

Legislative History for Connecticut Act

<u>SB66</u>	<u>PA 219</u>	<u>1978</u>
<u>Senate</u> : P. 1573-1579, 1873-1875, 1936		
<u>House</u> : P. 3673-3676 (4p)		
<u>House Institutions</u> : P. 42-43, 50-57, 60-61		
P. 70-77, 79, 81-95, (11p)		
P. 111-112 (38p)		

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CONNECTICUT
GEN. ASSEMBLY
SENATE

PROCEEDINGS
1978

VOL. 21
PART 4
1263-1671

Tuesday, April 18, 1978

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Total Voting	33
Necessary for Passage . . .	17
Voting Yea	21
Voting Nay	12

THE MOTION TO RECOMMIT HAS BEEN PASSED.

THE CLERK:

Cal. 347. File 226. Favorable report of the joint standing Committee on Humane Institutions. Substitute for Senate Bill 66. AN ACT CONCERNING RIGHTS OF PATIENTS OF MENTAL HEALTH FACILITIES.

THE PRESIDENT:

Senator Mary Martin.

SENATOR MARTIN: (18th)

Mr. President, the Clerk has an amendment and I would waive its reading of the amendment in order to explain it to the circle.

Because this bill has been changed so many times since the file copy, the amendment is quite lengthy. If you will bear with me, I will try to explain to you the amended bill. It has been amended because of the many objections to the bill which we have worked on for two years now. And now everyone is in agreement with the bill. It has been endorsed by the Connecticut Hospital Association.

THE PRESIDENT:

Senator, did you move acceptance and passage?

SENATOR MARTIN:

All right. I move acceptance of the committee's

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favorable report and passage of the bill.

THE PRESIDENT:

Go ahead, Senator, you may remark on it, if you care to.

SENATOR MARTIN:

As I was saying, it has been endorsed by the Connecticut Hospital Association, the Connecticut Psychiatric Society, the Mental Health Association of Connecticut, the Connecticut Legal Services, the Connecticut Department of Mental Health. You all have copies on your desks of the amendment and also the fact sheet and the new file, ah, corrected file copy and if you would go along with me, it would be much easier to explain. It states that S.A.M.A voluntary patients may receive medication or treatment but shall not be forced to accept unwanted medication or treatment except in accordance with procedures set forth in Subsection C of this section. This gives voluntary patients in mental hospitals the right to refuse unwanted treatment. This subsection gives those persons who enter the hospital voluntarily rights similar to those enjoyed by persons in regular mental hospitals and encourages voluntary admissions and treatment; treatment which the patient understands and accepts is more beneficial than forced treatment and more consistent with respect to the patient's privacy and dignity. However, if an emergency arises, subsection C provides that the doctors may take

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emergency measures without the patient's consent. This provision permits necessary emergency treatment without undue delay. If the condition of the voluntary patient deteriorates, and such patient becomes incapable of informed consent, but emergency conditions do not exist, the hospital can petition for involuntary commitment. This procedure takes about ten days. The patient gets full due process, legal protection, prior to commitment pursuant to Public Act 77-595, including legal representation and examination by court appointed physicians not affiliated with the hospital. Involuntary patients may receive treatment without consent. This is existing law and is not being changed. Section (c) states if the head of the hospital in consultation with a physician determines that the condition of a patient either voluntary or involuntary is of an extremely critical nature, then emergency measures may be taken without the consent, otherwise provided for in this section. Section (d), no psycho surgery or shock therapy shall be administered to any patient without such patient's written informed consent, except as provided in this subsection. Such consent shall be for a maximum period of thirty days and may be revoked at any time, if it is determined by the head of the hospital and two qualified physicians that the patient has become incapable of giving informed consent, shock therapy may be administered upon order of the court of probate if, after hearing, such court finds that the patient is incapable of informed consent

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and there is no other reasonable alternative procedure. Section (d) provides that no psychosurgery may be administered without written informed consent. Psychosurgery is a hazardous and experimental procedure. It should never be performed in the absence of informed consent. This subsection also provides that shock treatment shall not be performed without the patient's written informed consent. If the patient is considered incapable of informed consent, shock treatment may be performed only after a hearing in probate court at which it is determined that the patient is legally incapable of informed consent and there is no reasonable alternative. Since shock treatment is an intrusive and a potentially hazardous procedure, appropriate safeguards should surround its use where the patient is incapable of informed consent. The present law provides that where the patient is incapable of consent, next of kin, guardian or physician appointed by the probate court may consent. Few patients have legal guardians and the probate court is rarely, if ever, applied to for consent. Consent by next of kin, the usual procedure is not of sufficient safeguard. The most patients who receive shock treatments are women, and next of kin is often the husband. The husband does not always have the wife's best interest as his primary concern. For instance, there have been several cases in which husbands signed the consent for shock treatment and during the treatments filed for divorce and custody of the children. Consent by a probate judge, after considering all

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the medical evidence and the patient's situation, is a far more appropriate safeguard. In section 2(a), no patient may be placed involuntarily in seclusion or a mechanical restraint unless necessary because there is imminent physical danger to the patient or others and a physician so orders. A written memorandum of such order and the reasons therefor shall be placed in the patient's permanent clinical record within twenty-four hours. Section 2 provides that restraints and seclusion shall be used only when necessary to prevent imminent physical danger to the patient or others. Unless a patient requests restraints or seclusion as an alternative to medication, restraints or straitjacketing is a frightening and humiliating procedure. Seclusion is commonly used as a punishment in prisons. These procedures should never be used unless necessary. In line 108, strike out the words "as deemed appropriate by the". In line 109, strike out the words "superintendent of such mental health facility". In line 116, after the period insert the following: These rights shall be denied only if the superintendent, director, or his authorized representative determines that it is medically harmful to the patient to exercise such rights. An explanation of such denial shall be placed in the patient's permanent clinical record." In line 117, strike out the words "any patient or his or her attorney shall". Strike out line 118 in its entirety. In line 119, strike out the words Hospital Records, and to make copies thereof,". In line 121, after

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the word hospitalization, strike out the period and insert the following: Any patient or his or her attorney shall have the right to inspect all of such patient's hospital records, and to make copies thereof." Strike out lines 167, 168 and 169 and 170 in their entirety and insert the following in lieu thereof: Those operations defined as lobotomy, psychiatric surgery, behavioral surgery and all other forms of brain surgery, if the surgery is performed for the purpose of modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain". In line 181, after July 1, bracket 1978 and insert 1979 which is when the bill will take effect, if passed. Mr. President, I move the adoption of the amendment.

THE PRESIDENT:

The question is on the adoption of Senate Amendment Schedule A. If there are no further comments, all in favor please say Aye. Senator Houley.

SENATOR HOULEY: (35th)

Mr. President, point of inquiry. Does the President rule this as a technical amendment or an amendment of substance, sir?

THE PRESIDENT:

I would say that the amendment is one of substance. That is my ruling. The question is on the adoption of Senate

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Amendment Schedule A. All in favor please say Aye. Opposed
Nay. The Ayes have it. THE AMENDMENT IS ADOPTED and I
believe that inasmuch as it is an amendment of substance,
and has been so ruled, it will have to go downstairs, Senator
Martin. roc

SENATOR MARTIN:

ALL RIGHT, Mr. President. Thank you.

THE PRESIDENT:

You are very welcome.

THE CLERK:

Continuing with the Calendar, we are going to turn
back to page five of the Calendar, Cal. 65, File 14. Favorable
report of the joint standing Committee on Banks. Substitute
for Senate Bill 53. AN ACT CONCERNING SECOND MORTGAGE LENDERS.

THE PRESIDENT:

Senator Dinielli.

SENATOR DINIELLI: (31st)

Mr. President, I move for acceptance of the joint
committee's favorable report and passage of the bill.

THE PRESIDENT:

Will you remark on it, Senator?

SENATOR DINIELLI:

Yes, the Clerk has an amendment.

THE CLERK:

The Clerk has Senate Amendment Schedule A, Sub-
stitute Senate Bill 53. LCO 3337, offered by Senator Dinielli.

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GEN. ASSEMBLY
SENATE

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1978

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PART 5
1672-2081

Thursday, April 20, 1978

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THE PRESIDENT:

It will be passed temporarily.

THE CLERK:

Cal. 716, File 619. Favorable report of the joint standing Committee on Finance. Senate Bill 633.
AN ACT CONCERNING THE SALES TAX EXEMPTION FOR NEWSPAPERS.

THE PRESIDENT:

Senator Beck.

SENATOR BECK: (29th)

Mr. President, this permits those newspapers which are not presently exempt from the sales tax at the point of purchase to be exempt as are daily newspapers. Daily newspapers now do not pay a sales tax on the assumption that they are taxed at the end point which they are not, so that one set of newspapers has a tax and the other does not. This will even the tax levy and it has the unanimous support of the Finance Committee. I would move that this be placed on Consent.

THE PRESIDENT:

Hearing no objection, it will be placed on Consent.

THE CLERK:

Turning to page nineteen of the Calendar, under the heading MATTER, IT Should be RETURNED FROM LEGISLATIVE COMMISSIONER. Favorable report of the joint standing committee on Humane Institutions. Cal. 347, Files 226 and 613.

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Substitute for Senate Bill 66. AN ACT CONCERNING RIGHTS
OF PATIENTS OF MENTAL HEALTH FACILITIES, as amended by
Senate Amendment Schedule A.

THE PRESIDENT:

Senator Martin.

SENATOR MARTIN: (18th)

Mr. President, I move acceptance of the committee's
favorable report and passage of the bill as amended by
Senate Amendment Schedule A.

THE PRESIDENT:

Will you remark?

SENATOR MARTIN:

This bill, as I pointed out the other day, is endorsed by the Connecticut Hospital Association, the Connecticut Psychiatric Society, the Mental Health Association of Connecticut, Connecticut Legal Services and the Connecticut Department of Mental Health. This is not the original bill which the committee wrote. We have made many changes to the bill as I explained in the amendment the other day. It is through this amendment that everyone agrees that the bill is a good bill and I would like to just briefly mention some fine points of the bill. No patient, voluntary or involuntary, could have psychotherapy surgery or shock therapy without having given written informed consent. No patient could be placed voluntarily in seclusion or in restraint unless there was imminent physical danger to himself or others. Medication

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could not be used as a substitute for a rehabilitation program. An in litigation regarding hospitalization, a person or his attorney would have the right to inspect and make copies of hospital records. In-hospital rights would be posted on each ward of all mental health facilities. And if there is no objection, Mr. President, I ask that the bill be placed on the Consent Calendar.

THE PRESIDENT:

Senator Madden.

SENATOR MADDEN: (14th)

No objection and quite the contrary, Mr. President, this bill has been two years in the making in the Humane Institutions Committee. I think it indicates a small step forward in terms of reform in the mental health area and will go a long way to provide the kind of care that we always thought people were getting and now they will be assured of getting.

THE PRESIDENT:

Hearing no objections, the bill will be placed on the Consent Calendar.

SENATOR STRADA: (27th)

Mr. President, before we go any further, may I ask the Clerk to go back to page three, Cal. 403, I would move suspension for immediate consideration and ask that that be taken up, just as soon as I mark two others, if I may.
Page five - Cal. 535 was originally marked passed temporarily,

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[Cal. 655-SB231] SB 239, SB 394, SB 396, SB 417, SB 461, SB 526
 all items on the page, 656, 657, 658, 659, 660, 661.
 SB 110, SB 465, SB 620. SB 268
 Page nine - Cal. 665, 667, 669. Page ten - Cal. 672.
 HB 5575 SB 480, SB 370, SB 638,
 Page eleven - Cal. 678. Page twelve - Cal. 699, 700, 701,
 SB 284 SB 633 SB 66
 703. Page thirteen - Cal. 716. Page nineteen - Cal. 347.

roc

And that's the end of Consent Calendar.

