Substituted Judgment and the Right to Refuse Shock Treatment in Washington:  
_In re Schuoler_

_I. INTRODUCTION_

One of the most significant developments in modern constitutional thought revolves around judicial protection of fundamental privacy and liberty interests. These interests are derived from the first, eighth, and fourteenth amendments, the "penumbra" of privacy rights found generally in the Bill of Rights, and the common law doctrine of informed consent. Courts have held these interests to be of such paramount concern to individual freedom that states may not derogate these interests unless a compelling state interest is at stake. The judiciary's function is to balance the individual's liberty interest against the state's interest in regulating or protecting persons and to focus on the nexus between those two interests.

This Note will consider the process of protecting an individual's constitutional right to refuse intrusive psychiatric treatment—specifically, an involuntarily committed mental

1. "Fundamental" interests include certain non-economic interests valued so highly by the courts that any state law burdening such a right is subject to the "strict scrutiny" standard of judicial review. In contrast, a state law that burdens a non-fundamental right is generally subject to deferential review by the courts. See Roe v. Wade, 410 U.S. 113, 155 (1973).


3. The doctrine of informed consent generally refers to the tort law theory that requires a doctor to adequately inform his patient about the nature of some proposed treatment and receive the patient's consent before performing the treatment. J. LUDLAM, _INFORMED CONSENT_ 19-23 (1978). If the doctor exceeds the scope of his patient's consent or misrepresents the severity of the operation, the patient may bring an action for battery against the doctor. _Id._ at 23-24. If the doctor fails to disclose possible complications or alternative methods of treatment, the patient may bring an action in negligence. _Id._ at 24. This doctrine raises serious concerns in the case where a mental patient refuses to give, or is incapable of giving, informed consent to a doctor to undergo electroconvulsive treatment (ECT).
patient’s right to refuse electroconvulsive “shock” treatment (ECT). This issue illustrates the classic academic conflict between personal freedom and state interests. The decision-making process that is used to enforce or override the mental patient’s privacy rights will directly affect the interests of the patients, their families, the mental health professionals involved in administering ECT, the states, and the courts. Each of these groups has an interest that conflicts to some degree with the other interests.4

Analysis of this issue is particularly timely because the Washington Supreme Court has recognized, for the first time in In re Schuoler, the right to refuse ECT.5 Among other significant themes, the existence of Schuoler may suggest a current trend in psychiatric treatment toward a preference for the use of ECT over alternative methods of treatment, such as antipsychotic drugs.

This Note will first analyze and evaluate two competing decision-making models established in other jurisdictions. The Note will then apply that analysis to Schuoler and critically evaluate that decision. The Note will conclude that while the Washington court follows the more appropriate judicial substituted judgment model, its poor articulation of that model may defeat the purpose of the decision: to protect a mental patient’s right to refuse ECT.

4. The patient has an interest in freedom from nonconsensual treatment and in recovering or retaining mental health. The right to be free from nonconsensual treatment is founded in the doctrine of informed consent, discussed supra note 3. Aspects of this right may be seen in the decision-making system of the judicial substituted judgment model, discussed infra text accompanying notes 40-74. The patients’ families have an interest in attaining the greatest welfare and care for their loved ones. The mental health professionals perceive and arguably have a duty to treat the patient in his “best interests,” and the states have an interest, through their police and parens patriae powers, in caring for persons who cannot take care of themselves. Finally, the courts have an interest in executing legislative acts and in regulating nonconsensual treatment that the mental health professionals deem to be in the patients’ best interests.

Between 1977 and 1980, the number of involuntary commitments per year in Washington institutions rose from 325 to 1,129. The total number of voluntary and involuntary commitments in Washington rose from less than 1,000 to over 1,500 per year. Durham & La Fond, The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment, 3 YALE L. & POL’Y REV. 395, 417 (1985) [hereinafter Empirical Consequences]. Interestingly, the increasing incidence of Washington commitments was at least partly caused by a statutory broadening of the definition of “gravely disabled.” Id. at 417-428; see infra text accompanying notes 121-24.

5. 106 Wash. 2d 500, 723 P.2d 1103 (1986).
II. BACKGROUND

Involuntary commitment is the process of confining a person within the walls of a mental institution, whether publicly or privately administered, against his will. When committing an individual, the state has an interest in depriving the patient of his liberty interest, for the benefit of others or the patient himself, through either its police power or its parens patriae power.

A person is committed if he falls within one of several statutorily defined categories of mental illness. These categories generally require that the person is unable to take care of himself or is a danger to himself or others. Once a patient is committed, the state undertakes the patient's care, protection, and treatment, if necessary. This treatment may include administering psychotherapy, antipsychotic drugs, and possibly ECT; in the past, it has included even psychosurgery.

Courts have struggled over the past decade with determining the proper relationship among the judiciary, the mental health professional (MHP), and the patient when deciding how to treat an involuntarily committed patient. The controversy has centered on which of these three parties should have the authority to determine whether a patient should receive intrusive psychiatric treatment. MHP's have taken the posi-

6. For a general discussion of the involuntary commitment process, see R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL (1968).
7. The state uses its police power to prevent a patient from harming himself or others. The state uses its parens patriae power to provide a patient with his essential daily needs. See WASH. REV. CODE § 71.05.150 (1987); Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 HARV. J. ON LEGIS. 275, 279-80 (1983), reprinted in American Psychiatric Association, Issues in Forensic Psychiatry 57-180 (1984).
8. See infra note 109.
10. "Mental health professional" includes psychiatrists, psychologists, and psychiatric nurses, and may include physicians, registered nurses, and social workers. See WASH. REV. CODE § 71.05.020(11), (12) (1987). Although this term may be used with reference to individuals who effectuate commitments of the mentally ill, for purposes of this Note, MHP refers to those persons who treat patients who have already been committed.
11. Antipsychotic drugs, ECT, and psychosurgery are examples of treatment considered to be highly intrusive. "In essence, intrusiveness measures the extent to which a treatment alters the behavior and thought processes of the patient." Note, Regulation of Electroconvulsive Therapy, 75 MICH. L. REV. 363, 375 (1976). Intrusiveness may also be thought of in terms of the degree and likelihood of adverse
tion that they should have the authority to act in the patient’s best interests without any judicial intervention. Conversely, public interest and civil rights groups have taken the position that the courts should regulate the administration of intrusive treatment, giving particular deference to the patient’s expressed or implied preference.

Courts as well as MHP’s have regarded ECT and antipsychotic drug therapy as two highly intrusive and potentially dangerous procedures. There is a great deal of controversy over the efficacy and potential side effects of these treatment methods. Many authorities find ECT to be a more extreme method of treatment than antipsychotic drug therapy, while

side effects caused by the treatment, such as memory loss and impairment of ability to learn. See Schuoler, 106 Wash. 2d at 506, 723 P.2d at 1107-08.

