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IS TODAY THE DAY WE FREE ELECTROCONVULSIVE THERAPY?

Mike Jorgensen, Florida Coastal School of Law
ABSTRACT

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By Mike E Jorgensen

Electroconvulsive Therapy, or “ECT,” has become increasingly more popular to treat certain mental illnesses, especially severe depression and pseudo dementia. The stigma it suffered due to prior barbaric type applications in the past are largely historic, and most medical professionals will agree that ECT is safe today, has very minimal side effects, not inherently abusive, and no long-term detriments. Yet, with the increase in popularity and the safe applications, ECT is still treated archaically under the law and the legislative restraints are causing an indigent, elderly population to be deprived of this useful, and sometimes solely effective treatment.

Depression unfortunately affects the elderly, especially elderly women, in the greatest percentages. Proportionably, elderly women tend to suffer more poverty too. In many, if not all of the states, an elderly person who is incapacitated may not be allowed to have ECT treatments unless her proxy decision maker obtains a prior court order allowing said treatments. The practical problems with requiring a judicial order is that it is an unreasonable restraint that makes ECT unavailable to the indigent and to those that need timely treatment. The elderly, especially elderly women, will be a significantly impacted group due to the legislative restriction.

As a practical matter, ECT is not inherently harmful or subject to be abused. After sixty years of use, ECT should not be singled out as an “experimental” or an “unorthodox” treatment, but should be treated as other medical procedures. Most medical procedures are allowed without judicial intervention, and may be applied if the competent adult provides informed consent. Additionally, most medical procedures are administered without prior judicial approval if the incapacitated adult is represented by a proxy or surrogate decision maker.

As a legal matter, the prior judicial authorization requirement is arguably an unconstitutional restraint on ECT availability. If it is not unconstitutional, the legislative restraints are certainly unwise and outdated. The prior consent requirement violates a person's autonomy and as implied under the Constitution, expressed in many state constitutions, provided for by statutes and as found in the common law, as it unreasonably restricts a fundamental right of privacy and self-determination. As individuals have the right to refuse treatment, they also have the right to seek orthodox treatments, and if they suffer incapacity, the person's rights are protected by using proxies and substitute judgment, not necessarily pre-treatment hearings.

The States' restraints that require prior approval are not compelling and do not serve the State's interests, but contrarily, frustrate the State's policies and purposes. Even if the legislative requirement was found to be compelling, the legislation as adopted by many states is not the least drastic method to protect the government’s interests under either the state's parens patriae or police powers. The legislation is not narrowly drawn and it is either overbroad or
underinclusive, as applied.

Whether the legislative restraint is deemed constitutionally compliant or not, the law should be conformed to acknowledge modern medical technology improvement in the administration of ETC. If the law is updated, the individual or vulnerable group's safety is still guarded and protected. The courts are still available for contested matters, or matters where abuse may be alleged. Courts have always functioned as arbitrators of contests to make decisions for those who can not agree among themselves. Hence, due process is still applied as needed, and the incapacitated protected, even without the prior judicial consent safeguard.

Due process does not require a judicial hearing to safeguard the vulnerable person's rights. Many health care providers that administer ECT will do so in institutions that already have in place reviewers or bio-ethic committees that could serve in an administrative capacity to protect a patient's due process. Additionally, ECT is not administered in a vacuum, but there are already established several layers of protection for the patient. The patient's first layer of protection is her loved ones and family members. Not everyone enjoys the companionship of loving family members and friends however, but the individual is still protected by the fact that it will require more than a unilateral decision on behalf of a professional to administer the ECT. Second, and at the very least, there will be the medical doctor or psychiatrist to administer the ECT, the anesthesiologist, the other staff members and nurses, all of which have other commitments to professionalism, regulatory boards and judicial oversight. The third level of protection is in the administrative arena where many institutions already have boards and committees in place to address the ethics of treatment or palliative care in the event there is a question of administration of the treatment. Finally, if the previous safeguards are not available or effective in resolving the concerns, the courts are open to render judicial guidance and decisions.

Proxies make irreversible life decisions for principals without prior judicial oversight. The administration of ECT does not cause an irreversible detriment, and should not require prior judicial authorization to protect this vulnerable group. Under Equal Protection, the group that suffers from incapacity has the right to refuse medical treatment through proxies. The decisions will result in irreversible consequences, but said decisions are without prior judicial consent. Equal Protection is violated when the rules require the same group to have judicial consent before applying non-irreversible ECT, and said rules are not rationally related to a legitimate state purpose.

The recommended solution proposed in this article would be for the legislature and courts to adopt a procedure similar to the procedures established by the Florida Supreme Court in the case of *In re Guardianship of Browning*, where the court provided constitutional safeguards with administrative privacy procedures for the decision-maker. The principal would first be protected by the administrative process and loved ones, and the courts would be accessible and available on an “as-needed” basis, but not as the first line of concern.

To require prior approval is practically, and perhaps constitutionally, incorrect and the laws should be updated to be in conformity with the advances in technology and the growing need in the community among the indigent elderly and groups suffering from severe depression and like illnesses readily and effectively treated by ETC.
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IS TODAY THE DAY WE FREE ELECTROCONVULSIVE THERAPY?

By Mike E. Jorgensen [1]

_I am not an advocate for frequent changes in laws and constitutions, but laws and institutions must go hand in hand with the progress of the human mind._

_Thomas Jefferson_

The Issue

Many States require a proxy to obtain prior court authorization before consenting to electroconvulsive therapy ("ECT"), also sometimes referred to as “shock therapy” and "convulsive therapy," on behalf of the incapacitated ward.1 Obtaining prior judicial approval is beyond the

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financial ability of many indigent and elderly persons, and persons fitting in historic higher poverty categories.2 In addition to lacking access to ECT treatment for financial reasons, the prior consent restraint requirement delays the treatment and obtaining court approval may cause
a significant delay that may impair the patient, especially when ECT is required immediately or is time sensitive due to the patient's suicidal thoughts or lack of desire to live caused by depression. When States require prior judicial authorization, many persons who suffer from mental illness and who would benefit from ECT treatment are harmed when they are denied access to the treatment in a timely fashion due to indigence.

Not only are the above judicial approvals often unnecessary and impractical, but the legislative restraints are likely unconstitutional, and if not unconstitutional, the legislative impediments are outdated and unwise. Individuals requiring ECT fall within groups or categories. The group that is most noncontroversial are those who have mental capacity and may either refuse or request ECT. Such individuals have statutory, common law and constitutional protections of autonomy and self-determination. The more controversial group are those who are mentally incapacitated and either have refused ECT, requested ECT or who have not expressed a decision either way. The most difficult member of this group is the person who is compelled to have ECT while incapacitated due to her potential to harm herself and when she recovers due to the effectiveness of the treatment, determines that she no longer requires treatment. When enjoying capacity, she has the right to exercise her autonomy and refuse ECT, which then allows the individual to spiral downward towards depression and reaching the point where she can again harm herself or others. In such cases since she may refuse ECT under autonomy while capacitated and the physicians may not treat her until she loses capacity. At this point, the level of ECT is much higher than it would have been had she been on ECT maintenance treatments. Whether she enjoys capacity or suffers incapacity, the individual's rights are protected, but the standards currently applied to proxy decision makers is unwise and unmanageable.

Whether in the capacity or incapacity group, the courts afford each group's autonomy interests differently. The category we are primarily concerned with in this article are those who were competent, but are now incapacitated. When these individuals enjoyed capacity, they may have either created medical advance directives that did not provide for mental health care decisions or they failed to provide directives at all. The category includes those who may have consented to ECT before or who may have refused ECT treatments prior to losing capacity. The current laws are outdated and States could easily develop, as suggested below, other less restrictive procedures that protect the vulnerable individuals from the misuse of ECT and at the same time continue to protect the incapacitated individual's rights and self-determination.

One reason the incapacitated have more scrutiny in the decision of whether to have ECT is due to the continuing stigma about ECT. Due to significant improvements in the way that ECT is administered, arguably, ECT today should not be treated differently by the legislatures and the courts than any other legal and orthodox medical procedure. In many statutes, ECT is considered experimental or segregated to be treated differently as an unorthodox type of medical treatment. The law has not kept pace with the increased improvements in ECT technology, thus making the legislative restraints archaic and outdated.

The prior authorization requirements for proxies are more likely to cause injury than what injuries the individual may experience that the State is attempting to prevent through restraints. This article discusses the wisdom of reevaluating the prior judicial restraint requirement, and then evaluating ECT's effectiveness and its benefits against the current legislative restraints that prevent the indigent elderly from access to and the timely receipt of said treatments.
I. Electroconvulsive Therapy

1. An Introduction to the Electroconvulsive Therapy Issue

ECT is not a new concept, but in the past sixty years has been the subject of both criticism and popularity as a treatment for major depression and pseudo dementia. Despite the increase in the use of ECT by medical professionals, ECT remains stigmatized today from the attention it received six decades ago when it was labeled as a barbaric, pseudo-medical procedure. With current advances in medical technology, ECT is considered safe by the American Psychiatry Association, and is deemed extremely effective when used as treatment for certain mental illnesses and emotional disorders, especially for obtaining remission of the symptoms of major depression and the prevention of suicide.

Unlike today, patients having ECT fifty years ago may have received more than one hundred treatments. Also, the amount of electricity used was greater, and the waveform and the stimulus were different. The ECT of the past did not apply anesthetics or muscle relaxants, but patients were shackled to the gurney where they occasionally suffered broken bones and vertebrae. Today, patients are provided anesthetics, muscle relaxants, oxygen and they are closely monitored.

Today, ECT produces minimal damage to the patient. Two advances used by physicians today improve the procedure with the first advance being the use of "nondominant unilateral ECT, which is the use of electrodes only to the right side of the patient's head (as opposed to bilateral ECT)." The unilateral application "protects the left side of the brain, the site of language and auditory memory." The second advance is the introduction of brief-pulse stimulus, which is a "quick jolt of electricity instead of a steady stream, making it less likely that the patient will later suffer serious problems with memory."

2. Clinic Case Illustration

In March 1999, Mrs. T's daughter approached the Florida Coastal School of Law's Elder Law Clinic ("Clinic") seeking assistance to help her obtain a guardianship over her mother's person and property. Mrs. T was seventy one years of age and she had been residing in a nursing home for several months. Mrs. T suffered from dementia, believed to have been caused by Alzheimer's disease, along with major depression from an affected disorder. Mrs. T's treating psychiatrist believed ECT would assist Mrs. T with a recovery from her depression if she were to undergo sufficient treatments. Even though Mrs. T had been receiving ECT, the psychiatrist would not continue with ECT since Mrs. T was unable to provide informed consent. The daughter sought guardianship over her mother and had no resources to pay for the guardianship or for the court hearing necessary to obtain approval for the ECT treatment.

The request for ECT was not the first time Mrs. T had needed ECT. In her fifties, Mrs. T lost a child through an unexpected death, and she suffered from depression. At that time, Mrs. T had undergone ECT treatments when the antidepressant medicines and the sessions with the psychotherapist failed to correct or mitigate her depressive condition. Mrs. T requested the ECT in the 1980s while competent. The ECT treatments stabilized Mrs. T and she was again able to regain the ability to function in life and continue the raising of her family.Mrs. T did not require
maintenance treatments or the use of anti-psychotic drugs for several years after the initial treatments.

The elderly are more often likely to suffer depression disproportionately in their demographic group than other population groups. In October 1998, as Mrs. T aged, she started suffering from depression again. She isolated herself from others, became partially catatonic and would not talk. When her psychiatrist started Mrs. T on ECT treatments again in 1998, Mrs. T was able to provide informed consent. She had undergone approximately four treatments in the hospital by the end of October 1998, but during November and December, before she could complete the treatment regime, her HMO denied coverage for the continuation of reimbursement for the ECT treatments. By the time the HMO conceded and authorized further treatments in late December 1998, the psychiatrist opined that Mrs. T was no longer able to provide "informed consent" for the ECT treatments due to the deterioration of her mental capacity to consent.

ECT was recommended by Mrs. T's psychiatrist due to Mrs. T's refusal to eat and her state of withdrawal and isolationism. Such disorders, identified as affective disorders, are treatable by ECT to place the depression into remission. The psychiatrist prescribed anti-psychotic and antidepressant drugs in December 1998 to assist Mrs. T, but the drugs were ineffective to stabilize her condition. The psychiatrist told the Clinic that for patients who do not respond to the medication regiments, "ECT is the primary treatment, and its early use may be lifesaving." As in Mrs. T's case, when the anti-psychotic drugs were ineffective over a several-month treatment plan to stabilized Mrs. T's depression, ECT was recommended to rapidly relieve the symptoms and obtain a remission of her depression. The psychiatrist believed that if the ECT stabilized Mrs. T, she could then be placed on the anti-psychotic drugs, if needed at all, and remain in a stabilized condition.

In 1999 the Clinic prepared and filed a Petition to Determine Incapacity with the Mental Health Division of the Duval County, Florida court and simultaneously filed a Petition for the Appointment of a Guardian with the Duval County Probate Court. Mrs. T was appointed an attorney ad litem and a medical exam committee was appointed by the court to examine Mrs. T and offer an opinion as to Mrs. T's capacity. The committee opined that Mrs. T needed a plenary guardianship. The attorney ad litem agreed after visiting Mrs. T and reviewing the Medical Exam Committee's written report and recommendation. The Florida Probate court, after receiving testimony and being otherwise fully advised, found Mrs. T to be incapacitated and appointed the daughter as plenary guardian. At the guardianship hearing, Mrs. T lost all of her civil rights not retained by statute.

At the time the guardianship petition was filed, the Clinic also filed a Petition for Extraordinary Authority for Guardian to Consent to ECT Treatment ("the authorization hearing") in circuit court pursuant to statutory mandates. The authorization hearing was deemed a different matter than the determination of incapacity, and was therefore placed with a different judge than the judge who determined her incapacity. As in the "incapacity hearing," the attorney ad litem was willing to waive Mrs. T's presence at the authorization hearing, but the court would not accept the waiver of Mrs. T's presence at the authorization hearing. Further, the court stated that if Mrs. T could not attend the authorization hearing, the judge was willing to make a personal visit to her at the nursing home. The court received testimony from the guardian, Mrs. T's psychiatrist, and also attempted
to examine Mrs. T. Mrs. T was unable to provide informed consent. After learning that Mrs. T would not improve without the proposed use of ECT, that she had used ECT previously several years earlier and that it assisted her, and that Mrs. T was not competent to offer testimony in her own behalf, the court found that ECT was appropriate and issued an order accordingly.28

Mrs. T received the ECT treatment without suffering any maladies or significant negative side effects and the court's case was administratively closed. The court procedure was not time sensitive and the matter took approximately sixty-five days from the time the Petition to Appoint a Guardian was filed and the court issuing an order authorizing such treatment. The psychiatrist volunteered his time and testimony on behalf of the Clinic. Had the psychiatrist charged for his services, however, the fees would have been several hundred, if not thousands, of dollars. Mrs. T and her family would not have had sufficient resources to pay for the additional hearing. But for the Clinic providing free legal services, and her psychiatrist volunteering his time, Mrs. T would not have received the ECT treatments under the statutes existing as they did in 1999.

3. The Question and the Response

ECT is used to treat persons with severe depression and pseudo dementia. Due to the underlying conditions, the individual is typically unable to consent or refuse ECT treatment. By the time ECT is determined to be a treatment option, other orthodox treatment alternatives such as therapy, counseling and medications have been proven to be ineffective to bring the individual's depression into control.29 When an individual is incapacitated, proxies and surrogates, or guardians are designated to assist the individual with making decisions and protecting the individual from further harm to his person and property.30 In most cases, proxies, surrogates and guardians are often volunteers and family members.31 They act in the individual's best interest and where possible, substitute the individual's decisions for their own as if the individual had made the decision.32

When statutes require the proxy to obtain prior court approval before being allowed to consent to ECT treatment, the restraint creates financial costs and time delays that may not only prejudice the timely and effective ECT treatment, but may prevent the individual from obtaining the treatment at all. Due to progresses made in the ECT application, the minimization for abuse, the response should be that States should adopt less restrictive methods of making ECT consent more readily available for proxies, reserving judicial intervention only for the cases that require attention. A few states appear to give proxies and guardians authority to consent without the necessity of prior court approval.33 The court has not abandoned its duty to provide remedies and due process by not requiring pre-treatment approval and the court continues to be available to resolve contested matters and possible abuse should the matters arise.34

This article recommends that proxies be allowed to consent to the principal's ECT therapy without prior court approval upon the proxy reaching an agreement with the treating physicians, psychiatrists, other caregivers and possibly ethic committees. Judicial intervention should be reserved for cases where such action is needed.35 Administering ECT is different than depriving an individual of liberty or property, thus requiring a "pre-deprivation hearing" in order to satisfy due process.36 Unless the ECT abuse is foreseeable, a hearing is required if at all post-treatment. A post-treatment hearing would protect the individual, and the risk of harm prior to the ECT application to that individual is minimal.37
II. The Electroconvulsive Therapy Process

1. What is ECT?

ECT is considered an "experimental treatment," (and an orthodox treatment) under many state proxy and guardianship statutes. ECT has suffered extreme opinions ranging from being cruel to being highly regarded. Despite the continued controversy, due largely to significant increases in technology in the administration of ECT, ECT is becoming more widely used by the medical community to treat depression and pseudo dementia. The treatment uses electric currents directed at certain parts of the brain to cause a grand mal seizure or series of seizures. The "shock" is necessary to treat the illnesses and diseases. Although physicians use the word "shock" in referring to the therapy, ECT produces no form of psychological, physiological, or surgical shock. Nevertheless, use of the word continues among journalists, movie producers and critics, despite the medical community's long-time preference for "convulsive" as the proper modifier.

