Chapter 20: Food and Drug, Health, and Welfare Law

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CHAPTER 20

Food and Drug, Health, and Welfare Law

WILLIAM J. CURRAN and ROBERT H. HAMLIN, M.D.

A. FOOD AND DRUG LAW

§20.1. Shellfish areas: Emergency determinations of contamination. The laws on control of shellfish digging areas continue to be amended each year. Nothing has as yet been done about resolving the conflict of jurisdiction between the Departments of Public Health and Conservation, but the changes are making cooperation between the Departments more effective. This year, legislation\(^1\) enables the Department of Public Health to act immediately in an "emergency" as determined by the Department to declare an area contaminated, with shellfish digging prohibited therein. The designation of such an area must be reported immediately to the Department of Conservation's Division of Marine Fisheries and its Division of Law Enforcement for the necessary action to enforce the determination.

§20.2. Proposal for a sanitary code. There has been, in the past, much discussion of a uniform sanitary code to be enacted either as a state statute or by state Health Department regulation. Such codes are in operation in a number of states. During the 1956 legislative session, the Legislative Research Council was ordered \(^1\) to conduct an investigation and study as to the advisability of establishing such a code. The Council is to report its findings to the 1957 General Court. Considering the notable success which has been achieved after similar references to the Council in the few years of the Council's existence, this development will be watched with interest.

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\(^1\) Acts of 1956, c. 288.

\(^1\) House No. 2858 (1956).
B. Public Welfare

§20.3. Revision of the welfare laws. The comprehensive revision of the public welfare laws has formerly been under study in a special legislative commission. During the 1956 legislative session this study was taken from the hands of the commission, the commission was dissolved, and the task was given over to the Legislative Research Council. As was indicated in the previous section, such a reference has in the past produced good results. With the failure of efforts to obtain a general revision of the General Laws, these piecemeal revisions seem the only means of comprehensive improvements in the state statutes.

§20.4. Old Age Assistance: Extension of benefits. The 1956 legislation broadens the Old Age Assistance laws to make aliens eligible if they have been residents of the United States for twenty years or more and residents of Massachusetts for three years during the nine years preceding the date of their application for assistance and continuously for one year in the three years immediately preceding such application. The alien then must meet all other normal eligibility requirements, of course.

Legislation also allows assistance benefits for chiropody treatment after consultation, confirmed in writing, by the recipient’s attending physician.

The real estate lien law in regard to Old Age Assistance recipients has been subject to much re-examination and litigation. In 1956, the General Court authorized an exemption from a sale of real estate by the recipient during his lifetime of "the amount allowable to be possessed by the recipient" ($500 for a single person, and $1000 for a husband and wife).

§20.5. Nursing homes: Minimum rates for assistance. In 1953, the legislature consolidated hospital per diem rate-setting for all state agency medical care programs in the Commission on Administration and Finance. During the 1956 Survey year, the legislature took the logical step of consolidating the rate-setting for care programs in nursing homes in the same agency. Chapter 696 of the Acts of 1956 thus adds a new Section 30L to Chapter 7 of the General Laws to accomplish this purpose. The Director of Hospital Costs and Finances established under the 1953 legislation is thus required, after a hearing, to set minimum per diem rates at least annually for all state payments to nursing and convalescent homes.

§20.3. 1 Resolves of 1954, c. 21.
2 House No. 3024 (1956).

§20.4. 1 Acts of 1956, c. 653.
2 Id., c. 721.
3 Id., c. 637.

§20.5. 1 G.L., c. 7, §30K.
C. Public Health

§20.6. Rehabilitation Commission. In accord with the recommendations of Governor Herter in his annual message, the General Court has enacted a sweeping revision and reorganization of the state’s widespread program for vocational rehabilitation.1

Formerly, the programs in this area were spread among many, and often competing, agencies. Under the new legislation a Massachusetts Rehabilitation Commission has been established. It will serve directly under the Governor and Council and will not be a part of any of the state’s constitutional departments. Administratively, it will be composed of a commissioner appointed by the Governor and Council and an eleven-member advisory council. The council will consist of six ex officio members (the Commissioners of Public Welfare, Public Health, Education, and Mental Health, the Director of Employment Security, and the Chairman of the Industrial Accident Board, or their representatives) and five persons appointed by the Governor.

