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The inclusion of a chapter on food and drug, health, and welfare law in a survey of state law is in itself something new for projects of this type.

The proper method by which a review of material in this area is best offered presents something of a challenge to the authors. Active programs in these fields are generally interrelated; separation comes more in administration than in purpose. However, it was decided that a breakdown based on administrative considerations rather than functional programing might be more helpful to the lawyers and government administrators who will constitute the bulk of the readers of the SURVEY. This chapter is therefore divided into four parts corresponding to the four administrative areas in the field: food and drug, welfare, public health, and mental health.

## A. FOOD AND DRUG LAW

**§23.1. Dispensing of harmful drugs: Oral prescriptions.** By Chapter 577 of the Acts of 1954, the Massachusetts law was changed to conform to the federal law[1] in regard to the dispensing of so-called harmful drugs on the oral prescription of a physician, dentist, or veterinarian.

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§23.1. [1] The federal law is the Durham-Humphrey Law, 21 U.S.C. §353 (1953).

Any of these professional personnel or their "expressly authorized" [2] representatives (e.g., nurses) now may give oral (usually telephoned) prescriptions for these drugs under certain specified conditions. A written prescription must be delivered to the druggist within seven days. When giving the oral prescription to the druggist the person must state his own name and address and the name and address of the patient. The druggist must immediately enter the prescription on a regular prescription form. The prescription cannot be renewed unless the oral prescriber expressly so authorizes in the original prescription.

The previously cumbersome definition of harmful drugs in the Massachusetts law [3] was repealed. The term is now defined so as to include all those drugs, exclusive of narcotics, on which, under federal law, the manufacturer or distributor is required to place the following label: "Caution — Federal laws prohibit dispensing without prescription" (the so-called Rx legend drugs).

The new law also limits the sale of harmful drugs by manufacturers, jobbers, wholesalers, and dealers in drugs other than retail pharmacists to certain specified buyers, namely, licensed wholesale druggists, licensed hospitals and sanatoria, licensed clinics, pharmacists, registered physicians, dentists, veterinarians, or superintendents of colleges or scientific institutions.

The new law is designed to deal more realistically with the dispensing and labeling of both prescription and over-the-counter drugs. At the same time, it defines "harmful drugs" in terms of the broader and more effective federal law, thus providing a uniform law for the trade to follow.[4]

§23.2. **Possession of hypodermic instruments.** In another effort to deal more realistically with a problem in drug law, Chapter 226 of the Acts of 1954 changes the law [1] in regard to the possession of a hypodermic syringe, needle, or other instrument adapted for the use of narcotic drugs by subcutaneous injection.

Under the former law, a person other than those specifically listed in the statute,[2] who require the instruments in their profession or employment (such as physicians, dentists, nurses, embalmers, druggists, etc.) was required to have a permit to possess these instruments. The permit was obtained by a patient from his physician who issued it under the requirements of the law [3] and the regulations of the Board of Registration in Medicine. Under the new law, the physician must give a

[2] G.L., c. 94, §187, inserted by Acts of 1954, c. 577, §2. The term "expressly authorized representative" is not defined in the legislation. How the druggist is to know in each case who is an "expressly authorized representative" is thus left unclear.

[3] G.L., c. 94, §187A.

[4] For an article on the federal administrative enforcement of the Durham-Humphrey Law, see Crawford, The Retail Druggist and the Federal Law, 8 Food Drug Cosmetic L.J. 721 (1953).

§23.2. [1] G.L., c. 94, §209.

[2] Ibid.

[3] G.L., c. 94, §209A.

written prescription to his patient to purchase such an instrument. The prescription must contain the name and address of the patient and a description of the instrument to be purchased. The pharmacist is required to record the sale and its date on the prescription. The prescription is good for only one year unless the physician indicates on the prescription that it can be renewed.

The original law was, of course, designed to prevent hypodermic instruments from falling into the hands of narcotic drug addicts. However, the law had little effect in curbing the use of narcotic drugs. Few addicts use a syringe; most will make an injection with any type of sharp instrument.

§23.3. **Miscellaneous pure food and sanitation legislation.** Some changes in food law and sanitation should be noted. As further evidence of the acceptance of oleomargarine as a food on the general consumer market, the restrictive laws [1] requiring a license to transport oleomargarine for sale and the posting of placards on vehicles transporting it and on premises where it is sold were repealed.[2]

Of particular importance to the dairy products industry was an amendment [3] to the pure foods law in regard to ice cream mix and frozen desserts. The definition of a "stabilizer" in these products was broadened from "pure gelatine or vegetable gums" to "any non-toxic nutritive stabilizing or emulsifying agent approved by the department [of Public Health] and used singly or in combination." A new definition was also added to broaden the term "sugar" to include sucrose, dextrose, invert sugar (syrup or paste), maple syrup and sugar, corn syrup, corn syrup solids, honey, and brown sugar.

