Due Process and Organized Health Services

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IN ANALYZING the legal and legislative aspects of several specific problems of health service, our intention is to determine how the rights of the individual are balanced against the public interest, where there is a conflict or an apparent conflict of these interests. In these problems, we shall see the operation of the guiding principle of the due process clause of the 5th amendment to the U.S. Constitution, which provides that "no person shall be . . . deprived of life, liberty, or property, without due process of law" and is applicable to the Federal Government and of the similar clause in the 14th amendment which is a restraint on action by the States.

Due process may be either procedural or substantive. Procedural due process refers to all the elements of a fair trial—the right to notice, to a hearing, to counsel, to an appeal, and, in general, to all the procedures to guarantee fundamental constitutional rights in a democratic society. These procedural rights may seem self-evident upon recital, but a long legal history has defined each of them in specific circumstances. For example, the right to counsel means the actual provision or financing of counsel if the defendant is poor, and the right to appeal means the printing of expensive appeal papers if the defendant cannot afford them.

Substantive due process is the guaranteeing of certain fundamental rights, and today these rights are conceived to be not only the rights of individuals but the rights of the community at large (*1*). A fundamental right, however, may still be regulated by a State for the common good through the exercise of its police power or through other powers. The only requirements are that the action of the State not be arbitrary or oppressive and that the character of the regulation bear a reasonable relation to the common good sought to be accomplished.

Substantive due process is the issue that arises most frequently in connection with the constitutionality of regulatory legislation dealing with social and economic matters, including health. In 1923 the Supreme Court invalidated a minimum wage law for women on the ground that it interfered with the fundamental right of freedom of contract (*2*), but with the abandonment of the laissez-faire philosophy in social and economic matters the Court has repeatedly upheld protective legislation requiring government intervention even though it may limit individual rights to some extent. Due process is thus not static and immutable but must be continually reexamined in specific situations as science opens the possibility for new health services for the individual and for society.

Here we shall examine three kinds of problems: one in which the law presents no barrier to effective health action; another in which the law, in the opinion of many, presents a serious barrier to maximum health protection despite liberal interpretation of it to meet modern needs; and a third in which the legal situation is in a gray area; that is, the law has been modernized over the years but still has not kept pace with medical and social progress in this field.

Fluoridation

Fluoridation is a good example of a situation in which the law presents no specific barrier to health action. McKray has given an excellent summary of the litigation on this issue, showing how the courts started out with the principle

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of *Jacobson* v. *Massachusetts* (*3*), where the police power was held the basis for control of contagious diseases, and moved on in *Dowell* v. *City of Tulsa* (*4*) to recognize the police power as the basis for measures to protect and promote the public health even though no epidemic or possibility of contagion is involved. Both the Oregon (*5*) and Missouri (*6*) courts disposed of the basic due process issue by relying on the Supreme Court's thinking in the case which finally upheld the constitutionality of a minimum wage law for women as a protective measure even though it interfered with freedom of contract. Chief Justice Hughes said in that case in 1937 (*7*):

> Liberty in each of its phases has its history and connotation. But the liberty safeguarded is liberty in a social organization which requires the protection of law against the evils which menace the health, safety, morals and welfare of the people. Liberty under the Constitution is thus necessarily subject to the restraints of due process and regulation which is reasonable in relation to its subject and is adopted in the interests of the community is due process.

Now that the highest courts of nine States have sustained the constitutionality of fluoridation legislation, including California, Oregon, and Washington among the western States (*5*, *6*, *8*), the greatest single obstacle to fluoridation of public water supplies has been the public referendum. Timorous city councils, frightened by the virulence of the objections, have felt compelled in many instances to submit this technical and scientific question to popular debate and vote. Misrepresentation of the issues and even charlatanism have ensued, and fluoridation has been defeated in many communities. Taking the long view, Dr. Crabtree, dean of the Graduate School of Public Health at the University of Pittsburgh, expressed what many of us have felt (*9*):

> Surely some time tomorrow the citizen will be dismayed when he is told that the mid-20th century generation in the United States felt that it could place so little reliance upon professional and scientific viewpoints in matters pertaining to local public health policy that it turned to the popular referendum as the safer and thus the instrument of choice to determine public policy on such completely technical issues as the fluoridation of water supplies.

