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## THE REGULATION OF ELECTROCONVULSIVE THERAPY IN CALIFORNIA: THE IMPACT OF RECENT CONSTITUTIONAL INTERPRETATIONS

### I. INTRODUCTION

The right to personal autonomy is relatively new in the panoply of protected constitutional interests.<sup>1</sup> The nature and scope of this right, and whether it should be ranked along with other rights traditionally regarded as fundamental, are points of vigorous contention in legal and political circles.<sup>2</sup> It has become generally accepted by courts that patients treated for physical illnesses have a right derived from notions of privacy to determine their own medical destiny.<sup>3</sup> There has been greater reluctance to extend such rights of patient self-determination to persons confined for mental illnesses. Given that persons without mental disorders have a right to refuse most medical treatment, the question becomes whether such rights are forfeited due to affliction with such conditions.

Legislation restricting the imposition of treatment upon unwilling mental patients has commonly brought criticism from some members of the medical community.<sup>4</sup> These health care

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1. Rights related to personal autonomy are generally thought to be subsumed in the right of privacy first articulated in *Griswold v. Connecticut*, 381 U.S. 479 (1965). The United States Supreme Court has described the nature of the right of privacy in the following manner: "The cases sometimes characterized as protecting 'privacy' have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 598-600 (1977). Though the California laws regulating Electroconvulsive Therapy (ECT) have some bearing on the disclosure aspects of privacy, their relation to the decisionmaking facet of privacy is of more concern.

2. The recent Supreme Court confirmation hearings of Judge Bork and Justice Kennedy largely focused on their respective views of privacy rights.

3. This right, known as "informed consent", was described fully in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). Californians were given the same right to informed consent in *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

4. Kramer, *Use of ECT in California, 1977-1983*, 142 AM. J. PSYCHIATRY 1190 (1985).

providers believe since persons with mental disabilities have been committed for the purpose of treatment,<sup>5</sup> society has made a judgment that the patient has no right to refuse treatment proposed by a professional.<sup>6</sup> It is the clash of this viewpoint with those held by patient advocates—that anyone not determined by a court to be incompetent to make medical decisions retains a right to refuse treatment—which shapes the discussion in this article.

Electroconvulsive Therapy (ECT) is growing in popularity amongst the clinical psychiatric community in California despite legislation regulating its use.<sup>7</sup> Further increase in the clinical use of ECT would impact women and the elderly most severely of all groups.<sup>8</sup> Physicians have been successful in overturning municipal ordinances designed to ban the use of ECT within city limits,<sup>9</sup> and have now set their sights on the statutory and adminis-

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According to Kramer, "Legislation generated by this controversy [over ECT] has the potential to deprive patients of treatment that may be lifesaving." *Id.* at 1190.

5. See CAL. WELF. & INST. CODE §§ 5150, 5250 (West 1984). Section 5150 authorizes "treatment and evaluation" for seventy two hours for persons judged to be a danger to themselves or others, or to be gravely disabled. Section 5250 authorizes an additional fourteen days of "involuntary intensive treatment" under certain conditions. See also *Doe v. Gallinot*, 657 F.2d 1017 (9th Cir. 1981) (due process clause of the fourteenth amendment requires hearing by neutral decisionmaker for certification under section 5250).

6. The attorney representing the defendant hospital in a recent class action brought by involuntarily committed patients asserting their right to refuse antipsychotic drugs stated: "[I]t's a self-evident proposition that when the Legislature authorized that people be involuntarily committed, it authorized that they be treated. There's no purpose in setting up involuntary commitments and letting those same people decide the treatment." *Patient Can Reject Mind Drugs, State Court Rules*, *The Recorder*, Dec. 17, 1987, at 8, col. 3, discussing *Reise v. St. Mary's Hospital and Medical Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (1987), cert. granted (the administration of antipsychotic drugs held to be within the strictures of the Lanterman-Petris-Short Act).

7. From 1977 to 1981, the average number of patients receiving ECT in California was 2,599 per year. From 1982 to 1985, that average climbed to 2,867 patients per year—an increase of 368 patients per year or just over 9%. CAL. DEP'T. OF MENTAL HEALTH, 1985 ANNUAL REPORT TO THE CALIFORNIA STATE LEGISLATURE ON ELECTROCONVULSIVE THERAPY AND PSYCHOSURGERY.

8. In 1985, women received 70.5% of the ECTs administered in California. Persons aged sixty five and over comprised 48.5% of the population receiving ECT in 1985. *Id.*

9. *Northern Cal. Psychiatric Soc'y v. City of Berkeley*, 178 Cal. App. 3d 90, 223 Cal. Rptr. 608 (1986). Berkeley City Ordinance 5504 prohibited, without exception, the administration of ECT to any person within the city. The California Court of Appeals ruled that the state legislature intended to retain ECT as a treatment option despite heavy regulation, and that municipal regulatory authority was preempted by the state legislation.

trative provisions governing ECT in California.<sup>10</sup>

The various constitutional theories supportive of, and hostile to, state regulation of psychiatric treatment to the voluntarily and involuntarily confined comprise the bulk of the discussion in this article. Central to the arguments of both those who attack and those who defend such legislation are notions of privacy. Those seeking to set aside ECT regulation stress the privacy inherent in the patient-physician relationship. In support of its enactments, the state emphasizes protecting the patient's medical welfare, as well as the patient's rights to refuse treatment and to control what happens to their own bodies and minds. The current debate concerning privacy and whether it is a fundamental constitutional right might become less meaningful in this context, since the privacy sword is wielded by both sides. Constitutional adjudication of state regulation of intrusive psychiatric therapies would become more of a policy choice than a doctrinal analysis.

This article will begin with a brief description of ECT. Those less interested in the medical aspects may ignore this section. Such information could be important to an attorney, however, especially in an ECT malpractice action or other direct dealings with an ECT patient. The existing California regulatory scheme of ECT will be detailed, followed by constitutional arguments regarding the review committee, risk disclosure, and substitute consent provisions of these laws. It is the purpose of this discussion not only to provide the reader with an introduction to the California ECT laws, but to argue that such laws are a valid and important means of protecting the mentally ill.

## II. ECT: HISTORY, PURPOSE, AND EFFECTS

Electroconvulsive therapy is a psychiatric treatment which

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10. *Doe v. O'Connor*, No. C 646194 (Superior Ct. of Cal., Cty. of Los Angeles). The plaintiffs in this case, including a group named as "The International Psychiatric Association for the Advancement of Electrotherapy", seek to have the California statutes and rules regulating ECT declared unconstitutional. In their complaint, they claim that the legislative scheme "unduly limits and effectively prohibits patients from receiving, and licensed physicians from administering, accepted and appropriate forms of treatment for severe and often incapacitating mental illnesses or conditions." Plaintiffs rely upon the first, fourth, fifth, eighth, ninth, and fourteenth amendments to the United States Constitution and article I, sections one, two, and seven of the California Constitution.

creates a seizure in the brain by the induction of an electric current.<sup>11</sup> ECT was developed roughly half a century ago when Ugo Cerletti, a professor of neuropsychiatry, and Lucio Beni, a neuropsychiatrist, drew upon their experimentation with the induction of electrical convulsions in animals. In 1938, Cerletti and Beni performed the first electroconvulsive treatment on humans, against the protests of their patient.<sup>12</sup> Early ECT was administered without the benefits of anesthesia, muscle relaxants, or oxygenation.<sup>13</sup> Bone fractures, apnea, fright, and death were common, in some cases even probable, side effects of ECT.<sup>14</sup> The treatment was prescribed for a number of disorders for which it is now thought inappropriate, in particular schizophrenia.<sup>15</sup> Use of ECT as a method of keeping patients manageable and quiescent rather than as a treatment for their conditions is well known.<sup>16</sup> With the development of antipsychotic medications in the 1950's and 1960's, use of ECT subsided considerably.<sup>17</sup>

The most remarkable aspect of ECT is that no one, not even those physicians who prescribe it, possess a clear understanding of its physiological operation. A recent conference of ECT practitioners noted the "[i]dentification of biological mechanisms underlying the therapeutic effects of ECT" as "[a]mong the most important immediate research tasks."<sup>18</sup> Some authorities believe that ECT reduces psychotic behavior by disabling all of the mind's higher functions.<sup>19</sup> Others who defend ECT rely

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11. *Electroconvulsive Therapy—Consensus Conference*, 254 J.A.M.A. 2103, 2103 (1985).

