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I. INTRODUCTION

The movement of progressive societies has hitherto been a movement from Status to Contract.

—Sir Henry Maine

The contractual order of society is an order of right and law. It is a government under the rule of laws, as differentiated from the welfare state or paternal state. Right or law is the complex of rules determining the orbit in which individuals are free to act. No such orbit is left to wards of a hegemonic society. In the hegemonic state there is neither right nor law; there are only directives and regulations which the director may change daily and apply with what discrimination he pleases and which the wards must obey. The wards have one freedom only: to obey without asking questions.

—Ludwig von Mises

The law of contracts articulates and enforces the societal interest in the orderly administration of agreements affecting the production and distribution of goods and services. Since, by definition, contracts are entered into by consenting individuals, the concept of contract occupies a pivotal position in the ideology of individualism. The law's recognition of contracts is also a profound recognition of individual autonomy.

In contracting, then, the individual creates a private relationship which the state will enforce. Contract is, therefore, a process by which men shape their own destiny, weaving their self-interest into the fabric of society. Individual decisionmaking begins the process, individual decisionmaking brings that authority of the state into the contract, and individual decisionmaking can end the contract by mutual agreement. Contract and au-

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tonomy are inseparable. When the right to contract is severed from the individual, so is a large portion of his humanity. Yet in contract, as in other areas of the law, the right is taken away with astonishing regularity in the name of mental health.

II. THEORETICAL BASIS OF INCOMPETENCY TO CONTRACT

The right to contract and the concept of mental competence have been closely intertwined since the Romans.[1] Because contract is essentially consensual, the capacity to consent to being bound by it is necessary to the initial act of contracting. This capacity, it has been long held, is a "mental" quality, and this mental quality may be impaired by, among other things, "lunacy" or "mental illness." Thus, in an 1872 decision,[2] the Supreme Court held that "[t]he fundamental idea of a contract is that it requires the assent of two minds. But a lunatic . . . has nothing which the law recognizes as a mind, and it would seem, therefore, upon principle, that he cannot make a contract which may have any efficacy as such."[3]

The position that mental competency is a prerequisite to contracting is usually linked with the policy of protecting the alleged incompetent from himself.[4] However, although all the states claim a connection between competence and contract,[5] and most profess to protect the alleged incompetent,[6] there is a vast disparity between ends and means, ostensible aims and actual practices.

In some states, usually by statute, the contract of an incompetent is void, and cannot be enforced by the "incompetent" or his guardian against the "healthy" party.[7] In others, although protecting the incompetent is the professed aim, such protection is denied if it injures the other party to the contract. The party alleging incompetence—or, more often, the party for whom incompetence is being alleged—may avoid the contract only if the benefits received can be returned to the other party, placing him

1. *Mental Illness and the Law of Contracts*, 57 MICH. L. REV. 1021, 1023 (1959) [hereinafter cited as 57 MICH. 1021].

2. Dexter v. Hall, 82 U.S. (15 Wall.) 9, 20 (1872).

3. *Id.*

4. Annot., 46 A.L.R. 416, 434-35 (1927) [hereinafter cited as 46 A.L.R. 416]; 57 MICH. 1021, 1025-26; Green, *Public Policies Underlying the Law of Mental Incompetency*, 38 MICH. L. REV. 1189, 1213 (1940).

5. 57 MICH. 1021, 1024.

6. *See* note 4, *supra.*

7. 46 A.L.R. 416, 417-19 (1927); Annot., 95 A.L.R. 1442, 1443 (1935) [hereinafter cited as 95 A.L.R. 1442]; Weihofen, *Mental Incompetency to Contract or Convey*, 39 S. CAL. L. REV. 211, 230 (1966) [hereinafter cited as Weihofen]; 57 MICH. 1021, 1059-62.

in *status quo ante*.[8] The basis for this rule is the equitable doctrine of avoiding unjust enrichment, and placing the loss, as between two innocent parties, on the party who made it possible.[9] This leads to the curious result of protecting only prudent incompetents, while refusing to protect the improvident incompetent who has wasted or dissipated the consideration for the contract. If the policy of the law, however, were truly to protect the incompetent, then it would be necessary to protect him against his past improvidence no less than against his expected future blunders. This, in fact, is the rule in a few jurisdictions. In *Gibson v. Soper*[10] the court articulated this policy as follows:

> The law . . . intends that he who deals with infants or insane persons shall do it at his peril. . . . If the law required restitution of the price as a condition precedent to the recovery of the estate, that would be done indirectly which the law does not permit to be done directly, and the great purpose of the law in avoiding such contracts, the protection of those who cannot protect themselves, defeated.[11]

If the only purpose in voiding the contracts of an incompetent were the avowed purpose of protecting him, then he and he only—either acting through his guardian or on his own behalf after restoration of his competency—could initiate court action for avoiding the contract. But such is not the case. During the incompetent's lifetime, action for voiding his contracts may be initiated by his "next friend" and sometimes even his creditors, and, after his death by his heirs, executors, and administrators.[12] Where a contract is set aside after the death of an incompetent, its voiding obviously cannot be justified on the ground of protecting the incompetent contractor. In such cases, then, where the aim of the avoidance can only be the protection of the estate, considerations of equity would require restitution as a condition for voiding the contract; otherwise, the heirs of an improvident decedent would find shelter behind the alleged (or real) incompetence of the deceased at the expense of an innocent third party. Nevertheless, in distinguishing between conditional and uncon-

8. Weihofen, *supra* note 7, at 231; 57 MICH. 1021, 1026; RESTATEMENT (SECOND) OF CONTRACTS § 18(c) (Tent. Draft No. 1, 1964).

9. 46 A.L.R. 416, 419; 95 A.L.R. 1442, 1443; Weihofen, *supra* note 7 at 231; 57 MICH. 1021, 1079-89; C. MORRIS, TORTS 248 (1953). Morris cogently argues that the law should not intervene between two innocents, as there exists no reason for shifting the loss, and the legal process adds yet another expense to be borne by one not at fault. The healthy party may even be the superior risk-bearer, and thus in Morris's terms should bear the loss no matter who occasioned it.

10. 6 Gray (Mass.) 279, 66 App. Dec. 414 (1856).

11. *Id.* at 282; 66 App. Dec. at 417; 46 A.L.R. at 434.

