DAMAGE ACTIONS AS A STRATEGY FOR ENHANCING THE QUALITY OF CARE OF PERSONS WITH MENTAL DISABILITIES

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INTRODUCTION

The lives and limbs of persons with disabilities are no less precious than those of temporarily able-bodied individuals. Yet this obvious proposition of equality is not much evidenced in state tort or federal civil rights litigation. Although actions for injunctive relief for violations of the constitutional and statutory rights of persons with mental disabilities are now common, actions for recovery of damages due to the inadequate care of these persons are all too rare, even when those labeled as mentally ill or mentally retarded have been seriously harmed. The paucity of damage cases is particularly striking given the well-publicized inadequacies of mental health and retardation service systems.[1] Historical reliance on large institutions as the primary means of caring

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This Article is dedicated to those who have suffered humiliation without apology and harm without compensation. An earlier version of this material was presented at a colloquium entitled "Rights of People with Disabilities" sponsored by the N.Y.U. REVIEW OF LAW AND SOCIAL CHANGE in April 1989.

1. *See generally* D. TORREY, S. WOLFE & L. FLYNN, CARE OF THE SERIOUSLY MENTALLY ILL: A RATING OF STATE PROGRAMS (2d ed. 1988); U.S. GEN. ACCOUNTING OFFICE, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO

for those believed to have mental handicaps[2] has subjected millions of vulnerable citizens to a regimen of abuse, neglect, excessive restraint, mind-altering medications, and experimental treatment devices.[3] This regimen is not the product of sporadic incidents in isolated settings, but rather of a pattern discernable in many public and even some private facilities.[4] It has directly and proximately caused the death, disfigurement, prolonged pain, and regression of thousands of disabled Americans. For some, it may even have been the source of, or at least the primary contributing factor to, their disabilities.[5]

In this context of pain and harm, one would think damage actions would flourish. Tort law has traditionally provided remedies for personal injuries, ensuring vigorous advocacy for the victims and demanding adequate compensation through creative calculations of suffering and ingenious concepts of legally cognizable wrongs. By attaching legal and financial penalties to subnormative behavior, the tort system serves as a general deterrent to injurious conduct. Given the plethora of pain and suffering imposed upon residents of public mental institutions, a more natural forum for tort and civil rights litigation could hardly be imagined. But instead there has been silence. Lawyers, like everyone else, accepted the veil of invisibility and the paradigm of beneficent protection which pervaded the lives of those labeled as mentally ill and mentally retarded.

This deficit was not unique to the law of remedies. It pervaded the professional standards — or lack of them — that governed the care of individuals

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MORE, H.R. DOC. No. 152, 76th Cong., 1st Sess. (1977); Mechanic & Aiken, *Improving the Care of Patients with Chronic Mental Illness*, 317 NEW ENG. J. MED. 1634 (1987).

2. *See generally* T. BRADDOCK, R. HEMP, G. FUJIURA, L. BACHELDER & D. MITCHELL, PUBLIC EXPENDITURES FOR MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES IN THE UNITED STATES 8 (1989); NATIONAL ASS'N OF STATE MENTAL HEALTH PROGRAM DIRECTORS, STATE MENTAL HEALTH PROGRAM INDICATORS *passim* (1986); Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 RUTGERS L.J. 595, 636 (1983); Goldman, Gattozzi & Taube, *Defining and Counting the Chronically Mentally Ill*, 32 HOSP. & COMMUNITY PSYCHIATRY 21 (1981).

3. The literature documents a chronicle of inhumane and callous custodial confinement. *See generally* D. ROCHEFORT, THREE CENTURIES OF CARE OF THE MENTALLY DISABLED IN RHODE ISLAND AND THE NATION *passim* (1981); D. ROTHMAN, THE DISCOVERY OF THE ASYLUM *passim* (1971); A. DEUTSCH, SHAME OF THE STATES *passim* (1947).

The federal courts have been presented with this history through lengthy trials, demonstrating that those past abuses have continued unabated. *See* Society for Good Will to Children v. Cuomo, 737 F.2d 1239 (2d Cir. 1984); Lelsz v. Kavanagh, 673 F. Supp. 828 (N.D. Tex.), *rev'd on other grounds*, 824 F.2d 372 (5th Cir.), *cert. dismissed sub nom.* Association for Retarded Citizens of Texas v. Kavanagh, 483 U.S. 1057 (1987); Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295 (E.D. Pa. 1977), *aff'd on other grounds*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981), *aff'd on remand*, 673 F.2d 647 (3d Cir. 1982), *rev'd*, 465 U.S. 89 (1984), *consent decree entered*, 610 F. Supp. 1221 (E.D. Pa. 1985), *order aff'd*, 901 F.2d 311 (3d Cir. 1990), *cert. denied*, 111 S.Ct. 140 (1990); New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

4. D. ROTHMAN, *supra* note 3; A. DEUTSCH, *supra* note 3.

5. *See generally* T. SZASZ, M.D., THE MANUFACTURE OF MADNESS *passim* (1971); E. GOFFMAN, ASYLUMS *passim* (1961); Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250 (1973).

with disabilities.[6] While government regulations[7] and the protocols of selected professional associations[8] stipulate certain preferred treatment practices, most aspects of care have been unaffected by existing standards.[9]

Recently, the legal profession has recognized the potential for new clients, substantial damage awards, and the challenge of reforming the quality of clinical care offered to persons with disabilities.[10] Nevertheless, much of this

6. Until eighteen years ago, one of the few national programmatic standards in existence were the licensing guidelines of the Joint Commission of Accreditation of Hospitals. Originally issued in 1918, the *Standard of Efficiency for the First Hospital Survey of the College*, 3 BULL. AM. C. OF SURGEONS 1 (1918), was subsequently adopted intact in 1951 by the Joint Commission. These guidelines mostly suggested appropriate methods for organizing staff, maintaining records, and operating safe buildings. *See* JOINT COMM'N ON ACCREDITATION OF HOSPS., ACCREDITATION MANUAL FOR PSYCHIATRIC FACILITIES *passim* (1972). When the federal government began financing long-term health care and mental retardation facilities, it added new requirements for life-safety codes and staff qualifications. 42 C.F.R. §§ 482, 483 (1988) (institutional certification standards).

Only recently have these national regulating and licensing bodies incorporated standards concerning admission, discharge, quality of care, individualized treatment, restraint and seclusion, and legal rights. *See* Health Care Financing Administration, Conditions of Participation, 42 C.F.R. § 441C (1988) (elders in mental hospitals); 42 C.F.R. § 441D (1988) (adolescents and children in psychiatric facilities); 42 C.F.R. § 441G (community-based services); 42 C.F.R. § 442D (1988) (standards for skilled nursing facilities); 42 C.F.R. § 442F (1988) (standards for intermediate care facilities other than facilities for the mentally retarded); 42 C.F.R. § 483 (1988) (standards for intermediate care for the mentally retarded in federally-funded facilities); JOINT COMM'N ON ACCREDITATION OF HEALTH CARE ORGS., MINIMUM STANDARDS FOR HOSPITALS *passim* (1987) (standards for acute and long-term care facilities for persons with disabilities); ACCREDITATION COUNCIL ON SERVS. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, STANDARDS FOR SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES *passim* (1987) (institutional and community mental retardation programs).

But no national standards still exist on basic elements of care for persons labeled as mentally ill, such as the appropriate utilization of various forms of psychiatric interventions for different diagnostic categories. Klerman, *The Psychiatric Patient's Right to Effective Treatment: Implications of* Osheroff v. Chestnut Lodge, 147 AM. J. PSYCHIATRY 409, 413-14 (1990).

7. *See, e.g.*, MASS. REGS. CODE tit. 104, §§ 17.00, 22.00 (1989) (Massachusetts licensing standards for mental health and retardation programs, respectively); Rhode Island Department of Mental Health, Mental Retardation, and Hospitals, Program Standards for Mental Health and Retardation Services, *issued pursuant to* R.I. GEN. LAWS § 40.1-24-1-20 (standards for community residences for persons with mental disabilities); 42 C.F.R. §§ 483.400-483.800 (1988) (federal Medicaid regulations for intermediate care facilities for the mentally retarded).

8. The American Psychiatric Association has almost completed a project to establish guidelines for the treatment of certain types of mental illnesses, but to date still relies almost exclusively on peer review mechanisms. *See* AMERICAN PSYCHIATRIC ASS'N COMM'N ON PSYCHIATRIC THERAPIES: THE PSYCHIATRIC THERAPIES (1984). For the most comprehensive, albeit dated, review of statutory, regulatory, administrative and peer association standards for mental health care, see D. HOGAN, THE REGULATION OF PSYCHOTHERAPISTS (1977) [hereinafter THE REGULATION OF PSYCHOTHERAPISTS].

9. For instance, few states or professional associations have detailed guidelines on abuse, neglect, client consent, administration of psychotropic medication, electro-convulsive treatment, behavioral modification programs, compensation for labor, sexual privacy, communication with friends and family, or standards and procedures for the termination of clients from programs. No formal protocols on the use of medication and other forms of psychiatric treatment for specific types of disabilities have yet been formulated. Klerman, *supra* note 6, at 414-15.

10. *See* Youngberg v. Romeo, 457 U.S. 307 (1982) (institutionalized person with retardation has constitutional right to safety, freedom from unnecessary restraint, and habilitation;

new awareness reflects old values. The initial recipients of this new attention were not the institutionalized disabled who had been damaged by inadequate or deleterious care, but instead either infants who had become disabled through negligent medical care[11] or nonhandicapped individuals who were victims of the dangerous conduct of a few persons with disabilities.[12]

It is only in the past decade that a more enlightened understanding has emerged concerning the potential of damage actions to address a broad range of harms suffered by vulnerable citizens. Actions are being brought on behalf of those with handicaps, not because they were born wrongfully, but as a result of the inadequacies in the care and support services offered to sustain them.[13] The consequence, if not the intended purpose, of some of these cases

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excessive shackling and lack of minimally-adequate care give rise to civil rights damage claim if hospital clinicians did not exercise professional judgment); Feagley v. Waddill, 868 F.2d 1437 (5th Cir. 1989) (summary judgment not appropriate in case involving drowning of young woman at state school for persons with retardation); Savidge v. Fincannon, 836 F.2d 898 (5th Cir. 1988) (defendant officials not entitled to qualified immunity in actions against them as individuals charging physical abuse and lack of adequate care to institutionalized retarded child; case subsequently settled for substantial, undisclosed sum); Wagenmann v. Adams, 829 F.2d 196 (1st Cir. 1987) (court affirms jury verdict of over $400,000 in compensatory and punitive damages for false arrest and intentional infliction of emotional distress through detention in a state hospital); Heck v. Commonwealth, 397 Mass. 336, 491 N.E.2d 613 (1986) (discovery rule applies to time period for presenting claim to state agency under Massachusetts Tort Claims Act when mentally ill woman is denied treatment at a state hospital and then suffers permanent injuries in suicide attempt; case subsequently settled for significant figure); Clites v. State, 322 N.W.2d 917 (Iowa Ct. App. 1982) (overmedication of person with retardation resulting in serious side-effects and permanent harm contravenes customary standards of care; jury award of $760,165 for past and future expenses and pain upheld).

11. In a spate of creative lawmaking inspired by new medical technology, attorneys conceived of a new cause of action — termed "wrongful birth" — to compensate parents who bear infants with disabilities. The tort required a showing that the attending physician failed to conduct proper tests or adequately warn the family of the risk of this occurrence, thereby precluding the option to terminate the pregnancy. *See* Robak v. United States, 658 F.2d 471 (7th Cir. 1981); Phillips v. United States, 575 F. Supp. 1309 (D.S.C. 1983); Lininger v. Eisenbaum, 764 P.2d 1202 (Colo. 1988); Wilson v. Kuenzi, 751 S.W.2d 741 (Mo. 1988); Berman v. Allen, 80 N.J. 421, 404 A.2d 8 (1979); Becker v. Schwartz, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); Ellis v. Sherman, 512 Pa. 14, 515 A.2d 1327 (1986).

12. *See* Tarasoff v. Regents of the Univ. of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (psychotherapist has duty to warn potential victim when patient indicates intention to cause physical harm); Bell v. New York City Health & Hosps. Corp., 90 A.D.2d 270, 456 N.Y.S.2d 787 (App. Div. 1982) (hospital's wrongful release of psychiatric patient who subsequently suffered serious harm from attempted suicide); Shuster v. Altenberg, 144 Wis. 2d 223, 424 N.W.2d 159 (1988) (state recognized legal duty of psychiatrist to warn third parties of patient's potentially dangerous conduct).

13. *See* Cockerham v. Hughes, C.A. No. 4-86-224-K (N.D. Tex. Feb. 27, 1987) ($85,000 settlement for young man in retardation institution who was abused by staff); Bolivar v. Riquier, C.A. 88-4358 (Suffolk Super. Ct., Mass. 1990) (large, undisclosed damage settlement on behalf of young man with retardation who was improperly admitted to a mental hospital, confined for ten months, and then died from an untreated seizure disorder and grossly inadequate emergency medical care); Enquist v. Riquier, C.A. No. 88-4542 (Middlesex Super. Ct., Mass 1990) (substantial settlement approved for elderly man with organic brain disorder who was transferred from rest home to state mental hospital and then died of untreated pneumonia); Galenski v. Noonan, C.A. No. 88-162 (Hampshire Super. Ct., Mass. May 1989) ($120,000 settlement for elderly man in state hospital who was constantly restrained and died from choking

is to establish or extend the legal standards which govern the care of disabled citizens and thereby to enhance the quality of services provided.[14]

This Article explores the reasons for this historical pattern of inaction and then analyzes the potential for invoking traditional damage remedies on behalf of those with mental disabilities. It then focuses on several questions: Can damage actions be an effective means of enforcing existing standards of care for persons with mental disabilities? Can such actions contribute to the reform of the mental disability service systems by defining new standards of conduct for mental health and retardation professionals or institutional caretakers? Is the ability of litigation to establish standards or to reform systems dependent upon substantial court awards or settlements, and if so, are disabled victims of harm likely to receive adequate compensation from juries or defendants? The Article argues that with skillful advocacy, damage remedies may not only be useful in compensating victims for their injuries, but may also be a creative strategy for reforming the very systems of care which occasioned the harm. These reforms may result in either the definition of new standards of

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on a hot dog); Kelley v. Perkins, C.A. No. 85-1821 (Middlesex Super. Ct., Mass. Oct. 28, 1987) ($87,500 settlement for young woman who was sexually abused by her teacher at a school for the blind); Petty v. Miller, C.A. No. 428321-A (Travis Co., Tex. 1989) (jury award of $505,000 to compensate elderly woman for decades of unnecessary institutionalization).