12. Accounts have it that as Cerletti was placing the electrodes on the subject's head for a second ECT administration, the patient cried out, "Not another one. It's deadly!" Since the patient had previously been uncommunicative, Cerletti took this outburst as a sign of the positive therapeutic value of ECT. *ELECTROCONVULSIVE THERAPY: AN APPRAISAL* 8-9 (R. Palmer ed. 1981).

13. *Id.* at 15.

14. *Id.* at 15. One early study noted that over 35% of 212 ECT patients developed bone fractures, especially compression fractures of the back vertebrae.

15. See *Electroconvulsive Therapy—Consensus Conference*, *supra* note 11, at 2103.

16. *Id.*; See also P. BREGGIN, *ELECTROSHOCK: ITS BRAIN DISABLING EFFECTS* 135 (1979).

17. See *Electroconvulsive Therapy—Consensus Conference*, *supra* note 11, at 2103. The report noted that an estimated 33,384 patients admitted to psychiatric hospitals nationwide received ECT in 1980—amounting to roughly 2.4% of psychiatric admissions.

18. *Id.* at 2107.

19. P. BREGGIN, *supra* note 16. Dr. Breggin states:

ECT produces its primary effect through the dysfunction and damage it inflicts on the normal brain and hence on the mind. . . . An organically disabled person is a more helpless

heavily on the vast number of clinical research studies which demonstrate various degrees of improvement for patients treated with electroshock. Still, no satisfactory theory of why ECT produces any beneficial effect on patients has been forwarded; predominantly all of the evidence is empirical in nature.

ECT is used primarily in the treatment of affective disorders<sup>20</sup> such as: melancholic depression,<sup>21</sup> delusional depression,<sup>22</sup> acute mania,<sup>23</sup> and, to a lesser extent, schizophrenia.<sup>24</sup> ECT is considered most effective in the treatment of depressions.<sup>25</sup> Suicidal patients may be indicated for ECT, since its effects have a more rapid onset than antidepressant drugs.<sup>26</sup> ECT may also be effective for patients who have reached toxicity levels of, or are resistant to, their medication.<sup>27</sup> Geriatric depressives make up a

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person. As such he is often less troublesome to others. He usually but not always complains less about himself and his life situation; in many instances, the acute organic brain syndrome may include irrational euphoria that masquerades as "improvement". Ultimately the brain-disabled person is more manageable, docile, or tractable.

*Id.* at 135.

20. Affective disorders are those psychoses typified by a severe disorder in mood and secondary disturbances in thinking and behavior which are in consonance with the affect. L. HINSIE & R. CAMPBELL, *PSYCHIATRIC DICTIONARY* 20 (4th ed. 1973).

21. Melancholic depression is a morbid mental state, characterized by dejection, loss of interest in the outside world, loss of capacity to love, inhibitions of activity, and loss of self-esteem. *Id.* at 458.

22. Delusionally depressed patients are severely depressed with gross misinterpretations of reality, including delusions and hallucinations. *Id.* at 203.

23. Mania is a mental disorder characterized by violent, unrestrained behavior. *Id.* at 445.

24. Schizophrenia is characterized by disturbances in associations and mood, ambivalence of affect, intellect, and will, autism, attention defects, disturbances of the will, schizophrenic dementia, and disturbances of activity and behavior. *Id.* at 679.

25. The ECT conference cosponsored by the National Institute of Mental Health (NIMH) and the National Institute of Health (NIH) concluded that in the treatment of delusional depression, ECT was superior to either antidepressive or neuroleptic drugs when used alone, and at least as effective as a combination of the two. For the treatment of melancholic depression, ECT was rated roughly equal with tricyclic antidepressants and monamine oxidase (MAO) inhibitors. ECT was not recommended for patients with milder depressions, such as neurotic depression. The conference compared studies of ECT and lithium in the treatment of acute mania, and found the two stand in parity. In the treatment of schizophrenia and schizoaffective disorders, ECT compared unfavorably to the use of neuroleptics. *Electroconvulsive Therapy—Consensus Conference, supra* note 11, at 2104.

26. Kramer, *Electroconvulsive Therapy Use In Geriatric Depression*, 175 *J. NERV. MENT. DISEASE* 233, 233 (1987).

27. M. FINK, *CONVULSIVE THERAPY: THEORY AND PRACTICE* 53-54 (1979).

large part of this category of patients.<sup>28</sup> Use of ECT also avoids the development of tardive dyskensia,<sup>29</sup> a common and permanent side effect of psychopharmaceuticals. On the other hand, ECT is known to cause a variety of adverse side effects. The fright, bone fractures, and apnea which were once commonly associated with ECT can be virtually eliminated by the use of a general anesthetic, muscle relaxants, and proper oxygenation.<sup>30</sup> Broken teeth can usually be avoided by the use of a rubber bite block.<sup>31</sup> Other potential side effects include epilepsy, headaches, skin burns, nerve palsy, high blood pressure, and death.<sup>32</sup> Most ECT practitioners do not believe the treatment to cause permanent brain damage, though some physicians strongly dispute the claim.<sup>33</sup>

The major side effect of ECT is memory loss.<sup>34</sup> Memory of events both before ECT treatments (retrograde amnesia) and afterwards (anterograde amnesia) is affected, sometimes permanently.<sup>35</sup> ECT has a cumulative effect upon memory; that is, the greater the number and intensity of applications, the greater the likelihood and severity of amnesia.<sup>36</sup> Most of the innovative techniques in ECT concentrate on the problem of reducing memory loss.<sup>37</sup>

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28. Kramer, *supra* note 26, at 233. Such indicators may explain why 37% (or 48.5% in 1985. See *supra* note 8.) of all ECTs administered in California were to patients 65 years or older, though they constitute only 10% of the general population.

29. For a description of the effects of tardive dyskensia, see *Reise v. St. Mary's Hospital and Medical Center*, 196 Cal. App. 3d 1388, 1396-97, 243 Cal. Rptr. 241, 245-46 (1987), cert. granted.

30. Martin, *Electroconvulsive Therapy: Contemporary Standards of Practice*, 31 CAN. J. PSYCHIATRY 759, 759 (1986).

31. *Id.* at 764.

32. *Electroconvulsive Therapy—Consensus Conference*, *supra* note 11, at 2105.

33. See P. BREGGIN, *supra* note 19.

34. CAL. DEP'T. OF MENTAL HEALTH, *supra* note 7. In 1985, memory loss accounted for 97.4 % of all recorded complications from ECT in California. Complications were reported, as required by CAL. WELF. & INST. CODE § 5326.15(c)(4) (West 1984) for 833 of the 2,856 patients given ECT that year: a rate of just over 29%. Eight hundred and eleven of the 833 complications were attributed to memory loss, or 28.4% of all patients. It may be important to note that only incidents of cardiac arrest without death, fractures, memory loss, apnea, and death are required by the above statute to be reported. Patients who suffered from other side effects, such as epilepsy, tooth damage, skin burns, nerve palsy, or severe headaches, were not accounted for.

