in this comment will focus primarily on the consent of the long-term involuntary detainee. However, serious questions remain as to the propriety of allowing *any* mental patient—regardless of the period of hospitalization—to undergo psychosurgery. It has been suggested that the use of all psychosurgery on human beings should be suspended until the scientific and ethical ramifications of such experimental surgery are better understood.⁸⁵

D. *Kaimowitz v. Department of Mental Health*⁸⁶

The only case that has dealt with the issue of informed consent to psychosurgery is a 1973 Michigan (Wayne County Circuit Court) decision, *Kaimowitz v. Department of Mental Health*. *Kaimowitz* involved a mental patient, L.S., who had been committed to a state hospital under Michigan's criminal sexual psychopath law for raping and murdering a nurse at a previous mental institution. The record indicates that L.S. had been institutionalized since 1955.⁸⁷ He consented to participate in experimental research⁸⁸ being conducted at the Lafayette Clinic of Wayne State University, aimed at controlling aggressive behavior in persons

84. Spoonhour, in his excellent analysis of psychosurgery and informed consent, urges states to enact legislation to regulate carefully psychosurgery. In addition, he recommends

a requirement that the physician or institution show that the consenting patient's decision was voluntary and not subject to coercion or pressure, *thereby effectively barring consent by an imprisoned person or a patient institutionalized involuntarily or for a lengthy period.*

Spoonhour, *supra* note 7, at 452 (emphasis added).

Spoonhour concludes, upon the basis of his thorough analysis of the law regarding informed consent in analogous areas, that compliance with a requirement such as the one above, would be necessary to satisfy the tests that have been formulated by the courts. Lowinger concurs with Spoonhour and the *Kaimowitz* court that psychosurgery should be prohibited on prison inmates and long-term involuntarily detained mental patients altogether. Lowinger, *supra* note 81, at 19.

85. See SLOVENKO, *supra* note 7, at 247; Breggin, *The Return of Lobotomy and Psychosurgery*, 118 CONG. REC. 26 (1972) (daily ed. Feb. 24, 1972).

86. Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973).

87. *Id.*

88. The Michigan Legislature had appropriated \$228,400 (Holden, *supra* note 59, at 1111) for twenty-eight patients to undergo study for the control of aggressive behavior at the Lafayette Clinic. Lowinger, *supra* note 81, at 17.

Worthy of note is the great interest in this type of research displayed not only by the Michigan Legislature but also by the federal government. In 1970, the Neuro-Research Foundation was established at Boston City Hospital to study the control of violent behavior in human beings. Congress directed the National

suffering from "severe uncontrollable aggressive outbursts."⁸⁹ Drs. J.S. Gottlieb and Ernest Rodin of the Lafayette Clinic, the primary sponsors of the project, argued in their proposal for the research that certain types of aggressive behavior seemed to be linked to electrical abnormalities in the brain's limbic system.⁹⁰ If the section of the brain which triggers these abnormalities were removed, the doctors argued, the person's violent behavior might be controlled, allowing him to return to a normal life in the community.⁹¹

The Lafayette project called for experimentation on approximately twelve patients over the course of one year.⁹² After initial neurological, psychiatric, and psychological evaluations, each patient was to be operated on by having depth electrodes implanted in various parts of his brain.⁹³ The readings from the remotely controlled depth electrodes were to be carefully monitored, and electrical stimulation of various brain structures under varying degrees of environmental stress was to be conducted in order to identify areas of abnormal function. The affected areas were then to be removed and examined. Following the removal of the suspect brain tissue, psychiatric screening of the patients was to be conducted to ascertain the effect of the surgery on various cognitive and emotional functions.⁹⁴

Institute of Mental Health (NIMH) to award the foundation \$500,000 for its work. Louis Wienkowski, director of the NIMH, tried without success to dissuade Congress from making the appropriation. The Neuro-Research Foundation received the money with express provisions that no research on humans be undertaken. The Law Enforcement Assistance Administration of the United States Justice Department then donated an additional \$108,000 to the foundation.

In 1972, the Senate Labor, Health, Education, and Welfare Appropriations Subcommittee earmarked one million dollars for further research in this area to the National Institute for Neurological Disease and Stroke. Holden, *supra* note 59, at 1110.

A fascinating, albeit fictional, analysis of some of the political and social implications of this type of research is contained in A. BURGESS, *A CLOCKWORK ORANGE* (2d ed. 1972).

89. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973) Appendix Item No. 1, *Proposal for the Study of Uncontrollable Aggression at the Lafayette Clinic*, by J.S. Gottlieb, M.D. & E. Rodin, M.D., at 2.

90. *Id.* at 2. The limbic system may be described as that area of the brain which borders and separates the phylogenetically "lower" brain (source of basic stereotyped behavior patterns) from the more advanced neocortex (source of complex cognitive functions in higher life forms). Signals from the "lower" brain are transmitted by the limbic system, and it is thought that this system, with its input of information from the "lower" brain, is responsible for guiding affective behavior and for a human being's sense of individuality and reality. Chorover, *supra* note 59, at 237.

91. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973), at 4.

92. *Id.* at 2.

93. *Id.* at 3.

94. *Id.* at 3-4. This phase of the project is strikingly similar to the fictional-

After learning of the Lafayette project, a Detroit attorney and members of a medical human rights committee filed a complaint in the Circuit Court of Wayne County, seeking a writ of habeas corpus on behalf of L.S. and others similarly situated in Michigan mental institutions.⁹⁵ The complaint alleged that L.S. was being "illegally detained in the Lafayette Clinic for the purpose of experimental psychosurgery."⁹⁶ Because of the tremendous publicity generated by the suit, the state Department of Mental Health terminated funding the project, and the experiments were suspended.⁹⁷

Thereafter, counsel for the Department of Mental Health moved to dismiss the suit on grounds of mootness. A three-judge court ruled against the motion to dismiss, reasoning that because there was no assurance that the project would not be continued at a later date, the case "was ripe for declaratory judgment."⁹⁸

The principal issue before the *Kaimowitz* court was whether an involuntarily detained mental patient can render effective con-

ized scenario outlined in M. CRICHTON, *THE TERMINAL MAN* (1972).

A second phase of the proposed surgery involved the administration of an experimental antiandrogen substance, which had been used in Europe to treat "severe sexual psychopathy with associated aggressive behavior." *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973) Appendix Item No. 1, at 5. For this phase of the project, another group of twelve patients from Michigan's state hospital system were to be transferred to the Lafayette Clinic and their "testicular function . . . depressed by antiandrogens." *Id.* at 6. "Environmental manipulation and psychological evaluations" similar to that conducted on the surgical candidates were to be conducted. *Id.* The two groups of patients were to be compared closely to determine the effectiveness of the respective treatments. If the surgery or the drug sufficiently controlled a patient's violent behavior, then he would be released into society under close supervision. If the results of the experiments proved to be unsatisfactory, the individual patient would be detained. *Id.*

Commentators have been skeptical of the criteria used to select subjects for the Lafayette Project. Few standards existed for this type of study and the criteria being applied were founded on speculation rather than scientific certainty. Lowinger, *supra* note 81, at 18. A good example of the inadequacy of the selection criteria was the selection of L.S. for the project. A psychiatrist who examined L.S. at the trial testified that he had manifested no aggressive behavior for 18 years. *Id.*

Lowinger compares the Lafayette Project with other research conducted on various disadvantaged groups of individuals. For instance, slaves in the South prior to the Civil War were used in experiments which led to the development of ether anesthesia. Experimental research on the poor and helpless was conducted in studies at the Willowbrook Hospital in New York, where mentally retarded children were purposely infected with hepatitis to test vaccines, and in tests of birth control devices among Mexican-Americans in the Southwest, which resulted in unwanted pregnancies. *Id.*

95. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973), at 1.

