The Right To Refuse Medical Treatment or To Direct the Course of Medical Treatment: Where Should Inmate Autonomy Begin and End?

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."¹

I. INTRODUCTION

The phrase "inmate autonomy" may seem strange at first. Individuals who are subject to criminal confinement are by definition not free to make choices for themselves. Yet some decisions are so fundamental and important to human existence that even an inmate is, or should be, allowed some degree of personal autonomy. Determining the medical treatment an individual should receive is one such decision. This Note will review which health care decisions an inmate is currently allowed to make for himself and which health care decisions are made for him. Then it will discuss the problems associated with allowing an inmate more control over these decisions.

There are many complicated issues that must be considered when examining this topic. The state and federal prison systems must first and foremost be concerned with maintaining order within prisons and carrying out the basic goals of a prison, whether they are aimed at deterrence,

¹. Schloendorf v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.). The full quote from the opinion authored by Benjamin Cardozo reads:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained. Id. (citations omitted). Although overruled on other grounds, this quote by Justice Cardozo is a basic statement about informed consent that is still valid today. See Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269 (1990); In re K.L., 806 N.E.2d 480, 484 (N.Y. 2004).
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retribution, or rehabilitation. However, after assuming full responsibility for the lives of these prisoners, providing adequate health care is a necessary and expensive undertaking. The expenses incurred by the state and federal prison systems are an important part of any discussion about prisons, but it is especially important when health care is involved. Health care costs are a huge issue for all prison systems and will become an increasingly large issue as health care costs continue to rise for society in general. An enormous amount of money is spent on prisoners—individuals who are being punished by society for their antisocial behavior. When the state is paying the full cost of inmate health care, there is a danger that the costs involved will affect treatment decisions and that all considerations of patient autonomy related to health care will be overlooked. This Note seeks to clarify these issues and recommend an approach that will assist state and federal prison systems in dealing with the competing concerns of providing inmates with adequate health care, finding a way for prison systems to deal with rising health care costs, and

2. See Overton v. Bazzetta, 539 U.S. 126, 133 (2003) (stating that security in the prison setting is “perhaps the most legitimate of penological goals”); Ewing v. California, 538 U.S. 11, 25 (2003) (“A sentence can have a variety of justifications, such as incapacitation, deterrence, retribution, or rehabilitation.”).

3. City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 245 (1983) (“If . . . [a] governmental entity can obtain the medical care needed for a detainee only by paying for it, then it must pay.”); Richard Siever, Note, HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System, 58 VAND. L. REV. 1365, 1378 (2005) (“This fiscal dilemma within the country’s prison system results from a combination of the high cost of health care, diminishing governmental budgets, reluctant prison administrations in allocating meager funds to medical services, and increasing taxpayer frustration with the government’s willingness to spend tax dollars on criminals.”).

4. Siever, supra note 3, at 1378; NATIONAL COALITION ON HEALTH CARE, FACTS ON HEALTH CARE COSTS 1 (2009), http://www.nchc.org/documents/Cost%20Fact%20Sheet-2009.pdf (“In 2008, total national health expenditures were expected to rise 6.9 percent—two times the rate of inflation. Total spending was $2.4 TRILLION in 2007.”).


6. John V. Jacobi, Prison Health, Public Health: Obligations and Opportunities, 31 AM. J.L. & MED. 447, 457 (2005) (“Decent prison treatment, including health care, is costly. As prisoners are out of view and frequently outside the public consciousness, the default position of governments funding prisons is likely to tend toward less, and less humane, treatment.”).
increasing inmate autonomy in health care decisions.

Section II of this Note discusses instances where an inmate can control his medical treatment and instances in which he cannot. Section III discusses the related topic of the physician-patient relationship in the prison setting and how it is necessarily different than the physician-patient relationship in the rest of society. Section IV discusses the attempts of prison systems across the country to deal with the rising costs of health care by requiring inmates to make a financial contribution to their medical treatment. Section V concludes this Note by advocating for the continuation and escalation of the trend of requiring prisoner co-payments for health care, but also for an accompanying increase in an inmate’s ability to control the course of his medical treatment.