14. The absence of regulatory protocols or professional guidelines which describe appropriate treatment and habilitation is often an invitation for judicial intervention and the creation of legal standards. Klerman, *supra* note 6, at 415, 417. The question of whether and to what extent damage litigation can actually have this effect is ultimately an empirical one. Virtually no convincing data exists to provide an intelligent answer, nor does the question lend itself easily to reliable research. *See* Bonnie, *Professional Liability and the Quality of Mental Health Care*, 16 PSYCHOANALYSIS, PSYCHIATRY, AND THE LAW 229 (1988).

One commentator has carefully reviewed the literature and canvassed medical opinion on this issue. *Id.* The author posits three possible responses to the query and then suggests an affirmative answer, at least in selected circumstances.

The most widely held view is that malpractice suits have little or no effect on the quality of psychiatric care. Since there is little perceived risk of liability among most mental health practioners, since the correlation between challenged clinical decisions and substandard practice is doubtful, and since insurance coverage is available to reimburse clinicians for almost all good faith decisions, there is supposedly little economic incentive to modify behavior. The lack of perceived risk flows from statistics which suggest that the probability of a claim being filed, even when there is an instance of substandard practice, is low; that the resultant harm is modest, at least compared with other malpractice cases such as those involving surgery or obstetrics; and that ultimately, there is a small probability of success in malpractice cases involving mental health professionals. *Id.* at 231.

An alternative position assumes there *is* a demonstrable effect from the presence or perceived threat of litigation, but that it produces an adverse effect on the quality of care. From this perspective, legal actions mostly encourage practioners to avoid suits by minimizing risks rather than improving clinical decisionmaking. Such defensive practices may involve costly and excessive recordkeeping, overly cautious decisions concerning admission and discharge, or simply an unwillingness to treat individuals with challenging behaviors. *Id.* at 233-44.

Finally, a third view, supported by the author, assumes the existence of an effect which positively impacts on quality of care. While litigation is not likely to significantly alter clinical practice where a clear standard of care already exists and is generally applied, "the threat of liability does exert a significant behavioral effect in those situations where the standard of care is ambiguous, or is subject to professional disagreement, and where a judicial ruling or verdict relating to a specific clinical practice becomes known." *Id.* at 234.

care or modifications in the behavior of mental health and retardation professionals.

I.
THE HISTORICAL ROLE OF INJUNCTIVE ACTIONS IN IMPROVING QUALITY OF CARE FOR PERSONS WITH DISABILITIES

Damage actions are a second generation response to society's harmful treatment of persons with disabilities. In the past two decades, injunctive relief has been the primary means of addressing those administrative policies, legislative enactments, and clinical decisions which created or perpetuated the injurious conditions and extended institutionalization of disability service systems.[15] The initial focus was understandably on the abuse that had become synonymous with institutional confinement.[16] Subsequently lawyers shifted their attention to the absence of less restrictive alternatives to hospitalization[17] and the concomitant barriers to residing in real neighborhoods and participating in the opportunities of community living.[18]

These institutional conditions and residential alternative actions resulted in demonstrable improvements in the quality and quantity of care offered to

15. *See, e.g.,* Jackson v. Indiana, 406 U.S. 715 (1972) (confinement of disabled offenders must bear reasonable relationship to purposes of commitment); Mills v. Rogers, 738 F.2d 1 (1st Cir. 1984) (right to refuse medication); Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *vacated,* 422 U.S. 563 (1975)(right to liberty and limitations on civil commitment); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) (right to treatment).

16. *See, e.g.,* Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221 (E.D. Pa. 1985), *order affirmed,* 901 F.2d 311 (3d Cir.), *cert. denied,* 111 S. Ct. 140 (1990); New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, remanded in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

17. Federal courts have entered sweeping orders in most of these institutional reform cases: Homeward Bound, Inc. v. Hissom Memorial Center, No. 85-C-437-E (N.D. Okla. July 24, 1987); Thomas S. v. Flaherty, 902 F.2d 250 (4th Cir.), *cert. denied,* 111 S. Ct. 373 (1990); Association for Retarded Citizens of North Dakota v. Olson, 561 F. Supp. 473 (D.N. Dak. 1982), *aff'd in part, remanded in part,* 713 F.2d 1384 (8th Cir. 1983); Garrity v. Gallen, 522 F. Supp. 171, 239 (D.N.H. 1981); Medley v. Ginsberg, 492 F. Supp. 1294 (S.D.W. Va. 1980); Kentucky Ass'n for Retarded Citizens v. Conn, 510 F. Supp. 1233 (W.D. Ky. 1980), *aff'd,* 674 F.2d 582 (6th Cir. 1982), *cert. denied sub nom.* Bruington v. Conn, 459 U.S. 1041 (1983); Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221 (E.D. Pa. 1985); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), *aff'd,* 550 F.2d 1122 (8th Cir. 1977); Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Horacek v. Exon, 357 F. Supp. 71 (D. Neb. 1973); Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1395 (5th Cir. 1974).

State officials have often recognized the merits of these actions and entered consent decrees: Brewster v. Dukakis, 544 F. Supp. 1069 (D. Mass. 1982); Michigan Ass'n for Retarded Citizens v. Smith, 475 F. Supp. 990 (E.D. Mich. 1979); New York State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); Evans v. Washington, 459 F. Supp. 483 (D.D.C. 1978).

18. *See* Burlington School Comm. v. Department of Educ., 471 U.S. 359 (1985) (education); Alexander v. Choate, 469 U.S. 287 (1985) (limitations on access to medical care); City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985) (zoning restrictions on group home for persons with retardation); *see also* R. PERSKE, CIRCLES OF FRIENDS *passim* (1988) (personal relationships).

those labeled as mentally ill and mentally retarded. The number of individuals with disabilities who were involuntarily confined decreased significantly.[19] The number and perhaps the competency of staff at those facilities subject to litigation increased dramatically.[20] Court orders established standards for the use of restraint, seclusion, and behavior modification techniques.[21] Judicial decrees incorporated several administrative approaches to enhance quality and stability, such as staff recruitment and training requirements, quality assurance systems, client rights protection mechanisms, and public education provisions.[22] Through class action lawsuits, at least the face, if not the spirit, of several large public facilities throughout the country was transformed. This wave of litigation created a primary reliance on the courts for the modification of service systems.

Success in these actions prompted advocates and administrators to search for new subjects of reform. The next obvious target was the states' continued reliance on institutional care, despite the professional consensus that small, integrated settings in the community were more beneficial. Although advocates were not generally as successful in these actions as they were in the earlier actions for reform,[23] these cases had a dramatic impact on selected service systems.[24] In a few states, they even obviated the need for large public facili-

19. Institutional populations plummeted from 1955 to 1980, with the census of mental health facilities diminishing from in excess of 550,000 to less than 125,000. Talbot, *Toward a Public Policy on the Chronically Mentally Ill Patient*, 50 AM. J. ORTHOPSYCHIATRY 43 (1980). During this same period, state retardation institutions were similarly downsized, from a high of over 200,000 to less than 140,000 persons. Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 RUTGERS L.J. 595, 636 (1983). Although the reasons for this declining trend are complex, modifications of the standards and procedures for involuntary admission and detention is commonly cited as a major contributing factor.

20. *See* Massachusetts Ass'n for Retarded Citizens v. Dukakis, C.A. 75-5210-T (D. Mass. Dec. 18, 1978) (settlement order), *interpreted*, 576 F. Supp. 415 (D. Mass. 1983); New York State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

21. *See* Lelsz v. Kavanagh, 673 F. Supp. 828 (N.D. Tex. 1987), *rev'd on other grounds*, 807 F.2d 1243 (5th Cir. 1987); Society for Good Will to Retarded Children v. Cuomo, 737 F.2d 1239 (2d Cir. 1984); New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972).

22. Garrity v. Gallen, 522 F. Supp. 171, 239 (D.N.H. 1981); Wuori v. Concannon, Civ. No. 75-80-P (D. Me. Jan. 14, 1981); Brewster v. Dukakis, C.A. No. 76-4423F (D. Mass. Dec. 7, 1978); Michigan Ass'n for Retarded Citizens v. Smith, 475 F. Supp. 990 (E.D. Mich. 1979); Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221 (E.D. Pa. 1985).

23. *See* Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1 (1981) (Federal Developmental Disabilities and Bill of Rights Act, 42 U.S.C. § 6000, does not create statutory obligation to fund community services); Lelsz v. Kavanagh, 807 F.2d 1243 (5th Cir. 1987) (no constitutional right to less restrictive services); Society for Good Will to Retarded Children v. Cuomo, 737 F.2d 1239 (2d Cir. 1984) (no general right to community care); Kentucky Ass'n for Retarded Citizens v. Conn, 510 F. Supp. 1233 (W.D. Ky. 1980), *aff'd*, 674 F.2d 582 (6th Cir. 1982), *cert. denied*, 459 U.S. 1041 (1983).

24. *See* Brewster v. Dukakis, C.A. No. 76-4423F (D. Mass. Dec. 7, 1978) (creation of comprehensive community mental health system for one-third of state); Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975) (subsequent consent order restructuring mental health services in District of Columbia); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and*

ties and forced the closure of certain institutions.[25]

Not only did injunctive actions challenge the design of disability systems, but they also affected the most critical aspects of service delivery. The entire legislative scheme for involuntary commitment was declared unconstitutional in many states.[26] Psychiatrists' unreviewable discretion to administer psychotropic medications was sharply curtailed by judicial supervision of the doctrine of consent. This doctrine was made applicable even to those persons who lacked the capacity to accept treatment.[27] The right of institutional residents to present their grievances to both administrators[28] and the courts[29] was recognized, resulting in remedies which firmly established due process models to protect clients' rights, including the right to be represented by legal advocates in these procedures.[30]

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remanded in part, 550 F.2d 1122 (8th Cir. 1977) (development of community support programs for thousands of people with retardation).

25. *See* Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221 (E.D. Pa. 1985) (large state institution closed); Michigan Ass'n for Retarded Citizens v. Smith, 475 F. Supp. 990 (E.D. Mich. 1979); New York State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975).

26. *See, e.g.*, Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Kendall v. True, 391 F. Supp. 413 (W.D. Ky. 1974); Lessard v. Schmidt, 475 F. Supp. 1318 (E.D. Wis. 1976).

27. *See In re* Orr, 176 Ill. App.3d 498, 531 N.E.2d 64 (1988); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988); *In re* Bryant, 542 A.2d 1216 (D.C. 1988); State *ex rel* Jones v. Gerhardstein, 141 Wis. 2d 710, 416 N.W.2d 883 (1987); *In re* Mental Commitment of M.P., 510 N.E.2d 645 (Ind. 1987); Reise v. St. Mary's Hosp. & Medical Center, 271 Cal. App. 3d 199, 209 Cal. Rptr. 1303 (Cal. Ct. App. 1987); Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); People v. Medina, 705 P.2d 961 (Colo. 1985); Opinion of the Justices, 123 N.H. 554, 465 A.2d 484 (1983); Rogers v. Commissioner, 390 Mass. 489, 458 N.E.2d 308 (1983).

28. *See* Coe v. Hughes, C.A. No. K-83-4248 (D. Md. 1985) (state funding of legal assistance programs at state hospitals and promulgation of grievance procedure for inmates); McBride v. Okin, C.A. No. 81-0268-M (D. Mass. 1984) (case challenging lack of meaningful access to courts and to a client grievance procedure for institutionalized persons with mental disabilities; litigation settled by promulgation of complaint and investigation regulations which establish comprehensive due process scheme for review of any allegation of illegal, dangerous or inhumane incidents or conditions, including a right to an administrative hearing with counsel, witnesses, and written decision); *see also* MASS. REGS. CODE tit. 104, § 24.00 (1988). As a result of these cases there is now a general statutory right to file complaints and have them responded to in a timely and reasonable manner. *See* Protection and Advocacy for Mentally Ill Individuals Act of 1986, Pub. L. No. 99-319, § 201, 100 Stat. 478, 485-88 (1989).

29. *See* Ward v. Kort, 762 F.2d 856 (10th Cir. 1985); Doe v. Hogan, C.A. No. H88-239 (EBB) (D. Conn. 1989) (creating state-funded advocacy system in order to ensure access to courts by residents of state hospitals); Logan v. State, C-83-1143J (D. Utah 1985) (settlement entered approving state-funded advocacy system).

30. The Final Consent Decrees in Brewster v. Dukakis, C.A. No. 76-4423F (D. Mass., Dec. 7, 1978), and in Massachusetts Ass'n for Retarded Citizens, C.A. No. 75-5210-T (D. Mass. 1978) (settlement order), *interpreted*, 576 F. Supp. 415 (D. Mass. 1983), mandated a detailed treatment planning procedure which included the rights to notice, participation, representation, written decision, and appeal. MASS. REGS. CODE tit. 104, §§ 16.00, 21.00 (1988). The decrees also required new regulations concerning expansive clients' rights in all services, *id.* §§ 15.00, 20.00 (1988); standards for community programs, *id.* §§ 17.00, 22.00; and licensing procedures, *id.* §§ 18.00, 23.00. Each of these regulatory schemes recognized the need for assistance to clients in exercising procedural protections and provided for legal advocacy at all stages of the processes.

Considering the impressive record of reform of the past twenty years, it is questionable why new strategies would be necessary. But the federal courts are now less receptive to arguments for the redesign of service systems and less willing to assume responsibility for overseeing the implementation of their handiwork.[31] Through strained interpretations of constitutional precepts and undue deference to disability professionals,[32] the rights of persons with mental disabilities have been narrowed. Wherever fiscal constraints are a significant factor in restricting administrative options, judges have been even less aggressive in mandating expensive reforms and resolving constitutional questions involving the separation of powers in favor of the exercise of judicial authority.[33] The litigation itself is costly, lengthy, and demanding, making it difficult for attorneys to pursue these cases. Even the most successful cases, because of their systemic focus and the length of time involved, may leave some individuals with little direct benefit. Formal relief is necessarily prospective, and ignores the years of harm produced by the rights violations at issue. Even successful suits against specific institutions or geographical areas may not result in modifications to facilities located elsewhere in the state. Finally, since most injunctive cases are brought on behalf of a class of similarly situated persons seeking to reform an entire institutional practice or service system, the cases sometimes may not produce adequate redress for individual injuries. Damage actions thus may represent not only an alternative strategy for achieving longstanding goals but also an approach designed to alleviate specific harms. What is less clear is whether the focus on individual compensation inherent in damage actions will extend beyond the particular case and inure to the benefit of other disabled persons.