12. See infra notes 23-39 and accompanying text. See Amicus Curiae Brief of the International Psychiatric Association for the Advancement of Electrotherapy at 18-23; Schuoler, 106 Wash. 2d 500, 723 P.2d 1103.

13. See infra notes 40-74 and accompanying text. See Brief of Amici Curiae The Defender Association, Evergreen Legal Services, & American Civil Liberties Union of Washington at 79-81, Schuoler, 106 Wash. 2d 500, 723 P.2d 1103.

14. The term “implied preference” here refers to the subjective method of determining an incompetent person’s intent under the substituted judgment model, discussed infra text accompanying notes 55-60 and 91-97.

15. Schuoler, 106 Wash. 2d at 506, 723 P.2d at 1107. ECT is a very controversial method of treating severe cases of mental illness. The use of ECT causes severe side effects such as short- and long-term memory loss and impairment of the ability to learn new material. Id. (quoting AMERICAN PSYCHIATRIC ASSOCIATION, ELECTROCONVULSIVE THERAPY: REPORT OF THE TASK FORCE ON ELECTROCONVULSIVE THERAPY OF THE AMERICAN PSYCHIATRIC ASSOCIATION, 57 (1978) [hereinafter TASK FORCE ON ECT]).

ECT is administered by attaching electrodes to one or both temples and passing an electric current through the brain for a split-second. The resulting convulsion, similar to a grand mal seizure, lasts for less than a minute, and the patient regains consciousness within half an hour. ECT has also been known to cause broken bones and dislocations as well as respiratory and cardiovascular complications. Note, Regulation of Electroconvulsive Therapy, 75 Mich. L. Rev. 363, 365-67 (1976); see P. Schrag, Mind Control 151-60 (1978).

16. The term “antipsychotic drugs” refers to such drugs as Thorazine, Mellaril, Prolixin, and Haldol, which are generally used in severe cases of schizophrenia and depression. These drugs have been found to cause severe long-term side effects, such as tardive dyskinesia, which causes involuntary muscle contractions. See Rogers v. Okin, 478 F. Supp. 1342, 1359-60 (D. Mass. 1979), aff’d in part and rev’d in part, 634 F.2d 650 (1st Cir. 1980); Mills v. Rogers, 457 U.S. 291, 293, n.1 (1982); P. Schrag, Mind Control 106-11 (1978).

17. See, e.g., Gundy v. Pauley, 619 S.W.2d 730, 732 (Ky. Ct. App. 1981) (McDonald, J., concurring) (“I can envision no greater insult to the person as a whole than the involuntary administration of ECT when the patient is neither suicidal nor dangerous to others.”). State statutes generally tend to provide greater protections against improper treatment with ECT than with antipsychotic drugs. The Washington Involuntary Treatment Act (ITA), for example, prevents psychiatrists from treating patients with ECT without a court order but does not provide any such protection
others find ECT to be more effective than drugs with some types of psychological disorders, and especially in cases of severe depression. However, states generally view ECT as a more intrusive method of treatment than drugs.

While few courts have directly confronted the issue of the right to refuse ECT, some states have established substantive and procedural requirements for protecting the right to refuse antipsychotic drugs. The following analysis will apply two decision-making models, developed for antipsychotic drug treatment, to the case of ECT. This application should reveal the proper groundwork for analyzing how the administration of ECT should be regulated.

from treatment with antipsychotic drugs. See WASH. REV. CODE § 71.05.370 (1987). ECT is often used as a last resort treatment for patients who do not respond to treatment with antipsychotic drugs; such was the case with Ms. Schuoler. See infra text accompanying notes 70-82.

18. TASK FORCE on ECT, supra note 15, at 14-16 ("ECT was shown to be a superior antidepressant treatment for depressed patients diagnosed as manic-depressive and involutional psychotic."); Note, Regulation of Electroconvulsive Therapy, supra note 11, at 366.

19. Compare WASH. REV. CODE § 71.05.370 (1987), which provides an absolute right to refuse psychosurgery and a qualified right to refuse ECT but does not provide a right to refuse antipsychotic drugs with N.J. STAT. ANN. § 30:4-24.2d (1), (2) (West 1981), which provides an absolute right to refuse shock treatment and psychosurgery, but only requires a physician's written order for medication. Also compare with MASS. GEN. LAWS ANN. ch. 123, § 23 (West Supp. 1987), which provides mental patients with the right to refuse shock treatment and lobotomy but authorizes the hospital superintendent to deny these rights for good cause, and further provides that such treatment shall not be performed without the written consent of the patient's legal guardian or his nearest living relative.

20. See Price v. Sheppard, 239 N.W.2d 905, 910 (Minn. 1976) (judicially authorized administration of ECT must be necessary and reasonable as well as the least intrusive method, as determined by various factors); Gundy v. Pauley, 619 S.W.2d at 731-32 (in the absence of a judicial declaration of incompetence, or emergency posing an immediate danger of harm to others or to the patient, the patient may not be compelled to undergo ECT against his will, simply because it was considered in his best interest); Conservatorship of Waltz, 180 Cal. App. 3d 722, 227 Cal. Rptr. 436 (1986); Northern Cal. Psychiatric Soc'y v. Berkeley, 178 Cal. App. 3d 90, 223 Cal. Rptr. 609 (1986); Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976); In re W. S., Jr., 152 N.J. Super. 298, 377 A.2d 969 (1977).

Other courts have treated ECT and antipsychotic drugs identically. See, e.g., In re Guardianship of Roe, 383 Mass. 415, 436-37, 421 N.E.2d 40, 53 (1981), where the Supreme Judicial Court of Massachusetts treated drugs in the same manner as it would treat psychosurgery or ECT "[b]ecause of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side effects. . . ."
III. TWO MODELS FOR REGULATING TREATMENT REFUSAL: MEDICAL SECOND OPINION AND JUDICIAL SUBSTITUTED JUDGMENT

Two states have established doctrines that deal with the issue of regulating intrusive treatment. New Jersey adopted the medical second opinion model as a means of regulating the administration of antipsychotic drugs to involuntarily committed mental patients. Massachusetts adopted the judicial substituted judgment model to protect involuntary mental patients from unwanted drug treatment. These two models vary in their methods of reviewing an involuntarily committed mental patient’s refusal of antipsychotic drugs.

A. The Medical Second Opinion Model

New Jersey's medical model provides that an MHP has the authority to decide whether to treat the patient with antipsychotic drugs. The MHP's decision is reviewed through hospital administrative regulations, rather than through the courts. The standard for measuring the patient's constitutional right to refuse antipsychotic drugs is "whether the patient constitutes a danger to himself or others." This standard appears to establish the threshold requirement for finding that a compelling state interest exists to override the patient's right to refuse intrusive psychiatric treatment.