96. *Id.* at 1-2.

97. *Id.* at 5.

98. *Id.* at 7.

sent to psychosurgery.⁹⁹ The court recognized that the possible connection between brain dysfunctioning and violence might be the subject of legitimate study. The court also noted that certain types of conventional neurosurgical procedures—such as temporal lobectomy to relieve epilepsy and operations to remove tumors or alleviate Parkinson's disease—were distinguishable and thus to be excluded from consideration.¹⁰⁰

In deciding whether experimental brain surgery on mental patients could be justified, the *Kaimowitz* court applied a risk-benefit analysis in balancing the inherent dangers of psychosurgery against its benefits to the individual and society.¹⁰¹ The court considered the fact that there was no known medical syndrome associated with violent behavior.¹⁰² It also noted that no assurance could be given by the doctors that the patients subjected to surgery could safely be returned to society.¹⁰³ In addition, the *Kaimowitz* court observed that the state of knowledge respecting psychosurgery on humans was limited and that experiments on monkeys had resulted in erratic behavior in the animals, characterized by heightened rage reaction or placidity.¹⁰⁴

Turning to the ethical considerations involved in the Lafayette project, the court emphasized that in a free society, "one of a person's greatest rights is the right to inviolability of his person."¹⁰⁵ Because of this right, a physician is precluded from unconsented to violation of a patient's "bodily integrity."¹⁰⁶

The reasoning employed by the *Kaimowitz* court has particular relevance to an analysis of the provisions for informed consent set forth in AB 4481. It is noteworthy that the court found guidance for its discussion of informed consent in the judgments of the military tribunals that tried German war criminals following World War II.¹⁰⁷ The court agreed with the Nuremberg judges that:

99. *Id.* at 8.

100. *Id.* at 10-11.

101. *Id.* at 13, 16, 22.

102. *Id.* at 16-17.

103. *Id.* at 17.

104. *Id.* See text accompanying notes 77-80.

105. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973), at 18.

106. *Id.*

107. The Nuremberg Tribunal found that:

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements

[T]he involuntarily detained mental patient must have legal capacity to give consent. He must be so situated as to be able to exercise free power of choice without any element of force, fraud, deceit, duress, overreaching, or other ulterior form of restraint or coercion. He must have sufficient knowledge and comprehension of the subject matter to enable him to make an understanding decision. The decision must be a totally voluntary one on his part.¹⁰⁸

In the most important part of its analysis, the *Kaimowitz* court

of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject, there should be made known to him the nature, duration and purpose of the experiment; the methods and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

United States v. Karl Brandt, Trial of War Criminals Before the Nuremberg Military Tribunals, Vols. 1 & 2, THE MEDICAL CASE (U.S. Printing Office 1948), reprinted in S. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 305 (Russell Sage Foundation 1972).

108. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973), at 24-25.

considered three factors—competency, knowledge of risks, and voluntariness—to be determinative in ascertaining whether a long-term involuntary detainee was capable of rendering an informed consent.¹⁰⁹ The court reasoned that because of a patient's "mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenomenon of 'institutionalization,'"¹¹⁰ his ability to render informed consent is seriously undermined.¹¹¹

As to the second element—knowledge of risks—the court summarily concluded that because the effects of psychosurgery are so uncertain, "knowledgeable consent to psychosurgery [is] literally impossible."¹¹²

Regarding the voluntariness element, the court noted that one reason L.S. had consented to the psychosurgery was his desire to demonstrate to his doctors that he was cooperative. The court recognized that the involuntarily detained mental patient will often tell his doctor what he thinks the doctor wants to hear.¹¹³ The record indicates that L.S. had been told that if he consented to the experiment he might be released.¹¹⁴ This desire to cooperate with institutional authorities formed part of the coercive atmosphere which tainted L.S.'s consent to psychosurgery.¹¹⁵ The *Kaimowitz* court concluded that the coercive environment of the mental institution precludes mental patients from reasoning as equals with their doctors, and that this "inherent inequality" renders it impossible for the patient to give a truly informed consent.¹¹⁶

The proponents of the Lafayette project went to great lengths to obtain what they considered to be a valid informed consent from L.S.¹¹⁷ On the surface, it appeared that meticulous attention had

109. *Id.* at 22.

110. *Id.* at 25.

111. *Id.*

112. *Id.* at 27.

113. *Id.* at 28-29.

114. *Id.* at 28.

115. *Id.* at 29.

116. *Id.*

117. *Id.* at 3-4. This is the consent form that L.S. signed:

Since conventional treatment efforts over a period of several years have not enabled me to control my outbursts of rage and anti-social behavior, I submit an application to be a subject in a research project which may offer me a form of effective therapy. This therapy is based upon the idea that episodes of anti-social rage and sexuality might be triggered by a disturbance in certain portions of my brain. I understand that in order to be certain that a significant brain disturbance exists, which might relate to my anti-social behavior, an initial operation will have to be performed. This procedure consists of placing fine wires into my brain, which will record the electrical activity from those structures which play a part in anger and sexuality. These electrical waves can

been paid to all the legal requirements for informed consent;¹¹⁸ yet, upon the court's careful scrutiny of the mental institution's inherently coercive atmosphere, it became clear that no truly informed consent was possible.¹¹⁹

Because it thoroughly analyzes the problem of informed consent to psychosurgery, the *Kaimowitz* opinion is helpful in considering the strengths and weaknesses of AB 4481.¹²⁰ Since California's new law allows a long-term involuntary detainee to consent to psychosurgery, it is arguable that the legislature failed to recognize the problem of inherent coercion in the mental institution.¹²¹ AB 4481 should be amended to prohibit psychosurgery on patients who have been confined for a substantial period of time,¹²² except under the most extreme circumstances. Even then it should be permitted only under the strictest supervision.

then be studied to determine the presence of an abnormality.

In addition electrical stimulation with weak currents passed through these wires will be done in order to find out if one or several points in the brain can trigger my episodes of violence or unlawful sexuality. In other words this stimulation may cause me to want to commit an aggressive or sexual act, but every effort will be made to have a sufficient number of people present to control me. If the brain disturbance is limited to a small area, I understand that the investigators will destroy this part of my brain with an electrical current. If the abnormality comes from a larger part of my brain, I agree that it should be surgically removed, if the doctors determine that it can be done so, without risk of side effects. Should the electrical activity from the parts of my brain into which the wires have been placed reveal that there is no significant abnormality, the wires will simply be withdrawn.

I realize that any operation on the brain carries a number of risks which may be slight, but could be potentially serious. These risks include infection, bleeding, temporary or permanent weakness or paralysis of one or more of my legs or arms, difficulties with speech and thinking, as well as the ability to feel, touch, pain and temperature. Under extraordinary circumstances, it is also possible that I might not survive the operation.

Fully aware of the risks detailed in the paragraphs above, I authorize the physicians of Lafayette Clinic and Providence Hospital to perform the procedures as outlined above.

Id. at 3-4 n.5.