II. INMATE AUTONOMY IN HEALTH CARE DECISIONS AND THE ABILITY TO CONTROL MEDICAL TREATMENT

What health care decisions are currently within an inmate’s control? Case law has created a situation in which inmates may completely refuse medical treatment in some situations, but in others they may lack any ability to make decisions about their medical treatment. Inmates should be able to refuse medical treatment just as any other individual in the rest of society can. However, there are several ways that a prisoner’s right to control his own body can be denied. For instance, inmates are not allowed to refuse medication if it is decided that they may pose a danger to themselves or to others. It is also reasonably well established that a prisoner is not allowed to go on a hunger strike in an attempt to commit suicide; thus, courts have ordered that inmates be fed against their will with a feeding tube to prevent their deaths. Most states will also take action to intervene with any hunger strike, regardless of the reason behind it, should the situation become life-threatening. Other states force any type of medical treatment on prisoners. These decisions have been justified by balancing the personal autonomy of the inmate with state interests arising from the special circumstances that face prison administrators, such as

10. See id. at 152.
maintaining order.12

A. Informed Consent and the Right To Refuse Medical Treatment in Prisons: The Beginning of an Inmate’s Autonomy

The doctrine of informed consent is the standard that was developed by the law to protect an individual’s interest in the integrity of his own body.13 It is also at the heart of the physician-patient relationship. Informed consent ensures that the patient “has both knowledge and comprehension, that consent is freely given without duress or undue influence, and that the right of withdrawal at any time is clearly communicated.”14 A person can therefore be advised of a proposed medical treatment and decide not to listen to the physician’s advice; the physician is complying with the standards required by medical ethics, but the final decision is reserved for the patient, ensuring personal autonomy in health care decisions.15 It has been said that “the patient’s right to an informed consent makes no sense without a right to an informed refusal.”16

The ability of an inmate to refuse medical treatment is a much more complicated matter. The United States Supreme Court has decided prisons have a responsibility to provide medical care for inmates under the Eighth Amendment of the Constitution.17 Failing to provide adequate health care is considered cruel and unusual punishment and is therefore a violation of

14. STEDMAN’S MEDICAL DICTIONARY 898 (27th ed. 2000). Stedman’s defines informed consent as:

Voluntary consent given by a person or a responsible proxy (e.g., a parent) for participation in a study, immunization program, treatment regimen, invasive procedure, etc., after being informed of the purpose, methods, procedures, benefits, and risks. The essential criteria of [informed consent] are that the subject has both knowledge and comprehension, that consent is freely given without duress or undue influence, and that the right of withdrawal at any time is clearly communicated to the subject.

Id.

15. Thor v. Superior Court, 855 P.2d 375, 380 (Cal. 1993). The court stated:

While the physician has the professional and ethical responsibility to provide the medical evaluation upon which informed consent is predicated, the patient still retains the sole prerogative to make the subjective treatment decision based upon an understanding of the circumstances. Accordingly, the right to refuse medical treatment is equally “basic and fundamental” and integral to the concept of informed consent.

Id.

the Eighth Amendment. The Court has also decided that inmates have a due process right to refuse medical treatment because the right to self-determination is too important to be denied, even for prisoners.

The forced feeding of inmates on hunger strikes has led to a considerable amount of jurisprudence on the issue of the refusal of medical treatment in the prison setting. Three states have allowed inmates to refuse medical treatment—thereby permitting a hunger strike to proceed—based on a test balancing the inmates’ interests and the interests of the prison in maintaining order. In Zant v. Prevatte, the Supreme Court of Georgia decided there was no compelling interest sufficient to override an inmate’s right to refuse unwanted medical treatment. When he was on a hunger strike to protest the Department of Corrections’ refusal to transfer him to another state prison, Prevatte was found to be sane, rational, and normal, and his refusal to eat was not part of any religious practice. He claimed to be in danger while in the Georgia prison system because other inmates threatened his life. After he stopped eating, prison doctors monitored him for almost a month until Prevatte refused to even be examined. When the trial court took the case, Prevatte was within weeks of dying if he did not eat. Prevatte argued that “he had the right to control his own body; ... his right to express himself through his hunger strike is of constitutional proportions and that it would be a violation of those rights” if he was forced to eat. The state argued that the prison had a compelling state interest in protecting the lives of inmates and, therefore, forced feeding should be allowed. The Court ruled that “Prevatte, by