THE PRESIDENT:

Senator Reimers.

SENATOR REIMERS:

Mr. President, through you, sir, a question to the Clerk, what is the status of Cal. 522.

THE CLERK:

We had a roll call on 522.

SENATOR REIMERS:

Thank you.

THE PRESIDENT:

The question now is on the adoption of the Consent Calendar. The machine is open. Please cast your votes. The machine is closed and locked.

Total Voting	33
Necessary for Passage . . .	17
Voting Yea	33
Voting Nay	0

THE CONSENT CALENDAR IS ADOPTED. [See pp 1935-1936 (top)]

SENATOR STRADA:

Mr. President, I would not move for suspension of the rules for immediate transmittal of all the items to the appropriate place.

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CONNECTICUT
GEN. ASSEMBLY
HOUSE

PROCEEDINGS
1978

VOL. 21
PART 9
3566-3969

Wednesday, April 26, 1978 287.

the day when Gene Migliaro would support a bill for bussing, and efr
Irving Stolberg would oppose it.

MR. SPEAKER:

Are there any further relevant remarks about the merits
of the issue at hand? Well, if not, will the members please be
seated; the staff and guests come to the well. The machine will
be opened. Have all the members voted, and is your vote properly
recorded? If so, the machine will be locked. The Clerk will
take a tally. Will the Clerk please announce the tally.

The following is the result of the vote:

Total number voting	140
Necessary for passage	71
Those voting Yea.	94
Those voting Nay.	46
Those absent and not voting	11

The bill as amended is passed.

TAPE
#40

THE CLERK:

Calendar 1067, Substitute for S.B. 66, Files 226 and
613, an Act concerning rights of patients of mental health
facilities. As amended by Senate Amendment Schedule "A".
Favorable report of the Committee on Humane Institutions.

RICHARD L. MERCIER:

Mr. Speaker, I would move for the acceptance of the
Joint Committee's favorable report and passage of the bill in
concurrence with the Senate.

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MR. SPEAKER:

efr

The question is on acceptance of the Joint Committee's favorable report and passage of the bill in concurrence with the Senate, and will you remark, sir?

RICHARD L. MERCIER:

Mr. Speaker, the Clerk is in possession of Senate "A", and may I be allowed to summarize?

MR. SPEAKER:

Will the Clerk please call L.C.O. 2757, Senate "A".

THE CLERK:

Senate Amendment Schedule "A", L.C.O. 2757.

MR. SPEAKER:

Is there objection to the request of the gentleman of the 44th to summarize in lieu of Clerk's reading? Hearing no such objection, the gentleman first to summarize.

RICHARD L. MERCIER:

Mr. Speaker, the amendment is the bill. This legislation expands in-hospital rights of the mentally ill, while at the same time affording them appropriate care and treatment. It is endorsed by the Connecticut Hospital Association, the Connecticut Psychiatric Society, the Mental Health Association of Connecticut, Connecticut Legal Services, and the Connecticut Department of Mental Health. Mr. Speaker, I would move passage of the bill as amended by Senate "A".

MR. SPEAKER:

The question is on adoption of Senate "A". Will you remark further on the amendment? If not, the question is on the

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amendment. All those in favor of Senate "A" will indicate by saying "aye". Opposed. The "ayes" have it. Senate "A" is adopted and ruled technical. Will you remark on the bill as amended?

RICHARD L. MERCIER:

Mr. Speaker, the amendment is the bill, and I would move for passage.

MR. SPEAKER:

Will you remark further on the bill as amended? If not, will the members please be seated; the staff and guests come to the well. The machine will be opened. Will the members please check the board and make sure your vote is...please check the board. Thank you. Thank you. Have all the members voted, and is your vote compatible with your desire...your intention? The machine is still open. For what purpose does the gentleman rise?

UNIDENTIFIED REPRESENTATIVE:

Mr. Speaker, I mistakenly pressed Representative Reynolds' button here. All right. Thank you.

MR. SPEAKER:

If the gentleman would push both the "yea" and the "nay" simultaneously, it should clear. Have all the members present voted, and is your vote properly recorded? If so, the machine will be locked. The Clerk will take a tally. The Clerk please announce the tally.

The following is the result of the vote:

Total number voting 141

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Necessary for passage	71	efr
Those voting Yea.	141	
Those voting Nay.	0	
Those absent and not voting	10	

The bill as amended is passed.

THE CLERK:

Page 11 of the Calendar, Calendar 1095, H.B. 5021, File 708, an Act concerning refunds of motor fule tax on fuel used in certain vehicles for transporting passengers. Favorable report of the Committee on Appropriations.

CHESTER W. MORGAN:

Mr. Speaker, I move acceptance of the Joint Committee's favorable report and passage of the bill.

MR. SPEAKER:

The question is on acceptance and passage. Will you remark, sir?

CHESTER W. MORGAN:

Yes, Mr. Speaker. The Clerk has an amendment, L.C.O. 3865. Will the Clerk please call, and I would like to yield to Representative Moynihan for a summarization.

MR. SPEAKER:

Will the Clerk please call L.C.O. 3865, designated as House "A".

THE CLERK:

House Amendment Schedule "A", L.C.O. 3865.

MR. SPEAKER:

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STANDING
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HUMANE INSTITUTIONS

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DR. PLAUT: Next bill is Raised Committee Bill No. 61. The issues raised in this Bill are also addressed in Bill No. 66 which is a bill submitted by the departments. I personally prefer the language in Raised Committee in 66, not surprisingly, so I will only comment briefly here on why I have some difficulties with the language of Bill 61. Again, the thrust and intent are fully behind. The language in this bill does some, I think some distressing things which would require a conservator. Now, as I understand the law, technically a conservator would be a general conservator, so that this would be, I think, a major interference with civil liberties to get a total general conservator for this one very small item as this bill is drafted. Also, when you compare the language of this bill with Raised Committee Bill No. 66, I think you will find Raised Committee Bill No. 66 gives more protection to the voluntary patient than this Bill does. There is more emphasis on the protection of the voluntary patient than the Raised Committee Bill No. 66, provably somewhat greater flexibility of the involuntary patient under Bill No. 66 as compared to this one but they both address the same issue.

SENATOR MADDEN:

DR. PLAUT: My comments about 62 are very similar...

SENATOR MADDEN: May I ask a particular question?

DR. PLAUT: Certainly.

SENATOR MADDEN: One of the differences between 66 and 61 are the provision of Line 30-1/2 through 32 that consent may be withdrawn at any particular point in time. If you have any problems with that kind of language where a person wants their given consent withdrawn.

DR. PLAUT: Line 30-1/2 through 32 of 61, no of 66, which is the protection that is offered in 61, I don't believe, but it is in 66.

SENATOR MADDEN: Is there any particular problem in dealing with that administratively?

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gmV

HUMANE INSTITUTIONS

February 21, 1978

DR. PLAUT: No and the reason is the following.
of a patient's verbally form of
consent in refusing to put it in writing. That leaves the
physician in a particularly ambivalent situation because
if he administers the treatment anyway, he is liable for it
in having violated the patient's wishes; and if he doesn't
and the illness gets worse, the patient is in a position of
saying you should have treated me. Yet, this gives the patient
more protection; but it does put an added burden. Also,
with that, the patient must put a refusal in writing.
this gives the patient more protection
but it also gives the facility more protection.

SENATOR MADDEN: How about access of patients to
give that withdrawal or consent in writing?

DR. PLAUT: Could you state that again, Senator, I'm sorry.

SENATOR MADDEN: Access, I'm concerned about you have a patient who
says to the doctor, I would like to refuse treatment. I
just don't happen to have a pen or paper around
in order to be able to write

: The doctor will give him the forms.

: Administratively, you don't have any problems
with that?

: No sir.

DR. PLAUT: Can we go back and then come back to keep it in sequence
so that it is easier? Are we done with 61, Senator?

: If you like.

DR. PLAUT: I am opposed to 62. I think that the procedures outlined
in 62 are unreasonable and unnecessary and, here again, I think
that the procedures outlined in 66 are adequate.

REPRESENTATIVE MERCIER: How do you follow the same? In 66, Section
2

SENATOR MADDEN: Is it the two hours that bothers you?

DR. PLAUT: is it the two hours that bothers me; it
is observation every ten minutes,
that's maybe a little too frequent but it's not that.
It is mostly the two hours which bother me.

- DR. PLAUT: Now on the second page in line -- it's quoted Line 56, I don't know what happened to line 55, the machine went from line 54 to 56. I believe there was an omission in the original legislation that the word admitted and omitted are transposed. And I think it was omitted in the original legislation. But you really didn't want a patient under the age of 18 admitted to a Department of Mental Health Facility. So I think that is just clarifying both legislative and intent-wise. And then the rest of the changes are definitional, that is they provide definitions where in this section of the law, not definitions are used. In our discussion of that bill, Raised Committee Bill No. 66, this is the Department Patient's Rights bill which I have referred to as addressing the issues in some of the earlier bills that we consider better language. If we make that through it, I will point out the major thrusts of the bill, lines 22 and 23, as I said, provides the strongest possible protection for the voluntary patients. We have already discussed the effect of line 30½, 31 with the written consent.
- SENATOR MADDEN: May I ask a question? Does this apply to not only state facilities but also all private hospitals? It does. I just wanted to make that clear.
- DR. PLAUT: On the following page, lines 45½ to 48, deals with the consent requirement -- written consent requirement -- informed consent requirement for psychosurgery or shock therapy.
- SENATOR MADDEN: Does that include both voluntary and involuntary, it's in the involuntary section, but it says "any patient", that's why I just asked, if that was your intent.
- DR. PLAUT: Well, because Line 22/23 say no treatment shall be administered to a voluntary patient, this would be . Here, you see, we are making the distinction between medication and these others, but these others are all for the voluntary under the . Lines 59, 60, 61 has to deal with the restraint machine which we discussed earlier. Line 64 through 66 is an additional control over the medications, line 71 and 72-3 is an attempt to make unnecessary repeated physical examinations which are frequently very distressing to patients. Now a patient comes into the emergency room of the general hospital and after their complete physical exam, find out that the problem is a psychiatric problem and the patient is physically healthy, he is put in an ambulance and is brought to the state hospital and they have to do another complete physical exam or they would be liable for malpractice. This can go on

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gcs

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DR. PLAUT (Continued): too often and it's very distressing to the patients and this allows us not to do unnecessary physical examinations when it has been recently done. Lines 83 and 84 address the patient's rights

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gbs

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DR. PLAUT: I would like the to consider adding to Belt Section 5 the words in English and French.

#4

REP. MERCIER: (Inaudible)

DR. PLAUT: I think the number of people who do not speak English but other languages in our facility is very, very small and not unusual to . I think if we will try to some other language it wouldn't make any sense to attempt to post them in other languages.

SEN. MADDEN: Do you have any sort of requirement that an individual in a language other than English and Spanish be given a copy of his rights to bother you in any way?

REP. MERCIER: Let me tell you (inaudible)

SEN. MADDEN: There are concerns --

REP. MERCIER: There are you'd have in this case, you know, the Northeast section around Hartford you have a large American population. In Waterbury, you have a lot of Italian population. And you might have some of the older people who speak only Italian.