Reviewing New Jersey's model, a federal court of appeals held in *Rennie v. Klein* that involuntarily committed mental patients have a constitutional right to refuse administration of antipsychotic drugs. That right may be overridden, however, if the patient's doctor determines that the patient 1) will harm himself or others without the drugs; 2) cannot improve without the drugs; or 3) can improve without the drugs, but only at a significantly lower rate. The physician who makes the decision to administer such drugs must exercise professional

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21. See infra text accompanying notes 23-36.
22. See infra text accompanying notes 40-69.
23. See Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983). On previous hearing, the court noted that no New Jersey appellate courts have reviewed this issue. Rennie v. Klein, 853 F.2d 836, 842 (3d Cir. 1981). Therefore, all discussion of New Jersey's medical model will be through reference to federal court decisions.
24. See, Rennie, 720 F.2d at 270 n.9 (quoting N.J. Ad. Bull. 78-3 (1975)).
25. Rennie, 720 F.2d at 269.
26. 720 F.2d 266.
27. Rennie, 720 F.2d at 274 (quoting N.J. Ad. Bull. 78-3, § 11(B) (1975)).
Judgment. 28

The Rennie court also determined that under New Jersey's model, MHP's need not select for the patient the "'least intrusive treatment' available under the circumstances." 29 Although one factor MHP's must consider is the possibility and extent of harmful side effects, 30 MHP's may constitutionally administer antipsychotic drugs to a patient whenever in their professional judgment they deem such an action "necessary to prevent the patient from endangering himself or others." 31 The omission of the "least intrusive" requirement from constitutional scrutiny is significant in that MHP's may apply the treatment they think is in the patient's best interests, regardless of how the patient views the relative intrusiveness of the treatment.

Relying on the Supreme Court's holding in Youngberg v. Romeo, 32 the Rennie court held that an MHP's judgment on the dangerousness of a patient and the MHP's decision to administer medication will be presumed valid unless shown to be a "substantial departure from accepted professional judgment, practice or standards." 33 The Youngberg court justified this presumption of validity because "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making [treatment] decisions." 34

An additional rationale for the medical model, found in Parham v. J.R., 35 is that "[t]he judicial model for factfinding for all constitutionally protected interests, regardless of their nature, can turn rational decision-making into an unmanageable enterprise." 36 Presumably, the court was referring to the possibility that an incompetent patient might be deprived of necessary treatment if the treating doctor's petition for authorization were to be tied up in the courts. Proponents of the medical model argue that it avoids congestion in the courts and

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28. Rennie, 720 F.2d at 269.
29. Id. at 269 n.9.
30. Id. at 269.
31. Id.
33. Rennie, 720 F.2d at 269.
34. 457 U.S. at 322-23. Further, the Youngberg court relied on Bell v. Wolfish, 441 U.S. 520, 544 (1979), which held that courts should not "second-guess the expert administrators on matters on which they are better informed. . . ."
36. Id. at 608, n.16.
allows MHP's to make more effective, educated decisions for patients.

However, the medical model has been criticized over the past decade as a dangerous method of decision-making. Critics note that the level of deference provided to MHP's through the medical model creates opportunities for unlimited application and abuse.\(^{37}\) By elevating the importance of improving the patient's condition, MHP's diminish the importance of protecting the patient's privacy and liberty interests.\(^ {38}\) Further, the science of psychiatry itself is inexact and very controversial; different schools of thought often conflict directly on methods of treatment. Because some psychiatrists tend to follow exclusively one method of treatment for certain types of patients, one should not defer to their recommendations without sufficient scrutiny.\(^ {39}\) One solution to the shortcomings of the medical model is the regulation of treatment decisions through the judicial model.

### B. The Judicial Substituted Judgment Model

The Massachusetts judicial substituted judgment model provides extensive safeguards for protecting the fourteenth amendment or "penumbral" privacy rights of mental patients. This system limits the authority of MHP's in making treatment decisions for their patients by assuming that patients have the right to personally exercise treatment decisions until a court deems them incompetent.\(^ {40}\) However, a doctor may override a patient's desires if an emergency situation requires

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37. See Suzuki v. Quisenberry, 411 F. Supp. 1113, 1123 (D. Haw. 1976) ("Given the present state of medical knowledge regarding abnormal behavior and its treatment, few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of such treatment as will give (them) a realistic opportunity to be cured"); Guardianship of Roe, 383 Mass. 415, 437 n.11, 421 N.E.2d 40, 53 n.11 (1981) ("The obvious potential for misuse of [antipsychotic] drugs provides an additional reason to require judicial approval prior to [their] forcible use . . . upon incompetent individuals."); Empirical Consequences, supra note 4, at 397 (there has been an historical shift from the medical model to the judicial model); Ennis, Judicial Involvement in the Public Practice of Psychiatry, in LAW AND THE MENTAL HEALTH PROFESSIONS 5-17 (1978); Comment, Civil Commitment, supra note 2, at 501-03.


39. See id. at 32. Deference to other doctors' recommendations without independent investigation is better known as "rubber-stamping."

that the patient receive treatment.\textsuperscript{41}

Once the patient is found incompetent, the court must enter a substituted judgment stating whether the patient would accept or refuse treatment if he were competent.\textsuperscript{42} This judgment relies on a number of factors regarding the patient's character and circumstances.\textsuperscript{43} Further, an emergency or an extreme case of physical deterioration are the only situations sufficiently compelling to allow doctors to administer anti-psychotic drugs to incompetent patients without prior court approval.\textsuperscript{44} Given these substantive and procedural requirements, mental patients are well-protected from the dangers encountered when MHP's have virtually unlimited authority.

In Rogers v. Commissioner of the Dep't of Mental Health,\textsuperscript{45} seven mental patients brought a class action, representing all patients voluntarily and involuntarily committed to two units of Boston State Hospital. The representatives challenged the hospital's seclusion and medication of patients against their will. The court in Rogers extended the reasoning of its earlier decision in In re Guardianship of Roe,\textsuperscript{46} which held that non-institutionalized mental patients have the right to refuse anti-psychotic drugs.

The Massachusetts Supreme Judicial Court reaffirmed its "preference for judicial resolution of certain legal issues arising from proposed extraordinary medical treatment."\textsuperscript{47} The court recognized that protection of constitutional interests by use of the judicial model can render the process unmanage-

\textsuperscript{41} The Supreme Judicial Court of Massachusetts has accepted the dictionary definition of "emergency": "an unforeseen combination of circumstances or the resulting state that calls for immediate action." Rogers, 390 Mass. at 509 n.25, 458 N.E.2d at 321 n.25 (quoting Webster's Third New Int'l Dictionary 741 (1961)). Massachusetts statutory law provides:

In addition to [various enumerated rights] and any other rights guaranteed by law, a mentally ill person in the care of the department shall have the following legal and civil rights: . . . to refuse shock treatment, to refuse lobotomy, and any other rights specified in the regulations of the department; provided, however, that any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered in the treatment record of such person.