35. *Electroconvulsive Therapy—Consensus Conference*, *supra* note 11, at 2105.

36. Valentine, Keddie, & Dunne, *A Comparison of Techniques in Electroconvulsive Therapy*, 114 BRIT. J. PSYCHIATRY 989, 989 (1968).

37. Innovative techniques in ECT use include unilateral ECT, brief pulse ECT, low

Of the several intrusive psychiatric therapies developed in the 1930's (including psychosurgery and insulin coma therapy), only ECT remains widely used today. In California alone, at least 131,000 ECTs were performed in the years 1977 to 1985.<sup>38</sup> Other statistics indicate that ECT is on the rise after being dealt an initial setback by the enactment of the Lanterman-Petris-Short Act (LPS Act).<sup>39</sup> ECT advocates are becoming more vociferous in their demands for the relaxation of state regulation.<sup>40</sup> They argue that the goal of commitment is the improvement of the patient's condition, and that ECT is an effective way to produce results. The legislation regulating ECT, they say, deprives the committed person of the opportunity, and perhaps the right, to treatment which may result in discharge from the care facility.

### III. PRESENT CALIFORNIA ECT LAW

The Lanterman-Petris-Short Act<sup>41</sup> sets forth the statutory restrictions placed upon the use of ECT as a treatment for mental illness in a non-criminal setting.<sup>42</sup> Complementary provisions can be found in the California Administrative Code.<sup>43</sup> The purpose of the LPS Act is to recognize the civil rights of the mentally ill and ensure the protection of these rights.<sup>44</sup> This sec-

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energy ECT, and multiple-monitored ECT. See Fontaine & Young, *Unilateral ECT: Advantages and Efficacy in the Treatment of Depression*, 30 CAN. J. PSYCHIATRY 142 (1985); Squire, *ECT and Memory: Brief Pulse v. Sine Wave*, 143 AM. J. PSYCHIATRY 596 (1986); *Electroconvulsive Therapy—Consensus Conference*, *supra* note 11; Maletsky, *Conventional and Multiple Monitored ECT: A Comparison in Major Depressive Disorders*, 174 J. NERV. MENT. DISEASE 257 (1986).

38. CAL. DEP'T. OF MENTAL HEALTH, *supra* note 7. I say "at least" 131,000 treatments because not every ECT administration may have been reported. In its report, the Department of Mental Health stated its suspicion that ECT use was underreported. It hinted that not all treatments in a series were being reported. A true appraisal of the number of ECT's performed between 1977 and 1985 might be something closer to 150,000 or even 200,000. Compare these numbers with the fact that the Department of Mental Health has received no reports of psychosurgery in the years 1977 to 1985.

39. See *supra* note 7.

40. See *supra* notes 9-10 and accompanying text.

41. CAL. WELF. & INST. CODE §§ 5000-5579 (West 1984 & Supp. 1988).

42. The use of organic psychiatric treatments in prisons is dealt with at CAL. PENAL CODE §§ 2670-2680 (West 1982).

43. CAL. ADMIN. CODE tit. 9 §§ 835-849 (1985).

44. See *California State Psychological Ass'n v. County of San Diego*, 148 Cal. App. 3d 849, 198 Cal. Rptr. 1 (1983). The appellate court said, "LPS protects the rights of civilly committed mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism. The act provides for prompt evaluation and



tion will describe the existing ECT laws in California. Attorneys in state can use this summation as a practice guide, while mental health advocates out of state may look upon it as an model of patient-protective regulation. In addition, the review committee, risk disclosure, and substitute consent provisions will be introduced. Later in this article, these facets of California's ECT laws shall be subjected to constitutional analysis.<sup>46</sup>

The fundamental proscription of the California ECT laws consists of a ban on the treatment unless the patient gives his or her informed consent.<sup>46</sup> The LPS Act defines convulsive treatment as any treatment of a mental disorder which depends on the induction of a convulsion by any means.<sup>47</sup> This definition is broader than the clinical usage of the term ECT. The induction of a cerebral seizure, rather than general bodily convulsions, is the purpose of ECT.<sup>48</sup> In general, both the voluntarily and involuntarily confined have a right to refuse ECT.<sup>49</sup> This right can be denied only by a judicial determination of incompetency and the subsequent procurement of consent from a responsible relative, guardian, or conservator of the patient.<sup>50</sup> The right to refuse is the flip side of the right to informed consent, which is recognized in California.<sup>51</sup>

The right to informed consent has its origins in the common law<sup>52</sup> as well as the federal<sup>53</sup> and state constitutions.<sup>54</sup> In Califor-

treatment while protecting public safety and safeguarding individual rights through judicial review." *Id.* at 854-55, 198 Cal.Rptr. at 4.

45. See *infra* Section IV, *CONSTITUTIONAL ARGUMENTS REGARDING CALIFORNIA'S REGULATORY SCHEME FOR ECT*.

46. CAL. WELF. & INST. CODE § 5325(f) (West 1984).

47. *Id.*

48. Martin, *supra* note 30. "ECT is a medical procedure consisting of the electrical induction of a series of generalized or grand mal convulsions, under general anesthetic, for the treatment of certain mental disorders." *Id.* at 759-60.

49. CAL. WELF. & INST. CODE § 5325(e) (West 1984). The LPS Act treats minors differently in some respects. ECT is absolutely prohibited for those under twelve years of age. Persons between twelve and sixteen may be given ECT when there is an emergency, adequate review of the decision to treat with ECT is made, and the treatment is considered lifesaving. Anyone over the age of sixteen has the same rights as an adult. See CAL. WELF. & INST. CODE § 5326.8 (West 1984). The difficult problem of the constitutional rights of minors is beyond the scope of this article.

50. CAL. WELF. & INST. CODE §§ 5326; 5326.7(e)-(h) (West 1984).

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

52. *Schloendorff v. New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). Judge Cardozo wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."; *Canterbury v. Spence*, 464 F.2d

nia, a physician has the duty to divulge information which would be material to a reasonable patient's intelligent choice of treatment.<sup>56</sup> Failure to live up to this duty may expose the physician to malpractice liability. A money judgment on the theory of intentional or negligent failure to obtain informed consent would be an inadequate remedy, however, in the case of an already performed ECT.<sup>56</sup> Recognizing this situation, the legislature developed substantive standards by which informed consent is to be judged<sup>57</sup> and procedural safeguards to guarantee these standards are met prior to clinical intervention.<sup>58</sup> The substantive disclosure aspects of California's ECT laws ensure the patient is provided with all information relevant to the treatment decision. The patient's decision is more likely to be knowing and intelligent. The procedural mechanisms serve both medical and legal purposes. Required medical review tends to confirm that the patient arrived at a decision voluntarily, and not by coercive or unduly persuasive tactics. Such review also reduces exposure to the potentially harmful side effects of ECT by screening out patients for whom ECT is not a medical necessity. Judicial review of a patient's competency prior to the administration of treatment against his or her wishes prevents the competent patient's will from being overborne. Through these means, the California ECT laws test the presence of the three "first principles" of informed consent: knowledge, voluntariness, and competency.<sup>59</sup> The patient's right to refuse treatment is a corollary of the right to informed consent; the refusal is the self-actuating remedy of

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772, 782 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 242-43, 502 P.2d 1, 9-10, 104 Cal. Rptr. 505, 513-14 (1972).

53. *Rennie v. Klein*, 720 F.2d 266, 269-70 (3d Cir. 1983) (holding the right to refuse treatment protected under the fourteenth amendment due process clause of the United States Constitution).

54. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 301 (1986) (citing right of privacy protected by CAL. CONST. art. I, § 1).

55. *Cobbs v. Grant*, 8 Cal. 3d 229, 242-43, 502 P.2d 1, 9-10, 104 Cal. Rptr. 505, 513-14 (1972).

56. *Aden v. Younger*, 57 Cal. App. 3d 662, 129 Cal Rptr. 535 (1976). The appellate court stated: "The objective of the challenged law [an earlier, but similar, California statutory scheme regulating ECT] is to ensure certain medical procedures are not performed on unwilling patients." *Id.* at 673, 129 Cal. Rptr. at 542.

57. CAL. WELF. & INST. CODE § 5326.2 (West 1984).

58. CAL. WELF. & INST. CODE §§ 5326.7; 5326.75 (West 1984).

59. *Kaimowitz v. Department of Ment. Health, 2 PRISON L. RPTR.* 433 (Aug. 1973) (criminal sex offender seeking experimental psychosurgery to leave confinement in an institution). "To be legally adequate, a subject's informed consent must be competent, knowing, and voluntary." *Id.* at 476.

the decision not to consent. The right to informed consent is meaningless without the right to refuse treatment.<sup>60</sup>

California ECT law is unusual in that it expressly lists what information the physician must disclose to obtain voluntary informed consent.<sup>61</sup> The listed relevant factors include: (1) the necessity for treatment due to the nature and severity of the patient's disorder; (2) the nature of the recommended procedure, including the frequency and duration of the treatment; (3) the nature, degree, duration, and probability of medically known side effects and significant risks of the procedure (especially memory loss) and whether such adverse effects may be controlled to any extent; (4) whether there is a division of expert opinion as to the efficacy of the treatment; (5) reasonable alternative treatments, and why the physician recommends this particular treatment; (6) that the patient has the right to accept or refuse the treatment; and (7) that the patient can revoke given consent at any time prior to or between treatments.

Failure to adequately disclose any of the listed elements precludes a finding of informed consent and prohibits administration of ECT to voluntary and involuntary patients.<sup>62</sup> A twenty-four hour grace period must lapse between the disclosure of the information and the procurement of the patient's written consent.<sup>63</sup> Coercive tactics used in order to obtain a patient's consent are forbidden.<sup>64</sup> Intentional violations of the patient's rights to adequate disclosure and refusal of treatment subjects the physician to a penalty of no more than \$5000 per violation.<sup>65</sup>

The attending physician must disclose all the information relevant to an informed consent determination to a responsible relative of the patient's choosing, and, if he or she has one, the patient's guardian or conservator. This requirement can be waived by the patient.<sup>66</sup>

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60. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 301 (1986).

61. CAL. WELF. & INST. CODE § 5326.2 (West 1984).

62. CAL. WELF. & INST. CODE §§ 5326.7(d); 5326.75(a); 5326.85 (West 1984).

63. CAL. WELF. & INST. CODE § 5326.5(e) (West 1984).

64. CAL. WELF. & INST. CODE § 5326.5(a), (b) (West 1984).

65. CAL. WELF. & INST. CODE § 5326.9(b) (West 1984).

66. CAL. WELF. & INST. CODE § 5326.7(c); see *Aden v. Younger*, 57 Cal. App. 3d 662, 681, 129 Cal. Rptr. 535, 547 (1976) (invalidating a forced disclosure provision without the

The clear and intended effect of requiring all this disclosure is to involve the patient in the decisionmaking process. No longer can he or she be ignored. Those who oppose ECT regulation complain that forced disclosure deters people from using ECT. They challenge these requirements as an unconstitutional interference with the practice of medicine. Perhaps their concerns are misdirected. More likely it is the content of such disclosure, detailing the risks inherent in ECT, which turns people away from the treatment.<sup>67</sup>

The Lanterman-Petris-Short Act sets forth a number of procedural criteria that must be met before ECT can be administered.<sup>68</sup> The procedures requiring review of the medical components of the decision to treat with ECT ensure that the treatment is not administered carelessly or without adequate medical justification.<sup>69</sup> Such review is desirable for at least two reasons. First, ECT may have debilitating side effects on patients, especially in memory and learning functions. Such risks should be avoided whenever possible. Second, ECT has been used as a restraint rather than as a treatment. This type of abuse can be curtailed by review for medical need.

In order to preserve a detailed and permanent record of the medical treatment of the committed person, the attending physician must enter certain information relating to the recommendation for ECT into the patient's chart. Adequate documentation must justify the use of ECT.<sup>70</sup> All other reasonable treatment approaches (for example, psychotherapy) must have been carefully considered, but need not be exhausted.<sup>71</sup> ECT must be definitely indicated and the least drastic treatment alternative available.<sup>72</sup>

ECT is considered excessive if administered more than fif-

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waiver option as violative of the patient's rights to privacy and confidentiality).

67. In another context (the regulation of securities), but with equal applicability, Justice Brandeis commented on the value of full disclosure. He wrote, "Sunlight is said to be the best of disinfectants; electric light the most efficient policeman." L.D. BRANDEIS, *OTHER PEOPLE'S MONEY* 63 (1933).

68. CAL. WELF. & INST. CODE §§ 5326.7; 5326.75 (West 1984).

69. CAL. WELF. & INST. CODE § 5326.7(a) (West 1984).

70. CAL. WELF. & INST. CODE §§ 5326.7(a); 5326.75(a) (West 1984).

71. *Id.*

72. *Id.*

teen times in a thirty day period, or more than thirty times per year.<sup>73</sup> When more than one cerebral seizure is induced in a single session, each seizure shall be considered a separate treatment.<sup>74</sup> If the treating physician wishes to continue ECT administration beyond these limits, he or she must get approval from a review committee of the facility or county; any such approval must be for a fixed number of additional treatments.<sup>75</sup> A patient may not consent more than thirty days in advance.<sup>76</sup>

A facility which performs ECT must designate a qualified committee to review ECT treatments of voluntarily and involuntarily confined patients and verify the appropriateness and need for such treatments.<sup>77</sup> For involuntary patients, the review committee is composed of two board-certified or board-eligible psychiatrists or neurologists.<sup>78</sup> At least one of the physicians must have personally examined the patient.<sup>79</sup> The two physicians must unanimously agree (and so note in the patient's chart) with the recommendation of the treating physician before ECT can be administered.<sup>80</sup>

The procedural mechanisms for administering ECT to voluntarily committed patients are identical to those for the involuntarily confined, except for the treatment review committee provisions. For voluntary patients, the review committee is made up of one (rather than two) board-certified or board-eligible psychiatrist or neurologist.<sup>81</sup> The scope of the inquiry is limited to verification of the patient's capacity to consent and that such consent has been given in writing.<sup>82</sup> This verification must be noted in the patient's chart.<sup>83</sup> Post-treatment review committees

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73. CAL. ADMIN. CODE tit. 9 § 836(a) (1985).

74. CAL. ADMIN. CODE tit. 9 § 836(a) (1985). This definition is limited to reporting and recordkeeping purposes, but there is nothing to indicate that another standard would or should be used when considering the maximum number of treatments permissible.

75. CAL. ADMIN. CODE tit. 9 § 849(b) (1985).

76. CAL. WELF. & INST. CODE § 5326.7(d) (West 1984).

77. CAL. WELF. & INST. CODE § 5326.91 (West 1984); CAL. ADMIN. CODE tit. 9 § 847 (1985).

78. CAL. WELF. & INST. CODE § 5326.7(b) (West 1984).

79. *Id.*

80. *Id.*

81. CAL. WELF. & INST. CODE § 5326.75(b) (West 1984)

82. *Id.*

83. *Id.*

for both the voluntarily and the involuntarily confined are to be established by any facility performing ECT, or by the Department of Mental Health.<sup>84</sup> These bodies act as "watchdogs" by screening charts of performed ECT's for appropriateness and need.