12. Weihofen, *supra* note 7, at 232-33; 57 MICH. 1021, 1064-66.

ditional powers to avoid contacts, the courts ignore the identity of the party initiating the process to avoid the contract.[13]

III. DEFINITIONS OF INCOMPETENCY

The methods used for adjudication of incompetency, and the criteria by which incompetence is judged, vary widely. There is, again, not much connection between theory and practice. In theory, incompetency must have existed at the moment of the formation to make the contract void or voidable.[14] How does a court determine whether the contractor was incompetent at any one moment? How is incompetency defined? There is little accord among the states as to the weight to be given previous or continuing commitment to a mental hospital, a prior adjudication of incompetency, or acts which the court may view as abnormal. An adjudication of incompetence is conclusive when made, but the effect of the passage of time on the adjudication has different weight in different jurisdictions. In some jurisdictions there is a conclusive presumption that the contract of an adjudicated incompetent is void; in others, such prior adjudication is merely evidentiary.[15] Even in states in which carefully drawn distinctions exist theoretically in defining incompetency, those distinctions may be ignored in practice. For example, in New York commitment to a mental hospital and mental incompetency are legally unrelated. Thus, persons civilly committed are legally competent unless they have also been adjudged incompetent. Nonetheless, the director of one of the major state hospitals for such persons volunteered the information to one of us (G.A.) that he considers *all* of his inmates incompetent and will not allow them to exercise any contractual power. Since they are confined to his institution and have no unsupervised contact with the world, all are *de facto* incompetent.

The most glaring inconsistency, however, between theory and practice is in the tests applied to determine incompetency. The traditional test is cognitive: Was the person capable of understanding the nature and effect of the transaction in dispute?[16] There has been little judicial articulation of a definition of under-

13. *See* note 12, *supra.*

14. 57 MICH. 1021, 1025.

15. Weihofen, *supra* note 7, 211-15.

16. The precise wording of the test varies from "did he know what he was doing and the nature of the act done" to "was he mentally competent to deal with the subject before him with a full understanding of his rights . . . whether he actually understood the nature and effect of what he did." Green, *Judicial Tests of Mental Incompetency*, 6 MO. L. REV. 141 (1941); Weihofen, *supra* note 7, at 216; 57 MICH. 1021.

standing. In *Fischer v. Gorman*,[17] the court offered this "definition": "We are dealing with 'understanding' and not with mere 'consciousness.' 'Understanding' . . . suggests the concept of a mind with the faculty of applying its powers of reason to the elements it comprehends, to the end that a judgment or conclusion may be formed."[18]

A New York court defined understanding somewhat differently as "such mental capacity . . . that he could collect in his mind without prompting all the elements of the transaction, and retain them for a sufficient length of time to perceive their obvious relations to each other, and to form a rational judgment in regard to them."[19] The emphasis here is more on proper reasoning and less on accurate perception.

Some jurisdictions have added an "insane delusion" test: "whether that insane delusion, if a person has it, is a moving cause to some act which would not have been done except for that delusion."[20] This test is motivational rather than cognitive —the party might have understood the nature of the transaction and its consequences, but might have been impelled by an extravagant and mistaken belief into contracting. Cases in point are conveyances that cut off a wife's property rights because of an ostensibly mistaken belief in her infidelity,[21] or that bypass a wife and children for supposedly conspiring against the contractor.[22] But can a court determine what is "rational" or "understood," particularly when the original contractor is dead or cannot testify for himself?

There is considerable evidence that the courts, whatever they may say about understanding or cognition, actually look to the facts of the transaction and apply a conventional normal-abnormal test to the end result. The practical effect of applying this theoretical standard is to deprive the alleged incompetent of his right to contract because his transaction is eccentric or does not meet the normative standards of the courts. This is punishment for deviancy, not protection against helplessness.[23]

The cognitive test for competency is essentially the same as the traditional test for criminal responsibility. Both the

17. 65 S.D. 453, 274 N.W. 866 (1937).
18. *Id.* at 459, 274 N.W. at 870.
19. Paine v. Aldrich, 133 N.Y. 544, 546, 30 N.E. 725, 726 (1892).
20. Meigs v. Dexter, 172 Mass. 217, 52 N.E. 75 (1898); Green, *Judicial Tests of Mental Incompetency*, 6 MO. L. REV. 141, 152 (1941); 57 MICH. 1021, 1031.
21. Eubanks v. Eubanks, 360 Ill. 101, 195 N.E. 521 (1935).
22. Riggs v. American Tract Society, 95 N.Y. 503 (1884).
23. Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271 (1944).

M'Naghten rule[24] and the rule of "understanding" for the avoidance of contracts were formulated in England in the 19th century. M'Naghten holds that a man is not responsible for his criminal act if, at the time of the offense, "he was labouring under such a defect of reason . . . as not to know the nature and quality of the act he was doing," and adds the additional ground that if he did understand his acts, he is excused if he did not know they were wrong. This moral importation did not find explicit recognition in the law of contracts, although as we have seen, the courts implicitly consider the "rightness," or normality, of the contract as an overriding factor in determining incompetence.[25] M'Naghten also provided for an "insane delusion" test, holding that the defendant would be accountable to the same extent as he would be if the facts of his delusion were true. The contract version invalidates the contract which is a product of an insane delusion if, under all the circumstances, the contractor would probably not have made the contract if he had been "sane."[26] Here again a moral standard is applied. What the courts mean is that the contract *ought* not to have been made.

In this century there occurred a steady expansion of the criteria for criminal irresponsibility, and it seems likely that there will be a similar widening of the criteria for contractual incapacity. In *Durham v. United States*[27] the accused was declared "not criminally responsible if his unlawful act was the product of mental disease or mental defect."[28] The Model Penal Code has adopted a slightly different standard: "A person is not responsible if . . . as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law."[29]

A similar change—from a strict and exclusive reliance on cognition to a vague and expansive reliance on motivation, volition, and mental illness—is reflected in the Restatement (Second) of Contracts,[30] which provides that: "A person incurs only voidable contractual duties by entering into a transaction if by reason of mental illness or defect (a) he is unable to understand in a reasonable manner the nature and consequences of the trans-

24. The rule of M'Naghten's Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (1843).

25. Green, *supra* note 23.

26. *See* note 1, *supra.*

27. 214 F.2d 862 (D.C. Cir. 1954).

