

Shock and the Law

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If someone is receiving electroshock as an out-patient, the common law right to refuse treatment stands firmly in place. The situation changes once the potential shock patient is admitted to a psychiatric institution, and the provisions of mental health legislation come into play. It is not possible to deal with the legislation of all the jurisdictions in Canada, and I shall confine myself to the Ontario situation, except for the general statement that *no* Canadian jurisdiction distinguishes in its legislation between electroshock and other forms of psychiatric treatment, applying the same rules to all. The sole exception is that two provinces (Ontario and Prince Edward Island) grant special status to psychosurgery, as will be mentioned later. Several American states do single out electroshock for special consideration—such as California, Massachusetts and New Jersey.

In Ontario, in theory, the voluntary or "informal" psychiatric patient retains all the rights she would have had as an out-patient; she may accept or refuse any form of treatment. In practice the situation is not so simple. Once a person admits herself to the hospital, she may at any time be made an involuntary patient upon the doctor's completing a form stating that she meets the criteria for commitment. It is not unusual for a refusal of treatment to quickly lead to commitment.

As well, a psychiatric ward is an inherently coercive setting, and it is very difficult for a patient to make a truly voluntary and informed choice about whether to have any treatment. The typical voluntary patient for whom electroshock is suggested is likely to be a woman suffering from severe depression, listless, apathetic, uncritical of her doctor, aware that she is liable to the additional stigma of commitment if she does not cooperate, and very susceptible to persuasion or intimidation by staff, and often by family. I hesitate to carry this argument too far; I do

not mean to suggest that *by definition* a psychiatric patient is incapable of making a voluntary decision, but only that special care must be taken to ensure that a choice is truly voluntary and informed. Persuasion or coercion by staff and family is generally not ill-intentioned; on the contrary, it is usually based on a sincere belief that electroshock will alleviate the patient's distress and restore her mental well-being. Nonetheless, coercion it is, and it therefore invalidates the consent.

The involuntary patient faces the same hurdles and more. First, the treating doctor must make a determination as to the patient's competency to make a decision about electroshock. This determination is not reviewable; in contrast, the doctor's determination that a patient is not competent to manage her financial affairs *is* reviewable by a Regional Review Board. A finding of incompetency to make treatment decisions is of immense significance, since its effect is to deprive the patient of all rights whatsoever to make decisions about her treatment. Such a finding might be susceptible to attack under the Charter (Section 7) as depriving the patient of security of the person in a manner not in accordance with the principles of fundamental justice. A particular concern in practice is that the question of the patient's competency is rarely raised except when treatment is refused. I leave you to speculate on the legal implications of administering treatment to a consenting but non-competent adult, which happens daily in our psychiatric institutions.

If the patient is found not to be competent, the right to make a decision about whether she should receive electroshock passes to her nearest relative, if there is one, and otherwise to the Review Board. This raises further questions. First, suppose that the nearest relatives, as defined in the *Mental Health Act*, are the parents? What if they disagree? Is the consent of either of them enough? Is the doctor bound by the reply of the first one he asks? In *Re T*, you may recall, the doctor appears to have used a sort of 'shopping list' approach.¹ First, Mrs. T. was considered *competent* to make her own decision about electro-

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shock. In spite of this, the doctor sought consent from the family. The husband refused, and he went to the father. The father refused, and he went to the brother. The brother also refused, at which point the doctor appears to have given up on the family. This sort of approach is clearly totally unacceptable, and probably represents an extreme, but the danger is obvious.

Also, as already mentioned, if a relative is empowered to give a substituted consent, it should be on the basis of what the patient would have decided had she been competent. The forms in use in at least one of our psychiatric institutions for obtaining a substituted consent state explicitly that the person consenting has satisfied himself that the treatment is for the patient's benefit; no reference is made to the proper basis for determination. A family member consenting on an improper basis might well be liable to legal action as a result, and there is in my opinion an obligation on the doctor to inform the family of its responsibility to consider what the patient's wishes would have been if she had been competent.