By creating a seizure, ECT is one of the most effective and arguably, safe, treatments for patients suffering severe depression, including patients that are suicidal, and patients that are not in a position to take traditional medications. Since the ECT treatment is used to combat depression and suicidal thoughts, the treatment may significantly impact the elderly population, who are known to have higher depression and suicidal rates as compared to other population groups. When many types of psychiatric care are seemingly ineffective, ECT is believed to be more potent than antidepressant drugs, i.e., thyroid hormones or lithium, and works rapidly for those who do not respond to antidepressants. For some people, ECT is the only treatment that is effective.

A. Brief History of ECT

The idea of using electricity on the brain occurred in ancient times, and when used at first, may have had barbaric-like side effects. The ECT of yesterday is much different than the ECT procedures today. The theory of electroconvulsive therapy commenced hundreds of years ago when mental illness was treated by using electric eels and fish. Electricity was used again in 1937 when doctors Ugo Cerletti and Lucino Bini treated schizophrenic patients with applications of electricity. Doctors Cerletti and Bini conducted animal experiments to investigate epilepsy and realized that electricity could cause a convulsion more easily than chemical agents. The doctors learned that the electricity did not impact the heart if the electrodes were placed on either side of the head, because the heart was outside of the electrical field. In 1938, the doctors applied electricity for the first time to humans, instead of using eels applied to humans. The extremely schizophrenic patient responded well to the treatment and was able to live an apparently normal life with the therapy.

The weight of medical authority supports ECT treatment in certain situations, especially with depression. The major side effect of ECT is short-term memory loss that ends within one to two weeks after treatment. Some opponents to ECT argue that patients may suffer bone
fractures, damaged teeth, long term memory loss, and possibly loss of life, however, this view is not ubiquitous in the medical community.  

B. Prior ECT Abuse or Misuse

The use of ECT increased in popularity during World War II and was part of training for armed service medical personnel.  With mounting accusations that ECT was being inappropriately administered along with the introduction of Thorazine, in 1950, ECT became the second or last resort for treating mental illness.  Despite being used for conditions that may have been inappropriate for such treatments, ECT still had valuable uses.

ECT has made much progress in use and application over the past sixty years.  Today, ECT is regarded by many psychiatrists as a safe and painless therapy.  Although it should not be used for every emotional disorder, "forty years of experience, however, have demonstrated that ECT has an important though currently limited role in the practitioner's choice of treatments for mental disease. . ."  

2. Preparation for ECT

If the psychiatrist is considering applying ECT as a therapy for the patient, the psychiatrist first interviews the patient and considers the patient's vegetative and behavioral symptoms that accompany the patient's mental illness.  The doctor should obtain a complete history and perform a physical examination, and with the information, make an educated decision as to the possible effectiveness of the ECT treatment based on a proper diagnosis of the patient's condition, as not all mood disorders will be favorably treated by ECT.  If the patient is determined to be likely benefitted by the use of ECT, the physician will prepare the patient for the procedure.  As with all medical procedures today, the patient will need to consent to the treatment after being informed of the need for the procedure, the alternatives to the procedure, and the risks inherent to the procedure.  If the patient is incapacitated, the physician will require consent through a proxy decision maker.

3. How does ECT work?

"How ECT works" is not largely understood.  Due to clinical and technological developments, the administration of ECT and the techniques used should be modified as necessary.  Nonetheless, the ECT administration today is much different than the administration techniques of sixty years ago.

One significant difference today is that ECT is administered under anesthesia.  In the early history of ECT treatments, prior to the practitioners using anesthesia and muscle relaxants, patients sometimes experienced bone and teeth fractures due to the induced convulsions.  Even with the use of anesthesia, the physician should consider bone pathologies, severe osteoarthritis, or bone injury given that in early treatments, the seizure sometimes caused bones to fracture.  Another difference is that practitioners may use oxygenation to reduce the risk of memory loss, post-seizure headaches and nausea.  Oxygenation is also "thought to increase the
duration of the seizure, which is believed to have a positive correlation with outcome."78

A. The Process for Obtaining the Induction of the Grand Mal Seizure

After anesthetic preparation, the physician induces the seizure or convulsion.79 With the use of anesthetics, the patient is medically induced to paralysis in order to prepare for the administration of electric current to obtain the seizure.80 With current technology, the patient is given the least amount of electrical current necessary to produce a full grand mal seizure. If a seizure is not induced at the lesser levels of electric current, the current settings may be increased in intensity and duration until a seizure occurs.81

The number of treatments vary according to the patient's condition and treating psychiatrist's observations as to its effectiveness.82 To treat depression, the patient may receive two or three treatments per week and the treatment period may last for a few weeks or a few months.83 The treatments will be continued until symptoms are reduced, and “stabilizing treatments” thereafter may be required. The principal criteria for termination of ECT is measured by the patient’s improvement in “alteration of mood and vegetative symptoms.”84

Stabilizing or maintenance treatments, along with prescribing antidepressant medication, may reduce relapses into depression.85 The maintenance treatments may be given on an outpatient or ambulatory basis.86

ECT may be administered to patients in a series of treatments, with initial treatments designed to reduce the symptoms and maintenance treatments to keep the patient from regressing into a pre-treatment position.87 The initial treatments range between six to twelve treatments over a two week period.88 During the treatment, the patient's heart rate is monitored and the treatment time usually lasts no more than ten minutes in the operating room.89 Today, the patient receives an anesthetic and muscle relaxant intravenously, which causes her to become unconscious.90 While the patient is unconscious the physicians place a rubber block into the patient's mouth to prevent injuries to the tongue and teeth. Oxygen is provided to the patient through a mask placed over the mouth. Once the electrodes are connected to the temples, the physician shoots electric current through the brain, thus causing a grand-mal seizure for approximately 20 seconds.

Once the procedure if completed, as the anesthetic wears off, the patient recovers in about thirty minutes. The patient may be confused and not knowing where he is or what had just happened.91 Many physicians believe the memory loss is short term.92

B. Injuries, complications and risks

Opponents to the procedure argue that ECT causes permanent memory loss, and even brain damage.93 Some extreme opponents argue that ECT causes death, but that accurate statistics are not found because most states, excepting Texas, fail to require that records be kept of those individuals who have died within fourteen hours of having ECT treatment from other conditions.94 Much of the controversy originates from the early, wide-spread use of ECT as an attempt to treat many ailments that were probably not appropriate for ECT treatment.95 As a result, the treatments seemed very invasive without the noted benefit of progress against the
ailment. In the early stages, the ECT convulsion caused bone and teeth fractures when the muscles contracted violently during the grand mal seizure. Today the instances of bone and teeth fractures is much less, if at all, with the concurrent use of muscle relaxants, anaesthesia and oxygenation. In the early history of ECT treatments, "it has been contended that improper methods of restraint, rather than the contractions by themselves, were the cause of the patient's injuries." With the use of anesthetics, muscle relaxants and oxygenation, the risk of fractures has been greatly reduced to relatively minimal proportions. To reduce the risk, the physician should during the preparatory work-up, determine whether the patient has any preexisting fractures or other conditions that would contraindicate ETC. The other times the patient is at risk for a fracture, i.e., during the administration of the therapy, or during the postoperative phase of the treatment, may be prevented and treated as in other surgeries.

Proponents and opponents both agree that ECT has not been sufficiently studied to show that it is linked to causing death. The controversy whether ECT causes death lingers with the public, but no solid empirical evidence supports this premise.

Although ECT is not entirely safe, much of the debate about its effectiveness, and its dangerous propensities or side effects, have been addressed and over time, have been shown to tilt the balance toward's the individual's freedom and autonomy and less in protecting the government's interests. This is especially true today where ECT appears to support the State's interests. Today, the potential benefits of ECT, its reduced potential to injure, and the need among the elderly for the use of ECT diminish the need for automatic judicial safeguards, but mandate a lesser alternative non-judicial procedure.

C. The Practical Benefits of ECT

ECT is effective in many instances where other forms of treatment are ineffective. When an individual is denied ECT, as a practical matter, they may be further injured by not having the treatment. Even small changes in the ability to obtain medical treatment, for example increased co-pays, have significant detrimental impacts on the indigent and their access to treatment. The prior consent requirement on proxies is a practical and harmful restraint on indigent elderly and precludes them from obtaining needed medical treatment. A requirement that causes the elderly to have to budget more to obtain the treatment makes the treatment inaccessible to them.

When the state requires prior judicial approval, the financial cost of retaining counsel, retaining the psychiatrist expert, retaining the attorney ad litem, and the costs on transporting the ward to and from the hearing, will prevent many indigent persons from receiving treatment at all, and many from timely treatment. The prior approval restraint is not accomplishing a compelling state interest, does not promote the state's objective of preventing suicide, and significantly inhibits autonomy and the timely and effective access to treatment.

III. Basics of Self-Determination

1. Informed Consent, Self-determination and the Right to Privacy
A. The Right to Privacy and Autonomy

Over time, an individual's right of choice to make personal health care decisions has been recognized, enhanced and accepted with much deference. The personal autonomy, however, is not without limits and should a state have an interest, and narrowly defines such interest(s), it may be able to demonstrate a compelling interest that will supercede an individual's right to autonomy. The state may act under its parens patriae powers to protect the innocent and vulnerable, including from medically-acknowledged and bona fide health risks and treatments, but it can not exclude due process. How much due process is required for a person who is currently incapacitated and refusing ECT, but when he enjoyed capacity, he either requested ECT, refused ECT, or failed to consider ECT?

Legislative and judicial recognition of a person's autonomy and the right to make choices about medical treatment, free from overreaching governmental intrusion, is referred to as "self-determination." The right of self-determination and autonomy is found in the common law origins and indirectly under the federal Constitution, Bill of Rights and Amendments. The right of autonomy can also be found expressly in many state Constitutions and in statutes. Self-determination is the concept that each man and woman is considered to be his or her own master. When courts have balanced the state's interest against the individual's interest, typically the individual will prevail, but not always. One test the courts may use to guide whether autonomy exceeds the State interest is the extent of the invasiveness of the procedure versus the likelihood of recovery.

Also, how privacy rights are applied depend on the nature of the health care decision at issue. Autonomy rights include the right to refuse artificial life support. A second category is the individual's right to refuse medical treatment for non-artificial life sustaining procedures. Another category is the individual's right to choose certain medical treatments. ECT is not considered "artificial life support" and there is little controversy in principle that a competent individual may refuse artificial life support. Also, when concerning non-artificial life support medical decisions, it should not be assumed that a person has conscientiously "refused" ECT if the individual has not provided for ECT in a directive. To the contrary, the probability is more likely that individuals who require ECT failed to consider the mental health aspect when preparing a directive, or failing to make a directive at all, rather than making an affirmative determination to refuse ECT. As set forth in the table below, however, many states have adopted statutory provisions allowing an individual to specifically designate mental health decisions in "directives for mental health care." Hence, it is likely that the trend will be for individuals to not only consider their medical directives, but also their mental health care in advance too. Even under the mental health care directives, some states will require the proxy to obtain court authorization before the surrogate may consent to ECT. Under such circumstances, the individual has already expressed informed consent for the treatment and in such cases, there are no sufficient state interest to require the proxy to obtain prior court authorization to consent to what the ward could have consented to if competent and did in fact consent to when preparing the mental health care directive.
B. Autonomy

Autonomy originates from the common law right to choose what happens to one's body, and is closely aligned to the privacy rights found in the Constitution and state statutes. Any health care choices made by the patient if enjoying capacity, or her proxy if she is incapacitated, including consenting to ECT, must be based on informed consent. Informed consent assists the State with protecting innocent and vulnerable groups. With informed consent, the proxy has fiduciary responsibilities and the risk of abuse is diminished. Hence, the requiring of judicial pre approval for ECT is excessive and exceeds any State interest whether autonomy is exercised by the principal or by the individual's proxy.

Since informed consent is required from the patient, or from the patient's surrogate through substituted judgment, or in certain cases after consideration of the patient's best interest, the patient or proxy is generally required to have an understanding of the procedure, be notified of alternatives to the procedure, be told of the collateral risks, and be given adequate information before choosing or refusing ECT. In this way, either the competent adult or her proxy, expressly or vicariously, may accept or refuse the treatment thus negating the need for prior court approval.

If the patient or the individual's surrogate is given sufficient information as to the ECT procedure, alternatives to ECT, the risks of ECT and information necessary to make a decision, the individual already enjoys much protection against potential abuse and vulnerability. The proxy's fiduciary responsibilities, the physician's professional responsibility before performing the procedure, and the fact that ECT is not inherently a restraining or controlling therapy provide built in safeguards within the decision making process. ECT has low risk for abuse since treatment is not unilaterally decided and it. The physician, the anesthesiologist and institutional staff would be the minimum number of person's who could act on behalf of the ward. Unless the foregoing professionals were profiting somehow by working in a diabolical conspiracy, there is little systematic reason sufficient to warrant much judicial concern about potential abuse.

In addition, the ward may have other family members who would also be concerned about treatment, and in many instances, bio-ethic committees of hospitals or other care providing institutions, that would be concerned with potential abuse of ECT administration. In essence, under informed consent, there are already safeguards built into the therapy process before the incapacitated person receives ECT and the additional legislative restraint to further make ECT unavailable arguably violates the individual's autonomy. Society presumes a level of trust in its surrogates and favors the assistance of helping those in need, and in that trust, that the surrogate will make decisions in either the ward's best interests, or that would exercise substituted judgment on behalf of the ward.

i. Common Law Right to Privacy

Autonomy and informed consent are not only statutory, but also found under the common law. The common law right originates under implied and expressed privacy rights. The landmark Supreme Court decision in Griswold v. Connecticut extended the right of privacy to the "right to die" by creating a zone of autonomy which protected individual citizens from
governmental intrusion in personal matters. Arguably, this same right to privacy protects the individual's rights to choose treatments absent a compelling state interest interfering with said individual right.

In *Griswold*, the director of Planned Parenthood League of America of Connecticut and its medical director, a licensed physician, were convicted for giving married persons information and medical advice on birth control contraception. The married couple were healthy adults making a medical treatment choice, i.e., the chemical alteration of a normal birth cycle to prevent pregnancy. As with any drug, the couple's choice was not only a personal moral choice, but also a choice concerning potential health risks. The Court held that the state could not make the choice of a marital couple's decision to use prescription contraceptives a crime. The treatment choice allowed the couple to choose whether to have an unwanted pregnancy and the Court also recognized a couple's right to decide not to have any children as a personal decision not to be restrained with unnecessary governmental interference.

The "unwritten constitutional right of privacy" was found to exist in the penumbra of specific guarantees of the Bill of Rights, rather than as an expressed right found in the body of the Constitution. The Court held that the right to privacy was broad enough to encompass a patient's right to decline medical treatment under certain circumstances. This decision was further supported in *Cruzan v. Missouri Department of Health*, when the Court elucidated that in order to "consent to treatment" or decline treatment that the patient had to have capacity to make an informed decision, much like what is required in many statutes today.

### ii. Self determination and autonomy under Statutes and Constitutions

The right to privacy has evolved to not only recognize an individual's right under the federal Constitution to be informed prior to the administration of the medical or treatment procedure, but to also refuse medical treatments that affect the body of the person. Self-determination is the right of a [person] to be free from affirmative governmental interference in [making medical] decision[s] and an individual is deemed to possess this medical autonomy under the Fifth Amendment, as well as other authorizing statutes and cases. The federal Constitution does not explicitly mention any right of privacy, yet "in a line of decisions, however going back . . . as far as Union Pacific R. Co. v. Botsford. . . the (United States Supreme) Court recognized that a right of personal privacy, or a guarantee of certain zones of privacy . . . do exist." Although the United States Supreme Court discussed privacy in cases such as *Roe v. Wade* and *Griswold v. Connecticut*, the Court did not express how far the zone of privacy applied; the rulings have seemingly been a case-by-case decision. The *Roe* Court found that "the roots of that right in the First Amendment; in the Fourth and Fifth Amendments; in the penumbras of the Bill of Rights; in the Ninth Amendment; or in the concept of liberty guaranteed by the first section of the Fourteenth Amendment." Thus, support to make decisions about one's medical care is found under the implication of the Constitution, expressly stated in statutes and State constitutions, and is also grounded in the common law.

