J Forensic Sci, Oct. 1977, Vol. 22, No. 4

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The Electroconvulsive Therapy Fight in California

In the summer of 1974, California psychiatrists were enjoying the wisdom of living there at that time of year and taking their vacations up in the mountains, secure in their belief that their collective interests were not under immediate threat, but if they were, *somebody* would be protecting them. Thus ended an age of innocence.

A northern California Assemblyman, John Vasconcellos, was quietly moving AB4481, which deals with electroconvulsive therapy (ECT), through the legislature. Apparently he waived the initial reading, and the bulk of his information came from the Network Against Psychiatric Assault (NAPA), a loose amalgam of former psychiatric patients, dissident professionals, and others who believed sincerely bad things were being done in the name of Psychiatry. A newspaper interview [*1*] with one of the members of NAPA provides some interesting data:

> In her telephone conversation with the [Santa Monica] *Evening Outlook*, Miss Dolan said she was a junior at the University of Massachusetts attending the University of California on a special study project this year. She said that in addition to being a member of NAPA, she was affiliated with the "Mental Patient Law Project" which she described as an organization of "attorneys, law students and legal workers." She said, "It is very new," and is attempting to raise private funds for more work in the field of mental patient civil rights. Miss Dolan said she herself wrote the bill that Vasconcellos introduced. ... Asked how Vasconcellos got involved with her proposed law, she said, "We shopped around until we found a legislator who would back it."

In his defense, Vasconcellos states [*2*]:

> Contrary to many accusations, AB4481 was given full hearing in both the Assembly and the Senate last year, at which representatives of the State Department of Health, Local Mental Health Directors, American Psychiatric Association and California Hospital Association participated resulting in the bill being amended several times. It was three months going through the legislature, passed both houses with only one dissenting vote and was signed by the Governor. ... I have given deep and serious thought to this issue. I have listened to whomever cared to speak, and sought differing viewpoints—and I really resent the charges that the bill was done carelessly, or secretly or as an assault on the medical profession.

In response, Miss Dolan claims authorship; the Court of Appeal, Fourth Appellate District, Division One, State of California, has opinions as to how well it was prepared; its secrecy may be as much our (psychiatrists) fault as anyone's; and the medical profession most certainly interprets it as an assault on its integrity.

Our trouble began partly as a result of the organization of psychiatry in California at that time—the Association of California Branches (ACB). None of the four California District Branches wished to lose their autonomy, so a unanimous position had to be available

Presented at the 29th Annual Meeting of the American Academy of Forensic Sciences, San Diego, Calif., 16 Feb. 1977. Received for publication 1 March 1977; accepted for publication 16 March 1977.

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on an issue before opposition could be mounted. The chairperson of our Governmental Affairs Committee was thus hamstrung in his attempt at opposition. This has been remedied by the formation of the California Psychiatric Association, which corresponeds to Area VI of the American Psychiatric Association. Now majority "weighted" voting determines policy, and the system allows much more rapid response. When the California Medical Association (CMA) saw the timidity of the ACB, they backed off from active opposition since, at that time, ACB had rather minimal input to the CMA. When we discovered what was happening, our last-minute campaign of opposition was ineffective.

What was our concern about? Our attention was drawn toward the rules applying to voluntary and competent patients who might, for example, be private patients working with the private physician of their choice, though our concern for the public patient was no less [*3*, § 5326.4]:

> The treatment physician gives adequate documentation entered in the patient's treatment record of the reasons for the procedure, that all other appropriate treatment modalities have been exhausted and this mode of treatment is critically needed for the welfare of the patient. ... A responsible relative or the guardian or conservator of the person [is] given the oral explanation by the treatment physician as required by this section. ... A review by a committee of three physicians, one appointed by the facility and two appointed by the local mental director [*sic*], two of whom shall be either board certified psychiatrists or board certified neurosurgeons of the case and the patient's treatment record [meaning?] who unanimously agree with the treatment physician's determinations ... and the patient has capacity to give informed consent.