118. *Id.* at 5. For a thoughtful criticism of the use of medical committees which decide whether valid consent has been obtained, see Offir, *Psychosurgery and the Law—The Movement to Pull Out the Electrodes*, 7 *PSYCHOLOGY TODAY*, May, 1974, at 69. Offir points out that (1) no independent investigation of the Lafayette project was undertaken before its approval, and (2) one of the lay members of the review committee indicated he had approved of the Project because of the "good intentions and technical competence" of the hospital personnel involved. *Id.* at 70.

119. *Kaimowitz v. Department of Mental Health*, Civil No. 73-19434-AW (Cir. Ct. of Wayne County, Mich., filed July 10, 1973), at 31.

120. *Kaimowitz* has already begun to play a role in developing statutory guidelines for the regulation of psychosurgery. See Mich. Stats., P.A. 258, § 716, at 638 (West Legislative Service 1974). A comprehensive analysis of the Michigan legislation is contained in Morris, *Institutionalizing the Rights of Mental Patients*, 62 CALIF. L. REV. 957 (1974).

121. See note 84 *supra*.

122. Unfortunately, a list of proposed amendments to AB 4481 prepared by

IV. AB 4481 AND SHOCK TREATMENT

A. Background

As it does with reference to psychosurgery,¹²³ AB 4481 requires that the treating physician who feels shock treatment is necessary must first fully advise the patient of its risks as well as its benefits.¹²⁴ The physician must then obtain the unanimous approval of a review committee composed of three doctors. The review committee also has to determine whether the patient is capable of rendering informed consent.¹²⁵ At this point AB 4481 makes an important distinction between psychosurgery and shock treatment. If the review committee determines that the patient is incapable of rendering informed consent, psychosurgery *may not* be performed.¹²⁶ However, upon the same conclusion as to the patient's capacity to consent, shock treatment *may* be administered over the patient's objections if the committee believes the treatment is medically justified.¹²⁷ Presumably, the rationale for the distinction is that shock treatment is less drastic than psychosurgery, since it does not involve removal of a portion of the patient's brain. Some psychiatrists argue that shock treatment may even be necessary, in certain instances, to save a patient's life.¹²⁸ Psychosurgery, on the other hand, will rarely be necessary to save a patient's life¹²⁹ and is therefore prohibited by the new law, absent a showing of the patient's capacity to render his or her informed consent.¹³⁰

The shock treatment provisions of AB 4481 recently have received a good deal of attention in the press.¹³¹ The debate over shock treatment is polarized between those who view it as an effective and relatively harmless medical technique¹³² and others

Assemblyman Vasconcellos fails to include such a prohibition. Amendments, *supra* note 26.

It will be difficult for legislatures to determine what period of time is "substantial." L.S. has been institutionalized for almost seventeen years. *Kaimowitz v. Department of Mental Health, Civil No. 73-19434-AW* (Cir. Ct. of Wayne County, Mich., filed July 10, 1973), at 2-3.

123. CAL. WELF. & INST'NS CODE § 5326.3 (West Supp. 1975).

124. *Id.* § 5326.4(1)-(6).

125. *Id.* § 5326.4(e). *But see* text accompanying note 202 *infra*.

126. *Id.* § 5326.3(b).

127. *Id.* § 5326.4(f). *But see* text accompanying note 202 *infra*.

128. Margolis, *San Francisco Chronicle*, Feb. 26, 1974, at 44, col. 2 (letter to the editor).

129. *But see* discussion of stereotaxic surgery, *supra* note 76.

130. CAL. WELF. & INST'NS CODE § 5326.3(b) (West Supp. 1975).

131. *See, e.g.*, *San Francisco Sunday Examiner and Chronicle*, Jan. 19, 1975, § A, at 4, col. 1; *San Francisco Chronicle*, Jan. 21, 1975, at 3, col. 1.

132. Statement of Langley Porter Neuropsychiatric Institute Concerning Electroconvulsive Therapy, subd. 2, Dec. 9, 1974 [on file with SANTA CLARA LAWYER].

who analogize its use to forcible rape.¹³³ A brief survey of the history and nature of shock treatment will help to illustrate why it has become so controversial an issue.

B. *History of Shock Treatment*

The term "shock treatment" encompasses those methods of psychiatric therapy in which drugs, hormones, or electric shock are used to induce a convulsive state in the body.¹³⁴ The history of shock treatment dates back to the 1930's when scientists discovered that certain symptoms of psychosis could be alleviated if coma or convulsions were induced in patients by injecting insulin into the body.¹³⁵ In 1933, an earlier researcher in the field, Dr. M. Sakel, investigated the use of insulin therapy to treat schizophrenia.¹³⁶ Within a few years, other researchers began to experiment with such drugs as metrazol to induce shock (either a coma or convulsions) in mental patients.¹³⁷ The use of metrazol was pioneered by Dr. L. von Meduna.¹³⁸ Sakel and von Meduna were pioneers of what is known as "pharmacologic" or drug-induced shock treatment. The research conducted by these two men also inspired an Italian scientist named Ugo Cerletti to experiment with the use of electrically induced convulsions to treat mental disorders.¹³⁹

Cerletti and his assistant, Bini, administered the first electroshock treatment on a human being in 1938. Their technique was to induce an epileptic-like seizure in a patient by applying a 70-130 volt shock for a fraction of a second through electrodes attached to the subject's skull.¹⁴⁰ Cerletti's announcement of success in treating psychotic symptoms with his new technique¹⁴¹ soon

133. Statement by Wade Hudson, *supra* note 14, at 4. The use of shock treatment to intimidate and coerce patients is vividly portrayed in K. KESEY, *ONE FLEW OVER THE CUCKOO'S NEST* (1962).

134. Krouner, *supra* note 10, at 398.

135. *Id.* at 399.

136. Sakel made the important finding that deeper hypoglycemic states, which had resulted unintentionally from the treatment of psychosis, usually had a beneficial effect on the psychosis itself. L. KALINOWSKY & P. HOCH, *SHOCK TREATMENT AND OTHER SOMATIC TREATMENTS IN PSYCHIATRY* 4 (1952) [hereinafter cited as KALINOWSKY].

137. Krouner, *supra* note 10, at 399.

138. Von Meduna, a Hungarian psychiatrist, observed a smaller incidence of epilepsy among schizophrenics than in the population as a whole. He also noted that schizophrenic symptoms seemed to disappear for a short time after an epileptic convulsion. Von Meduna tried to induce convulsions in schizophrenic patients through the use of metrazol. This drug proved to be unreliable and induced serious side-effects. J. COLEMAN, *ABNORMAL PSYCHOLOGY AND MODERN LIFE* 660 (4th ed. 1972) [hereinafter cited as COLEMAN].

139. *Id.*

140. *Id.*

141. Cerletti & Bini, *L'Elettroshock*, in 19 *ARCHIVO GENERALE DI NEU-*

led to widespread use of electroshock therapy (EST) to treat a variety of mental disorders.¹⁴²

C. EST—Does It Work?

The procedure for administering EST is as follows: on the day of treatment the patient is not fed, and all drug therapy is suspended. Thirty minutes before the treatment, approximately 0.8 mg. of atropine (SO₄) is administered in order to decrease salivation and bronchial secretions.¹⁴³ Next, a quick-acting barbiturate, such as methohexital or surital, is injected to induce sleep.¹⁴⁴ One reason for putting the patient to sleep is to help him avoid the unpleasant sensation associated with the muscle relaxant, succinylcholine, which is administered after the barbiturate. Succinylcholine, often called anectine, is used to prevent muscle contractions during the convulsions, which can result in serious bone fractures.¹⁴⁵ Electrical current is delivered through one or two electrodes, which are secured against the temple.¹⁴⁶ A standard

ROLOGIA, PSICHIATRIA E PSICOANALIS 266 (1938).