18. See id.
19. Washington v. Harper, 494 U.S. 210, 221-22 (1990) (“We have no doubt that, in addition to the liberty interest created by the State’s Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”); see Thor, 855 P.2d at 378-79.
21. Thor, 855 P.2d at 379, 388; Singletary, 665 So.2d at 1101, 1110; Zant, 286 S.E.2d at 716-17.
22. Zant, 286 S.E.2d at 717.
23. Id. at 716.
24. Id.
25. Id. at 717.
26. Id. at 716.
27. Id.
28. Id.
29. Id.
30. Id.
virtue of his right of privacy, can refuse to allow intrusions on his person, even though calculated to preserve his life." Thus, Prevatte was allowed to refuse the examinations by prison doctors and remain on his hunger strike.

In a major decision on this issue, the Supreme Court of California decided *Thor v. Superior Court*, in which an inmate named Howard Andrews refused medical treatment and was in danger of dying as a result. While serving a life sentence in a California prison, Andrews fell or jumped from a wall and fractured a cervical vertebra, rendering him a quadriplegic in 1991. He was confined to a wheelchair and dependent on medical staff for assistance with all bodily functions, although Andrews's cooperation was necessary. While continuing to serve his sentence at the California Medical Facility at Vacaville, he refused to eat, refused his medication, and refused medical treatment in general. When examined by prison physicians, he was found to be depressed but competent to make decisions for himself. His physician, Dr. Thor, asked the court for permission to insert a feeding tube and to medicate Andrews despite his refusal to consent to these procedures. The Court's analysis noted that the common law recognized that medical treatment without consent constituted a battery and that its decision was based on "the long-standing importance in our Anglo-American legal tradition of personal autonomy and the right of self-determination." The decision stated:

In refusing to consent to further treatment, Andrews is exercising his fundamental right of self-determination in medical decisions. Petitioner has offered no evidence that allowing him to do so undermines prison integrity or endangers the public. Thus, considering the magnitude of the right at issue... we hold that petitioner must accede to Andrews' decision and may not force him to accept unwanted treatment or care.

In *Singletary v. Costello*, the Court of Appeals of Florida considered a similar situation when inmate Costello, sentenced to life imprisonment, initiated a hunger strike to protest his punitive transfer to another facility resulting from what he believed were false accusations in a disciplinary

31. *Id.* at 717.
32. *Id.*
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.*
39. *Id.* at 380-81.
40. *Id.* at 388.
report filed by another person.\textsuperscript{41} When prison officials attempted to force feed him, Costello went to court to get a temporary injunction to prevent the interruption of his hunger strike.\textsuperscript{42} The court’s analysis began by acknowledging that the general public has a right to refuse unwanted medical treatment.\textsuperscript{43} While inmates are necessarily stripped of some of their rights because of their criminal confinement,\textsuperscript{44} the right to refuse medical treatment is not one of those rights; inmates retain all rights that a citizen has except those that are expressly taken away.\textsuperscript{45} After balancing the interests of the state with those of Costello, the court held that both the United States and Florida Constitutions protected Costello’s right to refuse treatment.\textsuperscript{46}

In each of the cases above, the inmate was found to be sane and competent to make his own decisions.\textsuperscript{47} Especially in Singletary, the court made a distinction between initiating a hunger strike as a form of protest and initiating a hunger strike as a means of committing suicide.\textsuperscript{48} Therefore, the inmate’s motives for refusing medical treatment may also be a factor that courts will consider.\textsuperscript{49}

