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JUSTICIABILITY AND MENTAL HEALTH

LEWIS H. LARUE*

Patients in state owned mental hospitals should receive adequate treatment. Surely no one would seriously doubt this proposition, or at least no one would argue for the contra-proposition that mental patients should receive inadequate treatment. Yet the problem remains as to what role the courts should play in ensuring adequate treatment of patients in state owned mental hospitals. Some role is appropriate; cases of physical abuse can be dealt with by the normal processes of tort and criminal law. Such traditional issues are justiciable.

What about adequate medical treatment? Are the courts competent to investigate the question of what is adequate medical therapy for patients in mental hospitals? Are they able to do anything about it if the therapy is not adequate? Judges cannot ask these questions as innocent bystanders, since the judiciary does not, to use the language of equity, have clean hands. There are large numbers of patients who are in mental hospitals because judges have put them there. People who have not committed any crime are caught up in civil commitment proceedings, judged mentally incompetent or deranged and a danger to themselves or others, and committed to institutions. It makes one queasy.

The responsibility for civil commitment is an awesome one. If I were a judge, my stomach would not be strong enough to live with that responsibility unless I had some reason to believe, or at least to hope, that it would do some good. I suspect that others feel the same way. Thus, it is not difficult to understand why the Fifth Circuit would say in a case like *Wyatt v. Aderholt*¹ that treatment is the *quid pro quo* for confinement.

Yet notice carefully what has just been said. The question was whether judges are competent to decide, but I slid off into the proposition that the judiciary is partially responsible for what has happened and therefore has a moral duty to decide. Alas, it does not follow from the fact that we have a moral duty to do something that we are competent to do it well. Parents have the duty to raise their children well, but the job can be botched.

The danger of hubris, of assuming that one can do what one cannot do, is especially dangerous in a case like *Wyatt v. Aderholt* be-

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¹ *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), *aff'g*, *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

cause on the facts it seemed so easy. The court's description of one of the hospitals is instructive:

Bryce Hospital was built in the 1850's; it had 5,000 inmates of whom 1500 to 1600 were geriatrics, 1,000 were mental retardates, and there were allegedly other non-mentally ill persons. Patients in the hospitals were afforded virtually no privacy; the wards were overcrowded; there was no furniture where patients could keep clothing; there were no partitions between commodes in the bathrooms. There were severe health and safety problems: patients with open wounds and inadequately treated skin diseases were in imminent danger of infection because of the unsanitary conditions existing in the wards, such as permitting urine and feces to remain on the floor; there was evidence of insect infestation in the kitchen and dining areas. Malnutrition was a problem: the United States described the food as "coming closer to 'punishment' by starvation" than nutrition. At Bryce, the food distribution and preparation systems were unsanitary, and less than 50 cents per day per patient was spent on food.²

The court's description of the professional personnel available for treatment is also significant:

But at the time this suit was instituted there were ratios of only one medical doctor with some psychiatric training for 5,000 patients, one Ph.D. psychologist for every 1,670 patients, and one masters level social worker for every 2,500 patients at Bryce.³

On these facts it was a simple matter to decide that the treatment offered was inadequate. However, the relief sought was an injunction. In order to give this relief, a court might find it necessary to go further and determine what is adequate, which is not a simple matter. In this regard, the district court had help; several professional organizations requested leave of the district court to appear as *amici curiae* and leave was granted.⁴ As the case went forward, the district court had the advantage of the expertise of the American Orthopsychiatric Association, the American Psychological Association, and the American Association on Mental Deficiency. Together with the professionals working for the State of Alabama, these professional groups were able to agree on standards "necessary to define what would constitute

² *Id.* at 1310.

³ *Id.* at 1311.

⁴ *Id.* at 1308 n.3.

minimally adequate mental treatment at a state psychiatric institution.”⁵ The district court’s opinion set forth the standards in an appendix and ordered the state to implement them.⁶

At first blush, this seems to answer the question about competence. The proof of the pudding is in the eating; with the aid of professional advice, the court was able to do what it had a moral duty to do.⁷ After all, the only reason that the state appealed was that the Governor and the Commissioner of Mental Health did not want to make the expenditures necessary to implement the standards.⁸ But that is a political and economic aside. There may also have been some of the standard pique about federal courts telling Alabama what to do.