### iii. How Far Does Autonomy Extend?
Generally, the individual must be informed to be able to consent to the proposed medical treatment. Informed consent applies to every category of medical autonomy, distinguishing procedures from being considered a battery or a form of medical negligence.\textsuperscript{149} Even if the consent is given, but under less than "informed" circumstances, the physician does not escape liability for medical negligence.\textsuperscript{150} An individual's common law right carries with it the right of informed "refusal" of that treatment.\textsuperscript{151} This right of refusal may be exercised even when the treatment refused would have saved an individual's life.\textsuperscript{152} Hence, informed consent is required for both the refusal of artificial life support and for non-artificial treatments.\textsuperscript{153} An individual's autonomy is balanced only against the state's interest.\textsuperscript{154}

2. Prior Consent Requirements in Certain States

When legislation requires the proxy to obtain prior court authorization before consenting to the ward's ECT treatment, the ward's rights are also significantly restrained. The incapacitated elderly and indigent populations who are unable to provide informed consent without a proxy decision maker or a guardian, will be effectively denied access to ECT due to the delay and expense of the prior consent restraint imposed by statutes.\textsuperscript{155} As the technology of administering ECT has significantly improved, the consequences of the legislative restraint should be reconsidered in light of the current need to make ECT more available and accessible. Hence, the law that was enacted to protect the vulnerable, in reality harms the group of people the legislation seeks to protect.\textsuperscript{156} The effect of the restraints is contrary to the purposes behind the enactment of the laws designed to protect the incapacitated.\textsuperscript{157}

Not only do the restraints create a practical burden to ECT accessibility and frustrate the legislation's intended purposes, the prior approval statutes infringe and impair the ward's exercise of his or her constitutional right to accept and refuse medical treatment under the right to privacy.\textsuperscript{158} Although the state possesses a general interest in safeguarding incapacitated and vulnerable groups and preventing abuse by the proxy decision maker, the individual's right of autonomy to accept ECT treatment should prevail over the state's restraints in this instance where the individual consented to ECT when enjoying capacity or through substitute decision making, would have consented to said therapy.\textsuperscript{159}

The category of persons most affected by the prior approval mandates are those that at one time enjoyed capacity, but due to conditions have lost capacity. The group may have or may not have prepared and executed medical advance directives. The few persons that may have executed directives, may have or may not have included specific instructions concerning their mental health and what to do in the event of losing capacity. ECT is recognized as being safer, more acceptable, and enjoying greater levels of effectiveness than when the laws were enacted to protect the incapacitated person.\textsuperscript{160} The legislation should be modified to allow the incompetent individual more freedom of decision to accept ECT treatments through her proxy, and expedite the decision to make it more time sensitive and not financially prohibitive.

A. Power of the State

States frequently invoke legislation to protect those citizens unable to care for
themselves, including steps to preserve life, prevent suicide, protect innocent third parties, and maintain the ethical integrity of the medical profession. The most significant of the four interests is the preservation of life, which is particularly compelling when dealing with a child or vulnerable group, such as the mentally incapacitated. When the state requires prior judicial review, the state's interests originate under its *parens patriae* powers rather than its police powers. Some State interests are applicable as to whether ECT authorization is required by the court, and some State interests are not readily applicable when addressing the ECT issue. For example, how does requiring prior judicial consent promote the state's interest of protecting the innocent third party? Therefore, this article treats that State interest as neutral. Also, this article is not focusing on the State's interest in forcing an institutionalized individual to have ECT in situations where it would be in the patient's and institution's best interest.

Arguably, the right of a competent adult individual to choose a legal and orthodox medical treatment procedure under autonomy should always outweigh the government's interest. If the ECT treatments are orthodox, they may assist in accomplishing the state's interests of preserving life, deterring suicide, maintaining medical integrity, and protecting the vulnerable from abuse, rather than frustrating those policies.

The state's interests should not be maintained in a vacuum when the advent of the technology employed in administering ECT today is considered. If ECT is effective and due to modern medical technological improvements considerably more safe, then the state's interests are enhanced with the use of ECT, in contrast to the legislative alternative that requires more stringent and costly prerequisites.

i. Prevention of Suicide

ECT assists the state's interest in preventing suicide. Depression is the leading risk or cause of suicide, and ECT is oftentimes the only treatment that is effective to treat depression and to treat it in a timely manner. What interest would the state contemplate to support its restriction of an orthodox treatment when that treatment promotes the State's interest by reducing the potential for suicide?

ii. Right to Die versus Assisted Suicide

The most irreversible decision that a person may make is whether to intentionally and affirmatively take acts, or neglect taking actions, that will end or sustain life. If a person refuses artificial life support, the life's termination will be hastened. If the person decides to take a chemical "cocktail" that quickens his death, the death is accelerated. The right to privacy includes the right to refuse medical treatments that will otherwise sustain life and said decisions of autonomy trump the state's interests. In cases where the patient is terminal and seeking to accelerate death, not by refusing life support, but by taking a lethal dose of narcotics, life is not sustained and in said instances, in most jurisdictions, the actions are not protected under privacy. One can not ask or pre-plan assisted suicide in directives. Refusing life support and allowing death to occur "naturally," is not considered "assisted suicide," however.

Many state courts have interpreted the right of privacy, using *Griswold v. Connecticut* and *Roe v. Wade* for guidance, to question the individual's autonomy and decision to encourage
The right to die issue has been defined as a patient's right to refuse medical treatment or to have long term care withdrawn even if the patient will die if the treatment is terminated. This issue was considered in depth by the court in the case In Re Quinlan. When Karen Quinlan was twenty-two years old, she was found in a persistent vegetative state after mixing alcohol and drugs at a party. Months later, Karen's parents requested to remove her breathing tube, but the hospital refused. The Quinlan's case was brought the hospital refused. Karen's father, as her proxy, argued to remove the respirator based on three primary grounds, including Karen's constitutional rights of freedom of religion, freedom from cruel and unusual punishment by being maintained on artificial life support, and the violation of her autonomy under the right to privacy. The New Jersey court immediately dismissed the arguments against freedom of religion, stating that the freedom to exercise religion was not absolute, and of cruel and unusual punishment since the said principles only apply in penal matters and not civil matters. Ultimately, the issue of Karen's right to privacy became the primary focus of this case.

The Quinlan decision was decided before any state had passed legislation allowing an individual to prepare and employ a living will. The Court articulated rights that existed as implied in the Constitution, but had not been significantly implemented before it allowed Karen's father to remove the artificial life support. The Court held that Karen had a fundamental right to refuse artificial life support, thus introducing the way to expand personal autonomy over one's health care, to the point of making decisions that were irreversible in nature and inconsistent with the State's interest in preserving life. Since Karen had the fundamental right to "refused consent," she did not lose her constitutional right due to her incapacity. The Court agreed that Karen's father, as a proxy, could sustain Karen's fundamental autonomy rights, even though she was no longer able to express her intent. As agents for the principal, Karen's health providers and proxy acted with freedom from criminal and civil liability in exercising Karen's rights.

Once the Court articulated Karen's right to refuse unwanted artificial life support, even at the peril of hastening her death, the question soon became, "how far does self-determination extend?" After Quinlan, many state courts implemented legislation that allowed for written living wills, and the courts recognized a person's autonomy rights to refuse artificial life support over the State's interest in preserving life. It was not until fourteen years later, however, that the Court again addressed autonomy and considered where a State's could legislate the statutory restraints to self-determination. More specifically, if the directions were not written down by the principal, the Court considered how much evidence the state could require to prove the oral representations of the principal to refuse artificial life support. The specific question before the Court was whether the State's evidentiary standard was an unconstitutional restraint on a person's right to exercise autonomy?

The Nancy Cruzan facts were on "all fours" with the Quinlan factual situation. Unlike the Quinlan case, Nancy Cruzan's parents were denied the authorization to remove life support. When it became apparent that Nancy had virtually no chance of regaining her mental faculties or recovering from her vegetative state, her parents, as proxies, asked the hospital to
remove Nancy’s artificial nutrition and hydration equipment. The hospital argued that the removal of the support would cause Nancy’s death, and refused to do so. Similar to Quinlan, Nancy had not prepared written advance medical directives, but had verbalized her wishes should she be found in a vegetative state to refuse artificial life support. The Court agreed that Nancy had the right to refuse artificial support through a proxy, but the issue the Court addressed was whether the state’s evidentiary restraints were reasonable under the "clear and convincing" standard or whether such evidentiary standard violated due process and Nancy's fundamental rights to refuse life support. The Court upheld the state's restricting clear and convincing standards as reasonable and compelling.

The right to refuse life support has not been considered analogous to the individual’s desire to accelerate death by taking affirmative actions, such as administering lethal doses of narcotics to hasten death. In Washington v. Glucksberg, the issue was whether the state statute prohibiting a physician or other person from assisting an individual with committing suicide or "mercy killing," violated the Fourteenth Amendment. Specifically, did Washington’s law interfere with the terminally ill adult's fundamental right of autonomy and did the government have a compelling reason to do so? We know that the individual has a right to refuse treatment that will eventually lead to the individual’s death. Thus the core of the issue becomes the identification of the death agent. In cases where an individual refuses medical treatment, the treatment is not the source of death, i.e., the withdrawal of the artificial life support that allows the person to die naturally is not the cause of the death. In assisted suicide, however, the quickening of the death will be the death agent and society has always found hastening death, even if by a second, is illegal.

The Court found that Washington’s statute prohibiting suicide and/or assisting with suicide did not offend the Fourteenth Amendment as an unconstitutional restraint. The Court reviewed domestic and international expressions regarding assisted suicide and opined that the state's restraint prevailed over the individual's autonomy to hasten death for many different policy reasons, including protecting the vulnerable from pre-mature death. The Court found in addition to the state's other interests that two additional interests existed, i.e., the state had an interest to avoid involvement of third parties and the use of arbitrary, unfair, or undue influence to assist the individual, and to avoid further movement towards euthanasia and other abuse. Chief Justice Rehnquist, who was writing for the majority, found no justification for considering access to physician-assisted suicide as a fundamental right by the individual, as there was no such right to make a choice of accelerating one's death. Therefore, the lesser test of "rational basis" was more proper for determining whether an individual has authority for accelerating death. These state interests were sufficient reasons for the Court to uphold the legislation prohibiting euthanasia.

But some treatment choice decisions have been found to be fundamental rights, requiring a compelling state interest. The second seminal “assisted suicide” case before the Court was Vacco v. Quill. In Quill, the issue before the Court was whether the New York state law that allowed terminally ill patients to withdraw artificial life support, thus accelerating their deaths, violated the Equal Protection Clause of the Fourteenth Amendment when said rights were not extended to other patients who wanted to hasten death through assisted suicide. The Court found that the New York statute did not infringe upon any individuals' fundamental rights when it did not extend to "assisted suicide" that would hasten the death through a death
agent. The majority of this Court concluded that there is not a fundamental right to accelerate one's own death even though one has a fundamental right to remove artificial life support and the consequential results are analogous. The Court reasoned that the New York law gave all of it's citizens the right to refuse unwanted treatment, but not the right to obtain affirmative relief through a physician or other person that would hasten or quicken the natural process of dying. Since those who wanted to hasten death through suicide were not a suspect class, and the state had a distinct rational basis that promoted the state's purposes, there was no violation of equal protection in implementing New York's statute.200

iii. Removing Nutrition and Hydration

Although the Supreme Court has not addressed whether the removal of nutrition and hydration is suicide, Justice Scalia's opinion in *Cruzan* indicated that he would consider the refusal of nutrition and hydration a form of suicide.201 Perhaps allowing death to be hastened by starvation is in the mind of some to be equivalent to hastening the death through palliative drug injections as essentially the same. The Court opinions in *Vacco v. Quill* and *Washington v. Glucksberg* fail to explain the difference between assisted suicide and a dying terminally ill patient who stops all forms of nourishment when oral feeding is still possible. By not addressing this issue, it is plausible that the Justices support a terminally ill patient's constitutional right to end one's life by starvation or dehydration, because these methods are not considered euthanasia.202 Those individuals with serious depression often consider suicide and assisted suicide. In the case of *Compassion in Dying v. State of Washington*,203 the plaintiffs, three terminally ill patients and five physicians who treated terminally ill patients, and Compassion in Dying, a non-profit organization, sought the right to accelerate death and hasten suicide through “mercy killing” of those who were terminally ill.204 The three terminally ill patients included a sixty-nine year old cancer patient, a forty-four year old artist dying with AIDS, and a sixty-nine year old with late stage emphysema.205 The five physicians treated terminally ill patients and were of the belief that the individuals had the right to choose to end their lives, comfortably and to avoid the pain and suffering that was associated with their terminal and often painful conditions.206 The physicians opined that they had the right to mercifully assist their patients in such acts of accelerating their passing as to avoid a long and painful dying process.207

The district court found in the *Compassion in Dying* case that the restraining statute was unconstitutional for two reasons.208 First, the district court found that the statute violated the liberty interest guaranteed by the Fourteenth Amendment when the state placed an undue burden on the citizen's liberty interests in preventing assistance in committing suicide.209 In making this finding, court relied on the case of *Planned Parenthood v. Casey* and found that an individual has a definite right to define one's own existence, including the right to terminate that same existence.210 Second, the district court also held that the statute violated the Equal Protection Clause because it treated similarly situated groups of terminally ill patients differently, i.e., there is little difference between the Washington statute that allows patients to refuse life saving treatment, and the statutes that allow terminally ill patients to expedite their deaths to avoid prolonged pain and suffering.211 If the same rights applied to assisted suicide
that applied to the right of privacy in the area of reproduction, then the right would have to be extended to all citizens under equal protection. Therefore, the court could not limit or control assisted suicides.

When the district court ruled in favor of the plaintiffs, the State of Washington immediately sought appellate review in the Ninth Circuit. On appeal, the Ninth Circuit reversed the district court’s decision and held that there was no due process liberty interest in physician assisted suicide and that the application of the Washington statute did not violate the Equal Protection Clause of the Fourteenth Amendment. The Ninth Circuit majority disagreed with the district court’s reliance on Casey. The Ninth Circuit failed to see the connection between a right to define one’s own existence and the right to end one's condition.

Interestingly, the dissent in the Ninth Circuit opinion believed Washington's restraining statute was invalid as applied to the terminally ill who were mentally competent because the statute allowed terminally ill patients to refuse medical treatment and to withdraw life-sustaining equipment, which typically resulted in death. The dissent did not like the effect of a statute that prohibited terminally ill patients, who were not reliant upon life support, to hasten their death with assistance from a physician. In either situation, the individual who was dying suffered discomfort and pain. The individual who had artificial life support could end his or her life, while that terminally ill patient who was suffering the same horrendous discomfort, could not. To the dissent, the arbitrary discrepancy violated equal protection. The dissent concluded that denying a terminally ill patient the right to physician assisted suicide essentially denied that individual the right to die with dignity.

Whether the terminally ill patient has full capacity, or whether the suicidal patient is mentally ill and seeking premature death, the Court found that assisted suicide is not a fundamental right and therefore, the statutes that banned assisted suicide were rationally related to a governmental interest and did not violate due process or equal protection. There is "no [fundamental] right to die" in this sense found in the Constitution, and despite the fact that a person has the right to refuse artificial life support to hasten death, the person may not necessarily choose to accelerate death through using a chemical cocktail. Likewise, the Court remanded the Compassion in Dying case to have the court make findings consistent with the holding found in Washington v. Glucksberg. In both Glucksberg and Compassion in Dying, the Court found no fundamental or Constitutional right to physician assisted suicide.

Although the dissent attempted to argue that the Washington statute was a violation of the Fourteenth Amendment, the Court found that the case law did not support such a right within the meaning of the Fourteenth Amendment. However, over time and the development of much case law it has been established that there are some matters so private and decisions so personal that the state should not interfere with the individual's autonomy.

iv. ECT is not Assisted Suicide or as Unforgiving as Removing Nutrition and Hydration

The statutes that require prior judicial consent before a proxy may make decisions to administer ECT to the incapacitated patient falls between the two ends of the spectrum. ECT does not hasten death, therefore, it is not prohibited under assisted suicide statutes, and it is not
considered an "unorthodox" medical treatment, as is laetrile, and therefore consent is restrained. On the other spectrum end, since the courts have not agreed that ECT is a safe and effective remedy as are other treatments, they have imposed some restraints, and not a total prohibition. Nevertheless, when the State makes the treatment unavailable by requiring a judicial hearing that effectively prevents the indigent from participating, the judicial restraint must be tweaked so that ECT is treated the same as any other orthodox medical procedure to be decided between the physician and the patient, or the patient's proxy, and not unnecessarily supervised by the judiciary.

The prior consent restraint makes it unfeasible for patients who are mentally ill or indigent to obtain the ECT treatment to cope with their severe depression. Rather than protecting the vulnerable, the legislation in reality creates more suffering, more harm and more damage to autonomy. It is as if we are creating a Catch 22. We legislate an unrealistic judicial procedure to obtain the treatment and simultaneously legislate a restraint on accelerating the individuals' comfort. This legislation is destined to create much more suffering than necessary should the restraint be analyzed as a inhibitor of individual self-determination.

Ultimately, the Constitution does not explicitly guarantee an individual's right to die. Although, there is an implied Constitutional right to privacy, the Court has successfully evaded the issue of whether this right extends to the right to an individual to choose to end her own life under certain circumstances. The Court has repeatedly sent this issue back to the state courts to decide it at the local level. The various state courts that have addressed the right to die issue have determined that there is a difference in status between patients who wish to terminate their lives through assisted suicide and those patients who request the removal of life support. The Quinlan case was the first judicial decision indicating that there is a constitutional right to privacy and this is the basis for the right to withhold or withdraw life support. Furthermore, this situation is a portrayal of this belief held by many courts that there is a definite distinction between the self-infliction of deadly harm and the decision against medical intervention.