Courts have used an analysis adapted in Thor and Singletary when considering the scope of an inmate’s personal autonomy in health care decisions.\textsuperscript{50} This analysis consists of four state interests that must be considered and balanced against the individual’s right to refuse medical treatment: “(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.”\textsuperscript{51} The courts have also upheld an inmate’s right to refuse to take medication

\textsuperscript{42.} Id.
\textsuperscript{44.} Singletary, 665 So. 2d at 1104.
\textsuperscript{45.} Id. at 1104-05.
\textsuperscript{46.} Id. at 1102-03 (considering the United States Supreme Court’s decision in Cruzan, which held that a competent person has a liberty interest in refusing unwanted medical treatment).
\textsuperscript{47.} Thor v. Superior Court, 855 P.2d 375, 383, 390 (Cal. 1993); Singletary, 665 So. 2d at 1104; Zant v. Prevatte, 286 S.E.2d 715, 716 (Ga. 1982).
\textsuperscript{48.} Singletary, 665 So. 2d at 1109.
\textsuperscript{49.} Id.
\textsuperscript{51.} Myers, 399 N.E.2d at 456.
unless certain conditions are met.  

The courts that decided the cases above arrived at their holdings based on a respect for the liberty interest of the inmate. Forced medication and forced medical treatment require an affirmative act on behalf of the prison system and prison physicians, but these seem to have been even more difficult decisions for courts. The results of these decisions are, after all, to allow an inmate to refuse medical treatment or to stay on a hunger strike—and ultimately die. These courts have displayed wisdom in handing down principled decisions that demonstrate great respect for the inmate’s personal autonomy.

B. Forced Medical Treatment in Prisons: Where an Inmate’s Autonomy Seems To End

An early and very influential case on the issue of forced medical treatment came before the Supreme Judicial Court of Massachusetts (SJC) in 1979. In Commissioner of Corrections v. Myers, the defendant was a mentally competent inmate serving a long prison sentence in a medium security prison. While in prison, Myers developed a kidney condition that required dialysis and medication. After submitting to dialysis for one year, he suddenly refused to submit to any further treatments. Prison physicians did not attempt to treat him without his consent, and the Commissioner finally sought a court order to force the treatment on him.

The trial court had already concluded that the defendant’s refusal of treatment had nothing to do with his will to live or a religious belief, but instead was a form of protest against his placement in a medium security prison, as opposed to a minimum security prison. The SJC considered the state’s interests that were "implicated by an individual’s rejection of life-saving medical treatment: (1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4)
the maintenance of the ethical integrity of the medical profession."\(^{62}\) Unlike the courts discussed in the previous section, the SJC decided that "the Commissioner of Correction and the Department of Public Health possess the requisite authority to compel an unconsenting, competent adult prisoner to submit to medications and to hemodialysis, when such measures are reasonably necessary to save his life," and the relevant interests of the state and the individual are weighed against each other.\(^{63}\) Myers was forced to receive dialysis and subsequently received a kidney transplant.\(^{64}\)

Although the SJC went through an analysis very much like that of the court in Singletary,\(^{65}\) it reached the opposite result.\(^{66}\) The Court admitted that forcing kidney dialysis is a great medical invasion, and that inmates have "a constitutional right of privacy, arising from a high regard for human dignity and self-determination."\(^{67}\) However, what tipped the balance in favor of forced medical treatment was the "[s]tate’s interest in upholding orderly prison administration."\(^{68}\) The Court decided that it would simply be too disruptive to the prison system to have inmates refusing medical treatment and potentially dying in an attempt to manipulate prison administrators to grant a transfer to another prison, as Myers wanted.\(^{69}\)

In 1990, the United States Supreme Court took on this issue in Washington v. Harper, holding that an inmate may receive medical treatment against his will in some situations.\(^{70}\) Harper was an inmate who was treated for mental illness by a prison physician while incarcerated by the Washington Department of Corrections.\(^{71}\) After his diagnosis of manic-depressive disorder and later schizophrenia, Harper was given antipsychotic medications.\(^{72}\) Initially, Harper gave voluntary consent to treatment, including the administration of antipsychotic medications;\(^{73}\) however, after he refused his medication, the prison sought to force him to