\textsuperscript{42} Rogers, 390 Mass. at 500, 458 N.E.2d at 316.

\textsuperscript{43} Id. at 503, 458 N.E.2d at 317 (quoting Guardianship of Roe, 383 Mass. at 435-36, 421 N.E.2d at 52).

\textsuperscript{44} Rogers, 390 Mass. at 510-11, 458 N.E.2d at 321-22.


\textsuperscript{47} Id. at 434, 421 N.E.2d at 51.
able. However, it also found that the issue concerning a patient's right to refuse antipsychotic drugs requires "the process of detached but passionate investigation and decision. . . ." Contrary to the ideals of the medical model, the issue concerning a patient's right to refuse antipsychotic drugs is "only incidentally a medical question."

The court in Rogers noted that both common law and statutory law presume that a person is competent to manage his affairs. This presumption is rebutted only when a court finds him incapable of taking care of himself by reason of mental illness (incompetent), regardless of whether he has been committed. The purpose of commitment is to protect the patient or others from physical harm. That a person is committed does not imply an inability to make treatment decisions. Thus, a patient retains the unfettered right to refuse intrusive treatment until a court finds him to be incompetent.

The Rogers court pointed out that a patient "must be found incompetent before a judge may make a substituted judgment decision." The Massachusetts Supreme Judicial Court had previously rejected the proposition that doctors should be allowed to make substituted judgment decisions; a substituted judgment does not require medical expertise. Rather, the court should consider medical advice and opinion to the extent that the patient would use them if he were competent.

The court stressed in Rogers that the substituted judgment decision should reflect what the patient would decide, not what the doctor finds to be in the patient's best interests. "Even if the patient's choice will not achieve the restoration of the patient's health, or will result in longer hospitalization, that choice must be respected. The patient has the right to be wrong in the choice of treatment."

The substituted judgment model in Massachusetts entails a detailed consideration of multiple factors to ensure accuracy
and consistency in court proceedings.\textsuperscript{57} The court should consider: 1) a previously competent patient’s expressed preferences regarding treatment, which should be treated as a critical factor, but even a patient’s statements made while incompetent should be considered; 2) the patient’s religious beliefs; 3) the emotional and financial impact of treatment or non-treatment on the patient’s family; 4) the probability of adverse side effects of the treatment; 5) the consequences if treatment is refused; and 6) the prognosis with treatment.\textsuperscript{58} Although a judge should consider each of these factors, this list is by no means exhaustive.\textsuperscript{59} Again, the object of the substituted judgment is to give the fullest possible expression to the character and circumstances of the patient.\textsuperscript{60}

Next, if the court finds through a substituted judgment that the patient would accept the proposed treatment, the judge may order such treatment for the patient.\textsuperscript{61} If the court finds that the patient would refuse treatment, the MHP’s may administer treatment under the police power or the \textit{parens patriae} power,\textsuperscript{62} but only if there exists a compelling state interest that will override that refusal.\textsuperscript{63}

The court in \textit{Guardianship of Roe} rejected as insufficiently compelling a state interest in helping citizens function at their maximum level of capacity.\textsuperscript{64} The court held that although the state may occasionally “have a generalized \textit{parens}

\textsuperscript{57} \textit{Guardianship of Roe}, 383 Mass. at 444, 421 N.E.2d at 56-59.
\textsuperscript{58} \textit{Id.}, followed in \textit{Rogers}, 390 Mass. at 505-06, 458 N.E.2d at 318-19.
\textsuperscript{59} \textit{Guardianship of Roe}, 383 Mass. at 444, 421 N.E.2d at 57.
\textsuperscript{60} \textit{Id.} at 444, 421 N.E.2d at 56 (quoting Superintendent of Belchertown State School \textit{v. Saikewicz}, 373 Mass. 728, 747, 370 N.E.2d 417, 428 (1977)).
\textsuperscript{61} The statutory procedure is as follows:

After a hearing on the petition regarding antipsychotic medication treatment the court shall not authorize medical treatment unless it (i) specifically finds that the person is incapable of making informed decisions concerning the proposed medical treatment, (ii) upon application of the legal substituted judgment standard, specifically finds that the patient would accept such treatment if competent, and (iii) specifically approves and authorizes a written substituted judgment treatment plan. . . .

\textsuperscript{62} \textit{See supra} note 7.

\textsuperscript{63} Massachusetts has recognized four state interests generally recognized as sufficiently compelling to override a patient’s right to refuse medical treatment. The interests are: 1) the preservation of life; 2) the protection of the interests of innocent third parties; 3) the prevention of suicide; and 4) maintaining the ethical integrity of the medical profession. \textit{Guardianship of Roe}, 383 Mass. at 448, 421 N.E.2d at 59 (quoting \textit{Saikewicz}, 373 Mass. at 741, 370 N.E.2d at 423). These interests have also been recognized in Washington; see \textit{infra} text accompanying note 115.

\textsuperscript{64} \textit{Guardianship of Roe}, 383 Mass. at 449, 421 N.E.2d at 59.
patriae interest in removing obstacles to individual development, this general interest does not outweigh the fundamental individual rights here asserted.65 However, the court would allow the state to administer antipsychotic drugs to nonconsenting patients under the state's parens patriae power to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness," in cases in which even a small avoidable delay would be unacceptable.66 Absent an emergency situation, the court held that no state interest is sufficiently compelling to overcome a patient's refusal of antipsychotic drugs.67

In addition, the Guardianship of Roe court held that the Commonwealth may administer antipsychotic drugs under its police power without prior court approval only if a patient poses an imminent threat of harm to himself or others and if there is no less intrusive alternative to antipsychotic drugs.68 "No other State interest is sufficiently compelling to warrant the extremely intrusive measures necessary for forcible medication with antipsychotic drugs."69 Thus, Massachusetts holds a relatively high threshold interest for the justification of forcible medical treatment.

Although the judicial model has been criticized by psychiatrists as a device to frustrate their efforts in treating patients with mental disorders, the model provides scrutinizing protection of individuals' privacy or liberty interests.70 The judicial model embraces the common law doctrine of informed consent,71 which deters doctors from treating patients without first receiving consent from a patient who has received adequate information to make an informed decision.