Use of the medical review committees helps to forestall coercive and unseemly tactics which could undermine the voluntary nature of a patient's informed consent. In addition, medical review seeks to protect the patient's welfare by preventing his or her mental functions from being subjected to unnecessary ECT treatment.<sup>85</sup>

Judicial review is more clearly aimed at verifying the mental patient's ability and legal competency to consent. Unlike that other well-publicized intrusive psychiatric treatment (psychosurgery),<sup>86</sup> ECT may be forced upon an unwilling patient. The only mechanism for nonconsensual ECT is by obtaining a judicial determination of the patient's incapacity to consent to a medical procedure, and then to solicit surrogate consent from an appropriate person.<sup>87</sup>

In order to have a potential ECT patient declared incompetent, definite procedures must be followed. A request for a judicial determination of incompetency to consent can be initiated by either the treating physician or the patient's attorney by filing a petition in superior court. The court shall hold a competency hearing within three days after the petition is filed. The patient can retain counsel or will be appointed legal representation if he or she cannot afford an attorney.<sup>88</sup> If the patient's attorney is the one filing the petition for a declaration of incompetency, he or she should be disqualified from representing the

84. CAL. WELF. & INST. CODE § 5326.91 (West 1984); CAL. ADMIN. CODE tit. 9 § 847 (1985).

85. CAL. WELF. & INST. CODE § 5326.7(a), (b) (West 1984) (treating physician and review committee must make specific medical determination regarding the appropriateness of ECT before the treatment can be administered).

86. See CAL. WELF. & INST. CODE § 5326.6 (West 1984). The psychosurgery statute makes no distinction between voluntary and involuntary patients, and imposes greater restrictions on treatment. See also *Aden v. Younger*, 57 Cal. App. 3d 662, 683, 129 Cal. Rptr. 535, 548-49 (1976) (hazardous, experimental nature of psychosurgery justifies more extensive regulation than for ECT).

87. CAL. WELF. & INST. CODE §§ 5326.7(e)-(h); 5326.75(c) (West 1984).

88. *Id.*

patient at the hearing for conflict of interest reasons.<sup>89</sup>

Incapacity to give informed consent will be found only if the person cannot understand, or knowingly and intelligently act upon, the information the physician is required to disclose.<sup>90</sup> If a patient has previously been declared incompetent, then a guardian (for unmarried minors) or a conservator (for adults and married minors) must still follow this procedure.<sup>91</sup> This provision recognizes the fact that a person may be incompetent to make certain decisions, yet retain sufficient mental acuity to make medical decisions.

The California courts seem to grant judicial determinations of incompetency to consent to ECT reluctantly. The burden of proof is borne by the party seeking the declaration of incompetency; the applicable standard of persuasion is clear and convincing evidence.<sup>92</sup> Even if the patient's motives in refusing treatment are a blend of psychotic and rational choices, incompetency will not be found.<sup>93</sup> Only if a patient utterly lacks comprehension of what is being proposed will he or she be found incompetent.<sup>94</sup>

Once a patient has been determined legally incompetent, his or her rights to refuse treatment vanish. The treatment decision is turned over to a third party: either a responsible relative, guardian, or conservator.<sup>95</sup> The only limits on the discretion of this person appear to be the religious beliefs of the patient.<sup>96</sup>

#### The purpose of the ECT provisions in the Lanterman-Pe-

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89. CAL. RULES OF PROFESSIONAL CONDUCT Rule 5-102(b) (West 1981); *See also* MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7 (1983). These rules prohibit the attorney from representing interests adverse to the client. If the attorney has filed the petition for a determination of incompetency, his or her representation of the client at the competency hearing would be in conflict with the earlier acts. The sole exception to these rules requires the client's consent to the conflict of interest. Since the petition asks for a determination of incompetency, it is difficult to see how the attorney could in good faith believe the client was capable of consenting to the conflict in representation.

90. CAL. WELF. & INST. CODE § 5326.5(c) (West 1984).

91. CAL. PROB. CODE § 2356(c) (West Supp. 1988).

92. *Lillian F. v. Superior Court*, 160 Cal. App. 3d 314, 206 Cal. Rptr. 604 (1984).

93. *Conservatorship of Waltz*, 180 Cal. App. 3d 772, 227 Cal. Rptr. 436 (1986).

94. *In re Fadley*, 159 Cal. App. 3d 330, 205 Cal. Rptr. 572 (1984).

95. CAL. WELF. & INST. CODE §§ 5326.7(g); 5326.75(c) (West 1984).

96. CAL. WELF. & INST. CODE § 5357 (West 1984); CAL. PROB. CODE § 2355(b) (West 1981).

tris-Short Act is to guarantee that voluntary, competent, and knowing consent is obtained from a patient prior to treatment.<sup>97</sup> The regulations also protect the patient's welfare by limiting administration of potentially dangerous ECT to cases for which the treatment is definitely indicated and the least drastic alternative available.<sup>98</sup> The overall effect of the regulations has been to curtail the clinical use of ECT as treatment for persons with debilitating mental disorders. The constitutional balance between purpose and effect is the subject of the next section.

#### IV. CONSTITUTIONAL ARGUMENTS REGARDING CALIFORNIA'S REGULATORY SCHEME FOR ECT

As we have seen, California extensively regulates the administration of ECT.<sup>99</sup> This regulatory scheme has been subjected to constitutional challenge.<sup>100</sup> The attack on the ECT laws centers on the review committee, forced disclosure, and substitute consent provisions. Physicians and some patients believe that such regulation deprives them of a constitutional right to practice and to receive medical treatment. The state justifies its laws as protective of the welfare and autonomy of its citizens. Despite recent constitutional interpretations regarding state regulation of medical care, many questions remain in this area. This section will pose these questions as they relate to California's ECT laws and attempt to answer them. Since both sides utilize privacy rights in their arguments, the current legal status of privacy shall be explored.

#### PRIVACY RIGHTS

Those seeking to have the ECT laws declared unconstitutional rely heavily on the right of privacy in the patient-physician relationship. A natural starting point for this analysis would be to determine to what extent privacy rights should be protected. If privacy rights are found to be fundamental, then legis-

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97. CAL. WELF. & INST. CODE §§ 5326.5(a); 5326.7(d); 5326.75(a) (West 1984).

98. CAL. WELF. & INST. CODE §§ 5326.7(a); 5326.75(a) (West 1984).

99. See *supra* Section III, *PRESENT CALIFORNIA ECT LAW*.

100. See *supra* notes 9-10; see also *Aden v. Younger*, 57 Cal. App. 3d 662, 668, 129 Cal. Rptr. 535, 538-39 (1976) (Constitutional challenge to California's ECT laws brought by physicians).



lation (such as California's ECT laws) which infringes upon privacy rights must be examined with strict scrutiny. If privacy is not so regarded, then only a minimal scrutiny standard need be met.