B. Other State Interests

In addition to preventing suicide, the plausible purposes supporting the judicial authorization restraint may also include the consideration that incapacitated persons are perhaps more vulnerable to abuse than those enjoying capacity. Another state consideration is that the state wishes to provide due process before denying or authorizing an individual access to an orthodox medical treatment, or that the state wishes to protect against ECT abuse. These interests are balanced against the incapacitated person's need to obtain timely treatment, obtain possibly the only treatment that will be effective to combat the illness or save a life, and to exercise self-determination.

Typically a competent adult's medical autonomy prevails against the above state's interests. This would be especially true in that ECT further promotes the state's interest in assisting persons to overcome the mental illness and enhance the quality of life. Early in the science of ECT, the treatment side effects were much more negative and in some cases unsafe, and therefore, the public sentiment was, and in many cases still is, "would I want my grandmother to be subject to such barbaric tests?" With a better understanding of how ECT works today, the past stigmas are not currently true. With technological improvements, less
invasive procedures, minimal side effects and the consideration of whether the person is en-
joying capacity or not, ECT should be made available under the care and direction of the
trained and licensed physician without unnecessary judicial oversight.235

2. The Other State Concerns

Making ECT more reasonably accessible to the indigent incapacitated furthers the state's in-
terests of not only preventing suicide, but in preserving life, protecting the medical profession's integrity, and reducing abuse.236 Instead of the State making ECT inaccessible to certain indigent groups,237 the state should consider treating ECT as any other medical procedure at this point in time and not single it out as an a prohibited procedure that requires prior treatment due process.238 The State's primary concerns with making ECT readily available to the proxy are whether the prior consent restraints make the public generally safer and the possible prevention of abuse of a vulnerable group, i.e., the incapacitated.239 Rather than restraining ECT and making it financially difficult for the incapacitated person to obtain, the focus should be on how treating ECT as any other orthodox medical procedure accomplishes the state's purpose.240

A. Autonomy is Not Absolute Against Other State Interests

The most important question to states that have statutes that require prior approval is: What is the state's interest in having a judicial authorization requirement? As will be discussed below, persons have autonomy and much freedom in making medical decisions, but no right is absolute. Since autonomy is not absolute,241 the right to "choose" treatment and the right to refuse treatment must be balanced against the State's interests in protecting the general welfare of the public. The Court affirms that the "the outer limits of this aspect of privacy have not been marked by the Court."242 In essence, there are competing interests that are to be protected.243 The Court appears to have established that for an individual to choose a medical treatment without unjustified government interference, that the individual must show that the decision to choose medical treatment is "first, . . . a 'personal decision' . . . [e.g.,] They must primarily involve one's self or one's family. Second, they must be 'important decisions' . . . [e.g.,] They must profoundly affect one's development or one's life."244

B. Autonomy should Prevail When Individual Has Not Refused ECT

The decision to accept or refuse ECT is a personal and important decision weighed against the State's interest.245 If the individual is incapacitated and has never expressed any opinion as to ECT, the individual is unable to give personal informed consent to the procedure. Hence, the state will have an interest for the individual's general health and safety and under its parens patriae authority, protect those citizens unable to care for themselves.246 When the court exercises its parens patriae powers to protect the incapacitated, it does so by enacting legislative "safeguards" to protect the individual's welfare and due process.247

ECT is a medical procedure only administered by licensed medical doctors and psychiatrists. The process is administered to those who can consent, after receiving sufficient
information to give informed consent, and is sometimes administered to those who are institutionalized who refuse consent, and to those who can not provide consent. The court takes responsibility under its *parens patriae* powers to protect those who are not able to consent, yet it does not or has not distinguished between those patients who have affirmatively refused ECT and those incapacitated patients that have not given ECT a single forethought or those individuals who consented to ECT while enjoying capacity and then refusing ECT once they lose capacity. Arguably, those who have not made provisions for ECT prospectively should be treated much differently than those who have affirmatively refused ECT, either in the past or in the present. The state's interest in protecting the vulnerable is less significant with an individual who neglected to pre-specify ECT approval versus an individual is has refused ECT.

4. Judicial Involvement and Administrative Due Process

In the states that require prior judicial notice to consent to ECT treatment on behalf of the ward, the court may, and most likely does require a psychiatrist's assessment and evaluation to determine if such a procedure should be allowed. The psychiatrist, as an expert witness, would be entitled to professional fees for his or her time, whether appearing in person, or allowed by affidavit.

Much of the criticism against the use of ECT appears to be from the negative stigma that has haunted the procedure's past and the lack of empirical data that would provide support for overall acceptance of the ECT procedure. Case law includes many decisions that highlight the dangerousness of ECT, but the opinions written ten or twenty years ago may be under the prior administrations of ECT, where the advances in medical technology may not have been available, as they are today. If the purpose of the statutory consent requirement is to provide safeguards against the mistreatment, and mis-use of ECT as to vulnerable groups, then is the prior consent requirement is not accomplishing the intended purposes.

Hospital bio-ethics committees, review boards and independent panels could provide meaningful review without the necessity of a judicial hearing, and still provide the patient with due process. Using administrative boards and committees, where needed, are lesser restrictive methods to protect the incapacitated individual than the requirement for prior judicial consent, especially if the institution's bylaws provide for judicial review and a suspension of action until after the judicial hearing, if the proposed decision is disputed. Unless recent evidence can show that ECT is currently more harmful than other medical procedures that do not require prior judicial approval, the statutes that require prior judicial consent should be eliminated altogether, or at least modified accordingly, as outdated and regressive.

5. The Constitutional Concerns

Not only should the restraints on proxy consent be reconsidered by the legislature as outdated, unwise and possibly unnecessary, but the pre-treatment requirements may not be constitutional. The right of an individual to withhold artificial life support is a fundamental right, and the right of a patient to make medical decisions with her doctor has been considered fundamental, so the question is whether an individual's right to refuse ECT, and the reciprocal decision to choose ECT, a fundamental right?
ECT is a treatment choice made by a patient after being informed by the physician. Should the person be unable to choose due to incapacity, the individual's autonomy is exercised by a proxy. If ECT is a orthodox medical treatment and we protect that person's autonomy right to refuse the procedure as a "fundamental" right, and we protect the competent person's right to choose the orthodox treatment with her doctor as a fundamental right, does the right become less fundamental when exercised by the proxy? Arguably the person's decision is no less a fundamental right when that person is incompetent as when the person enjoys capacity, and the only distinction is whether the State's interests in protecting the incapacitated individual through restricting such rights a compelling reason. If a compelling interest standard is applied, then the prior consent restraint has to be measured, or at least reviewed, under Due Process and Equal Protection.

A. Due Process

ECT is administered by licensed, disinterested psychiatrists and physicians that hold medical degrees. Licensed physicians already offer a significant safeguard to the individual as the physician is subject to licensing boards, tort laws of malpractice, and institutional administrators. A court's disinterestedness may not be any more compelling than the professional subject to money damages and an injured reputation. The state's interests in protecting the vulnerable appears no more potent than the medical professional who has taken an oath to protect and serve those who require medical assistance. Additionally, courts are not as well equipped to determine the medical necessity of the procedures as would be a trained and licensed medical provider. Hence, any benefit the court may provide would be to the individual's general health and safety, but not improving on the medical decision.

Courts have historically been accessible when the patient's family, proxies and medical doctors are in disagreement as to treatment choices, including the withholding of artificial life support. Even in the situation where life support is to be removed, causing irreparable consequences, the courts have not made such decisions predicated on judicial review. The courts have allowed judicial accessibility in situations where there is not an agreement among the independent and interested parties, but to make the judicial inquiry mandatory, the question is whether the court or legislature has a compelling interest to do so. Is the prior consent restraint's purpose concerned that a family member or medical provider may attempt to abuse the vulnerable member by inflicting ECT? The fallacy with such an argument is that ECT is not a unilateral decision made in an isolated vacuum. The disinterested physician, other members of the ward's family and friends, and institutional committees also act as watch dogs of potential abuse. ECT is frequently performed in hospitals and are or can be under the auspice of hospital administration and bio-ethic committees. Since ECT is not administered in a hermetically sealed environment, the potential risk of ECT abuse has to be questioned. Our concerns with abuse more akin to the "Chicken Little's fear of the sky falling?" ECT is not inherently abusive, and it takes many independent parties to make a decision to administer ECT, hence requiring a conspiracy among many people to abuse a patient in a "non-forced" situation, i.e., within the confines of a prison or mental institution, which have further safeguards built into the system.

ECT typically assists the person with a return to capacity, thus making them less
vulnerable, not more vulnerable. The same is not true with all mental health medicines, where psychoactive drugs may be used to chemically restrain, but ECT does not fall into that category.

The case law does not show where an individual is subject to more potential abuse should he be receiving ECT treatments than if he were not receiving said treatments. The recent case law does not show that ECT is overly dangerous or unsafe. Medical evidence is to the contrary and supports the safe use of ECT today. As one can discern. ECT does not appear to be any more dangerous than many other medical and surgical procedures that occur daily without any judicial oversight. ECT is used to reduce the catatonic state, and so we must contemplate, “What is the abuse or the safety concerns that the judiciary should be concerned about and why would a judicial opinion be necessary to validate a medical decision?” Again, how is the prior approval requirement protecting the incapacitated individual's due process and also at the same time assisting a concurrent state interest? Under due process, by circumventing the individual's access to ECT, thus thwarting her autonomy, the state is unable to show that its interests are more important than an individual's medical needs and Constitutional right to privacy, regardless of whether the patient has capacity (or incapacity through a proxy) to choose.

Note, the state may have an interest as it regards institutional patients and those patients that have expressly refused ECT. Typically, the Constitution does not provide a duty to provide treatment unless established by statute. Statutes, for instance, provide that under the Fifth and Fourteenth Amendments that pretrial detainees, prison inmates and mental patients have a “right to medical treatment” when they are not voluntarily in the institutionalized facility. The state would have an interest in providing sufficient care, treatment and medication for those in its jurisdiction and custody.

Under such analogy, the Constitution does not require a patient have access to ECT, especially if the patient is a "voluntary admittee." Arguably, just as the state cannot unreasonably interfere with the patient making the choice to exercise ETC, even under autonomy, the individual's choice of treatment is not always "automatic." As stated, the individual's right to medical treatment has to be balanced against the State's interest in preserving the health of the patient.

i. Does an Administrative Hearing comport with Due Process

In the Washington v. Harper case, one question before the Court was: Whether a judicial hearing was required under the Due Process Clause of the Fourteenth Amendment before the State forcefully treated a mentally ill prisoner with antipsychotic drugs against his will? Walter Harper had been sentenced to prison in 1976 for robbery. From 1976 to 1980, while he was incarcerated at the Washington State Penitentiary, Harper was housed in the prison's mental health unit. In the prison, certain inmates suffering from the mental disorders of schizophrenia were treated with antipsychotic drugs therapy. The antipsychotic drugs, which altered the chemical balance in the brain, were administered with the intent that the therapy would allow the prisoner to organize his or her thought processes and regain a rational state of mind. Harper consented to the administration of antipsychotic drugs during this period of time.
Harper was subsequently paroled in 1980 on the condition that he participate in psychiatric treatment. While on parole, Harper continued to receive treatment. In December 1981, the State revoked Harper's parole after he assaulted two nurses at a hospital where he had been civilly committed and upon his return to prison, Harper "was sent to the Special Offender Center. . .established by the Washington Department of Corrections to diagnose and treat convicted felons with serious mental disorders." In the beginning, Harper voluntarily consented to antipsychotic drug treatment, but commencing November 1982, he refused to continue taking the prescribed medications. The treating physician sought to medicate Harper over his objections, pursuant to the Department's Policy 600.30.

Policy 600.30 included several substantive and procedural components, such as if a psychiatrist determined that an inmate should be treated with antipsychotic drugs but the inmate did not consent, the inmate could be subjected to involuntary treatment with the drugs, but only if he (a) suffered from a "mental disorder," and (b) was "gravely disabled" or posed a "likelihood of serious harm" to himself, others, or their property. Under the rule, an inmate who refused to take the medication voluntarily was entitled to a hearing before a special committee consisting of a psychiatrist, a psychologist, and the Associate Superintendent of the Center, none of whom may be, at the time of the hearing, involved in the inmate's treatment or diagnosis. If the committee determined by a majority vote that the inmate suffered from a mental disorder and was gravely disabled or dangerous, the inmate could be medicated against his will. Further Rule requirements provided that the inmate be given at least 24 hours' notice of the Center's intent to convene an involuntary medication hearing and that he receive "notice of the tentative diagnosis, the factual basis for the diagnosis, and why the staff believed medication was necessary."

At the Center's hearing, the inmate had the right to attend, present evidence and access to the assistance of a lay adviser who had not been involved in his case and who understood the psychiatric issues involved. The Rule required that Harper be given copies of the minutes of the hearing and he had the right to appeal the committee's decision to the Superintendent of the Center within 24 hours. The Superintendent then had 24 hours to appeal and the inmate was entitled to seek judicial review of a committee decision in state court.

After the initial administrative hearing, if the prior Rule requirements had been complied with, the Center could continue with the involuntary medication with only a periodic review. While at the Center, Harper was absent when members of the Center staff met with the committee before the administrative hearing. However, the committee conducted the administrative hearing, however, with Harper present and assisted by a nurse practitioner from different institution. The committee found facts that Harper was a danger to others as a result of a mental disease or disorder, and approved the involuntary administration of antipsychotic drugs. In June 1986, Harper sued the Center contending that the treatments violated his due process. The Washington Supreme Court concluded that the highly intrusive nature of the treatments with antipsychotic medications warranted greater procedural protections than those necessary to protect the liberty interests and that the absence of judicial review violated Harper's Constitutional rights.

On appeal, Harper argued that the State could not override his choice to refuse
antipsychotic drugs unless he had been found to be incompetent, and then only if the fact finder made a substituted judgment that Harper, if competent, would consent to drug treatment. The Court heard Harper's argument but found that Harper had received due process since he was not given the drugs until after it was determined by a medical finding that a mental disorder existed which would likely cause harm if not treated, that was prescribed by a psychiatrist, and that was approved by a reviewing psychiatrist to ensure that the treatment would be ordered only if it was in the prisoner's medical interests, given the legitimate needs of his institutional confinement.

The Court, in ruling that an administrative hearing process satisfied Harper's due process, found that Harper's suggested "substituted judgment" rule failed to take into account the government's legitimate interest in treating him to reduce the danger. Since Harper's suggestion was not responsive to the State's legitimate interests, the Court summarily rejected Harper's alternative argument. Once the Court determined that Harper's substantive due process was protected, it considered whether his procedural due process was also protected when the Rule did not provide him with a judicial hearing prior to the involuntary administration of the drugs.

The Court held that the administrative hearing procedures set by the SOC Policy comport with procedural due process, and concluded that a judicial hearing was not a prerequisite for the involuntary treatment of prison inmates, as balanced under the guiding factors of the Mathews v. Eldridge test. In its opinion, the Court explained that despite the significant side-effects and risks that were involved with the antipsychotic medications, that Harper's interests were "adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." Courts would be required to provide deference to the medical contingency in order to determine if the treatment were in the ward's best interest. Does the court add anything by providing prior judicial review, especially in cases where the ward has not expressed whether she would or would not choose ECT if needed? As stated in other situations, the Due Process Clause "has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer."

Regardless of whether the ward's due process is protected by an administrative hearing,
the legislative restraint is arguably required to be narrowly drawn.\textsuperscript{319} The autonomy to accept or refuse treatments are fundamental rights.\textsuperscript{320} When fundamental rights are restricted, the governmental intrusion or interference cannot be greater than what is necessary to accomplish the state's purpose.

