Mental Health: A Model Statute to Regulate the Administration of Therapy within Mental Health Facilities

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Note: Mental Health: A Model Statute to Regulate the Administration of Therapy Within Mental Health Facilities

I. INTRODUCTION

A treating physician has traditionally exercised exclusive control over the administration of therapy in mental health facilities. Mental patients have generally not been granted the right to participate in their own treatment decisions, even to refuse an unwanted therapy. Due to scientific and technological developments, new and powerful therapies have proliferated.


2. This example highlights the manner in which mental patients have been deprived of certain rights. See generally AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 175 (rev. ed. S. Brakel & R. Rock 1971) [hereinafter cited as THE MENTALLY DISABLED AND THE LAW]. After outlining the “rights of hospitalized patients,” this study concludes that these rights are not adequately protected by existing legislation. Though it is true that hospital doctors and administrators are often in the best position to determine which freedoms or restrictions are most likely to benefit the patient’s medical needs, it remains the function of the law to circumscribe the decisionmaking powers of hospital officials. In many states, owing to the absence of legal guidelines and reviewing machinery, hospital officials in effect have unlimited discretion in areas ranging from correspondence, visitation, and employment to mechanical restraints and major medical treatment. The fact that decisions in most or all of these areas involve considerations other than purely medical ones reinforces the point that patient rights are not sufficiently protected.

Id. at 171.

3. For example, extensive technological developments are taking place in the field of behavior modification and control: The chemicals and electronic hardware of behavior-control technology are proliferating even faster and more powerfully than are psychological tools. The host of tranquilizing and energizing drugs already on the market represents the bare infancy of an industry that will soon produce drugs much more precisely capable of steering people’s moods and emotions and, soon thereafter, of affecting important parts of their intellects, such as memory. Electronic miniaturization and improvements in surgery increasingly exploit discoveries of the exact locations in the
in recent years, exacerbating the problem of patient nonparticipation. Physicians presently have at their disposal a wide array of organic therapies which, although highly beneficial in treating some forms of mental illness, have the potential to produce brain where various behavioral functions are managed; skillful invasion of these sites permits interference with the functions; radio remote controls over epileptic seizures, sexual desire, and speech patterns are already operational. Few people yet have thought much on the long-range prospects of such technology.

P. LONDON, BEHAVIOR CONTROL 5 (1969). See Moya & Achtenberg, Behavior Modification: Legal Limitations on Methods and Goals, 50 NOTRE DAME LAW. 230, 233 (1974). Rapid technological development poses several dangers: new techniques may be used before their impact is fully understood, or before the legal and ethical implications of their use have been explored. This emphasizes the significance of a right to refuse treatment and highlights the importance of designing a regulatory procedure to deal with new types of therapy. See § 4 of the Model Statute developed in this Note; text accompanying notes 102-04 infra.

4. Organic therapy is defined in § 2(c) of the Model Statute developed in this Note. The term generally refers to procedures that affect or alter an individual's thought patterns, sensations, feelings, and perceptions through chemical, electrochemical, or surgical means. This Note includes "conditioning techniques" in the definition of organic therapy. See Shapiro, Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies, 47 S. CAL. L. REV. 237, 244 (1974). Although this may slightly distort the concept of organic therapy, the use of one term to represent the entire range of therapies a state might choose to regulate facilitates discussion.

The nature and effect of various organic therapies have been discussed by numerous legal commentators. For more detailed descriptions, see Beresford, supra note 1, at 336-44 (description of available organic therapies and an outline of their medical objectives); Schwartz, In the Name of Treatment: Autonomy, Civil Commitment, and Right to Refuse Treatment, 50 NOTRE DAME LAW. 808, 812-17 (1975) (review of chemotherapy, electroshock therapy, and psychosurgery as treatments administered during short periods of hospitalization on outpatient basis); Note, Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients, 45 S. CAL. L. REV. 616, 619 (1972) [hereinafter cited as Conditioning Prisoners and Mental Patients]; Comment, Legislative Control of Shock Treatment, 9 U.S.F.L. REV., 738, 739 (1975) [hereinafter cited as Control of Shock Treatment].

5. Shapiro, supra note 4, at 243-44. For example, it is generally accepted that electroshock treatment relieves some serious depressions. Beresford, supra note 1, at 338. With respect to psychosurgery, there is some evidence that selective destruction of portions of the frontal lobe, hypothalamus, thalamus, cingulate gyrus, and amygdala dampens violent or aggressive behavior. Id. at 341. Drugs may be prescribed to modify disturbed behavior or to alter discomforting moods. . . . An agitated, fearful schizophrenic may benefit from a major tranquilizer such as trifluoperazine (Stelazine) or haloperidol (Haldol), while a deeply withdrawn or suicidal patient may respond to an antidepressant such as amitriptyline (Elavil) or imipramine (Tofranil) . . . . Amphetamines or methylphenidate (Ritalin), which are classed as stimulant drugs, may par-
adverse, and possibly irreversible, side effects. Because these therapies powerfully influence both the mentation and overt behavior of a patient, their use may seriously jeopardize the patient’s autonomy, bodily integrity, and freedom of mentation.

In response to this problem, legal commentators have attempted to develop a theoretical framework for a constitutional right to refuse treatment. The right to refuse the most intru-

adoxically suppress the extreme hyperactivity that afflicts some young children.
Id. at 336 (footnotes omitted).

6. In the administration of electroconvulsive therapy, for example, patients may suffer fractures and cardiovascular complications, although both are rare. The most disturbing side effect now appears to be memory impairment, often temporary, but sometimes a "severe and permanent enough loss of memory to prevent resumption of previous voca-
tions." Beresford, supra note 1, at 339 (footnotes omitted). The range of possible side effects of drugs is much greater.

Implicit in every prescription of drugs is the risk of unexpected side effects. The range of adverse reactions for most drugs is so great that it is rare the physician indeed who can quote all the reported side effects of a particular compound. These side effects may include disturbances in mental function, mood or behavior and may raise the issue of whether the patient is becoming worse because of disease or because of treatment.
Id. at 337 (footnotes omitted).

Organic therapies may also be abused. State authorities, including medical personnel, have been known to administer intrusive organic therapies for improper purposes or in an improper manner. Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973) (use in mental institution of apomorphine to induce lengthy seizures of vomiting as punishment for infractions of behavior protocols, such as talking, swearing, or lying is cruel and unusual punishment prohibited by the eighth amendment); Mackey v. Procu nier, 477 F.2d 877 (9th Cir. 1973) (prisoner stated valid civil rights claim in alleging that the administration of succinycholine, a paralytic drug with frightening side effects, as part of an aversive treatment program was cruel and unusual punishment; drug was administered to fully conscious patients, although such use was not recommended); Shapiro, supra note 4, at 246; Conditioning Prisoners and Mental Patients, supra note 4, at 633-40. See generally Beresford, supra note 1, at 344-55. These extreme examples of abuse have created public controversy and may have been partially responsible for some legislative action. See A. Stone, Mental Health and Law: A System in Transition 98-99 (1975). Legislative regulations designed to minimize the risks to the patient associated with the responsible, legitimate administration of organic therapies also will control their use for improper reasons.

7. Mentation refers to any mental functioning or activity, including cognition, understanding, perception, volition, or emotion. Shapiro, supra note 4, at 246 n.14.

8. See, e.g., Friedman, supra note 1; Schwartz, supra note 4; Spoonhour, Psychosurgery and Informed Consent, 26 U. Fla. L. Rev. 432 (1974); Symposium—Psychosurgery, 54 B.U.L. Rev. 215 (1974); Note, Beyond the "Cuckoo's Nest": A Proposal for Federal Regulation of Psychosurgery, 12 Harv. J. Legis. 810 (1975); Note, Advances in Mental Health: A Case for the Right to Refuse Treatment, 48 Temp. L.Q. 534 (1975); Comment, The Right Against Treatment: Behavior Modification and the Involv-
A "qualified right to refuse" has been recognized by two courts, which imposed procedures to regulate the administration of organic therapy. A federal court in Alabama has established minimum constitutional standards for the treatment of the mentally ill in state institutions. Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd in part, remanded in part, decision reserved in part sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). Standard 9 of the district court's order dealing with the right to refuse treatment was subsequently modified to establish a procedure regulating the administration of adverse conditioning, electroconvulsive therapy (ECT), or "any other extraordinary or hazardous technique or procedure." Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55 (M.D. Ala. July 1, 1975). See note 44 infra. The Supreme Court of Minnesota has adopted a probate court procedure to regulate the administration of psychosurgery and electroshock therapy, although it declined to decide whether other therapies would also be subject to such regulation. Price v. Sheppard, 239 N.W.2d 905 (Minn. 1976).


Two federal appeals courts have recognized a constitutional right to treatment. In Donaldson v. O'Connor, 493 F.2d 507, 521 (5th Cir. 1974), remanded on other grounds, 422 U.S. 563 (1975), the court accepted the substantive due process argument developed in Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd in part, remanded in part, decision reserved in part sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974), see note 44 infra, and concluded that deprivation of liberty for the purpose of treatment is unjustified unless treatment is in fact provided. Nelson v. Heyne, 491 F.2d 352 (7th Cir.), cert. denied, 417 U.S. 976 (1974), held that the due process clause protects the right of juvenile offenders to rehabilitative treatment. See also Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), which held that civilly committed mentally retarded patients have a due process right to minimally adequate treatment designed to give them a realistic opportunity to be cured or to improve their mental condition.

The Supreme Court, however, in O'Connor v. Donaldson, 422 U.S. 563, 576 (1975), was willing to hold only that "a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." It declined to consider "whether mentally ill persons dangerous to themselves or to others have
sive therapies can be derived from the protection of an individual's autonomy and bodily integrity accorded by both the Bill of Rights and the developing right of privacy. The judiciary,

a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous mentally ill individual for the purpose of treatment." \textit{Id.} at 573.

9. The term "intrusive" is used to describe and characterize the potential effect of a particular therapy on a patient. The concept of intrusiveness of a therapy or program seems to involve the following criteria (which, while in the main conceptually distinct, are in fact interdependent): (i) the extent to which the effects of the therapy upon mentation are reversible; (ii) the extent to which the resulting psychic state is "foreign," "abnormal" or "unnatural" for the person in question, rather than simply a restoration of his prior psychic state (this is closely related to the "magnitude" or "intensity" of the change); (iii) the rapidity with which the effects occur; (iv) the scope of the change in the total "ecology" of the mind's functions; (v) the extent to which one can resist acting in ways impelled by the psychic effects of the therapy; and (vi) the duration of the change.

Shapiro, \textit{supra} note 4, at 262 (footnotes omitted). See \textit{Conditioning Prisoners and Mental Patients}, \textit{supra} note 4, at 619-21. While the criteria noted above emphasize the impact a therapy will have on a patient's mental processes, the concept of "intrusiveness" implicitly includes the effect a therapy may have on a patient's "physical autonomy." See Shapiro, \textit{supra} note 4, at 258-69.

Were these criteria literally applied, every organic therapy, including minor tranquilizers, could be classified as intrusive. The criteria, however, are designed to aid in ranking therapies according to their degree of intrusiveness. As Friedman, \textit{supra} note 1, at 90 noted:

Even guided by these criteria of intrusiveness, deciding which treatments are more restrictive is largely a matter of subjective opinion and theoretical disposition. But the idea that some techniques may be viewed as more onerous than others and that they may be categorized may contribute to making the search for the least restrictive alternative less difficult.

10. A number of commentators have argued that the Constitution's implicit recognition of an individual's "autonomy, bodily integrity and right to self-determination" requires protection of a mental patient's right to refuse the most intrusive organic therapies. See, e.g., Schwartz, \textit{supra} note 4, at 820-22. These writers have focused on the substantive protections provided by the Bill of Rights. The Supreme Court, for example, has noted in dictum that "the overriding function of the Fourth Amendment is to protect personal privacy and dignity against unwarranted intrusion by the State." Schmerber v. California, 384 U.S. 757, 767 (1966). See also Terry v. Ohio, 392 U.S. 1 (1968); Mapp v. Ohio, 367 U.S. 643 (1961) (fourth amendment protects an individual's personal integrity from arbitrary governmental interference). The due process clause has been used to exclude evidence obtained through violations of bodily integrity that "shock the conscience," Rochin v. California, 342 U.S. 165 (1952) (due process clause forbids policemen from pumping the stomach of a suspected narcotics dealer seen to swallow two capsules). Similarly, since an individual's right to free speech depends upon the independent ability to generate ideas, the first amendment has been relied on to restrict the use of psychosurgery. Kaimowitz v. Department of Mental Health, Civ. No. 73-19434-AW, (Cir. Ct., Wayne County, Mich.,
however, has either lacked the opportunity or been unwilling to
establish constitutional protection for the right of mental patients
to refuse treatment; only a few courts have done so. Because
the law is undeveloped in this area, and because the regulation
of organic therapies raises a wide range of complex problems ill-
suited to judicial resolution, effective protection of mental pa-
tients' interests can best be accomplished by legislative action.