142. Krouner, *supra* note 10, at 401. Because it is technically simpler to administer, more predictable and "cleaner", EST remains by far the most common form of shock treatment in use today, although research in other forms of shock treatment is continuing. See, e.g., Krantz, Manchey, Truitt, Ling & Kurland, *The Availability of Hexafluorodiethyl Ether by Intravenous Injection as a Convulsant in Psychiatric Treatment*, 129 J. NERV. MENT. DIS. 92 (1959). For more extensive discussion of pharmacologic shock treatment, see KALINOWSKY, *supra* note 136, at 6-94.

Electroshock therapy, which is also referred to as shock therapy, electrocoma, electric treatment, electroconvulsive therapy, convulsive therapy, and brief-stimulus therapy, has been defined as "the administration of an electric current directly to the surface of the head to induce an artificial epileptic seizure in order to ameliorate disabling symptoms." Letter from Dr. Leon Epstein, Acting Director of the Langley Porter Neuropsychiatric Institute, San Francisco, to Marc Frauenfelder, Coordinator, San Francisco Mental Health Advisory Board, Jan. 17, 1975, [on file with SANTA CLARA LAWYER] [hereinafter cited as Letter from Dr. Epstein].

143. Presentation by Dr. Robert J. Grimm, of the Neurological Sciences Institute, Good Samaritan Hospital, Portland, Ore. before the Society for Neuroscience, 4th Annual Meeting, St. Louis, Mo. Oct. 23, 1974, at 3 [on file with SANTA CLARA LAWYER] [hereinafter cited as Grimm].

144. Krouner, *supra* note 10, at 402. Certain undesirable side effects can occur as a result of barbiturate anesthesia, including nausea and apnea (prolongation of respiratory arrest). Barbiturates must be administered carefully during shock treatment, since patients with certain cardio-vascular ailments may be adversely affected. *Id.* A normal dosage of surital is between 200-250 mg. Letter from Dr. Epstein, *supra* note 142.

145. Before the development of anectine, doctors used curare which is derived from arrow poisons of South American Indians and is well-known for its strong paralytic effects. The use of curare in shock treatment often resulted in asphyxiation because of the prolonged paralysis of the respiratory muscles. Anectine is much more reliable and predictable. Krouner, *supra* note 10, at 402.

146. The two principal methods of administering EST are "unilateral EST"

40-100 milliampere shock is administered for a half to one-and-one-half second interval.¹⁴⁷ Oxygen is provided during the treatment to aid in respiration, which might be impaired by the relaxing effect of the succinylcholine upon the lungs.¹⁴⁸ Once the actual convulsion begins, it will last for thirty to forty seconds.¹⁴⁹ Semi-consciousness is usually regained in several minutes, but the patient is not fully conscious for approximately thirty minutes following the treatment.¹⁵⁰

Typically, EST will be administered between six and fifteen times at one- or two-day intervals.¹⁵¹ When EST is used to treat schizophrenia, the number of treatments will be increased, ranging from sixteen to twenty-five, and spaced at shorter intervals.¹⁵²

From numerous studies conducted over the past twenty years to measure the effects of EST on the human body,¹⁵³ scientists

(one electrode applied against the non-dominant hemisphere) and "bilateral EST" (electrodes attached to both sides of skull).

147. Grimm, *supra* note 143, at 3. There are variations in the amount of electric shock used. For instance, the Langley Porter Institute in San Francisco uses voltages ranging from 120-140 volts—sufficient to deliver a current of 400-600 milliamperes for 0.4 to 0.6 seconds. Letter from Dr. Epstein, *supra* note 142, at 1.

148. Letter from Dr. Epstein, *supra* note 142.

149. Grimm, *supra* note 143, at 3.

150. *Id.* at 4.

151. *Id.* The Langley-Porter Neuropsychiatric Institute administers an average of six to ten EST's per patient. Letter from Dr. Epstein, *supra* note 142.

152. Grimm, *supra* note 143, at 4. Recently experiments have been conducted on certain severe cases of schizophrenia, using so-called "regressive EST," which is a much more intense battery of treatments at closer intervals. The "effectiveness" of the treatment according to the researchers, derives from the occurrence of a phenomenon called "clinical regression," characterized as a "state of helplessness, apathy, confusion, memory loss, speech alteration, and gross disorientation." Regressive EST has only met with limited "success." Typical regressive EST treatment consists of shocks given twice daily, seven days a week. The treatment is usually continued until regression occurs, usually some six to eight treatments later. Murillo & Exner, *The Effects of Regressive ECT with Process Schizophrenics*, 130 AM. J. PSYCHIAT. 269 (1973).

153. See Grimm, *supra* note 143, at 6-10, for an excellent review of the major studies in the field. Grimm offers the following description of EST's neurochemical effects:

[I]n addition to altering brain permeability to small and large molecules, and redistributing electrolytes in brain [*sic*], a considerable number of cerebrospinal fluid (CSF) changes occur following ECT as well as alterations in metabolic brain activity. CSF changes include increases in potassium of intracellular origin, nucleoprotein, fragment debris, nucleases, transaminase, neuraminic acid and choline.

Transient reductions occur in brain concentrations of glycogen, glucose, ATP, concomitant with a rise in lactate, pyrovate and inorganic phosphate; and there is a significant rise in free fatty acids in brain [*sic*], especially arachidonic acid. Significantly, RNA content is diminished and protein synthesis is transiently inhibited. There is a consistent increase in 5-hydroxytryptamine (serotonin) that persists for 72 hours in CSF and brain [*sic*] after the last ECT. Norephrephrine levels in medulla and pons are also elevated.

Id. at 9-10.

Some of the cardio-vascular effects that have been associated with EST in-

have learned that EST affects the body in a variety of ways. Among the effects EST is reported to have produced are such serious medical complications as permanent epileptic disorders in previously healthy individuals,¹⁵⁴ respiratory ailments, such as apnea (respiratory distress or arrest), and aggravation of diseases already present in the lungs, such as tuberculosis.¹⁵⁵ As noted, the administration of EST has also been known to cause serious bone fractures.¹⁵⁶

Scientists disagree over the extent to which brain damage may be directly attributable to EST.¹⁵⁷ Anti-EST groups argue that serious brain damage, including memory loss and confusion, can, and often does, result from the use of EST.¹⁵⁸ Most scientists believe that if only a small number of EST treatments are given, and measures are taken to prevent oxygen deprivation, permanent brain damage can be avoided.¹⁵⁹ It is generally conceded that some memory loss and confusion are unavoidable consequences of receiving EST.¹⁶⁰ Some advocates of EST even contend that it "cleans" brain circuits, and that the retrograde amnesia which follows the treatment constitutes its therapeutic value.¹⁶¹

In addition to memory loss, a certain degree of impaired cognitive functioning results after almost all EST treatments.¹⁶² Studies of patients who have undergone extensive doses of EST indicate that this treatment may reduce one's overall intelligence level.¹⁶³ Reduced concentration and attention spans have been

clude: "Massive vagal discharge resulting in bradycardia and hypotension with diminished cerebral blood flow, quickly followed by compensatory tachycardia and hypertension" (Altschule, *Further Observations on Vagal Influences on the Heart During Electroshock: Therapy for Mental Disease*, 39 AM. HEART J. 88 (1950)); and EKG changes (Bellet, Samuel, Kershbaum, Alfred, and Furst, *The Electrocardiogram During Electric Shock Treatment of Mental Disorders*, 201 AM. J. MED. SCI. 167 (1941)).