In the case of \textit{In re Guardianship of R.E.J.},\textsuperscript{321} Ruth was appointed a guardian when she became incompetent as a result of severe depression. Ruth refused to eat and was near dehydration and starvation when Ruth's doctors determined that ECT was the only feasible treatment option to effectively and timely lift Ruth's depression.\textsuperscript{322} Ruth's attending physician testified that without ECT, Ruth would probably die from her depression-related health problems.\textsuperscript{323} Like many incapacitated persons, Ruth had not expressed and could not express a preference for or against ETC.\textsuperscript{324}

Ruth's guardian brought a motion before the circuit court seeking an order to permit ECT without Ruth's consent.\textsuperscript{325} The Wisconsin circuit court denied the motion on grounds that §§ 51.61(1)(k). . . did not grant a circuit court authority to order ECT without the patient's consent.\textsuperscript{326} Specifically, the court discussed that under "equal protection law, if a statute intrudes upon a fundamental right or makes a suspect classification, we analyze the statute with strict scrutiny. . . Under strict scrutiny, we require the statute to be narrowly drawn to further a compelling government interest."\textsuperscript{327} Not all state statutes prevent the court from ordering ECT, but in this case, the statute in question made ECT available only if Ruth had given consent.\textsuperscript{328} Since she was unable to provide consent due to her incapacity, the court found that under Wisconsin's statute, the court could not order ETC.\textsuperscript{329}

On the guardian's appeal, the Court of Appeals found that Ruth's constitutional rights had been violated and concluded that §§ 51.61(1)(k) denied Ruth a fundamental right, i.e., that the constitution "explicitly protects the right to life. . . [and] §§ 51.61(1)(k) denied Ruth the right to her life because it denied her the only medical treatment likely to save her life."\textsuperscript{330} As result, the court applied strict scrutiny to §§ 51.61(1)(k) and found that the section violated Ruth's equal protection because it was not narrowly tailored to promote the state's interest of protecting patients from unwarranted intrusions into their personal security through an unwanted ETC.\textsuperscript{331}

The court found that Ruth fit into a class of "incapacitated" persons unable to make informed decisions about their medical care.\textsuperscript{332} The statute that required informed consent from the individual was not narrowly tailored since it was overbroad or underinclusive.\textsuperscript{333} Section 51.61(1)(k) was overbroad, according to the court, when it attempted to protect patients from unwanted ECT treatments and the restraint prevented all patients unable to give "express and informed consent" from receiving ECT under any circumstances, whether they would have accepted it or not had they been competent to provide the consent.\textsuperscript{334} Since Ruth was in a class of citizens unable to express consent for the life saving treatment, it violated her right to equal protection of the laws.\textsuperscript{335}

As with \textit{In re REJ}, if an indigent person is deprived of ECT due to the legislative mandate for a judicial order, and the cost factor deprives the individual from obtaining the order and ultimately the life saving treatments, the prior consent requirement is similarly overbroad as it excludes the class of persons who are unable to afford the hearing.\textsuperscript{336}

The prior consent statutes are overbroad since they require all persons who failed to
expressly provide for ECT treatment in advance in written directives to obtain judicial authorization before having the ability to consent. Arguably, most people preparing advance directives rely on the attorney to protect him or her, and if they fail to specify a specific desire to have ECT, the failure was most probably unintentional and inadvertent. The prior consent rule covers not only those who refuse ECT or would have refused ECT, but also those that would have chosen ECT had they been competent and properly informed.

The statute is underinclusive as it does not require all proxies to obtain prior approval, but only those where the ward failed to so specify whether ECT treatments would be wanted should the circumstances warrant it. The individual's general welfare is not any more protected or less likely to be abused should the proxy have obtained prior authority by the ward to consent to such treatment. If the state is attempting to protect the ward's general health and safety, specifically against ECT being abused by the proxy, the statutes allowing ECT with proxy approval only would not prevent the abuse by the proxy should the proxy be so inclined to administer the ECT even if the ward would have rejected it had she enjoyed capacity. The reality is, however, is that ECT, unlike antipsychotic drugs, is not used to bring patients into submission, but rather to bring them out of their catatonic and depressive states. Unlike some drugs that would chemically restrain the patient, ECT is not inclined to be so abused. Where is the motive to use ECT in an abusive fashion? If the risk is not inherent in the treatment, the restraint that requires judicial authorization is both overbroad and underinclusive, thus frustrating the state's interests and purposes.

6. The Proxy as Substitute Decision Maker

When a patient suffers from incapacity, the only way to assist the patient is through proxies and surrogates. When an individual is incapacitated, the individual is inherently more vulnerable and possibly subject to increased abuse by those entrusted with the individual's care. In such instances, the state has significant parens patriae interests in protecting persons who, while suffering from serious mental illness or developmental disability, lack capacity to make reasoned decisions concerning their needs for medication. In such cases, the state's interest is the only interest that may overcome an individual's interest in refusing orthodox ECT or psycho surgery. Likewise, the state's interest is the only interest that will keep the proxy from assisting the principal with obtaining ECT treatments.

Historically, there has been little question that a competent person has a fundamental right to make many numerous health care decisions, and there appears to be a dichotomy between a person making decisions when they are competent versus when they are persons who are incapacitated. Once a person becomes incapacitated, the state imposes "safeguards" and the level of scrutiny the proxy receives increases and is much different than requirements imposed on the competent person. The friction contemplates how much more the state's interest should increase under parens patriae based only on the individual's incapacity, as compared to the individual still being able to exercise his or her constitutional and common law rights.

In Cruzan v. Director, Missouri Department of Health, the Court recognized that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment, but failed to extend that same right to an incapacitated person if the proxy could
not prove clear and convincingly that the decision was what the principal would have wanted if he or she could have expressed the decision personally. When the Court imposed the higher evidentiary standard, restraining the incapacitated person's self-determination, the Court specified that "an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment, or any other right."\(^{349}\) The Court differentiated that a competent adult does not require the protection that the individual requires who is incapacitated, and hence, justification for the additional restraint or *parens patriae* interference.\(^{350}\)

The Court did not leave the ward without a remedy, however, and as allowed in the *Quinlan* case, stated that "such a 'right' must be exercised for her, if at all, by some sort of surrogate. . . . [it] has *established a procedural safeguard* to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. . . ." (emphasis added)\(^{351}\)

The procedural safeguard allowed in *Cruzan* to protect Nancy Cruzan's refusal of artificial life support was that the moving party had to present clear and convincing evidence of the ward's wishes prior to allowing the proxy to act, i.e., a clear expression of the principal's substituted judgment.\(^{352}\) Once the procedural safeguard was deemed reasonable and the evidentiary standard was established, the Court did not require a judicial hearing before implementing the removal of artificial life support.\(^{353}\) In the end, the state's interest succeeded over the individual's autonomy, but the Court did not require a judicial hearing to protect the individual's due process and autonomy.\(^{354}\)

### A. The Purpose of Advance Directives

Advance directives allow a person to direct in writing their wishes concerning her future medical treatment,\(^{355}\) including such directives that may include a written document called a "living will" or similar name. The living will allows the individual to exercise his or her constitutional, statutory and common law right to refuse artificial life support. The living will may also be used to refuse any medical support, no matter how noninvasive the procedure or how great the potential for recovery. The instrument may direct the immediate removal of life support, direct the physician to prepare "do not resuscitate" orders, or require a delay in the implementation of the directive in the event of incapacity, i.e., ten days or some other triggering time period.

Other medical directives may include the principal making a designation of a proxy or surrogate decision maker for health care decisions in the event the principal is unable to make his or her own decision.\(^{356}\) The written directive may include specific provisions that implement mental health directions and desires.\(^{357}\) These directions may express consent for ECT and other "experimental" procedures dealing with mental health treatment.\(^{358}\) As set forth in the attached table, many states allow advance directives for mental health care in addition to the more common directives for general health care.\(^{359}\) The mental health directives often address specifically whether the principal wishes for ECT and whether the principal wishes the directives to become irrevocable upon incapacity.

The attorney preparing said directives may choose to place the surrogacy designations with the living will or may decide to keep the directives in separate instruments. Such directives
may also include the individual designation of an attorney in fact under a "durable" power of attorney." The durable power of attorney appoints a surrogate to assist the principal with financial matters including management and investment decisions.\textsuperscript{360}

Since the making of an advanced medical directive is significant, the person who is making the directives requires capacity at the time the documents are signed.\textsuperscript{361} Should the making of the durable power of attorney be delayed to when the ward lacks capacity, and it is no longer possible to have the principal prepare the power of attorney, it will be necessary for the court to appoint a guardian to make temporal decisions and judgments for the incapacitated patient and perhaps the patient's medical decisions as well.\textsuperscript{362}

Each state's statutes have to be reviewed to determine whether the statute allows the ward to make an expressed authorization for the surrogate to consent to experimental and mental health treatments. If said specific authorizations are contained within the directive, ECT would be allowed without prior court approval as the ward has already express consent after being informed.\textsuperscript{363} Its only when the surrogate's directives fail to specifically provide for authorization that the proxy should have to obtain court permission if at all for consent, under either the directive or a guardianship. Neither case law nor statutory history indicate any significant justifications to distinguish between guardians and surrogates when making decisions about whether ECT should be allowed without prior judicial authorizations.\textsuperscript{364} There is not justification why the constitutional right of decision should be easier to obtain for the member in society that had the privilege of education, and sufficient resources to hire an attorney to prepare advance directives that allowed the ECT treatment, than the under-privileged elder being denied such remedy since funding is not allowed to pay for the court costs necessary to fund the petition seeking ECT approval.

\section*{B. The Distinction Between Guardianship and Directive Statutes}

Upon incapacity, a person may be represented by a self-appointed surrogate, a court or statutorily appointed proxy, or by the appointment of a guardian.\textsuperscript{365} Both the directives statutes and guardianship statutes allow for proxy decision making.\textsuperscript{366} Guardianship law has existed over a long time period,\textsuperscript{367} while directive statutes are historically very new.\textsuperscript{368} Because of potential abuse, whenever a proxy is making decisions for the individual, legislation provides safeguards to protect the ward, her property, and her constitutional, statutory and common law rights.\textsuperscript{369} Even though the guardianship and directives statutory schemes may have similar purposes and protections in certain respects, a principal that consents to ECT in a directive is treated differently than the person who inadvertently or neglectfully, fails to specify the ETC when preparing the directive.

In guardianship law and in directive law, if the proxy is not chosen by the principal, there may be no direction as to whether the principal would have accepted or refused ETC. Under guardianship law, prior consent is mandated in most, if not all cases.\textsuperscript{370} In directive law, if the principal addressed mental health issues in the directive, typically no additional consent is needed before the ECT treatment is commenced. Is there justification in the history of the guardianship laws, or in the laws that regulate medical advance directives, to make a distinction in the protective purposes? Specifically, if the legislatures are concerned about a patient providing "informed consent," there are many times a proxy is allowed to provide informed
consent without judicial approval. The safeguard is the proxy is required to substitute the principal's judgment and wishes for those of the agent that is providing consent. Hence, consent is provided, either by the principal or by the proxy and the law is satisfied under the right to privacy.

Both statutory schemes allow for a proxy to make decisions for the ward. Both schemes consider the ward's wishes when limiting the ward's future decisions. Both statutes have similar evidentiary standards, i.e., preponderance of the evidence or clear and convincing evidence. Both provide for court oversight and access. Both may require a bond or waive a bond. The primary difference occurs if the patient makes a directive and specifically authorizes the proxy to make mental health decisions, and in this situation, the directives statutes do not require similar safeguards found in the court or statutorily appointed proxies. The error of requiring additional safeguards under guardian and directive statutes is that most likely, the competent ward did not consider mental health when making the directives; hence, begging the question, why impose burdensome safeguards on the proxy who is selected by the court or statute, when such safeguards are not imposed on the ward himself or on the ward's surrogate when the ward made a pre-mental health authorization?

A patient must provide informed consent to the treatment and a proxy may exercise informed consent on the principal's behalf through substituting the principal's consent for the decision. Yet, directive statutes for mental health care are primarily two types, i.e., 1) one type does not expressly require the proxy to obtain prior approval of ECT and 2) one type may require prior judicial approval before the proxy can consent to ECT treatment. Despite the controversial history of ECT and the possible short term side effects, due to advances in medical technology, the increasing need for effective treatments for the mentally ill, the legislature and judiciary should reconsider both the guardianship and directive statutes and make them more compatible and sensitive to the medical needs of the incapacitated elderly who may be relieved of depression through timely ECT treatment.

When determining whether the state may justifiably interfere with the proxy decision making, the balancing should further distinguish between a) those who need ECT and have never had it before and have never expressed an opinion either way, whether or not they previously prepared and executed advance directives; b) those who have had ECT and do not want ECT forced on them, and c) those who have had ECT and would most likely consent to additional treatments if they were competent.

Policy makers that have imposed the procedural safeguards must not ignore that proxy decision makers frequently provide consent on behalf of incapacitated patients for procedures that have much greater risk of causing death or serious permanent impairments. For example, proxy decision makers may use "substituted judgment" without prior judicial review to remove life support equipment that allows the incapacitated patient to die naturally, in an accelerated and irreversible manner. What distinguishes ECT to be singled out for a greater judicial scrutiny under either statutory scheme?

C. The History of Advance Directive Statutes

Every State has now enacted legislation permitting individuals to give advance medical
Directives for health care decisions should they become incapable of communicating their own wishes. Both guardianship and directive statutes have to be concerned with the state's parens patriae powers. Due process and constitutional safeguards are not to be replaced by, but are to be implemented in conjunction with the parens patriae powers, and guardianship statutes and many directive statutes include provisions for due process safeguards by providing mechanisms for hearings, representation, and notice. It is arguably a matter of fortuity that an individual by-passes the prior authorization statutes by executing appropriate directives that his or her attorney may have considered prior to that patient's incapacity. For the remaining majority, however, the restraint may not be protecting the ward, but instead, injuring the ward.

The authority for advance directives, or the right to autonomy and privacy, have existed since the inception of our freedoms found in this country, but the use of the living will, and other types of documents where the ward chooses a proxy decision maker in advance (other than powers of attorney), began to be developed in the United States in the late 1960's. In 1967, Luis Kutner is credited with promoting the first living will. A year later, Dr. Walter F. Sackett proposed legislation to the Florida legislature which would allow patients to make decisions regarding the future use of life-sustaining equipment. In 1968, the bill was defeated and again in 1973.

At the same time Dr. Sackett was introducing his legislation in Florida, Barry Keene, former State Senator of California, introduced similar legislation in California. Senator Keene's first attempts to pass legislation for the living will was unsuccessful, but in 1976, Keene reintroduced the bill and California became the first state to legally recognize the living will. This is the same year that the New Jersey Supreme Court rendered an opinion in the Quinlan case, which may have had an influence and bearing on California's legislative decision. With California leading the way, the majority of states enacted "living will" statutes within a short time period thereafter. The medical advance directive and proxy legislation progressed state-by-state and by 1992, all fifty states, as well as the District of Columbia, had passed legislation to legalize some form of advance directives. Even with states enacting medical advance directive laws and allowing the designation of proxy decisions makers, it was not until 1990 that the United States Supreme Court agreed to hear its next seminal case concerning the patient's right to withdrawal artificial life support under the right to privacy. Nancy Beth Cruzan's right to privacy was at issue and similar to Quinlan, the Court noted that Cruzan had not executed legally binding advance directives. One reason the Court may had waited fourteen years to hear a case that addressed advance directives and the evidentiary standard of proof may have been that prior to 1990, the Court believed that directives were decided as state matters rather than as federal matters. Although the Court ultimately denied the parent's request to withdraw artificial life support from their daughter, Nancy, for failing the evidentiary proof requirements, the Court confirmed that the individual had a right to refuse treatment, even life-sustaining treatment. In the relatively short history of medical advance directives, as evidenced by the number of states that enacted such legislation, the public has integrated autonomy into the law and the individual's right to participate in making personal health care decisions. The boundaries and limits of making medical decisions by the individual are not
well settled, however. Individuals have much discretion, while competent, to refuse artificial treatment, to refuse non-artificial treatments, and to choose treatment choices. Despite such freedoms, even though the removal of artificial life support may allow a person to die, it does not necessarily allow the quickening of death in terminal end of life conditions. Irrespective of the ability to choose to refuse resuscitation, the individual may not always be allowed to decide on what type of treatment they prefer. When the competent person may choose orthodox treatment choices, the incapacitated person may not, even though the law allows the incapacitated person to exercise his or her rights of choice through guardians and proxies. Even though we allow proxies to make the individual's treatment choice decisions, the right is not as absolute as if the person were competent, i.e., without the written expression found in a directive or court order. The answer of whether the restraint is sustainable is determined under the balancing of the individual's interest against the state's interests.

The concern is that as the elderly population increases dramatically and exponentially in both volume and proportionately in numbers, being a segment of society susceptible to depression, an effective treatment like ECT should not be denied to those who neither have the monetary resources to obtain court orders or do not have the time to wait to follow through the judicial procedure.

D. The Concept of Substituted Judgment

In Quinlan, the Supreme Court explored the concept of "substituted judgment," or having the proxy make the decisions that the ward would decide, if competent. The goal is not to do what necessarily most people would do, or what the court believes is the wise thing to do, "but rather what this particular individual would do if she were competent and understood all the including her present and future competency." The Quinlan Court allowed Karen's father to exercise Karen's rights by allowing him, as proxy, to express Karen's decision, or what was believed to be her decision. By allowing the proxy to substitute her judgment for his, Karen's rights were protected. The possible detriment, however, is if the proxy failed to substitute the proxy's judgment, but instead, used self-interest to take advantage of the vulnerable ward. The state would have a compelling reason to protect against such abuse. Therefore, in the Cruzan court, when the question was raised as to what should the proof be, i.e., substantial evidence, or a preponderance of evidence, or something greater, the clear and convincing evidence, the Court upheld the state's higher evidentiary standard as a legitimate restraint.

Although the facts were almost identical, Quinlan and Cruzan's results were juxtaposed, with Karen's life support removed and Nancy's life support compelled. A lesson to be learned from Cruzan is that reasonable people differ on how to protect the vulnerable from abuse and coercion. The questions should include, however, what are we protecting the vulnerable from concerning ECT treatments and how much restraint do we need to offer that protection? The Cruzan decision provides an example of what happens when the state and the judiciary establish standards that impose judicial restraints that may have not been intended, as they may not protect the ward, but far more serious, injure the ward by making treatment unaccessible. Unlike the issues in Cruzan and Quinlan, where an incorrect decision was not reversible, administration of ECT will not create an irreversible fatal condition.