At least 13 states have adopted regulations governing the
administration of the most intrusive types of organic thera-


11. The constitutional right of privacy protects an individual's right
to make fundamental decisions concerning the conduct of his life,
Roe v. Wade, 410 U.S. 113 (1973). Many commentators have
recognized that this right could also support a constitutional right to refuse treat-
ment. See, e.g., Developments in the Law—Civil Commitment of the
Mentally Ill, 87 Harv. L. Rev. 1190, 1194-95 (1974) [hereinafter cited as
Civil Commitment]. Cf. Price v. Sheppard, 239 N.W.2d 905 (Minn.
1976).

aff'd in part, remanded in part, decision reserved in part sub nom. Wyatt
v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); note 44 infra; Kaimowitz v.
Department of Mental Health, Civ. No. 73-19434-AW (Cir. Ct., Wayne
that experimental psychosurgery on an involuntarily confined mental
patient violated his first amendment right to generate ideas and his
constitutional right to privacy, and that the inherently coercive nature
of the institutional environment eliminated his ability to execute a vol-
untary, informed consent.

13. One court has designed a detailed procedure to regulate organic
therapies in order to protect patients' constitutional rights. See Wyatt
v. Hardin, 1 Mental Disability L. Rep. 55 (M.D. Ala., July 1, 1975);
notes 44-52 infra and accompanying text. Even in this instance, however,
the complex mixture of controversial issues with which the court was
faced, the necessarily long and involved litigation, see note 44 infra, and
the case-by-case nature of the adjudicatory process limited the court's
effectiveness as a "regulatory" body. More important, courts may lack
the necessary information and expertise to produce satisfactory regula-
tory procedures. See Price v. Sheppard, 239 N.W.2d 909 (Minn. 1976),
in which the court established a probate court review of certain types
of treatments, but failed to delineate precisely when such review must
be sought, for which types of treatment, for which patients, and what
role consent would play in the decision to seek review or administer
treatment. But see Note, Regulation of Electroconvulsive Therapy, 75
Mich. L. Rev. 363, 378, 395 (concluding that although Price is subject
to criticism, procedure would in "practical effect" determine patient's
competency and necessity of treatment).

In contrast, legislatures can design comprehensive regulatory sys-
tems with full consideration of the numerous issues that are necessarily
involved. Moreover, legislative protections can exceed "minimum con-
stitutional standards" and thus more effectively safeguard a broad range
of patient interests.
pies. Most existing regulatory schemes seek to protect the patient's interests by requiring his consent as a prerequisite to the administration of those therapies the state has chosen to regulate. State schemes differ significantly, however, in the particular procedural controls adopted and the extent to which they implement the underlying principle of consent. This reflects the complexity of designing such statutes, for legislatures must balance the same intricate legal, psychological, medical, and ethical considerations that complicate the administration of mental health care in general.

The design of any appropriate regulatory procedure, however, will ideally reflect several fundamental principles, derived from the same policies that underlie the constitutional arguments for protecting a patient's right to refuse treatment. Since an involuntary patient's presence in a mental health facility usually results from an exercise of the state's parens patriae power, the following notes provide a detailed analysis of the legal framework for consent in various jurisdictions:

14. ALASKA STAT. § 47.30.130(b) (1971) (consent required for surgery or "psychiatric therapies which the department determines"); CAL. WELF. & INST. CODE §§ 5325 & 5326.2-.95 (West Supp. 1977) (patient has a right to refuse convulsive treatment and psychosurgery); CONN. GEN. STAT. ANN. § 17-206d (West Cum. Supp. 1977) (no medical or surgical procedures including electroshock therapy may be performed without consent); MASS. GEN. LAWS ANN. ch. 123, § 23 (1972) (patient has right to refuse shock treatment and lobotomy); MICH. COMP. LAWS ANN. § 330.1716 (West 1975) (consent required for surgery, electroconvulsive therapy, or "another procedure intended to produce convulsions or coma"); N.Y. MENTAL HYG. LAW § 15.03(b) (4) (McKinney Supp. 1976) (consent required for "surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures"); N.C. GEN. STAT. § 122-55.6 (Cum. Supp. 1975) (informed consent required for "electroshock therapy, the use of experimental drugs or procedures, or surgery, other than emergency surgery"); OBO REV. CODE ANN. § 5123.86 (Page Supp. 1975) (informed consent required for surgery, convulsive therapy, aversion therapy, sterilization, experimental procedures, any unusual or hazardous treatment or procedures); TENN. CODE ANN. § 33-307 (Cum. Supp. 1976) (consent must be obtained prior to surgery); VT. STAT. ANN. tit. 18, § 7708 (1968) (consent required for surgery); WASH. REV. CODE ANN. §§ 71.05.370(7), (9) (1975) (involuntarily detained patient has right to refuse shock treatment and nonemergency surgery). See also GA. CODE ANN. § 88-502.3(a) (1971) (written consent required before therapy "which is not recognized as standard psychiatric treatment" may be given); IDAHO CODE § 66-346(a) (4) (Cum. Supp. 1975) (right "to refuse specific modes of treatment").

15. Civil Commitment, supra note 11, at 1347.

16. See § 1 of the Model Statute developed in this Note; notes 25-27 infra and accompanying text.

17. See sources cited in note 8 supra; Civil Commitment, supra note 11 (discussing a number of considerations that affect the design of both commitment and treatment regulations).

18. The sweep of the state's power under the parens patriae doctrine has traditionally been very broad.
a regulatory scheme should recognize the state's power and obligation under that doctrine to provide patients with the most effective and appropriate treatment possible. When the state acts as a substitute decisionmaker for incompetent patients who are unable to decide for themselves, it has a responsibility to check the treating physician's exercise of discretion in prescribing therapy\textsuperscript{19} to ensure that the patient's best interests are served. Because of the structure of present commitment laws, however, some patients within mental health institutions may be competent to make treatment decisions for themselves;\textsuperscript{20} such

\textsuperscript{19} THE MENTALLY DISABLED AND THE LAW, supra note 2, at 164. See STONE, supra note 6, at 97-106; cf. Goldiamond, Singling Out Behavior Modification For Legal Regulation: Some Effects on Patient Care, Psychotherapy, and Research in General, 17 ARIZ. L. REV. 105, 119 (1975) (implicitly accepts premise that regulation of the treatment prescription is appropriate; regulation should be based on a complete examination of all the relevant data).

\textsuperscript{20} Many individuals who are presently committed as mentally ill either retain or regain the capacity to make rational decisions about the conduct of their lives, including decisions regarding organic treatments. See, e.g., Shapiro, supra note 4, at 308; Civil Commitment, supra note
patients should have a right to refuse the imposition of certain therapies.

Finally, because only the more intrusive organic therapies will seriously jeopardize the patient's best interests, regulating all such therapies may be unnecessary.\textsuperscript{21} There are practical limitations on the state's ability to regulate, for control of all therapies would produce tremendous administrative complexity and severely tax the state's financial resources.\textsuperscript{22} Within the extremes of an absolute right for all patients to refuse all organic therapies\textsuperscript{23} and complete deferral to the treating physician's judgment, then, a regulatory scheme must determine

\begin{itemize}
\item that the evidence of [his] conduct clearly shows [both] that his customary self-control, judgment, and discretion in the conduct of his affairs and social relations is lessened to such an extent that hospitalization is necessary for his own welfare or the protection of society; [and] . . . (i) that he has attempted to or threatened to take his own life or attempted to seriously physically harm himself or others; or (ii) that he has failed to protect himself from exploitation from others; or (iii) that he has failed to care for his own needs for food, clothing, shelter, safety or medical care. . . .
\end{itemize}

\textit{Id.} \S 253A.07(17) (a). None of these standards would necessarily require a committing court to determine that a patient lacks the capacity to make a treatment decision, although a commitment based on the third standard could encompass such a finding. \textit{See} note 125 \textit{infra}.

\begin{itemize}
\item "[A]ccepted, nonexperimental or less intrusive therapies" require little or no regulation. \textit{See} \textit{STONE, supra} note 6, at 97. The intrusiveness criteria, \textit{see} note 9 \textit{supra}, will assist a legislature or administrative board to rank therapies according to their degree of intrusiveness. Once ranked, the therapies must be placed in a regulated or nonregulated category, a task that requires close consideration of a number of legal, ethical, moral, and pragmatic concerns. Choosing which therapies to regulate may also require consideration of the constitutional right to refuse doctrine, \textit{see} Shapiro, \textit{supra} note 4, at 245.

\item \textit{See} note 82 \textit{infra} and accompanying text.
\end{itemize}

\begin{itemize}
\item \textit{STONE, supra} note 6, at 102. An absolute right to refuse every form of treatment would be inconsistent with the state's \textit{pares patriae} power. Under that doctrine, a state can confine an incompetent individual in order to provide treatment. \textit{See} note 18 \textit{supra}. Even a patient's presence within a hospital is a form of treatment known as milieu therapy. \textit{Conditioning Prisoners and Mental Patients, supra} note 4, at 621. An absolute right to refuse every form of therapy, then, would eliminate all involuntary commitments except those that could be justified under the state's police power. The Model Statute developed in this Note eliminates this conflict by giving patients a right to refuse only regulated therapies. \textit{See} note 24 \textit{infra}; but \textit{see} note 125 \textit{infra}.
\end{itemize}
which therapies will be regulated and which patients will have the right to refuse regulated therapies.24

Although the appropriateness of regulating organic therapies may fairly be debated, the activities of state legislatures in this area indicate a growing acceptance of such regulations. In order to provide a guide for future legislative action, this Note will develop a Model Statute incorporating the described fundamental principles underlying an appropriate regulatory scheme. The Model Statute is grounded on the principle that the informed treatment decision of an individual with the capacity to make it should be determinative.25 In order to implement this principle, the statute utilizes a competency hearing to determine capacity.26 For an incompetent patient,27 who lacks this

24. This Note will use the term "regulated therapy" to refer to an organic therapy that the legislature has chosen to regulate. Therapies could be regulated in a number of ways. If the legislature determined that the risk posed by an organic therapy outweighed any potential benefit a patient might receive, the therapy could be banned altogether. See, e.g., Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 56 (M.D. Ala. July 1, 1975) (no lobotomy, psychosurgery, or other unusual, hazardous, or intrusive surgical procedure may be performed on any patient). All members of a specified group could be precluded from receiving a particular therapy. See, e.g., CAL. WELF. & INST. CODE § 5326.8 (West Supp. 1977) (no convulsive treatment performed on a patient under 12 years of age). Alternatively, the legislature could define the group of regulated therapies and provide that a patient's treatment decision will be determinative only under specified circumstances. See, e.g., WASH. REV. CODE ANN. §§ 71.05.370(7), (9) (1975). The majority of existing procedures, however, establishes the consent of the proposed patient as a prerequisite to the administration of a regulated therapy, see notes 14-15 supra. This more flexible approach has been chosen for the Model Statute developed in this Note.

25. See THE MENTALLY DISABLED AND THE LAW, supra note 2, at 164, 172. For a definition of capacity to make an informed treatment decision, see Model Statute § 2(e).

Predicating treatment on a competent patient's consent should avoid any potential constitutional problem, for consent may be deemed a waiver of any constitutional right to refuse. See Civil Commitment, supra note 11, at 1352. The Model Statute's use of the concept of "consent to treatment" also conforms to the requirement of common law—a valid consent must be competent, voluntary, and knowing. "To be effective, consent must be (a) by one who has the capacity to consent, or by a person empowered to consent for him, and (b) to the particular conduct, or to substantially the same conduct. . . . Consent is not effective if it is given under duress." RESTATEMENT (SECOND) OF TORTS §§ 892A(2), 892B(3) (Tent. Draft No. 18, 1972).

Finally, since patients being treated for physical illness ordinarily must consent to treatment, requiring competent mental patients' consent preserves their right to equal protection. See Civil Commitment, supra note 11, at 1228-31.