There has recently been an experiment in having people who wish to avoid particular treatments such as electroshock, should they ever be found incompetent to decide, prepare in advance a declaration of their wishes, accompanied by a statement by a physician that at the time of making the declaration they are competent to do so. Such a declaration should in theory be binding upon family members; it will be interesting to see the result if and when one of these declarations is challenged.²

The refusal of a competent patient, or of the nearest relative of an incompetent patient, can be overridden by a Regional Review Board. This is the only example in law where a competent refusal of treatment can be disregarded, and it is difficult to see any justification for it. A person has the right to suffer pain by refusing painkillers, even to die by refusing life-saving treatment, but not to remain depressed by refusing electroshock or antidepressants. This provision of the *Mental Health Act* appears ripe for a challenge under the Charter as denying security of the person (Section 7). I should add that there is already one legal decision confirming what probably no one ever doubted—namely, that medical treatment can constitute an infringement or assault on security of the person.³

The Charter does, of course, provide that one may be deprived of security of the person so long as the deprivation is done in accordance with the principles of fundamental justice. I would submit that the procedures before the Regional Review Board do *not* accord with those principles, and that if there is to be any forum in which this right can be infringed it should be a courtroom, in which at least basic protections are offered. As well, the criterion provided in the Act for the Board's decision is explicitly a "best interests" one, which is in my view an illegitimate use of the state's power to safeguard its citizens; that power should be exercised only by a court, not to protect the incompetent, and even then, to cite the *Dion* case from Quebec, "this jurisdiction is exercised in order to determine which decision the incapacitated person would have made if he had been competent to decide."

Since March of this year there are some procedural protec-

tions in Review Board hearings which were formerly lacking but there is still great scope for abuse. It not only is possible, but actually occurs, that treatment is ordered at a hearing of which the patient has less than 48 hours notice (bear in mind that in general it takes a lawyer four days to gain access to the clinical record). The Review Board—at least the one with which I am most familiar—does not require the attending physician to be present at the hearing unless a request is specifically made by the patient, who may well be unaware of the need to make the request. (In contrast, at a recent hearing at which I represented a patient, the Board refused my client's request that *she* not attend, and that I be allowed to argue her case in her absence.) Since the physician need not be present, the patient is deprived of her right of cross-examination. Even more disturbing, the Board is very lax about evidentiary rules, examining in advance of the hearing any documents submitted by the doctor and any documents copied by the patient's lawyer from the clinical record, on the ground that obviously these are going to be put into evidence, and so they have a right to read them in advance. (This sometimes presents a great temptation to order copies of such irrelevant items as the patient's clothing list for the satisfaction of imagining the Board puzzling over them.) In fact, if the doctor does not attend it is difficult to understand how the board can accept *any* documents into evidence to support the application to treat, as there is no one there to introduce them. The Board has also been known to insist that the patient present her case first, without knowing the doctor's reasons for wanting treatment ordered. Examples abound of such disregard of fundamental procedural protections, and complaints are shunted aside with the assurance that the Board only wants what is best for the patient, and that undue technicalities or analogies to the protections provided to a criminally accused are misguided.

In short, electroshock can be ordered over the refusal of a competent patient in a hearing of which she gets two days' notice, at which she is probably not represented by counsel, without the patient or her counsel getting access to the clinical record, in the absence of any properly admitted evidence supporting the application, and in the absence of any chance for the patient or her counsel to test the doctor's evidence by cross-examination. I believe this falls far short of being in accordance with the principles of fundamental justice.

Section 15 of the Charter guarantees equal protection and equal benefit of the law, without discrimination based on, among other things, mental disability. The statutory provisions setting different rules for treatment for voluntary and involuntary patients, and for competent and incompetent patients, may well be open to challenge under this section as well.

The Charter also guarantees freedom of thought in Section 2(b). It has been argued successfully in a number of American cases that various psychiatric treatments are unconstitutional because they drastically alter the patients' mental processes.⁴ Even the strongest proponents of electroshock would concede that it has this effect—in fact, that is the whole purpose of its use. Following electroshock, the patient is often confused and disoriented, with at least short-term and frequently permanent

memory impairment, so that a challenge under Section 2(b) might well be effective.

Section 1 of the Charter does, of course, allow for such limitations on the rights provided by the Charter as are demonstrably necessary in a free and democratic society. I, frankly, fail to see how that section could be used to justify the present *Mental Health Act* practice or procedure.