The important question of whether fluoridation can be properly instituted without a referendum was involved in the recent Missouri case, *Readey* v. *St. Louis County Water Company* (*6*, *10*). In this case the ordinance of the county council directing the St. Louis County Water Co. to fluoridate the water supply was taken on the initiative of the county council without submitting it to a vote. The county charter provided (*6a*) that the council should have power by ordinance to "exercise legislative power pertaining to public health, police and traffic, . . ." and power by ordinance to "provide the terms upon which the County shall perform any of the services and functions of any municipality or political subdivision in the County, except school districts, when accepted by a vote of a majority of the qualified electors voting thereon in the municipality or subdivision, which acceptance may be revoked by a like vote . . ."

An injunction was sought on the grouds that the ordinance violated the protection of the 14th amendment and was repugnant to the city charter in that it applied to persons within the municipalities. No contention of any procedural irregularity by the county council was made, and the court made a point of this, although there was no specific mention of the requirement of a vote (*6b*). The court held, on these facts, that fluoridation of the water supply is a reasonable exercise of the police power to protect the public health and welfare granted to the county by the Missouri Constitution and the St. Louis County Charter. The implication is that an ordinance enacted without a referendum, even where a referendum is provided for in the charter, is valid.

This case has been called the first decision to hold that fluoridation without a public referendum is valid and, further, excellent authority for other local governments to institute fluoridation even if the charter requires a referendum (*10*). The decision points in that direction, but it is questionable whether the opinion is sufficiently explicit to lay at rest the question of a referendum for all time.

As a result of all this litigation, we can now safely say that there is no legal barrier to instituting fluoridation. Unfortunately, however, a jurisdiction-by-jurisdiction fight may still have to be waged in some places. Somewhat less surely we can say that the way is now

clear for local governments to enact ordinances without a referendum, and experience has certainly shown this to be a wise procedure. Apparently, some scientific and technical questions are too complex or too confusing to put to popular decision. The many defeats of fluoridation in popular referenda, despite the overwhelming scientific evidence of significant reduction in dental decay and lack of untoward effects, indicate that the issue is subject to specious attack and to misleading contentions. The uniform stand of the courts in upholding the constitutionality and propriety of fluoridation ordinances should be helpful in convincing local governing bodies to institute fluoridation without a referendum. If a lawsuit follows, then, hopefully, it can be litigated while the children are drinking fluoridated water.

More generally, these cases illustrate the fundamental principle in the law of the balance of interests. The interest of those persons whose religious or other scruples are offended by fluoridation must be balanced against the general interest in public health and welfare. Some courts have dismissed the religious objection to fluoridation by holding that fluoridation is not mass medication but the addition to the water of a substance found naturally elsewhere—a mineral nutrient, not a drug or a medicine, in the words of Dr. Frederick J. Stare of the Harvard School of Public Health. In general, courts have held that as between the interest in the dental health of the total population and in the religious freedom of the few, the balance of interest favors fluoridation. Many measures to protect the public health and welfare entail some limitation or supposed limitation of individual rights as, for example, vaccination, compulsory treatment for tuberculosis or venereal disease, blood tests for marriage licenses, pasteurization of milk, chlorination of water. They are justified, however, because they are reasonable measures to achieve a legitimate public health objective. As a valid exercise of the police power, they are not an abuse of due process.

Abortion and Birth Control

To illustrate the second situation in which the law, despite liberal interpretation, presents a serious barrier to health protection, we turn to the field of maternal health, and specifically to the questions of illegal abortion and birth control.

Illegal abortion is a major public health problem (*11*). It has been estimated that 5,000 to 10,000 women die annually of illegal abortions, one of the most important causes of maternal death, and that for every woman who dies there are several who are disabled or rendered sterile (*12*). The thalidomide cases, and particularly the Finkbine case in Arizona, brought into sharp relief for the whole nation the rigidity of our statutes on justifiable abortion. The one salutary aspect of this tragic story is that this case may, as one writer put it, serve as a "catalyst to abortion reform" (*13*).

In all but six States the only ground for an abortion is to save or preserve the life of the mother. For example, the California Penal Code, section 274, states:

> Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such a woman, unless the same is necessary to preserve her life, is punishable by imprisonment in the State prison not less than two nor more than five years.

In the six exceptional States, Colorado (*14*), New Mexico (*15*), Alabama (*15*), the District of Columbia (*15*), Maryland (*16*), and Oregon (*17*), the ground has been broadened to include the health of the mother where the mother is threatened by serious and permanent bodily injury. The New Mexico statute states (*15*):

> An abortion may lawfully be performed when two (2) physicians who are licensed to practice in this state, in consultation deem it necessary to preserve the life of the woman or to prevent serious and permanent bodily injury.