The Commissioner is given “sole charge with the advice of the advisory council of the supervision and administration of the commission and of the vocational rehabilitation of all handicapped persons except the blind.”2 The Commissioner is given authority to prescribe regulations and to set up divisions within the Commission with administrative directors.

The new Commission entirely replaces the former State Board of Vocational Education and the Division of Rehabilitation in the Department of Education.3 The legislation also creates a new Industrial Accident Rehabilitation Board which will operate in, but not subject to the control of, the Division of Industrial Accidents in the Department of Labor and Industries.4 The membership of the new board is as follows: the Commissioner of Rehabilitation, the Chairman of the Industrial Accident Board, or their representatives, and five gubernatorial appointees, of whom one must be a physician, one an employee, one an engineer, one a representative of a casualty insurance company, and one a person who has undergone a rehabilitation training program.

Basically, the new Commission will attempt to coordinate present activities of the state government in the field of vocational rehabilitation and to administer federal grant-in-aid funds coming into the state in these areas; and, slowly, it will begin to establish its own operational program, including the maintenance of facilities for rehabilitation training. It is too early to evaluate the reorganization, but at least it can be said that the new structure gives promise of being an improvement over the former sprawling and uncoordinated programs in the field.

² Id., c. 602, §2, inserted as G.L., c. 6, §75.
⁴ Id. §5, inserted as G.L., c. 23, §24.
§20.7 Alcoholism: Procedural changes and a new agency. The interest of the legislature in the problem of alcoholism continues in evidence with the establishment ¹ of a new official position to be known as the Commissioner on Alcoholism. He is to be appointed by the Governor and Council and is to serve directly under the Governor. The legislation also creates an advisory council of twelve members. On the Council are eight ex officio members, the Commissioners of Public Welfare, Public Health, Public Safety, Mental Health, Correction, and Probation, the Chairman of the Parole Board, and the Registrar of Motor Vehicles, or their representatives, plus three appointees of the Governor and Council.

The legislation is otherwise very ambitious, but rather indefinite. The Commissioner is authorized to "coordinate" work of the various agencies working in this field, "make a continuous study of methods of treating alcoholism," and "prepare, in cooperation with the department of education, materials for use in the schools" relative to problems of alcoholism. He is authorized to operate facilities for the study and treatment of alcoholism.

The current operations of the Division of Alcoholism in the Department of Public Health do not seem to be affected by the new legislation except that it is now required to act "in cooperation" with the new Commissioner on Alcoholism "for the promotion of a preventive and educational program" relating to problems of alcoholism.

The remainder of the new legislation relates to the facilities for care and treatment of alcoholics. General Laws, c. 123, §62 is amended ² to allow commitment to any state mental institution designated by the Commissioner of Mental Health. Formerly, commitments were made only to penal institutions or to private institutions. General Laws, c. 123, §80, the provision for fifteen-day temporary care of alcoholics, is also amended to include the state mental hospitals designated under Section 62 and Lemuel Shattuck Hospital and any other state Public Health Department hospital designated by the Commissioner of that Department. Some adverse opinion has been expressed regarding the opening of these facilities to alcoholics. It remains to be seen how these facilities will be used to advantage for the care of such patients.

The legislation also establishes a treatment clinic at the penal institution at Bridgewater and provides that all persons convicted in the criminal courts of drunkenness be committed to this institution.

On the whole, the legislation may prove beneficial in attacking the perplexing problem of alcoholism. One hesitates, however, to commend the creation of another new and independent agency to act in the field. It was on the recommendation of the state's "Baby Hoover" Commission ³ that the former independent Commission on Alcoholism

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¹ Acts of 1956, c. 715.
² Id., c. 715, §10.
was abolished in 1954 and its personnel transferred to the Department of Public Health. It was thought at the time that the Department could conduct the program more effectively and more efficiently and that the need for a special agency was not evident. It has been difficult to discover, in the few years which have elapsed since the report of the "Baby Hoover" Commission, any change in the conditions warranting the Commission's conclusions.