All of what I have said so far applies not only to electroshock, but also to any other psychiatric treatment, with the sole exception of psychosurgery, which cannot be performed on an involuntary patient in Ontario, even with the patient's consent. In *Re T*, I attempted to demonstrate on behalf of my client that electroshock fell within the definition of psychosurgery in the *Mental Health Act* (Section 35), in which case the Board would have had no jurisdiction to authorize treatment. That argument failed at the trial level, even though Madam Justice Van Camp conceded in her decision that there were many unanswered questions about electroshock and that further research was needed. Because of subsequent events, the argument was not tested at the appeal level, where Charter arguments would have been made.⁵

The argument does, however, raise the question of whether electroshock should have some special status among psychiatric treatments, as psychosurgery does. The American case of *Wyatt v. Alderhold* has held that electroshock should not be considered as "just another somatic treatment."⁶ Electroshock may well be the most controversial treatment in common use today. Its advocates say it is safe and effective; its critics say it is harmful and ineffective. Opinions range from suggesting that it should be used whenever the doctor deems it appropriate, whether consented to or not, to demanding that it be totally banned, in the same way that our society has banned such purported treatments as Laetrile, and such substances as cyclamates and heroin. It is to be hoped that the Electroconvulsive Therapy Review Committee appointed this year by the Minister of Health will make some definitive findings about the risks and benefits of electroshock, and provide a solid foundation for determination of what our laws should say about its use.

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If the findings of that Committee are that electroshock is safe and effective, there will be no reason to consider it as different from any other treatment. I remind you, however, that the present laws regarding psychiatric treatment in general may be drastically changed through the application of the Charter.

If the Committee's findings are negative, and electroshock is found to present substantial risks for little benefit, it will require special consideration. Possibly it will be banned. Possibly it will be classed with psychosurgery as legitimate only for voluntary patients. Such a finding might well open the door to an attack on at least involuntary electroshock under Section 12 of the Charter, the provision forbidding cruel and unusual treatment or punishment. This suggestion has been raised by, among others, Morris Manning in his recent book on the Charter.⁷

At present, given the diversity of opinion about the merits of electroshock, a doctor who wishes to obtain an informed consent to the treatment is in somewhat of a quandary. What

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information should he give? I would suggest that at the very least the information should include the fact that it is a controversial treatment, and the psychiatry community itself is divided on the question, with some specifics as to the points in dispute—in particular, its therapeutic effectiveness, the possibility of permanent memory loss, and the risk of brain damage.

I would also suggest that the use of electroshock for the purpose of restraint rather than treatment, reported last year in the *Canadian Journal of Psychiatry*, is totally without legal justification, and that a treatment of this sort should never be used for non-therapeutic purposes and without proper legal authorization.⁸

As for the future, I would argue that at the very least the psychiatric patient is entitled to the same legal protections as the patient with physical illness. That includes, for the competent patient, the right to full information, the absence of coercion, and the right to say no without the possibility of being overruled by a paternalistic body presuming to know better what the patient should do. It includes proper safeguards to ensure that a person found not competent to make these decisions is in fact not competent, and not just disagreeing with the doctor. And in the case of the truly incompetent patient, if we are to allow a decision to be made on her behalf, I can only echo the words of Mr. Justice Durand of the Quebec Superior Court in the *Dion* case, as he quoted the Supreme Court of Massachusetts:

We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent... Such questions seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government has created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.⁹

Footnotes:

1. *Re T v. Board of Review for the Western Region* (1983), 44 O.R. (2d)153; also see Don Weitz, Shock Case: A Defeat and Victory. *Phoenix Rising*, vol.4 nos. 3-4, April 1984, 28A-30A.
2. See Don Weitz, The Statutory Declaration: A Legal Way to Save Your Body, Mind or Life from Psychiatric Treatment. *The Mad Grapevine*, (ON OUR OWN newsletter), October 1984, pp.6-9. (see edited version this issue).
3. *Petersen v. Minister of Health for the Province of Ontario et al.*, No.18495 (Ont. S.C., Dec. 23, 1983).
4. For example, *Kalmowitz v. Department of Mental Health*, Civil Action No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973).
5. See note 1 above.
6. *Wyatt v. Alderhold*, 503 F. 2d 1305 (5th Cir. 1974).
7. Morris Manning, *Rights and Freedoms and the Courts: A Practical Analysis of the Constitution Act 1982*. Toronto: Edmond-Montgomery Ltd. (1983).
8. J.J. Jeffries, and V.M. Rakoff, E.C.T. as a form of restraint. *Can. J. Psychiat.* Dec. 1983, vol.28, No.8, pp.661-663. Also see critique by Elaine Newman, ECT as restraint: illegal and undesirable. *Phoenix Rising*, vol.4, Nos.3-4, April 1984, pp. 24A-26A.
9. *Institute Philippe Pinel de Montreal v. Dion* (1983), 2D.L.R. (4th) 234.