DR. PLAUT: All right. I would be comfortable

SEN. MADDEN: I'm sure Senator organization would be happy to provide you with a translation ones you had providing him with a copy

DR. PLAUT: That's a good suggestion. Thank you. All right, the next section is the right to inspect the patient's records in front of the patient or his attorney in connection with litigation. The rest of the changes are really all again definitions but I want to point out that adequately terms are redefined 119 and a half of line 125, that they really need to be defined for the law to be needed there.

SEN. MADDEN: While we're on this section, shock therapy, I noted that you electro-shock and I have attempted to define just shock. The carbon dioxide in the , are there any other substances that produce -- why should be? That is my question.

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gbs

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DR. PLAUT: I think the language would be better if it said electric or other agents, because they react which have, in fact, very little use you are correct and it would be better legislation.

REP. MERCIER: How much of is it now?

DR. PLAUT: Relatively little.

SEN. MADDEN: How about private hospitals. Do you have any assessments?

DR. PLAUT: I do not know.

SEN. MADDEN: One of the sections that you on was the change in the line 51, which has to do with patient if they are in any danger, and you word immediately that precedes fatal. The word, could you explain that? I immediately fatal had a connotation that we all understood and now, you know, we're walking across the street to say that. I was just wondering if

DR. PLAUT: Well, we sort of these patients can do which we fatal and, some period of time which I in fact, changes.

SEN. MADDEN: O.K. Thank you.

DR. PLAUT: There's always , you know. Whichever way you is

SEN. MADDEN: Well, O.K. How often is that dealing immediately fatal with language for some time, why at this point in time we've had cases where we had people receiving treatment that ultimately fatal.

DR. PLAUT: I cannot answer your question.

REP. MERCIER: Do you have any idea how much or how often you use drug

DR. PLAUT:

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REP. MERCIER: the drug that's there, but, you know, obviously there are other drugs. There are tranquilizers,

SPEAKERS INAUDIBLE.

REP. MERCIER: The question is basically in that section which is what I'm asking is how long can other drugs tranquilizers?

DR. PLAUT: Do you mean what's listed on

?

REP. MERCIER: Yes. In addition to those, obviously tranquilizers.

DR. PLAUT: Yes, but these are the drugs which really reduce shock. That's why here.

REP. MERCIER: What I am wondering then is these seem to be the only ones that reduce shock, how about those that are used simply as tranquilizers? cases kept on tranquilizers for a long period of time.

DR. PLAUT: Yes, we do have such cases, and this is an issue which we are studying very intricately in the Department and I buildup and patients that have been on medication for some periods of time. I am not prepared to ask the legislature on the subject. It's a very complicated one, one that which may or may not require legislative attention and I'm just not ready yet. We need more data.

SPEAKER UNKNOWN: possible side effects of pretty good knowledge of what

DR. PLAUT: That's part of what we are looking at. There has recently been considerable interest in the medical literature on some of the major tranquilizers and side effects time. for instance is now requiring a second after 90 days because the danger of side effects is different after 90 days This is what we are looking at as to what should do in this area. I think we can do within the Department by guidelines and regulations, legislation may or may not be indicated. actively spending it right now and I don't feel that we are ready to legislative. We are very, very

SPEAKER INAUDIBLE.

SEN. MADDEN: I'd like to go back to that line 51 immediately again. If I read it with the word immediately removed, I can postulate a situation whereby you have a patient who happens to have a cancer tumor and that it would be ultimately fatal to him if that tumor was not removed. However, I would think that at least he would have the right to determine whether or not he wants the operation or not, and if we remove the word immediately, you can postulate on at least one reason and I'm sure if more, and this is where patients may be forced to undergo medication, treatment, if you will, that they may not want, and I'm concerned with that word immediately in all the other language that happens to be written into the Bill. Considering that, perhaps we can take more time before we remove that word immediately and while we are removing it --

DR. PLAUT: Let's think about it.

SEN. MADDEN: live without the word immediately being removed, and think about it we can work on it and possibly in the future we can come up with some change in that area.

DR. PLAUT: All right, sir.

SEN. MADDEN: O.K? I am really concerned about removing

DR. PLAUT: I can understand your concern. I can only reiterate my comment, when the legislature

SEN. MARTIN: Any questions? I have a question in the second with all the voting and Joseph Francis?

JOSEPH FRANCIS: I'm Joseph Francis from the Citizens Commission on Human Rights of Connecticut, and the Bill that I'm concerned with is Committee Bill No. 66. I basically agree with the way it stands except for a few points. The first point being, lines 45 to 48, they mention the words informed consent, and I don't see an outline of what informed consent is. From my own experience, I've dealt with people who have had and I have found that the people who didn't like , they got it as a result of not being informed on what their therapy consists of and how it was going to affect them. Currently it is a Bill in

JOSEPH FRANCIS (Continued): Massachusetts, that's House Bill No. 810, which gives a definition of informed consent. Now this definition is similar to a definition of out in California, a Bill concerning surgery. point out that the reason for treatment, that is, the nature and seriousness of the patient's illness these facts. A couple of other points, the nature, degree, and the probability of the side effects and significant risks, commonly known by the medical profession of such treatment, especially degree and the and how and to what extent immediate control . So that's one thing I would like put into the Bill is a more definite definition on what informed consent would be. In other words, the person would pretty much know what he is getting into before he got into it.

SEN. MADDEN: Do you think that the fact that it has to be in writing patient the opportunity to get the protection particular questions?

JOSEPH FRANCIS: I think it would help, but the thing is if these steps that are outlined followed because the person never gave his signature anywhere, well then the person would be really informed on what this treatment was going to consist of.

SEN. MADDEN: Considering the probability and malpractice, necessary? Could you live without it?

JOSEPH FRANCIS: I could live without it, but I would just prefer something that would be a little more, you know, informed consent. such consent would be for a maximum period of 30 days and maybe invoked at any time. That does give it a little more on how long it could last. I was looking for a few more lines like that. And then just the other area that I had a question on was line 119, I guess that would be 120 to 123, the definition of psycho-surgery. There is currently another Bill in Massachusetts that gives a definition of psycho-surgery and makes it more specific because as you already mentioned, you know, you other methods used that would be considered psycho-surgery. And the definition that's in the Senate Bill No. 394 does give a more specific definition and over that would, you know, go under this definition. For instance, they talk about the use, on one or more occasions, of or electrodes primarily for the purpose of

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JOSEPH FRANCIS (Continued): influencing or altering the thoughts or emotions and behavior of a person, by stimulation through electrodes with production of a lesion in the brain of that person. They give about three separate definitions of what psycho-surgery is, and it would include all of these as well as include everything else that was in use for that purpose.

SEN. MADDEN: Are you going to get copies of those --

JOSEPH FRANCIS: Yes, there are copies --

JUDY LERNER: Hello, I am Judy Lerner, I'm a Legal Services Belt attorney and I represent patients at Norwich State Hospital.
#5 I will speak briefly, you have my testimony, I hope that you read it. I'm supporting Bills Numbers 58, 59, 60, 61, 62 and 66. There are some conflicts between the provisions of the first five Bills and the last Bill. The Commissioner objected to Bill Number 58 on the grounds that it would unduly limit research. I would like to point out to the Committee that many other states have confidentially laws but none of them that I know of provide exceptions for research and the Departments do manage and the states do manage to conduct research. I agree with the Commissioner that it might be valuable to have an exception for departmental research or statistical research collected by the Department for departmental purposes. I don't think that the Bill should permit any research by any employee of the Department. What presently goes on is that Departmental employees are writing papers for their own courses and their own graduate work and they have free access to the files and discuss them afterwards a few months later as has been pointed out to me by who felt very strongly about the patient's right being violated. And I would like to eliminate that kind of activity, while not unduly the Department in conducting his own research. I think you have to weight the relative importance of personal privacy and medical research and I think, I hope that you come out on the side of privacy.

I also support Number 59, which grants the right to an independent psychiatric witness at post-commitment hearings. I don't think this will cost very much, because we're talking about, I think, a very small amount of hearings. And also if the released at this hearing the cost of the stay hospitalization and so ultimately possibly this position will cost nothing and might even save the state money.

REP. CONN (Continued): responsibility in his plant,
if he doesn't know
individual.

JUDY LERNER: I understand but studies have, many studies have
shown that as a population mental patients have no greater
percentage of dangerous individuals than the general popu-
lation. It's simply impossible to screen for dangerousness
whether you're talking about an ex-mental patient or an
ex anyone.

REP. CONN: I don't mean danger in an individual. I mean danger
in a job application.

JUDY LERNER: Well, I think that it might be that a question
such as - do you have any illness which will interfere with
the job, you know, might be a reasonable question. And I
hope that that will solve your problem.

Bills Numbered 61 and 66, issue of medication,
as the Commissioner pointed out, the Department Bill is
much more stronger to protect the rights of voluntary
patients. I could live with the conditions of Bill No. 66;
I would like to see additional protection for the involuntary
patient. Representative Yaccamo pointed out
about very serious drugs and they have very serious effects.
My clients they're suffering, but I've
vomiting, they're trembling, they're afraid the doctors
aren't properly monitoring the medication, they can't speak
to a doctor. The aids have standing orders to give them
the medication whenever the aids feel it is necessary.
They often beg for Artane or some other drug that will
counteract the effect of the medication and are told, you're
faking, you're -- there's nothing wrong with you, you don't
need it, go away. These drugs cause irreversible damage.
They cause in estimates up to 15 percent, they cause
which causes involuntary movement from the
mouth and other muscles, and is extremely unpleasant. We
are talking about serious drugs and drugs that can be
hazardous, although they are often beneficial. And I don't
think they should be used on involuntary patients either,
without consent, unless those people are violent. Or unless
they have a judicial hearing that a guardian could be ap-
pointed. I agree with the Commissioner's point that the
guardian might have too broad privileges and it is possible
to appoint a conservator in Probate Court for a specific
reason and that reason could be to consent to medication in
a hospital. It wouldn't have to be a general conservator
for all purposes.

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JUDY LERNER (Continued): Bill No. 62 deals with restraints and seclusion. The standard outlining the Bill came from the Joint Commission on Accreditation of Hospitals. Commissioner found it unreasonable and unnecessary but I hope this Committee will take a different view. We are talking about a public humiliation and incredible frustration. Someone in a straight jacket and strapped to a bed, and it seems that two or three hours of that is torture and I think that there should be guidelines to limit the use of this. And these guidelines are, in fact, advised by JCAH.

I strongly support the Commissioner's Bill, Bill No. 66, with the exception for involuntary patients that I just discussed. I would like to see a slightly stronger position in Section 4 which deals with property rights. Connecticut law already provides that patients can't be deprived of property rights and the Bill as proposed by the Commissioner leaves the patient's property rights to the discretion of the hospital. I would like to see something much stronger, such as the rights shall only be denied if it is absolutely necessary. And the right posted in the records. Many patients feel this particular deprivation of rights is the most serious one that they endure. They, you know, people who have always been accustomed to working and spending their own money, all of a sudden have to have a doctor's permission, have to beg for a dollar to buy a cup of coffee or a pack of cigarettes, and that's a humiliation which is often unnecessary, and I would like the Committee to consider that.

Section Five which gives of rights. I strongly believe, Commissioner that rights should be posted in Spanish and English and also that if a person has a different language that their rights should be explained to the personal language they understand. And I believe it is the hospital or community organization to arrange that.