26. The Model Statute adopts procedural protections for the competency hearing similar to the due process safeguards adopted by many
capacity, the statute establishes a third party decisionmaker to determine whether the administration of the proposed regulated therapy would serve the patient's best interests.

In order to familiarize the reader with this method of regulation, several examples of existing procedures will be examined to determine whether particular components are consistent with the underlying principles of the Model Statute. In addition, the manner in which these schemes deal with collateral issues, including the role of a patient's legal or natural guardian and the protection afforded the patient's due process rights, will be assessed. Conclusions drawn from this analysis will then serve as a framework for the development of a Model Statute to regulate the administration of organic therapies.\footnote{28}

courts for judicial commitment proceedings. The following procedural safeguards have been accorded constitutional status in the context of commitment proceedings:


(B) the right to be present at the commitment hearing and to participate therein, Suzuki v. Quisenberry, \textit{supra} at 1129; Lynch v. Baxley, \textit{supra} at 388-89; Lessard v. Schmidt, \textit{supra} at 1091; see also Bell v. Wayne County Gen. Hosp., 384 F. Supp. 1085, 1094 (E.D. Mich. 1974);

(C) the right to effective assistance of counsel, Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968); Suzuki v. Quisenberry, \textit{supra} at 1129; Lynch v. Baxley, \textit{supra} at 389; Lessard v. Schmidt, \textit{supra} at 1092; Dixon v. Attorney Gen., 325 F. Supp. 966 (M.D. Pa. 1971);

(D) the right to cross-examine witnesses and to offer evidence, Suzuki v. Quisenberry, \textit{supra} at 1130; Lynch v. Baxley, \textit{supra} at 394;

(E) adherence to the rules of evidence, Suzuki v. Quisenberry, \textit{supra} at 1130;


(G) a record of the proceedings and written findings of fact, Suzuki v. Quisenberry, \textit{supra} at 1133; Lynch v. Baxley, \textit{supra} at 396.

27. For the definition of competency used in the Model Statute, \textit{see Model Statute \S} 2(e); \textit{see also} text accompanying notes 120-21 \textit{infra}.

28. State regulations of the initial commitment process and of the treatment decisions of committed patients are conceptually interrelated. Discussion of the commitment process itself is beyond the scope of this Note, but the logic underlying the Model Statute's regulation of treatment decisions would support certain analogous adjustments in commitment proceedings. \textit{See note 125 infra}.\footnote{27}
II. EXISTING REGULATION OF THE ADMINISTRATION OF INTRUSIVE ORGANIC THERAPIES

A. THE MICHIGAN PROCEDURE

The Michigan statute regulating organic therapy is similar to the procedures adopted in a number of other states. Consent is a prerequisite to the administration of surgery or convulsive therapy, and the statute lists the individuals who are eligible to provide consent.

(1) Except as provided in subsections (2) and (3), a recipient of mental health services shall not have surgery performed upon him, nor shall he be the subject of electro-convulsive therapy or of another procedure intended to produce convulsions or coma, unless consent is obtained from:

(a) The recipient if he is 18 years of age or over and competent to consent.

(b) The guardian of the recipient if the guardian is legally empowered to execute such a consent.

(c) The parent of the recipient if the recipient is less than 18 years of age.

If none of these individuals can be found, a probate court may approve the administration of one of the regulated therapies.

The Michigan statute protects the interests of both competent and incompetent patients by explicitly distinguishing be-

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29. See note 14 supra. For a general discussion and critique of the Michigan regulatory procedure, see Morris, Institutionalizing the Rights of Mental Patients: Committing the Legislature, 62 CALIF. L. REV. 957, 992 (1974).


31. Subsection (2) of the Michigan regulatory procedure is an emergency exception.

If the life of a recipient is threatened and there is not time to obtain consent, the procedures listed in subsection (1) may be performed without consent after the medical necessity for the procedure has been documented and the documentation has been entered into the record of the recipient.

Id. § 330.1716(2).

32. Subsection (3) of the Michigan regulatory procedure provides:

If one of the procedures listed in subsection (1) is deemed advisable for a recipient, and if no one eligible under subsection (1) to give consent can be found after diligent effort, a probate court may, upon petition and after hearing, consent to performance of the procedure in lieu of the person eligible to give consent.

Id. § 330.1716(3).

33. The statute does not define this phrase, but it has been clarified by an administrative rule that defined "guardian" as a "person empowered to execute a consent pursuant to a probate court order," MICH. DEP'T OF MENTAL HEALTH, MENTAL HEALTH CODE EMERGENCY RULES 330.7001(1) (1975). See 9 MICH. J.L. REP. 620, 637 (1976).

34. See note 32 supra.
between them and by making the treatment decision of a competent patient determinative. Nevertheless, the statute fails to define what constitutes "competency," to provide for an initial competency hearing to make that determination, or to provide due process safeguards when the probate court's jurisdiction is invoked. Moreover, the statutory criterion guiding the probate court's determination of whether a treatment should be approved is extremely vague: the court may allow treatment if it is "deemed advisable." The Michigan procedure, therefore, inadequately implements the principle of competent consent and inadequately protects the incompetent patient.

In its recognition of the possible existence of both a legal and a natural guardian and its attempt to define their roles, the Michigan statute is clearly superior to the majority of existing regulations, which tend to ignore these issues. Allowing the patient's legal guardian to make a treatment decision for an incompetent patient, however, may give him too much responsibility since he will usually lack both the legal and medical expertise necessary to evaluate whether the patient's legal rights have been violated or whether a proposed therapy is in the patient's best interest. Similarly, the assumption that a parent or legal guardian will automatically act in the best interests of the ward when contemplating a treatment decision may not be justified. Yet the Michigan statute provides no way to pre-

35. See text accompanying notes 32-33 supra.
36. Since the statute does not provide for a competency hearing, presumably a doctor could proceed with treatment upon the consent of a patient he deemed "competent." If a patient were deemed incompetent by the physician, and no one eligible to consent could be found, the doctor would be obligated to invoke the jurisdiction of the probate court. At that point, the court might hold some type of competency hearing, but such a procedure is not specified in the statute. If the probate court merely accepted the certification of the treating physician as sufficient to establish the patient's incompetency, however, there would be no check on the physician's judgment. See note 19 supra and accompanying text.
37. The probate court might, on its own motion, provide the patient with certain due process rights, see note 26 supra; nevertheless, the legislature's oversight complicates the court's task.
38. See note 32 supra.
39. See, e.g., Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 56 (M.D. Ala. July 1, 1975); WASH. REV. CODE ANN. §§ 71.05.370(7), (9) (1975).
40. MICH. COMP. LAWS ANN. § 330.1716 (1) (b) (West 1975).
41. Under the Michigan procedure, a parent is empowered to consent or withhold consent for the child's treatment. Id. § 330.1716 (1) (c).
42. The validity of the assumption that a parent is the best repre-
vent a guardian from consenting to an inappropriate or dangerous therapy or refusing to consent to a potentially beneficial one.43

B. THE ALABAMA PROCEDURE

A federal court sitting in Alabama has developed regulations to implement what it established as the “minimum constitutional standards for adequate treatment of the mentally ill.”44

sentative of a child's rights has recently been questioned. See Ellis, Volunteering Children: Parental Commitment of Minors to Mental Institutions, 62 CALIF. L. REV. 840 (1974); Spoonhour, supra note 8, at 438-39.

43. A guardian may act in bad faith; but equally or more dangerous is the irrational decision of a parent or guardian acting in good faith will jeopardize the best interests of the ward. See Goldiamond, supra note 19, at 114.


The Wyatt decision has a long and complicated procedural history. The original suit was brought as a class action by the guardians of patients confined to Bryce Hospital in Tuscaloosa, Alabama. 325 F. Supp. 781 (M.D. Ala. 1971). The district court held that each patient who had been involuntarily committed in civil proceedings had a constitutional right to receive treatment that would cure or improve his mental condition. Id. at 784. The plaintiffs were then granted permission to enlarge their class to include patients involuntarily confined for mental treatment at Searcy Hospital, Mount Vernon, Alabama, and those individuals in Partlow State School and Hospital for the mentally retarded in Tuscaloosa, Alabama. 334 F. Supp. at 1342 n.1.

In the original action, the district court gave the defendants six months to implement a treatment program that would safeguard the patients' right to treatment. When the defendants failed to institute a program satisfying minimum medical and constitutional requisites within the specified time, the district court set a hearing date to receive evidence on the appropriate standards to protect the patients' constitutional right to treatment. Id. at 1344. After receiving evidence from "the foremost authorities on mental health in the United States," the district court established minimum constitutional standards for adequate treatment of the mentally ill in the Bryce and Searcy facilities. 344 F. Supp. at 379-86. In an accompanying opinion, the court ordered the implementation of similar standards for adequate habilitation of the mentally retarded at Partlow State School and Hospital. Id. at 387.

On appeal, the Fifth Circuit affirmed the district court's holding that the constitution guaranteed a right to treatment to civilly committed mental patients; that the suit was not barred by the eleventh amendment; that the right to treatment could be implemented through judicially manageable standards; and that granting relief did not infringe on legislative prerogatives. Wyatt v. Aderholt, 503 F.2d 1305, 1312-16 (5th Cir. 1974). The Fifth Circuit reserved decision on whether the district court could alter the state budget or take other steps to finance the right to treatment should the state fail to take appropriate action on
Among them is an administrative procedure to govern adverse conditioning programs, electroconvulsive therapy (ECT), and other extraordinary or hazardous techniques. The cornerstone of this regulatory system is a five member Extraordinary Treatment Committee that oversees the use of regulated therapies.

Before ECT can be administered to a patient, two Qualified Mental Health Professionals must independently recommend its use, and their recommendations must be approved by

the ground that the issue was premature. Id. at 1317-18. A decision on the award of attorney's fees was also reserved. Id. at 1319. See generally Note, The Wyatt Case: Implementation of a Judicial Decree Ordering Institutional Changes, 84 YALE L.J. 1338 (1975).

45. The original standard was: "Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, aversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice." Wyatt v. Stickney, 344 F. Supp. 373, 380 (M.D. Ala. 1972), aff'd in part, remanded in part, decision reserved in part sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). In Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55 (M.D. Ala. July 1, 1975), this single "standard" was expanded to an entire set of procedural regulations under the following rationale:

[In setting forth the minimum constitutional requirements for the employment of certain extraordinary or potentially hazardous modes of treatment, the Court is not undertaking to determine which forms of treatment are appropriate in particular situations. Such a diagnostic decision is a medical judgment and is not within the province, jurisdiction or expertise of this Court. But the determination of what procedural safeguards must accompany the use of extraordinary or potentially hazardous modes of treatment on patients in the state's mental institutions is a fundamentally legal question and one which the parties to this lawsuit have put at issue.

Id. at 55-56.

46. For the composition of the Extraordinary Treatment Board, see note 88 infra.

47. This discussion focuses only on the regulation of ECT. Under the regulatory scheme, psychosurgery is forbidden, Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 56 (M.D. Ala. July 1, 1975), and the procedures promulgated for aversive conditioning and "other unusual or hazardous treatment procedures" generally conform to those for ECT. Id. at 56-57.

48. The court defined "Qualified Mental Health Professional" as:

(1) a psychiatrist with three years of residency training in psychiatry;
(2) a psychologist with a doctoral degree from an accredited program;
(3) a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;
(4) a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional.

the superintendent or medical director of the hospital. After
the proposed patient executes a written consent, the Extraordi-
mary Treatment Committee must "determine, after appropriate
inquiry and interviews with the patient, whether [his] consent
... is, in fact, knowing, intelligent, and voluntary and whether
the proposed treatment is the least drastic alternative available
for the treatment of his illness." Only if the Treatment
Committee answers both these questions affirmatively can the
treatment be administered. The refusal of a competent patient
is determinative; but if "the patient is deemed incompetent ...
by either his attorney, the treating psychiatrist or the Extraordi-
ary Treatment Committee, the Committee may consent to such
treatment on his behalf if it determines that the evidence present-
ed to it clearly indicates ... that [it] is in the patient's best
interest." In reaching its decision, the Committee must "give
great weight to any expression by the patient of a desire not to
be subjected to ECT. Any doubts that ECT is in the best
interest of the incompetent patient shall be resolved against
proceeding with such treatment."