Strangely, a patient could be given ECT under this law even against his wish if he did not have capacity to give informed consent. When that happened, the following provision [*3*, § 5326] held:

> Information pertaining to a denial of rights contained in the person's treatment record shall be made available, on request, to the person, his attorney, his conservator or guardian, or the State Department of Health, Members of the State Legislature, or a member of a county board of supervisors.

To add insult to injury (and Vasconcellos denies this was meant as an assault on the medical profession), at the end [*3*, § 5326.5] comes this: "Any physician who violates Section 5326.3 or 5326.4 shall be subject to a civil penalty of not more than $10,000 for each violation or revocation of license, or both."

The impact of this law was greater than a casual reading of these abstracts would suggest.

1. "All other appropriate treatment modalities have been exhausted" would include a three-week trial of antidepressant medication in a hospitalized and painfully suffering severely depressed patient.
2. "Critically needed" could be open to differing interpretations and carries on the myth that ECT is a dangerous or drastic treatment. In fact, it may be safer than tricyclics in older depressed people or those with compromised cardiovascular function.
3. Telling a "responsible relative" could be contrary to the desire of confidentiality of the patient.
4. Consultation by a committee of three psychiatrists or neurosurgeons is time-consuming, expensive, and an intrusion in the doctor-patient relationship. And neurosurgeons? The author who resents being accused of careless bill writing appears not to know the diffference between psychosurgery and ECT.
5. What business is it of the "local mental director" when the treatments are to be given in a private setting? He is in charge of the county's mental health program but has no jurisdiction over the activities of local practitioners. And if he appoints two consultants from his program, does the patient have a say whether two public employees have the right of veto over privately arranged care? Yes, according to John Vasconcellos.
6. In a strange exception, the bill fails to provide any judicial review for the incompetent patient.

7. Many people, public and private, "on request," could review the medical record when a "denial of rights" occurs. This list of rights is not only about ECT. For example, a patient's first rights [*3*, § 5325] are "to wear his own clothes; to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases." Laudable, but it is often not possible to allow all this for a severely disturbed or suicidal patient; if "the professional person in charge of the facility" denies the right, this group has the right to see the medical record, irrespective of the desire of the patient!

The clinical response varied. Some psychiatrists refused to give ECT, which raises questions about their previously expressed belief as to how important it was, but generally we learned to live with the rules at considerable cost and prolongation of suffering for our patients. In our hospital, we had two occasions when a patient begged a hesitating consultant to approve ECT.

Our only recourse was to the courts, and to the courts we went [*4*]. One of the plaintiffs was a patient, Jane Doe, who had previously required ECT and might again and who, as a county employee, did not want her medical record available to her employer. The plaintiff physicians were psychiatrists Aden and Campbell, and they were joined later by neurosurgeon Brown and a potential psychosurgery patient, Betty Roe. Ultimately, amicus curiae arrived, including the California Psychiatric Association, the American Psychiatric Association, and the California Committee of the National Association of Private Psychiatric Hospitals.

An immediate injuction was obtained in Superior Court on 30 Dec. 1974, two days before the law was to take effect, prohibiting the State from enforcing any provisions of AB4481. Unfortunately, our legal counsels were unanimous in telling us to obey the law despite the injunction for fear of possible jeopardy if the injunction were overturned.

A writ of mandate was quickly obtained from the California Supreme Court, and the case was heard by the Fourth Appellate District Court of Appeal in June 1975. Then we waited and we waited, wondering if the Court of Appeal had forgotten us. They finally issued their opinion on 23 April 1976.