Rights explicit in the United States Constitution are universally regarded as fundamental.<sup>101</sup> An examination of the text of the federal constitution will not reveal an express reference to a right of privacy. This absence should not be surprising since the phrase was not part of the terminology known to the framers.<sup>102</sup> The United States Supreme Court has determined that a general right of privacy is implicit in the constitution.<sup>103</sup> The Court has been reluctant to define privacy rights broadly, such as by equating them with a concept of personal autonomy. Instead, the trend is to confine the right of privacy to narrow categories as defined by precedent.<sup>104</sup> The recent decision upholding Georgia's criminal sodomy statute indicates a desire to confine privacy rights to decisions related to the traditional family.<sup>105</sup> Lower federal courts have regarded the right to refuse treatment as a substantive due process concept, rather than one involving privacy, with a corresponding reduction in the level of judicial scrutiny.<sup>106</sup> California has an explicit right of privacy in its state constitution.<sup>107</sup> Case law is split, however, on whether these pri-

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101. See *Thornburgh v. American Coll. of Obst. & Gyn.*, 476 U.S. 747 (1986) (White, J., dissenting): "Fundamental liberties and interests are most clearly present when the Constitution provides specific textual recognition of their existence and importance." *Id.* at 790.

102. It appears that the phrase "right to privacy" was coined by Brandeis and Warren in their famous law review article. Brandeis & Warren, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

103. *Griswold v. Connecticut*, 381 U.S. 479 (1965), drawing upon *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

104. See, e.g., *Paul v. Davis*, 424 U.S. 693 (1976). The Court defined privacy rights as "matters relating to marriage, procreation, contraception, family relationships, and child rearing and education." *Id.* at 713.

105. *Bowers v. Hardwick*, 478 U.S. 186 (1986) (holding that a Georgia statute criminalizing consensual sodomy did not implicate a fundamental right of privacy); see Eichbaum, *Towards an Autonomy-Based Theory of Constitutional Privacy: Beyond the Ideology of Familial Privacy*, 14 HARV. C.R.—C.L. L. REV. 361 (1979). "A family-based formulation of privacy disregards individual choice altogether; it champions societal institutions and therefore perpetuates the status quo." *Id.* at 365.

106. *Rennie v. Klein*, 720 F.2d 266, 269, 271 (3d Cir. 1983) (less restrictive alternative analysis for a New Jersey statute curtailing the right to refuse antipsychotic medication is not required under the fourteenth amendment due process clause).

107. CAL. CONST. art. I, § 1.

vacy rights are implicated by medical decisionmaking.<sup>108</sup> Failure to find some trigger of a fundamental right, whether under privacy or due process doctrine, means that California's ECT laws would be tested by a minimal scrutiny standard.

## PATIENT'S RIGHTS

### REVIEW COMMITTEES

California ECT law requires both pre- and post-treatment review by medically qualified committees. Patients argue that such review interferes with the private decisionmaking relationship between themselves and their doctor. They further complain that the compulsory physical examination by members of the review committees is demeaning and intrusive of their privacy rights.

In *Doe v. Bolton*,<sup>109</sup> the United States Supreme Court held that the medical review committees established by the State of Georgia constituted a violation of a woman's privacy rights to make treatment decisions (an abortion) with the assistance of the attending physician.<sup>110</sup> Other abortion decisions have per-

108. This "split" exists mainly at the Supreme Court level. In *People v. Privatera*, 23 Cal. 3d 697, 591 P.2d 919, 153 Cal. Rptr. 431 (1979), a conviction of a physician and others for selling and prescribing laetrile in violation of the Health and Safety Code was held constitutional. The California Supreme Court said that the article I, section one right of privacy was not intended to apply to medical decisionmaking. The sponsors of the constitutional amendment were concerned solely with government surveillance and data collection activity. *Id.* at 709-10, 591 P.2d at 938-39, 153 Cal. Rptr. at 450-51. A somewhat contrary ruling is *Committee to Defend Reproductive Rights v. Myers*, 29 Cal. 3d 252, 625 P.2d 779, 172 Cal. Rptr. 866 (1981), in which the article I, section one right of privacy was used to insulate a woman's decision to seek an abortion. *Id.* at 275, 625 P.2d at 792, 172 Cal. Rptr. at 879. Supporting *Myers* use of the article I, section one right of privacy is *Conservatorship of Valerie N.*, 40 Cal. 3d 143, 707 P.2d 760, 219 Cal. Rptr. 387 (1985), in which sterilization was held to be within the scope of these privacy rights. *Id.* at 160-65, 707 P.2d at 771-74, 219 Cal. Rptr. at 398-401. California Appellate Courts seem to line up in holding that privacy rights under the California Constitution do encompass medical decisionmaking. *See, e.g., Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

109. 410 U.S. 179 (1973).

110. Justice Blackmun wrote for the Court:

The woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it are substantially limited by this statutorily imposed overview. . . . We conclude that the interposition

mitted state-mandated involvement of additional medical personnel.<sup>111</sup> The determinative factor in distinguishing these seemingly anomalous results is whether the added medical attention advanced some significant interest of the state.<sup>112</sup> PROJECT advocates, relying on *Doe v. Bolton*,<sup>113</sup> argue that review in the context of psychiatric therapy constitutes unnecessary interference.

Several distinctions between ECT and abortion must be noted. First, those committed to a state institution are treated by a number of staff personnel. They might not expect a private relationship with a single physician as a woman seeking an abortion would. Second, persons committed for mental illness are more susceptible to persuasion and coercion. This is especially true of the involuntarily committed for whom release from the institution may depend on compliance with the attending physicians.<sup>114</sup> Third, pregnancy is a condition readily susceptible of objective proof; thus, there can be little doubt that abortion, when desired, is the appropriate remedy. Such certainty is not available, however, in psychiatric diagnoses. Reviewing the decision to treat with ECT to confirm the necessity of using ECT furthers the state's interest in protecting the health and welfare of its citizens—an interest not involved in the pre-viability abortion situation.<sup>115</sup> Since state-mandated review of the decision to treat with ECT arguably furthers important state interests, the

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of the hospital abortion committee is unduly restrictive of the patient's rights and needs that, at this point, have already been medically delineated and substantiated by her personal physician.

*Id.* at 197-98.

111. *Planned Parenthood Assn. v. Ashcroft*, 462 U.S. 476, 482-86 (1983) (the participation by a second physician in an abortion procedure as required by Missouri law with the limited purpose of assisting in the event of a viable fetus being born alive upheld as furthering the state's compelling interest in preserving life).

112. Compare the United States Supreme Court's statements in *Doe v. Bolton*, 410 U.S. 179, 197-98 (1973), which indicated that review was unhelpful, to the ruling in *Ashcroft*, 463 U.S. 476, 482-86 (1983), where the presence of a second physician assisted in the preservation of life. *See also supra* notes 110-111.

113. 410 U.S. 179 (1973).

114. *See Kaimowitz v. Department of Ment. Health*, 2 PRISON L. RPR. 433 (Aug. 1973). "The inherently coercive atmosphere to which the involuntarily detained mental patient is subject has bearing upon the voluntariness of his consent." *Id.* at 477.

115. *See CAL. WELF. & INST. CODE* § 5326.7(a), (b) (West 1984) (Two member review committee must unanimously agree that ECT is definitely indicated and is the least drastic alternative available).

imposition on the patient-physician relationship might be tolerated.

It is possible that voluntarily confined patients would be treated differently than the involuntarily confined. In *Aden v. Younger*,<sup>116</sup> the court held that the review committee's verification of the medical appropriateness of the treatment decisions was violative of the voluntary (but not the involuntary) patient's privacy rights. The distinction between the two groups was based on the notion that voluntary patients are better able to protect their own interests. The difference between voluntary and involuntary patients is often more illusory than real; the classification may be arbitrary and bear no relation to the circumstances of their commitment.<sup>117</sup> In addition, voluntarily confined patients are equally vulnerable to threats and persuasion.<sup>118</sup> It may not be wise, therefore, to review voluntary and involuntary patients with different standards.