A key deficiency of the Alabama procedure is its relative
inflexibility. Although there are occasions when it might be
medically appropriate to administer ECT to a patient under
18 years of age, for example, no such patient can ever re-
ceive ECT even if he can make an informed treatment deci-

49. Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 56 (M.D. Ala.
July 1, 1975).
50. Id.
51. Id. at 56-57. The Alabama procedure lists several factors on
which this best interest determination should rest, which have been in-
corporated into the Model Statute. See Model Statute § 12(c).
52. 1 MENTAL DISABILITY L. REP. at 57.
53. See L. KALINOWSKY & H. HIFFIUS, PHARMOCOLOGICAL CONVUL-
SIVE AND OTHER SOMATIC TREATMENTS IN PSYCHIATRY 222-23 (1969); E.
VALENSTEIN, BRAIN CONTROL 158-62 (1973); Schwartz, supra note 4, at
813-14. Compare the California regulatory procedure's treatment of
this issue.

Under no circumstances shall convulsive treatment be performed
on a minor under 12 years of age. Persons 16 and 17 years of
age shall personally have and exercise the rights of this article.
Persons 12 years of age and over, and under 16, may be admin-
istered convulsive treatment only if all the other provisions of
this law are complied with and in addition:
(a) It is an emergency situation . . .

CAL. WELF. & INST. CODE § 5326.8 (West Supp. 1977). The Alabama pro-
cedure does not contain a provision allowing a treating physician to cir-
cumvent the ordinary procedure in an emergency situation. See Model
Statute § 15.
54. 1 MENTAL DISABILITY L. REP. at 57.
sion. This procedural prohibition limits the right of competent minor patients to control their treatment and prevents all such patients from receiving a potentially beneficial therapy.55

Another disturbing aspect of the Alabama administrative procedure is the ease with which a patient can be declared incompetent by his attorney or the treating psychiatrist.56 Under a literal interpretation of the court order, once either of these parties so specifies, a patient is considered incompetent for purposes of the regulatory procedure. Rather than conducting a competency hearing,57 the Committee investigates only whether the proposed therapy is in the patient's best interest. Although the court had previously held that a patient's right to refuse the administration of some organic therapies was a minimum constitutional standard for adequate treatment of the mentally ill,58 and made the patient's competency the determining factor in the regulation of organic therapy, this protection is seriously diminished if the question of competency can so easily be eliminated.59

55. This restriction might be unconstitutional under Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (Ct. App. 1976). In response to a challenge by voluntary patients to a regulation that precluded them from receiving potentially beneficial therapy, the Aden court declared the California administrative procedure unconstitutional. See note 60 infra. Whether a competent, consenting minor should be allowed to receive ECT presents a more difficult question, especially if the legal or natural guardian has also consented. If a court were willing to extend the Aden holding to involuntarily committed but competent patients, the same theory might apply. The total ban on psychosurgery under the Alabama procedure, Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 56 (M.D. Ala. July 1, 1975), might be challenged on the same theory.

56. See text accompanying note 51 supra.

57. In the course of determining the patient's "best interests," the court might of course review the question of competency, but that is not required. The Model Statute cures this defect by requiring the Board to determine a patient's competency in each case. See Model Statute §§ 5, 9.

58. See note 45 supra.

59. The Alabama procedure does require that "great weight" be given to the desires of the patient, see text accompanying note 52 supra; theoretically, this could afford some protection for a competent patient erroneously classified as incompetent. A literal interpretation of the regulation, however, requires the committee to give "great weight" to the wishes of any patient, competent or incompetent. Because giving great weight to the wishes of an obviously incompetent patient appears to make little sense, the intended effect of the provision is unclear, and the committee might tend to discount it. Thus, in practice, it would do very little to protect the rights of misclassified competent patients. Compare Model Statute § 13 and accompanying commentary.
C. THE CALIFORNIA PROCEDURE

The current California statute\(^6\) represents one of the most sophisticated and complete regulatory procedures enacted in any state. It is commendable in many respects, but some aspects of the law prevent full implementation of the underlying principle of consent.

The California procedure regulates only psychosurgery\(^6\) and convulsive treatment, with separate prerequisites for the administration of each. The provisions governing psychosurgery illustrate some of the advantages and deficiencies of the regulatory scheme.\(^6\) Only patients with the capacity to execute a "written informed consent," and who have done so, are al-
allowed to receive psychosurgery. No distinction is made between voluntary and involuntary patients. Before a consenting competent patient can receive psychosurgery, the treating physician must enter a signed statement in the patient's treatment record, outlining the reasons for prescribing psychosurgery and recording the treating physician's opinion that all other appropriate modes of treatment have been exhausted. The entry must also state that psychosurgery, as a mode of treatment, is definitely indicated and is the least drastic alternative available for the treatment of the patient at that time.86

A three member board reviews recommendations for psychosurgery.87 The review board is composed of three physicians,88 one appointed by the treating institution and two appointed by the local mental health director. Before a patient can receive psychosurgery, this board must unanimously agree that the treating physician's determinations in the patient's treatment record are substantively accurate, and that the patient has the capacity to give informed consent.89 There is no provision, however, for a hearing on these issues. In making their decision the board members are required to examine the patient and to review the treatment record.70

Another section of the regulation outlines what information must be given to the patient in a "clear and explicit" manner in order to constitute "voluntary informed consent." Id. § 5326.2. Compare Model Statute § 7(b). The California Department of Mental Health is required to promulgate a standard written consent form which contains the information generally appropriate to all patients. CAL. WELF. & INST. CODE § 5326.3 (West Supp. 1977). In seeking the written consent of prospective patients, the treating physician is required to use this standard consent form and supplement it in writing with the information which pertains particularly to the patient being treated. Id.

66. Id. § 5326.6(c).
67. Id. § 5326.6(d).
68. Two of the physicians must be either board-certified or eligible psychiatrists or neurosurgeons. All three physicians personally must examine the proposed patient. Id.
69. The board's agreement must be documented in the patient's treatment record and signed by each board member. Id.
70. Id. The convulsive therapy provisions establish separate prerequisites for the administration of such therapy to voluntary and involuntary patients. Compare id. § 5326.7 with § 5326.75. For involuntary patients, including a patient under guardianship or conservatorship, the treating physician must enter a signed statement in the patient's treatment record documenting the reasons for administering the treatment. This statement must also include the treating physician's opinion that all reasonable modes of treatment have been carefully considered, that the proposed treatment is definitely indicated, and that the prescribed convulsive treatment is the least drastic alternative available for the proposed patient at that time. Id. § 5326.7(a).
One of the deficiencies in the California procedure is its failure to insulate the review boards from both the mental health system and treating physicians. The statute does specify that the board members should not be personally involved with the treatment of the patient whose case they are reviewing; but because the members are appointed by personnel in the mental health care system, there is some risk that their decisions will be improperly influenced. Even if such influence may be

A review board verifies the substantive accuracy of the treating physician's prescription of convulsive treatments. The review is composed of two physicians, both of whom must be either board-certified or board-eligible psychiatrists or neurologists; one is appointed by the treating institution and one by the local mental health director.

As a prerequisite to the administration of a convulsive therapy, both board members must agree with the treating physician's determinations in the patient's treatment record. At least one of the board members must personally examine the patient. The board's agreement must be documented in the patient's treatment record and signed by each board member.

The patient must also execute a written informed consent before receiving convulsive treatment. An involuntary patient's capacity to consent and that he has in fact consented must be verified by the patient's attorney. If the proposed patient does not have his own attorney, a public defender is appointed by the court. If either the attending physician or the patient's attorney believes that an involuntary patient does not have this capacity, a superior court must determine the issue. Upon receipt of the appropriate petition, and after giving notice to the patient, the court must hold an evidentiary hearing at which the patient must be present and represented by counsel. If the patient's attorney who brought the petition is deemed to have "a conflict of interest, such attorney shall not represent the patient in this proceeding." If the court determines that the patient does not have the capacity to give a written informed consent, see note 65 supra, the proposed therapy may be administered if consent is obtained from a responsible relative, or guardian or conservator of the patient.

When treatment has been prescribed for a voluntary patient, the statute requires the treating physician to make the same determinations that are made for involuntary patients. The proposed patient must also execute a written informed consent. If a board-certified or board-eligible psychiatrist or neurologist, other than the patient's attending or treating physician, examines the voluntary patient and verifies that the patient has capacity to give consent and has done so, neither the review board nor the court need be consulted. If no verification is obtained, or if the proposed voluntary patient does not have the capacity to give an informed consent, however, then the procedures followed for involuntary patients apply.

As noted previously, the board members are appointed either by the local mental health director or the treating facility. See text accompanying note 68 supra.

unlikely, eliminating the mere appearance of "bias" would strengthen confidence in the board's procedures.

The entire design of the California procedure attests to the legislature's determination that the written informed consent of a competent patient be a prerequisite to the administration of psychosurgery. Nevertheless, the procedure pertaining to psychosurgery requires only a review of capacity, not of whether informed consent was actually given.\(73\) This failure to require that the execution of informed consent be verified undermines the utility of making the threshold determination that the patient has capacity.\(74\)

Another deficiency of the California law is that the psychosurgery provisions do not require a hearing by the board when it reviews the treatment recommendation and the patient's capacity to consent. The patient's due process rights may thus be jeopardized,\(75\) for the statute provides no forum in which a patient's attorney, guardian, or conservator could challenge the board's determination that the patient has capacity.\(76\) Moreover, a treating physician, knowing that only competent patients are allowed to receive psychosurgery, is unlikely to petition the board for treatment of a patient he deems incompetent. As a result, some competent patients may be improperly denied treatment,

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73. *Compare* id. § 5326.6(d) with § 5326.7(e) -(g) and § 5326.75(b).

74. Similarly, for involuntary patients recommended for convulsive therapy, the determination of whether informed consent was given is left to the patient's attorney in those instances in which the attorney believes the patient has capacity. *Id.* § 5326.7(e). In those instances in which the competency decision is left to the superior court, see note 70 supra, there is apparently no verification of whether informed consent was actually given. *Cal. Welf. & Inst. Code* § 5326.7(g) (West Supp. 1977). This conclusion is based on the fact that there is no provision for determining whether or not a responsible relative, guardian, or conservator has in fact given a written informed consent. In addition, if the court determines that a patient does have the capacity to give an informed consent, it is not clear that the issue of whether such consent was actually given will ever be considered before treatment is commenced.

75. In *Aden v. Younger*, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (Ct. App. 1976), the court held that the previous California regulatory procedure did not meet the requirements of procedural due process since its provisions for a hearing on the issues of competency and voluntariness were inadequate. *See* note 60 supra. On the basis of this precedent the new California regulations are also defective. The only explicit provision for a hearing applies to convulsive treatment and is intended to evaluate only the capacity of an involuntary patient to give informed consent. *Cal. Welf. & Inst. Code* § 5326.7(f) (West Supp. 1977).

76. *See also* Model Statute § 10 and accompanying commentary.
for they have no method under the statute to challenge the physician's determination.\textsuperscript{77}

\section*{III. A MODEL STATUTE GOVERNING THE ADMINISTRATION OF ORGANIC THERAPY}

\subsection*{A. Introduction}

As the overview of the procedures used in Michigan, Alabama, and California suggests, designing an effective regulatory scheme governing the use of organic therapies requires that many factors be taken into account and many competing interests be accommodated. The Model Statute developed in this Note is intended to assist state legislatures in that task.\textsuperscript{78} Although the statute could be enacted virtually as written,\textsuperscript{79} it is also intended as a general guide, directing attention to issues that have received inadequate treatment in the past. Thus, in some instances, the statute offers alternative approaches to a specific problem, and the Commentary delineates the different considerations that would influence a legislature to adopt one approach or another. In other instances deemed essential to the effective functioning of the regulatory procedure,

\textsuperscript{77} A similar criticism applies to the procedure for regulating convulsive treatment of involuntary patients. A hearing on the question of capacity is held only if the patient's attorney or the treating physician believes capacity is lacking. See note 70 supra. A patient deemed able to consent by both of these parties therefore is not entitled to a formal determination of his capacity.

\textsuperscript{78} Some of the key features of the proposed statute have been adapted from the regulatory scheme developed by the court in Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55 (M.D. Ala. July 1, 1975), while others come from several other suggested or existing systems. See CAL. PENAL CODE §§ 2670-2680 (West Supp. 1977); CAL. WELF. & INST. CODE §§ 5325-5326.95 (West Supp. 1977); Friedman, supra note 1, at 95; Shapiro, supra note 4, at 339-46; Control of Shock Treatment, supra note 4, at 773. See also Note, Rights of Institutionalized Mental Patients: Issues, Implications, and Proposed Guidelines, 25 U. KAN. L. Rev. 63, 79-85 (1976).