The soundness of this model rests on the assurance that MHP's will not be able to impose highly intrusive treatments on persons who do not want such treatments, except in the case of an emergency. The psychiatrist's relationship to the patient should be advisory rather than paternal.72 Provided

65. Id.
68. Id. at 511, 458 N.E.2d at 321-22.
69. Id. at 511, 458 N.E.2d at 322.
70. See supra text accompanying notes 40-44.
71. See supra note 3.
72. See Cole, Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?, in Refusing Treatment in Mental Health Institutions—Values in
the judicial model contains adequate legal definitions and tests for judges to follow, the regulation of ECT through the courts should decrease the likelihood of a rubber-stamp review of MHPs’ treatment recommendations.

The necessity for sufficient definitions of terms in the judicial model should become clear in the following analysis of In re Schuoler, a recent Washington case involving a patient’s right to refuse ECT. Although the models as detailed above apply to the administration of antipsychotic drugs, with some minor adjustments, the same tests may be applied to the administration of ECT.

IV. WASHINGTON’S DOCTRINE

A. Introduction

The facts in Schuoler are a prime example of how judges may unduly defer to the authority of MHP’s. On August 11, 1984, Loretta Schuoler was admitted to the Yakima Valley Memorial Hospital because of mental illness for the fourth time since March, 1983. Ms. Schuoler was non-communicative and appeared to be severely depressed. Five days later, she was involuntarily committed for a 14-day evaluation and treatment period. The following day, a judge pro tempore authorized Ms. Schuoler’s treating psychiatrist to administer ECT, without her consent, as a method of treating her depression. Ms. Schuoler subsequently appealed her case, even

CONFLICT 56-73 (1982). Of course, there is a school of thought which asserts that a paternal position is the better approach to treating mentally ill or incompetent patients. See TASK FORCE ON ECT, supra note 15 at 141.

73. 106 Wash. 2d 500, 723 P.2d 1103 (1986).

74. It is noted that a straight comparison of the different methods of regulating ECT in Washington, New Jersey, and Massachusetts would require a different analysis from that proposed in this Note. Each state has a different method of protecting patients from unwanted ECT. See supra notes 15-19 and accompanying text. Rather, this article compares Washington’s model for regulating ECT to New Jersey’s and Massachusetts’ models for regulating antipsychotic drugs not only because the two types of treatment are considered highly intrusive but also because in the abstract, these models are representative of the two competing schools of thought regarding the proper relationship between courts, patients, and doctors.

75. Schuoler, 106 Wash. 2d at 502, 723 P.2d at 1105.

76. Id. at 503, 723 P.2d at 1105.

77. Id. at 502-03, 723 P.2d at 1105-06 (“As a practical matter, a court probably can find a compelling state interest to treat an involuntarily committed person with ECT relatively often.”)
though she could not be provided with effective relief. The Washington Supreme Court reviewed the process of authorizing the nonconsensual administration of ECT because of the substantial public interest.

The court in Schuoler provided substantive and procedural guidelines for Washington courts to follow when considering whether to authorize the administration of ECT on a nonconsenting involuntarily committed mental patient. The court purported to adhere to the judicial model by providing involuntarily committed mental patients with substantial protection through the courts, pursuant to the Involuntary Treatment Act (ITA). The court followed previous Washington cases which held that an incompetent person or his guardian has the right to choose one medical treatment over another and to refuse treatment such as life support systems. These pre-Schuoler cases as well as the applicable section under the ITA evince Washington's preference for judicial regulation of critical medical decisions.

78. Id. at 503, 723 P.2d at 1106. Since she had already been subjected to shock treatment, the issue regarding her own case was moot.

79. Id. at 504-06, 723 P.2d at 1106-07.

80. WASH. REV. CODE § 71.05 (1987). Section 71.05.370 of the ITA provides:

Insofar as danger to the individual or others is not created, each person involuntarily detained . . . or committed for treatment and evaluation pursuant to this chapter shall have . . . the following rights:

. . .

(7) Not to consent to the performance of shock treatment or surgery, except emergency life-saving surgery, upon him, and not to have shock treatment or nonemergency surgery in such circumstance unless ordered by a court pursuant to a judicial hearing in which the person is present and represented by counsel, and the court shall appoint a [mental health professional] designated by such person or his counsel to testify on behalf of such person;

. . .

(9) Not to have psychosurgery performed on him under any circumstances.

Note that the statute provides an exception for surgery in emergency life-saving situations, but not for shock treatment. However, the phrase "in such circumstance" appears to refer to an emergency situation, and the refusal of shock treatment is included in this situation. Thus the statute could be read to require an emergency life-saving situation before a court can order ECT. Cf. infra text accompanying notes 115-21 (possible compelling state interests may require less than an emergency situation).


82. In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983) (husband of woman in chronic vegetative state sought to discontinue life support systems); In re Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984) (hospital sought removal of life support systems from brain-dead patient who had been severely mentally retarded since birth and had no family).
The *Schuoler* court developed a two-part test. The first part is a threshold test to determine whether a substituted judgment should be made. Recognizing the highly intrusive nature of ECT, the court acknowledged that involuntarily committed mental patients retain a fundamental liberty interest in refusing ECT. If a patient “appears unable to understand fully the nature of the ECT hearing—as severely mentally ill patients often are—the court should make a substituted judgment for the patient.” However, no guardian appointment or determination of competency is necessary for such a judgment to be made.

The second part of the test is a due process inquiry: denial of a patient’s right to refuse ECT must meet constitutional due process requirements. The desires of the patient may be overridden only if 1) there exists a compelling state interest and 2) administering ECT is both necessary and effective to further that state interest.

**B. Summary of Critique**

MHP’s have an interest in treating mentally ill patients as quickly and efficiently as possible. The *Schuoler* court was reluctant to create a rule that would frustrate the efforts of MHP’s to effectuate that goal. On the other hand, the legislature and the court have established a policy in favor of judicial regulation of MHPs’ professional decisions, at least with regard to intrusive treatment. Apparently, the *Schuoler* court reasoned that it was compelled to reach a compromise between these competing policies that would appease both MHP’s and advocates of patients’ rights. Yet this compromise may yield unfortunate results.

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83. *Schuoler*, 106 Wash. 2d at 507, 723 P.2d at 1108.
84. *Id.*
85. *Id.* at 506, 723 P.2d at 1107.
86. *Id.* at 508 n.4, 723 P.2d at 1109 n.4.
87. *Id.* at 509, 723 P.2d at 1109. The court also agreed with Ms. Schuoler that “the State should have to prove each element justifying the authorization of ECT . . . with ‘clear, cogent, and convincing’ evidence.” *Id.* at 510, 723 P.2d at 1110.
88. *Id.* at 513, 723 P.2d at 1111.
89. WASH. REV. CODE § 71.05.010 (1987) establishes the legislative intent behind the ITA: “(1) To end inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment; (2) To provide prompt evaluation and short term treatment of persons with serious mental disorders.” Whether the statute effectuates this intent is another matter. See generally Empirical Consequences, supra note 4. See supra text accompanying notes 80-83.
The Washington Supreme Court established a dangerous version of the judicial model. The court provided an indefinite basis for determining how to make a substituted judgment. It also provided an inadequate threshold test for determining when to make a substituted judgment. In addition, the court created a defective due process inquiry which fails to properly outline the situations that will give rise to a compelling state interest. The court's opinion implicitly gives judges discretion in deciding what state interests are sufficiently compelling, and it makes a curious assumption regarding commitments based on grave disability.