§20.8. Hospitalization of recalcitrant tuberculosis patients. For some years, since tuberculosis has ceased to be a number one disease killer, public health authorities have been more conscious of an underlying social problem: the uncooperative tuberculosis patient, the patient who refuses to accept necessary medical care and to follow medical advice, or who refuses hospitalization. After some years of failure in obtaining remedial legislation, the health authorities, with the cooperation of private groups working in the field, have succeeded in getting legislation in this area in 1956. Under Acts of 1956, c. 615, the General Court has authorized the compulsory hospitalization of a person with "active tuberculosis" if the person is unwilling or unable to accept "proper medical advice" and is thereby a serious danger to the public health.

The hospitalization of such a person may be initiated by a certification to this effect by a municipal board of health or any member thereof, or by two licensed physicians. The certification must also be approved by the State Commissioner of Public Health or his representative (probably, by the District Health Officers). The Commissioner or his representative, if he approves of the certification and concurs in it, must then petition the District Court to commit the person to the State Tuberculosis Treatment Center established under the legislation. A hearing is then held in the court at which the person may appear and protest the commitment.

The legislation also provides for an emergency commitment for a fifteen-day period prior to a court hearing if the Commissioner or his representative finds after examination of the person that immediate hospitalization is necessary to protect the public health.

The new law also provides for the problem of a patient already hospitalized who attempts to leave the institution against medical advice. Authorization is made to detain the person, or to transfer him to the State Tuberculosis Treatment Center pending a court hearing on his commitment.


2 The legislation authorizes the Department of Public Health, by regulation, to further define this term and to specify the methods for determining the presence of the disease. Acts of 1956, c. 615, inserted as G.L., c. 111, §94H.

3 The Department is also authorized to determine, by regulation, the minimum standards for proper medical care outside an institution. Acts of 1956, c. 615, inserted as G.L., c. 111, §94H.
§20.11 FOOD AND DRUG, HEALTH, AND WELFARE LAW

The state assumes all financial responsibility for patients hospitalized at the new state treatment center. No commitments can be made under the new law until the Commissioner has determined that the center, probably at Rutland Sanatorium, is ready to receive patients. The General Court appropriated $10,000 for the establishment of the center. The Department had requested $30,000 as a minimum amount necessary to establish the center with the necessary security safeguards.

§20.9. Noxious or offensive trades: Public hearings. An amendment to G.L., c. 111, §143 has been adopted by the 1956 legislature to require a public hearing in regard to the assignment of locations within municipalities where trades may be established otherwise found to be nuisances or noxious or offensive to the public health. This hearing is to be held by the board of health of the town, and any person aggrieved by the decision may, within sixty days, appeal to the state Health Department. The Department may, after a hearing, rescind, modify, or amend the decision of the board.

§20.10. Massachusetts Hospital School: Transfer to the Department of Public Health. After a number of years of effort in the legislature, the Massachusetts Hospital School, which gives rehabilitation and schooling to crippled children of school age (kindergarten to age twenty-one) who are mentally normal, has been transferred from the supervision of the Department of Public Welfare to the Department of Public Health.

The change is a quite logical one and will facilitate more effective cooperation between the Hospital School and the other programs of the Health Department. The functions and powers of the Hospital School's Board of Trustees will continue unchanged by the new legislation.

D. MENTAL HEALTH

§20.11. Commitment procedures. After the comprehensive changes in the commitment laws enacted last year and examined in the 1955 ANNUAL SURVEY, some additional changes, mainly declaratory, were made in 1956.

Under the new procedures, notice of a right to a hearing on an involuntary commitment under G.L., c. 123, §51 must be mailed to the

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4 Acts of 1956, c. 615, inserted as G.L., c. 111, §94E.
§20.9. 1 Acts of 1956, c. 275.
§20.11. 1 Acts of 1955, c. 637.
A person's nearest relative or guardian. The 1956 legislation amends this provision to make it clear that this requirement is fulfilled through a mailing to the last known address of the relative or guardian. The same section is also amended to make it clear that the hearing requirement does not apply to commitments from the criminal courts.