Maryland has the most liberal exception—the safety of the mother (*16*). In Oregon a physician's license cannot be denied or revoked for procuring an abortion if it was done with the concurrence of another physician for the relief of a woman whose health appeared in peril from the pregnancy (*17*). But Oregon defines as manslaughter an abortion producing death of a mother or child unless necessary to preserve the life of the mother (*18*).

Under the statutes of the majority of States

permitting abortion only to save the life of the mother, therapeutic abortion committees of hospitals must decide whether or not to allow abortions, and it is here that the dichotomy between law and practice is revealed. The noted authority, Dr. Alan F. Guttmacher, has said that the abortion laws make hypocrites of us all. He found that 90 percent of the abortions performed at Mount Sinai Hospital in New York City between 1953 and 1958 did not fall within the statutory requirements (*19*). An exhaustive study of therapeutic abortions in San Francisco and Los Angeles revealed that the standards of the law are not complied with and that "the deviation from the legal norm is not unwitting," although there are differences of opinion on what the proper medical standards should be (*20*). Actually, in view of the advances of medical science, the cases in which an abortion is justified to save the life of the mother are few, including perhaps a patient with severe heart disease, a patient with urinary disease with renal decomposition, or those with a few other conditions. The percentage of abortions performed on the basis of psychiatric indications has increased considerably (*21*), but if the law were literally interpreted, it would cover only cases of threatened suicide.

In tribute to law enforcement agencies and the courts, it must be pointed out that there are no known prosecutions of licensed medical practitioners who obtained concurring medical opinions as to the necessity of an abortion before it was undertaken (*19a*). As early as 1929 the Supreme Court of the State of Washington equated "necessity to save life" with "recognition and approval by the medical profession in the community" (*22*):

> If the appellant in performing the operation did something which was recognized and approved by those reasonably skilled in his profession practicing in the same community with him, and the same line of practice, then it cannot be said that the operation was not necessary to preserve the life of the patient.

In a California case in 1959 (*23*), the court stretched its interpretation of the statute to protect a doctor and to hold that the danger to the patient's life need not be that of immediate death. Compare the leading English case, *Rex* v. *Bourne* (*24*), in which an abortion performed on a 15-year-old girl, pregnant because of rape, was held justified under a statute permitting abortion only to save the life of the mother. Immediate danger of death was not requisite; the possibility that the girl would become a physical or mental wreck in the future was held sufficient justification.

Despite these adjustments in practice to the rigidity of the law, doctors and lawyers must concern themselves with the law. The law does not recognize ethical grounds (that the pregnancy was induced by rape or fraud or threats); nor genetic grounds (that the parent is feebleminded, that the pregnancy resulted from incest); nor prenatal damage (that there is a strong likelihod that the child will be defective as a result of drugs, X-ray, or disease); nor socioeconomic grounds (that the mother is unmarried or unable to support the child). As to socioeconomic grounds, it has been estimated that 90 percent of all criminal abortions are performed on married women who seek to avoid the economic burden of another child. These include deserted wives and women who have disabled husbands and are the sole support of the family, as well as women who feel that another child would prejudice the lives of their other children.

In recognition of these defects in the law, the American Law Institute has proposed a new statute on justifiable abortion in the Model Penal Code (*25*), as follows:

> (2) *Justifiable Abortion.* A licensed physician is justified in terminating a pregnancy if: (a) he believes there is a substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or the pregnancy resulted from rape by force or its equivalent as defined in Sec. 207.4(1) or from incest as defined in Sec. 207.3. . . .

On September 25, 1963, the distinguished Chief Justice of California, Justice Phil S. Gibson, at a meeting of the California Bar Association honoring Chief Justice Earl Warren of the U.S. Supreme Court, criticized the backwardness of our abortion law (*26*):

> Our statutory definition of criminal abortion has remained essentially unchanged since the enactment of the Penal Code in 1872, and as a result this state still refuses to permit an abortion unless it is necessary to preserve the woman's life. Should it be a crime for a licensed physician to perform an abortion when

the pregnancy resulted from rape or when there is a substantial risk that it would gravely impair the physical or mental health of the mother or result in a child born with grave physical or mental defects?