I'd like to draw your attention to Section IV, the attorney right to copy records. That is of particular importance to an attorney representing a person in the hospital. If the attorney doesn't have the right to copy records, they've got to use subpoenas. I've had Social Security disability cases where the Federal Hearing Officer refused to issue a Federal subpoena and I had no evidence with which to present my case.

Belt #6 No states allow attorneys to copy records.

Bill Number 65, I'd like to point out to the Committee that the Judiciary Committee has raised a Bill dealing with the commitment of children and deals with the 14-16 age requirement. If the Committee is interested in the informed consent,

DR. FREEBURG (Continuing): to resupport Section 2A, I'd like to say that I would wonder about adding after line 62, adding head of hospital or his authorized designee. I don't know if you feel that's necessary or not. I think that might be helpful. We also endorse Section 3, the new part 71-73. The Section 2B, we really wonder whether that ought to be in the law. This is good medical practice and I wonder why it's necessary to put standard medical practice in law in this kind of situation. We have no major objection to it except from that point of view. The problem of 14 and 16, is one that I have not consulted with our Society about, so that I'm speaking for myself in regard to this. I wasn't informed this was going to come up, but I think I would speak for many in our Society. I'm very concerned about this. First of all I think we need a tremendous amount of deliberation on the whole issue. I think the issue of what parents' rights are, where they leave off, is a question. On a very practical, I treat adolescents, and very practically, I know how many times they test out and test out and test out and they want their parents to set limits and say "no", and I see this over and over and over again and I really think that to take this sort of power away from parents is one that should be considered very, very carefully and long before it's done. Right now, I would oppose it. I think that it's also true that there are several court cases, I know there's one in Pennsylvania, there has been one in this state, I think, in process of appeal and it would be interesting to see how those court cases come out which deal with this issue of 15 year-old being signed in by his parents.

SB 66

SENATOR MADDEN: In your experience, do you know of any that has been so abused?

DR. FREEBURG: Could you define what you mean by so abused?

SENATOR MADDEN: Any child who has been committed when he really has no need of being committed by his parents?

DR. FREEBURG: I'm sure that it has happened. I have not had any personal experience, okay, but I'm sure it has happened. There are abuses everywhere in everything, but I don't think that the abuses, to my knowledge, are sufficiently numerous that one would require to do this kind of thing, and I also think that if one gets into a situation of committing 14-year-olds, which is what we're talking about, that's a hell of a drastic action again to take.

SENATOR MADDEN: Let me ask you a question in reverse. Have you seen people between the ages of 14 and 16 committed when they really needed the help and they

DR. FREEBURG: Yes, signed in by their parents. They can't be committed. Again, I think this is a terribly complex, it's just the rush into changing this that bothers me. It may be after due deliberation that it might be the best idea, but I have doubts about it and right now I wouldn't want to see it happen. In Section 6, of Bill 66, the copying of hospital records, attorneys are allowed to make notes from hospital records as the law now stands, and we feel that this is sufficient. Again, the more hospital records there are around, the more copies there are around, again, the more chance there is of violating confidentiality from our perspective. I just want to make sure I haven't left anything out. Oh, here it is, I heard some comments about medications. Again, it bothers me that physicians, physicians ought to be able, in my view, to use medications; they are the experts in terms of their effects, their effects vary from individual to individual with different doses in different individuals. It's a very complex thing and I would hate to see written into law restraints on using medications. Also, in the Bill 66, you asked a question, Senator, earlier, about no psycho surgery lines 45-47. No psycho surgery or shock therapy may be administered to any patient without such patient's written informed consent. That includes involuntary patients, I take Belt it, and, again, this seems to me to be totally paradoxical.

8 I just don't see how one gets written, reasoned written informed consent from somebody that the courts have determined does not have that reasoning. In other words, probate court, it seems like a paradox, I don't see how that can work.

SENATOR MADDEN: Let me pose this. We wrestled with this entire issue all last session and there was testimony offered to us that stated because someone may have a mental illness severe enough in that he's a danger to himself and others and has to be committed to a hospital involuntarily, but that does not necessarily mean, in all cases, that he does not have the ability to reason. He may truly have an illness when pressed into a certain situation he reacts in such a way that he's a danger to himself and others. Given that, that's fine this particular section for involuntary patients, would you feel that, based on that kind of situation, it's a reasonable section. And again, there was also testimony given last year regarding the debate that's going on in psychiatric circles regarding shock therapy and chemical therapy and their usefulness versus the dangers to the individual that has them given. What we're simply saying is that before that type, that drastic measure be used, that the consent be given. With the ultimate intent, quite obviously, to limit the number of instances in which that kind of treatment is used. There is the feeling, I have the feeling that it's such an unknown in terms of shock therapy and chemotherapy that, for certain, you know, we may do

SENATOR MADDEN (Continuing): more harm to the person in the attempt to try to get there quickly, than taking a slower and more round about process. That is the reason for that

DR. FREEBURG: Fine. Can I respond to that.

SENATOR MADDEN: Please. I would appreciate that.

DR. FREEBURG: First of all, I think that if you take the number of people who are probate court committed, the number of people who fall into the category we're talking about, are a smaller percentage of that category. Okay. Secondly, again, it takes out the flexibility that I think is important to have and this is what bothers me about it. It seems to me to be overrestrictive. Again, we're dealing with people on the most severe end of the emotionally ill spectrum. Very often they've been through many many different types of treatments before they get to that state and then there isn't much left open to use. So, they may have failed with treatment, advising medication, we've tried so on and so forth, and now you're left with shock, okay, now if you're left with shock and that's taken away, and we're at this point, I think that is a problem. Okay, now I have to say another thing about shock per se, and I must say this in perspective. Okay, I'm not talking about psychosurgery now, purely shock. Personally, I've been a psychotherapist for, psychiatrist for 16 years. I have probably used electric shock a dozen times in those 16 years, which is a relatively, I would say relatively standard for most therapists. There are some who use it quite a bit more, but not most.

SENATOR MARTIN: Have you always been in private practice?

DR. FREEBURG: I'm clinical director of the Institute of Living. I have a

SENATOR MARTIN: Eleven years.

DR. FREEBURG: And, I have a, I've been a section chief there for ten years and clinical director the last three years. I've I sorry, I lost my transcript. To give you a perspective of where I come from, because I'm not a user of shock, okay, the problem, there are certain types of illnesses, in which we don't know why shock works, okay. There is no question in my mind that used properly and used in a limited fashion, it can be very helpful in certain illnesses and those include middle-age depression, severe middle-age depression, acute onset psychoses of certain types, and, occasionally, longer term patients where everything else has failed and where it's worth trying. You don't get as good results, but you sometimes get good results. Now, it, okay.

SENATOR MADDEN: Have you always received permission from your

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SENATOR MADDEN (Continuing): patients before you use shock therapy.

DR. FREEBURG: Have I personally?

SENATOR MADDEN: The twelve so-called odd instances when it's been needed?

DR. FREEBURG: I can only think of one occasion when I have not. And, I did have permission from the responsible party, as we call it, the guardian.

SENATOR MADDEN: Was it someone who wasn't of age

DR. FREEBURG: No, it was probate court committed.

SENATOR MADDEN: But you did obtain permission from the guardian.

DR. FREEBURG: But I would not have gotten that permission from the patient, in that case, and it did help in that case, but you can't generalize from a case of one. But again, I think it's unnecessarily restrictive to do it this way. We are concerned with the same issues and we have to be given some flexibility to work.

SENATOR MARTIN: and we have testimony before us today, and papers from other states where people have received these treatments in excess and I know, I went to a seminar last year in which New Jersey and so forth, where especially the older patients have had excessive shock treatments and it was made known that that was in fact and it is used excessively. The point that you may not use it yourself that way, it is being abused. We realize this.

DR. FREEBURG: May I pose a question. How much is it being abused in the State of Connecticut which is what we're concerned with because I think, you know, there are a lot of differences in the different states, especially in the state institutions.

SENATOR MARTIN: We're also concerned with the private institutions where I think it's being abused more.

DR. FREEBURG: Well, I can only point out, right, that's what I was going to point out, in this state it's being used very little. I know at the Institute of Living, it's being used by

I understand that, I understand that, but I wonder if this is the way to go about doing that. You see, look, there was a time and I'm particularly concerned with senior citizens because we, as you know, have opened up a psychogeriatric unit at the Institute. We have a problem. If you give, if you go

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DR. FREEBURG (Continuing): to the population over 65, you have physical difficulties occurring especially in the cardiovascular system, very briefly. Now, if somebody is depressed in that age group, you can't use anti-depressants because they are cardiotoxic. Okay, now you've got a problem, what have you got left. And if you use two or three or four shock treatments, you can cure depression very frequently in the elderly, without doing harm, in fact. Now, I agree there are limits and this is a problem.

SENATOR MADDEN: If a patient agrees to that, I can understand.

we've got a cardiovascular problem, you've got a 50-50 shot of coming out of the operation that I'm going to offer you, what do you want to do? I mean, all of us here would say fine, you know everybody ought to have their shot if that's what they want to do. But, what we're concerned about is those patients who have this done to them, one they don't know what's going to happen to them and two, they're not sure what the results might be, and they don't know what's going on.

DR. FREEBURG: Let me pose something to you. It's very frequent in the elderly, again, not as frequent as people use to think it was. There were a lot of reactive depressions and psychotherapy is being used much more with the elderly, but there are elderly people, and sometimes pre-elderly people who do have brain damage, who are depressed with that and who are "demented" okay, they do not, you see what I mean by that, I mean they really, sorry, they really do not have the facility because they have lost brain tissue, okay, to reason and judge, to remember, okay, to orient themselves in time and space. Now, they cannot give this kind of consent. There is no way they could do it. There must be another way around that.

SENATOR MADDEN: Is there such a thing as terminal mental illness? I ask that because it was brought to our attention last year that people have died from shock therapy and I'm just wondering if that's a possibility, especially dealing with elderly, if perhaps it's worth the risk.

DR. FREEBURG: I don't believe that -- I don't know of any study in which somebody has died of shock treatment.

SENATOR MARTIN: Are you saying that could withstand shock treatment better than a younger person?

DR. FREEBURG: No, what, more better, no, what I'm saying is that they are making it alternative that a senior citizen can withstand shock therapy more safely, given properly, assuming it's done right, given properly and in the right amount, not excessive, you know, doses, and that they can withstand that

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DR. FREEBURG (Continuing): and it's safer frequently than giving medication, because the medication is toxic to the heart and if they have any cardiovascular problems that can be much more dangerous.

SENATOR MARTIN: What about excessive treatments to the younger person. I believe we have testimony where a young man, 17, received excessive shock treatments.

DR. FREEBURG: What's excessive? What's the word excessive mean.

SENATOR MARTIN: Well, he lost function

this is just one case, I'm sure there must be others.

DR. FREEBURG: Well, again, I have to, you have to define it more, Senator, because, if one says, one has to define excessive. If one uses.

SENATOR MARTIN: How would you define it?

DR. FREEBURG: How would I define it? I would say that it would be very rare to have to use more than 20 shock treatments in any

SENATOR MARTIN: What duration?

DR. FREEBURG: Pardon.

SENATOR MARTIN: 20 shock treatments. What time are they.

DR. FREEBURG: In a period of weeks, you mean. Oh, I say, at the rate of three a week. That would be very rare. I think that, I'm saying that in certain cases, that is not excessive. Now there are occasional

SENATOR MARTIN: will damage the brain. You will have some loss, some brain damage. Isn't that established.

