CA 3 held (5-4) that an involuntarily
confined mental patient had a
"liberty interest" (substantive 4th right)
that prevented her being "shackled"
on confined except to meet a
"compelling state interest," & that
"least restrictive means" must
be used.

Also, as to "treatment," there
also is a 4th right, if & if once is
provided - State must justify by
compelling interest.

Reversal (on basis of tentative view?)

1. State acted as patient patron & in
exercise of police power (Resp in violent).

2. Resp is entitled to adequate
housing & decent care. But

State is not required to justify it
by a "compelling state interest," or
to show "least restrictive means."

3. Standard in that of Estelle v Gamble
liable only for "deliberate indifference"

Also could hold no Count Tort (no 1983 case)
when pure negligence in the conduct.
Compelling resume for the Machinist.

As usual, make sure that the Machinist was clearly mentioned in the resume.
Allahabad (Def. A C of P)  
CA 3 in case had decided the
"controlling" cont. rights.

The "traditional" D/P standard should be applied: whether the treatment is rationally related to Leg. state interest.

Although case has not been tried, record is adequate to determine correct standard.

Considered some "liberty interest."

CA 3 was wrong in saying there is a cont. right to "treatment."
But concedes a right to "care."

Distinguish bet. "medical care" & "psychiatric care". Concedes obligation to provide the former, but says the latter may blend into med. care.

"Habilization", as defined by CA 3, requires a treatment designed to enable a patient to attain his maximum capability.

Mentally retarded who are not dangerous to themselves or others normally are not admitted. People are dangerous to themselves when they can't, alone, feed, care for themselves.
Allahverde (cont.)

C.4.3 agreed the Court, unless no obligation on a State court to undertake any care of mental patients.

Tariqali (Rest)

Q whether in addition to "care" there is a Court right to "treatment."

Argue care should be allowed to go to graph.
This memo discusses several possible articulations of the substantive rights of the involuntarily committed to care and protection.

1. Negligence. (a). To establish a medical-malpractice claim in an action against a treating physician, a pltf must establish: (1) the existence of the physician's duty to the pltf, usually based on the MD-client relationship; (2) the applicable standard of care and its violation; (3) a compensable injury; and (4) a causal connection between the violation of the standard of care and the harm complained of.

The standard of care imposed generally by negligence law is not one of acting in good faith, but rather of acting as would a reasonable man in like circumstances. For doctors, this objective standard is measured by the acts of a reasonable doctor in similar circumstances. The prevailing statement of the professional standard is referred to as the "customary practice" formulation: a
doctor has a duty to use the degree of care and skill expected of a reasonably competent practitioner in same class (with the same specialty) and in the same or similar circumstances (which traditionally limits the comparison to MDs in the MD's geographic area). King, The Law of Medical Malpractice, at 37-44 (1977).

When the action is against the hospital, the negligence standard of care is articulated slightly differently. Private hospitals are not the guarantors of the safety or health of their patients. The duty imposed on private hospitals is a duty to exercise reasonable care in accordance with sound hospital practice to protect the health and safety of patients.

If doctors have a good-faith immunity, a substantive right to care under a negligence standard will not result in liability against a treating physician in the absence of a lack of good faith. And doctors in state institutions should have at least a good faith immunity. In past immunity decisions, the Court has refused to extend liability when it would interfere with the proper functioning of institutions. E.g., Imbler v. Pachtman, 424 U.S. 409, 426 (1976) (Powell, J.) (even qualified immunity for prosecutor would have adverse effect upon the functioning of the criminal justice system).

State institutions cannot be attractive places in which to work. If doctors are subject to personal liability on the basis of judgments and decisions made in good faith, it will be even harder for such institutions to attract and keep the competent professionals they need to provide patients with good care. A doctor should, therefore, be protected provided he has reasonable
grounds for believing that his action does not work a constitutional
(White, J.).

Provided that doctors have this "good faith defense," they
will be protected regardless of the substantive standard. Would
negligence then be the appropriate standard, applicable in actions
for injunctive relief or instances in which a doctor acts without
good faith? This would impose the "customary practice" standard on
treating physicians and would obligate state institutions to provide
reasonable care in accordance with sound hospital practice to ensure
the safety of patients. This standard is doubtless desirable. But
it would mean that states could only commit those they could care
for at the generally accepted level afforded by private
institutions. This would impose severe financial constraints on
states and would constitutionalize medical malpractice in state
institutions. The choice before a state would then be one of two
extremes: either provide no care and protection or provide a fairly
high level of care and protection. As a historical matter, the
Constitution certainly has not been regarded as imposing this choice
on states.