There has been reluctance to review the laws as to sex crimes—perhaps because of the nature of the subject—with the consequent danger that these laws will lag behind the continually changing views of society with respect to moral values. A reexamination of our statutes in this field is long overdue.

Closely related to the abortion laws is birth control legislation. It goes without saying that appropriate birth control measures could prevent the need for many abortions.

State statutes in this field fall into four classes (see *27* and cf. brief filed amicus curiae by Planned Parenthood Association of America, Inc., in *Poe* v. *Ullman 28*) :

(*a*) States making no mention in their statutes of birth control. No western States are included in this group.

(*b*) States regulating advertising of contraceptive information and devices, distribution of contraceptive materials and devices, and distribution of literature and information on birth control. The following western States are included in this group: Arizona (*29*), California (*30*), Colorado (*31*), Idaho (*32*), Montana (*33*), Orgeon (*34*), Washington (*35*), and Wyoming (*36*).

(*c*) States having public health laws licensing the sale of contraceptive devices and means to prevent venereal disease or prescribing standards for such materials. Utah (*37*) is an example of this group, in which many of the States listed in group *b* are also included.

(*d*) Finally, two States—Massachusetts and Connecticut—which have exceptionally stringent laws on contraceptives. Massachusetts prohibits the distribution of contraceptives, but the law is construed as permitting sales by druggists (*38*). Connecticut even prohibits use (*39*). In Connecticut a physician may not advise qualified patients on means of contraception. The Connecticut statute was before the Supreme Court in *Poe* v. *Ullman* (*28*), in which the Court refused to rule on its constitutionality because the case did not present a "controversy" in that the statute had not been enforced for 80 years. Following this decision, the Planned Parenthood Association opened a clinic in Connecticut, whereupon the State attorney general filed suit against the doctor in charge for disseminating birth control information in violation of the statute. This enforcement of the statute raises the issue of constitutionality once more.

Statutes placing restrictions on making contraceptive advice freely available to all who desire it stand in the way of the full development of maternal and child health programs, impede welfare departments in their effort to rehabilitate clients, and interfere with clinic services provided in hospitals. A recent Arizona case shows the results of such a restrictive statute.

In *Planned Parenthood Committee* v. *Maricopa County* (*40*), the Planned Parenthood Committee contested the constitutionality of an Arizona statute enacted in 1901 which prohibited advertisement of any medicine or means for producing abortion or preventing conception. Because of the statute, the health department had ordered removal from its clinics of all birth control information and all literature publicizing the planned parenthood clinic, issuing a directive that patients who request such information may receive information about the clinic at the time of home nursing visits. The Planned Parenthood Committee contended that the statute was an unconstitutional deprivation of freedom of speech and an improper exercise of the police power in that it is arbitrary and unreasonable and not in support of a legitimate public policy.

The Arizona court upheld the constitutionality of the statute as a proper exercise of the State's police power. The court found no interference with free speech and explained its holding as follows (*40a*) :

. . . we do not agree with plaintiff [Planned Parenthood Committee] that the Arizona statute prohibits the dissemination of birth control information by a doctor to his patient, or by the Planned Parenthood Committee to those who seek such information from them, since person to person consultation is not "advertising," . . .

Some of the literature consists of instructions on the application and use of particular contraceptive devices and preparations which are identified by brand name. If such literature is placed on public display or generally distributed to the public, we think this would amount to advertising and fall within the prohibitive terms of the statute. . . . The only limitation it [the statute] imposes is that plaintiff may not ad-

vertise, in the sense of publicly advocating, specific trade branded devices or preparations in the contraceptive field. The restriction is not in the form of a prior restraint, but rather a post conduct punishment. For these reasons we think the "prior restraint" cases are distinguishable and do not control . . .

In our estimation the statute could reasonably protect both the morals and the health of the community inasmuch as stimulation of sales of contraceptives might lead to greater sexual activity among unmarried persons. . . .

Although in theory any general literature on birth control would be permitted under this decision, the practical result is no doubt continued reluctance on the part of the health department to distribute the literature of the Planned Parenthood Committee or to publicize the birth control clinics except in the most limited way. Anyone who knows the effort necessary to put over a program of health education will appreciate that the court's decision is tantamount to barring almost all information on birth control. Rare would be the health officer who would undertake the work and the risk of screening all pamphlets for any mention of what might be considered advertising of brand names. Amendment of this restrictive statute by the legislature is probably necessary now before health and welfare departments can make birth control information freely available to those who need it.