The difficult problem of sanitary inspection of the coastal waters and flats in order to determine what areas are so contaminated that shellfish obtained therefrom are unfit for human consumption[4] was somewhat eased by 1954 legislation,[5] relieving the Department of Public Health of the requirement of annual inspection. The department is now required to examine the coastal flats "from time to time" as conditions may require, or upon request of the Director of the Division of Marine Fisheries in the State Department of Natural Resources or various municipal officials, but "not more frequently than once in two years." The new law spells out more effectively the duties of the department in making these inspections and publishing the results.

§23.3. [1] G.L., c. 94, §§52, 56, and 57.

[2] Acts of 1954, c. 262.

[3] Acts of 1954, c. 664, amending G.L., c. 94, §65G. This act was passed as a result of recommendations of the Special Commission on Milk Marketing (House No. 2330, 1954). The life of the Commission was extended. Resolves of 1954, c. 103.

[4] For an examination of the difficulties involved in administering the program, see House No. 200, Thirteenth Report of the Special Commission on the Structure of the State Government (Public Health) 26 et seq. (1954).

[5] Acts of 1954, c. 243, amending G.L., c. 130, §74.

## B. Public Welfare

**§23.4. Programs for the aging: The Governor's Committee to Study State Hospitals.** Perhaps the outstanding development in the health and welfare field this year was the passage by the General Court of a comprehensive group of proposals in aid of the aging in our population. The adoption of these programs put Massachusetts in the forefront of the states taking active steps to provide better care and fuller lives for the aging.

One of the strongest forces behind putting these proposals before the legislature was the Governor's Committee to Study State Hospitals. It was appointed in March, 1953, and its report was published the following December. The Committee said quite bluntly at the beginning of its report, in the letter of transmittal to the Governor: "The outstanding problem which is not being adequately solved at present is that of our aging citizens. The span of life has been very much lengthened in this country, and it will increase still more. This means that the number of aging citizens who have retired from active work has increased greatly and will continue to increase."

The Committee proposed several programs in aid of this problem. Briefly they were as follows:

1. Preparing and educating the aging for old age
2. Postponement of the retirement age
3. Establishment of clinics for aging citizens
4. Improvement of nursing homes
5. Provisions for state and other public nursing homes

The Committee's report then goes into detail in outlining suggestions for carrying out these programs within the various state agencies. Portions of the report and recommendations enacted into law are discussed in other sections of this chapter.

**§23.5. Programs for the aging: State clinics and other facilities.** As a result of the recommendation of the Governor's Committee to Study State Hospitals, the General Court enacted legislation, Chapter 538 of the Acts of 1954, to provide for the establishment of clinics for the aging by the Department of Public Health in cooperation with local boards of health, hospitals, dispensaries, and other agencies. The location of the clinics was left up to the Department of Public Health. This legislation is designed, as most clinic programs are, to reduce the number of those entering state hospitals, private hospitals, or nursing homes. The Governor's Committee noted such a purpose.[1] Although the legislation does not spell out the programs to be initiated or the methods to be used, it is expected that they will take the form of geriatric clinics operated in cooperation with various agencies and hospitals and designed as "pilot studies" to encourage other agencies to carry on similar work.

§23.5. [1] Report of the Governor's Committee to Study State Hospitals 9 (1953).

The legislation also effects certain changes in regard to state hospitals and sanitoria and municipal tuberculosis sanatoria. It provides for admission of "aging persons" to the Lakeville State Sanatorium and allows no more admissions of persons "crippled by muscular dystrophy and other similar diseases." It provides that sanatoria in the state no longer needed for the care of tuberculosis patients be converted into homes for the care and treatment of the aging.[2] Conversion and operation is to be with the approval of the state health department.

The Committee had recommended the transfer of all crippled children at Lakeville State Sanatorium to the Massachusetts Hospital School at Canton, and had suggested converting the resulting space at Lakeville into a "home for the aging." Eventually, the committee suggested, all the facilities at Lakeville could be converted to this purpose as the remaining tuberculosis patients were transferred elsewhere.[3]

Municipal tuberculosis sanatoria are operating well below capacity, and the committee, therefore, proposed converting these institutions to homes for the aging when it seems appropriate to do so.