These shortcomings will encourage the courts to defer unduly to the authority of mental health professionals when deciding when to make substituted judgments, whether the patients would accept or refuse treatment if competent, and whether a compelling state interest justifies the administration of ECT to patients who refuse ECT. The court's decision also leaves room for improper application of the substituted judgment model and the development of insufficiently compelling state interests. While the decision in Schuoler tends to follow the judicial model, the decision actually allows for many of the same problems found in the medical model. The potential exists for patients' liberty interests to be subordinated to doctors' interests in treating the patients, whose rights to due process may thus be jeopardized.

C. Factors for Consideration in Making a Substituted Judgment

The Schuoler court has not provided a definitive array of factors to be considered when making a substituted judgment for an incompetent patient. The court recommended that judges consider three factors: "previous and current statements of the patient, religious and moral values of the patient regarding medical treatment and [ECT], and views of individuals that might influence the patient's decision." The court then referred to In re Ingram for an analogous standard used in making medical treatment decisions for incompetent persons.

The court in Ingram held that a judicial finding of incomp-
petency does not deprive a patient of her right to refuse amputative surgery.\textsuperscript{93} Rather, a judge is to make a substituted judgment for the patient to determine what that patient would do if she were competent to make the decision.\textsuperscript{94} The \textit{Ingram} court stated:

The goal is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all the circumstances, including her present and future competency. . . .

With this goal in mind, the court should consider all relevant factors that would influence this person's decisions regarding medical treatment. These would include the ward's prognosis if she chose no treatment; the ward's prognosis if she chose one treatment over another; the risk of adverse side effects from the proposed treatments; the intrusiveness or severity of the proposed treatments; the ability of the ward to cooperate and assist with post-treatment therapy; the ward's religious or moral views regarding medical care or the dying process; and the wishes of family and friends, if those wishes would influence the ward's decision. The court may also consider what most people would do in similar circumstances, but . . . this should not be regarded as controlling. . . .

Finally, the ward's expressed wishes must be given substantial weight, even if made while the ward is incompetent.\textsuperscript{95}

It is unclear whether the \textit{Schuoler} court intended a judge to consider all these factors when making a substituted judgment regarding ECT for a mental patient or whether the court only intended a judge to consider the few factors expressly listed in \textit{Schuoler}. The \textit{Schuoler} court may have provided a few examples of what factors a judge should consider, under the standard set forth in \textit{Ingram}, while inadvertently omitting the other factors. If the \textit{Schuoler} opinion is interpreted to

\textsuperscript{93} Id. at 836, 689 P.2d at 1368. \textsc{Wash. Rev. Code} § 11.92.040(3) (1987) prevents an incompetent's guardian from consenting to therapy that induces convulsions (such as ECT), psychosurgery, amputation, and any other mental health procedures that are intrusive on the person's bodily integrity or are protected under \textsc{Wash. Rev. Code} § 71.05.370 (1987), without a court order.

\textsuperscript{94} \textit{Ingram}, 102 Wash. 2d at 838-39, 689 P.2d at 1369-70.

\textsuperscript{95} Id. at 839-40, 689 P.2d at 1364-70. \textit{See also Note, The Substituted Judgment Doctrine Expands Beyond Life-Prolonging Decisions}, 5 \textsc{W. New Eng. L. Rev.} 565, 581-84 (1983).
require the comprehensive analysis required in *Ingram*, the substituted judgment inquiry in ECT hearings should provide as thorough a survey of the patient’s preference as the Massachusetts doctrine provides for antipsychotic drug hearings.\textsuperscript{96} Therefore, a judge would likely give full effect to the desires of the patient.

On the other hand, if *Schuoler* is interpreted to include a consideration of only the factors expressly listed in that opinion, the substituted judgment analysis would be incomplete. Given only the guidance of those factors articulated in *Schuoler*, judges would fail to take into consideration factors highly relevant to any patient’s decision, such as the patient’s prognosis with and without treatment, the risk of adverse side effects, the intrusiveness of ECT, and the patient’s ability to cooperate with doctors after treatment.\textsuperscript{97} If the judge does not fully consider the patient’s position, he may well rely more heavily on the opinion of the MHP and ultimately determine what the patient should decide, rather than what the patient would decide.

Thus, the court has provided an unclear and perhaps inadequate articulation of the standard of inquiry involved in an ECT substituted judgment decision. This uncertainty may in turn cause the courts to rubber-stamp the MHPs’ recommendations, thereby undermining the court’s role in protecting individuals’ rights. The logical interpretation of the *Schuoler* court’s opinion would include a consideration of all factors relevant to a patient’s decision. Even more alarming than the dangers involved with the uncertainty of the *Schuoler* court’s

\textsuperscript{96} See supra text accompanying notes 57-63. Curiously, the *Schuoler* court held that judges should consider the patient’s medical prognosis with and without treatment in relation to a completely different category of analysis. According to *Schuoler*, judges should consider this factor when deciding whether ECT will be necessary and effective to further a compelling state interest, i.e., the least restrictive alternative, rather than when making a substituted judgment for the patient. 106 Wash. 2d at 509, 723 P.2d at 1109. Consideration of this factor may be helpful in determining the necessity or prospective effectiveness of ECT in an individual case.

\textsuperscript{97} Consideration of these additional factors would be only helpful to a judge whose duty is to determine as precisely as possible the patient’s desires. For example, if a stubborn patient would rebel and refuse to cooperate with MHP’s after undergoing shock treatment, such treatment might not serve any useful purpose. For a description of the typical doctor-patient relationship in mental hospitals, see INFORMED CONSENT, supra note 9, at 179-83, 210-13. While the authors describe the decision-making process in ECT cases as “mutual,” they note that patients who initially refused ECT often accepted the treatment after persistence on the part of their doctors. It is all too possible that mental patients may become too dependent on their doctors and that doctors may thus become too influential on their patients.
substituted judgment standard, however, are those dangers involved in the court’s test for deciding when such a judgment should be entered.