28. *Id.* at 874-75.

29. MODEL PENAL CODE § 401 (Tent. Draft No. 4, 1955). *See also* Platt, *Choosing a Test for Criminal Insanity*, 5 WILLAMETTE L.J. 553 (1969).

30. RESTATEMENT (SECOND) OF CONTRACTS § 18(c) (Tent. Draft No. 1, 1964).

action, or (b) he is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of his condition."[31]

This broadened rule and two pertinent recent New York cases suggest that the criteria for competency to contract will be weakened and undermined just as those for criminal responsibility have been.

In *Faber v. Sweet Style Manufacturing Corporation*,[32] the New York Supreme Court allowed recission of an executory contract for the purchase of land allegedly made during the manic phase of a manic-depressive psychosis. The contractor was committed to a mental hospital, evidently by his wife and doctor, and the wife sought recission of the contract. There was no claim that the contract was unfair or that the other party knew of Faber's illness. Nevertheless, the court, referring to the proposed Model Penal Code test of criminal responsibility, held that: "Incompetence to contract also exists when a contract is entered into under the compulsion of a mental disease or disorder but for which the contract would not have been made."[33]

This broadened test was then cited as authority for the court's position in *Ortelere v. Teachers' Retirement Board of City of New York*.[34] Mrs. Ortelere, while on a leave of absence from a teaching position following a "nervous breakdown," changed her retirement application to elect maximum retirement allowance, which revoked her earlier election of benefits under which she named her husband a beneficiary of the unexhausted reserve upon her death. Selection of the maximum allowance extinguished all interests upon her death. Two months later, she unexpectedly died. Her husband sued, both as executor of her estate and as beneficiary under the former election, to have the second application set aside on grounds of incompetency. Mrs. Ortelere's psychiatrist testified that she was psychotic and incapable of making a voluntary, "rational" decision. The court quoted Durham, the Model Penal Code, and the Restatement (Second) of Contracts and held that, while there was no doubt that Mrs. Ortelere possessed unimpaired cognitive "judgment"[35] and understanding, her election would be avoided where, by reason of mental illness in the nature of a medically recognized and

31. *Id.*

32. 40 Misc. 2d 212, 242 N.Y.S.2d 763 (1963); *noted in* 39 N.Y.U.L. REV. 356 (1964).

33. 40 Misc. 2d 212, 216, 242 N.Y.S.2d 763, 768 (1963).

34. 25 N.Y.2d 196, 303 N.Y.S.2d 362 (1969); *noted in* 45 N.Y.U.L. REV. 585 (1970), 16 WAYNE L. REV. 1188 (1970).

35. 25 N.Y.2d 196 at 199, 303 N.Y.S.2d 362, at 365.

classified psychosis, she suffered volitional and affective impairments of her personality which rendered her unable to control her conduct or to make a rational decision, and where there had been no significant change of position of the other party, which was on notice of her illness. The two dissenting judges disagreed with the majority's view that Mrs. Ortelere's selection of benefits was "unwise and foolhardy," pointing out that both she and her husband needed the money, that she carefully investigated the alternatives, and that she had no reason to believe her arteriosclerosis would so drastically reduce her life expectancy.

> It is common knowledge [they wrote], that the present state of psychiatric knowledge is inadequate to provide a fixed rule for each and every type of mental disorder. Thus, the generally accepted rules which have evolved to determine mental responsibility are general enough in application to encompass all types of mental disorders, and phrased in a manner which can be understood and practically applied by juries composed of laymen. . . . This rule [the cognitive test] represents a balance struck between policies to protect the security of transactions between individuals and freedom of contract on one hand, and protection of those mentally handicapped on the other hand. . . . In the final analysis, the lay jury will infer the state of the party's mind from his observed behavior as indicated by the evidence presented at trial. Each juror instinctively judges what is normal and what is abnormal conduct from his own experience, and the generally accepted test harmonizes the competing policy considerations with human experience to achieve the fairest result in the greatest number of cases.[36]

Although the opinion of the dissenting judges in the *Ortelere* case gives less scope to psychiatric discretion than does the opinion of the majority, it goes much too far, in our opinion, in allowing a jury to determine what is normal and abnormal and to deny an "abnormal" individual the freedom to contract. Evidently, the dissenters were more concerned with framing workable rules for the court than with protecting persons alleged to be incompetent from attempts to deprive them of their right to make binding contracts. Nor, moreover, did the dissenters call attention to the dangers to this right that are obviously inherent in more elastic tests of competence to contract.

IV. FREEDOM TO CONTRACT V. PROTECTION FOR INCOMPETENTS

While we believe it is the individual right to make contracts that stands, at present, in greatest need of protection, most

36. *Id.* at 208, 209, 303 N.Y.S.2d at 373.

writers who address themselves to this subject believe that the protection of individuals from their own "incompetence," should be our first priority. Thus, commenting on the *Ortelere* case, a student argued that the court did not go far enough in "protecting the mentally ill."[37] In particular, he objected to the majority's holding that when incompetency was volitional the other party should have notice of it prior to contracting, but that it need not have such notice when the incompetency was cognitive:

> One can infer that the instant court found one type of incompetent more deserving of protection than another: The person who does not understand what he is doing deserves more sympathy than the person who is *unable to control his conduct*; or conversely, the latter type of incompetent presents a greater danger to the security of contracts because he is more difficult to discover. . . . If one adopts the latter standard . . . then one must conclude that the majority desired to extend protection more imaginary than real. The type of *illness* compelling one to act against his own best interest is often not visibile to the casual observer.[38]

The note's author contended that the fact that the burden of proof is in the person alleging incompetence to show it existed at the time of formation is sufficient to protect the security of contracts.[39] Pleading for greater psychiatric discretion, he wrote:

> More logically, an expert would be required to consider only whether a person was *compelled* to enter into a contract. Thus, severely "neurotic" persons would not be arbitrarily denied the opportunity to avoid a contract simply because experts decided that their illnesses belonged in one category rather than another. . . . If a psychiatrist were allowed to disregard categories and merely analyze an incompetent's behavior, his testimony would then be highly relevant in cases like the principle one.[40]

Inasmuch as in *Ortelere* the court recognized that the testifying psychiatrist deliberately distorted his testimony to fit his diagnosis within the traditional test of incompetency,[41] the suggestion that psychiatrists be given even more latitude strikes us as promoting psychiatry rather than equity. Furthermore, since

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37. Note, *Contracts—Competency to Contract of Mentally Ill Person Who Fully Understands Transaction But Is Unable to Control Conduct,* 16 WAYNE L. REV. 1188 (1970).