2. The standards applicable to prisoners. If the
involuntarily committed are only entitled to the substantive
standards afforded prisoners, their constitutional rights are not
violated if their treating physicians and the administrators of
their institutions are not deliberately indifferent to their
(medical treatment of prisoners). They would also have the right to conditions that are not equivalent to "serious deprivations of basic human needs"—conditions "cruel and unusual under the contemporary standard of decency." Scheuer v. Rhodes, 49 U.S.L.W. 4677, 4679 (1981) (Powell, J.).

The eighth amendment is not, however, the relevant limit on the ability of the state to subject the involuntarily committed to objectionable conditions. First, the state does not have the right to punish the involuntarily committed, and cannot, therefore, subject them to treatment or conditions as long as the conditions or treatment fall short of cruel and unusual punishment. Moreover, the state has committed these people to care and protect them. This is quite different from confinement to punish—confinement to care certainly suggests a higher substantive obligation on the state than that imposed after the state has afforded the procedures required prior to punishment.

In addition, the Estelle Court relied on the contemporary standard of decency manifest in modern legislation codifying the common-law view that "'it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of liberty, care for himself.'" 429 U.S., at 95-96. With the involuntarily committed, care should be given not just because the patients are unable to obtain it on their own due to their confinement, but because their very confinement—for care and treatment—is unjustified in the absence of that care and treatment. There is some force to the argument that, if a state cannot provide a reasonable level of care and protection, it should have to face
the political consequences of that inability, a pressure it will only feel if it is not allowed to confine the incompetent without such care.

3. Suggested standard. (a). General living conditions. Under *Bell v. Wolfish* (conditions of pre-trial detainees), at a minimum, the involuntarily confined are entitled to conditions reasonably related to their conditions of confinement, *i.e.*, because they are confined for care and protection, they should receive at least decent and adequate food, living conditions, and clothing.

(b). Protection and medical care. Because they are committed for protection, the involuntarily committed have the right to conditions designed to afford some degree of safety. On the other hand, the fact that the state has confined them to protect them cannot mean that the state is strictly liable for every injury sustained. Articulation of even a standard is difficult. The patient in the private institution would have the right to the exercise of reasonable care in protecting the safety of patients by the hospital administration. As a minimum, under the "reasonably related" standard of *Jackson v. Indiana*, the involuntarily committed are entitled to conditions that can reasonably be expected to provide enough safety to justify commitment.

Similarly, because they are committed for care, the involuntarily committed have the right to medical care and attention, at least sufficient to justify their committal.
Is it possible to articulate the level of protection and of medical care and attention which, together with decent living conditions, would justify commitment to care and protect? In my bench memo, I suggested that it is at the point at which the authorities are "deliberately indifferent" to the needs of the involuntarily committed that the state is not providing conditions reasonably related to the purposes of confinement.

That standard may be too low. The "deliberate" part of deliberate indifference certainly suggests more than mere indifference--it suggests a studied, intentional, and cruel attitude. This is borne out by the examples of deliberate indifference given by the Estelle Court:

"See, e.g., Williams v. Vincent, 508 F. ed 541 (CA2 1974) (doctor's choosing the 'easier and less efficacious treatment' of throwing away the prisoner's ear and stitching the stump may be attributable to 'deliberate indifference ... rather than an exercise of professional judgment'); Thomas v. Pate, 493 F. 2d 151, 158 (CA7), cert. denied sub nom. Thomas v. Cannon, 419 U.S. 879 (1974) (injection of penicillin with knowledge that prisoner was allergic, and refusal of doctor to treat allergic reaction); Jones v. Lockhart, 484 F. 2d 1192 (CA8 1973) (refusal of paramedic to provide treatment); Martinex v. Mancusi, 443 F. 2d 921 (CA2 1970) (prison physician refuses to administer the prescribed pain killer and renders leg surgery unsuccessful by requiring prisoner to to stand despite contrary instructions of surgeon)."

Thus, by deliberate indifference (sufficient to be cruel and unusual punishment), the Court meant a rather extreme indifference to unnecessary pain by a doctor or the intentional denial or delay of access to medical care by others.