If ECT effectively reduces otherwise non-treatable depression, which may be the
forerunner to suicide, arguably permitting the use of ECT by the proxy decision maker may promote the state's interest and compliment the holding in the Washington v. Glucksberg case.

IV. Wards May be Protected Without Prior Judicial Approval

1. No Presumption of Refusal

The "decision to obtain or reject medical treatment . . . is both personal and important enough to be encompassed by the right of privacy." If the state mandates that the proxy obtain prior approval before consenting to the ward's ECT treatments, the state in essence is creating a presumption that the individual would have refused ECT had the person been competent to decide. The effect of this presumption is that if the individual failed to specifically provide for ECT in a written directive, regardless of the reason, then the proxy would be unable to consent to said treatment absent an expensive evidentiary hearing. This presumption restrains the individual's rights unnecessarily.

Since the right to choose or withhold medical treatment is a protected interest, the level of scrutiny for the state to interfere should increase as the decision-making category changes from a "neglected decision" to an affirmative decision to refuse ECT, and unless the individual, while competent, affirmatively expressed a decision to refuse ECT, the presumption should not be that the individual would have "refused ECT" when the person becomes incapacitated.

Individuals suffering from incapacity are distinguishable from those possessing capacity, as the former deserves protection under the State's parens patriae powers. Many individual's that may be candidates for ECT may include the "incapacitated" category and those "seeking to choose treatment methods" category. Under substituted judgment, where the proxy has the responsibility to make decisions based on what the individual would have decided had the individual been competent, the burden should shift to allow ECT unless it could be shown by clear and convincing evidence that the individual would have refused ECT had the individual been competent. If the individual suffering from incapacity would have refused ECT, then the proxy would be abusing his or her duty by requiring ECT absent a compelling health and safety reason. Said analysis, however, is different for the proxy exercising substituted judgment and the evidentiary proof should be greater than in the situation where a state may be forcing ECT on an individual who is refusing said treatment. The right to refuse treatment historically has enjoyed more individual protection than the individual's right to choose treatment.

A. Incapacitated Groups are Vulnerable—Substituted Judgment

Substituted judgment is used as a safeguard to protect the vulnerable groups, including those incapacitated and who would benefit from ECT. Consider that a person possessing capacity has the fundamental right to refuse or consent to ECT, and those who suffer incapacity do not lose those fundamental rights as proxies exercise judgment and make decisions for the incapacitated. Even though the individual suffers incapacity and therefore the state has a greater interest in protecting the vulnerable person, the state's protective powers must still be...
carefully weighed against the individual's autonomy under substituted judgment. This balancing does not require an evidentiary hearing by a court in allowing the proxy to exercise substituted judgment when the individual would have most likely chosen ECT if the individual had been competent. A woman who has consented to ECT while capacitated does not need added governmental protections when she is incapacitated and requiring ECT.419

Common sense indicates that courts should exercise increased *parens patriae* supervision when ECT will be "forced" on the incapacitated, rather than the opposing situation where the patient never expressed refusal or acceptance of the treatment.420 Due to the compelling nature of force, the state's rights have to be balanced whenever it allows medical treatments of any kind to be forced in the patient's best interest.421 It is not common sense to "lump" all incapacitated persons into a group that automatically requires the additional safeguards imposed by judicial approval.

The individual's right to refuse ECT is fundamental and most decisions where the government's interest is raised deals with the state forcing the individual to have ECT over the individual's "fundamental" right to refuse.422 Substituted judgment is not a safeguard when forcing ECT on a patient in an institutional setting.423 Whether the individual is competent or incapacitated, if the state is able to "demonstrate a compelling interest in and obligation to legislate or regulate to preserve the safety, health and welfare of a particular class of patients or the general public from a medically-acknowledged, *bona fide* health risk," the state interests in forcing treatments such as sterilization, abortion and chemotherapy may prevail.424

The cases express and imply that it would be logical that the state's interest would have to be more compelling to overcome the individual's right to choose treatment, or refuse treatment generally, in comparison to the situation where the patient is forced to accept an unwanted treatment.425 Should the legislature fail to satisfy the narrow qualifications, it would have "neither a legitimate presence nor voice in the patient/health care provider relationship superior to the patient's right of personal autonomy which protects that relationship from infringement by the state."426 In the *In re Branning* case,427 the Illinois court articulated that the "[s]tate has significant *parens patriae* interest in providing for persons who, while suffering from serious mental illness or developmental disability, lack capacity to make reasoned decisions concerning their need for medication. . . " In situations where the individual may not know what is best for them, the state may not only refuse experimental treatments, but force a patient to have such treatments. The *Branning* court held that an individual's interest in refusing unwanted electroconvulsive shock therapy or psychosurgery was subservient to the State's interest, purely due to the State's duty to exercise *parens patriae* authority.428

In situations, however where the patient has not expressed an opinion as to ECT treatments one way or the other, but it is believed that had he been competent and understood the circumstances, he would have opted for ECT, but either did not have foresight to inquire or think about it, or did not understand the law that would require prior approval, the state's interest in providing additional judicial prerequisites should only prevail when it is shown to be in the individual's best interest for health and safety. The judicial scrutiny should be less, or not at all, in such situations since this circumstance is a different than a patient who is aware of ECT and refuses such treatment, regardless of capacity. Without the patient expressing ECT refusal while enjoying capacity, the judiciary's involvement should not be a necessary prerequisite.

Interestingly, the court struck down the Illinois statute that required a proxy to obtain
prior court approval for ECT as violating due process. The Illinois statute allowed a guardian or proxy to authorize ECT or psychosurgery on behalf of the ward only after obtaining court approval. The court found that the statute, as written, violated substantive and procedural due process since "it did not require showing that [the] ward was unable to make rational decision[s] for herself regarding treatment. . .". Since the statute did not require a showing of the ward's incapacity to make the decision of whether to refuse ECT, the state's *parens patriae* interest was not authorized to force the ECT treatment in the ward's best interest.

The court found that the statute violated procedural due process since it did not specify the level of evidence by which anything must be proved, it did not require input from any health care professional, notice of the limits on length of time any service may be forced on the ward, or proof that the ward was unable to make a rational choice for him or herself. Since the statute failed to provide for due process to the ward's informed consent, the court erred on the side of caution and vacated the order, thus, depriving the ward of ECT treatment.

This may be the correct result for a patient who conscientiously did not want ECT, but what about the patient who never thought about ECT prior to needing it as they were preparing the advance directives? Many people have not exercised their right to make directives for health care, and those that have made them may not have contemplated that mental health may be treated differently under the law than ordinary health care decisions.

**B. Proxies Are Trusted**

If the proxy or surrogate is someone the ward chose prior to becoming incapacitated, either in writing through directives, or orally to friends and family, the ward trusted the proxy to make correct decisions on her behalf. The ward made the decision to trust the proxy with choosing whether to refuse artificial life support for the ward, thus allowing an irrevocable consequence. If the ward trusted the proxy sufficiently to make life and death decisions without having to have prior judicial approval, then why would the presumption be anything but that the ward also trusted the proxy to make "best interest" decisions for her to accept treatment that prolongs life, entirely absent from requiring prior judicial approval? If the individual is satisfied with trusting the proxy to make "life and death" health care decisions, the legislature and court should trust the proxy to make less irrevocable decisions without the necessity of prior judicial approval, like the consenting to mental health treatments, including ECT.

Proxies operate with a fiduciary level of trust. If the ward did not choose the proxy, many state statutes provide for the appointment of the proxy in relationship priority. The priority usually selects the closest family member to the ward and extends outward to heirs and collaterals. Obviously the legislature made preliminary presumptions that the proxy was suited, acceptable and authorized to act for the ward as it being in the ward's best interest. With this presumption and the corresponding fiduciary like duties proxies have, the legislative requirements should be relaxed in the different situations. As stated previously, the State's compelling interest should be stronger in the "forced treatment case," than in the "uninformed ward" situation. Furthermore, the state's interest appears to be overbearing in such situations...
when prior judicial consent is required as it restrains a proxy from making timely and decisions based on "substituted judgment."\textsuperscript{446}

2. **The Right to Refuse or Withhold Medical Treatment, Self-determination.**

   As previously stated, the right to refuse treatment is considered a “fundamental right."\textsuperscript{447} Therefore, the government is required to have a compelling State interest before interfering or placing restraints on that right.\textsuperscript{448} The legislation that has been enacted that restrains that right, has to be precise and narrowly tailored to accomplish the State's interest.\textsuperscript{449}

   In balancing the state's interest against the individual's interest, the Court has provided some guidance. The "liberty protected by the Due Process Clause, is not a series of isolated points pricked out in terms of the (Bill of Rights, but) a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . ."\textsuperscript{450} The threshold test regarding the whether the individual's autonomy supersedes the State's interest appears to be measured by whether the invasion is minimal and the chance of recovery is great.\textsuperscript{451} The threshold test is almost silent in expressing the continuum regarding the individual's ability to choose his or her treatment plan.\textsuperscript{452}

   Hence, in terminal conditions where the treatment will be more invasive and the prospects of recovery dim, the individual's interest prevails over the state's interests.\textsuperscript{453} Likewise, for similar reasons, the chance of recovery with ECT treatments is significant in certain conditions. Despite the controversy of whether the ECT treatment is invasive, the prospects of recovery are great, and ECT is often the last hope of recovery for certain illnesses. Therefore, under the doctrine of informed consent, and in conjunction with the right to privacy, the individual's choice of ECT treatment should overcome the state's interest in requiring pre-approval prior to a proxy authorizing ECT.\textsuperscript{454} Again, this is not the situation where the individual consciously refused the treatment, but most likely failed to appreciate the significance of making a specific designation in a directive or is making irrational decisions based on her incapacity.\textsuperscript{455}

3. **The Right of Treatment Choice**

   Competent individuals have the right to refuse treatment under the Constitution, common law and statutes,\textsuperscript{456} and the case law implies that a “competent person” has the right to specifically consent to specific treatments, like ECT. Today ECT is recognized as an orthodox, and medically acceptable procedure. Therefore, a competent adult individual has the same right to choose ECT under his or her autonomy as an incapacitated person has through a proxy.\textsuperscript{457} Any restraint on that right may be an unacceptable infringement on an individual's right to privacy, whether the person is exercising the right him or herself, or whether through a proxy.\textsuperscript{458}

   As alluded to, the right to refuse medical treatment may not be the same as a constitutional “right to treatment" or the “right to choose treatment."\textsuperscript{459} In the case of *Andrews v. Ballard*, a Texas district court discussed an individual's right to choose treatment.\textsuperscript{460} The plaintiffs were several individuals who sought treatment in Texas for acupuncture, however, the
Texas Medical Practice Act, as then in effect, proscribed acupuncture being performed by anyone not licensed to practice medicine in Texas. The plaintiffs complained that the legislation deprived them of “choosing such treatments” in violation of their autonomy. In Texas, under the Act and accompanying rules, when only licensed physicians could perform acupuncture in the state, the plaintiffs maintained that their constitutional right of privacy was violated by the Act. They complained that the restrictions found in the legislation virtually eliminated the practice of acupuncture, thus thereby depriving them of their treatment choice.

The State in Andrews asserted that by limiting the administration of acupuncture to licensed medical physicians it was preserving the patient's health by protecting the public against misdiagnoses, by assuring that acupuncture was administered properly, and by assuring that any complications which may arise during acupuncture treatment would be remedied as quickly as possible. The Texas district court struck down the statutory provisions that the challenged articles and rules failed not because they were “unwise, improvident, or out of harmony with a particular school of thought,” but because they unjustifiably deprive[d] the plaintiffs of their constitutional rights. In each argument, the court found that the state's interest was “not necessary” to prevent such occurrences, but that there were less restrictive ways to accomplish the state's interests.

The State's second argument in Andrews is most akin to the argument to be raised for having restrictive safeguards on ECT, i.e., assuring that ECT is administered properly, as the improper application of ECT may cause unpleasant and possibly dangerous side effects. In Andrews, the state was worried that an acupuncture needle in unskilled hands could cause serious damage and that physicians were less likely than nonphysicians, as a class, to administer acupuncture treatment when they do not know how to safely and effectively do so. By analogy, is the state's prior consent restriction intended to make courts, as a class, less likely to make treatment decisions that will impair the patient's safety, i.e., that courts are better decisions makers than the medical community to prevent potential abuse and inappropriate administration of ECT?

A. The Court is not in a Better Position to Supervise Against Abuse

Like the physicians in the Andrew's case, where the court ruled that they were neither skilled nor trained in the practice of acupuncture and therefore less likely to accomplish the state's health and safety purposes, the courts in this instance are neither skilled nor trained in ECT administration, and are unable to protect against improper ECT administration any better than the physicians were able to protect acupuncture patients in Andrews. The state has an interest in assuring that ECT is administered properly but the ECT prior consent restraints lack “a rational relationship to a proper legislative purpose.” Whether or not such laws are irrational, they cannot be said to be “narrowly drawn,” to the State's interest in assuring that ECT is administered properly. Although ECT abuse may arise from improper administration of the procedure, the challenged judicial restraints do not serve to assure that first the potential abuse is real, or second, if it is real, that the restraints will prevent the abuse.

The rules may be tailored to achieve the “general health and safety” objective by allowing judicial access in the case of suspected abuse, much as we do in other cases of suspected elder abuse. The State's concern or perceived potential for abuse does not justify a prior hearing in
every case where a proxy is required to choose ECT treatment. The current legislation has not
determined what type of complications, if any, arise during ECT treatments that would be
prevented by prior judicial approval. The legislation has taken no steps to assure that the courts
are better trained to deal with potential abuse that would justify a different treatment than other
abuse cases that physicians have to deal with on a regular basis. The legislation has made no
determination that hospitals, bio-ethic committees, professional caregivers, and physicians are
not equally able to remedy those types of abuses as a prior judicial hearing. The legislation
arguably will not prevent such abuse of procedures, as the court will not be in the treatment room
when the ECT is being administered.

B. Less Intrusive Safeguards

The regulation of ECT is in itself not a violation of autonomy so long as it does not
significantly interfere with access to the medical treatment. The state may establish appropriate
minimum standards of administrative procedural safeguards to be met by those who provide
ECT treatment. There are clearly “less drastic means” the State could take to avoid the perceived
danger involved in the administration of ETC. For example, the state could require two
disinterested physicians to concur with the ECT treatment prior to administration. The statute
could allow for facilities to obtain approval through administrative processes that are already in
place in hospitals and other health providing institutions. The legislation could require ECT to
be performed only in specific licensed institutions that have an inherent propensity to provide
medical services with integrity. It could establish a protocol like in “end of life situations” where
so long as the family, proxy and providers are in agreement with the procedure, there is no
reason to hold a judicial hearing.472

The states that have prior judicial authorization statutes, however, have not implemented
any of the less drastic means mentioned above. States have required that proxies be required to
obtain prior judicial approval, but such requirements are simply not necessary to protect the
patient’s general health and welfare. Under the Andrews rationale, the prior approval legislation
is a violation of the patient’s autonomy.473 The indigent incapacitated elderly are not entitled to
obtain ECT treatment wherever they want, whenever they want, from whomever they want.
They are, however, entitled to obtain the ECT treatment.474

In Andrews, the Texas District Court found that the challenged articles and rules that
restricted treatments by only those that were medically licensed, did not withstand constitutional
scrutiny as the restrictions were not narrowly drawn and they violated autonomy by making said
treatments unavailable.475 Similarly, when legislatures make ECT financially impossible for
some wards to obtain treatment, such restrictions are not only unnecessary to serve the State's
interest in protecting the health and safety of the patient, but the restraints likely violate the
patient’s autonomy right to choose his or her medical treatments.476

4. Possible Plan to Protect the Vulnerable and Preserve Due Process

If the strict scrutiny standard is applied against the state’s requirement for a proxy
obtaining judicial approval, the state will require a compelling interest in adopting the
requirement.477 If the Court should find a compelling interest, arguably, there are less
restrictive methods to accomplish the safe-guards the statutes may be attempting to impose by
requiring prior court approval. We learned from the *Harper* case that a prior judicial hearing is not required to protect procedural due process.\textsuperscript{478}

If the patient has never expressed whether he would choose or refuse ECT, the presumption should be that the adult patient, now unable to express informed consent, would choose as a reasonable person would choose, and if the physicians and committee find that a reasonable patient would choose ECT, then the presumption is that a judicial hearing is not necessary. Rather than requiring expensive prior court approval, perhaps the proxy decision-maker should only be required to provide the recommendation of two concurring health care providers, i.e., the treating physician or the treating psychiatrist and one independent physician or psychiatrist. If the procedure is performed in an institution that has bio-ethic or review type committees, rules or procedures promulgated by that committee, or in some instances committee concurrence, may also be included.