DR. FREEBURG: No, it's not established. That's a matter of conjecture. I remember before this Committee last year, I did testify here last year, and I remember there was a lot of testimony which in my mind came up from the West Coast written by a neurology resident, at that time, and to my mind it was, I don't like to use the word, rather hysterical testimony. Okay, and, again, but, I want to make it clear, usually most people when shock treatment is used, between 8 and 12 shock treatments is sufficient. There are occasional people when and there is a form of treatment called maintenance shock which I don't think should be outlawed completely. Again, I'm talking about very limited usage, when

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DR. FREEBURG (Continuing): I'm talking about going up to 20 because that is not excessive in circumstances and I think if you talk to most psychiatrists, they will tell, you know, and it does not "fry the brain".

SENATOR MARTIN: I thought it was rather well established that each shock treatment will destroy part of the brain.

DR. FREEBURG: No, I don't think that's . We could argue that back and forth. Now, I could say one thing about the amnesia you're talking about. The amnesia recovers within four to six weeks and it does not occur in all cases, and it rarely occurs under 12 shock treatments. And, when it does, it's usually a hysterical amnesia rather than a true amnesia from the shock and that has to be differentiated. What I mean by that is that people under emotional circumstances, often repress things and forget whether or not they've had shock, if it's painful memory and that can be attached to the giving of shock when it has nothing to do with it. Am I being clear.

SENATOR MARTIN: I think we're going into something that we have to really be about background.

DR. FREEBURG: It's difficult. I understand that. I'm sorry.

SENATOR YACANONE: It is very complex. I don't know if I really understand it but I have questions. You mentioned shock treatment for something, in the psychiatric sections of the general hospital. But, it's less used in the State Hospital than it is in the other. Do you know any reason for it.

DR. FREEBURG: No, I don't know why that became a Department of Mental Health policy and actually I really don't know why they did that but I think there were a number of people who could be helped with it. Again, not huge numbers, and please remember I said, I used it maybe a dozen times in 16 years. Okay, but I think it has a usefulness and a purpose. I wish, you know, I wish we had other treatments.

SENATOR YACANONE: You said, Doctor, that you had gotten permission from most of those that you had.

DR. FREEBURG: All.

SENATOR YACANONE: All except one you said. Do you feel that they fully understood what to the best of your knowledge. And, when you mentioned maintenance therapy, what would that be?

DR. FREEBURG: Well, there are, again, I'm sorry I brought this up actually because it's rare, okay, but it really is rare. There are very occasional patients who are very seriously ill over a number of years, where every kind of treatment has been tried where they had some shock treatments, the course of shock treatments stopped, and then have one a week and then one a month and stay on one a month and it helps them to maintain their capacity to function.

REPRESENTATIVE YACANONE: I think I saw that on a documentary

DR. FREEBERG: But, it's worked.

REPRESENTATIVE YACANONE: But they didn't make that point

REPRESENTATIVE CONN: Of your 12 cases, were they all successful?

DR. FREEBERG: Well, I would have to back and refresh myself and look at the records because it is over .

REPRESENTATIVE CONN: At the time, did you have any serious reservations.

DR. FREEBERG: No, I have not had a case in which I felt I've had two cases that I can think of offhand. I've had several - well I pick and choose them very carefully, but I think that most of the cases that I've had have done well with shock and they've been . I've had two cases in which the patient did well for a period of maybe two to four months and then started to regress again. Where it didn't have an effect ongoing

SENATOR MARTIN: Well, thank you Dr. Freeberg, we've detained you quite a while. John Q. Tilson.

JOHN Q. TILSON: I am John Tilson, counsel for the Connecticut Hospital Association. We have some problems that are related that are related what Dr. Goodberg, but we also have some other problems in that the Connecticut Hospital Association is comprised of all of the general hospitals in the state, about two-thirds of whom have in-patient psychiatric services where the patient stays two weeks, thirty days would be a long period of time. So we're talking with respect to those institutions of a comparatively short-stay patient. And, also part of the Connecticut Hospital Association are the state hospitals and Dr. speaks for them, but we also have a number of the private institutions. The Institute of Living has been referred, Yale Psychiatric Institute, Elm and a number of other private institutions in the state, so

JOHN Q. TILSON (Continuing): to persons outside the institution because if you make it broad enough to cover in-house people, as far as I can see, you would just bring any kind of looking back to the records, research, totally impossible. On 59, we have no objection to that and I would feel that it's a desirable addition to the rights of the patients. That's the one about rights of patients at post-commitment hearings. 60, which is the one on psychiatric information on employment applications, is essentially a labor bill, really, rather than a Humane Institution bill, but we have some qualms about it because the bill doesn't have any provision in it about job related complications. I can see situations where if somebody had been under comparatively recent treatment for a propensity toward rape, for instance, it would not be desirable to have such a person operating in a hospital environment. I'm strongly in favor of making psychiatric information on job applications as secure as humanly possible, but I do think that if you're going to pass a bill of this kind, that some kind of language with respect to job related possibilities ought to be considered, because I'd be afraid if you didn't, that you would have really quite considerable problems. I can think of areas like _____, I can think of areas like hospital employees, where we would get no information whatsoever about past, and the past may be three days ago as far as that's concerned, you'd have really very considerable difficulty with. 61 is the bill about medication requiring written informed consent. It seems to me that this bill is much better taken care of by the language in bill 66. As it is, it would seem to require consent every time anybody got a sleeping pill. If you read it literally, no medication for which a prescription is required, shall be administered without written informed consent and it seems to me that you are making life for the psychiatrist and the psychiatric worker and the patients, as far as that's concerned, unduly complicated by requiring anything as detailed as provided for by this bill. It does seem, it seems to cover everything that would come up and it just seems to me that you are using a cannon to take care of something that a rifle, such as might exist in 66, would be much more appropriate. 62, which is the one about patients in seclusion or restraint, again, is better handled in bill 66, section 2, which deals with the problem of seclusion or restraint. This isn't, as far as the private institutions are concerned, so much a matter of staffing and funds as it is of concern about legislating in such detail the practice of medicine. You're talking about 1/2 hour line 30, ten minutes on line 31, two hours in line 32, if it seems to us that you are being much too detailed. Clearly, people should not be put into seclusion or restraint unless such is necessary and documentation of such ought to be readily available and in the patient records. But, it does seem to us that a detailed

JOHN TILSON (Continued): and as far as speed is concerned, one Belt of the earlier witnesses said that you could get a hearing #10 in 5 days, that's a good deal faster than my experience has been. The probate courts have been a little uneasy under the law which you people in your wisdom passed last time and they've done a certain amount of foot dragging in connection with hearings and my experience has been that it's taken maybe twice or three times as long as that period in order to get a probate court hearing. An unhappy thing that's developed in that is some of the probate courts are saying that, we want \$250 down payment before we will even consider the case because we've got to pay all the psychiatrists and as far as I can see if somebody brought a commitment for Jack the Ripper, they'd have to put up \$250 before the probate court is going to listen to the case, but as far as the voluntary -- the involuntary commitment of the 14 year old, I think it raises considerable problems and I'm inclined to think that you ought to consider further the very difficult question is at what age the child should have rights. They say at 14, it seems to us a little young. And that brings me to 66, the Department Bill here, I have no objection to most of it, but do have some problems with it. The first problem is in connection with Section I which now reads "no treatment shall be administered to a voluntary patient without the patient's written informed consent", then it skips a whole flock of lines and goes on to say "such consent may be withdrawn as to any particular treatment at any time." I ask the commission before the hearing today whether he literally meant what the bill says which seems to say that today we're going to have family therapy, you'll have to get consent for that and tomorrow we're going to have occupational therapy. Do you have to get special consent for that? And can the patient then say -- file a withdrawal saying I withdraw my consent this week to occupational therapy. By and large, the voluntary patient is in the hospital because he or she wants treatment. I think that requiring specific consent of this kind goes further than is necessary. The commissioner said what was intended was that there should be a consent to a general course of treatment and as to that, I didn't have any objection. Sure, a patient should consent to a general course of treatment, but I would think that by and large that's what the patient has voluntarily admitted himself or herself for and in any event, it should be made clear that you're not talking about individual consents for individual kinds of treatment within the general course of hospital -- short term hospital therapy.

SENATOR MADDEN: Mr. Tilson, I think what is referred there is that a general line of treatment may be laid out for a patient and they sure that's fine and then you get two days down the road and they are suddenly presented with something saying perhaps, I really don't want giving them the right to say that if ...

JOHN TILSON: If it's concerned with a general line of treatment, I don't have any essential objection to it because it seems to me that that is what consent is for. But I think that the language requires some rather close attention because I can see it being used to an extent whereby you'd be having patients shift in and out of individual treatments and again it seems to me that this is unnecessary with respect to a patient who is in a position to get out if they don't like general line of treatment that they are getting.

SENATOR MADDEN: Let me ask you this question. In a private institution, yes it might be possible for someone to say, you know, if he got to the point where a patient was not cooperating with the treatment offered, the physicians, or the staff or whatever, would the hospital have the opportunity to say, well, we're sorry, Mr. Tilson, but we -- you know, you can't take part in our program and we're going to ask you to leave. Would the hospital have that right?

JOHN TILSON: The hospital has this authority. Getting an unruly patient out of a hospital is sometimes more of a job than you would think it would be, but in theory at least, the hospital does have that right and obviously if a patient said they weren't going to cooperate with anything they went along, they would be asked to withdraw themselves. On the other hand, the voluntary patient who is in our hospitals as far as the general hospitals are concerned for a very short stay, can sign himself or herself out at very short notice, if they don't like the treatment. So ...

SENATOR MADDEN: What concerns me about it is, and again, you're providing for all kinds of written consents, that go beyond the real need of the patient in this particular category.

UNKNOWN SPEAKER: Again, you have the difference between a private hospital and a state hospital because the patient is going to be offered more in a private hospital than a state hospital.

JOHN TILSON: Certainly, and in the short term hospitals, a great deal more because they're there for just a comparatively brief period. Now, the big question was asked of Dr. Bridburg

JOHN TILSON (Continued): was in connection with the consent for psychosurgery or shock therapy. There, fundamentally I believe the patient's informed consent ought to be obtained. And I think that a typical patient in a mental institution has the capabilities of making his or her mind up as to whether or not treatment should be given. The only thing that bothers me about it is the blanket statement that no such therapy shall apparently ever be administered without the written consent of the patient. And there are going to be a few cases where the patient really isn't in a position to do that. It happens in connection with non-psychiatric patients. The patient goes in the general hospital for treatment and for one reason or another, age or unconsciousness or anything else, can't give informed consent, the doctor on informed consent under no circumstances broad enough to include consent given by other appropriate parties and I think that you ought to be careful of the language and make it clear that under the very extraordinary situations when the patient really is totally unable to give informed consent, one way or the other, that it should be possible to obtain that on the outside.

SENATOR MADDEN: If a patient is in that tough shape, is it reasonable to apply such admittedly tremendously controversial type of treatment to him?

JOHN TILSON: Well, it depends on what the reason they're in that shape. It may very well be that the person comes in with a terrible state of depression. They literally are unable to see black from white and on that kind of a patient, it's conceivable, it might be very much helped by the treatment. I think it's unusual. I think as Dr. Bridburg said, he's had only one patient in the past 16 years where he has not obtained permission, the consent from the patient. I think that's about the right percentage, but I just think that you in writing the legislation, you might take into consideration the really extreme case where literally the patient is unable to make the decision, then that patient can't give informed consent to the procedure or informed consent for not having the procedure and some kind of mechanism ought to be there whereby this in that very unusual kind of case can be obtained.