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31. *See* Pennhurst State School & Hosp. v. Halderman, 465 U.S. 89 (1984) (eleventh amendment bars federal court from ordering relief against state officials on state law grounds); United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (whatever federal right may exist in refusing anti-psychotic medication may be overridden by mental health clinician); Lelsz v. Kavanagh, 807 F.2d 1243 (5th Cir. 1987) (no federal right to certain community support services such as community placement); Society for Good Will to Retarded Children v. Cuomo, 737 F.2d 1239 (2d Cir. 1984); Mental Health Ass'n of California v. Deukemajian, 233 Cal. Rptr. 130, 135 (Ct. App. 1986) (state statutory rights are only precatory; implementation depends on availability of legislative appropriations).

32. *See* Youngberg v. Romeo, 457 U.S. 307 (1982) (standard for liability is whether any professional judgment was exercised; lack of funds may be defense to damage action for violation of constitutional right to adequate habilitation); Washington v. Harper, 110 S. Ct. 1028 (1990) (state psychiatrists are the appropriate decisionmakers for determining when the government's interest in forcibly medicating prisoners outweighs their liberty interest in privacy and bodily integrity); United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (professional judgment controls exercise of right to refuse drugs); Society for Good Will to Retarded Children v. Cuomo, 737 F.2d 1239, 1278 (2d Cir. 1984) (court is not free to weigh competing views of each party's experts; instead it must defer to state experts unless their conclusions are devoid of professional judgment).

33. This trend is particularly apparent in litigation to compel broad systemic reform, such as cases involving the creation of community services. *See* Lelsz v. Kavanagh, 807 F.2d 1243 (5th Cir. 1987); Mental Health Ass'n of California v. Deukemajian, 233 Cal. Rptr. 130 (Ct. App. 1986). It presents a stark contrast with earlier views of judicial power.

II.
THE ABSENCE OF DAMAGE LITIGATION ON BEHALF OF PERSONS WITH DISABILITIES

The historical perception that seriously handicapped persons were not whole persons,[34] but instead were to be segregated, isolated, and subjected to paternalistic protections like guardianship,[35] partially explains why there has been so little recourse to money damages for the harm suffered by them. In simple terms, there have been no perceived wrongs to right, few rights to vindicate, and little harm to redress. Only in the past few decades have the courts begun to recognize that disabled individuals are full citizens under the law, deserving of the same rights and remedies as those afforded to temporarily able-bodied persons.[36] This sometimes begrudging acknowledgment has recently been translated into the enforcement and expansion of legal rights. Thus recognition of the same factors which contributed to the explosion of damage actions to reform service systems during the past two decades partially explains the earlier absence of damage actions to compensate handicapped persons for their injuries.[37]

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34. History reveals the unequal status of individuals with mental disabilities and the law's evolution from total disenfranchisement to beneficent paternalism. *See* 1 W. BLACKSTONE, COMMENTARIES 303-7 (9th ed. 1783); 2 F. POLLOCK & F. MAITLAND, THE HISTORY OF ENGLISH LAW 464 (1959); 1 W. HOLDSWORTH, A HISTORY OF ENGLISH LAW 473 (7th ed. 1956); S. BRAKEL, J. PARRY & B. WEINER, THE MENTALLY DISABLED AND THE LAW 9-12 (3rd ed. 1985) [hereinafter THE MENTALLY DISABLED AND THE LAW].

35. For a brief but illuminating review of the evolution of commitment laws and related legal forms of segregation in England and America, see THE MENTALLY DISABLED AND THE LAW, *supra* note 34, at 11-17. *See also* BLACKSTONE, *supra* note 34, at 369-71 for a similar history of guardianship and other "protective" devices.

36. In its first 150 years of constitutional adjudication, the Supreme Court of the United States decided only one minor case involving the rights of people with disabilities. Chaloner v. Sherman, 242 U.S. 455 (1917) (guardianship). Ironically, when it finally ventured into the area, it nearly unanimously approved the sterilization of people with retardation. Its most esteemed member revealed a profound ignorance of the etiology of mental retardation and a disrespect for the abilities of those so labeled. Buck v. Bell, 274 U.S. 200, 207 (1927) (Holmes, J.). Subsequent research suggests that even the distorted facts relied upon by the Court were the product of intentional deceit by attorneys for both parties. Lombardo, *Three Generations, No Imbeciles: New Light on* Buck v. Bell, 60 N.Y.U. L. REV. 30 (1985). Not surprisingly, Justice Blackmun remarked three decades later: "Considering the number of persons affected [by state commitment laws], it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." Jackson v. Indiana, 406 U.S. 715, 737 (1972).

37. A review of damage actions and jury awards in published cases for the period 1850-1989 reveals a startling picture: both the actual number of damage cases filed and the relative rate of acceleration of these filings have risen dramatically.

In the first published compilation of malpractice actions involving psychiatrists, psychologists, therapists, or other specialists, only eighteen appellate decisions were located for the period 1946-1961. Bellamy, *Malpractice Risks Confronting the Psychiatrist: A Nationwide Fifteen Year Study of Appellate Court Cases*, 118 AM. J. PSYCHIATRY 769 (1962). A computer survey identified over three hundred malpractice or civil rights damage cases involving people with disabilities up to 1977. More than two-thirds of these were resolved between 1960-1977. 3 THE REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 14, 373 (search of all *reported* cases between 1850-1977 which included the terms "mental" or "electro-convulsive" or "psychiatrist" or "psychologist" or "psychotherapist" or "social worker" or "mental institution" or

If the courts and legislatures have been begrudging in affording constitutional protections and recognizing legal entitlements, those responsible for the care, control, and custody of persons labeled as mentally ill and mentally retarded were even more reluctant to have the parameters of their duties defined. Most professional associations avoided establishing standards to govern the conduct of their members. There was a reservoir of unquestioning public trust for what was often perceived as a charitable vocation and little apparent concern for accountability.[38] Public administrators resisted regulating the conduct of their employees, perhaps out of deference to their clinical expertise and well-intentioned motives and perhaps out of uncertainty as to the acceptable level of care.[39] The result of that lack of concern was predictable: the caretakers retained discretion in the rendering of "clinical judgments" concerning activities as diverse as sterilization, education, confinement, restraint, marriage, psychosurgery, forced labor, recreation, and bodily privacy.[40]

"mental hospital" or "wrongful commitment" or "sanity" or any root of the word "insane" when they appeared within fifteen words of the terms "malpractice" or "negligence").

But the most significant statistic covers the present: a similar search by the author conducted on August 23, 1989 using the same terms located over seventeen hundred reported cases decided in the past twelve years (1977-1989). Although the search results were not refined to eliminate all extraneous documents, it is reasonable to assume that most of the identified cases addressed similar issues to those studied by Hogan in his 1977 project. *Id.* Thus there has been an almost six hundred percent increase in reported decisions in this twelve-year period, as compared to the previous *ninety* years!

38. For an intriguing history of the regulation of the medical and psychiatric professions, describing a broad range of judicial, legislative, administrative, associational, private, and peer methods of promoting quality through rulemaking, see 1 REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 223-28, 332-35. One volume is dedicated to a survey of state law and policies which qualify as the formal regulation of mental health professionals. *Id.*, vol. 2. As a dispassionate study of the landscape in 1977, the treatise leaves little doubt of the need for a more structured, externally developed system of mandatory guidelines to protect those with disabilities who seek help from those who profess to help. *Id.*, vol. 3, at 14.

39. *See* U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, REPORT ON LICENSURE AND RELATED HEALTH PERSONNEL CREDENTIALING (1971).

40. Whatever level of discipline may have existed in the early years was entirely self-imposed. *See* American Psychiatric Association, Task Force on Peer Review in Psychiatry, *Position Statement on Peer Review in Psychiatry*, 130 AM. J. PSYCHIATRY 381 (1973). These suggestions of self-control were restrictive in scope and unyielding in their insistence on peer evaluation.

Statutes, regulations, and judicial decisions establishing limits to the exercise of professional discretion and viewing the fundamental liberties of persons with disabilities as "rights not privileges" are of recent vintage. *See* Youngberg v. Romeo, 457 U.S. 307 (1982); Protection and Advocacy for Mentally Ill Individuals Act of 1986, Pub. L. No. 99-319, § 201, 100 Stat. 478, 485-88; MASS. REGS. CODE tit. 104, § 15.00 (1988) (rights of persons in mental health programs in Massachusetts).

Only after the external regulators had acted did the internal associations acknowledge a more expansive view of their obligations and of the rights of their clients. *See* AMERICAN PSYCHIATRIC ASS'N, RIGHTS OF THE MENTALLY DISABLED: STATEMENTS AND STANDARDS 3 (1982) [hereinafter RIGHTS OF THE MENTALLY DISABLED] (in response to court decisions and newly recognized "rights," standards by professional organizations are appropriate); *see also* Joint Comm'n of Accreditation of Hosps., *Standards on Patients Rights* (1981); American Public Health Ass'n, *Rights Protection Within the Public Mental Health System* (1980); American Psychiatric Ass'n, *Standards for Psychiatric Facilities: A Patient's Bill of Rights* (1974), *all reprinted* in RIGHTS OF THE MENTALLY DISABLED, *supra*.

Neither substantive guidelines nor meaningful process existed to test the appropriateness of caregivers' interventions nor the efficacy of their conclusions.

The public's trust in disability professionals may have stemmed, in part, from the absence of independent monitoring mechanisms reporting the reality of life in mental health and retardation facilities. The media have generally stayed away, except for the occasional exposé.[41] Family members often have either abandoned their loved ones or been so indebted to the only medical alternative available to assist them with their burden that they have felt unable to question their proxies. Even elected representatives, charged with the public duty to care for those unable to care for themselves, were generally content to rely on occasional commissions and task forces to study the deficiencies which were already known and which remained largely unrectified.[42]

Complex injunctive litigation requires counsel familiar with both the emerging area of disability law and the intricacies of administrative service systems. Malpractice, civil rights, and other personal injury cases, however, involve skills well-known to many private lawyers.[43] Nonetheless, few have been willing to enter the courtroom on behalf of persons labeled as mentally ill or mentally retarded or to speak to a jury about the injuries imposed on these vulnerable citizens.[44] This wholesale lack of legal advocacy — particularly for those confined in isolated public institutions where the abuses were the most prevalent — contributed to the dearth of personal injury suits on their behalf, as well as to their continued legal invisibility.[45]

When attorneys have been willing to act, there has been little precedent to guide them in formulating the constitutional rights or standards of care which are the requisites of a claim for damages.[46] Moreover, there were few re-

41. *See generally Emptying the Madhouse*, LIFE, May 1981, at 56.

42. *See generally* PRESIDENT'S COMM. ON MENTAL RETARDATION, MENTAL RETARDATION PAST AND PRESENT *passim* (1976).

43. The absence of accepted rules of conduct which are supported by professional organizations was also an obstacle to injunctive relief. However, the traditional reliance in malpractice cases, as opposed to in civil rights damage actions, on customary standards of practice renders this deficiency particularly problemmatic in tort litigation.

44. *See generally* D. DAWIDOFF, THE MALPRACTICE OF PSYCHIATRISTS: MALPRACTICE IN PSYCHOANALYSIS, PSYCHOTHERAPY, AND PSYCHIATRY viii (1973); Slawson, *Psychiatric Malpractice: The California Experience*, 136 AM. J. PSYCHIATRY 650 (1979); Fink, *Medical Malpractice: The Liability of Psychiatrists*, 48 NOTRE DAME L. REV. 693 (1973); Rothblatt & Leroy, *Avoiding Psychiatric Malpractice*, 9 CAL. W.L. REV. 260 (1973).

45. S. HERR, RIGHTS AND ADVOCACY FOR RETARDED PEOPLE 143-45 (1983); S. HERR & R. WALLACE, LEGAL RIGHTS AND MENTAL HEALTH CARE 6 (1983).

46. *See supra* note 36. In the last eighteen years, the Court has been more receptive to at least hearing constitutional claims from those with disabilities. *See* City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985); Youngberg v. Romeo, 457 U.S. 307 (1982); Mills v. Rogers, 457 U.S. 291 (1982); Vitek v. Jones, 436 U.S. 407 (1980); Parham v. J.R., 442 U.S. 584 (1979); Addington v. Texas, 441 U.S. 418 (1979); O'Connor v. Donaldson, 422 U.S. 563 (1975); Jackson v. Indiana, 406 U.S. 715 (1972).

The legal literature reflects a similar dearth of attention to the rights of persons with mental disabilities. For example, one author conducted a detailed review of the Index to Legal Periodicals and a computer search for all legal publications from 1900-1977 relevant to the subject of malpractice and mental disability. 4 THE REGULATION OF PSYCHOTHERAPISTS,

sounding legal victories or impressive awards to sustain their confidence and encourage their investment of resources. Instead, lawyers were confronted with a myriad of procedural obstacles, several of which remain today, albeit in a less onerous form. For cases involving public officials or governmental entities,[47] for example, the most daunting of all was the maze of federal[48] and state[49] immunity doctrines which precluded liability, except in limited circumstances. Since many, if not most, seriously handicapped persons live in publicly operated or funded settings where they are especially vulnerable to abuse and neglect,[50] restrictions on the amount of compensation available from these

supra note 8, at 48-49. He discovered only two articles published between 1950-1960 (both surveys of the law by the American Law Reports). Between 1960-1970, the number increased to twelve. In the next seven years, there were over twenty-eight new articles in print — a two hundred percent increase in this short period as compared to the previous fifty years. *Id.* Since then, the numbers have increased exponentially.

47. These cases are commonly brought under the federal civil rights statute, 42 U.S.C. § 1983, or its state counterpart. *See, e.g.*, MASS. GEN. L. ch. 12, § 11I (1988) (establishing a cause of action for citizens whose civil rights have been interfered with).

48. *See* Federal Tort Claims Act, 28 U.S.C. §§ 2671-2680 (1982). The federal government's sovereign immunity is only waived to the extent provided by statute. The Act includes substantial procedural requirements and limitations, as well as precluding claims where the harm resulted from governmental behavior which fits within a long list of exceptions. 28 U.S.C. § 2680 (exceptions include intentional acts, discretionary acts, and acts outside the scope of employment).

The states' sovereign immunity is secured in the federal courts through the eleventh amendment to the United States Constitution. A limited exception to this blanket prohibition on money damages against states or their public officials was created through the fiction announced in Ex Parte Young, 209 U.S. 123 (1908) (unconstitutional acts of state officers cannot be attributed to the state itself and therefore are not barred by the eleventh amendment). For a thorough review of this eleventh amendment jurisprudence, see Pennhurst State School & Hosp. v. Halderman, 465 U.S. 89 (1984).

Recent Supreme Court decisions also require clear and unequivocal language in the statute itself before a waiver of immunity is found. Ironically, the intensified literalness of this constitutional condition has come at the direct expense of persons with disabilities. *See* Dellmuth v. Muth, 109 S. Ct. 2397 (1989) (no damage remedy for denial of special education for developmentally disabled student); Atascadero State Hosp. v. Scanlon, 473 U.S. 234 (1985) (no finding of employment discrimination on the basis of handicap); *Pennhurst*, 465 U.S. at 100 (court order requiring expenditure of state funds to create institutional alternatives is prohibited).