However, there is a finding of fact that the district court might have made, but did not: if the standards are implemented, how many patients will get well? Are the experts willing to make predictions about this? After all, aren’t scientists supposed to be able to make predictions about the future? Doesn’t science establish causation and doesn’t knowledge of causation give one the power to say what follows what? The record is silent.

In short, there is an ambiguity about the concept of adequate, competent treatment that the court said is the *quid pro quo*. If the treatment is supposed to be humane, safe, and dignified, then courts are competent to judge. But if the treatment is supposed to be medically efficacious, then the prospects for successful judicial analysis seem doubtful.

The language of the court of appeals is ambiguous. The first sent-

⁵ *Id.* at 1309.

⁶ *Wyatt v. Stickney*, 344 F. Supp. 373, 379-86 (M.D. Ala. 1972).

⁷ The court of appeals stated that in a prior case it had taken “note of the substantial agreement reached in this case . . .” and that it had “cited that development as evidence supporting our view that workable standards could be fashioned.” 503 F.2d at 1314.

⁸ *Id.* at 1316 n.10:

These standards have not been challenged on appeal. Indeed, Governor Wallace’s brief to this court begins with the affirmation: ‘We wish to emphasize at the outset that this appellant, Governor George C. Wallace, is in full and complete agreement with the ultimate achievement of the standards and goals for mental health facilities which are set forth in the District Court’s order[s] of April 13, 1972.’ Brief of Appellant, p.1.

. . . The governor argues that the prescribed remedy will entail the expenditure annually of a sum equal to sixty per cent of the state budget excluding school financing, and a capital improvements outlay of \$75,000,000. This is contested by appellees.

Id. at 1317.

ence of the opinion contains the phrase "minimum levels of psychiatric care and treatment" to which is appended an explanatory footnote: "'Treatment' means care provided by mental health professionals and others that is adequate and appropriate for the needs of the mentally impaired inmate. Treatment also encompasses a humane physical and psychological environment."⁹ It would be easy enough to know what the court meant by these sentences if we knew what the court meant by "needs." The greatest need of the patient is to get well. Does the court mean that it will now decide what is likely to help the patient get well? Apparently so, since later in the opinion, the court of appeals cites one of its own prior decisions as holding that "civilly committed mental patients have a constitutional right to such individual treatment as will help each of them to be cured or to improve his or her mental condition."¹⁰

Do we know what will cure or improve a patient's mental condition?¹¹ What is the evidence upon which the expert would base his prognosis that a given treatment will cure or improve the average mental patient? It is unfortunate that there was not an adversary hearing on this matter, with the various therapeutic schools offering their theories and the evidence in support of those theories. Indeed, one wonders why the state was not contentious about this issue. Also puzzling is the fact that the plaintiff's experts and the state's experts were able to stipulate to the relevant standards. Is it too cynical to surmise that the state's experts were less than vigorous in contesting with the plaintiff's experts? It could be that the state's experts had programs that they could not persuade the state authorities to adopt and that they saw a chance to get their programs adopted by the federal court. A disquieting thought for anyone who is concerned with the integrity of the judicial process.

However, the language which implies that courts should determine what is likely to help a mental patient get well and that patients have a constitutional right to that level of treatment was dictum. On the facts of the case cited for the proposition, no such expansive exercise of judicial omniscience was required. In the case cited, the

⁹ *Id.* at 1306 and n.1.

¹⁰ *Id.* at 1312, citing *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974).

¹¹ See generally, P. WINCH, *THE IDEA OF A SOCIAL SCIENCE* (1967). K. KESEY, *ONE FLEW OVER THE COO-COO'S NEST* (1963); For more detailed (and conflicting) analyses of the issues involved in mental therapy, see A. MACINTYFRE, *THE UNCONSCIOUS* (1958); W. POWERS, *BEHAVIOR: THE CONTROL OF PERCEPTION* (1973); B. SKINNER, *ABOUT BEHAVIORISM* (1974); J. YOUNG, *AN INTRODUCTION TO THE STUDY OF MAN* (1971). The history of the establishment of mental hospitals is recounted in M. FOUCAULT, *MADNESS AND CIVILIZATION* (1961, English translation 1965); D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* (1971).

doctors who were sued did not offer any treatment.¹² Furthermore, in *Wyatt v. Aderholt*, the district court did not decide what would "help each of them [the patients] to be cured or to improve his or her mental condition."¹³ To be sure, the district court claimed to be deciding that issue. Indeed, the second sentence of the district court's opinion is almost identical¹⁴ with the passage quoted above, and the opinion reads as though that were the question before the court and as though the standards that the court imposed upon the state would carry out that goal. But a reading of the actual standards imposed will show that they deal with more modest, or at least distinct, problems.