An amendment is also made in Section 77 of the same chapter to make it clear that the superintendent may allow a patient who is admitted on observation for forty days to remain beyond that period as a voluntary patient. There had been some doubt whether this could be done, since the only alternative to discharge specifically mentioned in the 1955 legislation was an application for prolonged judicial commitment. General Laws, c. 123, §79 was also amended to allow a superintendent to detain a patient beyond the ten-day temporary period pending determination of an application for prolonged judicial commitment.

Section 100 of the same chapter was also amended to give authority to a criminal court to commit any "child between seven and seventeen years of age complained of as a delinquent or wayward child" to a mental hospital if the child is found, either before trial or after sentence, to be mentally ill. The court is also given authority to commit the child for observation to determine his mental condition.

§20.12. Adjudication of sanity: Petition by a "friend." It is many years since any of our state mental hospitals have been known as "insane asylums." Today these institutions are hospitals, very much overcrowded, where mentally ill persons are cared for and treated. The hospitals are not heavily guarded prisons. Patients are discharged administratively from these hospitals daily, and the hospital superintendents would like to be able to discharge more of their patients. However, on our statute books certain laws are necessarily maintained to protect these patients from the possibility of abuse of their civil rights. Under G.L., c. 123, §94A, "any person adjudicated by any court to be an insane person" may petition a court "for adjudication of his or her sanity." The petition may also be made by "any parent, guardian, conservator, relative or friend of such person." The court, after a hearing, if it finds the person sane, may discharge him from custody.

This section is used very infrequently. First of all, most discharges are made, as indicated above, quite readily by the hospital if the person is sufficiently recovered to be released. Secondly, there are many other readily available discharge provisions, as well as habeas corpus, which are more apt to be used than Section 94A. Section 94A is not used largely because of the reluctance of the petitioners to "adjudicate sanity." Many committed persons are still competent to conduct some of their affairs and are not legally incompetent. Should

4 Id. §2.
5 Id. §4.
6 Id. §5.
7 Id. §7.
they lose such an adjudication, it might involve their loss of these powers. Many persons, citing the above reasons, have advocated that Section 94A be repealed.

In *Myrick v. Superintendent of Worcester State Hospital*¹ the Court had before it the petition of Lockwood Myrick filed under Section 94A as “friend” of a patient in the Worcester State Hospital. Ancillary to the petition, Myrick had requested the right to visit the patient at the hospital. He had been refused visiting rights by the hospital superintendent. The probate judge upheld this refusal, finding that Myrick was not a friend of the patient, and that the sister of the patient, on behalf of herself and her mother, had instructed the hospital not to allow Myrick to visit the patient because he confused and upset the patient. The judge concluded that it was in the best interests of the patient to refuse the permission to visit.

The Supreme Judicial Court held that the probate judge's finding made as a matter of law that Myrick could not visit the patient was erroneous. Justice Counihan, for the Court, asserted that the right to visit the patient was necessary to a proper investigation of the facts by the petitioning “friend” of the patient. Justice Counihan went on to find the error harmless, however, since it was within the probate judge's discretion to refuse the visits on the grounds that it would not be in the best interest of the patient.

The Court also found that the judge's ruling of law that Myrick was not a “friend” of the patient was erroneous. The Court asserted the petitioner need not be a “close personal friend,” but need only be “a person having the interests” of the patient “in mind,” or that he act “for the benefit” of the patient.²

The decision was one of first impression on this point. None of the supporting authorities for the decision involved a situation of this type. In cases where a “next friend” is allowed to bring a petition, it can be asserted that the proceedings can only “benefit” the petitioner and not hurt him. Here, on the other hand, the petitioner was acting in a situation where the proceedings might well actually cause harm to the patient, because of the traumatic experience of a trial. The failure of the petition might result in his adjudication as an “insane person” and loss of competency. In view of these conditions, the petition to force such an “adjudication” under Section 94A might be given greater scrutiny than is suggested in this decision.

¹ 1956 Mass. Adv. Sh. 465, 133 N.E.2d 487. The petitioner argued the case before the courts, including the Supreme Judicial Court, pro se.