154. Assael, *Centrencephalic Epilepsy Induced by Electrical Convulsive Treatment*, 23 ELECTROENCEPH. CLIN. NEUROPHYSIOL. 195 (1967).

155. Krouner, *supra* note 10, at 5.

156. SLOVENKO, *supra* note 7, at 409.

157. Grimm, *supra* note 143, at 6.

158. Statement by Wade Hudson, *supra* note 14, at 3.

159. Letter from Dr. Epstein, *supra* note 142.

160. Zamora & Kaelbling, *Memory and Electroconvulsive Therapy*, 122 AM. J. PSYCHIAT. 546 (1965).

161. See, e.g., J. BRENGELMAN, THE EFFECT OF REPEATED ELECTRIC SHOCKS ON LEARNING IN DEPRESSIONS (1959); Furlong, *The Mythology of Electroconvulsive Therapy*, in 13 COMP. PSYCH. 235, 236 (1972).

162. Kendall, Mills & Thale, *Comparison of Two Methods of Electroshock in Their Effect on Cognitive Functions*, 20 J. CONSULT. PSYCH. 423 (1956); Temple, Ruff & Armstrong, *Cognitive Functioning and Degree of Psychosis in Schizophrenics Given Many Electroconvulsive Treatments*, 123 BR. J. PSYCHIAT. 441 (1973).

163. D. KLEIN & J. DAVIS, DIAGNOSIS AND DRUG TREATMENT OF PSYCHIATRIC DISORDERS 139-72 (1969).

observed, as well as impairment of the patient's learning capacity due to damage to portions of the limbic centers of the brain.¹⁶⁴

There is little agreement among authorities on the incidence of death caused by EST.¹⁶⁵ British scientists report that the risk of death following EST is less than the danger of suicide among severely depressed patients on whom EST may be administered as a form of therapy.¹⁶⁶ A study of sixty-two EST-related deaths in the United States between 1947 and 1952 revealed that thirty-four were caused by cardio-vascular complications, nineteen by respiratory complications, four by cerebral complications, and five by miscellaneous causes.¹⁶⁷ By 1970, several hundred deaths attributed to the use of EST were reported in the United States.¹⁶⁸

Since Cerletti's first experiments in 1938, EST has been used to treat nearly every type of mental disorder known to man, including schizophrenia, psychoneurosis, anxiety states, and conversion hysteria.¹⁶⁹ Despite the development of modern anti-depressant drugs, many authorities consider EST to be the most effective treatment available for so-called affective disorders like manic-depressive syndromes, and involutional or senile depressions.¹⁷⁰

164. Hudspeth & Gerbrandt, *Electroconvulsive Shock: Conflict, Competition, Consolidation, and Neuro-Anatomical Functions*, 63 PSYCH. BULL. 377 (1965); Tecce & Tarnell, *Focal and Incidental Movement—Time as a Function of Shock Arousal in Humans*, 59 J. PSYCHOL. 155 (1965).

165. See, e.g., Alexander, Gahagan & Lewis, *Deaths Following Electrotherapy*, 161 J. AM. MED. ASS'N 577 (1965) (5 deaths in 70,000 treatments); Hussar & Pachter, *Myocardial Infarction and Fatal Coronary Insufficiency During Electroconvulsive Therapy*, 204 J. AM. MED. ASS'N 1004 (1968) (1 death in 10,000 treatments); Martin, *Inside the Asylum*, SATURDAY EVENING POST, Nov. 10, 1956, at 130 (1 in 2000).

166. Malik, *Fatal Heart Block and Cardiac Arrest Following ECT*, 120 BR. J. PSYCHIAT. 69 (1972).

167. Maclay, *Death Due to Treatment*, 46 PROC. R. SOC. 13 (1953).

168. McKenna, Brooks, Engle & Dalen, *Cardiac Arrhythmias During Electroshock Therapy: Significance, Prevention and Treatment*, 127 AM. J. PSYCHIAT. 530 (1970). The authors point out that there has been little study or documentation of deaths associated with EST. *Id.* However, it is well known that EST can be lethal to patients with serious heart problems. Krouner, *supra* note 10, at 403.

169. See KALINOWSKY, *supra* note 136.

170. See Kalinowsky, *Thirty Years of Empiricism*, 5 INT'L J. PSYCHIAT. 169 (1968); Ottosson, *Electroconvulsive Therapy—Electro-Stimulatory or Convulsive Therapy?*, 3 J. NEUROPSYCHIAT. 216 (1962). An affective disorder may be manifested by the sufferer's rapid and extreme change in mood, as from elation to severe depression. COLEMAN, *supra* note 138, at 321.

Although EST does seem to be effective in treating some affective disorders, such as severe depression, its usefulness in the treatment of schizophrenia remains dubious. Letter from Dr. Epstein, *supra* note 142. See Riddell, *The Therapeutic Efficacy of ECT: A Review of Literature*, 8 ARCH. GEN. PSYCHOL. 546 (1963). The class of schizophrenic disorders known as psychoneurosis includes conversion hysteria, mild reactive depression, and obsessive-compulsive syndrome. These

Few psychiatrists agree on exactly how EST works.¹⁷¹ Some experts feel that its occasional effectiveness is due to its physiological effect on the body.¹⁷² Others argue that EST may work because of its psychological effect on patients.¹⁷³ One interesting theory is that EST works, when it does, because of a "placebo" effect on the patient; that is, the patient's "thinking" he will be aided by EST helps to relieve the symptoms of his disorder.¹⁷⁴

disorders are typically characterized by insomnia and digestive disturbances. Research indicates that these disorders do not respond well to EST. Krouner, *supra* note 10, at 401 n.96.

171. SLOVENKO, *supra* note 7, at 408.

172. One of the first physiological theories was advanced by Dr. M. Sakel, who thought that one characteristic of schizophrenia was hyperactive nerve cells which tended to overrespond to normal stimuli. The theory was that this hyperactivity could be traced to the presence of some excitant hormone. Insulin, according to Sakel's theory, somehow neutralized the troublesome hormone, and insulin shock acted to protect nerve cells in the subcortical centers of the brain from the harmful effects of the excitant hormone. Krouner, *supra* note 10, at 400.

Sakel's theory was criticized because it did not adequately explain how the "excitant hormone" (which Sakel was never able to isolate) induced hyperactive nerve cells in schizophrenics, and because there was no explanation of how insulin protected the sub-cortical nerve cells. Krouner, *supra* note 10, at 400.

Dr. von Meduna theorized that his metrazol shock treatments were successful because of a basic antagonism between schizophrenia and epilepsy. This antagonism forced symptoms of schizophrenia to subside after the shock treatment. Sakel and von Meduna's theories have been discredited with subsequent research, but there still exists no accepted explanation of how EST works, if in fact it does. *Id.* Hoch, *Clinical and Biological Interrelations Between Schizophrenia and Epilepsy*, 99 AM. J. PSYCHIAT. 507 (1943).