Mental Hospital Admission Laws

The third situation is that in which the law has been modernized but still has failed to keep pace with advances in therapeutic and community programs. The laws governing admission to mental hospitals illustrate this situation. Here the question of due process is paramount, since a nonvoluntary admission to a mental hospital is at least a temporary deprivation of liberty, no matter how sick the patient may be.

Over the years many efforts have been made to surround such admissions with safeguards designed to prevent "railroading" of sane patients and to assure due process of law in the admission of mentally ill ones. One notable attempt to treat patients as citizens with rights occurred during the 19th century when a Mrs. Packard carried on a campaign to require jury trials of the issue of insanity. Her efforts resulted in legislation in many States providing for such trials. Actually, as Deutsch pointed out in his classic work, "The Mentally Ill in America" (*41*), the requirement of a trial by jury did not protect the insane at all or the sane either for that matter. Lay jurors were not qualified to pass on the technical question of mental illness, and the stigma and humiliation associated with trials by jury for mental illness in a court of law made many families avoid commitment proceedings and delay treatment for persons who might perhaps have been helped. Today in no State is a jury trial mandatory, but 14 jurisdictions authorize the use of a jury to decide the question of hospitalization, particularly if the patient demands it or in appeals (*42*).

This history documents the point, mentioned earlier, that reexamination of what constitutes due process of law has to be undertaken from time to time in the light of changed scientific and social conditions. The revolution that has been occurring in recent years in the care of the mentally ill has required a second look at our legal procedures for admission and discharge. Open-door wards and hospitals without bars or locks, the use of tranquilizers and other drugs, the creation of a therapeutic milieu within the hospital, the great increase in voluntary admissions, and the treatment of mental patients in clinics and in day or night hospitals while they remain in the community—all these developments make some of our well-established legal procedures obsolete. Some of the questions posed by this revolution in the care of the mentally ill are:

1. How can you detain a patient by a court order on an open ward when he is free to walk out of the hospital, go to town for a soda, and even go home?
2. Is a patient in a position to object to continued hospitalization if he is sedated with drugs?
3. With such a large proportion of our admissions today being senile patients, are any special measures needed for the protection of their rights?
4. Are the same procedures for involuntary hospitalization necessary when the average length of stay of new patients is from 4 to 6 months instead of for years?
5. If time is of the essence in instituting

treatment, what procedures can assure prompt treatment and still protect the patient's right to liberty if he is not ill as well as his right to due process in involuntary hospitalization if he is ill?

We have arrived at a stage which one writer in a recent law review article has characterized as "the illusion of due process" (*43*). Many of our procedures require the motions of due process without its substance. They do not in fact give real protection to the patient's rights in the light of modern methods of care. A few general comments on the statutes governing admissions may shed some light on this shortcoming in the laws and in their operation.

First, all the States have several and sometimes many ways of admitting patients to mental hospitals. All States provide for a voluntary admission and for several methods of nonvoluntary admission designed for use in varying circumstances, for a brief stay, in an emergency, for longer retention, and in cases where the initiative is taken by a relative or by a health officer or by a police officer. The flexibility that these various methods provide is generally helpful as long as the rights of all patients are protected with equal vigilance. Too often, however, one or another method is used predominantly because of convenience rather than because of the needs of the patient.

Second, the use of the voluntary admission is increasing. Nevertheless, even with all the encouragement of voluntary admissions given by hospital administrators and by physicians, most of whom believe that voluntary admission promotes the patient's cooperation in his treatment, only about one-fifth of admissions in New York and California are voluntary. Similar percentages exist in other States.

Third, the basic method of nonvoluntary admission is the court-ordered admission. This order may be issued on a petition and certificates of doctors that the patient is mentally ill and in need of hospitalization, or it may be issued after a hearing has been held. Varying provisions relate to the service on the patient or his representative of notice of the application for a court order, to his right to a hearing, to bring witnesses, and to be represented by counsel. Some States provide for dispensing with notice of the application for admission if notice would be ineffective or detrimental to the patient. California wisely repealed such a provision in 1961, for service of notice would seem to be much less traumatic than sudden involuntary hospitalization. Varying methods of selecting the doctors are provided. In some States the doctors are selected by the petitioner; in others, as in California and Colorado, by the court. In California, the court may have the aid of a counselor in mental health to advise on the patient's background and alternative methods of care. In actual practice, the role of the doctors and the weight their opinions carry with the court vary greatly not only from State to State but from court to court.