38. *Id.* at 1193-94.

39. This is questionable, to say the least: Should we not wonder how ready, under such circumstances, a prudent person would be to deal with another party of whom he had the least suspicion of eccentricity, particularly if the criterion of competency were extended to encompass any "mental disease."

40. *Id.* at 1195.

41. 25 N.Y.2d 196, 201, 204, 303 N.Y.S.2d 362, 367, 370.

the process of declaring a contract invalid is often initiated by parties other than the alleged incompetent, who may be dead or incarcerated in a psychiatric institution against his will, broadening the grounds for avoiding contracts would only encourage third parties to try to promote their interests as against those of relatives making embarrassing or inconvenient contracts. The student article thus exemplifies the dangers inherent in the protectionist philosophy: the result of such solicitude can easily be that the contractor is protected into a strait-jacket, both figuratively and literally.

It is essential, then, that we re-examine the conflict of interests that is adjudicated whenever the question before a court is whether or not to deprive an individual of his right to contract on account of mental defect or disease. Whose interests are actually protected? What societal interests are advanced, and what others are retarded, when contracts are voided, rather than enforced, in cases of so-called mental illness?

When the state declares a contract void, as it does in many jurisdictions after an adjudication of incompetence and the appointment of a guardian,[42] and in some states on the mere finding of incompetence after litigating the contract,[43] it is really declaring that an interest of the state more important than the policy favoring enforcement of contracts requires that the agreement in question be nullified. Aside from incompetence, only the most compelling societal interests will categorically block the contractual process and void the agreement: among these interests are illegal subject matter,[44] or the deepest moral sensibilities of the community, often expressed in a statute, that the bargain is so unconscionable as to be outlawed.[45]

Various and often inconsistent justifications are advanced for according special treatment to the contracts of incompetents. One of these is that, to be valid, contracts require "mutual assent"; hence, contracts that lack such assent should be void. Another is that since the aim of voiding the contracts of incompetents is to protect them from exploitation at the hands of the unscrupulous, contracts should be avoidable only by the weaker party. The courts have not resolved such inconsistencies.[46]

Still another reason for voiding the contracts of an adjudicated incompetent is to protect the freedom of the guardian in

42. Weihofen, *supra* note 7, at 228-29.
43. *Id.* at 230-31.
44. RESTATEMENT OF CONTRACTS § 598 (1932).
45. For a recent collection of articles on unconscionability and contract law *see generally* 31 U. PITT. L. REV. (1969-70).
46. *See, e.g.*, 46 A.L.R. 416, 95 A.L.R. 1442.

the proper management of the assets of his ward.[47] However, that requires the improbable assumption that all contracts made by an incompetent will be disadvantageous to him.[48]

It is important to keep in mind, moreover, that, in practice, the party wishing to avoid a contract is usually not the alleged incompetent but a relative anxious to prevent what it considers a waste of assets. In a widely-quoted article on the public policies underlying the law of mental incompetency,[49] Dr. Green recognizes this state of affairs, and asks, appropriately, "protection of whom?"[50] His answers are: (1) Protection for society from the incompetent—the traditional justification for civil commitment; (2) Protection for the incompetent from society—the traditional justification for paternalistic legislation of all types; and (3) Protection for the family or dependents of the incompetent from his acts injurious to their welfare.[51] A fourth category is conspicuous by its absence: Protection for the incompetent from members of his family who, for reasons of their own, desire to curtail his autonomy—or to remove him from society altogether. We must remember, in this connection, that a person declared incompetent is often deprived of rights to manage his property, and may in addition be civilly committed to a mental hospital for an indefinite period.

Dr. Green traces society's interest in a special category for incompetents to a basic recognition that "[t]wo of the ends of the law are security and equality."[52] The law must thus reconcile conflicting interests in the promotion of the security of transactions, freedom of contract, and the protection of "unequals." Significantly, Green never mentions what must surely be another end of the law in a free society—namely, liberty. It is precisely liberty—individual self-determination—that has been swallowed up in the battle between protecting transactions and protecting incompetents.

Whenever the question of competence to contract is actually litigated, the interests of several parties besides those of the alleged incompetent and his family come into play. Among these are the interests of the court itself and, most significantly, of the psychiatrists who examine the alleged incompetent, declare

47. Weihofen, *supra* note 7, at 212.

48. In some cases the guardianship has been abandoned without a formal restoration, yet those states which void the contract require that formality. Weihofen, *supra* note 7, at 213.

49. Green, *Public Policies Underlying the Law of Mental Incompetency*, 38 MICH. L. REV. 1189 (1940).

50. *Id.* at 1213.

51. *Id.*

52. *Id.* at 1206.

him to be incompetent, and then seek to "hospitalize" and "treat" him. In the voluminous legal and psychiatric literature on incompetence, there is no end of discussion of the interests of the alleged incompetent, his relatives and creditors, and of the state; of the interests of psychiatrists (and lawyers), there is no discussion at all.

VI. The Problem of Patient-Psychiatrist Contracts—A Special Case of Contractual Capacity Dilemma

Conventionally as well as legally, psychiatry is considered a medical specialty. The psychiatrist is a physician licensed by the state to practice medicine, not psychiatry—just as the cardiologist, dermatologist, urologist, etc. is licensed to practice medicine, rather than his particular specialty. We note this to emphasize that, like other physicians, in order to diagnose or treat his patient, the psychiatrist must enter into a contract with him (or, if this is legally authorized by the state and acceptable to the psychiatrist, with someone acting on behalf of the patient). While in emergencies physicians may treat patients without contract,[53] in other cases contract is required, not only to establish a basis for compensation, but, more importantly, to protect personal dignity and liberty. Thus, Anglo-Saxon law does not recognize—that is to say, it entirely disallows—nonconsensual treatment. For example, an operation without the patient's consent—except, again, for emergencies—is not treatment but battery.[54] In other words, unconsented surgery is, in the eyes of the law, tantamount to attack with a knife. There is no reason, from a legal point of view, to regard unconsented psychiatric interventions—whether they consist of lobotomy, electroshock, hospitalization, or psychotherapy—in a different light.[55]

The "assault" in all such cases consists—and this is the crux of the matter—in the absence of consent; it does not consist of inflicting demonstrable injury on the patient—although patients so treated often do suffer such injury. Since the basis of consensual medical treatment is a contract between physician and patient, it is necessary that the patient be fully and correctly informed about what the physician intends to do in carrying out the treatment.