Such a procedure would offer a less costly and less restrictive alternative that protects adults who are incapacitated and yet who would benefit from treatment, thus making the treatment accessible. Should a loved one, a medical caregiver, or committee disagree that ECT would be in the patient's best interest, then the court would be available to resolve said disputes.\textsuperscript{479} Having the judicial authorization as a forum to consider contested ECT matters makes the initial determination more time sensitive without compromising the seriousness of protecting the incapacitated patient from a debatable and potentially harmful medical procedure.

**Conclusion**

ECT has increasingly become more popular to treat certain mental illnesses, especially severe depression and pseudo dementia. The stigma it suffered due to prior barbaric type applications in the past are largely "history," and most medical professionals will agree that ECT is safe, very minimal side effects and no long term detriments. Yet, with the increase in popularity and the safe applications, ECT is still treated archaically under the law.

In many states, ECT may not be allowed unless a proxy decision maker obtains a prior court order allowing for said treatments. The practical problems with requiring a judicial order is that it makes ECT unavailable to the indigent and to those that need timely treatment. The elderly, especially elderly women, will be a significantly impacted group due to the legislative restraint.

As a practical matter, ECT is not inherently harmful or subject to be abused. It should not be singled out as an "experimental" or an "unorthodox" treatment, but should be treated as any other medical procedure.\textsuperscript{480} Most medical procedures are allowed without judicial intervention, and may be applied if the competent adult provides informed consent. Additionally, most medial procedures are allowed without judicial interference if the incapacitated adult is represented by a proxy or surrogate decision maker. ECT should not be treated any differently than other medical procedures.

As a legal matter, the prior judicial authorization requirement is an unconstitutional restraint on ECT availability. The prior consent requirement violates a person's autonomy and as implied under the Constitution, expressed in many state constitutions, provided for my statutes and in the common law, as it restricts a fundamental right of privacy. As individuals have the right to refuse treatment, they also have the right to seek orthodox treatments, and if they suffer incapacity, the person's rights are protected by using proxies and substitute judgment.
The states restraints that require prior approval are not compelling and do not serve the state's interests, but contrarily, frustrate the state's policies and purposes. Even if the legislative restraint was found compelling, the legislation as adopted by many states is not the least drastic method to protect the government's interests under either the state's parens patriae or police powers. The legislation is not narrowly drawn and it is either overbroad or underinclusive.

Should the law conform to modern medical technology with the administration of ECT, the individual or vulnerable group's safety is still guarded. The courts are still available for contested matters, or matters where abuse may be alleged. Courts have always functioned as arbiters of contests to make decisions for those who can not agree among themselves. Process is still available.

Due process does not require a judicial hearing to safeguard the vulnerable person's rights. Many health care providers that administer ECT will do so in institutions that already have in place reviewers or bio-ethic committees that could serve in an administrative capacity to protect a patient's due process. Additionally, ECT is not administered in a vacuum, but there are already in place several layers of protection for the patient. The patient's first layer of protection is her loved ones and family members. Not everyone enjoys the companionship of loving family members and friends however, but the individual is still protected by the fact that it will require more than a unilateral decision on behalf of a professional to administer the ECT. At the very least, there will be the medical doctor or psychiatrist to administer the ECT, the anesthesiologist, the other staff members and nurses, all of which have other commitments to professionalism, regulatory boards and judicial oversight. The third level of protection is in the administrative arena where many institutions already have boards and committees in place to address the ethics of treatment or palliative care in the event there is a question. Finally, if the previous safeguards are not available or effective in resolving the concerns, the courts are open to render judicial guidance.

As in cases where proxies make irreversible life decisions for principals that want the artificial life support removed, accomplished without prior judicial oversight, the administration of ECT that does not cause an irreversible detriment, does not require prior judicial oversight.

Under Equal Protection, the group that suffers from incapacity has the right to refuse medical treatment that will have terminal and irreversible consequences through proxies without prior judicial authorization, and to require the same group to have judicial consent before applying non-irreversible ECT, is a violation of Equal Protection and not rationally related to a legitimate state purpose.

The proposed solution would be very much like the procedure the Florida Supreme Court directed in the case of In re Browning, where the court established constitutional safeguards by providing procedures for the decision-maker. The Browning procedures that may be adopted here that would allow the proxy to make the ECT treatment decision in a private setting are:

1. "When the patient has taken the time and the trouble to specifically express his or her wishes for future health [and mental health] care in the event of later incapacity, the surrogate need not obtain prior judicial approval to carry out those wishes.

   This [would apply] whether the patient has expressed his or her desires in a 'living will,' through oral declarations, or by the written designation of a proxy to make all health care decisions in these circumstances."
2. When the patient has not expressed instructions, but has merely delegated full responsibility to a proxy, the designation of the proxy must have been made in writing.

a) "A surrogate must take great care in exercising the patient's right of privacy, and must be able to support that decision with clear and convincing evidence. Before exercising the incompetent's right to forego treatment, the surrogate must satisfy the following conditions: 1. The surrogate must be satisfied that the patient executed any document knowingly, willingly, and without undue influence, and that the evidence of the patient's oral declarations is reliable; 2. The surrogate must be assured that the patient does not have a reasonable probability of recovering competency so that the right could be exercised directly by the patient; and 3. The surrogate must take care to assure that any limitations or conditions expressed either orally or in the written declaration have been carefully considered and satisfied.

b) Likewise, when a proxy has been designated to make the decision without explicit instructions from the patient, the proxy must satisfy the following conditions: 1. The proxy must be satisfied that the patient executed the written designation of proxy knowingly, willingly, and without undue influence; and 2. The proxy must be assured that the patient does not have a reasonable probability of recovering competency so that the right could be exercised directly by the patient." 483

The Browning case included a dissent about the wisdom of removing judicial pre-requisites, and the Florida Supreme Court "emphasiz[ed]... that courts are always open to adjudicate legitimate questions pertaining to the written or oral instructions. First, the surrogate or proxy may choose to present the question to the court for resolution. Second, interested parties may challenge the decision of the proxy or surrogate." 484 Likewise, should there be a premonition or suspicion of abuse, the courts are open to provide due process and resolve said disputes.

To require prior approval is both practically and constitutionally incorrect and the laws should be updated to be in conformity with the advances in technology and the growing need in the community among the indigent elderly and groups suffering from severe depression and like illnesses readily and effectively treated by ECT.
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Alaska

§§ 13.52.010. Advance health care directives. ((g) Unless otherwise specified in a written advance health care directive, . . or (3) the primary physician or another health care provider in the case of mental illness where the situation is an emergency), §§ 13.52.045. Withholding or withdrawing of life-sustaining procedures; §§ 13.52.030. Surrogates, §§ 13.52.300. Optional form, AS §§ 13.52.390, AS §§ 47.30.825 and 47.30.830.


Adult may prepare a durable power of attorney for health care. It appears that if the principal delegated authorization for ECT to proxy, proxy does not require prior court approval. Otherwise, the proxy will require prior court approval. §§ 13.52.010 and 47.30.836.
Arizona A.R.S. § 36-561. The Department of Developmental Disabilities may not administer ECT, but may develop a program for the disabled.
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<tr>
<td>Arkansas</td>
<td>A.C.A. §§ 20-47-218</td>
<td>Court approval necessary if principal refuses ETC while institutionalized. § 20-47-218</td>
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<td>California</td>
<td>§§ 6924, 2670.5, 2354, 2355, 2356, 4652, 4503, 4505, 5325, 5326.1, 5326.7, 5326.8, 5326.75, 5326.85, 5326.91, 5326.95 and 5326.15; Conservatorship of Waltz, 180 Cal.App.3d 722, 227 Cal.Rptr. 436 (Dist.1986). § 5325, or the Lanterman-Petris Short Act, appears to be the exclusive statute that allows ECT of an involuntary patient. The Act recognizes the patient's right to refuse ECT. § 5326.7 provides that a patient may be given ECT via guardian but if the patient lacks capacity to give informed consent, a judicial hearing is required.</td>
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Cal.Welf. & Inst.Code §§ 5326.1, 5326.7 provides a list of when ECT may be administered on an involuntary patient. One provision allows a court hearing. ECT to minors requires court approval. § 6924, § 5326.8. |
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<td>Affirms patient's right to refuse treatment, § 82601.</td>
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**Illinois**

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<td>405 ILCS 5/2-102, 5/2-107</td>
<td>Proxy requires prior court authorization to approve treatment. 405 ILCS 5/2-110. All minors require court approval, including if natural parents consent. 405 ILCS 5/2-110.5. Permits a Mental Health Care Directive. 755 ILCS 43/75.</td>
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<td>Iowa Code § 229.6 (1985).</td>
<td>Any interested party may start involuntary commitment proceedings. § 229.6 (1985). Natanson v. Kline, 186 Kan. 393; 187 Kan. 186, (informed consent required before administering cobalt x-ray therapy). Mitchell v. Robinson 334 S.W.2d 11 (Mo. 1960)(Kansas solved the problem... by passing a statute which provides that “No person suffering physical or mental injuries from shock treatment shall... have a cause</td>
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<td>§ 144A.2(8) (West 1989 &amp; Supp.)</td>
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**Kansas**

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<td>Kentucky</td>
<td>KRS §§ 202A.422, KRS § 202A.430.</td>
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<td>Massachusetts</td>
<td>103. M.G.L.A. 111 §§ 4G</td>
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<td>Michigan</td>
<td>M.C.L.A. § 333.18501, § 330.1717, § 333.18201, § 700.5501</td>
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<td>North Dakota</td>
<td>NDCC, 25-01.2-09, NDCC, 25-03.1-40</td>
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<td>Ohio</td>
<td>R.C. §§ 5120.17, R.C. §§ 5123.86, R.C. §§ 5122.271, R.C. §§ 2135.01.</td>
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<td>Rhode Island</td>
<td>R.I.Gen.Laws §§ 23-4.11-2(h) (Supp.1992);</td>
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Permits a Mental Health Care Directive but proxy authorize for ECT is not applicable under § 137.008. The form directive appears to allow proxy to authorize ECT without prior approval. § 137.011.

Revocation not available after incapacity under same statute.

Minors require guardian's consent. § 578.002.
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<tr>
<th>State</th>
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<tr>
<td>Washington</td>
<td>Wash. Rev.Code Ann. §§ 11.92.043(5), 11.94.010 (3) (West 1998). RCWA 71.32.160, RCWA 71.32.260, RCWA 71.34.355, RCWA 70.41.020</td>
<td>RCW 71.05.217(7) requires hearing in order for State to force ECT on individual. Permits a Mental Health Care Directive and allows a proxy to approve ECT under §§ 11.94.010 and 71.32.260. Court approval required for minors. § 71.34.355. Washington expressly prohibits agent from consenting to ECT if the patient refuses, but appear implicitly to permit an agent to admit the principal under voluntary admission procedures. §§ 11.92.043(5).</td>
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West Virginia  
W.Va.Code §§ 16-30-2(6) (1985);

Wisconsin  
W.S.A. 46.90, W.S.A. 51.61, W.S.A. 155.20, W.S.A. 155.30, 243.07, 155.01.  
Wis.Stat.Ann. §§ 154.01(8) (West 1989 & Supp.1992); Permits a Health Care Directive but denies the proxy to approve ECT under § 155.20, 155.30 and § 46.90. Informed consent otherwise required § 51.61. A guardian is required to obtain court approval before (i) Committing the ward to a mental health hospital or other mental health facility; or (ii) consenting to Electro shock therapy. § 3-2-202. A health care decision made by an agent for a principal is effective without judicial approval. § 35-22-401 and § 35-22-406. Permits a Mental Health Care directive. § 35-22-302.

Wyoming  

U.S. Virgin Island (territory)  
Federal Statutes  
Uniform Health Care Decisions Act 1993 (specifically §5)
See Table of Statutes in Appendix A.

Sara Noel, Party in Mental Health Coverage: The Goal of Equal Access to Mental Health Treatment under the Mental Health Party Act of 1996 and the Mental Health Equitable Treatment Act of 2001, 26 Hamline L. Rev. 377 (2003) (“Currently over forty-four million Americans suffer from mental illnesses. While individuals afflicted with mental illnesses were once regarded as being possessed by demons and treated by performing exorcisms or removing portions of the skull, society now recognizes that most mental illnesses have chemical and biological origins which can be successfully treated. While this may be true, the issue of access to mental health treatment remains . . . . The prospect of litigating a claim in the hopes of obtaining reimbursement for the cost of treatment may prevent persons suffering from mental illness from seeking treatment. While individuals are aware of the costs of treatment and the possibility that their insurance will reject their claims, the cost of obtaining counsel to litigate a claim may deter them from seeking relief from the courts.”)

Electroconvulsive Therapy, http://www.enotes.com/mental-disorders-encyclopedia/electro-convulsive-therapy (last visited Dec. 15, 2007) (“ECT may become the treatment of first choice for depression if a patient with severe depression or psychotic symptoms is at increased risk of committing suicide and has not responded to other treatments. Although antidepressant medications are effective in many cases, they may take two to six weeks to begin to work. Some patients with mania and schizophrenia may not be able to tolerate the side effects of the antipsychotic medications used to treat these disorders. In addition, some patients may be unable to take their prescribed medications. For these individuals, ECT is an important option. ECT is also indicated when patients need a treatment that brings about rapid improvement because they are refusing to eat or drink, or presenting some other danger to themselves.”).

Id. (“ECT is also indicated when patients need a treatment that brings about rapid improvement because they are refusing to eat or drink, or presenting some other danger to themselves.”).


M. Fink, Electroshock, Restoring the Mind x-xi (Oxford U Press 1999) (“Because convulsive therapy is a technical discipline, it has spawned its own jargon: convulsive therapy, electroconvulsive therapy, ECT, electroshock, electroseizure therapy, and EST are accepted terms for the treatment.”).

In re Schuoler, 723 P.2d 1103 (Wash.1986)(criticizing "the nature of ECT.

Electroconvulsive therapy is a highly intrusive medical procedure. Adverse side effects of ECT
are documented in both the record and scholarly articles); American Psychiatric Ass'n, Task Force Report 14, Electroconvulsive Therapy 57 (Sept. 1978) ("Memory loss [both short and long term] has long been recognized to be a prominent effect of electroconvulsive therapy (ECT)"); ECT Today: Electroconvulsive Therapy, http://www.enotes.com/mental-disorders--encyclopedia/electroconvulsive-therapy (last visited Dec. 15, 2007) ("Overall, ECT is a very safe procedure. The complications encountered are no different from those that may occur with the administration of anesthesia without ECT. There is no convincing evidence of long-term harmful effects from ECT. Researchers are continuing to explore its potential in treating other disorders."). Contra Harold Sackeim, The Cognitive Effects of Electroconvulsive Therapy in Community Settings, 32:1 Neuropsychopharmacology, Jan. 2007, at 244-254 (concluding that ECT may cause long term memory loss (NIMH-funded research study). See http://www.ect.org/harold-sackeim-reverses-position-in-upcoming-study/ (last visited Nov. 25, 2007).

10 See, e.g., Ken Kesey, One Flew over the Cuckoo’s Nest (Penguin Books 1962).
11 H.J. Bernstein et al., Patient Attitudes About ECT After Treatment, 28:9 Psychiatric Annals 524 (Sept. 1998); page 524. In re Schuoler, 723 P.2d 1103, 1105-6 (Wash. 1986) (Drs. McCarthy and Hardy, both psychiatrists, testified that "ECT is a medically accepted form of treatment for patients who are mentally ill, particularly those suffering from depression. Both discussed the benefits and risks of ECT, and testified that ECT was the indicated treatment in a case such as Schuoler’s, where the patient had shown no improvement while on drug therapy and had in the past been able to function outside of a mental institution as the result of ETC. Dr. Hardy testified that without ECT Schuoler might regress into a vegetative state and be confined to the back wards of a state hospital for the rest of her life.").

13 Id.
14 Id.
15 Id.
16 Id.
17 The Elder Law Clinic was housed within Florida Coastal School of Law in Jacksonville, Florida. Case records are on file with author.
18 A disproportionate amount of the elderly suffer from depression and dementia. Should they be deprived of this helpful treatment due to their inability to pay for an expert witness to testify before a court, elderly will possibly suffer from being denied access to treatment rather than benefitting from said treatment. See, Caroline W. Jacobus, Legislative Responses to Discrimination in Women's Health Care: A Report Prepared for the Commission to Study Sex Discrimination in the Statutes, 16 Women's Rights L.Rep. 153, 279 (Spring 1995).
19 The affective disorders are psychiatric conditions in which a disturbance of affect, or mood, is either a primary determinate of the psychopathologic state or constitutes its core manifestation. Anxiety, depression, and elation are the three affects most commonly elaborated into clinical disorders, but by convention affective or mood disorder is usually limited to conditions characterized by morbid depression or elevation of mood. Merck Manual of Diagnosis and Therapy 1448 (Berkow, 14th ed. 1982 [one-volume edition]).
20 See M. Fink, Convulsive Therapy: Theory and Practice 215 (Raven Press 1979);
While ECT is not a broad-spectrum cure for all forms of mental and emotional disorders, it is a very effective treatment for the various forms of endogenous depression, especially for those patients whose depression will not respond to medication. Niall Gormley et al., *The Safety and Efficacy of Electroconvulsive Therapy in Patients over Age 75*, 13:12 *Int'l J. Geriatric Psychiatry* 871, 871-74 (Dec. 1998). For example, it has been reported that patients with delusional depression and patients for whom antidepressants will not work frequently experience a dramatic improvement in their symptoms following ECT. http://www.mhc.com/Algorithms/Depression/delusion.htm (last visited Feb. 2, 2008). It has also been reported that of the approximately 60 percent of depressed patients who do not improve on medication, 80 percent to 90 percent of them will respond favorably to as few as two ECT treatments. M. Lickey & B. Gordon, *Drugs for Mental Illness* 191 (Freeman & Co. 1983).