**§23.6. Programs for the aging: Employment and housing.** Under Chapter 578 of the Acts of 1954 a Division on the Employment of the Aging was established in the Department of Labor and Industries. The Division is given authority to establish programs to promote greater utilization of the aging in industry and the professions. A Council on Employment of the Aging was also established to aid the Division in the development of these programs. The ten-member Council is to consist of the Assistant Commissioner of the Department, the Director of the Division of Employment Security, the Chairman of the Massachusetts Commission Against Discrimination, and seven other members to be appointed by the Commissioner of Labor and Industries. Of these seven, two are to represent employees, two to represent employers, two to represent "qualified organizations engaged in social work," and one to represent the public.

The 1954 legislature increased the appropriation to provide public housing for the aging of low income from an original $5,000,000 to $15,000,000.[1] It should also be noted that this program was declared constitutional in an opinion of the Supreme Judicial Court during the survey year.[2]

**§23.7. Administrative changes in the Department of Public Welfare: The Advisory Board.** As a result of recommendations of the Subcommittee on Child Welfare of the Special Commission on Revision of the Public Health Laws,[1] the Advisory Board of the Department of Public Welfare was increased from nine members to fifteen, five of

[2] For the detailed provisions see Acts of 1954, c. 538, §§4, 5, and 6.
[3] Report of the Governor's Committee to Study State Hospitals 50 (1953).

§23.6. [1] Acts of 1954, c. 669, amending Acts of 1954, c. 668.
[2] Opinion of the Justices, 1954 Mass. Adv. Sh. 465, 120 N.E.2d 198,

§23.7. [1] House No. 2636 (1954).

whom must be women.[2] The new law also adds the requirement that five of the members be persons of "special experience and interest in child welfare." These persons will constitute a subcommittee to advise the Board on programs of the Division of Child Guardianship.

Another change in the law in regard to the Advisory Board should be mentioned. Under Chapter 340 of the Acts of 1954,[3] the Department must notify all of the state's municipal boards of public welfare of public hearings to be held by the Advisory Board relative to the adoption or amendment of departmental rules and regulations.[4] Under the former law, the Department was required to notify members of the legislature and the mayors and selectmen of all cities and towns. The new requirement adds to a notification list which is already thought by many to be too long. However, at least those added are more apt to be interested in receiving the notices than many of those already receiving them.

**§23.8. Rules and regulations: The new Medical Care Plan.** The State Department of Public Welfare promulgated during the survey year a comprehensive revision of its rules and regulations in regard to welfare payments for medical expenses.[1] The new Medical Care Plan for public assistance recipients went into effect on July 1, 1954, and superseded all of the systems of payment formerly in effect and administered by the municipal welfare boards.

The regulations make extensive revisions of fee schedules for medical expenses, which were necessary in view of the rising cost of medical care. Payments for professional medical services and hospital care now must be made direct to the persons rendering the care or services rather than to the welfare recipients themselves.

The new plan also requires that, in communities of 50,000 population and over, a "medical advisor" be appointed to advise the welfare board in relation to the rendering of medical care to welfare recipients and in regard to the payments for these medical services. The regulations also recommend, though they do not require, that these communities employ a medical social worker to aid in carrying out the program.

## C. Public Health

**§23.9. Administrative changes in the Department of Public Health.** During the survey year the Commissioner of Public Health completed a comprehensive reorganization of the Department. No new divisions

[2] Acts of 1954, c. 646, §2, amending G.L., c. 18, §§2, 3.

[3] Amending G.L., c. 118A, §10.

[4] For further discussion of changes in regard to the procedure for adoption, amendment, and repeal of regulations and other administrative changes, see an examination of the new Administrative Procedure Act in Chapter 14.

§23.8. [1] For a detailed examination of the new regulations, see Proceedings of the Council of the Massachusetts Medical Society, 251 N.E.J. of Medicine, Supp. 2, pp. 6 et seq. (1954).

were created, but the divisional structure of the Department was regrouped under seven bureaus, where formerly there had been only three. The seven are Environmental Sanitation, Institutions, Preventive Medicine, Administration, Health Services, Hospital Licensing and Survey, and the Institute of Laboratories, with each headed by a deputy commissioner.

The first three named were the original bureaus of the department. Only the Bureau of Health Services is entirely new; all of the other new bureaus were formerly divisions.