The standards are set out in Appendix A of the opinion.¹⁵ Part I contains definitions, Part II is entitled "Humane Psychological and Physical Environment." For the most part, Part II seems to be justified by that most ancient of maxims, first of all, do no harm. Furthermore, most of the Part II does not deal with medical treatment, but rather with custodial decency. For example, there are provisions dealing with clothing,¹⁶ bed linens,¹⁷ toilets,¹⁸ showers,¹⁹ dining facilities,²⁰ temperature control²¹ and nutritional standards.²² Those sections of Part II that do address medical standards are more procedural than substantive. For example, such "unusual or hazardous treatment procedures" as lobotomies are prohibited unless there is "express and

¹² In *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), the court stated in the first paragraph of the opinion that "[t]he plaintiff-appellee, Kenneth Donaldson, was civilly committed to the Florida State Hospital at Chattahoochee in January, 1957, diagnosed as 'paranoid schizophrenic.' He remained in that hospital for the next fourteen and a half years. During that time he received little or no psychiatric care or treatment." *Id.* at 509. Excerpts from the instructions to the jury appear in 1 *LEGAL RIGHTS OF THE MENTALLY HANDICAPPED* 611 (PLI, 1973). A jury verdict of damages against the doctors who were responsible for the lack of treatment was upheld on appeal. The most striking example of facts in support of the verdict is that one of the defendant-doctors had charge of the plaintiff for eight and one-half years and during this time the doctor spoke to the plaintiff for two hours or an average of fourteen minutes per year. *Id.* at 514.

¹³ 503 F.2d at 1312.

¹⁴ 344 F. Supp. at 374. "On March 12, 1971, in a formal opinion and decree, this court held that these involuntarily committed patients 'unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.'"

¹⁵ 344 F. Supp. at 379.

¹⁶ *Id.* at 380-81, §§ 11, 12, 13.

¹⁷ *Id.* at 382, § 19F.

¹⁸ *Id.* at 382, § 19B.

¹⁹ *Id.* at 382, § 19C.

²⁰ *Id.* at 382, § 19E.

²¹ *Id.* at 382, § 19I (2).

²² *Id.* at 383, § 20.

informed consent after consultation with counsel or [an] interested party of the patient's choice."²³ Similar procedural safeguards to insure informed consent are provided for "experimental research," which is also subject to screening by a Human Rights Committee before consent is sought.²⁴

The section about medication²⁵ contains two sentences that sound substantive. "Patients have a right to be free from unnecessary or excessive medication. . . . Medication shall not be used as punishment, for the convenience of staff, as a substitute for [a treatment] program, or in quantities that interfere with the patient's treatment program." Translated, this seems to say that "medicine shall be used for bona fide medical purposes only and not for extraneous purposes." The original has the advantage over my translation of spelling out some of the extraneous purposes, but the original does not spell out what is a legitimate medical purpose nor does it say which drugs and what dosages are either "unnecessary or excessive," except as it refers to "standards of use that are advocated by the United States Food and Drug Administration." It may or may not be that these sentences will force a major substantive change in practices of medication at the hospital. The rest of the section on medication is purely procedural: a notation must be made in the records; a physician is to review the medication weekly; and prescriptions cannot be written to cover more than a thirty day period.

Part III of the standards is entitled "Qualified Staff in Numbers Sufficient to Administer Adequate Treatment." The standards state who is qualified by use of an equal protection standard. For example, a psychologist for the hospital must meet the same "licensing and certification requirements" that the State of Alabama requires of "persons engaged in private practice of the same profession."²⁶ The advantage of this technique is that the court does not have to decide what the "licensing and certification requirements" should be; it need only tell the state to use requirements that it is already using. Presumably, the state is free to change these requirements.