49. Several states have interpreted their own constitutions so as to adopt the sort of immunity analysis found in the eleventh amendment. *See, e.g.*, Duarte v. Healey, 405 Mass. 43, 537 N.E.2d 1230 (1989). The Supreme Court has recently declared that federal immunity doctrines have a proper role in state court analyses of federal rights. Will v. Michigan Dep't of State Police, 109 S. Ct. 2304 (1989) (neither state nor its officials are "persons" within the meaning of 42 U.S.C. § 1983).

Most states have waived their sovereign immunity in their own courts through local versions of the Federal Tort Claims Act. *See, e.g.*, MASS. GEN. L. ch. 258 (1988). These statutes generally incorporate numerous exceptions. *Id.* § 10. Other states such as Michigan still retain their unrestricted immunity. *See* Perry v. Kalamazoo State Hosp., 404 Mich. 2d 205, 273 N.W.2d 421 (1978), *appeal dismissed*, 444 U.S. 804 (1979) (operation of state hospital is a governmental function for which sovereign is completely immune).

50. *See Care of Institutionalized Mentally Disabled Persons: Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources and the Subcomm. on Labor, Health and Human Services, Education, and Related Agencies of the Senate Comm. on Appropriations*, 99th Cong., 1st Sess., 500-503 (testimony of Steven Schwartz) (1985); Halderman v. Pennhurst State School & Hosp., 610 F. Supp. 1221 (E.D. Pa. 1985); New York

facilities and their staff is a drastic disincentive to damages actions.

Similar restrictions on liability have evolved from the Supreme Court's reluctance to permit civil rights damage actions against state officials.[51] Inappropriate or negligent behavior by caretakers is not sufficient to support a constitutional claim.[52] Even grossly negligent or intentional harm may not be enough to support a claim where a post-deprivation remedy exists under state law irrespective of whether the state remedy is adequate.[53] Regardless of the injuries caused by a direct care worker or staff clinician, administrators and professionals with overall responsibility for the facility have no *respondeat superior* liability[54] and may only be included as defendants if it can be shown that they acted with callous or reckless disregard for the established rights of the plaintiff.[55]

Some state courts have been more receptive to money damage claims, primarily because of their invocation of established common law tort principles.[56] Recently, the state courts have been constrained by legislative restric-

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State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

51. Significant protections against personal liability are still afforded governmental agents through newly developed immunity doctrines or other limitations on the liability of public officials. *See* Anderson v. Creighton, 483 U.S. 365 (1987) (liability for violation of clearly established right — prohibition on warrantless searches — requires careful fit of facts and law to determine whether official reasonably knew act was illegal); Harlow v. Fitzgerald, 457 U.S. 800 (1982) (official must have known that action violated clearly established right to be held liable); Parratt v. Taylor, 451 U.S. 527 (1981) (state-created post-deprivation remedy fulfills due process requirements and thus precludes liability in federal forum); *see also* Will v. Michigan Dep't of State Police, 109 S. Ct. 2304, 2312 (1989) (Brennan, J., dissenting); Atascadero State Hosp. v. Scanlon, 473 U.S. 234, 247 (1985) (Brennan, J., dissenting). *But see* Zinermon v. Burch, 110 S. Ct. 975 (1990) (§ 1983 damage action against state employees who confine person considered to be mentally ill in violation of state law may be brought in federal court; *Parratt* not applicable where the allegedly unconstitutional acts are neither random nor unauthorized).

52. Daniels v. Williams, 474 U.S. 327 (1986) (negligent act of public official does not violate due process); Davidson v. Cannon, 474 U.S. 344 (1986).

53. Zinermon v. Burch, 110 S. Ct. 975 (1990); Parratt v. Taylor, 451 U.S. 527 (1981); Temple v. Marlborough Div. of the Dist. Court Dep't, 395 Mass. 117, 479 N.E.2d 137 (1985).

54. *See generally* Rizzo v. Goode, 423 U.S. 362 (1976); Naughton v. Bevilacqua, 605 F.2d 586 (1st Cir. 1979) (director of public agency with jurisdiction over co-defendant state hospital not liable under doctrine of *respondeat superior* for actions of state hospital physicians who administered anti-psychotic drugs to allergic resident with retardation causing serious reaction).

55. *Cf.* Germany v. Vance, 868 F.2d 9 (1st Cir. 1989) (social worker's failure to inform court of falsified information in juvenile commitment petition did not constitute intentional violation of incarcerated minor's right of access to court; appeals panel reversed award of damages for alleged constitutional violation).

56. THE MENTALLY DISABLED AND THE LAW, *supra* note 34, at 578. The authors ranked various tort claims by order of frequency, generating the following list: (1) suicide; (2) negligent administration of somatic (nonverbal) therapy; (3) negligent diagnosis; (4) sexual activity with patient; (5) improper psychotherapy; (6) informed consent. *Id.* at 579-82. It is arguable that these claims are conceptually or practically different from those involving abuse, neglect, restraint, excessive medication, and gross mistreatment, which have only infrequently been presented to state tribunals. Whether local courts well versed in personal injury litigation will be equally receptive to these other claims is not yet known, although limited experience with selected cases indicates that they will. *See* Clites v. State, 322 N.W.2d 917 (Iowa Ct. App.

tions on malpractice actions that have limited not only certain categories of damages, but also the amount of an attorney's fee.[57] These statutory provisions have a particularly harsh effect on persons with disabilities since virtually all actions of a mental health or retardation professional are covered by malpractice statutes[58] and since handicapped plaintiffs frequently rely on general damages such as pain and suffering rather than compensatory damages for lost earnings or actual medical expenses.[59]

When state courts apply federal constitutional rights, they tend to rely on the interpretations of the United States Supreme Court and thus have customarily adopted many of the restrictions discussed above.[60] Some states have even applied a similar analysis for determining the scope of their own constitutional rights, at least in the context of damage claims.[61] Although not prohibi-

1982) (court awards mentally retarded resident of state hospital $760,000 as a result of finding of excessive medication and physical restraint).

57. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 231, § 60B (West 1989); *see also* Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499 (1989); Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413 (1987); Qual, *A Survey of Medical Malpractice Tort Reform*, 12 WM. MITCHELL L. REV. 417 (1986).

To what extent these additional restrictions will further constrain attorneys in filing damage actions for persons with disabilities who have been harmed by their caretakers is uncertain. But it is indisputable that the amount of the potential recovery must be considered in the calculus of the litigation. Among traditional disincentives to represent individuals with serious handicaps, financial caps on damage awards are among the most serious. *See* McNamara v. Honeyman, 406 Mass. 43, 543 N.E.2d 139 (1989) (upholding judge's remittitur of $1.7 million jury award because of state tort claims limit of $100,000 for actions involving the negligence or gross negligence of employees of state mental health facilities or state medical school).

58. Most malpractice statutes apply to all forms of treatment or assistance by a health care professional. This includes psychiatric and psychological treatment and habilitation, such as restraint and medication, as well as "treatment related" decisions, such as the denial of visitation and communication with family or friends. However, it recently has been held to exclude the question of whether a physician complied with a state civil commitment statute when she involuntarily admitted a person to a psychiatric facility. Leininger v. Franklin Medical Center, 404 Mass. 245, 534 N.E.2d 1151 (1989).

59. Most residents of public mental health and retardation facilities are poor, depend upon public assistance for medical care and subsistence benefits, and lack a significant employment history. They have few out of pocket expenses and much pain and suffering. *See, e.g.*, Savidge v. Fincannon, 836 F.2d 898 (5th Cir. 1987) (mentally retarded man who is beaten by staff and suffered permanent, serious injuries recovers $600,000, despite lack of any lost earnings, medical expenses, or out of pocket costs); Heck v. Commonwealth, 397 Mass. 336, 491 N.E.2d 613 (1986) (mentally ill Medicaid recipient who attempted suicide and suffered permanent spinal injuries when denied admission to state hospital recovers $50,000 for pain and suffering; state welfare agency agrees not to execute upon Medicaid lien); Kelley v. Perkins, C.A. No. 85-1821 (Middlesex Sup. Ct., Mass. Oct. 28, 1987) (developmentally disabled student who was assaulted by special education teacher settles case for $85,000; entire sum is placed in special trust and used to purchase house in order to avoid loss of Social Security and Medicaid eligibility); Whiston v. Commonwealth, C.A. No. 85-75725 (Hampshire Super. Ct., Mass. April 2, 1987) (state hospital resident who had been confined since suicide attempt at age seventeen awarded $32,500 for pain of second degree burns from being placed in scalding tub; no special damages, medical expenses, or lost earnings).

60. *E.g.*, Temple v. Marlborough Div. of the Dist. Court Dep't, 395 Mass. 117, 479 N.E.2d 137 (1985); Duarte v. Healy, 405 Mass. 43, 47-48, 537 N.E.2d 1230, 1232-33 (1989).

61. *Id.*

tive, these statutory and judicial doctrines constitute additional barriers lawyers must overcome if damage actions are to be a viable strategy for remedying injuries suffered by those with disabilities. Suits for compensation on behalf of individual with mental disabilities, particularly residents of public mental health and retardation facilities, are therefore generally an untested legal phenomenon.[62] In addition to the obvious goal of securing compensation for harm, damage actions have a two-fold purpose: (1) the enforcement or extension of existing rules, guidelines, or customary standards of care, where such have been established; and (2) the creation of new standards of care, where none currently exist. The next section examines two examples of the former approach, and the latter method is explored in the following section. Both strategies are analyzed in terms of their applicability to some of the critical but undefined areas of clinical practice which directly contribute to the pain and suffering of those with disabilities.

III.
ENFORCING EXISTING STANDARDS OF CARE: PHYSICAL RESTRAINT AND CONSENT TO PSYCHOTROPIC MEDICATION

Attorneys have been creative in invoking damage remedies to enforce *existing* rules of professional conduct. This is particularly evident where the actions of members of the mental health and retardation staff offend traditional concepts of decency and humane care. Similarly, judges or juries have found liability when the actions of such caregivers have violated either a general principle of medical care or a specific standard of mental health or retardation treatment.[63] The two paradigms are illustrated by: (1) the extension of the traditional requirement of informed consent to the administration of psychotropic medications; and (2) the specific state administrative and professional association rules which govern the use of restraint and seclusion.

A. Informed Consent to Treatment

The common law requirement of patient consent to medical treatment has become well established.[64] Yet hotly contested and protracted litigation

62. THE MENTALLY DISABLED AND THE LAW, *supra* note 34, at 578, 582.

63. For decades, if not centuries, courts assumed that the vagaries and stigma of mental illness and retardation excused physicians from compliance with the customary standards which governed most forms of medical care. This blanket exemption has recently been revoked. As psychiatry and psychology gradually have been accepted as valid branches of traditional medicine, mental health and retardation professionals increasingly have been held to ordinary standards of care. *See* Stepakoff v. Kantar, 393 Mass. 836, 473 N.E.2d 1131 (1985) (psychiatrist held to same standard of care as average member of medical profession practicing that specialty). Thus the traditional obligations of physicians to conduct proper assessments and tests, to render competent and accurate diagnoses, to maintain complete records, to regularly monitor side-effects and reevaluate treatment, and to obtain knowing and informed consent from their patients are equally applicable in the disability context.

64. Initially, only some vague concept of consent was required before a physician could

was required to convince the psychiatric community that these familiar rules are equally applicable to individuals with mental disabilities when they are treated with psychotropic medications.[65] The standards established by this litigation arguably fell well short of the common law rule, since these original claims focused only on the constitutional claims of persons who affirmatively "refused" specific forms of psychiatric drugs rather than on all individuals subjected to any type of disability treatment.[66] This advocacy near-sightedness has since been rectified by more discerning courts, which have rooted the "right" in principles of consent and battery, thereby extending its protection to all persons regardless of whether they affirmatively protest a proposed treatment.[67]

The consequence of applying familiar medical requirements to mental health and retardation care has been dramatic and could well portend a liabil-

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touch a patient in order to remove the contact from the scope of the law of battery. Pratt v. Davis, 118 Ill. App. 161 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906). Decades later, courts added the requirement that the consent must be informed. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957). The shift towards enhanced protections of medical consumers then began in earnest. In Canterbury v. Spence, 464 F.2d 772, 786-87 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972), the court of appeals mandated full disclosure of all "material" information to the patient in order to assist in rendering an informed decision. There now is a broad consensus that consent must be knowing, that caregivers have the burden of explaining in understandable terms the risks and benefits of a proposed procedure, and that patients are qualified to render treatment decisions which are in accord with their personal values rather than with the physician's paternalistic sense of what is best. *See generally* J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984); Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

The rule has been equally applied to those with mental disabilities who seek medical care. *See* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (elderly man with severe retardation cannot be treated with chemotherapy for advanced leukemia without his consent).

Because health care facilities and practioners are now acutely aware that the provision of medical treatment without proper consent is a battery, the consent process and the need for documentation have become extensive. Ironically, the practical problems in obtaining valid consent may serve to discourage health care workers from serving those with mental disabilities because of uncertainty in determining when and to what extent patients with cognitive limitations may have diminished capacity to understand and accept a proposed procedure. Although formal mechanisms exist in most jurisdictions for seeking consent from an external decisionmaker such as court appointment of a guardian *ad litem*, thereby minimizing the risk of liability, these alternatives may often be considered too cumbersome or time-consuming to invoke, absent exceptional circumstances.

65. *See* Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 458 U.S. 1119 (1982), *aff'd in part and modified in part*, 720 F.2d 266 (3d Cir. 1983); Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *aff'd in part and vacated in part sub nom.* Mills v. Rogers, 457 U.S. 291 (1982), *aff'd on remand*, 738 F.2d 1 (1st Cir. 1984); *see also* cases discussed *supra* note 27.

66. The distinction between the patient's "right to refuse" and the caregiver's obligation to obtain valid consent is significant. *See* Schwartz, *Equal Protection in Medication Decisions: Informed Consent, Not Just the Right to Refuse*, in AMERICAN BAR ASS'N, THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 74, 77-78 (1986) and cases cited at *supra* note 65.

67. *See* Rogers v. Commissioner of the Dep't of Mental Health, 390 Mass. 489, 497-98, 458 N.E.2d 308, 314 (1983); *see also* cases cited *supra* note 27.

ity revolution.[68] Continued adherence to the longstanding practice of medicating residents of public institutions solely upon a physician's assessment of the person's best interest or the needs of the facility now risks incurring significant damage awards.