Victory! For the moment at least. The Court found the act to be unconstitutional for the following reasons [*4*,*5*]:[2]

1. Failure to provide for adequate notice of hearing on the issues of competency and voluntariness is a denial of due process.
2. "Critically needed for the welfare of the patient" as a criterion for treatment is unconstitutionally vague.
3. The requirement of informing a "responsible relative" is an unconstitutional invasion of the patient's right to privacy.
4. Government officials cannot have access to medical records nor the identity of a patient but only to information about a right denied.
5. For a voluntary and competent patient, it is an invasion of the patient's right of privacy in selecting and consenting to ECT to compel such a patient to appear before a review panel, though the court agreed a review of competency and consent was acceptable. "The state has varied interests which are served by the regulation of ECT, but these interests are not served where the patient and his physician are the best judges of the patient's health, safety and welfare" [*4*].

Though Vasconcellos resents charges of careless bill writing, the bill lacked a severance clause so the entire patient's rights section of the Welfare and Institution Code was declared unconstitutional. Thus, we were without law in this area until the arrival of AB1032, although the State had, in the meantime, gotten the Court of Appeal to reinstate the other

[2]R. Thorn and A. J. Stone, unpublished documents, 1976.

patient's rights provisions [*4*]. An important issue was resolved when the Court successfully distinguished between psychosurgery and ECT [*4*], which AB4481 had failed to do adequately.

Anticipating what was coming, Vasconcellos introduced AB1032 in March 1975. Much negotiating now occurred. Arguments were heard; pychiatrists appeared to be united. By this time other legislators had become interested after initially wondering what all our frantic letters were about. We thought we had a good chance to block AB1032, drawn up to meet the constitutional challenges. But again it sailed through the Assembly without serious challenge. The Senate was another matter. Because of potential costs to public programs, it got side-tracked to the Senate Finance Committee where, by a vote of 6 to 5, it was blocked. Another victory? No! A few days later the same committee granted the bill reconsideration, but not until 1976.

Again, negotiations, offers of compromise, amendments (twelve in all), and our hopes were stimulated when we heard rumors that Vasconcellos, knowing he could not get the two-thirds vote in the Senate necessary to pass the bill as emergency legislation (going into effect immediately), might give up the battle. We were wrong again—it passed the Senate in August 1976, with one vote to spare for a majority even though a surprising number of Senators decided it would be better to sit it out and were absent.

While all this was going on we again, as organized psychiatry, behaved strangely. Perhaps Will Rogers' statement, "I don't beling to an organized political party, I'm a Democrat!" applies equally to us. A committee of the CPA busily prepared a series of "guidelines" entitled, "Proposal for Regulation, Prescription, Administration and Evaluation of Convulsive Therapy." And, in draft form and without approval of the Council of the CPA, the guidelines were sent to the Director of the State Department of Health and to Vasconcellos! Leave it to us to do a good job since these "guidelines" in many ways were more constricting than AB4481 and AB1032.

The *Psychiatric News* headlined, "California Area Branches Draft ECT Guidelines" [*6*] and in the article a voice cried out, "How could you Californians do this to us?" By now, the California ECT fight had taken on national implications because of the likelihood of other legislatures passing similar laws.

After a spirited discussion, Area VI Council (CPA) passed the following position statement:

> ECT has long been an accepted and well-documented, effective part of the medical armamentarium for the treatment and service of severe emotional disorder. It is recognized that as with any medical procedure there must be careful consideration of the risk-benefit factor to the patient. To this end peer review systems must have been developed throughout the state at the local level. It is imperative that the physicians be required to submit their work to active peer review and to comparison of standards established by medical audit. It is self-evident that physicians must not proceed in a way that is contradictory to law and that they must be especially concerned with the civil rights of patients, carefully explaining treatment procedures, risks and alternative treatments.
>
> It is unconstitutional to pass legislation or to enact state regulations that will interfere with competent patients giving voluntary informed consent to ECT by licensed qualified physician specialists acting in accordance with accepted standards of medical practice and diagnosis in the use of ECT.

Still, AB1032 passed and took effect 1 Jan. 1977. The following outline points out some of the major provisions of the bill.

1. A very detailed process of informed consent is required, spelling out verbally and in writing, risks, how ECT is given, alternatives, differences of opinion, and side effects. The patient must wait 24 h before then giving consent.
2. Consent can only be for a 30-day maximum and can be revoked at any time.
3. A consultant must evaluate the patient's capacity to give informed consent and verify that he did.