173. Some of the psychological explanations for the occasional success of shock treatment include: (1) a theory that the retrograde amnesia induced by EST helps the patient analyze problems more effectively (Furlong, *The Mythology of Electroconvulsive Therapy*, 13 COMP. PSYCHIAT. 235, 236 (1972)); (2) a theory that undesirable behavior ceases because EST effectively "punishes" the patient for such behavior (Dies, *Electroconvulsive Therapy: A Social Learning Theory Interpretation*, 146 J. MENT. DIS. 334 (1968)); and (3) a theory that EST works to satisfy certain guilt complexes through punishment being administered by a "doctor-father" figure. Miller, *Psychological Theories of ECT: A Review*, 5 INT'L J. PSYCHIAT. 154 (1968).

174. Grimm points out that before EST should be used, several important factors should be considered:

- (1) behavior per se is not connected with EST, in that certain types of depression are unaffected by convulsions in the patient;
- (2) duration of illness is not determinative—long-standing endogenous depression and short-term acute psychotic depression are equally responsive to EST; and
- (3) since epileptics can still suffer depression after EST, the convulsion itself may not be the determinative factor in EST's effectiveness.

Grimm concludes that after thirty-five years with no controlled studies to distinguish EST effects from the effects of factors like anesthesia, shock and anesthesia combined, psychological responses to anesthesia, fear of transient depersonalization after treatment, or the possible "placebo" effect (that is, studies in which patients were successfully treated by a shock treatment device which did everything but actually pass current), it is impossible to ascertain whether and how EST itself really works. Grimm, *supra* note 143, at 5-6.

This brief discussion of shock treatment illustrates that it is a potentially dangerous procedure, which may or may not be effective in treating certain forms of mental illness. Hopefully, as the research on shock treatment continues, scientists will be able to provide more information on how this peculiar treatment works and when, if ever, it should be used.

V. INFORMED CONSENT AND AB 4481

A. Background

An early position on the issue of informed consent to shock treatment is found in an advisory opinion by the Pennsylvania Department of Justice, entitled *Shock Therapy in State Hospitals*. The Department concluded that mental patients have no right to consent because the

care, treatment, and maintenance of mental patients is a government function . . . best carried out by the agencies of [Pennsylvania] uncontrolled by the dictates of the patient, his friends, relatives or others [T]he superintendents of state mental hospitals, in their sound discretion may administer to patients of state mental hospitals, electric shocks and such other treatments, which, in the exercise of reasonable skill and judgment, are indicated, after observation and diagnosis, as being necessary and proper for the patient's best welfare, without first obtaining written permission for such treatment from such patients, their friends, relatives, guardians or other persons who may be legally entitled to give such consent on behalf of such patients. . . . While such consent may be desirable in some cases, it is not essential under the laws of this commonwealth.¹⁷⁵

175. 64 PA. D. & C. 14, 35 (1948). This unenlightened approach to the rights of mental patients harkens back to the medieval era when the mentally ill were classified as "idiots" and "lunatics." It was thought that the mentally disturbed person was possessed by the devil and totally incapable of independent thought or judgment. The King was given ultimate responsibility for "idiots" and the history of barbaric treatment inflicted on the mentally ill by the King's custodians is a tragic one. See generally S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* 2-8 (1971) [hereinafter cited as BRAKEL & ROCK].

The Pennsylvania Department of Justice's rationale for contending that hospitals did not need to obtain informed consent from shock treatment patients was that "[a]n insane person has no constitutional or statutory rights of liberty in the ordinary and conventional sense of the term." 64 PA. D. & C. 14, 27. *Wilson v. Lehman*, 379 S.W.2d 478 (Ky. 1964), is a good example of how courts traditionally applied the Pennsylvania Department of Justice approach to the rights of mental patients. In *Wilson*, plaintiff had undergone repeated EST for severe depression. She brought suit on a negligence theory alleging permanent brain damage. *Id.* at 479. The Kentucky Court of Appeals sustained a lower court's directed verdict for the defendant. The court held that the plaintiff was presumed to have agreed to the EST because (1) she "voluntarily" submitted to it, and (2) plaintiff's husband did not try to stop the EST treatments even though he knew they were being administered. *Id.* at 480. For an interesting discussion of the

The opinion illustrates the archaic assumptions that mental illness denotes mental incompetence, and that a mental patient does not deserve the same consideration that other persons receiving dangerous medical treatment are accorded. Fortunately, courts and legislatures now recognize that patients in mental institutions are not presumed to be incompetent,¹⁷⁶ and that the same requirement of informed consent for other medical treatment should apply to mental patients receiving psychosurgery or shock treatment.¹⁷⁷

B. *Capacity to Consent*

AB 4481 is significant because it recognizes a patient's right to refuse psychosurgery or shock treatment, as long as he or she

Wilson case, see Morse, *Tort Liability of the Psychiatrist*, 16 BUFFALO L. REV. 649 (1967). Further discussion of the rights of mental patients is contained in Note, *Hospitalization of the Mentally Ill: Due Process and Equal Protection*, 35 BROOKLYN L. REV. 187 (1969). An excellent discussion of modern California law and the rights of the mentally ill is found in Comment, *Limitations on Individual Rights in California Incompetency Proceeding*, 7 U.C.D.L. REV. 457 (1974) [hereinafter cited as Comment]. Finally, for a fascinating analysis of how eighth amendment "cruel and unusual punishment" attacks can be used to protect the rights of the mentally ill, see THE MENTAL HEALTH PROJECT, LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 739-42 (1973).

176. See Comment, *supra* note 175, at 457.

Many mental health statutes provide that a mental patient is to be considered legally competent until a formal adjudication of incompetency is undertaken. See e.g., ALASKA STAT. § 47.30.070(1) (1971); D.C. CODE ANN. § 21-564(a) (1973); KAN. STAT. ANN. § 59-2933 (Cum. Supp. 1973); MD. ANN. CODE art. 59, § 51 (1972); MASS. GEN. LAWS ANN. ch. 123, § 25 (Supp. 1972); MINN. STAT. ANN. § 253 A. 18.1 (1971); N.J. STAT. ANN. § 30:4-24.2 (Supp. 1974); N.Y. MENTAL HYGIENE LAW § 29.03 (McKinney Supp. 1973); N.C. GEN. STAT. § 122-55.3(c) (1974); ORE. REV. STAT. § 426.375(i)(c) (1971); TEX. REV. CIV. STAT. ANN. art. 5547-83(b) (Supp. 1973).

Modern psychiatry also recognizes that mental illness does not necessarily affect decision-making capacity or reasoning ability. See, e.g., COMMITTEE ON NOMENCLATURE AND STATISTICS—AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISEASES 38-41 (2d ed. 1968); J. PAGE, PSYCHOPATHOLOGY: THE SCIENCE OF UNDERSTANDING DEVIANCE 32-35 (1971).

The following commentators argue that relatively few committed mental patients are incapable of deciding whether or not to seek treatment. Dershowitz, *Psychiatry in the Legal Process: A Knife that Cuts Both Ways*, 4 TRIAL, Feb.-Mar. 1968, at 32; and Siegal, *The Justifications for Medical Commitment—Real or Illusory*, 6 WAKE FOREST INTRA. L. REV. 21, 31-33 (1969).