Although the statute is designed to aid state legislatures, courts faced with constitutional challenges similar to those posed in Wyatt, see notes 44-45 supra and accompanying text, may find it necessary to impose regulations to protect patients' constitutional rights. The Model Statute could be utilized in those circumstances, for the availability of a model alleviates some of the difficulties inherent in judicial promulgation of such standards. See note 13 supra.

\textsuperscript{79} The statute leaves certain decisions to the legislature's judgment, see, e.g., Model Statute § 4(a); note 99 infra; and legislatures would necessarily have to choose between proposed alternatives, see, e.g., Model Statute § 3(b).
the statute incorporates, and the Commentary advocates, one approach as preferable. The Model Statute, then, should serve as a practical aid to future reform of laws governing the administration of organic therapies.

B. THE MODEL STATUTE

Section 1. Statement of Purposes

(a) All competent persons have a fundamental right not to have their thought processes, states of mind, or patterns of mentation altered through the unconsented administration of a regulated organic therapy.

(b) The general purposes of this Statute are:

(1) to preserve the right of a competent patient to make an informed treatment decision that is determinative;

(2) to reduce the risk that an incompetent patient will receive a regulated therapy that will not serve his best interests; and

(3) to adopt only those procedural restrictions whose marginal benefit to the patient outweighs the costs caused by increased administrative complexity.

(c) This Statute shall be construed to protect the fundamental right and to promote the general purposes stated in this section.

Commentary: This statement of the legislative purposes underlying the proposed model should guide the decisionmaking of both the Extraordinary Treatment Board80 and a reviewing court.81 The primary objective of the regulatory procedure is to protect the patient's rights without impairing the delivery of beneficial treatment. Thus, provisions have been incorporated only if the resulting complexity or financial burden would not hinder the effective delivery of beneficial therapy.82

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80. See Model Statute § 3.
81. See Model Statute § 14.
82. When designing a regulatory procedure, the legislature will inevitably be concerned with the expense of implementing particular provisions. If a patient's constitutional rights were involved, see note 8 supra, considerations of cost might have to give way; but the basic design of this statute anticipates constitutional developments, and most financial considerations relate to features of the statute that exceed any proposed constitutionally required minimum. It is also important from the standpoint of patients' interests that the system for delivering treatment not be overly burdened by administrative complexities. While part of the impetus for adopting regulations is to prevent unwarranted treatments, a patient's interests would be harmed if the complexity of the regulatory scheme impeded receipt of useful treatments. This question may also raise constitutional issues. See note 8 supra.
Section 2. Definitions

As used in this Model Statute:

(a) "patient" means an individual under observation, care, or treatment in a hospital;
(b) "hospital" means any public or private hospital\textsuperscript{83} to which an individual might be involuntarily committed;
(c) "organic therapy"\textsuperscript{84} refers to:

(1) psychosurgery, which includes lobotomy, stereotactic surgery, psychiatric and behavioral surgery, and all other forms of brain surgery performed for:
   (A) modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain; or
   (B) modification of normal brain function or normal brain tissue in order to modify thoughts, feelings, actions, or behavior; or
   (C) treatment of abnormal brain function or abnormal brain tissue in order to control thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, action, or behavior;
(2) electronic stimulation of the brain by means of electrodes implanted in the brain;
(3) shock therapy, including, but not limited to, electroconvulsive or other convulsive therapy, whether effected electrically or chemically, and insulin shock treatments;
(4) the use of any drugs, electrical shocks, shock therapy, electronic stimulation of the brain by means of electrodes implanted there, or infliction of physical pain when used as an adverse or reinforcing stimulus in a program of aversive, classical, or operant conditioning; and

\textsuperscript{83} In some states, the laws permit involuntary commitments to private hospitals. See, e.g., MICH. COMP. LAWS ANN. § 330.1518(2) (West 1975). Whether statutory protection should extend to voluntary patients in state or private institutions, see, e.g., Note, Regulation of Convulsive Therapy, 75 Mich. L. Rev. 363, 370 n.55 (1976), raises questions beyond the scope of this Note.

\textsuperscript{84} Except for the definition of psychosurgery, this definition of organic therapy was taken from a recent California statute and the proposals that led up to its enactment. CAL. PENAL CODE §§ 2670-2680 (West Supp. 1977); Shapiro, supra note 4, at 339-46. The definition of psychosurgery comes from the new California regulatory procedure. CAL. WELF. & INST. CODE § 5325 (West Supp. 1977).

The organic therapies included in Model Statute § 2(c) (1)-(4) are similar to those recognized by several state legislatures as appropriate subjects for regulation. See STONE, supra note 6, at 105; note 14 supra. Because the role played by psychotropic drugs in the delivery of mental health services is likely to expand, see note 3 supra, subsection (5) permits the regulation of a significantly larger number of drug treatment programs than do any existing regulatory procedures. For discussions of these treatments, see sources cited in note 4 supra.
(5) the use of any psychotropic drug, including, but not limited to, antipsychotic, antianxiety, antidepressant, or stimulant medication.

d) "a regulated therapy" means any organic therapy that is regulated pursuant to § 4(a) and § 4(b) of this Statute.

e) a patient has "the competency to make an informed treatment decision" if the patient has the ability to understand and appreciate the significance of:

(1) the nature of a proposed organic therapy;
(2) the potential risks and benefits inherent in the proposed procedure; and
(3) the possible alternative courses of action.

(f) a patient's treatment decision is "an informed and voluntary treatment decision" if it is:

(1) based on an understanding of the nature and consequences of the proposed procedure; and
(2) wholly voluntary and free from duress.

Section 3. The Extraordinary Treatment Board

(a) There shall be established an Extraordinary Treatment Board [hereinafter referred to as the Board] to supervise the administration of organic therapy in state mental hospitals.

(b) The Board shall be appointed by the governor [from a list of qualified applicants] and shall be comprised of three members: a board-certified psychiatrist or a clinical psychol-
The appropriate size and composition of an administrative board depends on a number of considerations: whether the board will operate on a full time basis, whether various experts are available and willing to serve, whether the board's decisions must be unanimous, and whether the size of the board will permit it to function efficiently.

The composition of the administrative Board in the Model Statute reflects the conclusion that a small board, which must make unanimous decisions, will be able to protect the patient's interests without sacrificing professional expertise. See note 89 infra. Because the availability of particular personnel may be limited, however, alternative specifications are provided. It might be extremely difficult to find both a psychiatrist and an internist who are available and willing to serve on the Board at the same time: the legislature could therefore provide that a psychologist could replace the former and a general practitioner the latter. For an example of how flexible membership qualifications could be designed to deal with this problem, see note 48 supra and accompanying text. For the few cases involving a treatment proposal for psychosurgery, however, it is probably necessary to have a neurologist on the Board since only a neurologist is likely to have the expertise needed to evaluate such a treatment proposal.

The Alabama Extraordinary Treatment Committee illustrates an alternative model.

The members shall be so selected that the [five member] committee will be competent to deal with the medical, psychological, psychiatric, legal, social and ethical issues involved in such treatment methods; to this end, at least one member shall be a psychiatrist licensed to practice in this state; at least one member shall be a neurologist or specialist in internal medicine; and at least one member shall be an attorney licensed to practice law in this state.

Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 56 (M.D. Ala. July 1, 1975). The Alabama procedure does not specify whether the committee's decisions must be unanimous. If the size of the Board is increased, a requirement of unanimity, see Model Statute § 10, will mean that fewer regulated therapies will be approved. To avoid this, a legislature that wanted a larger board could allow some form of majority rule. This would cause other difficulties, however; for example, the perceived value of having nonmedical Board members might be largely eliminated if the medical members could control the Board's actions.

When determining the composition of the Board, a legislature should also consider whether Board members will be employed on a full time basis. Because the availability of the most qualified specialists may vary inversely with the amount of time the members will be required to spend on Board operations, a number of part time boards might be created in hopes of attracting the most qualified people. The availability of qualified personnel in a given area will limit the legislature's decision to establish either rotational membership or a number of part time boards.

89. Under the proposed procedure an organic therapy will be approved only if the attorney is convinced that the patient's legal rights have not been jeopardized. See Model Statute § 10(a). The Model assumes that an attorney's legal training and experience will cause him to emphasize the patient's legal rights. In contrast, a doctor's training
(c) None of the members of the Board shall be affiliated with a state mental hospital or with the [state] Mental Health Department.

(d) Members of the Board shall serve four year [staggered] terms\(^9\) and shall be compensated at [ ].

Commentary: Whether a court or an administrative board should be charged with the task of implementing an organic therapy regulatory program is a question fundamental to the design of the regulatory scheme. The question can be analyzed by comparing how effectively each body would accomplish two major goals of regulation: determining whether a proposed patient has the capacity to make an informed treatment decision and determining whether a treating physician's treatment recommendation\(^1\) was substantively correct.\(^2\) These two issues can be respectively characterized as "legal" and "medical." If a patient has the capacity to make a treatment decision, he will be legally entitled to refuse a regulated therapy. In contrast, whether a treatment is appropriate for a particular patient is essentially a medical question. Characterizing these issues as "legal" or "medical" is necessarily somewhat artificial: the determination of

and experience will naturally cause him to focus on treatment. Bazelon, Institutionalization, Deinstitutionalization and the Adversary Process, 75 COLUM. L. REV. 897, 909-12 (1975). Placing both medical and legal professionals on the Board should give the reviewing body a perspective that is compatible with the balancing process necessary to substantively review an organic treatment decision.

\(^{90}\) The legislature could minimize the risk that certain board members might come to dominate the Board's decisionmaking by providing for staggered rather than concurrent terms.

\(^{91}\) Although the psychiatric physician's ability to identify accurately those members of society who are mentally ill, to diagnose correctly the particular dysfunction, and to treat individual patients effectively, has been seriously questioned, see, e.g., Albers, Pasewark, & Meyer, Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception, 6 CAP. U. L. REV. 11 (1977), this Note accepts the more traditional view that the expertise of the psychiatric physician is a valuable asset in the treatment of mental illness. Given that there are questions as to the general competence of treating physicians, however, when the legislature considers regulatory schemes for organic therapies of questionable efficacy, it should recognize that stronger arguments exist for heavy regulation or prohibition. See note 24 supra.

\(^{92}\) The Model Statute is premised on the appropriateness of substantively reviewing a treating physician's medical judgment. This issue is unsettled, but there is strong precedent to support such review. See, e.g., Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55 (M.D. Ala. July 1, 1975); Price v. Sheppard, 239 N.W.2d 905 (Minn. 1976); CAL. WELF. & INST. CODE §§ 5326.6-.7 (West Supp. 1977).
competency will raise a number of medical questions; the approval of a treatment may in turn affect legal rights.

To the extent that the evaluation of a patient's capacity can be characterized as a "purely" legal issue, however, a court, because it is designed to resolve legal issues and preserve legal rights, is arguably the superior decisionmaker. The court's lack of medical expertise, which could hinder it in dealing with the medical aspects of the competency determination, could be partially remedied by reliance on medical experts. An administrative board, on the other hand, would have the independent medical expertise to resolve the medical questions involved in the competency issue, but might be less well equipped to decide purely legal questions. As our system of administrative law attests, however, administrative agencies are often entrusted with the power to resolve issues affecting individuals' legal rights. Placing a lawyer on the board and requiring unanimous decisions would both ensure that the board has legal expertise and minimize any criticism that physicians alone were determining a patient's legal rights. Furthermore, the same due process safeguards present in a judicial proceeding could be provided in an administrative hearing. Finally, judicial review of the

93. One commentator has argued that a court of law is the only appropriate forum for evaluating capacity to consent. Capacity to consent, and thereby to exercise a legal right, like any other question of mental capacity is primarily a legal issue. Medical opinion may be helpful in understanding mental competency, but doctors are not trained to make a determination of whether a person should be deprived of basic legal rights. Informed Consent and the Mental Patient, supra note 8, at 755-56. But see Civil Restraint, supra note 8, at 114.