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53. Restatement of Restitution §§ 113-117 (1937).

54. W. Prosser, Law of Torts, at 105 (3d ed. 1964). [Hereinafter cited as Prosser].

55. Perhaps the psychiatric tort, in the absence of physical contact, might more precisely be titled intentional infliction of mental distress or invasion of privacy, the intentional torts most closely analogous to completely nonphysical therapy. *See* Prosser, *supra* note 54, at 112.

Consent obtained without such knowledge on the part of the patient is legally ineffective, because it is not "informed."[56] In surgical interventions, "informed consent" requires that the patient be apprised of the likely effects of the operation and its risks.[57] What constitutes "informed consent" in cases of psychiatric treatment has yet to be fully explored in court decisions.[58]

Some of the grosser psychiatric abuses represent problems closely resembling surgical malpracice and a few of them have been litigated. In the case of *Wilson v. Lehman*,[59] the issue was consent to electroshock therapy. However, the court did not deal with capacity to consent, but only with proof of consent. Mrs. Wilson could not remember whether or not she had consented, because of shock-induced amnesia. Her husband had not given written consent for the treatment, but had not removed her from the hospital. The court evidently believed that he was estopped from claiming lack of consent, although it did not actually say so. It relied, instead, on the presumption of consent from the fact of treatment, and failed to consider whether or not that presumptive consent could have been informed or capable. It is important to note that the determining factor in the decision seems to have been lack of actual injury as a result of the treatment. But this decision is inconsistent and ironic for it holds that Mrs. Wilson suffered from a mental disease severe enough to require electroshock treatment for it, but not severe enough to render her unfit to execute a valid contract.

Another case dealing with consent to treatment is *Farber v. Olkon*,[60] a decision involving a legally incompetent adult child (aged 31 years), on whose behalf a parent consented to electroshock treatments and a lobotomy. The result was two broken legs, permanently deformed hips, and brain damage. In ruling on an action brought for injuries, the court held that where such a "child" is incompetent and has no legally appointed guardian, the right to consent to treatment is lodged in the parent who has legal responsibility for maintaining the child. The child therefore had no right to complain.

In *Lester v. Aetna Casualty and Surety Co.*,[61] the court held

56. Morse, *The Tort Liability of the Psychiatrist*, 16 BUFFALO L. REV. 649, 650-652 (1967); 18 SYRACUSE L. REV. 691, 692-94 (1967) [hereinafter cited as Morse]; Annot., 99 A.L.R.2d 599, 614-16 (1965) [hereinafter cited as 99 A.L.R.2d 599].

57. PROSSER, *supra* note 54, at 107.

58. 99 A.L.R.2d 599, 614-16.

59. 379 S.W.2d 478 (Ky. 1964).

60. 40 Cal. 2d 503, 254 P.2d 520 (1953).

61. 240 F.2d 676 (5th Cir. 1957). For an extended discussion of third-party consent, *see* Morse, *supra* note, 56 *passim*.

that a legally competent patient may be deprived of his right to contract for electroshock treatment, if, in the judgment of the patient's wife and psychiatrist, it is "unwise" to require the patient to consider the hazards entailed in the treatment. The court held that, in such a case, the wife could give sufficient consent. This case is especially interesting as the patient argued, quite sensibly, that allowing his wife to consent for him deprived him of his freedom to contract, and hence of liberty, without due process of law. The court was not impressed.

Once the physician-patient relationship is established, the physician has broad discretion as to treatment methods. Malpractice standards are generally very protective of physicians, including psychiatrists. As a rule, a physician is absolved from liability, even for undesirable and harmful treatment, so long as he can demonstrate that his patient gave informed consent for the treatment, and that the treatment falls within the broad range of what constitutes acceptable treatment within his profession or specialty.[62] However, in *Hammer v. Rosen*,[63] in a suit brought aginst a well-known psychiatrist specializing in the treatment of seriously disabled "schizophrenic" patients, the court ruled that where the "treatment" involved beating a patient, the burden of proof must, because such treatment is seemingly improper, be shifted from the plaintiff to the defendant. This case merits special attention.

The patient, Alice Hammer, was an adult but legally incompetent patient, placed under the care of Dr. John Rosen by her parents. Before Dr. Rosen entered the case, Alice Hammer had received more than 200 electroshock treatments "without improvement."[64] Dr. Rosen treated Miss Hammer between 1948 and 1955 and collected over $55,000 in fees.

> It was brought to the attention of the patient's family that the defendant made claims to dramatic success in the treatment of schizophrenic patients. The defendant was sought out, requested to, and did agree to treat the patient. Nurse H. Louise Wong, who attended the patient for 12 days during September 1948, testified that on two occasions she took the patient to the defendant for treatment. On the first occasion she requested the defendant to permit her to be present. Defendant, stating that he did not allow anyone to be present during his treatment of the patient, refused, excluded

62. 99 A.L.R.2d 599, 604-05.

63. 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960). Morse, *supra* note 56, offers another view of the case at 16 BUFFALO L. REV. 663-65, 18 SYRACUSE L. REV. 704-707. PROSSER, *supra* note 54, at 166.