But if the doctors and supervisors in a state institution are simply indifferent to the medical needs and safety of their patients, has not the state failed to provide conditions reasonably
related to the care and protection for which they confined the individuals? This standard would be at least somewhat lower than the *Estelle* standard, because mere indifferent indifference—rather than the higher standard of deliberate indifference (with its overtones of intentional infliction of unnecessary pain) would violate the constitutional rights of the involuntarily committed. Another formulation might be that doctors are indifferent when they fail to make any attempt to provide decent conditions or care to residents of state institutions.

This standard would be far from the negligence standard. The question would not be, what treatment or conditions would be customary in a private hospital or in treatment from a private physician. Instead, the question would be whether those the state has employed to care for and protect the involuntarily committed have made at least a reasonable effort to do so.
Youngberg v. Romeo
Conf. 1/13/82

The Chief Justice

Panel: see Revised & Remand
(Did not vote until after
rehearing of both cases - at length)

Agreed generally with Selby’s
standard

We discussed 80-1417 (Medlin) & these cases
together - a common theme discussion over
my objection, difficult to know which case
one was talking about. My notes are not
readily usable to state what we think

Justice Brennan

Vaccate Remand?
Here we deal only with patients convicted of be-
wholly incapable of making decisions.
CA’s went too fast. Even counsel conceded CA’s were
not valid must not be accepted.
Would hold that “basic care” in all that is
necessary. (WJB did not define “basic care”)

Whether shackles are needed, should be left
to med. staff.
(WJB seems to be somewhat
between Adams & Selby)

Justice White

Vaccate & remand

Agree with Selby

(BRW left during the discussion)
Justice Marshall
Rev & Remand

After argument, TM agreed
with GPS & remanded to Roe

Justice Blackmun
Vacate & Remand.

The standard applied by CA 3 is
wrong.
There should be "flexible" review in
medical cases—higher than rational
but less than compelling.

Justice Powell
Vacate & Remand (protolly affirm judgment
as remanded for trial in proba
agree generally with Secby
Justice Rehnquist

(As went way to far.)

Justice Stevens

Agree generally with J. SCOTUS.
The 14th Amendment speaks of "deprivation" of liberty. This does not require highest level of care. Established the minimum need for decent care.
"Deliberate indifference" standard in 8th Amendment.
Standard in civil cases.
This is min. care about as tolerated by SCOTUS.

Justice O'Connor

Vote to Remand for trial on correct standards.
Med. jurisprudence should control.
As to declaring a Court of right of treatment, we should not include a Court of right to any particular level.
"Scribbery" for better than Adams.
January 13, 1982

MEMORANDUM TO THE CONFERENCE:

Re: No. 80-1429 - Youngberg v. Romeo

The above could well have been set back-to-back with No. 80-1417, Mills v. Rogers. Since I overlooked that the next best thing is to discuss them together. (Each involves a good bit of "insanity"!)

Accordingly, I suggest discussion of Youngberg be laid over until Friday's conference.

Regards,
MEMORANDUM

TO: Mary DATE: Feb. 22, 1982
FROM: Lewis F. Powell, Jr.

80-1429 Youngberg v. Romeo

This memorandum, dictated at home on Sunday, reflects my initial reaction to your draft of Feb. 19. I should say that I am quite "cold" on the case, and on the eve of two weeks of argument I will have no opportunity to go back to the briefs or even to your fine bench memo. Thus, for the most part my comments are suggestive and inquisitive, rather than definitive.

My general impression is that the draft is quite a bit too long. In a case of this kind where there is no real guidance in our cases, and subjective judgments will be made by all of us, the less we write the more likely we are - in all probability - to obtain a Court.

I now comment briefly on the various parts of the draft.

Part I (p. 1-12)

This is an excellent statement of the case.

Part II (p. 12-24)

Subpart A (p. 13-18). The draft finds a liberty interest continues following commitment, makes clear that this is substantive rather than procedural, but reasons that
the *Matthews v. Eldridge* factors also apply for purpose of analysis. (13-17) Subject to some editing that I have undertaken, I think to this point, the draft is on target.

In stating, in accord with the *Matthews* formula, respondent's interests in the first full paragraph on page 17, I would think it desirable to state them in terms of respondent's three claims (see p. 10 of your draft). As now framed, this takes no account specifically of the claimed rights to be free of physician constraints or the right to safety and protection.