The first of these damage cases made news. In *Clites v. State of Iowa*,[69] a young man with retardation was awarded $760,000 for the severe, permanent side-effects, regression, and mental suffering resulting from extended administration of anti-psychotic medications. The state appeals court upheld the award, concluding that the employees of a public institution had failed to obtain consent to the use of these drugs from the person's family or guardian, despite the fact that they routinely sought permission for other ordinary activities like photographing the resident. The court also found that the doctors violated customary community standards of care and rejected the argument that different, less rigorous standards were applicable to public mental institutions.[70]

The ramifications of this decision have been profound. Just one year later the Massachusetts Supreme Judicial Court adopted the fundamental premise of *Clites* in its landmark holding that all person subjected to anti-psychotic medications, including residents of public institutions, have a constitutional and common law right not to be medicated *without their consent*.[71] The court cited with approval state law which mandated that health care professionals provide patients with meaningful information of the risks and benefits of any proposed procedure in order to ensure that the consent is knowing and informed.[72]

The extension of the basic principle of consent to institutionalized persons with disabilities was quickly adopted by the highest courts of numerous jurisdictions.[73] However, these decisions have met with the resistance of the psychiatric community, whose concern with excessive process only partially masked its underlying fear of extensive liability. This anxiety is not misplaced. If physicians responsible for the care and custody of individuals with handicaps are required to compensate them for treatment or habilitation which does not conform to the customary standards of professional practice, as delineated

68. The extension of the medical doctrine of informed consent into psychiatric practice illustrates how malpractice litigation can improve quality of care for persons with disabilities. Bonnie, *supra* note 14, at 235-36. Involving clients in the treatment decisionmaking process, through the provision of information and personal interaction, is in itself a progressive reform. *Id.*

69. 322 N.W.2d 917 (Iowa Ct. App. 1982).

70. *Id.* at 919-20. The court specifically determined that customary standards of "industry practice" required individualized evaluation and regular monitoring of psychotropic medications, periodic consultations among physicians, the temporary suspension of medication administration ("drug holidays"), avoidance of the simultaneous use of multiple anti-psychotic drugs (polypharmacy), and a prohibition of those interventions designed solely for the convenience of staff or the maintenance of institutional order. *Id.* at 920-21.

71. *Rogers*, 390 Mass. at 497-98, 458 N.E.2d at 314.

72. *Id.*

73. *See* cases cited *supra* note 27.

by the *Clites* court, or for the use of significant psychiatric or behavioral interventions without their consent, public employment could truly become expensive.

A pattern may be emerging. While constitutional claims are problematic,[74] and litigation alleging harm solely on the basis of the lack of proper consent may not result in substantial damage awards,[75] common law actions are rapidly proliferating. Those cases that combine challenges to a range of improper medication practices, particularly in public facilities, with demonstrable physical harm are likely to succeed. Where the patient or guardian has never even been informed of the potentially grave consequences of these mind-altering drugs, juries may well be convinced to award substantial damages.

B. Restraint and Seclusion

Where standards of professional conduct cannot be easily gleaned from traditional common law principles, courts have referred to legislative and administrative enactments or professional association guidelines to impose liability for some of the most intrusive or flagrantly abused behavioral interventions.[76] Perhaps due to its publicized history of abuse, the employment of restraint and seclusion is now widely regulated through substantive limitations and procedural mechanisms. These publicly and privately adopted rules present courts with at least a threshold on which to assess the acceptability of the use of restraint when presented with complaints by handicapped residents of mental institutions.

The impetus for such rules was a unique blend of federal litigation and media exposés. It began in a mental hospital and state school for persons with retardation in Alabama where outrageous conditions of abuse and neglect, including the pervasive reliance on physical restraint for the convenience of staff, were paraded before the federal court.[77] The judge subsequently sought the assistance of mental health experts to draft judicial standards on the appropriate use of restraint and seclusion that were eventually adopted as the remedy for constitutional violations.[78] The approach was soon extended to curtail similar abuses and establish parallel standards in several other institu-

74. *See* Lappe v. Loeffelholz, 815 F.2d 1173 (8th Cir. 1987) (right to hearing prior to the forcible administration of psychotropic drugs was not clearly established and therefore prison official is immune from liability); Naughton v. Bevilacqua, 605 F.2d 586 (1st Cir. 1979).

75. *See* Bee v. Greaves, 669 F. Supp. 372 (D. Utah 1987) (jury awards pretrial detainee who was forcibly treated with anti-psychotic drugs $100 in general damages and $300 in punitive damages).

76. Many states have statutes or agency regulations governing the use of sterilization, lobotomy, electro-convulsive therapy (ECT), physical aversive punishment, restraint, seclusion, and similar control devices. *See* THE MENTALLY DISABLED AND THE LAW, *supra* note 34, at 456-59.

77. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

78. Wyatt v. Stickney, 344 F. Supp. 387, 395-407 (M.D. Ala. 1972). The mental retardation standards were frequently cited by courts as the professionally accepted guidelines for institutional restraint and seclusion.

tions for persons with retardation.[79]

Practices which were declared illegal and remedied through broad judicial decrees were once commonplace in many state facilities.[80] To forestall litigation, many legislatures and executive agencies adopted preemptive strategies. Soon state laws abounded with limitations on restraint strikingly similar to the *Wyatt* and *NYSARC* standards.[81] Almost all incorporated minimal procedural protections such as requiring an evaluation by a physician, imposing time limitations on restraints, and mandating safety precautions.[82]

So as not to surrender their professional prerogative, the American Psychiatric Association created a Task Force to study the matter of restraint and recommend guidelines for its members.[83] The Task Force published its conclusions, including detailed standards, in a widely read report.[84] The combination of state law, agency policies, and professional literature[85] form a body of rules to which courts may refer to assess challenges from people with disabilities to conditions of restraint.

In the few damage cases to date, these standards, considered together with the customary level of care in the community, form the basis for imposing liability. In *Clites*, an Iowa court reviewed the industry standards and declared that tying a retarded man spread eagle on a bed was "cruel and inhuman" and certainly an appropriate basis for the jury's award of substantial damages.[86] In *McCartney v. Barg*,[87] the jury awarded $250,000 to a severely

79. *See* New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975).

80. Legal challenges soon proliferated. *See* Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979); Eckerhart v. Hensley, 475 F. Supp. 908 (W.D. Mo. 1979); Davis v. Balson, 461 F. Supp. 842 (N.D. Ohio 1978).

81. Most states forbid the use of "excessive restraint" or restraint employed as "punishment or primarily for the convenience of staff." THE MENTALLY DISABLED AND THE LAW, *supra* note 34, at 275-76. Many have established detailed substantive standards for the utilization of restraint, often requiring an imminent threat of danger to the individual or others in the facility. *Id.* For a classification of state restraint statutes, see Note, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836, 1841 n.25 (1986).

82. THE MENTALLY DISABLED AND THE LAW, *supra* note 34, at 357 (Table 6.2); Note, *supra* note 81, at 1841. It can be argued that even more stringent standards are required to protect institutionalized persons from excessive or unnecessary restraint or, when such restraint is imposed, to support liability judgments against unqualified clinicians. This argument rests primarily on the perceived weakness of many state restraint statutes and the self-serving nature of professionally established standards. *Id.* at 1842-50.

83. Bonnie applauds the organization's willingness to promulgate standards but warns that an expansion of malpractice actions could discourage innovation out of fear that voluntarily announced, aspirational standards will be invoked to impose liability on unwitting practioners. Bonnie, *supra* note 14, at 237.

84. *See* AMERICAN PSYCHIATRIC ASS'N, REPORT OF THE TASK FORCE ON THE PSYCHIATRIC USES OF RESTRAINT AND SECLUSION (1985).

85. For an exhaustive listing of the psychiatric literature on restraint and seclusion, see Note, *supra* note 81, at 1843 n.32.

86. Clites v. Iowa, 322 N.W.2d 917, 921 (Iowa Ct. App. 1982). The court relied upon both customary practice and professional association guidelines, such as the pharmaceutical company's recommendations for dispensing its medication.

87. C.A. No. C83-26 (N.D. Ohio 1988). The jury was instructed with respect to the pro-

retarded woman with serious behavior problems who was continuously restrained and heavily medicated for years in a psychiatric facility. In *Cobb v. Nazimi*,[88] a jury awarded $300,000 to a mentally ill man who had been unnecessarily restrained in a state hospital for several years.

A number of other cases which have settled for large, but undisclosed, amounts have involved prolonged or punitive use of restraint on seriously disabled residents of state facilities.[89] Courts have interpreted state statutes and regulations governing restraint in a creative manner so as to create an even broader foundation for damage actions.[90]

The United States Supreme Court has recently federalized this right. In *Youngberg v. Romeo*,[91] the Court declared that freedom from unnecessary restraint was a protected liberty interest under the fourteenth amendment to the United States Constitution and that professional standards must be used to determine when and to what extent restraint of an institutionalized resident is excessive or unnecessary.[92] While *Romeo* highlighted the significant distinction between civil rights violations and negligence, it left no doubt that existing state rules and professional guidelines could form the basis for a finding

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fessional judgment standard enunciated in Youngberg v. Romeo, 457 U.S. 307, 316 (1982), for constitutional claims of excessive restraint. The jury heard evidence concerning state policies, associational guidelines, and customary practice to inform its understanding of "professional judgment."

88. No. 87-3731 (D.W. Va. 1987), *rev'd on other grounds*, 851 F.2d 730 (4th Cir. 1988), *cert. denied*, 109 S. Ct. 1177 (1989). Like McCartney v. Berg., C.A. No. C83-26 (N.D. Ohio 1988), evidence was introduced with respect to state law, professional, and community standards for restraint and other limitations on movement.

89. *See, e.g.*, Galenski v. Noonan, C.A. No. 88-162 (Hampshire Super. Ct., Mass. May 25, 1989) (elderly man with mental illness restrained and secluded continuously for three months in violation of state law and acceptable psychiatric practice).

Occasionally, suits are brought for the *failure to restrain* a resident of a mental institution where subsequent harm results to himself or others. *See* Topel v. Long Island Jewish Medical Center, 55 N.Y.2d 682, 431 N.E.2d 293, 446 N.Y.S.2d 932 (1981) (suicide patient not properly restrained and monitored); Deidrich v. State, 393 N.W.2d 677 (Minn. Ct. App. 1986) (mentally ill man confined in state facility who fell from third story window stated claim upon which relief could be granted). These decisions are analytically analogous to the failure to confine or warn cases and distort the principle that people with disabilities should be compensated for their injuries in a similar manner and amount to temporarily able-bodied individuals.

To ensure that physicians do not over-utilize restraint out of fear of liability for the failure to do so, one commentator has suggested that when harm is perpetrated *by* the individual herself, as opposed to when she is the victim of improper restraint, various forms of immunity, financial caps on liability or high standards of blameworthiness should be applied. Note, *supra* note 81, at 1855. Obviously, a calculation of damages that is dependent on the status of the person who causes the harm only perpetuates a not-so-subtle discrimination in compensation for injuries to persons with disabilities.

90. In O'Sullivan v. Secretary of Human Servs., 402 Mass. 190, 521 N.E.2d 997 (1988), the Supreme Judicial Court declared that the use of restraint or seclusion without a specially trained observer who actually maintained eye contact with each confined resident violated a state statute. It concluded that ignoring the procedural and substantive limitations of a new statute could give rise to liability since the provisions were clear on their face. *Id.* at 194, 521 N.E.2d at 1000-01.

91. 457 U.S. 307 (1982).

92. *Id.* at 322.

of unconstitutional conduct under appropriate circumstances. Moreover, the Court offered attorneys, in addition to traditional state law malpractice causes of action, a new federal claim based on the use of restraint on helpless persons with handicaps.

It is not surprising that many of the successful damage suits brought on behalf of individuals labeled as mentally ill or mentally retarded involve the unauthorized or unconsented to use of intrusive treatment such as psychotropic medication or the excessive and punitive use of restraint. Both of these claims are built upon established rules of professional conduct, although many cases have required courts to define or refine the limits of customary standards of practice. In each, courts have had legal precedents from other domains of health law or professional guidelines[93] as a reference point for the extension of liability to those with disabilities. This more manageable foundation obviously makes the task easier,[94] but it is not the critical determinant of whether damage actions will proliferate to compensate persons with handicaps who have suffered harm. The litmus test for the future may be the issue of money.

IV.
THE POTENTIAL OF DAMAGE ACTIONS TO ESTABLISH NEW STANDARDS: THE DUTIES TO WARN AND CONFINE

Many aspects of the care, treatment, habilitation, or control of persons with disabilities either wholly lack standards or are guided by vague, virtually meaningless proscriptions of acceptable practice. In these areas it often has been left primarily to courts to craft directives for acceptable clinical decisionmaking. Although reluctant to intrude into a domain of professional unpredictability and cognizant of the fact that malpractice and civil rights damage cases — unlike product liability actions — are decided with reference to professional norms rather than societal ones, courts have tentatively accepted the task of establishing standards of conduct on selected clinical matters.[95] Their

93. Some private guidelines for care may be self-serving, vague, subjective, or even obvious. Thus associational guidelines which require that physicians exercise "reasonable professional discretion" in administering psychotropic medication or that they "periodically review" the necessity for seclusion orders are of little utility in supporting a determination of liability.

94. It is also arguable that intrusive interventions, like restraint, unconsented to medication, and neglect raise issues far easier for courts to condemn than the elusive issues of appropriate mental health treatment or adequate habilitation. Quality of care decisions are more subjective, less amenable to specific guidelines, and more difficult to criticize under a general community practice or professional judgment standard. Thus, the lesson of these two examples is not automatically transferable to all injuries suffered by persons labeled as mentally ill or retarded.

95. There may be a correlation between the likelihood of judicial activism and the inaction of governmental bodies and professional associations. As one noted psychiatrist has observed in the context of assessing what constitutes appropriate mental health treatment:

> Given that there are no government bodies judging the efficacy of claims for psychotherapy, and given the limited efforts undertaken by professional associations, it is understandable that individual patients use the courts to redress their grievances. . . . In the absence of professional criteria for standards of care, the courts are increasingly

decisions on the scope of doctor-patient confidentiality and the responsibility to involuntarily institutionalize are informative, although hardly encouraging.

For centuries the common law has imposed no affirmative duty on health care providers or caretakers to intervene in order to prevent harm to third persons. This familiar rule also governed therapists' relationships with their patients.[96] But when Tatiana Tarasoff was killed by a person under psychiatric care, the standard was radically revised. Relying upon the special relationship exception to common law principles, as codified in the Restatement (Second) of Torts, section 315, the California Supreme Court declared for the first time that therapists owed a duty to warn potential victims of imminent violence from their clients and to take other reasonable steps to avert the harm.[97]

Although subsequently limited by the California court to a duty to warn only *identifiable* victims,[98] the establishment of a new standard of conduct has spawned extensive litigation and related rulings in other jurisdictions,[99] substantial damage awards,[100] and considerable controversy within the psychiat-

becoming the arena in which these disputes are adjudicated. Thus, case law and individual precedents may become the criteria for adequacy of diagnosis and treatment. Klerman, *supra* note 6, at 415.