64. Hammer v. Rosen, 181 N.Y.S.2d 805 (Sup. Ct. 1959).

> Nurse Wong from his office, locked the door and directed her to return at the end of an hour. Within 15 minutes thereafter Nurse Wong heard screams which she identified as those of the patient emanating from the defendant's office. She returned, attempted to gain access to defendant's office but was again excluded by defendant. After completion of the treatment on the first occasion, Nurse Wong observed that the patient's body was covered with bruises, and her clothes were torn and disheveled. There was no one in defendant's office except the patient and the defendant. . . .[65]
>
> Apart from the testimony of Nurse Wong, there was ample evidence in the record of defendant's assaults on the patient on various occasions in the course of his treatments. Mrs. Hammer testified that after treatments she observed her daughter was 'beaten up' and had 'blue eyes'; that her daughter returned from treatments 'black and blue.' Mrs. Hammer also testified to conversations with the defendant wherein he stated that the assaults complained of were part of the treatment. In addition, Emma Reitz, a maid in the employ of the Hammers, testified to circumstances establishing that the defendant slapped the patient without justification during the summer of 1950 at Bolton Landing, N.Y.[66]

Dr. Rosen, the record informs us, ". . . argues that the treatment was knowingly and freely consented to by reason of the fact that the patient's mother testified that if beating was a means of cure, she was agreeable to the treatment."[67]

The appeals court ruled that, "With respect to the evidence, it is necessary merely to point out that the testimony given by three of the plaintiff's witnesses, indicating that the defendant [Dr. Rosen] had beaten Alice [Hammer] on a number of occasions, made out a prima facie case of malpractice which, if uncontradicted and unexplained and credited by the jury, would require a verdict for the plaintiff."[68]

"As to the second of the defendant's arguments—that there was no expert testimony to support the plaintiff's charge of malpractice—the simple answer is that the very nature of the acts complained of bespeaks improper treatment and malpractice and, if the defendant chooses to justify those acts as proper treatment, he is under necessity of offering evidence to that effect."[69]

We might note here that Dr. Rosen articulated his view of

65. *Id.* at 806.
66. *Id.* at 806-07 (dissenting opinion).
67. *Id.* at 807.
68. *Id.*
69. Hammer v. Rosen, 7 N.Y.2d 376 at 379-80, 165 N.E.2d 756 at 757, 198 N.Y.S.2d 65 at 66-67 (1960).

the psychiatric patient's capacity to contract, in one of his publications, in these rather revealing words: "The individual who comes in, seeking a treatment, does not know what he is doing. He may have to be brought in, forcibly, for that matter. But even if he is capable of recognizing and expressing his desire to be treated, he does not really know what he is letting himself in for."[70]

In the case of *Hammer v. Rosen*, then, there was no doubt that Dr. Rosen had appropriate consent from the patient's parents for treating her; there was doubt only about whether beating her was appropriate treatment. Even on this issue the court did not rule that beating was, regardless of circumstances and consent, malpractice, leaving the door open for support, from Dr. Rosen, that it was "proper treatment." Indeed, Dr. Rosen could have protected himself from this suit by a contract specifically authorizing him to physically discipline patients—an intervention neither invented by Dr. Rosen nor practiced by him alone. (There is massive evidence that, for more than 300 years, mental patients have regularly been beaten in mental hospitals; occasionally, they have been beaten to death).

VII. THE CONSENT PROBLEM

As we have seen, the physician's contractual obligations to his patient are minimal, being limited essentially to conforming his interventions to a broad range of prevailing practices, and to imposing these on the patient only with the patient's informed consent to them. A physician may, however, exceed this minimal obligation by promising a specific result. Should he do this, he will be held to the expectations his promises have evoked. Thus, physicians have contracted themselves into obligations to cure, although failure to cure would not otherwise have constituted malpractice.[71]

Moreover, while contractual incapacity might well serve as a valid defense to other contract provisions, it is unlikely that a court would be persuaded that the patient's incompetence ef-

70. *Id.* at 380, 165 N.E.2d 756 at 757, 198 N.Y.S.2d 65 at 67. We will not belabor our complete rejection of this paternalistic psychiatric posture. It should suffice to note that the "mental patient" often does not, in fact, know "what he is letting himself in for." But, in our view, this is not because he is incompetent or stupid, as Rosen implies, but because the psychiatrist does not tell him what he proposed to do for and to him. The remedy for this is not coerced psychiatric treatment, but, on the contrary, the abolition of all such treatment and the requirement of strict "informed consent" for all psychiatric interventions.

71. PROSSER, *supra* note 54, at 165; 99 A.L.R.2d 599, 601 n.3.

fectively destroyed his reliance on a physician's promise. Generally, where a substantial disparity of sophistication exists between the parties, contracts are strictly interpreted against the stronger party.[72] While the patient's incompetence might help the physician to discredit testimony about disputed facts, it is not likely to help him defeat the effect of a promise to cure.

Courts have clearly not applied the normal contractual requirement of informed consent to psychiatric contracts, as illustrated by the *Wilson* case, cited previously.

Mrs. Wilson, it will be recalled, was given electric shock treatment. After the treatment, she could not, because of shock-induced amnesia, remember whether or not she had given verbal consent to it. There was no record of her written consent, nor that of her husband. Nevertheless, the court presumed that consent had been given.

There is good reason, indeed, why, in Mrs. Wilson's case, the court presumed consent—indeed, "informed consent"; had it not, it would have cast doubt on the consent given by all psychiatric patients for their "voluntary" treatment, especially where, from the radical nature of the treatment employed, the logical inference would be that the patient suffered from "severe" mental illness and hence had limited or no capacity to contract. What, in concrete terms, would this mean? In every case where a person now voluntarily consents to outpatient electroshock therapy or to mental hospitalization—(and to whatever additional treatment while confined)—two types of psychiatric treatments most authorities consider appropriate only for patients suffering from "major" mental diseases—there would be a presumption of incompetence to execute valid contracts. The attending psychiatrists would not be entitled to compensation for such "non-consensual" treatment, and would, indeed, be liable to the patient in battery and perhaps criminally for assault. The upshot would be a radical diminution of psychiatric treatment consequent to contract between patient and physician. A brief psychiatric digression into the history of psychiatry here will show how very real this possibility is and how relevant it is to the issues at hand.

Until approximately 1900, there was, for all practical purposes, no such thing as voluntary psychiatric treatment. The relationship between patient and psychiatrist was not based on a contract between them, as it was in medicine and surgery—but was based on a contract between a third party (usually the

72. RESTATEMENT (SECOND) OF CONTRACTS § 232 (Tent. Draft No. 5, 1970).

patient's family or the state) and the psychiatrist, as it was in pediatrics or penology. In other words, the psychiatrist entered into a contract with the so-called patient's family or the state to do something to or with him, and this was (euphemistically) called "psychiatric treatment." As a rule, treatment was nothing but imprisonment in an institution called a "mental hospital."