Fourth, several of the western States have adopted in whole or in part the provisions of the Draft Act Governing Hospitalization of the Mentally Ill (*44*), a model act prepared in 1952 by the Public Health Service. These States are Idaho (*45*), North Dakota (*46*), New Mexico (*47*), Utah (*48*), and Alaska (*49*). The purpose of the draft act was to broaden access of the mentally ill to hospital facilities, to safeguard patients' rights in nonvoluntary admissions, and to remove as much as possible the stigma of hospitalization for mental illness. It was definitely a great step forward at the time it was proposed. Now, however, the model act is considered complex and cumbersome, and new thinking on the subject is incorporated in the bill S. 935, introduced for the District of Columbia in the 1st session of the 88th Congress in 1963.

Today both doctors and lawyers are generally agreed that, wherever possible, voluntary admissions should be used and increased. This avoids the whole issue of compulsion. The British Mental Health Act of 1959 (*50*) goes one step farther and substitutes for the voluntary admission (in which the patient makes a written application for admission) an informal admission without any legal process. This informal or nonstatutory admission is like an ordinary admission to a general community hospital for a physical illness. This method of admission is now in use in this country for patients with acute mental illness admitted for short periods to general hospitals, and there is support for extending the informal admission to State mental hospitals. [New York State

in its 1964 amendments to the mental hygiene law, discussed below, is the first State to authorize informal admissions to mental hospitals.]

The contentious issue is with regard to court-ordered admission in nonvoluntary cases. In California, in hearings before a Senate Judiciary Subcommittee during the 1961 session of the legislature, judges differed on this method of admission. One judge of the Superior Court contended that too much reliance is placed on the courts, that it would be better to allow physicians to decide the necessity for admission and thus avoid judicial proceedings that may aggravate the patient's condition and brand him as mentally ill. Another judge disagreed, pointing out that in the first 6 months of 1962 his psychiatric court handled 1,512 petitions. Of these, 196 patients were found not mentally ill enough to require hospitalization, although doctors had recommended their hospitalization. The judge pointed out that if there had been no court hearing, the added 196 would have been committed. Of course, the question of what happened to these 196 patients and whether they were subsequently hospitalized was not answered. The matter really comes down to a balance in hospitalization procedures between medical considerations and legal ones.

The most promising solution seems to lie in distinguishing initial methods of admission for a limited period of time from retention for a longer period. Initial admission can properly be a system of medical admission in which the initial decision is made by doctors. This assures the patient prompt treatment, and in many cases time is of the essence. At the same time, safeguards must be provided for the rights of patients who are kept more than a few days in the hospital.

In New York State, the Association of the Bar of the City of New York, in cooperation with the Cornell Law School, conducted a study of admission procedures, and a distinguished committee of judges, lawyers, and psychiatrists made recommendations (*51*) that are the basis for a drastically amended mental hygiene law [passed by the State legislature at its 1964 session (*52*)]. In brief, initial admissions will be medical to allow prompt initiation of therapy, but a system of immediate and continuing judicial review will be instituted after admission. In this way, the court order before admission is abolished, but nonvoluntary patients will be informed of their right to contest their hospitalization immediately after admission, and even those who do not request a hearing will have their cases reviewed by a judge. This review will occur not merely after admission but periodically at stated intervals to renew the authority of the hospital to retain the patient and to assure that no patient becomes a forgotten man. To make this process a meaningful protection and not an illusion of due process, a new agency called the Mental Health Information Service will advise the court on the patient's case and will inform the patient of his rights.

This sketchy review of mental hospital admission laws shows that even laws that have been amended and modernized may still need scrutiny in the light of actual practice under them to determine whether the protection afforded by the court is a meaningful protection of patients' rights or simply a rubber stamp of the doctors' decision. Actually, I believe that physicians and health personnel generally have a deep and abiding concern for safeguarding the liberty and rights of mental patients and that judges and lawyers have a keen appreciation of these patients' medical needs and of the importance of avoiding legalistic procedures that delay treatment or aggravate the illness. Health service and hospital administrators can play a significant role in promoting laws that give real protection to patients' rights and that are at the same time a positive aid in the treatment of mental illness. Above all, the law in mental health, as in all fields of health, must be geared to implement modern developments in science and in patterns of health service.

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