96. No reported cases before 1976 reflect a willingness to impose liability on psychiatrists or other counselors who fail to prevent harm to third parties by persons who are not within their physical control. There is, of course, a wealth of authority awarding damages when an individual with disabilities is injured while in the care or custody of a defendant, regardless of the source of the harm, as well as when he injures another, either in the facility or shortly after his release. 3 THE REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 343-58 (collecting cases); Morse, *The Tort Liability of the Psychiatrist*, 19 BAYLOR L. REV. 208 (1967).

97. Tarasoff v. Regents of the Univ. of California, 17 Cal. 3d 425, 435, 551 P.2d 334, 343, 131 Cal. Rptr. 14, 23 (1976).

98. Thompson v. County of Alameda, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

99. Numerous federal and state courts have adopted the reasoning of *Tarasoff* without its limitation to identifiable victims. *See* Currie v. United States, 644 F. Supp. 1074 (M.D.N.C. 1986), *aff'd*, 836 F.2d 209 (4th Cir. 1987); Lipari v. Sears, Roebuck, and Co., 497 F. Supp. 185 (D. Neb. 1980); Bradley Center v. Wessner, 250 Ga. 199, 296 S.E.2d 693 (1982); Evans v. Morehead Clinic, 749 S.W.2d 696 (Ky. App. 1988); McIntosh v. Milano, 168 N.J. Super. 466, 483-84, 403 A.2d 500, 511-12 (1979); Peterson v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983).

Others have incorporated the identifiable victim condition. *See* Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983); Beck v. Kansas Univ. Psychiatry Found., 580 F. Supp. 527 (D. Kan. 1984); Brady v. Hopper, 570 F. Supp. 1333 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984); Hasenie v. United States, 541 F. Supp. 999 (D. Md. 1982); Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981), *aff'd*, 676 F.2d 686 (3d Cir. 1982); Cooke v. Berlin, 153 Ariz. 220, 735 P.2d 830 (Ct. App. 1987); Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 487 (Ct. App. 1983); Williams v. Sun Valley Hosp., 723 S.W.2d 783 (Tex. Ct. App. 1987).

Some courts have read the case broadly and implied a duty to act beyond a mere warning. *See* Lipari v. Sears, Roebuck, and Co., 497 F. Supp. 185 (D. Neb. 1980); Naidu v. Laird, 539 A.2d 1064 (Del. 1988); Evans v. Morehead Clinic, 749 S.W.2d 696 (Ky. Ct. App. 1988); Schuster v. Altenberg, 144 Wis. 2d 223, 424 N.W.2d 159 (1988). The most commonly referenced affirmative action is civil commitment or voluntary confinement.

100. Before the court reversed and remitted the jury's determination of liability, Linda Paddock recovered $2.15 million for Dr. Chacko's failure to hospitalize her and prevent her suicide attempt. Paddock v. Chacko, 522 So. 2d 410 (Fla. Dist. Ct. App. 1988).

ric community.[101]

Courts have undertaken a traditional balancing approach in formulating this duty to warn. Those sympathetic to the victims of harm have scrutinized and then dismissed policy arguments which contend that mandating this duty is inadvisable because: (1) the injury is too remote; (2) the injury is disproportionate to the culpability of the therapist; (3) predictions of dangerousness and future harm are not reliable; (4) informing third parties of confidential communications violates the ethical precepts of the psychotherapist-patient relationship; and (5) physicians will be reluctant to treat persons in the community.[102] Conversely, it is generally these same factors, and particularly the third and fifth ones above, that lead other jurisdictions to refuse to recognize such a duty.[103]

The creation of a heightened standard of conduct for mental health professionals by most courts which have considered the issue is perhaps not surprising, particularly since the foundation of the rule is to ensure compensation of temporarily able-bodied persons who have suffered at the hands of those with disabilities. In fact, the balancing of public policy factors commonly give short shrift to claims that a duty to warn may well result in greater infringements on the rights of those labeled as mentally ill.[104]

This tension is even more stark in cases seeking to extend the duty to include an affirmative obligation to prevent threatened harm by confining handicapped individuals.[105] While acknowledging that the imposition of a

101. Spokespersons for the American Psychiatric Society vehemently opposed imposition of the duty to warn upon practitioners, citing ethical considerations of confidentiality and the impropriety of designating psychiatrists as the guarantors of society's safety. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 371 (1977). Ironically, it was left to the American Psychiatric Association and the professional literature to demonstrate that psychiatrists were also poor predictors of future conduct and ill-equipped to determine who might actually be at risk of harm. *See generally* 1 J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (3d ed. 1981). Some courts dismissed this self-proclaimed limitation, noting the contradiction between the legislative assumptions of psychiatric expertise in predicting harm, which is incorporated in all civil commitment statutes, and this recent admission of professional inadequacy. *See Lipari*, 497 F. Supp. at 192; *Schuster*, 144 Wis. 2d at 223, 424 N.W.2d at 169; *McIntosh*, 168 N.J. Super. at 466, 403 A.2d at 514. Other courts have acceded to the psychiatrists' suggestion, relying on a mass of clinical research which demonstrates that therapists are indeed poor predictors of dangerousness and should neither be entrusted with the responsibility nor punished for their inability to foresee harm. *See Paddock*, 522 So. 2d at 414, *quoting* Nesbitt v. Community Health of So. Dade County, 467 So. 2d 711, 717 (Fla. Dist. Ct. App. 1985) (Jorgensen, J., dissenting).

102. *See Lipari*, 497 F. Supp. at 185; *Evans*, 749 S.W.2d at 696; *Schuster*, 144 Wis. 2d at 223, 424 N.W.2d at 159.

103. *See Paddock*, 522 So. 2d at 410.

104. Although Bonnie recognizes the potential for defensive practice which might produce negative consequences, he concludes that the judicially created duty to warn is more likely to improve quality of clinical practice, particularly for persons with violent behaviors who are treated in community settings, by injecting greater care and caution into the assessment and decisionmaking process. Bonnie, *supra* note 14, at 236.

105. *See Lipari*, 497 F. Supp. at 185; *Naidu*, 539 A.2d at 1064; *Evans*, 749 S.W.2d at 696; *Schuster*, 144 Wis. 2d at 223, 424 N.W.2d at 159; Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 U. PUGET SOUND L. REV. 255 (1988);

duty to commit certainly entails a substantial risk to those with mental illness, the courts have comforted themselves with a variety of platitudes that it is society, even more than its individual citizens, which deserves the foremost protection.[106] Thus, in one clear example where courts have formulated a new standard for mental health and retardation professionals, they have done so to compensate non-handicapped persons, often at the expense of citizens with disabilities.

The potential of judicial activism to benefit those with disabilities has been proven in the injunctive context but is less clear with respect to damage actions. The mere formulation of a new standard of conduct or the extension of an existing one, taken alone, is a neutral event, at least from the perspective of individuals with handicaps. The relevant inquiry is whether the rule is designed to improve the quality of treatment, rehabilitation, environmental design, freedom of choice, or conditions of confinement which are offered to those with disabilities. Where standards are established to compensate non-handicapped individuals or protect society from the acts of those labeled as mentally ill or mentally retarded, there is generally no direct or residual benefit to the class of persons with disabilities. To the contrary, such standards frequently disadvantage this class and create real obstacles to their exercise of other rights and opportunities. Thus, as used in this Article, the measure of a "beneficial" rule is the extent to which a judicially developed standard of practice is intended to enhance the quality of care provided to persons with disabilities and to compensate *them* for historical inadequacies and professional negligence.

Whether damage actions can have this salutary impact in areas of clinical decisionmaking that lack meaningful guidelines remains speculative.[107] A re-

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Note, *The Psychotherapist's Calamity: Emerging Trends in the* Tarasoff *Doctrine*, 1 B.Y.U. L. REV. 261 (1989).

106. *See, e.g.*, Currie v. United States, 644 F. Supp. 1074, 1082 (M.D.N.C. 1986) ("This court believes that this rule will not have an unduly adverse backlash, leading to any significant risk of overcommitment by psychotherapists seeking to avoid liability."); *Lipari*, 497 F. Supp. at 193 ("Despite the defendant's protests to the contrary, a psychotherapist is not subject to liability for placing his patient in a less restrictive environment so long as he uses due care in assessing the risks of such placement."); *Schuster*, 424 N.W.2d at 175 ("Finally, the mere initiation of detention proceedings does not threaten the patient's constitutionally protected liberty.").

107. To the extent the question has generated any interest, researchers and other commentators disagree. *See* Bonnie, *supra* note 14 (discussion of three competing views — no effect, negative effect, and positive effect — and conclusion that litigation *can* improve the quality of care where existing standards are unclear or nonexistent). Hogan, in his comprehensive study of this issue suggests that it is unlikely, although he concedes that the dearth of data make any inference mostly conjecture. 3 THE REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 26-27. Moreover, he recognizes that the answer could well depend upon whether the cases involve physical harm and demonstrable events, such as ward conditions in a public mental health facility, rather than emotional stress resulting from poor communications with a psychotherapist. *Id.*

Some other commentators argue that litigation has only a negative influence. *See* Morris, *Lawsuits and Quality of Patient Care*, 215 J. AM. MED. A. 1211 (1971); Stone, *The* Tarasoff *Decisions: Suing Psychiatrists to Safeguard Society*, 90 HARV. L. REV. 358 (1977). Others are of the opposite persuasion. *See* Brook, Brutoco & Williams, *The Relationship Between Medical*

liable conclusion requires an empirical analysis which is both premature and extraordinarily complex.[108] Even a reasonable hunch involves a careful examination of those factors which influence a court's judgment that a new standard of conduct is necessary.[109]

While there is no definitive list of these factors, the analysis predictably begins with traditional tort policy concerns, including the desirability of compensating victims of harm, the undesirability of discouraging discretionary acts by public employees, and certain elements quite specific to the emerging area of disability law.[110] Other relevant considerations in evaluating whether "beneficial rules" are likely to evolve from damage litigation against mental health and retardation professionals include:

1. the nature and severity of the harm suffered;

Malpractice and Quality of Care, 1975 DUKE L.J. 1197; Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179. The answer, if there is one, may depend more on who asks the question and the definition of "positive influences or outcomes," rather than a mere conclusory label.

108. Hogan noted that there was virtually no research conducted in this area and even raw data was very difficult to obtain. 1 THE REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 321. Bonnie concurs, explaining that the complexity of the research design renders a convincing study unlikely. Bonnie, *supra* note 14, at 230. Although Hogan conducted an impressive analysis of over three hundred reported cases between 1900-1977, the study glaringly omitted all damage actions which were settled before trial or were resolved by a jury without further appeal — the vast majority of all malpractice and civil rights actions. *See* 3 THE REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 3 (study at best includes only one tenth of the cases filed and may reflect only one hundredth of the raw data). Thus its conclusions, which represent by far the most thorough and reliable to date, are nevertheless highly suspect and open to considerable debate.

109. There is at least some evidence, which may be illustrative of an emerging pattern, that damage actions can promote new, beneficial standards of clinical practice. For instance, in Bolivar v. Riquier, C.A. 88-4358 (Suffolk Super. Ct. Mass. 1990), the state and private defendants recently settled a civil rights and wrongful death action which alleged that a mentally retarded man was inappropriately admitted to a mental health facility, was urged to sign a "voluntary" admission form although believed to be under a guardianship, and was provided with inadequate monitoring of his seizure disorder and grossly negligent emergency medical care. Within months of the filing of this action, the Massachusetts Department of Mental Health promulgated new rules proscribing the admission of individuals with retardation to its state hospitals and prohibiting persons from signing a voluntary application until there had been a clinical determination of their competency to consent to care. More rigorous protocols on the treatment and monitoring of seizure patients were adopted by the facility. Finally, certain of the physicians responsible for the medical care provided to the decedent, as well as the superintendent of the facility, subsequently resigned.

110. For instance, the federal courts have recently become extremely cautious of intruding into the domain of state mental health and retardation experts and have therefore adopted a standard of excessive deference to disability professionals when determining compliance with constitutional standards. *See* Youngberg v. Romeo, 457 U.S. 307 (1982). State courts, on the other hand, have become almost enamored with the intellectual challenge of applying traditional concepts of consent to those with severe disabilities and have decidedly eschewed reliance on medical decisionmakers. *See* Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). The issue of safety and freedom from harm — both for and from people with disabilities — continues to starkly color the landscape of developing tort doctrines.

2. the degree of sympathy with the victim as compared with other actors;
3. the relative ability of the victim and wrongdoer to bear the cost of the harm;
4. the existence of a professional consensus on what constitutes acceptable practice;
5. the likelihood of an appropriate standard arising without judicial action;
6. the degree of resistance to or acceptance of a new judicial standard;
7. the ability to monitor and enforce the judicial standard; and
8. other public policy consequences of a court-imposed standard.

Applying these factors to the judicially created duty to warn, the rationale for the courts' willingness to fashion a new rule creating a duty to warn emerges. Virtually all of the initial cases, beginning with *Tarasoff*, involved the death of a innocent victim. In contrast, the disabled assailant was responsible for a violent crime and presumably presented an ongoing threat to society. Although the psychiatric client was the actual wrongdoer, liability was imposed on a private mental health professional who had insurance or was otherwise capable of compensating the victim. The rule was justified by analogy to the Restatement on Torts exception concerning the duty of a caregiver to protect third parties if there is an established relationship with a person, as well as to the public health responsibility of medical care personnel to prevent harm to others from contagious diseases. The courts apparently recognized that, absent judicial rulemaking, there was little possibility of a duty to warn evolving from professional associations, public regulation, or other methods of informal self-governance. While the courts acknowledged the significant resistance of mental health professionals to such a duty, they made little mention of the direct and indirect consequences to most persons with disabilities within their care.

A similar analysis governs the duty to confine, with two critical differences: (1) those courts which have found such an obligation have done so without reference to any accepted legal or professional standard of conduct requiring intensive, affirmative intervention to prevent a generalized and remote harm; and (2) the courts which have rejected this new rule have recognized the practical consequences that such a standard would have, including the unnecessary institutionalization of many persons with disabilities. Deference to the public policy of placing persons labeled as mentally ill in community settings has convinced many courts that establishing a duty to confine is both unwarranted and unwise.

These illustrative but limited examples indicate three possible trends. First, where non-handicapped individuals are harmed by persons with serious disabilities, courts are sometimes willing to create new standards of conduct which require considerable care from mental health and retardation profes-

sionals to prevent that harm, at least where there are no compelling conflicts with other accepted public policies.[111] Second, the existence of a related or analogous standard of care to which the court can refer is useful but not necessary.[112] Third, the acceptability of the new standard by disability professionals and their associations is not conclusive.