The major changes on the division level were made in the Bureaus of Preventive Medicine and Health Services. The Bureau of Preventive Medicine is now made up of the Division of Cancer and Chronic Diseases, and four other divisions — Communicable Diseases, Venereal Diseases, Dental Health, and Alcoholism. The Bureau of Health Services contains the Division of Local Health Services plus the Divisions of Maternal and Child Health and Health Information.

Also noteworthy was the transfer of nursing, social work, and nutrition services to the Division of Local Health Services. This change, plus the general reorganization of the local health services around a new bureau of that name are the most significant changes in the Department as a result of the reorganization. It would seem to reflect the growing importance of this portion of the Department's programs. It might be noted that, though most of its proposals were defeated, the "Baby Hoover" Commission's recommendations in regard to this Department also emphasized the local health programs and suggested a reorganization of these services in a manner much like the one adopted by the Commissioner.[1]

Two other organizational changes due to 1954 legislation should be noted. The Commission on Alcoholism (an independent agency) was abolished and its full-time employees were transferred to the Division on Alcoholism of the Department of Public Health.[2]

The Division of Smoke Inspection in the Department of Public Utilities was transferred to the Department of Public Health.[3] There, in all probability, it will be placed in the Bureau of Environmental Sanitation. Under the same legislation, the Department of Public Health and the local boards of health are given authority to promulgate rules and regulations in regard to "pollution or contamination of the atmosphere." [4]

**§23.10. Public health housing standards.** Significant changes in the law establishing minimum standards and rules and regulations on

§23.9. [1] House No. 200, Thirteenth Report of the Special Commission on the Structure of the State Government 11 et seq. (1954).

[2] Acts of 1954, c. 581. This was the only recommendation made by the Special Commission on the Structure of State Government in its Thirteenth Report which was passed by the General Court in 1954. See Appendix B of House No. 200 (1954).

[3] Acts of 1954, c. 672.

[4] G.L., c. 111, §142A, inserted by Acts of 1954, c. 672, §3.

housing as it affects public health were enacted in 1954. Under Chapter 209 of the Acts of 1954 [1] the powers of local boards of health to enact and enforce minimum housing standards were substantially increased. The local boards may now enact and enforce "reasonable and necessary" regulations "in accord with accepted standards of public health, sanitation, housing and home safety practice, and may define the responsibilities of owners and tenants." [2] Under the former law the local boards of health had no power to enact regulations of their own in this field; they could only adopt the regulations of the state health department.

## D. Mental Health

**§23.11. Emergency commitment of epileptics.** During the survey year the Department of Mental Health requested and received an informal opinion of the Attorney General [1] in regard to the emergency commitment of an epileptic under Sections 62 and 69 of Chapter 123 of the General Laws. The commitment was procured without notice or hearing because, under the statute, it was certified by the examining physician as "one of emergency." [2] The Department asked the opinion of the Attorney General as to whether, after the person is hospitalized, a regular judicial commitment with notice and an opportunity for a hearing is necessary in order to commit the epileptic permanently.

The Attorney General answered the question in the affirmative, asserting that due process of law requires notice and an opportunity for a hearing before permanent commitment. Otherwise, the Attorney General asserted, the person must be discharged from the institution as soon as practicable.

**§23.12. Defective delinquents and sex offenders.** As a result of recommendations by the Special Commission on Commitment, Care and Treatment of the Criminally Insane and Defective Delinquents,[1] comprehensive revisions of the laws in regard to defective delinquents [2] and sex offenders [3] were passed by the 1954 General Court. The developments in the law are discussed in detail in the chapter on criminal law.[4]

The changes in the law in regard to the commitment of defective delinquents to the Department of Correction were intended mainly to correct abuses in the former law under which a number of persons were

§23.10. [1] Inserted as G.L., c. 111, §128B to 128E. The act repeals G.L., c. 111, §128.
[2] G.L., c. 111, §128C, inserted by Acts of 1954, c. 209, §2.

§23.11. [1] May 6, 1954.
[2] G.L., c. 123, §62.