To this arrangement, which of course is still with us, there was added, during the end of the nineteenth century and the begining of the twentieth, another, based on contract between psychiatric patient and psychiatric physician. This age was inaugurated by the early medical psychotherapists, such as Janet and Freud, who pioneered not only in practicing a novel type of psychiatric treatment, but more significantly in basing their contact with their clients on a contract with them rather than with their surrogates (familial or judicial). In short, they treated their mental patients *as if* they were "sane" enough to be accorded the dignity of entering into a binding contract with them. It is for this reason that we view the early psychoanalysts as humanists and liberators; while their contemporary "liberal" followers who do not hesitate to coerce where they cannot contract must be viewed in the opposite light.

IX. The Discretion Problem

One of us (T.S.S.) has previously suggested that we distinguish between two radically different types of "psychiatry," or psychiatric practices: Institutional Psychiatry, in which contract for services is between the psychiatrist and some party other than the "patient"; and Contractual Psychiatry, in which it is between the psychiatrist and the patient. The arrangement in Institutional Psychiatry resembles the arrangements parents make for services for their children—for example, in authorizing experts to remove a child's tonsils or teach him French; it may thus be said to rest on, or make use of, a pediatric or paternalistic model of human relationships. On the other hand, the arrangement in Contractual Psychiatry resembles, indeed is essentially identical with, those that clients generally make with experts in free, capitalist societies—for example, in retaining an architect to build a house or a lawyer to secure a divorce; it may thus be said to rest on, or make use of, the traditional legal model of contracts.

Because of the diversities of psychiatric practices, and because these diversities are now becoming more clearly defined and understood, it seems necessary now to establish contractually the limits of the psychiatrist's undertaking. Let us indicate briefly what this entails.

Many of the difficulties surrounding the contemporary practice of psychiatry—for both patients and psychiatrists—derive from ambiguities and uncertainties about the nature of the psychiatrist-patient relationship. In particular, we believe that people continue to fear and distrust psychiatrists and psychiatric institutions for a good reason: that is, not because psychiatrists are any worse (or better) intentioned than other professionals, but because they enjoy too much discretion over their client once the client places himself in their care. It seems likely—observation surely supports this impression—that individuals are often unwilling to seek psychiatric care because they do not know whether or not their psychiatrist eschews forms of treatment they do not want (for example, commitment or electroshock). In other words, they fear that, even though they had sought out outpatient psychiatric treatment or mental hospitalization voluntarily, they might, at any moment, and at the discretion of their own psychiatrist, lose their power to contract for further care, including the rejection of all such "care." This fear and mistrust is, unfortunately, perfectly well grounded in the reality of present-day mental hygiene laws. Hence, it seems likely that while more precise definitions of the psychiatrist's contractual powers and limitations would curtail some of the current psychiatric practices, it would expand others, by removing the presently justified fears of many persons to sacrifice their autonomy and yield to the total discretion of a psychiatrist.

X. CONTRACTUAL PROTECTION

Many recent psychiatric malpractice cases are based on the failure of the psychiatrist to restrain the patient adequately,[73] with the result that the patient killed himself (or more rarely, injured or killed another person). These cases are now decided without coming to grips with the question of what the psychiatrist promised to whom. If the psychiatrist contracts with the patient's family to restrain the patient (and if the contract is otherwise valid), then the psychiatrist should, on the one hand, be allowed to use the requisite force necessary to carry out his "treatments," and, on the other, be held strictly liable for his contract. However, if the psychiatrist contracts with the patient to engage in types of psychiatric "treatment" that expressly eschew coercion and restraint—in short, if the psychiatrist makes no promise to protect the patient from his own suicidal acts (or others from his aggressive propensities)—then it is just as absurd

73. Morse, *supra* note 56, at 665-73, 18 SYRACUSE L. REV. at 707-15 (1967); Annot., 99 A.L.R.2d 599, at 620-21, 624-25 (1965).

to hold the psychiatrist liable for failure to restrain the patient as it would be for his failure to remove the patient's appendix or refract his eyes.

Psychiatrists thus need clearly-articulated and enforceable contracts: to protect themselves when they are engaged in restraining patients and also when they are engaged in explicitly eschewing restraints. Psychiatric patients need such contracts even more: to protect themselves from their own "mental diseases" (in so far as this conceptualization is considered meaningful and deserving of legal ratification), and also from the "therapeutic assaults"—however justified or rationalized—of their relatives, employers, and psychiatrists.

For all of these reasons it is of paramount importance both to the patient and to the physician that the patient be in a position to contract legally. The potential legal incompetence of a patient creates innumerable stumbling blocks even for psychiatrists who would willingly treat by direction of third parties. For psychiatrists whose professional ethics prohibit involvements with third parties, the absence of binding consent would be fatal.

It is possible, of course, that the law will recognize contractual capacity to consent to treatment in patients whose capacity would be otherwise denied. It cannot be counted on to do so, however, and that is a sufficient cause for serious concern. Furthermore, much of contractual incapacity is not derived from common law, but is legislative.[74] The courts would be compelled to abide by the mandate of the statute.

The failure of the courts to examine the issue of consent in psychiatry until now may reflect a judicial policy of protecting the psychiatrist's therapeutic discretionary powers far beyond the protection afforded other physicians. It may also, as one commentator has conjectured, reflect the greater shrewdness of psychotherapists.[75]

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74. 46 A.L.R. 416; 95 A.L.R. 1442; Weihofen, *supra* note 7, at 228, 230; 57 MICH. 1020, 1117-18.

75. Heller, *Some Comments to Lawyers on the Practice of Psychiatry*, 30 TEMP. L.Q. 401 (1957); 99 A.L.R.2d 599, 620 n.20. A revealing sidelight on the judicial attitude toward the psychiatrist-patient relationship, as against other doctor-patient relationships, may be found in the proposed Rules of Evidence for federal trial courts. Under proposed rule 504, a patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, any confidential communications made during the course of psychiatric/psychological diagnosis or treatment. PROPOSED RULES OF EVIDENCE FOR THE U.S. DISTRICT COURTS AND MAGISTRATES (Revised Draft, March 1971). The rules contain no such provision for a general physician-patient privilege. *Id.* Rule 504, Advisory Committee's Note, at 53. Psychotherapists are accorded special treatment because, in the words of the Advisory Committee, "confidentiality is a *sine qua non* for successful psychiatric treatment. . . . A threat to secrecy blocks suc-

XI. CONCLUSION

In this discussion we have been concerned with the relations between contract law and psychiatry, and especially the professed policy of protecting mentally incompetent persons from the consequences of their contracts. This protection is usually seen as protection against overreaching by those dealing with incompetents.[76] Correspondingly, the policy of the state is seen as protecting the weak against fundamentally unfair agreements. It has been widely recognized that courts do, in fact, look to the fairness of the bargain in determining whether to uphold the contract.[77] One writer has called this evaluation "perilously close to judging the adequacy of consideration."[78] There is no doubt that the "adequacy" of consideration, no less than the utility of the subject matter, is being judged; that this is "perilous," however, is by no means clear.