In re: Guardianship of H. T., Case No. 99-01831, Division CV-C (4th Jud Circ. in and for Duval Cy, Fla. (1999)).


In re: Guardianship of H. T., Case No. 99-01831, Division CV-C (4th Jud Circ. in and for Duval Cy, Fla. (1999)).


In re: Guardianship of H. T., Case No. 99-01831, Division CV-C (4th Jud Circ. in and for Duval Cy, Fla. (1999)).

Id.


Id.

In re Ingram, 689 P.2d 1363 (Wash. 1986).

Michigan and South Carolina appears to give proxies the right to consent without prior court approval. M.C.L.A. § 330.1717 and S.C. § 44-22-40 and 62-5-501, respectively. Ohio allows proxy to consent unless the principal refuses. If the principal refuses, the proxy is required to obtain a court order. R.C. §§ 5123.86. Washington expressly prohibits agent from consenting to ECT if the patient refuses, but appears to implicitly to permit an agent to admit the principal under voluntary admission procedures. §§ 11.92.043(5).

In re Guardianship of Browning, 568 So.2d 4 (Fla. 1990).

Id.


An example of an “unorthodox” treatment would be laetrile treatments that have not been approved by the FDA.

See the Table in Appendix A identifying state's statutes authorizing medical advance


Id. ("ECT today is a far more refined and limited therapy. Most important, perhaps, is the use of anesthesia and muscle relaxants before administering the shock, which causes a 30-second convulsion in the brain without the accompanying movements. Thus, there is no physical damage. The pretreatment also leaves no memory of the therapy itself. The amount of current used today is lower and the pulse of electricity much shorter — about two seconds — reducing the risk of post-treatment confusion and memory disruption. While memory losses still occur in some patients, now the most serious risk associated with ECT is that of anesthesia. Most patients require a series of six to eight treatments, delivered over several weeks. . . . it is not universally effective. About three-fourths of patients are relieved of their debilitating symptoms at least temporarily. The remaining one-quarter are not helped, and some may be harmed. Despite its long history, no one knows how ECT works to ease depression and mania. There is some evidence that it reorders the release of neurotransmitters, favoring an increase of substances like serotonin, which counters depression. Some experts view it as a pacemaker for the brain that disrupts negative circuitry. The beauty of ECT is the speed with which it works. Antidepressants can take as long as six weeks to relieve serious depression. Mrs. Dukakis reported that she had begun to feel better after the first in an initial series of five outpatient ECT treatments given over a two-week period.").


Jacobus, supra note 12, at 279 ("While the prevalence of some serious mental illnesses, such as schizophrenia, decreases with age, the prevalence of other mental illnesses increases. Depression and suicide risk remain significant problems among the elderly. Isolation, chronic disease, and life transitions contribute to depression . . . . Depression, the most common mental disorder among Americans, tends to be the most frequently missed diagnosis among the elderly . . . If treatment is sought, lack of awareness or education on the part of medical professionals can result in their accepting the depressed state of a chronically ill or disabled elder
as a normal reaction to diminished capacities rather than a true mental disorder. . . .The prevalence of severe dementia among the elderly is approximately 4.1 percent. Over the next twenty years, organic mental illness resulting in dementia and other outcomes will become an increasing concern to health care providers. . . .There is a concern that elderly persons with organic syndromes are inappropriately referred to mental health treatment settings for management of difficult behavior, because nursing home staff are not equipped to deal with the aggressive and combative behavior of such individuals. Such organic mental disorders do not usually respond to psychiatric care).

47 R. Abrams, ECT and Psychotic Depression, 155:2 Am J. Psychiatry 306, 306-7 (Feb. 1998) (Abrams questions why patients willing to accept ECT are given drug therapy at all when ECT has proven more effective); and L. W. Lazarus, Essentials of Geriatric Psychiatry, 185-88 (Springer 1988)(includes many good references on page 186).

48 See JoAnnie Schrof Fischer, Taking the Shock out of Electroshock, U.S. News & World Report, Jan.24, 2000, at 46; Realmentalhealth.com, Electroconvulsive Therapy (ECT), http://www.realmentalhealth.com/depression/ect.asp (last visited Dec. 16, 2007)("During the last decade, the 'typical' ECT patient has changed from low-income males under 40, to middle-income women over 65. This coincides with changing demographics. The increase in the elderly population and Medicare, and the push by insurance companies to provide fast, 'medical' treatment rather than talk therapy. Unfortunately, concerns have been raised concerning inappropriate and even dangerous treatment of elderly patients with heart conditions, and the administration of ECT without proper patient consent.").


50 Id.


53 Id.

54 Id.

55 Id.


57 WebMD.com, Electroconvulsive Therapy (ECT) to Treat Depression, www.webmd.com/ depression/guide/electroconvulsive-therapy (last visited Dec. 17, 2007)("ECT is one of the fastest ways to relieve symptoms in severely depressed or suicidal patients, or patients who suffer from mania or other mental illnesses. ECT is generally used when severe depression is unresponsive to other forms of therapy, or when these patients pose a severe threat to themselves or others, and it is dangerous to wait until medications take effect. . . .ECT remains misunderstood by the general public. . . . Many of the risks and side effects have been related to the misuse of equipment, incorrect administration, and improperly trained staff. . .
In fact, ECT is safe and among the most effective treatments available for depression. Short-term memory loss is the major side effect of ECT, although this usually goes away within one to two weeks after treatment.

—58 HealthierYou.com, Electroconvulsive Therapy: Consensus Development Conference Statement, www.healthier-you.com/ectcon.html (last visited Dec. 17, 2007) ("In the past, up to 40 percent of patients suffered from various complications, the most common being vertebral compression fractures. With present techniques, these risks have been virtually eliminated. In one recent study of almost 25,000 treatments, a complication rate of 1 per 1,300 to 1,400 treatments was found. These included laryngospasm, circulatory insufficiency, tooth damage, vertebral compression fractures, status epilepticus, peripheral nerve palsy, skin burns, and prolonged apnea. . . There are other possible adverse effects from ETC. Some patients perceive ECT as a terrifying experience; some regard it as an abusive invasion of personal autonomy; some experience a sense of shame because of the social stigma they associate with ECT; and some report extreme distress from persistent memory deficits. The panel heard eloquent testimony of these attitudes from former patients who had been treated with ETC. It is clear, however, that these attitudes are not shared by all ECT patients. The panel also heard moving testimony from former patients who regarded ECT as a wholly beneficial and lifesaving experience. There are insufficient systematic studies to permit any definitive assessment of the prevalence of these various perceptions among ECT patients. Numerous ECT studies have been conducted with animal models. Many of these suffer from methodological shortcomings.

—59 Univ.of Medicine & Dentistry of N.J., Side Effects and Risks, www.theuniversityhospital.com/ect/effects.htm (last visited November 10, 2007) ("Occasionally, a patient may have a headache, muscle aches, or nausea after the treatment. . . Additionally, some people may exhibit mental confusion resulting from the combination of anesthesia and/or ECT treatment. Acute confusion, if it occurs, typically lasts for 30 minutes to 1 hour. . . Memory loss is one of the greatest concerns of people who receive ETC. . . The second type of memory loss that may occur involves memory loss for past events. Recent past events (2 to 6 weeks before treatment) are more sensitive to ETC. However, some patients may describe "spotty" memory loss for events that occurred as far back as 6 months before beginning ETC. This memory impairment is potentially permanent. Although it is rare, some patients have reported a more severe memory loss of events which date back further than the 6 months preceding ECT treatments.")

Research suggests ECT may be particularly beneficial for patients who need immediate stabilization of their condition and who cannot wait for medications to work, most patients with mania -- especially elderly patients with severe mania, patients who suffer suicidal thoughts and guilt during the depressive phase, pregnant patients, patients who cannot tolerate drug treatments, patients with certain types of heart problems, and young patients. In a review of studies, about 80% of ECT-treated patients experienced improvement, and for some, it is the only treatment that works.

Renato M.E. Sabbatini, PhD, The History of Shock Therapy in Psychiatry, http://www.cerebromente.org.br/n04/historia/shock_i.htm (last visited November 25, 2007) ("As it happened with psychosurgery, electroconvulsive therapy was a highly troublesome therapy. First, there were many examples of ECT being used to subdue and to control patients in psychiatric hospitals. Troublesome patients received several shocks a day, many times without proper restraint or sedation. Medical Historian David J. Rothman affirmed in an NIH Consensus Conference on ECT in 1985: 'ECT stands practically alone among the medical/surgical interventions in that misuse was not the goal of curing but of controlling the patients for the benefits of the hospital staff.' However, in the 70's, strong movements against institutionalized psychiatry began in Europe and particularly in the USA. Together with psychosurgery, ECT was denounced by libertarians, and the most famous libel was a 1962 novel written by Ken Casey, based on his experiences in an Oregon mental hospital. Titled "One Flew Over the Cuckoo's Nest", . . . Bad press turned into a series of legal actions involving the abuses of shock therapy. By the mid-1970s ECT had fallen into disrepute. Psychiatrists increasingly made use of powerful new drugs, such as thorazine and other antidepressives and antipsychotics.")

HealthierYou.com, Electroconvulsive Therapy: Consensus Development Conference Statement, www.healthieryou.com/ectcon.html (last visited Dec. 17, 2007) ("In the early days of ECT, mortality was a significant problem. The commonly quoted overall mortality rate in the first few decades was 0.1 percent or 1 per 1,000. Over the years, safer methods of administration have been developed, including the use of short-acting anesthetics, muscle relaxants, and adequate oxygenation. Present mortality is very low. In the least favorable recent series reported, there were 2.9 deaths per 10,000 patients, another series, 4.5 deaths per 100,000 treatments were reported. Overall, the risk is not different from that associated with the use of short-acting barbiturate anesthetics. The risk of death from anesthesia, although very small, is present and should be considered when evaluating the setting for performing ECT.")


M. Fink, Electroshock: Restoring the Mind (Oxford Univ. Press 1999) (referencing M. Fink, Electroconvulsive Therapy: Theory and Practice, page 215 (1979)); RealMentalHealth.com, Electroconvulsive Therapy (ECT), http://www.realmentalhealth.com/depression/ect.asp (last visited Dec. 17, 2007) ("Today, ECT is administered to an estimated 100,000 people a year, primarily in general hospital psychiatric units and in psychiatric hospitals. It is generally used in treating patients with severe depression, acute mania, and certain schizophrenic syndromes. ECT is also used with some suicidal patients, who cannot wait for antidepressant medication to take effect.")

Behavioral symptoms are those which typically accompany the more severe mood
disorders, including stupor, catatonia, suicidal thoughts and activity, refusal of food, delusions, feelings of worthlessness and guilt, uncontrollable excitement or agitation, and resulting exhaustion. RealMentalHealth.com, Electroconvulsive Therapy (ECT), http://www.realmentalhealth.com/depression/ect.asp (last visited Dec. 17, 2007).


__69__ *Id.* These include anxiety, initial insomnia, worsening of symptoms in the evening, tearfulness, self-pity, hypochondriasis (a morbid, obsessive preoccupation with bodily function and organs, and with imagined disease), hysteria, paranoia, and a fluctuating course of generally mild symptoms. *Id.* Other factors that may affect whether ECT will be affective include age. Generally, patients under 35 do not respond as well to ECT as those who are older; ECT has been applied safely and successfully to patients as old as 87 without complications. *Id.*

__70__ Conservatorship of Fadley, 205 Cal.Rptr. 572 (Cal. Dist. Ct. App. 4 Dist. 1984) ("The court's duty is 'to determine the patient's capacity to give written informed consent' to the therapy."); Matter of Rosa M., 597 N.Y.S.2d 544 (N.Y.Sup. Ct. 1991) (Patient was still required to provide informed consent for ECT despite of her subsequent incapacity).

__71__ In re Quinlan, 355 A.2d 647, 664 (N.J. 1976); In re Guardianship of Browning, 568 So.2d 4 (Fla. 1990) (holding that since Mrs. Browning was unable to exercise her constitutional right of privacy by reason of her medical condition, her guardian was authorized to exercise it for her. "As in Bludworth, we do not limit the ability to exercise this right only to a legally appointed guardian, but recognize that it may be exercised by proxies or surrogates such as close family members or friends."); Grimes v. Kennedy Krieger Inst., Inc., 782 A.2d 807, 856 (Md., 2001) (finding generally that courts "tread cautiously when third parties are relied on to make decisions for an incapable patient. When the proposed medical course does not involve an emergency and is not for the purpose of bettering the patient's condition, or ending suffering, it may be doubtful if a surrogate decision maker—a guardian, a committee, a health-care proxy holder, a relative, or even a parent could properly give consent to permitting a ward to be used in experimental research with no prospect of direct therapeutic benefit to the patient himself.").


__76__ Fink, supra note 14, at 222.

__77__ Abrams, *supra* note 21, at 47-48; Fink, supra note 14, at 226.

__78__ *Id.*; HealthierYou.com, Electroconvulsive Therapy: Consensus Development
The total number of treatments a patient will receive depends upon many factors such as age, diagnosis, the history of illness, family support, and response to therapy. Patients with depression, for example, usually require six to 12 treatments. Treatments are usually administered every other day, three times a week.

A few patients are placed on maintenance ECT. This means they return to the hospital every one to two months, as needed, for an additional treatment. These individuals are thus able to keep their illness under control and lead a normal and productive life.

The anesthetic may be Brevital and the muscle relaxant may be succinylcholine.

Statistics on the effectiveness of ECT are sparse. In an article found in the Medical News Today dated December 22, 2006, named "Electroconvulsive Therapy Causes Permanent Amnesia And Cognitive Deficits, Prominent Researcher Admits," the article represented that Harold Sackeim, a ECT researcher, asserted for almost twenty five years that permanent amnesia from ECT was so rare that it could not be studied. The National Institute of Mental Health estimates that more than 3,000,000 people have received ECT over the past generation. In a recent study, Sackeim now asserts that ECT may cause long term memory loss. http://www.ect.org/electroconvulsive-therapy-causes-permanent-amnesia-and-cognitive-deficits-prominent-researcher-admits/ (last visited Feb. 2, 2008).

Note, however, a recent study concludes that ECT may cause long term memory loss. Sackeim, supra note 8.

ECT has a high rate of therapeutic success, relative speed in ameliorating depressive symptoms, and an excellent safety profile. It should be considered as an initial treatment for severe major depression accompanied by psychotic features, catatonic stupor, severe suicidality, food refusal leading to nutritional compromise, as
well as in other situations where rapid antidepressant response is required. ECT is also indicated as a first-line treatment for patients who have previously shown a preferential response to this treatment modality or who prefer it. It should be considered for all depressed patients with functional impairment whose illness has not responded to medication or who have a medical condition that precludes the use of antidepressant medications. ECT has been in continuous use for almost 60 years and its safety and efficacy have been documented by the National Institutes of Health, the American Psychiatric Association, the U.S. Agency for Health Care Policy and Research (AHCPR), the British Royal College of Psychiatrists. Hermann and colleagues determined that the rates of ECT use are highly variable, greater than for most medical and surgical procedures."

See also Dennis Cauchon, Doctor's Financial Stake in Shock Therapy, USA Today, Dec. 6, 1995, at LIFE:6D (The American Psychiatric Association estimates that the risk of death from ECT is rare, about 1 per 10,000 patients with few medical problems. Critics of the ECT procedure believe that the death rate is much higher, perhaps as much as 1 per 200 patients, but admit that such statistics are unsupported with accurate empirical evidence.).

—95 WebMD.com, Electroconvulsive therapy (ECT) to Treat Depression, http://www.webmd. com/depression/-guide/electroconvulsive-therapy (last visited Dec. 19, 2007) ("ECT remains misunderstood by the general public. Many of the risks and side effects have been related to the misuse of equipment, incorrect administration, and improperly trained staff. In fact, ECT is safe and among the most effective treatments available for depression. Short-term memory loss is the major side effect of ECT, although this usually goes away within one to two weeks after treatment.").

—96 RealMentalHealth.com, Electroconvulsive Therapy (ECT), http://www.realmentalhealth. com/depression/ect.asp (last visited Dec. 19, 2007) ("After 60 years of use, ECT is still the most controversial psychiatric treatment. Much of the controversy surrounding ECT revolves around its effectiveness vs. the side effects, the objectivity of ECT experts, and the recent increase in ECT as a quick and easy solution, instead of long-term psychotherapy or hospitalization.").

—97 Note, that although use of a muscle relaxant drug may reduce the risk of fractures, it also increases the danger of respiratory failure or cardiac arrest. Pettis v State, 336 So. 2d 521 (La. Ct. App 1976).