§23.12. [1] House No. 2780 (1954).
[2] Acts of 1954, c. 556.
[3] Id., c. 686.
[4] Sections 15.11, 15.12.

committed without the proper legal safeguards of notice and a hearing.[5]

The new law relative to sex offenders entirely replaces the much criticized Chapter 123A of the General Laws. It discards the phrase "psychopathic personality" in the former law and uses instead the term "sex offender." [6] The Commission asserts that it recommended this change because "the legal profession is not clear in its mind about the concept of psychopathic personality in the context of chapter 123A; and rightly so because the concept of psychopathic personality is a very controversial one even within the medical circles." [7]

The report continues, "It appears to us that sex offenders should be thought of in terms of mental aberration, exclusive of insanity. This would include the ill-defined concept of psychopathic personality as well as the more clearly defined concept of neurosis." [8] However, the Commission adopts substantially the same *definition* for this new term as for the old: namely, "Any person who by a course of misconduct in sexual matters has evidenced a general lack of power to control his sexual impulses, and who, as a result, is likely to attack or otherwise inflict injury, degradation, pain or other evil on the objects of his uncontrollable desires." [9]

Under the new law, a person convicted of certain sex offenses [10] may be committed to the Department of Mental Health for sixty days for "examination, diagnosis, and treatment." The Department is required to report to the court within that time as to whether the person is a "sex offender" as defined above. If the report is in the affirmative, the court then sentences him on the criminal conviction and commits him to the Department of Correction, but he is immediately transferred to the Department of Mental Health for care and treatment for a period not to exceed the length of the sentence.

The legislation sets up in the Department of Mental Health a "treatment center" for these sex offenders.[11] Any prisoner in custody already may be transferred from jail or prison to this treatment center under certain procedure set up under the legislation.[12] The center is also

[5] House No. 2780, pp. 11 et seq. (1954). See particularly the statistics in Appendix I.

[6] G.L., c. 123, §1, inserted by Acts of 1954, c. 686, §1.

[7] House No. 2780, p. 20 (1954).

[8] Ibid.

[9] G.L., c. 123A, §1, as amended by Acts of 1954, c. 686, §1. For a criticism of the old definition and other aspects of the old law, see Curran, Commitment of the Sex Offender in Massachusetts, 37 Mass. L.Q., No. 1, p. 58 (1952).

[10] G.L., c. 123A, §3: "rape, carnal abuse of a minor child, sodomy, incest, lewd and lascivious conduct, unnatural act or indecent exposure, or an attempt to commit any such crime."

[11] Id. §2. The wisdom of establishing such a center seems questionable in view of the fact that most authorities agree there is no special form of treatment for these persons. Reports from other states having such a system indicate that these persons either receive no treatment at all, or, if suffering from a recognized mental disease, they receive the normal methods of care and treatment for that disease. See The Habitual Sex Offender, N.J. Legis. Comm. Rep. 4 (1951); Report of the Governor's Study Commission on the Deviated Criminal Sex Offender, Michigan (1951).

[12] G.L., c. 123A, §5.

made available for voluntary treatment of persons who may desire it,[13] and it may also render care to any of the victims of sex offenders.[14]

**§23.13. Physician's certification for commitment: Immunity from civil liability.** In a very significant decision, *Mezullo v. Maletz*,[1] the Supreme Judicial Court held that a physician who makes certification under Sections 51 and 77 of Chapter 123 of the General Laws, to the effect that a person he has examined is mentally ill and is a proper subject of treatment in a mental hospital, is completely immune from *civil* liability to the person as a result of his action, even though the certification is negligent, in bad faith, or a part of a conspiracy with another person to procure the commitment. The Court arrived at this conclusion in spite of the fact that there is criminal liability imposed on the physician who conspires with another person to wrongfully commit.[2] It should be noted that the case deals only with a situation where the person is committed after a full court hearing and the opinion asserts nothing in regard to a nonjudicial commitment. The decision is discussed in full in another chapter of the SURVEY.[3]

**§23.14. Other changes in the commitment laws.** Under Chapter 598 of the Acts of 1954, aging persons who are *not* mentally ill may be hospitalized on a voluntary basis in the institutions conducted by the Department of Mental Health. The General Court in 1954 also authorized the purchase of the Cushing General Hospital, formerly a Veterans' Administration hospital, for use by the Department of Mental Health for the care of these aging but not mentally ill persons.[1]

Legislation during the survey year also granted jurisdiction to the District Courts to commit persons, including juveniles, to the state schools for the mentally defective.[2] No such commitment is allowed, however, without the express consent of the Department of Mental Health. Formerly these commitments were under the exclusive jurisdiction of the Probate Courts.

[13] Id. §9.
[14] Id. §10.

§23.13. [1] 1954 Mass. Adv. Sh. 259, 118 N.E.2d 356.
[2] G.L., c. 123, §110.
[3] Sections 5.1-5.3.

§23.14. [1] Acts of 1954, c. 469.
[2] Acts of 1954, c. 218, amending G.L., c. 123, §66.