What then can be gleaned from these examples concerning the likelihood of courts formulating new "beneficial rules," where the victims of the harm are *persons with disabilities* and the perpetrators are health care workers and mental health and retardation professionals? The potential for creativity is vast, since there are few, specific standards of care concerning abuse or neglect; behavior modification and the limits of acceptable modes of highly intrusive or experimental treatment; the utility and effectiveness of various forms of psychiatric interventions such as long-term psychotherapy; mental capacity and consent; knowing and voluntary waivers of civil rights; permissible restrictions on fundamental rights (*e.g.*, communication, association, religious practice); sexual freedom and privacy; voluntary employment and reasonable compensation for labor; varying deprivations of physical freedom; and other assorted liberty interests.

It is clear that to some courts, this shift in *personae* is sufficient to deter the formulation of new standards of conduct. Whether under the guise of deference to professional judgment,[113] extensions of governmental immunity,[114] or simply an overt lack of sympathy with disabled victims,[115] some courts have been reluctant to craft new rules of liability in the ambiguous areas of treatment and rehabilitation. This conclusion is particularly apt in pure malpractice cases raising only quality of care claims. The courts' reluctance may be due to the difficulty of defining an acceptable level of "quality"

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111. *See* Comment, *The Psychotherapist's Duty to Protect Third Parties From Harm*, 11 MENTAL & PHYSICAL DISABILITY L. RPT. 141, 142 (1987).

112. *See generally* Klerman, *supra* note 6.

113. *See* cases cited *supra* note 110.

114. *See* cases cited *supra* notes 48-49 and 51-53.

115. In his review of earlier cases, Hogan found that plaintiffs prevailed less than a third of the time. 3 THE REGULATION OF PSYCHOTHERAPISTS, *supra* note 8, at 377. Recently, the United States Supreme Court has led the way in decisions adverse to those with disabilities. In several cases, the Court has disregarded the prolonged history of discrimination and abuse imposed upon those with handicaps, both in institutions and local communities, and concluded that minimal scrutiny of obvious prejudice is sufficient. *See* City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985); Pennhurst State School and Hosp. v. Halderman, 451 U.S. 1 (1981). In other holdings, it has wholly ignored the issue of disability, deciding instead that doctrines of federalism and immunity preclude relief. *See* Dellmuth v. Muth, 109 S. Ct. 2397 (1989); Atascadero v. Scanlon, 473 U.S. 234 (1985); Pennhurst State School and Hosp. v. Halderman, 465 U.S. 89 (1984).

But this hostility is not reserved for the High Court. State decisions imposing a duty on psychiatrists to confine those with mental illness reflect a similar tilt towards the stigma and fear which attach to the very word "disability." *See* cases discussed *supra* note 99. One court, professing a concern for the physical abuse suffered by a resident of a state facility for persons with retardation, affirmed an award of two dollars as full compensation for his actual expenses and pain and suffering. Shapiro v. Chapman, 70 Md. App. 307, 520 A.2d 1330 (1987).

in the psychiatric, psychological, or rehabilitative contexts,[116] or perhaps due to an assumption that the existing common law standard of customary practice is adequate.

In many jurisdictions, however, courts have been willing to clarify or create new standards of care in order to compensate and protect individuals with mental disabilities. This is especially evident in cases where no existing, common law standard is easily applicable, such as those involving serious harm to institutionalized persons from gross neglect,[117] physical abuse,[118] and death.[119] Often the statement of the new or expanded rule is no more than a welcome reiteration of the traditional malpractice formulation: that mental health and retardation professionals owe those within their custody a duty of ordinary care, as defined by customary practice in the community, taking into consideration the vulnerability or needs of the person with a mental disability, her dependency on the caregiver for protection and treatment, and the exigencies of the environment.[120] Occasionally, courts will articulate more precise

116. *But see generally* Klerman, *supra* note 6. The exception to this trend may be due to the impressive array of psychiatric experts who testified in *Osheroff v. Chestnut Lodge* that scientific evidence conclusively required a particular form and level of treatment, even if neither governmental bodies nor the professional psychiatric association were willing to announce a new standard of care.

117. *See, e.g.*, Cobb v. Nizami, 851 F.2d 730 (4th Cir. 1988); Clark v. Cohen, 794 F.2d 79 (3d Cir. 1986); Burke v. Medfield State Hosp., 1988 WL 22486 (D. Mass. 1988); Shackleford v. Dep't of Health and Human Resources, 534 So. 2d 38 (La. Ct. App. 1988); Fields v. Senior Citizens Center, 528 So. 2d 573 (La. Ct. App. 1988); Sayes v. Pilgrim Manor Nursing Home, Inc., 536 So. 2d 705 (La. Ct. App. 1988); Killeen v. State, 66 N.Y.2d 850, 489 N.E.2d 245, 498 N.Y.S.2d 358 (1985).

118. Significant state court decisions concerning abuse include: Shackleford v. Dep't of Health and Human Resources, 534 So. 2d 38 (La. Ct. App. 1988); Shapiro v. Chapman, 70 Md. App. 307, 520 A.2d 1330 (1987); De Sanchez v. Genoves-Andrews, 161 Mich. App. 245, 410 N.W.2d 803 (1987); Sharpe v. South Carolina Dep't of Mental Health, 292 S.C. 11, 354 S.E.2d 778 (1987); Psychiatric Inst. of Wash. v. Allen, 509 A.2d 619 (D.C. 1986).

Federal decisions include: Youngberg v. Romeo, 457 U.S. 307 (1982); Savidge v. Fincannon, 836 F.2d 898 (5th Cir. 1987). Abuse of disabled persons in institutions has been amply chronicled in several injunctive actions: Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239 (2d Cir. 1984); Lelsz v. Kavanagh, 673 F. Supp. 828 (N.D. Tex.), *rev'd on other grounds*, 807 F.2d 1243 (5th Cir. 1987); New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973).

Given the indisputable persistence of physical and psychological abuse, particularly in large state facilities, the dearth of litigation on this particular issue is most probably related to the several factors discussed in Part II, *supra*.

119. *See, e.g.*, Estate of Conners v. O'Connor, 846 F.2d 1205 (9th Cir. 1988); Feagley v. Waddill, 868 F.2d 1437 (5th Cir. 1987); Fields v. Senior Citizens Center, Inc., 528 So. 2d 573 (La. Ct. App. 1988); Bolivar v. Riquier, C.A. No. 88-4358 (Suffolk Super. Ct. Mass. 1990).

120. A proper standard of liability for determining the adequacy of care to severely handicapped persons must require the caregiver to take into account the individual's needs and disabilities, deficits and dependencies. *See* Sayes v. Pilgrim Manor Nursing Home, 536 So. 2d 705, 709 (La. Ct. App. 1988). Similarly, the defense of contributory negligence should be tailored to the circumstances of the person with handicaps and cannot arbitrarily assume the same level of responsibility of a non-handicapped, competent person. *See* Fields v. Senior Citizens Center, Inc., 528 So. 2d 573, 581 (La. Ct. App. 1988); Cowan v. Doering, 111 N.J. 451, 545 A.2d 159 (1988) (court affirms $600,000 award to patient who jumps from second story window of mental hospital; issue of contributory negligence should not be submitted to jury).

rules of professional conduct directly related to the action or area in question.[121]

This receptivity is not boundless nor even probable. Only cases presenting dramatic illustrations of misconduct, where the harm suffered is severe, have resulted in the judicial formulation of specific new rules of professional behavior and significant awards of liability. If the victim rather than the perpetrator of the harm is disabled, the judiciary may be less willing to evaluate the adequacy of treatment.[122] Like the examples of the duties to warn and confine, disability professionals are in a preferred position to assume the costs of rectifying the harm, although there may be greater judicial resistance to exacting payment of those costs from public officials or their agents.[123]

The critical distinction between these classes of cases may lie in whether there exists a consensus on the definition of appropriate professional conduct. Absent a clear reference point for their rulemaking, courts have been reluctant to imply a standard for clinical care when the objects of their protection are people labeled as mentally ill or mentally retarded. Whether prompted by an unusual deference to clinical judgment,[124] a reluctance to interfere in a helping profession and perhaps deter future offers of assistance,[125] or a hostility to the

121. *See* Bell v. New York City Health and Human Hosps. Corp., 90 A.D.2d 270, 456 N.Y.S.2d 787 (App. Div. 1982) (standard for release from psychiatric hospital); Reiser v. Prunty, 224 Mont. 1, 737 P.2d 538 (1986) (standard for emergency detention and hospitalization of person with mental illness).

122. That the status of the injured party is even deemed relevant, either overtly or *sub silentio*, is a matter of concern, raising serious questions of stigma and discriminatory justice. But there is little debate that courts are more sensitive to the pleas of a family of a non-handicapped victim of violence than they are to the disabled recipients of institutional abuse or prolonged neglect. Ironically, most jurisdictions are more willing to mandate a higher standard of care from mental health and retardation professionals with respect to innocent third parties than they are with regard to the vulnerable persons entrusted to their care.

123. There is no reason to suspect that injuries to non-handicapped persons from individuals with disabilities are more likely to involve private practitioners and facilities than in cases of harm to the disabled resident herself. Therefore, intensified scrutiny in the latter situation due to its purported effect on public funds raises the same prospect of discriminatory justice as does differential rulemaking based upon the status of the victim.

124. *See* Washington v. Harper, 110 S. Ct. 1028 (1990); Youngberg v. Romeo, 457 U.S. 307 (1982); United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (en banc). It is noteworthy that this same level of deference is not evident when courts consider the claims of psychiatrists and psychologists, who are opposed to new forms of liability such as a duty to protect *non-disabled* third parties, that they know what is best for their patients and that their member associations are quite capable of self-regulation.

125. Arguments against judicial rulemaking by mental disability professionals often begin and end with the questionable concern that time spent on legal process and respecting individual rights is inevitably time taken from client care. The Supreme Court subscribes to this view quite unconditionally. *See* Parham v. J.R., 442 U.S. 584 (1979); Addington v. Texas, 441 U.S. 418 (1979).

Such arguments also include the warning that heightened standards of care and increased liability will force the best and most qualified caretakers away from serving those in need. *See* United States v. Charters, 863 F.2d 302 (4th Cir. 1988) (en banc); Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *aff'd in part, remanded in part*, 738 F.2d 1 (1st Cir. 1984) (right to refuse medication).

There is little empirical evidence to support these predictions. On the contrary, data sug-

claims of injury from those with mental impairments, many judges have simply been unwilling to formulate new standards of care in the many undefined areas of treatment and habilitation. They have evidenced less resistance when there are clear analogies to other legal standards of liability or where the professionals themselves have articulated definitions of appropriate care.

V.
COMPENSATING HARM TO PEOPLE WITH DISABILITIES: THE CRITICAL ISSUE OF VALUATION

Given the dangerousness of most institutional environments and the vulnerability of many persons with serious disabilities, demonstrating liability for violations of ordinary standards of care is the straightforward portion of most damage actions; convincing the jury to award substantial compensation is more difficult.[126] A variety of factors contribute to this challenge: (1) the paucity of damage litigation on behalf of persons with handicaps; (2) the relatively few awards or settlements of significant value; (3) the negative stereotypes and perceived lack of worth of individuals labeled as mentally ill or mentally retarded; (4) the reality that most plaintiffs will have had preexisting conditions which impair their abilities and activities and which may be difficult to separate from new limitations on functioning; (5) the exclusion of seriously handicapped persons from competitive employment with the consequence that few can demonstrate loss of earnings or future economic harm; (6) the reluctance of courts and juries to compensate the disabled victims of public employees' incompetence when the state must continue to fund their care in state-supported facilities or with government benefit programs such as Medicaid and Medicare; and (7) the unfortunate fact that severely handicapped residents of public institutions have shorter life expectancies and thus are assumed to experience less in their lives than their disabled counterparts in the community.[127] These factors, whether alone or in combination, are apparent in most trials or negotiations when persons with handicaps can demonstrate that they have been harmed. Historically, these elements have significantly influenced the scope of any award to compensate individuals with disabilities for their suffering.

The likelihood of successfully countering each of these factors is gradually improving. Courts, legislatures, and professional organizations are estab-

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gest that the threats are exaggerated and the predicted consequences questionable. *See* Schwartz, *Equal Protection in Medication Decisions: Informed Consent, Not Just the Right to Refuse*, in AMERICAN BAR ASS'N, THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 74, 77 (1986).

126. In Shapiro v. Chapman, 70 Md. App. 307, 520 A.2d 1330 (Ct. Spec. App. 1987), the court of special appeals declared that excessive punishment and abuse suffered by a mentally retarded man violated his common law and constitutional rights but then refused to overturn a jury verdict awarding him only two dollars compensation for the psychological indignity and physical harm which he suffered.

127. *See* U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 80 (1984).

lishing rules which either adopt the customary standard of practice applied to the treatment of temporarily able-bodied citizens or impose higher expectations on caregivers due to the person's vulnerability and disability.[128] The American public is beginning to accept the proposition that individuals with handicaps are full and equal persons — in the legal, moral, and practical sense of that word.[129] This transformation of perception is not easily converted into a declaration of equal worth, but it nevertheless presents the possibility that the opposite view may not prevail. Recent awards in damage actions increasingly recognize that, at least with respect to the intangibles of pain and suffering, harm to those with differences in abilities should not be differently valued.[130]

The practical impact of even isolated large verdicts is resounding. The existence of new precedents has predictably encouraged others to initiate similar litigation. This spiralling effect may signal the beginning of revolution in damage actions for citizens with disabilities.[131] At a minimum, it suggests the potential for alternative strategies to the passive acceptance of harm.

While the complexities of causation will always present technical challenges to separating preexisting disabilities from the consequences of the alleged harm, there is some evidence that this factor may promote juror sympathy, rather than disdain, and thus serve as a foundation for even higher verdicts than would otherwise result.[132] In part this is simply the consequence of the enhanced perception of people with disabilities already discussed; in part it reflects the traditional emotionalism of the courtroom drama. But mostly it acknowledges the truth that those who cause harm to those who are especially vulnerable may properly be taxed more severely, or at least not less so. Thus a young woman born with mental retardation and serious hearing

128. *See supra* text accompanying notes 95-125.

129. *See* City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 443 (1985) (persons with retardation have made substantial gains in last two decades through political process); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327; Minow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection, and Legal Treatment of Difference*, 22 HARV. C.R.-C.L. L. REV. 111 (1987).