In contrast, the court made a more substantive decision when it decided the question of staff ratios. The witnesses disagreed about such questions as how many psychiatrists, psychologists, and social workers were needed in order to be able to deliver adequate medical treatment.²⁷ The state's witness testified that 1 professional per 125

²³ *Id.* at 380, § 9.

²⁴ *Id.* at 380, § 8.

²⁵ *Id.* at 380, § 6.

²⁶ *Id.* at 383, § 21.

²⁷ 503 F.2d at 1311.

patients in each of these categories would be enough, while the plaintiff's witnesses claimed that 1 per 30-50 were needed. The district court adopted the state's figures, and this resolution was not contested on appeal. The opinions do not state why or how the district court resolved this difference among the witnesses, and it could be that the court just "gave" one to the state. However, it would be possible to adjudicate this issue without deciding difficult medical questions such as what sort of treatment will help mental patients "to be cured to to improve his or her mental conditions." I may be wrong about this, but I assume that any plausible theory of treatment and therapy presupposes that professionals will observe, talk to, or otherwise have some contact with the patient. Therefore, the first factual inquiry would be as to the difference in "contact hours" that various therapeutic procedures would require. If there were no disagreement about this matter, then the next factual inquiry would be a practical problem in logistics. If so many contact hours are needed, and a set work week is established, and if the number of patients is known, then it should be practicable to determine how many professionals are needed. On the other hand, it might well be that different procedures require different numbers of contact hours, and further, there might be a serious dispute over what the appropriate mix of procedures should be. Would the court then have to adjudicate among the experts and decide what "will help" to cure? I think not, for the court of appeals said in connection with a related issue that "plaintiffs here do not seek to *guarantee* that all patients will receive all the treatment they need or that may be appropriate to them. They seek only to ensure that conditions in the state institutions will be such that the patients confined there will have a *chance* to receive adequate treatment."²⁸ If the state need only to provide a "chance" and not a guarantee," then it seems to follow that the state's duty as to this part of the problem is to make a bona fide choice among reasonable therapeutic practices. Thus, if there is a conflict of testimony about the number of contact hours that are required, and if there is no reason to doubt the good faith of the state's witnesses, then the figure that the state's witness proposes should be the figure that the court adopts. Of course, this is the result that was reached in the district court, but it is not possible to discern whether the same theory was used.

The passage quoted above from the court of appeals' opinion referred to Part IV of the standards entitled "Individualized Treatment Plans." The Fifth Circuit characterized this part of the standards as

²⁸ *Id.* at 1316.

requiring "only the establishment of a program, institution-wide in scope, for developing and formulating individual treatment plans; it of course does not require the formulation, in this suit, of each individual plan."²⁹ Once again, the content of the standards is procedural. The procedures are detailed, but in general, the hospital is required to examine each patient immediately after admission, state the diagnosis of the patient's problem and what the plan of treatment for the problem is, and assign someone to administer the plan. Most of the detail in this part of the standards prescribes record keeping requirements. The spirit of the provisions seems to be: "Make a decision and write it down."

What sort of knowledge does a court need to have in order to justify these requirements for individualized plans and records: As you will recall, at an earlier place in this note I intimated that there was not enough evidence to support scientific propositions about treatment and cure.³⁰ No one is able to say that a particular treatment used on certain types of patients will lead to some determinable percentage of cures. But the more I have thought about this, the more struck I have been by the entailments of my doubts; our ignorance supports the sort of relief that the court gave in Part IV of the standards.

The "science" of the mind is in no way comparable to the science of physics or chemistry. Yet we do know that sometimes the mentally ill get better when dedicated professionals try to help them. Some parts of medicine are based on knowledge of biochemistry, including the treatment of certain mental disorders. However, a large part of the practice of medicine, including mental health medicine, is a craft or art. The practitioner is often in the position of saying: "I do this because I have tried it before, and sometimes it works." And of course sometimes it does, even if the practitioner does not know why. In short, professionals often act upon empirical hunches, empirical because they are based on experience but hunches because there are no precisely formulated scientific laws that explain the matter.

There is a peculiar combination of knowledge and ignorance in mental health medicine. In a particular case there may be good reason to believe that several things are worth trying but no ability to predict which of the bag of tricks is likely to work. If I have described accurately the state of our knowledge and ignorance in this area, then the only rational way to proceed is by way of individualized treatment plans. Generalized plans cannot be prescribed because of inadequate knowledge. Doing nothing is also unacceptable because that

²⁹ *Id.*

³⁰ See text accompanying n.11 *supra*.

would be refusing to use existing knowledge. If we rule out both generalized plans and nothing, then individualized plans are what is left.