D. Determining When to Make Substituted Judgments

As the Massachusetts doctrine dictates, competency determinations are an integral element of substituted judgment proceedings. A substituted judgment should be made only when the patient is incompetent to make a treatment decision. Nevertheless, the Schuoler court refused to incorporate competency hearings and guardian appointments under the guardianship statutes with ECT hearings under the ITA. The court reasoned that the legislature intended the two statutes to work independently of each other, rather than in conjunction with each other. In addition, the court reasoned that the appointment of a guardian would be futile because the guardianship statute expressly prohibits guardians from consenting to ECT for their wards. Further, the time consuming process involved in a competency hearing and guardian appointment could frustrate the purpose of the involuntary commitment statute. Thus, the court was faced with the problem of bypassing competency hearings yet somehow determining a patient’s competency to refuse ECT.

The court’s solution to this dilemma was to allow a judge to make a substituted judgment if the patient cannot fully understand the nature of the ECT hearing. The court apparently perceived a patient’s inability to fully understand ECT

98. See supra notes 51-52 and accompanying text.
100. 106 Wash. 2d at 504-05, 723 P.2d at 1106-07; WASH. REV. CODE § 71.05.370(7)(1987).
101. The court stated that the purpose of the guardianship statutes is to provide a system where one person makes decisions for another who is not legally competent to make decisions. Schuoler, 106 Wash. 2d at 504, 723 P.2d at 1106. On the other hand, according to the court, the ITA provides for the needs of persons who are a danger to others or themselves, or who are gravely disabled; these persons may be competent or incompetent. Id. Although the court may have accurately interpreted the intended purposes of these statutes, problems with the court’s decision may arise when a person committed under the ITA is incompetent but has not yet had a competency determination. This was the case with Ms. Schuoler. Reply Brief for Appellant at 3-5, Schuoler, 106 Wash. 2d 500, 723 P.2d 1103. The accompanying discussion in the text is most pertinent to this type of situation.
102. Schuoler, 106 Wash. 2d at 505, 723 P.2d at 1107.
103. Id. at 505-06, 723 P.2d at 1107. See supra note 96.
104. Schuoler, 106 Wash. 2d at 507, 723 P.2d at 1108.
hearings to be the equivalent of his incapacity to make a medical treatment decision. However, the court's perception is erroneous because persons capable of making informed medical decisions might not fully understand the nature of ECT hearings.

The Schuoler court's inquiry into whether the patient fully understands the nature of the ECT hearing does not satisfy the need for a bona fide competency finding. An alternative would be to require, before entering a substituted judgment, a competency determination that inquires whether the patient is incapable by reason of mental illness of making an informed medical decision. This route would be far less offensive to the line of precedent in this State and would assure that substituted judgments are made only for truly "incompetent" patients.

Determining when to make substituted judgments must be viewed in light of the statutory criteria for involuntary commitments. Subsequent to the Schuoler decision, the Washington Supreme Court acknowledged a correlation between the grave disability standard of commitment and a person's ability to make a treatment decision. In In re LaBelle, the court

105. The court's application of this test appears to be at variance with its statement of the rule. Rather than observing whether Ms. Schuoler fully understood the nature of the ECT hearing, the court noted that both of her doctors testified that discussing ECT itself with her was futile and concluded that a substituted judgment should have been made. 106 Wash. 2d at 507, 723 P.2d at 1108.

106. The court's purported competency test allows for an unprecedented extension of the substituted judgment doctrine beyond its accepted use in Washington. Prior to Schuoler, the substituted judgment model had been applied only in cases where the patient already had been deemed legally incompetent. Ingram, 102 Wash. 2d at 830, 689 P.2d at 1374; Colyer, 99 Wash. 2d 114, 660 P.2d 738. See also Gundy v. Pauley, 619 S.W.2d 730, 731-32 (Ky. Ct. App. 1981) (an involuntarily committed patient cannot be compelled to undergo ECT against his will simply because it is considered to be in his best interests, without a judicial determination of incompetence or the existence of an emergency that poses an immediate danger of harm to himself or others); Rogers, 390 Mass. at 490, 458 N.E.2d at 314-15 ("a distinct adjudication of incapacity to make treatment decisions (incompentence) must precede any determination to override patient's rights to make their own treatment decisions."). A person in Washington is "incompetent" under the guardianship statute, by reason of mental illness or otherwise, if he is incapable "of either managing his property or caring for himself or both." WASH. REV. CODE § 11.88.010(1)(b)(1987). Extending the application of the substituted judgment doctrine in Washington to cases where the patient has not been formally adjudged incompetent might be justified, but only if a bona fide competency finding is made. Cf. Comment, Civil Commitment, supra note 2 at 495-99 (analyzing the importance of legal competency when determining whether there is a right to refuse medical treatment).

107. See infra note 109.

construed the "cognitive or volitional control"\textsuperscript{109} definition of grave disability to implicitly require "that the individual is unable, because of severe deterioration of mental functioning, to make a rational decision with respect to his need for treatment."\textsuperscript{110} The court explained its construction of the definition as follows:

This requirement is necessary to ensure that a causal nexus exists between proof of "severe deterioration in routine functioning" and proof that the person so affected "is not receiving such care as is essential for his or her health or safety". So construed, RCW 71.05.020(1)(b) is neither unconstitutionally vague nor overbroad.\textsuperscript{111}

The \textit{LaBelle} court's holding may help simplify the problem in \textit{Schuoler} of deciding when to make a substituted judgment for a patient not deemed incompetent, but only to the extent that the patient has been committed under the "cognitive or volitional control" definition of grave disability. The implicit requirement that a person committed under this category is unable to make a rational treatment decision should allow a

\begin{itemize}
  \item \textsuperscript{109} WASH. REV. CODE § 71.05.240 (1987) provides in part:
    At the conclusion of the probable cause hearing, if the court finds by a preponderance of the evidence that such person, as the result of mental disorder, presents a likelihood of serious harm to others or himself, or is gravely disabled, and, after considering less restrictive alternatives to involuntary detention and treatment, finds that no such alternatives are in the best interests of such person or others, the court shall order that such person be detained for involuntary treatment not to exceed fourteen days in a facility certified to provide treatment by the department of social and health services.
  \item \textsuperscript{110} WASH. REV. CODE § 71.05.020 (1987) provides in part:
    \begin{enumerate}
      \item (1) "Gravely disabled" means a condition in which a person, as a result of a mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;
      \item (3) "Likelihood of serious harm" means either: (a) a substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others. \ldots
    \end{enumerate}
  \item \textsuperscript{111} \textit{Id.}
\end{itemize}
court holding an ECT hearing to make a substituted judgment for the patient. However, the problem of determining when a patient is incompetent still exists for patients who are committed not under the “cognitive or volitional control” category, but rather under “the dangerousness to self or others” category.\footnote{E. Grave Disability and Compelling State Interests}