Following the *Aden* ruling, the California legislature created new standards for voluntary patients.<sup>119</sup> A review committee of one physician is mandated, but only to verify the patient's competency to consent—not whether the treatment decision was a good one. This alteration removes the constitutional defects of the *Doe v. Bolton* variety, since there is no state interference with the decision to treat. Given that medical review protects interests which apply with equal force to the voluntarily and involuntarily confined,<sup>120</sup> however, the decision in *Aden* to treat the two groups differently may not have been compelled by precedent.<sup>121</sup>

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116. *Aden v. Younger*, 57 Cal. App. 3d 662, 684, 129 Cal. Rptr. 535, 550 (1976).

117. *See Id.* at 674, 680, 129 Cal. Rptr. at 542-43, 547.

118. Note the anticoercion provisions of the LPS Act apply equally to voluntarily and involuntarily committed patients. CAL. WELF. & INST. CODE § 5326.5(a), (b) (West 1984).

119. CAL. WELF. & INST. CODE § 5326.75 (West 1984).

120. As already noted, these interests include the prevention of coercion and the finding of medical appropriateness. *See supra* notes 64 and 98 and accompanying text.

121. *See supra* note 112 and accompanying text, reconciling the competing results of *Doe v. Bolton* and *Ashcroft*.

## DISCLOSURE OF THE ELEMENTS OF INFORMED CONSENT

As previously noted, California law requires the physician to convey specific risks and alternatives as part of the informed consent determination.<sup>122</sup> The United States Supreme Court twice held that similar provisions in abortion statutes were an unconstitutional infringement on the patient-physician relationship.<sup>123</sup> The Court said that such information constituted a "parade of horrors" which was "designed not to inform the woman's consent but rather to persuade her to withhold it altogether."<sup>124</sup>

The abortion statutes can be partially distinguished from California's ECT laws on the basis that some of the condemned information in those laws was clearly unrelated to the patient's well-being. Other information noted in the abortion cases seems highly relevant to an informed risk-benefit determination. Moreover, there are some remarkable similarities between elements of the unconstitutional abortion statutes and California's ECT laws.<sup>125</sup> Perhaps most importantly, it is virtually unquestioned that the ECT regulations were passed with the intent of curtailing its use, the factor which damned the abortion laws. The greater risks associated with ECT may justify additional disclosure since the patient needs more protection.

## SUBSTITUTE CONSENT

Provisions for substitute consent can be found in California Welfare and Institutions Code sections 5326.7(e)-(h) and 5326.75(c). Voluntary and involuntary patients are treated in essentially the same manner.

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122. See CAL. WELF. & INST. CODE § 5326.2 (West 1984).

123. *Thornburgh v. American Coll. of Obst. & Gyn.*, 476 U.S. 747 (1986); *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983).

124. *Akron*, 462 U.S. at 444-45.

125. For example, in *Thornburgh*, 476 U.S. 747, the Court invalidated provisions requiring the physician to inform the woman of "detrimental physical and psychological effects" and the "particular medical risks" of abortion. *Id.* at 759-65. In *Akron*, 462 U.S. 416, a provision characterizing abortion as "a major surgical procedure" and listing potential physical and psychological complications was held unconstitutional. *Id.* at 442-45. Compare with the information which must be given to prospective ECT patients. See CAL. WELF. & INST. CODE §5326.2 (West 1984)

In *Youngberg v. Romeo*,<sup>126</sup> the United States Supreme Court established that a minimally adequate level of treatment is guaranteed to committed patients by the fourteenth amendment due process clause.<sup>127</sup> The California Supreme Court relied on the fourteenth amendment liberty interest and the express California constitutional rights to privacy and equal protection in holding that an incompetent woman had the right to a sterilization procedure.<sup>128</sup> The thrust of these two decisions is that a committed individual has a right to treatment, and incompetence cannot be a barrier to the exercise of personal rights. Taken together, the rulings seem to mandate substitute consent provisions in legislation regulating the administration of "minimally adequate" medical treatment to those committed in state institutions.

If it is accepted that incompetents have some right to treatment, then the question becomes who gets to decide, and under what conditions treatment will be provided. There are at least three competing models: professional judgment, substituted judgment, and the California approach.

The professional judgment standard was articulated in *Youngberg v. Romeo*.<sup>129</sup> Under this standard, the only constraint upon substitute decisionmaking is that the treatment plan cannot deviate from accepted professional practice.<sup>130</sup> Furthermore, if the decision is made by a professional, (including a physician, nurse, or those "subject to the supervision" of either) then it is presumptively valid.<sup>131</sup> Physicians prefer this standard since it gives them the most latitude and authority in the decisionmak-

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126. 457 U.S. 307, 319 (1982).

127. Justice Blackmun noted in concurrence:

If a state court orders a mentally retarded person committed for "care and treatment", however, I believe that due process might well bind the state to ensure that the conditions of his commitment bear some reasonable relation to each of these goals. In such a case, commitment without any "treatment" whatsoever would not bear a reasonable relation to the purposes of the person's confinement.

*Id.* at 326.

128. *Conservatorship of Valerie N.*, 40 Cal. 3d 143, 160-65, 707 P.2d 760, 771-74, 219 Cal. Rptr. 387, 398-401 (1985).

129. *Youngberg*, 457 U.S. at 322.

130. *Id.* at 323.

131. *Id.* at 323.

ing process.

The substituted judgment standard focuses on the needs and desires of the patient rather than the physician. The approach of this standard is to ask what decisions this individual would have made were he or she competent.<sup>132</sup> A number of factors have been indentified as essential to such a determination: the expressed preferences of the patient, the patient's religious convictions, the impact on the patient's family, the probability and severity of adverse side effects, the patient's prognosis with and without the proposed treatment, and any other relevant factors. Most significantly, the substituted judgment model requires a court to be the one making these decisions for the incompetent patient by balancing these factors.<sup>133</sup>

California charts a course all its own. As firmly enunciated in the right to die cases,<sup>134</sup> an individual has the right to refuse treatment, even if such proposed treatment is in accordance with accepted professional judgment. Courts do not consider any of the medical implications of the proposed treatment; the focus is on the patient's legal competency.<sup>135</sup> If a patient has been declared incompetent under the legislated standard, the decision

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132. *Rogers v. Commissioner of Dep't. of Ment. Health*, 390 Mass. 489, 459 N.E.2d 308, 318-19 (1983) (class action alleging constitutional violations in forced druggings); *see also* *Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40, 56-59 (1977) (forced administration of antipsychotic drugs for an incompetent); *Superintendent v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 427-32 (1977) (terminally ill incompetent seeking discontinuation of cancer treatment).

133. *Rogers*, 458 N.E.2d at 318-19.

134. *See Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 95 Cal. Rptr. 484 (1983). The *Bouvia* court stated:

By refusing petitioner relief which she sought [removal of a forced feeding tube], the trial court, with the most noble intentions, attempted to exercise its discretion by issuing a ruling which would uphold what it considered a lawful object, i.e., keeping Elizabeth Bouvia alive by a means which it considered ethical. Nonetheless, it erred for it had no discretion to exercise. Petitioner sought to enforce only a right which was exclusively hers and over which neither the medical profession nor the judiciary have any veto power. The trial court could but recognize and protect her exercise of that right.

*Id.* at 1135, 225 Cal. Rptr. at 299.