The thesis of this paper so far has been that the district court did not decide the medical question of what treatment will help cure a mental patient, but rather it decided the question of what procedures should be used in the delivery of medical treatment. The question of proper procedures is traditionally considered to be a justiciable question. Indeed, the bulk of what is taught in courses that bear the title "Administrative Law" is nothing more than procedures that judges have held that administrators must follow.³¹

The question then arises: is there any reason to believe that a court is less competent to prescribe procedures for the delivery of medical treatment than it is for the delivery of other goods and services that the state provides? And beyond this question lies another: what good does it do to prescribe procedures when the substance is intractable?³² Both of these questions are elegant ways of asking: what good will it do? If the professionals who run the mental hospitals in Alabama follow the procedures prescribed by the district court, will anything good happen? A pessimistic view would be that the standards prescribed by the district court will bureaucratize medical practice in the hospital. At the worst, the letter of the procedures would be followed but not the spirit, so that the lack of care that was visible before the procedures were required will now be concealed. However, it is just as rational to choose procedures on the assumption that those who must implement them will act in good faith.³³ The question of good faith or bad can be left to a subsequent inquiry.

Procedural rules do good in different ways. A rule of procedure is a good rule if following it is likely to lead to a better substantive result.³⁴ Alternatively, a rule of procedure is a good rule if following

³¹ For example, K. DAVIS, *ADMINISTRATIVE LAW, CASES-TEXT-PROBLEMS* (5th ed. 1973) allocates the first third of the book to problems of judicial review and the remainder of the book to procedures before the administrative body. A substantial portion of the latter two-thirds of this casebook is devoted to informal proceedings and builds on his book, *DISCRETIONARY JUSTICE* (1969), in which he proposes techniques by which discretion can be "confined, structured, and checked." *Id.* at 216. The theme of these materials is that we should design procedures that can be efficient and yet fair.

³² Judge Henry J. Friendly argues in his book *THE FEDERAL ADMINISTRATIVE AGENCIES* (1962), that the failure to define substantive standards is the principal reason why administrators do not do their job better.

³³ Since the state officials who will be governed by the standards cooperated in setting them, there is reason to believe that they will carry out the standards in good faith.

³⁴ The rules excluding hearsay evidence and providing for cross-examination can be justified as promoting truth.

it is the decent thing to do.³⁵ Sometimes, these alternative criteria overlap, and a particular procedure might recommend itself to us as both decent and prudent, *i.e.*, as the sort of rule we would follow both to be good and to do good.³⁶

In medicine, there are both types of rules and there are rules to which both justifications are applicable. An ancient and venerable text on this problem appears in Plato's last dialogue, *The Laws*. In Book IV of this dialogue, the Athenian discusses with his companions whether laws should have prefaces, *i.e.*, should laws simply state what is to be done or avoided and the penalty, or should the legislator also state the reasons for the laws? By way of suggesting an answer to this question, the Athenian discusses two ways of practicing medicine:

And did you ever observe that there are two classes of patients in states, slaves and freemen; and the slave doctors run about and cure the slaves, or wait for them in the dispensaries—practitioners of this sort never talk to the patients individually, or let them talk about their own individual complaints? The slave doctor prescribes what mere experience suggests, as if he had exact knowledge; and when he has given his orders, like a tyrant, he rushes off with equal assurance to some other servant who is ill; and so he relieves the master of the house of the care of his invalid slaves. But the other doctor, who is a freeman, attends and practices upon freemen; and he carries his enquiries far back, and goes into the nature of the disorder; he enters into discourse with the patient and with his friends, and is at once getting information from the sick man, and also instructing him as far as he is able, and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure. Now which is the better way of proceeding in a physician and in a trainer?³⁷

It is clear enough from the passage that the Athenian believes that the doctor who talks and persuades is better than the doctor who

³⁵ E. GRISWOLD, *THE FIFTH AMENDMENT TODAY* (1955) argues that the principal justification for the privilege against self-incrimination is that it is cruel to compel a man to choose between incriminating himself, perjuring himself, and contempt of court and that in the absence of the privilege all accused persons would be subject to this cruel trilemma.