SENATOR MADDEN: I want to know how many cases there are where's it's so important that the hospital continue to have this type of discretion. I think it's a large number of cases maybe I could understand, but time after time, where this is the same where it's a relatively small, very minute number of cases. In that case, I don't understand why it

SENATOR MADDEN (Continued): would be such a burden to avoid having to give him that kind of treatment. Alternative methods ...

JOHN TILSON: Well, it's not a burden. It's simply that if you're going to treat mental illness like other illnesses, and one of things that we're always talking about is that they ought to have the same life as everybody else. If you're going to do it on that basis, then it seems to me that there are situations where a person can't make up -- cannot give the consent. And in that limited number of cases, perhaps somebody on the outside should do it. My own feeling is that it should be extremely limited and it should happen on very rare occasions. But I think that if you're writing a statute which says it can never happen, it may very well be making a mistake that's going to hurt somebody some time. While I would like to put every -- any kind of a limitation on it that you like, but I think never is a very strong word to use under these circumstances.

SENATOR MADDEN: You're obviously very well versed in the law dealing with health delivery. Would you be willing to offer to this committee language that is available general health or is that the language, or is that the language that is being eliminated?

JOHN TILSON: Well, you know, to a certain extent, it's the language that's back in the beginning, it's being eliminated. Where I think that it ought to be perhaps even more detailed than the earlier language. The earlier language, of course, was not dealing with this type of treatment. It was dealing with medical or surgical procedures. It was dealing with completely. And it's been taken out because no further reference is being made to those in the beginning of the statute. But, it did cover the situation, the odd situation and perhaps it should be more specific and more detailed, but something along those lines, even if it's a court order or a court hearing, seems to me that something of that kind should be put in there so that the person who really needs it and can't make up his or her own mind, it should be possible.

REPRESENTATIVE CONN: Can you, in your opinion, would you say that if it was left in as it is now worded, because there might be a case at some time where it would be a case of life or death?

JOHN TILSON: I was going to get to immediately, I don't think it's a question of life or death, whether a person gets shock treatment or not. I think it's a question of cure or not cure,

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HUMANE INSTITUTIONS

February 21, 1978

JOHN TILSON (Continued): but it doesn't seem to me that under some odd circumstances that patient should be deprived of something that may be very beneficial. If the patient is unable to make up his or her own mind on the subject. And you could draw this strictly as you like.

REPRESENTATIVE CONN: Do you think that there's a chance of a person needing shock treatment in relation to a heart problem? In other words, when we spoke of the ...

JOHN TILSON: You're now getting into the medical field and ...

REPRESENTATIVE CONN: I mean, suppose a person in a psychiatric institute that has a heart condition. Would that shock treatment be under this at all or not?

JOHN TILSON: Yes, I would suppose it would prohibit it unless the patient agreed to it, but it's treatment for heart surgery or -- I mean for heart condition, the patient can make up could consent or not consent. We're only talking about the -- I'm only talking about the patient who is unable to make that decision.

SENATOR MADDEN: Shock therapy is defined in Section 7K of the bill to mean a form of psychiatric treatment in which electric current is administered to the patient and results in loss of consciousness or whatever. I know what you're referring to. If someone has a heart attack in one of the methods of reviving them is the shock.

JOHN TILSON: That's quite different.

SENATOR MADDEN: You're talking psychiatric treatment vs. the life saving technique, it would appear to me.

JOHN TILSON: The word immediately raises some odd questions. If you take the word immediately out, you do get into the problem of the patient who has cancer and is going to die. On the other hand, if you leave it in, I had an experience with a patient who had left the psychiatric institution, jumped off a bridge, had fractured skull, brought into the hospital and says I don't want my fractured skull treated. Now, how immediate that fatal is going to be was awfully hard to tell. And I must say I agonized a good deal over the word immediately in there, we finally treated the patient. But it's not a very good word because it has the connotation of being, you know, five minutes. What is immediate? I don't know anything better and I think that it would be a

JOHN TILSON (Continued): mistake to omit the whole thing completely, because then you would be in a situation if the person had cancer and you'd be able to force them to take treatment for that where you couldn't force them to take treatment for cancer if they weren't in a mental institution. I can't really give you any immediately helpful language on it, but law itself, as it presently exists, is really rather awkward and perhaps should be modified in some way as to connote something other than -- I was worried about was that it might mean five minutes or ten minutes. On the rest of the bill, essentially, I don't have any serious problems. I think that Section 2A handles the restraint matter, seems to me, better than the earlier bill does and I would be in favor of that. Section 2B, I'm not sure that this is really necessary. It's awfully hard to legislate medical practice. I think this is a step toward legislative practice and I have some misgivings about it although, obviously, one kind of medication shouldn't be used as a substitute for any other kind. I'm a little concerned if you start writing in there what they can and can't do you may have problems with it. The rest of Section 3 seems to be OK, Section 4 is OK, Section 5 I'm not so sure about, furnishing the patient a copy in every language that we might have in our institutions, but fundamentally obviously, they ought to know their rights.

SENATOR MARTIN: I think this is done everywhere now. I think this is ...

JOHN TILSON: Section 6 is already taken care of as far as the general hospitals are concerned. There is a statute that requires, that permits the patient to expect his or her records after being discharged from the general hospital. It does not apply to the psychiatric institutes which are not general hospitals. Maybe that section which is 4-104 might be amended rather than starting a new section herein this. But fundamentally, the idea is correct. Section 7 is technical and then we would have no objection to it with the addition of the language that the commissioner suggested on other forms of shock treatment.

SENATOR MARTIN: Are there any further questions? Thank you. Is Robert Rope here? Elliott ? Are there any further question from anyone in the room here ? Then I'll call the hearing to a close. Thank you for coming.

SB 66

*Given Definition
of informed
consent*

HOUSE No. 810

By Mr. Jordan of Springfield, petition of William G. Robinson and other members of the House for legislation to restrict the use of convulsive treatment in mental health facilities. Human Services and Elderly Affairs.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Seventy-Eight.

AN ACT TO RESTRICT THE USE OF CONVULSIVE TREATMENT.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 23 of Chapter 123 of the General Laws as
2 most recently amended by Chapter 291 of the Acts of 1974 is
3 hereby amended by striking the words "to refuse shock treatment"
4 in the fifth paragraph and by striking the last clause in the fifth
5 paragraph beginning with the words "and provided further
6 that..." and ending with the words "nearest living relative".

1 SECTION 2. Chapter 123 of the General Laws is hereby
2 amended by inserting a new section after section 23:

3 *Section 23A. Convulsive Treatment*

4 (a) Any person receiving treatment at a mental health facility or
5 in the psychiatric ward of a general hospital, whether public or
6 private, and any private office, shall have the right to refuse
7 convulsive treatment including, but not limited to, any electrocon-
8 vulsive treatment, any treatment of the mental condition which
9 depends on the induction of a convulsion by any means, and
10 insulin coma treatment.

11 (b) Quarterly, any doctor or facility which administers
12 convulsive treatments shall report to the local mental health
13 director, who shall transmit a copy to the Commissioner of Mental
14 Health, the number of persons who received such treatments
15 wherever administered, in each of the following categories:

- 16 (1) Involuntary patients who gave informed consent

17 (2) Involuntary patients who were deemed incapable of giving
18 informed consent and received convulsive treatment against their
19 will.

20 (3) Voluntary patients who gave informed consent.

21 ~~(4) Voluntary patients deemed incapable of giving consent.~~

22 (c) Quarterly, the Commissioner of Mental Health shall forward
23 to the Board of Registration and discipline in Medicine any
24 records or information received from such reports indicating
25 violation of the law, and the regulations which have been adopted
26 thereto.

27 (d) The Commissioner of Mental Health shall annually submit
28 to the Legislature the accumulation of such reports which shall
29 indicate:

30 (1) The age distribution, the sex, and race of the patients.

31 (2) The source of the treatment payment

32 (3) The average number of treatments

33 (4) The number of cardiac arrests without death, fracture cases,
34 "reported" memory loss, incidents of apnea, and all autopsy
35 findings in case of death following administration of convulsive
36 treatment.

37 (3) To constitute voluntary informed consent, the following
38 information shall be given to the patient in a clear and explicit
39 manner:

40 (1) The reason for treatment, that is, the nature and seriousness
41 of the patient's illness, disorder or defect.

42 (2) The nature of the procedures to be used in the proposed
43 treatment, including its probable frequency and duration.

44 (3) The probable degree and duration (temporary or permanent)
45 of improvement or remission, expected with or without such
46 treatment.

47 (4) The nature, degree, duration, and the probability of the side
48 effects and significant risks, commonly known by the medical
49 profession, of such treatment, including its adjuvants, especially
50 noting the degree and duration of memory loss (including its
51 irreversibility) and how and to what extent they may be controlled,
52 if at all.

53 (5) That there exists a division of opinion as to the efficacy of the
54 proposed treatment, why and how it works and its commonly
55 known risks and side effects.

56 (6) The reasonable alternative treatments, and why the physician
57 is recommending this particular treatment.

58 (7) That the patient has the right to accept or refuse the proposed
59 treatment, and that if he or she consents, has the right to revoke his
60 or her consent for any reason, at any time prior to or between
61 treatments.

62 (f) The Department of Mental Health shall promulgate a
63 standard written consent form, setting forth clearly and in detail
64 the matters listed in paragraph (e), and such further information
65 with respect to each item as deemed generally appropriate to all
66 patients. The treating physician shall utilize the standard written
67 consent form and in writing supplement it with those details which
68 pertain to the particular patient being treated.

69 The treating physician shall then present to the patient the
70 supplemented form and orally, clearly, and in detail explain all of
71 the above information to the patient. The treating physician shall
72 then administer the execution by the patient of the total
73 supplemented written consent form, which shall be dated and
74 witnessed.

75 The fact of the execution of such written consent form and of the
76 oral explanation shall be entered into the patient's treatment
77 record, as shall be a copy of the consent form itself. Should entry of
78 such latter information into the patient's treatment record be
79 deemed by any court an unlawful invasion of privacy, then such
80 consent form shall be maintained in a confidential manner and
81 place.

82 The consent form shall be available to the person, and to his or
83 her attorney, guardian, and conservator and, if the patient
84 consents, to a responsible relative of the patient's choosing.

85 (g) (1) For purposes of this chapter, "written informed consent"
86 means that a person knowingly and intelligently, without duress or
87 coercion, clearly and explicitly manifests consent to the proposed
88 therapy to the treating physician and in writing on the standard
89 consent form prescribed in paragraph (f) of this section.

90 (2) The physician may urge the proposed treatment as the best
91 one, but may not use, in an effort to gain consent, any reward or
92 threat, express or implied, nor any other form of inducement or
93 coercion, including, but not limited to, placing the patient in a

94 more restricted setting, transfer of the patient to another facility, or
95 loss of the patient's hospital privileges. Nothing in this paragraph
96 shall be construed as in conflict with paragraph (e). No one shall be
97 denied any benefits for refusing treatment.

98 (3) A person confined shall be deemed incapable of written
99 informed consent if such person cannot understand, or knowingly
100 and intelligently act upon, the information specified in paragraph
101 (e).