177. The need for a patient's informed consent to shock treatment is recognized by the American Medical Association and the American Psychiatric Association. Krouner, *supra* note 10, at 406. Despite this recognition, it is interesting to note the reaction of the chairman of the psychiatric committee at a large San Francisco hospital to AB 4481:

Electric shock therapy is a valid treatment modality and in many cases the only form of treatment available. It is deplorable that a small group of ill-informed fanatics appear to have influenced Assemblyman Vasconcellos to sponsoring AB 4481.

Trapnell letter, *supra* note 15 (emphasis added).

is capable of giving informed consent.¹⁷⁸ On the crucial question of capacity to consent, the new law breaks with the rest of California law which has traditionally vested this type of determination in the superior court, and places it instead with a review committee composed of physicians.¹⁷⁹

The review committee is required to make the determination of capacity to consent when considering whether to allow a patient to undergo psychosurgery.¹⁸⁰ If the committee determines the patient cannot give an informed consent, then the psychosurgery may not proceed.¹⁸¹ However, the law's shock treatment provisions are quite different. The review committee *can* authorize the shock treatment over a patient's objections if the committee determines that the shock treatment is necessary.¹⁸² Because of the serious risks a person is exposed to when contemplating psychosurgery or shock treatment, the issue of capacity to consent should be determined in the same manner as that used to determine mental capacity during a commitment or guardianship proceeding conducted by a court.

The law presently requires the superior court to determine a patient's mental status when considering commitment or appointment of a guardian to manage the patient's affairs.¹⁸³ This

178. Cal. Stats. (1974), ch. 1534, at 4328.

179. The review committee, which can authorize shock treatment on an unwilling patient who is deemed incapable of rendering informed consent, is composed of three physicians. One physician is to be appointed by the mental facility and the other two by the local mental health director. The law further requires that at least two of the physicians be Board-certified psychiatrists or neurosurgeons. CAL. WELF. & INST'NS CODE §§ 5326.3(e), 5326.4(e) (West Supp. 1975). *But see* text accompanying note 202 *infra*.

180. *Id.* § 5326.3(e).

181. *Id.* § 5326.3(b).

182. *Id.* § 5326.4(f). *But see* text accompanying note 202 *infra*.

183. In California, the power to determine the issue of mental incompetence is vested solely in the superior court. CAL. PROB. CODE § 1460 (West Supp. 1975). The jurisdiction of the court is bifurcated—one level of jurisdiction ceasing when competence or incompetence is adjudicated, the second jurisdictional function continuing during guardianship or conservatorship, if the individual is found to be incompetent. *Browne v. Superior Court*, 16 Cal. 2d 593, 107 P.2d 1 (1940).

The state traditionally assumes a *parens patriae* role in dealing with minors or the mentally incompetent. This means the state views itself as the protector and guardian of persons under disability to insure that the rights of the minor or incompetent are not abused. Comment, *supra* note 175, at 460. A minor's status is determined solely by age; mental incompetence is statutorily defined in California,

to mean or refer to any person, whether insane or not, why by reason of old age, disease, weakness of mind, or other cause, is unable, unassisted, properly to manage and take care of himself or his property, and by reason thereof is likely to be deceived or imposed upon by artful or designing persons.

CAL. PROB. CODE § 1460 (West Supp. 1975).

method is altogether appropriate when one considers that commitment or appointment of a guardian involves the deprivation of a person's freedom and his right to make basic decisions affecting his life.¹⁸⁴ Constitutional requirements of due process and equal protection have been held applicable to these types of hearings.¹⁸⁵ There is no reason why the determination of a person's capacity to consent to dangerous and irreversible forms of medical treatment should be regarded as any less deserving of the procedural safeguards that attach in a commitment or guardianship proceeding.¹⁸⁶ It has been observed that brain surgery is probably the most fearsome type of operation—"the invasion of cold steel of man's citadel of reason."¹⁸⁷ Shock treatment, especially if frequently administered, has the equally "fearsome" potential of affecting one's "citadel of reason." Yet, despite the serious nature of psychosurgery and shock treatment, the California Legislature has enacted a law which does not allow a court to determine capacity to consent to these treatments. This transfer of power to determine capacity to consent is without precedent to California law, which up to now has clearly required judicial preeminence in the determination of mental capacity.¹⁸⁸

AB 4481's ban on psychosurgery when a patient is considered incapable of informed consent is undermined by vesting the crucial determination of that capacity in a committee of doctors rather than a court. Capacity to consent, and thereby to exercise a legal right, like any other question of mental capacity, is primarily a legal issue.¹⁸⁹ Medical opinion may be helpful in under-

184. Two consequences flow from a determination of mental incompetency. First, the individual is precluded from exercising certain rights such as the right to contract or engage in certain professions. Second, after a guardianship is established, the guardian is given legal authority to act as an officer of the court to perform certain functions for the mental incompetent. Comment, *supra* note 175, at 460-61.

185. See, e.g., *Jackson v. Indiana*, 406 U.S. 715 (1972); *Baxtrom v. Herald*, 383 U.S. 107 (1966); *Thorn v. Superior Court*, 1 Cal. 3d 666, 673, 464 P.2d 56, 61, 83 Cal. Rptr. 600, 605 (1970).

186. The state of Washington has recently enacted legislation which requires a hospital to obtain a court order permitting EST on a patient who objects to the treatment. Before the court order is issued the patient has a right to a hearing where he may be represented by counsel and where he can have court-appointed psychiatrists testify on his behalf. See WASH. REV. CODE ANN. § 71.05.370(7) (Supp. 1974). The statute provides that its procedures can be dispensed with in an emergency, where delay may be fatal to the patient. *Id.*

The statute strikes a reasonable balance between competing interests, that is, the right of a mental patient to refuse treatment versus the right of the mental institution to treat patients in a manner it deems necessary. It also helps guarantee that EST will not be resorted to unless other less dangerous forms of treatment fail.

187. SLOVENKO, *supra* note 7, at 247.

188. See note 183 *supra*.

189. See Comment, *supra* note 175, for a thorough analysis of the legal ration-

standing mental competency, but doctors are not trained to make a determination of whether a person should be deprived of basic legal rights.¹⁹⁰

When an institution is considering whether or not to perform psychosurgery, the consent of the patient is imperative. Equally essential is the patient's capacity to consent. If the law is prepared to allow mental patients to undergo psychosurgery at all, it should strictly insure, through a *judicial* determination, that a patient has the capacity to consent. *Kaimowitz* illustrates how the coercive atmosphere of a mental institution can deprive a patient of the opportunity freely to consent to psychosurgery with full knowledge of the consequences.¹⁹¹ The case also demonstrates that there is no substitute for a determination of the capacity to consent to such treatment.¹⁹²

AB 4481's supposed "protection" of a mental patient's right to refuse shock treatment is illusory. As the law presently stands, shock treatment can be administered over a patient's objections upon determination by a review committee of his inability to consent.¹⁹³ The law thereby creates an unacceptable possibility of abuse. Outside of a courtroom there is no guarantee that a patient's due process rights will be observed, and AB 4481 provides absolutely no guidelines as to the appropriate procedure for determining capacity to consent.¹⁹⁴ Due process safeguards such as

are for incompetency proceedings.

190. Commentators have been critical of California law because it relies too heavily on medical opinion in the adjudication of what is basically a legal question. Comment, *supra* note 175, at 476. The dangers of overemphasis on medical opinion in areas involving moral values is thoughtfully analyzed in T. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY* (1963).