This criticism, however, appeared in an evaluation of the California regulatory system, which uses an administrative review board wholly composed of physicians associated with the state mental health system, see Cal. Welf. & Inst. Code §§ 5325-5326.95 (West Supp. 1977); see generally Control of Shock Treatment, supra note 4, at 751, and the author never investigated whether an administrative procedure could be designed that would adequately protect a patient's legal rights. The Model Statute minimizes the impact of the problems raised by the author of the article quoted above by using a mixed medical and legal review committee, see note 89 supra and accompanying text, and requiring unanimous decisions, see Model Statute § 10(a). It also prohibits Board members from being associated with the treating institutions. See Model Statute § 3(c).

94. But see note 98 infra.

95. "The very identifying badge of the American administrative agency is power, without previously existing rules, to determine the legal rights of individual parties." K. Davis, Administrative Law Text § 1.07 at 20 (1972).

96. See note 89 supra and accompanying text.
decision made by the board would provide an ultimate safeguard for the patient's legal rights.

With respect to the ability of a court or board substantively to review a treatment recommendation, the board's medical expertise clearly makes it a superior decisionmaker. While there might be some danger that medical members of the board would be influenced by a sense of loyalty to those within their own profession and hence defer routinely to treating physicians' recommendations, this risk can be minimized. Formal relationships between board members and the treating facilities could be prohibited; placing nonmedical members on the board could counterbalance any potential undue influence from the medical profession; and unanimous decisions by the board could be required. A court, on the other hand, while it is unlikely to be influenced by a sense of colleagueship with physicians, might nevertheless be more likely to rely completely on the recommendations of treating physicians or other medical experts, since its lack of medical knowledge would prevent it from independently evaluating the appropriateness of a treatment.

97. See Bazelon, supra note 89, at 910.

98. Because courts handle medical issues in other contexts, such as medical malpractice, they arguably can handle the medical issues that arise in reviewing an organic treatment decision. The same authors who advance this argument, however, recognize its limitations. “Even if we were all agreed, however, that courts do indeed soundly adjudicate matters of medical malpractice, the analogy, given present biomedical technology, is not fully persuasive.” Shapiro, supra note 4, at 324. In a medical malpractice case the judge or the jury is asked to determine whether the plaintiff's injuries were the proximate result of the defendant's failure to possess or exercise the skill and learning common to members of that profession. W. Prosser, HANDBOOK OF THE LAW OF TORTS 162 (4th ed. 1971). To compensate for the fact-finder's lack of medical expertise, the plaintiff must produce expert testimony to support an inference that the defendant's conduct did not conform to the appropriate standard. Id. at 164. No such standard exists to help the decisionmaker evaluate a prospective organic treatment decision. Compare Civil Restraint, supra note 8, at 107.

The existence of an objective standard in a medical malpractice case distinguishes it from the decisionmaking necessary in reviewing a treatment decision. Approval of the administration of a particular organic therapy requires a balancing process. That the variables that must be weighed are peculiarly medical in nature (for example, an assessment of the risks relevant to the administration of a particular therapy, in a particular manner, to an individual patient) emphasizes the need for a decisionmaker with some medical knowledge. Since a court cannot fully understand the reasons underlying the original prescription, it cannot comprehensively and independently review an organic treatment proposal.

We do not suggest that the court should or can decide what particular treatment this patient requires. . . . We do not decide
Perhaps the most compelling argument favoring the administrative board is one unrelated to the two major issues of determining competency and approving treatment decisions. An administrative board, if empowered to do so, could implement a comprehensive regulatory scheme far more readily and efficiently than either the legislature or the courts. It would build up a body of knowledge and a familiarity with treatment procedures that would permit it to plan for technological devel-

whether the agency has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion. Tribby v. Cameron, 379 F.2d 104, 105 (D.C. Cir. 1967). See Bazelon, supra note 89, at 910. But see Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55 (M.D. Ala. July 1, 1975) as quoted in note 45 supra. This outline of a court's proper function dramatizes its limitations. One of the explicit objectives of regulation is to narrow the treating physician's existing discretion, and thus to insure that the treatment prescriptions advance the patients' best interests. See Model Statute § 1. Even though a court cannot fully understand the original treatment prescription, it could rely on medical experts to perform this function. Reliance on such experts, however, not only creates the problems noted in the text but also involves the court in resolving conflicts of medical opinion, a unique problem in itself. One commentator notes:

Medical evidence that there is a reasonable basis for the treatment and that it is being evaluated in a reasonable way should allay concerns about the appropriateness of the treatment and spare the court from immersing itself in the nuances of the biological effects of the treatment or of the statistical methods used to determine its efficacy. Where medical opinions are divided, a court may either require a fuller exposition of the relevant data, recognizing the limits of its own expertise, or may take the conservative view that efficacy is unproven. Beresford, supra note 1, at 351. See also Civil Commitment, supra note 11, at 1333-44; Civil Restraint, supra note 8, at 114. Professor Beresford's statement, while outlining a possible standard for judicial review of the efficacy of a treatment program, also highlights the problems associated with judicial review of a physician's selection of a particular treatment program. A judge will not have the expertise to determine whether a "reasonable basis" for the treatment exists, and a more complete exposition of conflicting medical opinion, while it might dramatize the issue, cannot provide the judge with the knowledge necessary to resolve the dispute. Faced with this dilemma, courts may be tempted to adopt the "conservative view" and unnecessarily deprive the proposed patients of potentially beneficial therapy.

Conflicts about organic treatment decisions, moreover, are closer to psychiatric malpractice than to general malpractice cases. In physical medicine there is relative certainty compared with psychotherapy, both in diagnosis and in the efficacy of particular treatments. In the psychiatric malpractice field, the courts have exhibited extreme reluctance to examine the issues of treatment and great confusion in trying to decide when negligence has occurred. Civil Restraint, supra note 8, at 111. The judiciary is likely to be similarly reluctant in its evaluation of organic therapy decisions.
opments and to promulgate rules for regulating certain treatments. This is a distinct advantage, for it assures a broad and flexible approach to the regulation of proliferating organic therapies. On balance, then, because an administrative board could capably handle both the legal and medical issues, and because it has the added advantage of flexibility, the administrative approach has been chosen for the Model Statute.

Section 4. *The Determination of Regulated Therapies*

(a) Regulated therapies shall include [ ].

(b) The Board may on its own initiative determine which organic therapies other than those specified in subsection (a) warrant classification as regulated therapies. For each therapy being considered, the Board shall, after notice, hold public hearings to receive additional information. In reaching its decision to classify an organic therapy as a regulated therapy, the Board shall consider:

1. the intrusiveness of the therapy and its impact upon the patient;
2. the extent and quality of the available knowledge concerning the therapy's effectiveness;
3. the potential harms and the probability of their occurrence;
4. the risk posed by unknown harms and the probability of their occurrence; and
5. the administrative complications that would arise from the decision to regulate the therapy.

(c) The Board shall place an organic therapy in the regulated category whenever it determines that the risks that the therapy will be administered improperly and that such improper administration will jeopardize the patient's well-being outweigh

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99. This decision is one that each legislature must make pursuant to the considerations discussed in notes 84-85 supra.

100. Although it raises some of the same issues, the decision to regulate a particular organic therapy is more general than the determination of whether a specific therapy would advance the best interests of a particular patient. Compare Model Statute § 4(b) with § 12(c)-(d).

101. Whether the Board's regulatory or deregulatory decisions should be unanimous has been left to the legislatures. Legislatures should evaluate the impact of a unanimity requirement upon the availability of treatment and the potential risks to patients from unregulated treatments. The decision to place a therapy in a regulated class, for example, adds procedural complexities to the treatment process but does not preclude patients from receiving the therapy; deregulation, however, removes the procedural safeguards and increases the risk that a therapy may be inappropriately used. Because the patients' interests may be more adversely affected by the latter, a unanimity requirement might be preferable for deregulation, while a majority vote would suffice for decisions to regulate.
the administrative or medical advantages anticipated by requiring only the treating physician's prescription.

[(d) The Board shall also be empowered to declassify a regulated therapy. The Board shall make this decision after a public hearing and a decisionmaking process as set forth in subsections 2(b) and (c).]

Commentary: In determining which therapies fall into the regulated category, the proposed model distinguishes between those organic therapies that are per se regulated and those that may become regulated.\(^{102}\) The designation of certain organic therapies as per se regulated allows the legislature to structure the regulatory procedure to conform to its judgment of which therapies are potentially most dangerous, while the flexibility necessary to respond efficiently to new technological developments\(^{103}\) is provided by the authority given to the Board to regulate previously unregulated therapies. Thus, when new therapies become available or new applications of existing therapies are proposed, treating physicians in states adopting the Model Statute will not have to await legislative or judicial adjustments in the class of regulated therapies.\(^{104}\)

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102. The approval of the Board must be obtained prior to the administration of a regulated therapy. See Model Statute § 5. Friedman has proposed a tripartite classification of behavior modification techniques into regulated, monitored, and unregulated categories that could probably be adopted for other organic therapies as well. Friedman, supra note 1, at 96–97. A therapy in the middle group could be administered without approval, but the Board would periodically monitor its use. The legislature could either establish the tripartite system itself or give the Board the power to do so in a restricted set of circumstances or whenever the Board deemed it appropriate.

Such a tripartite classification would be most useful if the legislature wished to restrict the group of regulated therapies. Allowing the Board to monitor the use of the most intrusive unregulated therapies would provide the legislature with the empirical data necessary to determine whether to expand the original group of regulated therapies. This same observation would apply if the Board were given regulatory powers. See note 103 infra and accompanying text.

103. Existing regulatory procedures would have to be adjusted when new types of organic therapies are developed, see note 3 supra, or novel applications of existing therapies, including the alteration of a specific treatment program, see note 85 supra, are introduced.

104. The Alabama procedure, for example, provides that:

No patient . . . shall be subjected to any other extraordinary or hazardous technique or procedure not specifically mentioned herein unless the treating psychiatrist or the medical director of the hospital has first obtained:

a. The written approval of the Extraordinary Treatment Committee . . . ; and

b. The express and informed consent of the patient in writing to the administration of such treatment.

Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 57 (M.D. Ala. July 1, 1975). This provision is a workable, but incomplete, response to the
The requirement of public hearings and the access of treating physicians to the Board will also allow them to influence the decision to regulate certain treatments. As the category of regulated therapies expands beyond the most intrusive types of organic therapies, such access becomes more necessary. In determining when to extend the regulatory system, the Board must weigh the marginal benefits to the patient against the costs imposed by increased administrative complexities; because treating physicians must comply with and implement the regulatory procedures, they are ideal sources of information on the effect of increased complexity on the delivery of therapy.

The Model Statute could be designed to empower the Board to deregulate a formerly regulated organic therapy. As a matter of policy, the desirability of this alternative depends on whether the value of a flexible procedure and the perceived need for an efficient method of updating the regulatory system outweigh the advantages of a legislative determination of the class of regulated therapies. It would seem reasonable to permit the Board to deregulate therapies, for it would acquire empirical knowledge from numerous applications of a treatment and be able to assess whether the risks associated with its use had been sufficiently reduced. On the other hand, because deregulation may entail more serious risks of harm to patients than the initial decision to regulate, the legislature might prefer to retain the deregulatory decision for itself.

Section 5. A Condition Precedent to Treatment

No regulated therapy shall be administered in a state mental hospital without the express, written approval of the Board.

Section 6. The Treating Physician’s Treatment Recommendation

(a) Prior to the administration of a regulated therapy, the treating physician shall submit to the Board a written recommendation requesting that the Board approve the prescribed therapy.

105. The procedure described in this section is very similar to that instituted by the Wyatt court. Id. at 56. See text accompanying notes 47-50 supra.
(b) The physician's treatment recommendation shall include:

(1) a detailed, clinical rationale for the administration of the proposed therapy;

(2) a list of all alternative treatments that were considered and a complete explanation of why they were rejected;

(3) a full description of the treatment program within which the regulated therapy will be administered; and

(4) the written approval of the superintendent or medical director of the treatment facility.

(c) Upon receipt of the treatment recommendation, one of the members of the Board shall interview the proposed patient.

(d) The Board shall have access to this patient’s medical records and treatment program.

Commentary: This section is designed to provide the Board with the information necessary to execute its functions.

106. The components of a complete treatment program are described in note 85 supra.

107. The appropriate scope of this interview merits careful consideration by the legislature, for it must protect the patient's interests without creating unduly burdensome procedures. For most types of intrusive therapy, both administrative flexibility and the patient's best interests can be advanced by conducting the hearing in his presence; the Board member should physically examine the patient prior to the treatment hearing. Consistent with this approach, the Minnesota commitment statute provides for a judicial commitment hearing "at a hospital, a public health facility, the proposed patient's residence, or such other suitable and appropriate place as the court may determine." Minn. Stat. § 253A.07(13) (1976). If this degree of flexibility were adopted, the patient would be able to attend the treatment hearing in all but the most exceptional circumstances.