102 (h) Convulsive treatment may be administered to an involuntary
103 patient, including anyone under guardianship or conservatorship,
104 only if:

105 (1) The attending or treatment physician enters adequate
106 documentation in the patient's treatment record of the reasons for
107 the procedure, that all reasonable treatment alternatives have been
108 carefully considered, and that the treatment is definitely indicated
109 and is the least drastic alternative for this patient at this time. Such
110 statement in the treatment record shall be signed by the attending
111 and treatment physician or physicians.

112 (2) A review of the patient's treatment record is conducted by a
113 committee of two physicians, at least one of whom shall have
114 personally examined the patient. One physician shall be appointed
115 by the facility and one shall be appointed by the local mental health
116 director. Both shall be either board-certified or board-eligible
117 psychiatrists or board-certified or board-eligible neurologists. This
118 review committee must unanimously agree with the treatment
119 physician's determinations pursuant to subdivision (1). Such
120 agreement shall be documented in the patient's treatment record
121 and signed by both physicians.

122 (3) A responsible relative of the person's choosing and the
123 person's guardian or conservator, if there is one, have been given
124 the oral explanation by the attending physician as required by
125 paragraph (e). Should the person desire not to inform a relative or
126 should such chosen relative be unavailable, this requirement is
127 dispensed with.

128 (4) The patient gives written informed consent as defined in
129 paragraph (g) to the convulsive treatment. Such consent shall be
130 for a specified maximum period of time not to exceed 30 days, and
131 shall be revocable at any time before or between treatments. Such

132 withdrawal of consent may be either oral or written and shall be
133 given effect immediately. Additional treatments in number or
134 time, not to exceed 30 days, shall require a renewed written
135 informed consent.

136 (5) The patient's attorney, or if none, a public defender
137 appointed by the court, agrees as to the patient's capacity or
138 incapacity to give written informed consent and that the patient
139 who has capacity has given written informed consent.

140 (6) If either the attending physician or the attorney believes that
141 the patient does not have the capacity to give a written informed
142 consent, then a petition shall be filed in superior court to determine
143 the patient's capacity to give written informed consent. The court
144 shall hold an evidentiary hearing after giving appropriate notice to
145 the patient, and within three judicial days after the petition is filed.
146 At such hearing the patient shall be present and represented by
147 legal counsel. If the court deems the above-mentioned attorney to
148 have a conflict of interest, such attorney shall not represent the
149 patient in this proceeding.

150 (7) If the court determines that the patient does not have the
151 capacity to give written informed consent, then treatment may be
152 performed upon gaining the written informed consent as defined in
153 paragraphs (e) and (g) from the responsible relative or the guardian
154 or the conservator of the patient.

155 (8) At any time during the course of treatment of a person who
156 has been deemed incompetent, that person shall have the right to
157 claim regained competency. Should he do so, the person's
158 competency must be reevaluated according to subdivisions 5, 6,
159 and 7.

160 (i) Convulsive treatment for all other patients including but not
161 limited to those voluntarily admitted to a facility, or receiving the
162 treatment in a physician's office, clinic or private home, may be
163 administered only if:

164 (1) The requirements of subdivisions 1, 3, and 4 of paragraph (h)
165 are met.

166 (2) A board-certified or board-eligible psychiatrist or a board-
167 certified or board-eligible neurologist other than the patient's
168 attending or treating physician has examined the patient and
169 verifies that the patient has the capacity to give and has given

170 written informed consent. Such verification shall be documented
171 in the patient's treatment record and signed by the treating
172 physician.

173 (3) If there is not the verification required by subdivision 2 of this
174 section or if the patient has not the capacity to give informed
175 consent, then subdivisions 2, 5, 6, 7 and 8 of paragraph (h) shall
176 also be met.

177 (j) Under no circumstances shall convulsive treatment be
178 performed on a minor 12 years of age. Persons 16 and 17 years of
179 age shall personally have and exercise the rights under this article.
180 Persons 12 years of age and over, and under 16, may be
181 administered convulsive treatment only if all the other provisions
182 of this law are complied with and in addition:

183 (1) It is an emergency situation and convulsive treatment is
184 deemed a lifesaving treatment.

185 (2) This fact and the need for and appropriateness of the
186 treatment are unanimously certified to by a review board of three
187 board-eligible or board-certified child psychiatrists appointed by
188 the Commissioner of Mental Health.

189 (3) It is otherwise performed in full compliance with regulations
190 promulgated by the Commissioner of Mental Health.

191 (4) It is thoroughly documented and reported immediately to the
192 Commissioner of Mental Health.

193 (k) No convulsive treatment shall be performed if the patient,
194 whether admitted to the facility as a voluntary or involuntary
195 patient, is deemed to be able to give informed consent and refuses
196 to do so. The physician shall indicate in the treatment that the
197 treatment was refused despite the physician's advice and that he
198 has explained to the patient the patient's responsibility for any
199 untoward consequences of his refusal.

00 (l) (1) Any alleged or suspected violation of the laws governing
01 the denial of rights herein described shall be reported to the
02 Commissioner of Mental Health, who shall investigate and report
03 each such alleged or suspected violation and the results of the
04 investigation to the Board of Registration and Discipline in
05 Medicine. The latter board shall investigate further, if warranted,
06 and shall subject any physician or physicians to any penalty the
07 board finds necessary as a result of its findings.

208 (2) Any physician who intentionally violates paragraph (3)
209 through (k) shall be subject to a civil penalty of not more than five
210 thousand dollars (\$5,000) for each violation. Such penalty may be
211 assessed and collected in a civil action brought by the Attorney
212 General in a superior court.

213 (3) Such intentional violation shall be grounds for revocation of
214 license.

215 (4) The remedies provided by this subdivision shall be in
216 addition to and not in substitution for any other remedies which an
217 individual may have under law.

218 (m) In any facility in which convulsive treatment is performed on
219 a person whether admitted to the facility as an involuntary or
220 voluntary patient, the facility will designate a qualified committee
221 to review all such treatments and to verify the appropriateness and
222 need for such treatment. The local mental health director shall
223 establish a post audit review committee for convulsive treatments.
224 Records of these committees will be subject to availability in the
225 same manner as are the records of other hospital utilization and
226 audit committees and to such other regulations as are promulgated
227 by the Commissioner of Mental Health. Persons serving on such
228 review committees will enjoy the same immunities as other persons
229 serving on utilization, peer review, and audit committees of health
230 care facilities.

psychosurgery
follows HEW

SENATE No. 394 *deinstitution*

By Mr. D'Amico, a petition (accompanied by bill, Senate, No. 394) of Gerard D'Amico, B. Joseph Tully, Alan D. Sisitsky and Bill Owens for legislation to control the use of psychosurgery. Health Care.

of psychosurgery

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Seventy-eight.

AN ACT TO CONTROL THE USE OF PSYCHOSURGERY.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 17 of Chapter 6 of the Massachusetts
2 General Laws shall be amended by inserting in the first para-
3 graph after the words "Massachusetts Commission for the
4 Blind" the following:
5 and the Psychosurgery Review Board

1 SECTION 2. Chapter 6 of the Massachusetts General Laws
2 shall be amended by adding after section 183 the following sec-
3 tion:

- 4 Section 184. Psychosurgery Review Board
- 5 (a) There shall be a Psychosurgery Review Board, hereaf-
6 ter referred to as the Board, the members of which shall be
7 appointed by the Governor.
- 8 (b) The term of office of each member shall be four years.
- 9 (c) No member may serve for more than a total of eight
10 years in all.
- 11 (d) The Board shall comprise seven members and shall con-
12 sist of:
 - 13 1. a member of the Massachusetts Bar of not less than ten
14 years standing, who shall be Chairman;
 - 15 2. a neurosurgeon, nominated by the American College of
16 Surgeons;
 - 17 3. a neurologist, or neuroscientist, nominated by the Mas-
18 sachusetts Medical Society;
 - 19 4. a clinical psychologist, nominated by the Massachusetts
20 Ps_ cholo_ical A. sociation;
 - 21 5. a member of the genera pu__c, nom nated by the Civil

22 Liberties Union of Massachusetts, or such other body, as
23 the Governor shall appoint for that purpose.

24 6. a psychiatrist, nominated by the Massachusetts Psychia-
25 tric Association,

26 7. a minister of religion.

27 (e) Each person or body nominating a prospective member
28 of the Board shall at the time also nominate an alternate mem-
29 ber to attend any meeting of the Board when the principal
30 nominee shall be unavailable.

31 (f) A quorum for any such meeting shall be constituted by
32 six members of the Board.

33 (g) Decisions of the Board shall be made by the majority
34 vote of not less than five members of the Board.

35 (h) No member of the Board shall be directly engaged in
36 practicing psychosurgery.

37 (i) Notwithstanding the terms of office specified in para-
38 graph (b) of this section, at the time of the initial appoint-
39 ment of the Board three of the members and their alternates
40 shall be appointed for a period of four years, two members and
41 their alternates for a period of three years, and the remaining
42 two members and their alternates for period of five years.

1 SECTION 3. The General Laws are hereby amended by in-
2 serting after Chapter 123A the following Chapter:

3 CHAPTER 123B

4 Section 1. Definitions:

5 (a) "Psychosurgery" means:

- 6 1. the creation of one or more lesions, whether made on
7 the same or separate occasions, in the brain of a per-
8 son by any surgical or altering the thoughts, emotions
9 or behavior of that person, or
- 10 2. the use of such a purpose of intracerebral electrodes to
11 produce such a lesion or lesions whether on the same sep-
12 arate occasions, or
- 13 3. the use on one or more occasions of intracerebral elec-
14 trodes primarily for the purpose of influencing or alter-
15 ing the thoughts, emotions or behavior of a person by
16 stimulation through the electrodes without the produc-
17 tion of a lesion in the brain of that person.

18 (b) "Behavior", for the purpose of this section,

19 1. does not include grand mal, petit mal or Jacksonian
20 epilepsy.

21 2. does not include complex apparently automatic behavior
22 whether presumed to be secondary to cerebral dysrhyth-
23 mia or not.

24 (c) "Experiment" means: a technique or procedure about
25 which there is not sufficient data to recommend it as a recog-
26 nized treatment or to predict accurately the outcome of its
27 performance, and "Experimental" has a corresponding mean-
28 ing.

29 (d) "Patient" means: for the purpose of this section any
30 person upon whom psychosurgery is intended to be performed.

31 (e) "Mentally ill person" means: a person who owing to
32 mental illness requires care, treatment or control for his own
33 good or in the public interest, and is for the time being in-
34 capable of managing himself or his affairs and "mentally ill"
35 has a corresponding meaning.

36 (f) "Informed consent" means: free and voluntary consent
37 by a person to the performance upon him of psychosurgery,
38 after:

- 39 1. a fair explanation has been made to him of the pro-
40 cedures to be followed, including an identification and
41 explanation of those which are experimental;
- 42 2. a full description has been given to him of the attendant
43 discomforts and risks, if any;
- 44 3. a full description has been given to him of the benefits,
45 if any, to be expected;
- 46 4. a full disclosure has been made to him of appropriate
47 alternative treatments, if any, that would be advan-
48 tageous for him;
- 49 5. an offer has been made to him to answer any inquiries
50 concerning the procedures or any part of them;
- 51 6. notice has been given to him that he is free to refuse
52 or to withdraw his consent and to discontinue the pro-
53 cedures or any of them at any time;
- 54 7. full disclosure has been made to him of any financial re-
55 lationship between him and the medical practitioner, in-
56 stitution or hospital to whom consent is to be given for

57 psychosurgery;

58 8. notice has been given to him that he has the right to
59 legal advice and representation at any time during con-
60 sideration relating to the performance of psychosurgery
61 upon him.