³⁶ The presumption of innocence might be justified on the double grounds that it honors the self-respect of the accused and promotes the orderly presentation of proof.

³⁷ PLATO, *THE LAWS*, Book IV, 720b8-e3 (Jowett translation).

orders. Further, it appears that there are two reasons for judging the freeman's doctor to be better than the slave doctor: what he does is morally preferable and medically more efficacious. It is morally preferable because he treats the patients like a free and responsible person. It is medically more efficacious because the patient cooperates in providing information and following the prescribed cure.

Perhaps the case of *Wyatt v. Aderholt* stands for the neoplatonic doctrine that the professionals in mental health hospitals must be citizen-doctors and not slave-doctors. At any rate, a substantial part of the standards promulgated by the district court can be read as being consistent with this theory of medicine.

Thus the district court actually dealt with issues that are justiciable as opposed to the issues that it stated it would deal with, which are not justiciable. The court did not assume a task that is better left elsewhere. Of course, justiciability is only one of the doctrines that helps us mark out the proper relationship between the courts and other parts of the government. The eleventh amendment³⁸ also limits courts.

The eleventh amendment was passed to over-rule the case of *Chisholm v. Georgia*.³⁹ The several states of the Union had large debts outstanding, and they wished to manage their debts without interference of federal courts. In light of this history, one can construe the amendment as prohibiting lawsuits which would have a substantial impact on the treasury of the state. *Edelman v. Jordan*⁴⁰ rejects this broad theory and reads the amendment as prohibiting those suits in which the relief sought is money as compensation for past harm. Injunctions that shape the future conduct of state officials are permitted, even though there is an impact upon the state treasury.⁴¹

³⁸ "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State." U.S. CONST., amend. XI.

³⁹ 2 U.S. (2 Dall.) 419 (1793).

⁴⁰ 415 U.S. 651 (1974). For a discussion of the implications of *Edelman*, see Note, *The Eleventh Amendment Does Not Bar The Award of Attorneys Fees Based on The Private Attorney General Theory*, 32 WASH. & LEE L. REV. 133 (1975).

⁴¹ *Id.* at 668:

State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often an inevitable consequence of the principle announced in *Ex parte Young*. . . ."

I would like to acknowledge the help given me by Mr. Thomas A. Schmutz ('76) on this point.

The most significant issue of judicial competence that remains in this case is the issue of what relief the court can give if the state does not obey its order and spend what is needed to comply with the standards. The plaintiffs suggested that the district court could either reallocate funds by enjoining non-essential expenditures and transferring them to the mental health budget or encumber or sell non-essential property owned by the Mental Health Board. The district court reserved decision.⁴² The court of appeals, noting that "serious constitutional questions" would be raised by this relief, went on to say that the district court would have no jurisdiction to enter such relief; a three-judge court would be required.⁴³

All of the doctrinal limitations are important. While judges have a responsibility to decide any question that is properly before them, they also have a responsibility not to usurp the power of other branches of the government to decide the questions that are properly theirs. It is good to remember what John Marshall, who established the practice of judicial review, said in *McCulloch v. Maryland*.⁴⁴ Referring to the scope of review in a case where the issue was the exercise by Congress of the necessary and proper clause power, he said that "the degree of necessity . . . is to be discussed in another place."⁴⁵ Questions of degree are not easily adopted to the judicial method. At any rate, the question of what kind of medical treatment is likely to help a mental patient get well is not likely to be suitable for judicial inquiry.

Yet it also seems true that a more activist form of judicial review should be used in the area of patients' rights than in necessary and proper clause cases. Anyone who has been involuntarily committed to a mental hospital qualifies for membership in a "discrete and insular minority"⁴⁶ and is arguably entitled to have the protection of the courts since he lacks all power to protect himself. However, there is no reason why an activist review cannot be scrupulous about questions of competence. Procedural decency is within the court's competence; substantive medical questions are not.

⁴² 344 F. Supp. at 377-8.

⁴³ 503 F.2d at 1317-18.

⁴⁴ 17 U.S. (4 Wheat.) 316 (1819).

⁴⁵ *Id.* at 423.

⁴⁶ *United States v. Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938).

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