4. For involuntary patients, or patients unable to give informed consent, two consultants are required to pass on the attending physician's judgment that ECT is definitely indicated and is the least drastic alternative available at the time. One of these consultants must be appointed by the local mental health director.

5. Involving a relative is the patient's decision, but a conservator or guardian must be informed. For the involuntary patient, a lawyer must agree that the patient has the capacity for giving informed consent. If not, or if the doctors think not, a court hearing must be held to decide competency.

6. No ECT is permitted for any patient under the age of 12. Patients aged 16 and 17 are to be treated like adults. For patients between the ages of 12 and 15, approval must be given by parent or guardian and three child psychiatrists appointed by the local mental health director, and the state director of health must be notified.

7. Major record-keeping is required. Data including incidences of "reported" memory loss of 15 min or more preceding the treatment are to be reported to the state quarterly.

8. A medical staff committee must review all cases.

9. Penalties of $5000 per violation or revocation of medical license, or both, are provided. A suspected or alleged violation must be reported to the state director of health.

Bill AB1032 is an attempt to get around the Court of Appeal ruling. It requires a very complicated, time-consuming, and expensive procedure. How well it will work remains to be seen. At the time of this writing, another lawsuit against the state is being considered. The issues are not as clear this time, although a number are present. For example, can a patient be required to have a lawyer and can a lawyer make judgment of competency? The state Department of Health developed a consulting form in the case of voluntary patients that requires the consultant to say "that convulsive treatment is the treatment of choice for the welfare of this patient and that the patient is capable of giving informed consent and has consented to the treatment." Clearly, the first part of the statement is in direct violation of the Court decision.

A last word about Assemblyman John Vasconcellos. While I have not spoken too highly of his bill writing and am in basic disagreement on these issues, it must be pointed out he is considered a bright and capable legislator who is deeply concerned about civil rights.

Obviously, the ECT fight in California is not over. What have we learned from the struggle so far?

1. California psychiatrists are not very well organized for such a struggle. Three thousand of us do not speak with one voice. Our response time is too long.

2. It is very difficult to keep up with what is happening at the state capitol as bills move about, change form, gather unexpected adherents. Considerable cost is required to keep up, and the individual members of professional associations will have to be convinced it is in their best interests to do so.

3. Our critics, while relatively small in number, exert an unusual influence on certain legislators who apparently distrust "experts" as having a selfish interest and being motivated only to maintain the status quo (which means to rip off the public, imprison dissenters, and assault people we label "mentally ill").

4. We have done a lousy job of telling our side of the story.

5. The patient's rights movement, a part of the "consumerism" of our times, has greater appeal than we realized. Psychiatrists must respond to it, not as adversaries, but by demonstrating that we, too, are advocates for the rights of our patients.

6. Those in the patient's rights movements betray an arrogance that may trample civil rights when they presume to decide themselves what rights of others shall be protected and to determine the cost of the loss of other rights.

7. A dedicated legislator is tough to beat. He keeps coming back and in time we get weary and reluctant to pay the heavy cost of continuing the struggle.

8. When we are right, and others ignore us, the courts are our best protector.

9. The issues are bigger than ECT. If the state can regulate this form of medical treatment, where will it stop—psychopharmacology, psychotherapy, general medicine? The principle as stated by the court [6] must be defended: "... but those interests are not served where the patient and his physician are the best judges of the patient's health, safety and welfare."

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[3] Cal. Welfare and Institutions Code (West 1972).

[4] *Aden v. Younger,* 57 Cal App. 3d 662, Mod. 58 Cal. App. 3d 990(a), Mod. 59 Cal. App. 3d 174(d) (1976).

[5] "ECT Law Declared Unconstitutional," *Psychiatic News,* 18 June 1976, pp. 1,4,5.

[6] "California Area Branches Draft ECT Guidelines," *Psychiatric News,* 6 Feb. 1976, p. 1.

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