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cessful treatment." *Id.* quoting report No. 45, Group for the Advancement of Psychiatry 92 (1960). At the same time, the rule grants three significant exceptions to this privilege: examination by order of the judge, in which case disclosure is limited to the particular purpose for which the examination is ordered, *Id.* Rule 504(d)(2); disclosure when the mental or emotional condition is an element of the patient's claim or defense, or, after his death, when any party relies on the patient's condition as an element of his claim or defense, on the theory that, by injecting his condition into the litigation, the patient waives the privilege, *Id.* Rule 504(d)(3), Advisory Committee's Note at 55; and, the *piece de resistance,* that "There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization." *Id.* Rule 504(d)(1). This remarkable provision allows the *doctor* to waive the *patient's* privilege because, according to the Advisory Committee:

> The interests of both patient and public call for a departure from confidentiality in commitment proceedings. Since disclosure is authorized only when the psychotherapist determines that hospitalization is needed, control over disclosure is placed largely in the hands of a person in whom the patient has already manifested confidence. Hence damage to the relationship is unlikely. *Id.* Advisory Committee's Note at 54.

The Committee ignores the early damage to the patient-psychiatrist relationship inflicted on it by the patient's knowledge that anything he might say could be used to place him in involuntary incarceration, and the later damage caused by such shocking abuse of trust. Were this judicial solicitude for the rights of psychiatrists at the expense of their patients carried over into the field of contract, the psychiatric profession would indeed have been correct in ignoring the effect on the doctor-patient contract on the adjudication of contractual incapacity.

76. Green, *Fraud, Undue Influence, and Mental Incompetency: A Study in Related Concepts,* 43 COLUM. L. REV. 176, 183 (1943); Green, *Public Policies Underlying the Law of Mental Incompetency,* 38 MICH. L. REV. 1189, 1210, 1216, 1219 (1940).

77. Green, *supra* note 23.

78. Note, *Contracts—Competency to Contract of Mentally Ill Person Who Fully Understands Transaction But Is Unable to Control Conduct,* 16 WAYNE L. REV. 1188, at 1195 (1970).

Courts have, by tradition, accorded great weight to the right to contract freely. But this right has never been absolute; nor is it clear that it would be desirable if it were. The doctrine of consideration—meaning that contracts will not be enforced by courts unless the contracting parties actually exchange something of value—remains accepted legal practice, though it is much disliked by legal scholars.[79]

In short, there is little reason to refuse to allow a court power to look at a bargain as a whole. Furthermore, judicial power to review contracts in the light of considerations of fairness and the public interest has been recognized by the Restatement (Second) of Contracts, which contains three sections designed to protect weaker parties from overreaching by stronger.[80] Traditional contract doctrine has also allowed recission for fraud,[81] duress,[82] or undue influence[83] in the formation of a contract. Modern contract doctrine refuses enforcement to an adhesionary contract, a standard form contract between two parties of grossly unequal bargaining power, unless the party seeking to enforce it can demonstrate notice of the contested provisions and procurement of the "understanding consent" of the weaker party.[84] Even innocent misrepresentation will suffice for recission of a contract, placing both parties in *status quo ante*.[85] Courts now covertly apply equitable doctrines to attempted avoidance of an incompetent's contract, and it would seem more sensible, and less dangerous to the rights of the alleged incompetent and the "healthy" party, to look at the bargain, rather than at the parties. Such a course is certainly less perilous to the interests of the avoiding party than an adjudication of incompetency, and protects the good faith contractor who had no reason to know the other party was incompetent, and whose bargain is fair. The appointment of a legal assistant to those in need of help might also avoid some of the difficulties raised in a competency proceeding.

It must be admitted, of course, that if the defense of incompetency is disallowed, and the courts are restricted to settled contract doctrine, legal or equitable, some unfortunate contracts will

79. RESTATEMENT (SECOND) OF CONTRACTS, § 19(a) (Tent. Draft No. 1, 1964).

80. RESTATEMENT (SECOND) OF CONTRACTS (Tent. Draft No. 5, 1970), §§ 231, 233, 2341.

81. RESTATEMENT OF CONTRACTS §§ 471, 475 (1932).

82. *Id.* §§ 492, 494, 495.

83. *Id.* §§ 497-99.

84. Henningsen v. Bloomfield Motors, Inc., 32 N.J. 358, 161 A.2d 69 (1960); Steven v. Fidelity & Gas Co. of New York, 58 Cal. 2d 862, 377 P.2d 284, 27 Cal. Rptr. 172 (1962).

85. RESTATEMENT OF CONTRACTS § 476 (1932).

survive. A basic policy decision must here be confronted. Will the interests of the incompetent and of society be better served by allowing some "undesirable" contracts to survive and be enforced, or is the sounder policy to continue to make void or voidable the contracts of the allegedly insane? Clearly, some interests of the incompetent are served if he is allowed to avoid a contract, not unfair when made, but inconvenient when sought to be performed. However, in this area, no less than in torts, the other consequences of assuming the role of incompetent mental patient clearly tip the scales against this strategy for the "patient." Noncontracting parties, whether they be physicians or creditors should, of course, be denied the gambit of improving their lot by casting one of the contractors as insane.

In short, we favor doing away with the legal recognition of mental incompetency as a ground of avoiding contracts (or making the criteria for such avoidance operational not psychiatric, and precise in the extreme), because we believe that this policy is most consistent with the traditional moral aims of Anglo-Saxon law, and especially contract law—namely, the expansion of the scope of individual self-determination and the protection of personal dignity; and because we cherish and support these values and rank them, on our own scale, higher than security or "mental health."