Even if it is determined that the regulation demands only that the Board interview the patient, for certain organic therapies the physician Board member should physically examine the patient prior to the treatment hearing. See Cal. Welf. & Inst. Code §§ 5326.6(d), .7(b) (West Supp. 1977). This should certainly be a requirement for psychosurgery and perhaps for electroconvulsive therapy, but whether it could be implemented depends on the composition of the Board. An "effective" examination prior to administration of these therapies probably requires special expertise. See note 88 supra. Under the Alabama administrative procedure, a patient must receive "a complete physical examination, including neurological examination... ten (10) days prior to the commencement of each series of electro-convulsive treatments." Wyatt v. Hardin, 1 Mental Disability L. Rep. 55, 57 (M.D. Ala. July 1, 1975).

108. The Minnesota Hospitalization and Commitment Act requires that a written plan be devised for each hospitalized individual that "describe[s] in behavioral terms the case problems, and the precise goals, including the expected period of time for hospitalization, and the specific measures to be employed in the solution or easement of said problems." Minn. Stat. § 253A.17(9) (1976). The suggestion that the Board have access to such treatment plans could be adopted by states that have similar statutory provisions.
On the assumption that the necessarily more comprehensive information available to the treating physician will be useful to the Board, the physician is required to state the reasons supporting the treatment proposal. Requiring the Board to interview the patient is also intended to elicit necessary information.

Section 7. The Consent of the Patient

(a) In conjunction with the treatment recommendation made to the Board, the treating physician shall seek the patient's written consent to the proposed treatment.

(b) It shall be the responsibility of the treating physician to communicate directly to the patient in language that the patient can understand:

(1) the nature and seriousness of the patient's disorder;
(2) the procedures to be used in administering the proposed therapy;
(3) the potential benefits that the patient might derive from the therapy;
(4) the nature, degree, and duration of the side effects and the significant risks of the treatment that are commonly known to the medical profession;
(5) the probability that either the benefits or the hazards associated with the therapy will materialize;
(6) the existence of conflicting medical opinion as to the efficacy of the proposed treatment and/or its potential risks and side effects, if such conflict exists; and
(7) the alternative treatments available and the reasons for the physician's recommendation of this particular therapy.109

109. Merely listing the factors exposes the problems inherent in the development of such an informational standard by raising the following questions: (1) How much detail is required adequately to inform a patient? (2) What details will be counterproductive because they confuse the patient? (3) Should the informational standard be modified for different therapies and different patients?

The informational standard outlined in the Model Statute is a modified version of California's standard. CAL. WELF. & INST. CODE § 5326.2 (West Supp. 1977). Although the California legislature had previously adopted a more detailed informational standard for the administration of organic therapy in prisons, CAL. PENAL CODE § 2673 (West Supp. 1977), the provision did not appear to require communication of more information.

In developing an informational standard, the legislature will necessarily write in generalities, and even if it did not require administrative interpretation, the Board would be forced by practicalities to make such interpretations. In light of these realities, the legislature should establish a general standard and allow the Board to particularize it for each regulated therapy, much as California has done with written consent forms. CAL. WELF. & INST. CODE § 5326.3 (West Supp. 1977).
(c) The written consent signed by the patient shall include:
(1) a statement of the nature of the treatment to which he has consented;
(2) a description of the purposes, risks, and possible consequences of the treatment;
(3) a statement of the probable duration and intensity of the proposed therapy and whether such therapy would have to be continued indefinitely for optimum therapeutic results;
(4) a notice that a person does not waive his right to refuse any organic therapy by having previously given his informed consent, and that he may withdraw his consent at any time. After the patient withdraws his previous informed consent, the attending physician may gradually phase out the therapy rather than immediately terminating it, if sound medical-psychiatric practice suggests that sudden cessation would create a serious risk of mental or physical harm."

110. Even if the legislature elects to determine the information a patient should receive prior to the administration of a particular therapy, the Board could develop consent forms for individual therapies. See CAL. WELF. & INST. CODE § 5326.3 (West Supp. 1977). This form, whose general substance would be identical to the information provided orally by the physician, would guide the physician in explaining the procedure to the patient and ensure that the patient will receive the information necessary to make an informed consent. If the patient is illiterate, the consent form could be read to him as part of the oral explanation.

111. The substance of this notice provision is based on CAL. PENAL CODE § 2670.5(d) (West Supp. 1977).

112. A competent individual, or a formerly incompetent patient who regains his capacity during the course of treatment, should be entitled to withdraw his consent and halt further treatment. The Alabama administrative procedure accepted this principle as basic and provided that

[a] competent patient may withdraw his consent to ECT at any time and for any reason. A patient who is incompetent at the inception of a course of treatment may refuse to participate in further treatments at any time that he is restored to competence. Such withdrawal of consent or refusal to participate may be either oral or written and is to be given effect immediately.


Since disorientation of the patient is one of the objectives of an electroconvulsive therapy treatment program, a patient is likely to become destabilized during the course of treatment, see Schwartz, supra note 4, and a competent patient, who had previously consented to the therapy, is likely to want to withdraw his consent before the course of therapy is completed. Thus, for some organic therapies administered seriatim, it might be necessary to interpret a competent patient's initial consent as a waiver of the future right to withdraw from that treatment program; but a competent patient should certainly retain the right to refuse psychosurgery until the time of the operation. See, e.g., CAL. WELF. & INST. CODE § 5326.6(d) (West Supp. 1977).

Withdrawal of consent by a patient who is incompetent prior to the
(d) The treating physician's recommendation to the Board shall include his opinion of the patient's capacity to make an informed treatment decision.

(e) When the treating physician believes that the patient clearly lacks the capacity to make an informed treatment decision, and that no therapeutic purpose would be served by providing such information, the physician need not seek the patient's consent but must clearly note in the treatment proposal that the patient's consent was not received.113

(f) When the treating physician believes that a patient's physical or emotional well-being would be jeopardized by provision of all the information necessary to establish an informed consent, he should seek the patient's consent based on the partial information provided but should indicate in the treatment recommendation the relevant information the patient did not receive.]114

initiation of the treatment program raises a different issue. The Alabama procedure purports to give such a patient the absolute right to withdraw consent upon regaining capacity. Since the only way to test the patient's competency would be to return to the treatment committee or to a court, see CAL. WELF. & INST. CODE § 5326.7(h) (West Supp. 1977), some type of waiver provision would be a practical necessity in this situation as well.

An absolute right to withdraw consent could create further difficulties. Once the administration of a therapy has begun, it might be harmful to the patient to withdraw the therapy suddenly. A medical need to remove the patient gradually from the refused therapy will, in practice, limit the patient's right to refuse. See CAL. PENAL CODE § 2670.5(d) (West Supp. 1977).

The provision of a right to withdraw consent could also prove troublesome if a patient consented and withdrew consent numerous times during the course of a treatment; this could conceivably impede the whole treatment program. Avoidance of this problem appears to necessitate some limitation on a patient's right to withdraw consent. Thus, although the theoretical framework of the Model Statute would otherwise require the inclusion of this provision, because of the complex administrative problems outlined above, this judgment would best be made after careful legislative consideration of its benefits and disadvantages.

113. This section is intended to apply only to those situations in which the patient is completely unable to understand and, due to this lack of understanding, to communicate with the physician, thus making it a pointless exercise to require the physician to attempt to gain an informed consent.

114. Although it might be argued that the patient has a right to the most complete information available, the analogous tort doctrine of "informed consent" was never absolute, and sound policy principles appear to support the recognized exception. Beginning with a decision in Kansas in 1960, it began to be recognized that this was really a matter of the standard of professional conduct, since there will be some patients to whom disclosure may be undesirable or even dangerous for success of the treatment or the patient's own welfare; and that what should be done is a matter for professional judgment in the light of the applicable medical standards. Accordingly, the prevailing view now is that the action, regardless of its form, is in reality
Commentary: This section of the proposed model is designed to provide the patient with the information necessary to make an informed treatment decision, an objective that is relatively straightforward and needs little commentary. The informational standard itself illustrates the tension among protecting the patient's right to be informed, establishing a procedure that can be easily administered, and adjusting the informational requirements when the patient's capacity so requires.

Section 8. The Role of the Patient's Natural or Legal Guardian

(a) The patient,115 the patient's guardian (either natural or legal), or the patient's attorney may initiate a treatment hearing by direct petition to the Board. Upon receipt of such a petition the Board may direct the appropriate treating physician to complete a treatment recommendation containing a detailed clinical rationale for not administering the requested therapy.

(b) The patient's guardian shall have the right to attend the treatment hearing outlined in section 9 and to present evidence before the Board.

(c) In reaching a decision on the treatment recommendation, the Board shall consider the opinion of the patient's legal or natural guardian as an independent representative of the patient's interests.

Commentary: The guardian's role in the formulation of a treatment decision has been ignored by a majority of existing procedures.116 While the Model Statute recognizes that it would be inappropriate to delegate the ultimate responsibility for the treatment decision of an involuntarily confined mental patient to

PROSSER, HANDBOOK OF THE LAW OF TORTS 165 (4th ed. 1971) (footnotes omitted). See STONE, supra note 6, at 104. The California legislature, however, appears to have either eliminated or severely restricted a physician's discretion not to disclose certain risks when he believes the knowledge would be harmful to the patient. See note 109 supra.

Under the Model Statute the Board makes the treatment decision for incompetent patients, and thus proper administration of the therapy does not depend on their execution of an informed treatment decision. For clearly incompetent patients, the physician could be allowed some discretion in the amount of information disclosed about the proposed therapy. If the Board is uncertain of the patient's competency, the patient should be provided with all the information before his treatment decision becomes determinative. See Model Statute § 13(b). Any other resolution of this issue would conflict with the principle of an informed treatment decision.

115. Cf. MINN. STAT. § 253A.16(2) (1976) (patient may initiate administrative hearing to review his continued confinement).

a parent or legal guardian,\textsuperscript{117} such an individual could be immensely valuable in helping the Board determine what treatment would serve the patient's best interests. Whenever the patient's guardian believes the patient could benefit from a particular therapy,\textsuperscript{118} he may request a Board hearing even though the treating physician has not recommended such treatment.

Permitting the guardian to attend the treatment hearing and directing the Board to consider his views provides the guardian with an opportunity to advance the best interests of his ward. Because the Board retains the ultimate decisionmaking authority, the danger of relying too heavily on the guardian's capabilities is eliminated.\textsuperscript{119}

Section 9. \textit{The Board's Treatment Hearing}

(a) After providing the patient and the individuals specified in section 10(e) with adequate notice, the Board shall conduct an administrative hearing upon each treatment recommendation it receives.

(b) The Board shall determine at such hearing:

(1) whether the proposed patient has the competency to make an informed treatment decision; and

(2) whether the patient's treatment decision was in fact informed and voluntary.

\textit{Commentary:} This section outlines the threshold issues the Board must resolve in the treatment hearing—whether the individual has the ability to assimilate the relevant information, whether the relevant information has actually been communicated to the patient, and whether the patient's ultimate decision was free and voluntary. Because the last two deficiencies can be cured, the key issue becomes the patient's ability to understand the relevant information.

Any determination of competency requires the Board to determine how much understanding constitutes "capacity." The standard adopted in this section is that of the hypothetical, ordinary, uncommitted patient, who will rarely understand all the intricacies or implications of the information he receives when making the same type of treatment decision. The definition of capacity is intended to eliminate any requirement that the capacity of the individual be evaluated under a subjective "reasonable-
ness” or “rationality” criteria. The competency formulation specifically directs the Board to focus only on whether the patient has the ability to decide, not whether he has exercised that ability in a “reasonable” manner. Thus, in determining the patient’s competency to make an informed treatment decision, the Board should not consider whether or not the proposed patient has actually consented to the therapy.

Section 10. The Patient’s Rights in the Administrative Hearing

(a) The Board shall approve the administration of a regulated therapy only upon the unanimous agreement of its members that each condition necessary to approve a treatment recommendation has been met.