The \textit{Schuoler} court continued its discussion with an analysis of the State’s power to administer ECT against a patient’s will. Relying on \textit{Roe v. Wade},\footnote{113} the court held that a judge may order the administration of ECT “upon a nonconsenting involuntarily committed patient when the petitioning party proves 1) a compelling state interest to administer ECT, and 2) ECT is both necessary and effective for furthering that interest.”\footnote{114} Washington has acknowledged four commonly noted interests sufficiently compelling to justify disregarding a patient’s refusal of medical treatment. Those interests are: “(1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession.”\footnote{115}

The \textit{Schuoler} court’s opinion may be interpreted to require judges to consider only whether there exists a state interest as compelling as the ones listed. Under this standard, judges could decide for themselves whether other state interests such as assuring the health of the patient are sufficiently compelling to order ECT against a patient’s wishes.\footnote{116} In contrast, under

\footnote{112. A person may be involuntarily committed in Washington under two alternative categories. Petitions for commitment may be filed when a person is either “gravely disabled” or “presents a likelihood of serious harm to others or himself. . . .” \textit{Wash. Rev. Code \S 71.05.150(1)(b) (1987).} The state’s \textit{parens patriae} power presumably invokes commitments pursuant to grave disability. The latter criterion may be referred to as the “dangerousness category,” which is invoked by the police power.}

\footnote{113. 410 U.S. 113 (1973).}

\footnote{114. \textit{Schuoler}, 106 Wash. 2d at 508, 723 P.2d at 1108.}

\footnote{115. \textit{Id.} (quoting \textit{Ingram}, 102 Wash. 2d at 842, 689 P.2d at 1371 (quoting \textit{Colyer}, 99 Wash. 2d at 122, 660 P.2d at 743)). It is unclear whether Washington law holds these stated interests to be exclusive or merely indicative of a requisite intensity. The Massachusetts court has held that other state interests—such as the preservation of institutional order and the maintenance of efficiency—may be sufficiently compelling to deprive a patient of fundamental liberties. Commissioner of Correction \textit{v. Myers}, 379 Mass. 255, 399 N.E.2d 452 (1979). However, Washington courts apparently have not recognized any compelling interests other than the four mentioned.}

\footnote{116. Although the court may correctly imply that the four recognized state
the Massachusetts judicial model, a patient's refusal of anti-psychotic drugs may be overridden only to remedy an emergency situation\textsuperscript{117} or to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness," when there can be no delay.\textsuperscript{118} Unlike the \textit{Schuoler} opinion, the Massachusetts doctrine provides well-defined requirements for the forcible administration of intrusive treatment.

The \textit{Schuoler} court did not comment on what other state interests might be sufficiently compelling to order ECT. However, the court applied the facts of Ms. Schuoler's case to the test provided and noted that her treating psychiatrists' testimony revealed a compelling state interest. Ms. Schuoler's disabilities and repeated admissions to medical facilities have "constituted a tremendous financial burden for the State."\textsuperscript{119} Further, one doctor testified that without treatment, she "may end up in the back wards of (a) state hospital, a helpless creature that nobody can ever take care of."\textsuperscript{120} The court failed to explain how these findings give rise to any particular compelling state interest.

The court did not provide an adequate description of or limitation on the type of state interests a judge may utilize to override a patient's refusal of treatment. This lack of precision may lead judges to assume that state interests involving less than emergency situations are sufficiently compelling. If such assumptions are made, they may be corrected only on appeal, after the damage has been done.

In addition, the court asserted in an alarming footnote that "[a]s a practical matter, a court probably can find a compelling state interest to treat an involuntarily committed person with ECT relatively often."\textsuperscript{121} The court rationalized this assertion by noting that involuntary commitment requires the state to find that a person presents a likelihood of harm to himself or others or is gravely disabled.\textsuperscript{122} Thus, the court has created an unfounded assumption that simply because a person is involun-
tarily committed, his illness will give rise to a compelling state
interest for administering ECT. This assumption may defeat
the entire process of judicial protection of the patient's right to
refuse treatment on a case by case analysis. Further, it may
negate altogether the patient's right to refuse treatment.

The court's analysis fails when viewed in light of the cur-
rent definition of grave disability.

The 1979 ITA required proof of explicitly dangerous
behavior in order to commit a person as dangerous to self or
others. In contrast, commitment for grave disability/cogni-
tive or volitional impairment, is more subjective and hence
elastic since it is phrased in diagnostic terms. Moreover, it
does not require proof of specific types of behavior. Conse-
quently, this criterion may encourage excessive judicial de-
ference to the opinions of mental health professionals,
thereby effectively insulating their commitment recom-
mandations from judicial review. . . . In addition, inapproprate
judicial deference to professionals' commitment recom-
mandations based on "grave disability" may also be encouraged,
since there is empirical evidence indicating that expert wit-
tesses seldom testify on behalf of patients at commitment
hearings.123

Thus, a gravely disabled person may still be subject to the
unquestioned expertise of mental health professionals. Given
the court's propensity to rely on MHP's, one should be dis-
rupted by the Schuoler court's assumption that a compelling
state interest to treat gravely disabled persons with ECT will
be found relatively often. The court could have avoided this
reliance on MHP's opinions by providing better definitions of
compelling state interests and by requiring the existence of an
emergency situation, as the Massachusetts doctrine has done.124

IV. CONCLUSION

The Washington Supreme Court has put some meat on the
bare section of the ITA that merely requires a judicial hearing
and authorization to administer highly intrusive psychiatric
treatment to involuntarily committed mental patients. The
court has established substantive and procedural guidelines for
judges to follow in deciding when to respect a mental patient's

123. Empirical Consequences, supra note 4, at 429-30 (footnotes omitted). See also
LaBelle, 107 Wash. 2d at 207, 723 P.2d at 146.
124. See supra notes 40-72 and accompanying text.
right to refuse ECT. These guidelines are a step in the right direction.

The Schuoler court has attempted to satisfy the competing interests of various groups involved in the ECT decision-making process. However, through an array of misperceptions and inarticulate standards, the court has created a hybrid decision-making model. This resulting model purports to effectuate the goals of the judicial substituted judgment model but in reality encourages the potential for abuse found in the medical second-opinion model.

To mitigate against the dangers of the Washington hybrid model, the courts of this state should make proper adjustments. First, courts should fully consider all factors enumerated in the Ingram opinion when making a substituted judgment for a patient. Second, courts should make a bona fide competency determination, inquiring whether the patient is capable of making an informed medical decision, when deciding whether to make a substituted judgment at all. Finally, courts should recognize that patients committed as likely to cause serious harm to self or others, or as gravely disabled because of failure to provide for their essential human needs, will not necessarily give rise to a state interest sufficiently compelling to justify the nonconsensual administration of ECT. Without these further refinements, the consequences of this hybrid model may be formidable.

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