135. *Reise v. St. Mary's Hospital and Medical Center*, 196 Cal. App. 3d 1388, 1407-08, 243 Cal. Rptr. 241, 253 (1987), cert. granted.

to administer treatment is not made by the courts. Instead, the conservator, responsible relative, or guardian has the power to accede to the treatment proposal.<sup>136</sup>

Health care providers attacking the ECT laws would rather not have to obtain a judicial determination of incompetency. Emphasis is put on the delay in providing the patient with treatment. Little regard is given to the patient's desires. Instead, the focus is on administering medicine as the attending physician chooses.<sup>137</sup>

Of the three substitute consent approaches, the professional judgment standard advocated by the federal courts is the most permissive.<sup>138</sup> Unlike the federal standard, the substituted judgment and the California approaches require a judicial determination of incapacity to consent before the patient's will can be overborne.<sup>139</sup> While California courts are unwilling to second guess the physician with respect to purely medical conclusions,<sup>140</sup> they concur with courts following the substituted judgment standard that incompetence is a *legal*, not a medical, determination.<sup>141</sup> Such legal rulings must, of course, be made by legal bodies.

## RIGHTS OF THE PHYSICIANS

Licensed ECT practitioners argue that the California laws regulating administration of the treatment are an unconstitutional deprivation of their right to practice their trade. Their theory is that, once licensed, a physician may practice medicine according to his or her best professional judgment. State regulation of medical practitioners has long been upheld as a legiti-

136. CAL. WELF. & INST. CODE §§ 5326.7(g); 5326.75(c) (West 1984).

137. See *supra* note 6.

138. See *Reise*, 196 Cal. App. 3d 1388, 1405-06, 243 Cal. Rptr. 241, 252 (1987), cert. granted (discussing the extreme deference of the courts to the physician's decision under the federal standard).

139. See *supra* notes 132-33 and 87-96, respectively and accompanying text.

140. See *supra* note 135 and accompanying text.

141. *Reise*, 196 Cal. App. 3d at 1406, 243 Cal. Rptr. at 252 (1987), cert. granted; *Rivers v. Katz*, 67 N.Y. 2d 485, 496-97, 504 N.Y.S.2d 74, 80, 495 N.E.2d 337, 343 (1986) (involuntarily confined patients challenged forcible administration of antipsychotic medications); *Rogers v. Commissioner of Dep't. of Ment. Health*, 390 Mass. 489, 458 N.E.2d 308, 312-15 (1983).



mate exercise of its police powers.<sup>142</sup> Unless the legislation restricting the physician is “patently arbitrary and totally lacking in rational justification,” any constitutional challenges will fail.<sup>143</sup> The rational basis of California’s ECT laws cannot be seriously questioned—to protect the welfare of its citizens is certainly rational. Any other claims by the physicians will generally be regarded as derivative of those of the patients.<sup>144</sup>

### JUSTIFICATIONS OF THE STATE FOR ITS ECT LAWS

The state justifies its regulation of ECT on at least two grounds: to protect the welfare of the mentally ill and to protect the competent individual’s right to refuse treatment. The potentially dangerous side effects of ECT are a valid reason for state intervention in the administration of psychiatric treatment.<sup>145</sup> Failure to adequately oversee the ECT process could result in unnecessary treatments and injuries to patient’s mental functions.

The protection of the patient’s right to refuse treatment is also a valid state interest. The scope of the patient’s right to refuse has been the subject of much litigation in state and federal courts.<sup>146</sup> The federal rights said to be implicated in the

142. *Barsky v. Board of Regents*, 347 U.S. 442 (1953) (physician’s suspension from practice of medicine for a prior conviction was upheld). “It is equally clear that a state’s legitimate concern for maintaining high standards of professional conduct extends beyond initial licensing. Without continuing supervision, initial examinations afford little protection.” *Id.* at 451.

143. *Association of Amer. Phys. & Sur. v. Weinberger*, 395 F. Supp. 125, 131-32 (N.D. Ill. 1975), *aff’d*, 423 U.S. 975 (1975) (challenge to federal professional standards review law).

144. *See Whalen v. Roe*, 429 U.S. 589, 604 (1977).

145. *Aden v. Younger*, 57 Cal. App. 3d 662, 680-81, 129 Cal. Rptr. 535, 546-47 (1976).

146. *See, e.g., Mills v. Rogers*, 457 U.S. 291 (1982) (determination under the federal constitution of rights of the involuntarily detained to refuse forcible administration of antipsychotic drugs avoided for a determination of such rights under state law); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983); *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988) (action by an involuntary patient relying on Minnesota’s constitutional right to privacy attacking forcible administration of neuroleptic drugs in non-emergency situations); *In re Mental Commitment of M.P.*, 510 N.E.2d 645 (Ind. 1987) (involuntarily committed patient asserting right to refuse antipsychotic medication); *Rogers v. Commissioner of Dep’t. of Ment. Health*, 390 Mass. 489, 458 N.E.2d 308 (1983); *Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1977); *Reise v. St. Mary’s Hospital and Medical Center*, 196

right to refuse include the first amendment,<sup>147</sup> fourteenth amendment,<sup>148</sup> and right to privacy.<sup>149</sup> After the decision by the United States Supreme Court in *Youngberg v. Romeo*, the federal courts have given far less weight to the individual's concerns. Rather, the inquiry is whether the physicians seeking to override the patient's wishes have exercised their best professional judgment. If they have done so, the individual has no right to refuse any proposed treatment plan.<sup>150</sup>

A state may protect the right to refuse more vigorously than does the federal constitution.<sup>151</sup> Apart from the LPS Act itself, it is possible that the explicit California constitutional right of privacy provides such additional protection. If so, the state's interest in protecting the patient's right to refuse is increased, since the right itself would be considered more important. As previously noted, however, current case law is divided as to the applicability of this privacy right to medical treatment decisions.<sup>152</sup>

## V. CONCLUSIONS

If any right can be said to be in a state of flux, it is the right of privacy. Ever since its first enunciation, courts have been uncertain of its perimeters and strength. Except in the emotionally charged area of abortion, state legislation has largely survived attacks based on privacy grounds. By giving legally competent patients the power to control their own destiny in treatment decisions, the California legislature was responding to a perceived imbalance in bargaining strength between mental patients and their physicians. In this sense, the California ECT laws are reminiscent of the labor laws declared unconstitutional by the

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Cal. App. 3d 1388, 243 Cal. Rptr. 241 (1987), cert. granted; *Keyhea v. Rushen*, 178 Cal. App. 3d 526, 223 Cal. Rptr. 746 (1986) (involuntary administration of antipsychotic drugs to prisoners); *Kaimowitz v. Department of Ment. Health*, 2 PRISON L. RPTR. 433 (Aug. 1973).

147. See, e.g., *Kaimowitz*, 2 PRISON L. RPTR. at 477-78, quoting from *Stanley v. Georgia*, 394 U.S. 557 (1969): "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds. . . ." *Stanley*, 394 U.S. at 565.

148. See, e.g., *Rennie*, 720 F.2d at 269-70.

149. See, e.g., *Rogers*, 458 N.E.2d at 317.

150. See *Rennie*, 720 F.2d at 269-70.

151. *Mills v. Rogers*, 457 U.S. 289 (1982). "[I]t is distinctly possible that Massachusetts recognizes liberty interests of persons adjudged incompetent that are broader than those protected directly by the Constitution of the United States." *Id.* at 303.

152. See *supra* note 108.

494 GOLDEN GATE UNIVERSITY LAW REVIEW [Vol. 18:469

United States Supreme Court in the *Lochner* era.<sup>153</sup> California's ECT laws protect the patient's welfare as well as their right to refuse unwanted treatment. Any attendant imposition on the freedom to make medical decisions is justified by these compelling interests. To invalidate ECT laws on nebulous privacy or liberty grounds and pave the way for an untoward increase in the use of this potentially devastating treatment would not only deprive the mentally ill of a fairly won political victory, but would also exalt the form of individual rights over its substance.

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153. *Lochner v. New York*, 198 U.S. 45 (1905). Of course, another parallel can be drawn in that those seeking to invalidate the legislation rely upon unenumerated constitutional rights.

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