Subpart B (p. 19-24). My impression of these five pages in particular is that they are a bit discursive, and are not as sharply focused on the precise claims as may be desirable.

Would it make sense, Mary, to eliminate subpart B, and restructure Part III by identifying and addressing in order respondent's claims (i) to be free from physical restraint, (ii) to protection and safety, and (iii) to treatment. After all, these are the interests claimed in this case, and those that must be weighed against the state interests.

There does not now seem to be a logical flow from page 19 to the end of the draft. If we structure this around respondent's three claims, there would be a logical flow. Also, the draft could be substantially shortened.
I note, for example, that in Part III the draft returns - at least it seems to me - to what already has been said about the presence of a substantive due process claim and its distinction from procedural due process (see pp. 28-30).

It is clear that the state owes respondent a duty to take reasonable measures to protect him from violence by other patients. The state owes a duty to other patients to protect them from respondent's violence, and also to protect respondent himself from his own self mutilation. Thus, reasonable shackling - on the basis of this record - is necessary at times.

Medical care and treatment are quite different kinds of duties. I suppose care (other than medical care) could be defined or identified as suggested on p. 24, to mean food, shelter, clothing and reasonable safety. The state's conceives these duties. In view of respondent's specific allegations, and his profound handicap, special safety measures - in addition to those generally applicable - probably are required. I would address "safety" biefly as separate from the conceded duty to provide food, shelter and clothing.

The most difficult question is what level of medical care and treatment is required. Here, I think we are generally agreed that the substance of Chief
Seitz's formulation is about right. Perhaps you can frame it more felicitously. (Any help here from amici briefs?)

Part IV (p. 32-33)

I understand that you have not concluded your draft of this part. My recollection is that Judge Seitz, and the judges who agreed with him, would remand this case for retrial under proper instructions with respect to the applicable standards. I believe Seitz also agreed with the majority that on a retrial the testimony of respondent's experts should be admitted. Perhaps the best things for us to do with respect to this is simply to say in a footnote that we have no reason to disagree with the view that such testimony should be admitted.

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I am aware, Mary, that restructuring the opinion as above suggested will require substantial rewriting. I emphasize that there is no time pressure whatever. It may be a good idea before you undertake changes in the organization of the opinion, to have David read the draft simply to have the benefit of his advice as to how to organize it. I may not have made the best suggestions.

This is not an easy case, and yet it is quite an important one. So take your time.

L.F.P., Jr.
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L.F.P., Jr.
MEMORANDUM

TO: Mary  DATE: March 26, 1982
FROM: Lewis F. Powell, Jr.

80-1429 Youngberg v. Romeo

Your revised draft of 3/24 is quite good and I congratulate you on putting together so well the "humpty dumpty" that I handed you a few days ago.

I have indicated on the left margin pages on which I have made an occasional "fly specking" editing change.

The only substantive point that still concerns me is our reliance on the Matthews v. Eldridge formula. In thinking further about this, I am not sure that it is useful. Of its three factors, the one that often is decisive in a procedural due process case concerns the "risk of error". This factor is not specifically involved in a substantive due process case. I have dictated a very rough alternative that would substitute for portions of pages 13-15. I suggest that you discuss with David whether my concern about reliance on Matthews is well founded, and whether something along the lines of my rider is preferable. Of course, you will have to edit and clarify my rough draft. I omitted Parham altogether, and perhaps this should be included.
It is still also desirable to add a footnote indicating in a general way what we mean by "professionals". We can be reasonably certain that the average state mental institution is understaffed with genuine professionals. Rather, they use employees that a hospital like George Washington would characterize as "orderlies", or "interns" - sometimes people who have had no formal training. Yet, some people with practical experience are very good indeed. Try a draft of a rather broad definition to be added as a footnote, making clear that the term "professional" is not limited to graduate M.D.'s in medicine, psychiatry, or even physical therapy.

Subject to the foregoing, I think you have a fine draft. Let's have your editor review it and then move it to a printed Chambers draft promptly. I would like, if it seems reasonable, to circulate both your case and Mills before the Chief Justice makes assignments for the March arguments. This would mean circulating by April 2.

I have mentioned to Dick the importance of Mills and Romeo being entirely consistent, both in substance and terminology. In addition to David, you and Dick should collaborate.

L.F.H., Sr.

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ss

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