62 *Section 2.* The following classes of persons shall be presumed
63 to be incapable of giving free and voluntary consent to the
64 performance upon them of psychosurgery;

65 1. a person under the age of eighteen years;

66 2. a person convicted of any crime and under sentence in
67 respect thereof, whether in custody or not and whether
68 the sentence has been suspended or not;

69 3. a person awaiting trial on a criminal charge, whether
70 such person is in custody or not;

71 4. a person convicted of crime, who is on probation or
72 parole;

73 5. a person convicted of crime who has escaped from law-
74 ful custody;

75 6. any person subject to the Governor's pleasure in respect
76 of his liberty;

77 7. a person released on recognizance in respect of a crim-
78 inal charge, whether or not he has been found guilty in
79 respect of that charge, during the period of the recog-
80 nizance;

81 8. a person under arrest in respect of a criminal charge;

82 9. any person under involuntary commitment to a mental
83 institution.

84 *Section 3.*

85 (a) Psychosurgery shall not be performed on any person
86 who;

87 1. refuses to have such psychosurgery performed upon him,

88 or

89 2. is deemed to refuse to have such psychosurgery per-
90 formed upon him.

91 (b) a person shall be deemed to refuse to have psychosur-
92 gery performed upon him if he neither consents to nor re-
93 fuses to have such psychosurgery performed upon him.

94 *Section 4.* Any person intending to perform or to cause to
95 be performed psychosurgery on a patient shall:

96 (a) make application in writing to the Psychosurgery Re-
97 view Board for its permission for the performance of the said
98 psychosurgery on the said patient;

99 (b) Provide with such application information in writing as
100 to:

- 101 1. the exact nature of the psychosurgery proposed to be
102 performed;
- 103 2. the clinical indications for such psychosurgery;
- 104 3. the hospital or institution in which it is proposed that
105 the psychosurgery be performed;
- 106 4. whether, in his opinion, the patient is capable of giving
107 informed consent to the psychosurgery;
- 108 5. whether, in his opinion, the patient has given informed
109 consent to the psychosurgery;
- 110 6. whether he is in doubt as to the giving of informed con-
111 sent by the patient.

112 *Section 5.* Within ten days of its receiving the application
113 and information referred to in Section 4, the Board shall ar-
114 range a meeting for the purpose of hearing and determining
115 the application. Such meeting and hearing shall take place
116 within a further twenty-one days.

117 *Section 6.*

118 (a) After such hearing and after the Board has made such
119 inquiries and examinations as it thinks fit in relation to the
120 said application and the said patient, the Board shall grant
121 the said application in accordance with subsection (b) of this
122 Section if it is satisfied that,

- 123 1. the patient has the capacity to give informed consent
124 to the proposed psychosurgery; and
- 125 2. the patient has in fact given informed consent to the
126 proposed psychosurgery, and
- 127 3. the proposed psychosurgery has clinical merit and is
128 appropriate for the patient, and
- 129 4. the person or persons undertaking the performance of the
130 proposed psychosurgery are properly qualified to do so,
131 and
- 132 5. the hospital or institution in which it is proposed that
133 the psychosurgery be performed upon the patient is a
134 proper place in which to perform it, and

135 6. that all persons reasonably entitled to receive notice of
136 the hearing have in fact received such notice.

137 (b) The Board shall grant permission in writing to the ap-
138 plicant for the performance of the proposed psychosurgery,
139 specifying the name of the medical practitioner or practition-
140 ers to perform the said psychosurgery, the nature of the psy-
141 chosurgery to be performed, and the hospital or institution in
142 which it is to be performed and the period during which it
143 must be completed.

144 (c) Permission granted under subsections (a) and (b) of
145 this Section shall become null and void at the expiration of
146 the period specified by the Board unless the Board otherwise
147 determines at a further hearing held for that purpose.

148 *Section 7.* If the Board after such hearing and after mak-
149 ing such inquiries and examinations as it thinks fit, in relation
150 to the said application and the said patient, is satisfied that
151 the patient has not given and still does not give informed con-
152 sent, the Board shall refuse the application and state in writ-
153 ing its reasons for so doing.

154 *Section 8.* If the Board, after such hearing and after mak-
155 ing such inquiries and examinations as it thinks fit, in relation
156 to the said application and the said patient, is not satisfied as
157 to any or all of the matters set out in Section 6 (3), (4), (5),
158 or (6) of this Act, the Board shall refuse the application and
159 state in writing its reasons for so doing.

160 *Section 9.* If the Board, after such hearing and after mak-
161 ing such inquiries and examinations as it thinks fit, in rela-
162 tion to the said application and the said patient, is satisfied
163 that the requirements of Section 6 (3), (4), (5), (6) and (7)
164 have been made out, but that:

165 (a) 1. the patient has no capacity to consent to the pro-
166 posed psychosurgery by reasons of the application
167 to him of any of the subsections of Section 1 (f)
168 hereof, or

169 2. there is substantial doubt as to the patient having
170 given informed consent, for any reason,
171 the Board shall then refer the application to a Jus-
172 tice of the Superior Court.

173 (b) The Justice to whom the application is so referred shall

174 conduct a hearing to determine, and shall determine,

- 175 1. whether the patient has the capacity to give informed
176 consent; and
177 2. whether the patient has in fact given informed consent;
178 and
179 3. whether, in circumstances where he finds that the pa-
180 tient has no capacity for the giving of informed con-
181 sent, a guardian should be appointed to consent on the
182 patient's behalf.

183 In determining the questions referred to subsection (b) (3)
184 of this section, the guardian shall make such inquiries as he
185 thinks fit and in determining the question as to whether he
186 should consent on the patient's behalf, the guardian shall not
187 so consent unless he is satisfied that he has before him all
188 information necessary for the formation of an informed con-
189 sent within the meaning of Section 1 (f) of this Act.

190 (d) If the Justice finds that the patient has the capacity to
191 give informed consent but has not and does not give informed
192 consent, then the Justice shall forthwith make an order re-
193 fusing the application.

194 (e) If the Justice finds that the patient has no capacity to
195 give informed consent and if the Justice appoints a guardian,
196 who declines to give consent on the patient's behalf, then the
197 Justice shall forthwith make an order refusing the applica-
198 tion.

199 (f) If the Justice finds that the patient has capacity to give
200 informed consent, and has given and still gives such informed
201 consent, then the Justice shall remit the application to the
202 Board for the purpose of its granting the application.

203 (g) If the Justice finds that the patient has no capacity to
204 give informed consent, he shall appoint a guardian for the
205 purpose of giving consent. If the guardian does give informed
206 consent, the Justice shall remit the application to the Board
207 for the purpose of it granting the application.

208 *Section 10.*

209 (a) Before any hearing before the Board or a Justice takes
210 place under any of the provisions of this Act, the patient, the
211 person making the application, and the patient's next of kin, if
212 any shall receive five clear days notice of such a hearing and

213 shall be entitled to attend and be heard at such hearing.

214 (b) The patient may be represented by counsel at any hear-
215 ing.

216 *Section 11.* A copy of the order granting or refusing the ap-
217 plication shall be served personally or by registered mail with-
218 in seven days of the making of the order on the patient, his
219 legal representative, if any, and the person making the ap-
220 plication.

221 *Section 12.* After completion of psychosurgery, the person
222 performing the same shall make a written report as to the
223 operation and its results to the Board.

224 *Section 13.* The Board shall take all reasonable steps to en-
225 sure that appropriate continuing observations are made in re-
226 spect of each patient with a view to monitoring the effects of
227 psychosurgery. The Board may make such provisions for the
228 making of such observations and the recording or otherwise
229 dealing with such information as the Board shall see fit.

230 *Section 14.* No person shall perform, cause to be performed
231 or knowingly permit to be performed psychosurgery on any
232 patient without complying with the requirements of this Act.

233 *Section 15.* The following penalties shall be imposed against
234 any person performing psychosurgery or causing psychosur-
235 gery to be performed contrary to the requirements of this
236 Act.

- 237 (a) first violation will result in
238 1. suspension of medical license, or
239 2. fine of not more than \$5,000 or
240 3. up to 1 year in prison, or
241 4. any combination of the above.

- 242 (b) Second violation will result in
243 1. revocation of medical license, or
244 2. fine of not more than \$15,000 or
245 3. up to 5 years in prison, or
246 4. any combination of the above.

MR. ENGELBRECHT (Continued): of these bills are already incorporated in Proposed Bill No. 66 which you have already had a public hearing on and in any event, the Commissioner expressed the opinion that in 5268 any patient's attorney shall have the right to expect a copy of all of such patient's hospital records. The caveat only if litigation is in progress or in process, which is part of Proposed Bill 66. And even though the Department's bill which is 66 did not state that hospital rights shall be posted in Spanish and English, I believe in his testimony at the time the Commissioner recommended that both of those things be done at that time.

Proposed Bill 5270, the definition of facility, we are asking that this bill be withdrawn. This bill was instituted by the Planning Section of the Department of Mental Health and we have upon investigation, found that we can do this under departmental regulation or in-house rather than asking the Legislature to pass a bill in this regard.

And 5271 which is a bill which Comm. Manson testified on, the work release and educational release programs, we would suggest two minor changes. In Line 22 where it says with the concurrence of the superintendent of such institution, we would suggest that the word "or director" be added to the word "superintendent" because some of the Department of Mental Health facilities have a director and some have a superintendent, and the institution is a term we do not use anymore. We have statutorily changed that to the word "facility, so if those changes were made just merely for clarification. Other than that, the Department is in support of this particular piece of legislation.

SEN. MARTIN: Judith Lerner.

JUDITH LERNER: Hello, I'm Judith Lerner. I'm speaking today on behalf of Connecticut Legal Services and the Mental Health Association of Connecticut. Both these organizations support Belt Bills 5268 and 5272. Both of these bills were discussed #5 extensively last week Bill No. 66. However, they both have different versions of the bill -- of the parts of Bill No. 66. 5268, we would prefer the version in Bill 66. As the gentleman over there mentioned, this provides the denial of the patients' rights for the record for good cause and we feel that that's too vague and too limiting and we prefer the version in the Commissioner's bill.

5272 is identical to the version in 66 except that it provides for posting of the rights in Spanish and in English, which we certainly support.

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HUMANE INSTITUTIONS

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JUDITH LERNER (Continued): As a matter of strategy, I think these two bills won't meet very much opposition and I think they might do better standing on their own than as part of the nominated bill.

Thank you.

SEN. MARTIN: Thank you, Judy.

John Pyatak.

MR. PYATAK: Madam Chairman, members of the Committee. My name is John Pyatak. I am Legislative Liason with the Legislative Office of Legal Services, representing Connecticut Legal Services and the Legal Services programs in New Haven and Hartford, and I would like to associate my remarks today for the record with Judy Lerner, the previous speaker in support of House Bill 5272. This bill would provide the patients' right be prominently be posted in English and Spanish. The bill would help inform not only the patient, but doctors, and other institutional personnel of the legal constraints or rights associated with their actions.

We are also in support of 5268 as it is written in Senate Bill 66.

Thank you very much.

SEN. MARTIN: Thank you.

Is there anyone else here who would like to speak?

Then I call the meeting to an end. Thank you. Thank you for coming.