(b) The patient shall be present at the administrative hearing [unless, in the Board’s judgment, the patient’s physical and emotional condition prevents the patient from attending.]\(^\text{122}\)

(c) The following parties shall have the right to attend the treatment hearing and present evidence before the Board:
   (1) the patient’s legal or natural guardian;
   (2) the patient’s counsel; and
   (3) the treating physician or a representative of the treatment facility.

(d) The Board shall have the power to call and examine as witnesses:
   (1) members of the patient’s family;
   (2) members of the hospital staff; and
   (3) any other individual who, in the Board’s judgment, could contribute relevant information.

(e) The patient has a right to be represented by counsel at the hearing, and, if unrepresented, counsel shall be appointed by the Board.\(^\text{123}\)

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120. There is a natural, but unfortunate, tendency to make capacity dependent on the “rationality” of the patient’s decision. See Price v. Sheppard, 239 N.W.2d 905, 911 (Minn. 1976). The ability to decide should be clearly distinguished from the “reasonableness” of the decision actually made. Civil Commitment, supra note 11, at 1212-22, 1344.

121. As Friedman, supra note 1, at 77, recognized:
   Any determination of the reasonableness of a result is based on the balancing of complex factors and is likely to be subjective. Thus, adoption of this standard may result in a Catch-22 logic—any decision with which the reviewer of competency disagreed would provide a basis for labelling the client incompetent and for substituting the reviewer’s opinion as to the best result for the client.

See Shapiro, supra note 4, at 311-13; Civil Commitment, supra note 11, at 1217.

122. See note 107 supra.

123. This provision is adopted from the Alabama procedure, Wyatt v. Hardin, 1 MENTAL DISABILITY L. REP. 55, 56 (M.D. Ala. July 1, 1975). In Alabama, the list of counsel is compiled by a committee and approved by the court, but appointment of counsel is by the Board. A useful guide
(f) The patient shall have the right to present evidence at the hearing and to examine witnesses testifying for another party.

(g) Informal evidentiary rules shall govern the hearing.

Commentary: This section sets out certain provisions designed to protect the patient's interests at the administrative hearing. The establishment of a forum in which all interested parties can present their opinions rests on the assumption that the Board will be better able to reach a decision that is in the patient's best interests after a complete exploration of the issues. By providing the patient with counsel, the Model Statute allows the patient independently to influence the Board's decision.\textsuperscript{124}

Section 11. The Decisionmaking Process for a Competent Patient

(a) When the Board determines that the patient has the competency to make an informed treatment decision, the patient's refusal to consent to the administration of a regulated therapy shall be determinative.\textsuperscript{125}

\textsuperscript{124} The scope of the right to counsel and the role that counsel should play has been examined by other authors. See, e.g., Litwack, The Role of Counsel in Civil Commitment Proceedings: Emerging Problems, 62 CALIF. L. REV. 816 (1974).

\textsuperscript{125} By making the treatment decision of a competent patient determinative, the Model Statute departs from the rationale of existing commitment statutes and highlights the inconsistencies between the theory underlying the state's power to commit and the practices actually permitted by such legislation. When the patient has been committed under the state's \textit{parens patriae} power, the state acts to protect his best interests. See note 18 supra. Theoretically, a patient confined for treatment under the \textit{parens patriae} power should be unable to make his own treatment decision. Because the existing commitment standards are so broad, however, a competent patient could also be involuntarily confined. See note 18 supra.

According to the logic underlying the Model Statute, the Board's determination that an individual has the capacity to make his own treatment decision would theoretically preclude the state from confining him involuntarily under the \textit{parens patriae} power. A patient's continued
(b) When the Board determines that the patient has the competency to make an informed treatment decision, and the patient consents to the therapy, the Board shall further determine whether the patient's treatment decision was in fact informed and voluntary.

(c) In making this determination, the Board shall consider the adequacy of the information provided the patient under section 7.126

(d) A competent patient's involuntary or uninformed consent shall be construed as a denial of consent and shall preclude the imposition of the proposed therapy until such defective consent is cured pursuant to subsection (e).

(e) The Board shall make arrangements to cure any defect in the patient's treatment decision relating to the inadequacy of the information received or the involuntariness of the decision.127

(f) The Board shall approve the administration of the recommended therapy for a competent mental patient whose positive treatment decision was in fact informed and voluntary.128

Section 12. The Decisionmaking Process for an Incompetent Patient

(a) The Board shall have the power to approve the administration of a regulated therapy for a patient who, as the Board has determined, lacks the competency to make an informed treatment decision.

involuntary confinement could not be constitutionally justified unless he could be classified as "dangerous." See O'Connor v. Donaldson, 422 U.S. 563 (1975) (a state cannot constitutionally confine, "without more," a nondangerous individual). See note 8 supra.

126. Because of the "inherently coercive nature of confinement" in a state mental health facility, the Board must scrutinize carefully the information provided to the patient and the voluntariness of the consent to guard against the exertion of subtle pressures on the patient to consent to a therapy. See Kaimowitz v. Department of Mental Health, Civ. No. 73-19434-ÄW (Cir. Ct., Wayne County, Mich., July 10, 1973), summarized at 42 U.S.L.W. 2063 (1973) and [1973] 13 CRIM. L. REP. (BNA) 2452.

127. If a patient's treatment decision were simply uninformed, the Board would be able to provide the patient with the necessary information. If a patient's consent were not voluntary, however, the patient might have to be transferred to another institution in order to eliminate subtle coercive influences. Thus, the legislature should seriously consider providing the Board with authority to order the patient's transfer.

128. This provision conforms to the decision in Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (Ct. App. 1976), which emphasized the constitutional limitations on the state's ability to interfere with the treatment decision of a competent patient. See notes 55 & 60 supra. This section of the Model Statute assumes, however, that a competent patient could not execute an informed consent to a medically inappropriate therapy since by definition the information communicated to the patient pursuant to section 7 would have been erroneous.
(b) The Board shall approve the treatment recommendation only if it determines that:
   (1) all other less intrusive forms of treatment that are medically appropriate for the patient's condition would be ineffective; and
   (2) the administration of the proposed treatment is consistent with the patient's best interests.

(c) In evaluating whether the administration of the proposed therapy is consistent with the patient's best interests, the Board shall consider:
   (1) the evidence presented at the administrative hearing;
   (2) the written recommendation of the treating physician prepared pursuant to section 6;
   (3) the results of an interview [and/or physical examination] with the patient conducted by [one of] the Board members; and
   (4) the possibility that an effective alternative mode of treatment might be developed in the future;

(d) A therapy shall be in the patient's best interest if the Board determines that the potential benefits to the patient outweigh the possible dangers or risks.129

Commentary: If a patient has the capacity to make an informed treatment decision, the Board's decisionmaking process pursuant to section 11 is relatively simple. Once the patient refuses the therapy, that decision is determinative. For a patient who consents, the Board must inquire further to insure that he has been adequately informed and that his decision is voluntary.

If a patient lacks the capacity to make an informed treatment decision, the Model Statute follows the traditional parens patriae approach under which the Board's ultimate objective is to protect the patient's best interests.130 Since it is assumed that the more intrusive of two equally appropriate therapies would never serve the patient's best interests, the Board is required to approve appropriate therapies in an ascending order of intrusiveness. Once it determines which "appropriate therapy" is the least intrusive, the Board must further evaluate the potential risks and benefits associated with the administration of that therapy to the proposed patient. The medical qualifications of the members should permit the Board to conduct this evaluation effectively.

129. Since the entire rationale for regulating therapies is the dangers associated with their administration, a proposed treatment should be disapproved whenever the threshold issues cannot be satisfactorily resolved in favor of treatment. See Model Statute § 13.
130. See note 18 supra.
Section 13. The Decisionmaking Process for a Patient Whose Capacity to Make an Informed Treatment Decision Cannot Be Clearly Determined 131

(a) In the event that the Board is uncertain whether the proposed patient has the competency to make an informed treatment decision, the Board shall further consider whether:

(1) the proposed therapy is the least intrusive medically appropriate therapy available; and

(2) the administration of the proposed therapy would serve the patient's best interests.

(b) If the Board determines that the proposed therapy is the least intrusive medically appropriate therapy available, and if the administration of the proposed therapy would be in the best interests of the patient, then the Board shall:

(1) approve the administration of the proposed therapy if the patient has consented; or

(2) not approve the administration of the proposed therapy if the patient has refused to consent.

Commentary: This section exists to restrict the risk that the Board will act contrary to the expressed wishes of a competent patient. Once the patient consents to the treatment prescription and the Board determines that the administration of the proposed therapy, as the least intrusive medically appropriate alternative, would serve the patient's best interests, it should grant its approval. The question of competency is irrelevant since administration of the proposed therapy would be proper whether or not the patient were competent. If the patient is competent, his decision to be treated is determinative, as it should be; if the patient is incompetent, the Board could still approve the administration of this therapy because it has already found the treatment to be in the patient's best interests.

The situation is similar when the patient refuses the administration of the proposed therapy. Effectuating the patient's refusal makes the decision of the competent patient determinative. Although this procedure prevents an incompetent patient from receiving a regulated therapy that would serve his best interests, the overriding need to respect the decision of a competent patient justifies this sacrifice in this group of cases.

Section 14. Review of the Board's Decision

(a) The Board shall maintain written records of its determinations and the reasons therefor. These records shall be avail-

131. This portion of the proposal follows a scheme developed in Wexler, Reflections on the Legal Regulation of Behavior Modification in Institutional Settings, 17 Ariz. L. Rev. 132 (1975).
able for examination by patient's counsel and a reviewing court in camera.

(b) The patient, his legal guardian, or any interested member of the patient's family is entitled to seek review of the Board's decision on the record in a court of competent jurisdiction.

(c) If the patient, the patient's legal guardian, a member of the patient's family, or the patient's attorney shall timely indicate in writing an intention to seek judicial review pursuant to subsection (d), no regulated therapy shall be commenced unless and until authorization is received from the court to which the matter is presented.

(d) The mere notice of an intention to seek review shall not preclude the administration of a regulated therapy unless the appeal is actually perfected within ten days.132

Commentary: One of the key features of an administrative regulation of organic therapy is the provision for judicial review. When the Board has not fulfilled its function, the affected parties can petition a court for review. Because automatic review of the Board's initial decision would create an unnecessarily burdensome procedure, the Model Statute represents a compromise. Upon receipt of a request for review, the court should determine on the record whether the decision of the Board was clearly erroneous. If there was such error, the reviewing court should proceed de novo rather than remand to the Board for reconsideration.133

Section 15. Emergency Exception

Notwithstanding the other provisions of this statute, when the life of the patient is in serious danger, as determined by the treating physician in consultation with the medical director of the facility, and there is insufficient time for a Board review of the treatment recommendation, a regulated therapy may be administered without the Board's consent. The necessity for the therapy shall be documented and entered into the patient's medical records.134

132. In determining the appropriate time within which to allow an appeal from the Board's decision, the legislature should weigh the importance of timely treatment against the right of a patient to have meaningful access to the appeals process. Since Fed. R. Civ. P. 59(b) requires a motion for a new trial to be served within ten days, there appears to be no reason to provide an extended period in this situation.

133. If the legislature adopts a system of rotational membership or multiple boards, see note 88 supra, it could require the reviewing court to remand the case to a board with different members for rehearing.

134. This emergency provision is based upon the Michigan statute. See note 31 supra.
Section 16. Legal Remedies

(a) Any physician who intentionally violates the provisions of this statute shall be subject to a civil penalty of not more than [ ]. The Attorney General may bring a civil action to assess and collect this penalty.

(b) The penalty provided in this section shall not be construed to bar any other remedy the patient may have under law.136

IV. CONCLUSION

The Model Statute is not intended to represent the only appropriate method for regulating the administration of organic therapy. Many factors peculiar to individual states, including the existing mental health system, financial constraints in the state budget, and the propensities of state legislatures, will necessarily influence the quality of mental health care. Because the Model Statute represents a workable balance between the competing interests that mold any regulatory procedure, it is perhaps most useful as a standard by which legislatures could judge the efficacy of proposed or existing regulatory systems. Many of the existing regulatory deficiencies outlined by this Note appear to result from legislatures' inadvertent failures to adequately explore all the implications of proposed regulatory schemes. If this hypothesis is accurate, the Model Statute's alternative regulatory provisions and emphasis on the balance of competing interests underlying the various provisions will provide a useful tool for both the reform of existing schemes, and implementation of new procedures in the future.

135. This provision is substantially the same as a provision of the California law. CAL. WELF. & INST. CODE § 5326.9 (b), (d) (West Supp. 1977).