The California Supreme Court, in *In re Waite*, reversed a lower court determination of mental competency on several grounds, including over-reliance on "expert" medical testimony used by the petitioner to prove incompetence. 14 Cal. 2d 727, 731, 97 P.2d 238, 240 (1939).

The court concluded that:

[t]he opinions of the doctors as to [appellant's] "lack of judgment" and "intelligence defect" are to be tested by a consideration of the facts from which those opinions are derived; and if those facts do not justify the conclusions, the opinions are arbitrary, and without substantial value as evidence.

Id.

191. See text accompanying notes 86-120 *supra*.

192. *Id.*

193. CAL. WELF. & INST'NS CODE § 5326.4(f) (West Supp. 1975). *But see* text accompanying note 202 *infra*.

194. Another problem with AB 4481 is that it fails to define what standards are to be applied by the review committee in determining whether a patient is capable of rendering informed consent. Assemblyman Vasconcellos has proposed the following guideline:

A person confined shall be deemed incapable of informed consent if such person cannot understand, or knowingly and intelligently act upon the information specified in . . . the informed consent provisions of AB 4481.

notice, right to counsel, or right to call witnesses are not provided for in AB 4481.

The new law fails to recognize that determination of capacity to consent is the equivalent of a determination of mental competency; as such, the law needs revision to return the capacity to consent determination to the courts where it belongs.

C. Third Party Consent

Another troublesome feature of AB 4481 is the role the statute assigns to the guardians or relatives of a minor or legally adjudged mental incompetent in the informed consent determination. Section 5326.4(c) of the bill permits shock treatment to be performed only after certain conditions have been satisfied.¹⁹⁵ The condition relating to parents or guardians states that shock treatment shall be performed only after "a responsible relative or the guardian or conservator" is given an "oral explanation" of the risks and benefits associated with shock treatment.¹⁹⁶ AB 4481 provides that shock treatment can be administered as long as three conditions are met:

- (1) the relative or guardian is given an oral explanation of the treatment;
- (2) adequate documentation of the need for the treatment is entered into the patient's record; and
- (3) the review committee unanimously approves the proposed procedure.¹⁹⁷

The new law does *not* require that the treating physician obtain consent of a relative or guardian. It requires only that an "oral explanation" of the procedure be given.¹⁹⁸ If the statute

§ 5326.3(c) of Amendments, *supra* note 26, at 3.

Assuming, *arguendo*, that the reviewing committee has legal authority to find a patient incapable of giving consent to shock treatment, it is essential that the law provide careful guidance on what criteria are to be used in this determination. Since the question of capacity to consent involves a patient's ability to consider factors relating to the risks and benefits of the treatment, the capacity standard should focus on a patient's decision-making ability. One proposed standard is contained in the National Institute of Mental Health's *Draft Act Governing Hospitalization of the Mentally Ill*, reprinted in BRAKEL & ROCK, *supra* note 175, at 469.

The *Draft Act* states that a patient lacks capacity to consent when, as a result of mental illness, he loses the "power to make choices or becomes so confused . . . that he cannot make a decision having any relation to the factors bearing on his hospitalization." *Id.* A lucid analysis of the problems inherent in developing a workable standard of capacity to consent is contained in *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1216-22 (1974).

195. CAL. WELF. & INST'NS CODE § 5326.4(a)-(g) (West Supp. 1975).

196. *Id.* § 5326.4(c).

197. *Id.* § 5326.4(c)-(e).

198. *Id.* § 5326.4(c).

means what it says, then the universally recognized right of relatives or guardians to withhold consent, in all but the most extreme circumstances, has been abrogated. This provision of AB 4481 would allow the physician to proceed with the shock treatment, not only against the wishes of the patient considered incapable of consent, but also against the wishes of the parent, relative, or guardian.¹⁹⁹ To deny a close relative or guardian the exclusive right to make decisions affecting the well being of his or her child or ward constitutes a gross infringement of the rights of a mental patient.

VII. CONCLUSION

California has made great strides forward in insuring that the legal and civil rights of mental patients are protected. It is no secret that mental health legislation in this state has been a model for other states presently engaged in updating and modernizing their mental health laws. AB 4481 should be viewed as a further step in California's continuing effort to protect mental patients from being denied basic civil rights.

Unfortunately, the bill is far from perfect, with serious problems remaining to be solved. Because of the inherent coercion of the mental institution, the bill's provisions dealing with the ability of a long-term involuntary detainee to render informed consent for psychosurgery should be reexamined. Equally questionable are the provisions of AB 4481 that allow a mental patient to be subjected to shock treatment against his or her wishes if a review committee determines that the patient does not have the capacity to give informed consent. There is nothing objectionable in allowing a committee of doctors to determine the medical advisability of psychosurgery or shock treatment for a given patient. But the determination of a patient's capacity to give informed consent is a legal decision that belongs with a court, not with a medical review committee. Finally, the provisions of the bill which allow shock treatment to be administered to a minor or a mental incompetent without a parent's or a guardian's consent need to be amended explicitly to require such consent.

199. The list of proposed amendments to AB 4481 prepared by Assemblyman Vasconcellos's office is ambiguous on this point. On pages 5-6 of the proposed revisions, section 5326.7(f) states that if the patient is incapable of giving informed consent, then written informed consent is to be obtained, pursuant to sections 5326.3 and 5326.4. However, the suggested sections 5326.3 and 5326.4 retain the same provisions as the present law. Under the proposed revisions, consent would be required only for psychosurgery. With respect to EST, the old law and new proposals require only that the parent or guardian be given "the oral explanation" of the procedure. Nothing is said about obtaining actual consent. Amendments, *supra* note 26, at 5-6.

AB 4481 faces serious judicial and legislative challenges in the near future. The bill is being attacked by doctors in court as an unconstitutional invasion of the doctor-patient relationship.²⁰⁰ Amendments are being considered in the state legislature to modify the stringent penalty provisions and to clarify some of the confusion which presently surrounds the bill.²⁰¹ One such amendment is contained in a bill presently moving through the state legislature. The bill will amend AB 4481 to provide for a judicial determination of capacity to consent before shock treatment is administered to an involuntarily detained patient.²⁰² This type of amendment is urgently needed because the issue of capacity to consent, like mental competency, is primarily a legal one which should be left for a court to decide. Until the law recognizes this crucial point, serious questions remain as to how effective AB 4481 will be in truly protecting a mental patient's right to refuse psychosurgery and shock treatment.

Zachary E. Zwerdling

200. See note 16 *supra*.

201. See notes 26 & 32 *supra*.

202. The new bill, AB 1032, was introduced by Assemblyman Vasconcellos on March 4, 1975. As of this writing, AB 1032 has passed the state assembly and is on its way to consideration by the senate.

AB 1032 requires that a three-doctor review committee give unanimous consent to the proposed shock treatment. In addition, the patient's attorney or a representative from the Public Defender's office must agree that the involuntarily detained patient has the capacity to give written informed consent.

The bill requires a court hearing on the patient's capacity to consent, if in the judgment of the attending physician or the attorney representing the patient, the patient lacks such capacity. If the patient does not have the necessary capacity, the bill authorizes specified relatives or a guardian to consent in his place.

AB 1032 further provides that in the case of voluntarily admitted patients, a physician other than the attending physician must verify the patient's capacity to give informed consent.

The bill does not affect AB 4481's psychosurgery provisions.