130. In Kelley v. Perkins, C.A. 85-1821 (Middlesex Super. Ct., Mass. Oct. 28, 1987), for example, a moderately retarded, hearing- and sight-impaired young woman sued her special education teacher and school for sexual abuse. A psychiatrist submitted an affidavit describing how the psychological trauma to the plaintiff was even more devastating and long-lasting than it would otherwise be to a non-handicapped person since she lacked the ability to fully understand and communicate her feelings about the experience. The doctor further stated that, even with the assistance of a qualified therapist, there was little likelihood that she would ever be able to be free of her fear of men or the emotional scars of the assault. The case then promptly settled for a significant sum.

131. *See supra* note 37. It is noteworthy that the computer search could not reach unreported judicial decisions, any simple jury verdicts, and all actions which were settled prior to trial. Since these constitute the vast majority of damage cases and since the number of such matters has dramatically increased in the past fifteen years, it is reasonable to assume that the startling difference previously noted between the periods 1900-1977 and 1977-1989 grossly underestimates the actual difference.

132. *See supra* notes 10 & 13.

and speech impairments may be even more traumatized by a sexual assault from her school teacher than her non-disabled counterpart might be, both because she is more dependent on certain adults for care and protection and because she is less able to understand and ultimately integrate the shock of coerced intimacy.[133]

The economics of disability are also changing. No longer is it assumed that serious handicaps preclude employment.[134] On the contrary, the work ethic and experience is no longer denied even to those with multiple impairments. As vocational programs are developed and research on productivity and earning capacity conducted, a body of knowledge is emerging which demonstrates that harm to persons with disabilities results in real economic loss.[135] The value of this diminution in future earnings may be less than with nonhandicapped persons but it is still substantial.[136] Moreover, the professional consensus on employment for those with disabilities is changing so rapidly that even the total absence of a work history for a long-term resident of a state institution is no predictor of her inability to earn competitive wages in the future.

In those states which retain the collateral source rule, payment of medical expenses by public benefit programs is of no consequence.[137] Even in those jurisdictions which have abolished the rule in the wave of medical malpractice reform, the modification simply places those with disabilities in a similar position as nonhandicapped individuals who have private insurance or receive employer compensation. Therefore, what previously was a limitation on

133. *See supra* note 130.

134. The professional consensus now is that virtually all persons with disabilities are capable of employment, including those with severe handicaps. W. KIERNAN & J. STARK, PATHWAYS TO EMPLOYMENT FOR ADULTS WITH DEVELOPMENTAL DISABILITIES (1986). *See generally* Wehman, Hill, Hill, Brooke, Pendleton & Britt, *Competitive Employment for Persons with Mental Retardation: A Follow-up Six Years Later*, 23 MENTAL RETARDATION 274 (1985).

135. *See* Horner & Bellamy, *Structured Employment: Productivity and Productive Capacity*, in VOCATIONAL REHABILITATION OF SEVERELY HANDICAPPED ADULTS: CONTEMPORARY SERVICE STRATEGIES 85 (G. Bellamy, G. O'Connor & O. Karan eds. 1979).

136. *See* Psychiatric Inst. of Wash. v. Allen, 509 A.2d 619, 625 n.8 (D.C. 1986) (evidence of earning potential of non-disabled student is relevant to determination of lost wages of student with handicap).

The actual value of these damages has been seriously underestimated and often ignored. Thus, even if a severely handicapped individual was capable of earning only $25.00 per week, she would still accumulate $1,250.00 per year. If she had been unnecessarily institutionalized for twenty years, without appropriate habilitation and with excessive reliance on medication she would be entitled to $40,950 in lost earnings, including accrued interest. *See* Clark v. Cohen, 794 F.2d 79 (3rd Cir. 1986).

137. The rule permits plaintiffs to recover from defendants their actual expenses even when those costs have been paid from another source such as private insurance or public funds. Since many disabled persons are indigent or covered by various Social Security programs, 42 U.S.C. §§ 416-425, 1381-1382, 1395-1395w, 1396-1397f (1982 Supp. & 1987), they frequently receive federal funding for costs associated with their injuries. Those confined in state institutions or community facilities may have the total cost of their care paid by a third party who also may be the defendant in the damage suit or the defendant's public employer. Some individuals may have private insurance or otherwise use their own funds for actual expenses. The abolition of the rule for all of these individuals is likely to reduce the amount of damages recovered.

compensation for one class of victims has now been extended, on an equal basis, to all others.

Finally, and most significantly, the duration and quality of lives of those with serious disabilities are markedly improving. As prolonged institutionalization becomes disfavored among professionals,[138] fewer and fewer citizens labeled as mentally ill or mentally retarded will be condemned to decades of segregation in massive public institutions. Placement in supportive community living arrangements and integration in real neighborhoods is increasingly becoming a reality, particularly for those with retardation and other developmental disabilities.[139] As the locus of care is shifted, their life expectancy and range of experiences is concomitantly expanded.[140] In fact, the failure to transfer residents of state hospitals and schools to alternative residential environments can be asserted as a separate and distinct basis for liability.[141] Moreover, an appropriate community living arrangement may either be incorporated into the remedy sought or be purchased with the compensation obtained.[142]

There is hardly compelling data or judicial precedent to fairly resolve the critical issue of fair valuation of harm when the victim already has a serious disability. But there is mounting evidence that the distorted history of stigma, devaluation, and grossly inadequate compensation may be waning. To the extent that inexcusable injuries suffered by individuals with disabilities are substantially compensated, damage cases may serve to enhance the perception that even vulnerable, severely handicapped persons may be useful and productive citizens. If this prediction is realized, even in part, then damage litigation could constitute an effective strategy for social reform, at least as to the public perception of those with disabilities, and perhaps as to the actual service systems that care for them.

CONCLUSION: THE POTENTIAL FOR REFORMING SERVICE SYSTEMS FOR PERSONS WITH DISABILITIES THROUGH DAMAGE ACTIONS

There are no common definitions or accepted measures of systemic reform and there is little empirical research on the legal factors or strategies

138. *See* Ferleger, *supra* note 2; Heal, Sigelman & Switzky, *Research on Community Residential Alternatives for the Mentally Retarded*, in NORMALIZATION, SOCIAL INTEGRATION, AND COMMUNITY SERVICES 215 (R. Flynn & K. Nitsch eds. 1980).

139. *See generally* NORMALIZATION, SOCIAL INTEGRATION, AND COMMUNITY SERVICES (R. Flynn & K. Nitsch eds. 1980).

140. *See supra* note 127.

141. *See* Savidge v. Fincannon, 836 F.2d 898 (5th Cir. 1987), *reh'g denied*, 843 F.2d 499 (5th Cir. 1988) (undisclosed settlement for unnecessary institutionalization); Clark v. Cohen, 794 F.2d 79 (3d Cir. 1987) (undisclosed settlement for decades of unnecessary confinement); Petty v. Miller, C.A. No. 428321-A (Travis Co., Tex. 1989) (jury verdict of $505,000 for twenty years of inappropriate and illegal hospitalization).

142. The settlements in *Petty* and *Clark, supra* note 141, were applied to the cost of alternative community support programs for the plaintiffs. Kathy Kelly, *supra* note 130, used her recovery to purchase her own home.

which appear to generate systemic change.[143] There is not even agreement on whether legal actions or judicial initiatives designed to force modifications of unconstitutional systems is consistent with our democratic government.[144] Yet it is undeniable that lawyers, litigation, and the courts have been instrumental in promoting dramatic alterations to numerous service systems, particularly those which directly affect poor, disenfranchised citizens.

Much has been achieved through injunctive litigation and structural reform cases for those with disabilities when measured in terms of either their access to ordinary community opportunities or the availability of specialized support services from governmental agencies.[145] This direction should not be abandoned. But nor should it be exclusive. Damage actions, brought on constitutional, statutory, and especially common law grounds, offer significant potential for modifying the very systems designed to serve those considered to be disabled.

The success of this strategy requires the enforcement, extension, and development of standards of conduct and causes of action highly relevant to the exigencies, preferences, and values of people with disabilities and especially those in institutions.[146] When standards exist but are ignored, damage actions can clearly be an effective enforcement mechanism.[147] Even in the absence of substantial compensatory awards, damage litigation may have a promotive, if not intimidating, effect.[148] Agency officials and hospital administrators often will modify practices solely to *avoid* the possibility of legal action, particularly

143. This is due in part to the difficulty of isolating the legal action from a host of other social variables; it is partially the consequence of the limited interest of social science researchers in the impact of litigation as a significant change agent. A few landmark cases provide notable exceptions. *See* D. ROTHMAN & S. ROTHMAN, THE WILLOWBROOK WARS (1984).

144. *Compare* Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV. 1281 (1976) (describing the appropriate role for a judge in balancing all relevant interests in system change) *with* Frug, *The Judicial Power of the Purse*, 126 U. PA. L. REV. 715 (1978) (criticizing federal courts for usurping legislature's role in ordering expenditures to reform institutional systems) *and* Diver, *The Judge as Political Powerbroker: Superintending Structural Change in Public Institutions*, 65 VA. L. REV. 43 (1979) (questioning adequacy of federal courts to implement broad structural reform).

145. *See* cases cited *supra* notes 16-17.

146. As noted above, the judicial system need not defer to professional organizations or governmental bodies to formulate these rules; in the absence of some initiative from those most directly affected by the imposition of standards, courts have traditionally fashioned legal expectations for a wide range of parties. *See supra* notes 117-121 and accompanying text.

147. Some observers, relying upon an economic analysis that sees limited deterrence effect from random and improbable risks, would disagree. *See* Bonnie *supra* note 14, at 231. The more convincing view, however, recognizes the chilling effect of successful litigation, especially in public sector activities, and acknowledges the substantial modification of actual practice which is likely to result. *Id.* at 232-33.

148. In one instance where several doctors and administrators were served with a civil rights complaint alleging negligence, wrongful death, and constitutional claims for a young man with retardation who was improperly admitted, retained, and medicated in a state mental hospital, one doctor resigned and others threatened to leave. The medical director announced to the press the next day that if such suits continued, the hospital would have to dramatically alter the way it treated residents and might even have to close. Derby, *Resignation of Doctor Deemed Not Enough*, Evening Gazette (Worcester), July 28, 1988, at 13, col. 1.

where there is a real risk of liability and significant damages. Thus, even the capacity and potential of damage actions can be creative catalysts for reform, even though the nature of the change is not inherently predictable.

In the absence of relevant and specific rules of professional conduct, litigation can promote the extension of existing standards or the formulation of new ones. This function is particularly promising in those areas of mental health and retardation services which are either substantially unregulated[149] or especially insulated from meaningful review.[150] When a court awarding damages grounds its decision on an extension of an established standard,[151] a new interpretation of an existing rule,[152] or the creation of an entirely novel claim,[153] there is a significant potential for reform of vital features of the disa-

149. Despite the recent promulgation of federal and state regulations and the publication of private guidelines by professional organizations, *see supra* notes 6-8, there has been only limited attention to substantive rules concerning a host of institutional activities, including: physical and psychological abuse and neglect; the intimidating and coercive environment inherent in "total institutions"; the quantity, duration, frequency, and types of psychotropic medication, including the use of these drugs for behavioral control; the entire "privilege" system in mental hospitals whereby residents' freedom of movement is restricted; the inappropriate continuation of institutionalization beyond that required by the individual's needs; the assessment and implementation of vocational programming; and employment practices of public agencies which effectively preclude the termination of workers who are suspected of violating clients' rights.

Noninstitutional settings have mostly been overlooked in this avalanche of rulemaking. There are few, if any, meaningful standards in many states governing community mental health and retardation facilities; nursing, rest, and board and care homes; outpatient clinics and nonresidential services; crisis and respite shelters; or the entire provision of support services to people's families or in their natural homes.

150. That most voluntary standards are written by the same professionals who are the subject of the guidelines reveals an obvious limitation of self-regulation. Thus the American Psychiatric Association understandably is not eager to restrict the flexibility or authority of its members who practice in state hospitals, except as to patently unacceptable practices or what is clearly "bad medicine." Nor has the American Psychological Association been willing to enter the fray as to the proper use of intrusive or painful behavior modification. Professional organizations for social workers, rehabilitation specialists, and unions representing direct care staff have barely considered enacting rules of self-governance.

Not surprisingly, the fundamental allocation of power and discretion, especially in institutional settings, has not been altered by the standards created by public and private bodies. Nor is such reform likely through internal regulation. Similarly, the processes and decisionmaking forums which are critical to the continuation of existing authority are not substantially modified by these standards. Thus, some state officials candidly admit that public institutions are frequently staffed by an occasional "thug" who can successfully resist termination notices by invoking antiquated and insensitive civil service protections. Similarly, certain mental health clinicians insist on maintaining unreviewable control over a resident "reward" system, where "good patients" (those who comply with the doctor's orders) must earn their fundamental constitutional rights to associate with their family and friends or to walk outside on a sunny day.

151. One example is the development of the informed consent requirement in the administration of psychotropic medication. *See supra* notes 27 & 64-65 and accompanying text. Another example is the development of a health caregiver's duty to prevent harm to third parties. *See supra* notes 95-105 and accompanying text.

152. *See, e.g.*, O'Sullivan v. Secretary of Human Servs., 402 Mass. 190, 521 N.E.2d 997 (1988) (restraint requires constant visual observation under amendment to state statute).

153. The admission of an incompetent person to a state hospital, based upon his signature

bility service system.[154]

Ultimately, the critical determinant of the success of this approach is whether judges and juries will conclude that the harm suffered by those with disabilities is really worth very much. Only when it becomes expensive to act unprofessionally or unconstitutionally will the negative consequences of damage actions inspire reform in the caretakers and systems which confine those with serious disabilities.

Attorneys must develop an understanding of the pain experienced by handicapped victims of harm in order to be effective in their presentation to juries, judges, and other decisionmakers of the value of that pain. They must themselves believe in the equality of the lives and limbs of their clients, regardless of the presence of a prior disability or the reality of preexisting limitations. They must appreciate the harshness of institutional confinement in order to identify the harms generated by the environment as well as by the gatekeepers. With this understanding and conviction, lawyers can successfully mold a damage action strategy to ensure adequate compensation for their victimized clients and perhaps even modify the conditions and systems which generated that harm.

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on a "voluntary" application form, was inherently coerced and therefore gives rise to a civil rights damage action. Zimeron v. Burch, 110 S. Ct. 975 (1990).

154. One thoughtful commentator has suggested that these are precisely the situations where reform is most likely and the enhancement of the quality of care most probable. Bonnie, *supra* note 14, at 234-35. Since the judicial establishment of standards of care will usually be communicated to practioners through normal training and educational methods, it is reasonable to assume that clinicians will thereafter conform their conduct to the new rules. While Bonnie postulates that the operative principle for this modification of practice is voluntary compliance and goodwill, rather than an interest in avoiding future liability, the outcome of systemic change is conceded.