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62. Id. at 456 (citing Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977)).
64. Id. at 454-55.
66. Myers, 399 N.E.2d at 458.
67. Id. at 455.
68. Id. at 458.
69. Id.
71. Id. at 214.
72. Id.
73. Id.
continue the treatment.\textsuperscript{74}

In reaching its decision in Harper, the Court acknowledged that the "forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."\textsuperscript{75} The Court engaged in a lengthy discussion about the gravity of the consequences of forcibly medicating an inmate with powerful medications,\textsuperscript{76} including the effects of the drugs on brain chemistry and possible side effects.\textsuperscript{77} The Court noted that while "[t]he purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes . . . it is also true that the drugs can have serious, even fatal, side effects."\textsuperscript{78}

The Court had already set the standard for determining the validity of a prison regulation that infringed on an inmate's constitutional rights in Turner v. Safley.\textsuperscript{79} A court is to determine if the regulation is "reasonably related to legitimate penological interests" of the correctional facility.\textsuperscript{80} Several factors are used to make this determination, among them are the following: (1) there must be a "valid, rational connection between the prison regulation and the legitimate governmental interest put forward to justify it"; (2) the prison restriction must be reasonable, in that "there are alternative means of exercising the right that remain open to prison inmates"; and (3) a court must consider "the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally."\textsuperscript{81} After applying this analysis to Harper's situation, the Court held that, within the prison environment, "the Due Process Clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."\textsuperscript{82} The state law was consistent with these requirements and upheld by the Court; the prison was allowed to forcibly medicate Harper.\textsuperscript{83}

Having reached this conclusion, the Court next had to decide what form

\textsuperscript{74}  Id.
\textsuperscript{75}  Id. at 229 (citing Schmerber v. California, 384 U.S. 757, 772 (1966)).
\textsuperscript{76}  Id. at 215-16.
\textsuperscript{77}  Id. at 229-30.
\textsuperscript{78}  Id. at 229.
\textsuperscript{79}  482 U.S. 78 (1987).
\textsuperscript{80}  Id. at 89.
\textsuperscript{81}  Id. at 89-90. The Court also added that "the absence of ready alternatives is evidence of the reasonableness of a prison regulation." Id. at 90.
\textsuperscript{83}  Id.
of procedural due process was required to ensure that a person like Harper would not be denied his liberty interests without a fair hearing.\textsuperscript{84} Harper wanted a judge to determine whether he should receive medication, but the Supreme Court decided that prison physicians and officials were better equipped to make that determination.\textsuperscript{85} The Court stated that "[d]ue process is not violated by use of informal, traditional medical investigative techniques. . . . The mode and procedure of medical diagnostic procedures is not the business of judges."\textsuperscript{86} The Court acknowledged the fallibility of medical and psychiatric diagnosis, but it did not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision to a judge or outside decision maker after a judicial-type hearing.\textsuperscript{87} The Washington Department of Corrections' policy called for a hearing committee made up of internal decision makers, all staff of the prison, but none who had any role in the inmate's treatment, to review the physician's decision to forcibly medicate the patient and determine: (1) "whether the inmate suffers from a 'mental disorder';" and (2) "whether, as a result of that disorder, he is dangerous to himself, others, or their property."\textsuperscript{88} Under the policy, "the hearing committee reviews on a regular basis the [physician]'s choice of both the type and dosage of drug to be administered, and can order appropriate changes."\textsuperscript{89}

The Court approved the Department of Corrections' procedures, stating that although the hearing committee was not made up of outside decision makers:

The procedures . . . meet the requirements of due process in all other respects, and we reject respondent's arguments to the contrary. The Policy provides for notice, the right to be present at an adversary hearing, and the right to present and cross-examine witnesses. The procedural protections are not vitiated by meetings between the committee members and staff before the hearing. Absent evidence of resulting bias, or evidence that the actual decision is made before the hearing, allowing respondent to contest the staff's position at the hearing satisfies the requirement that the opportunity to be heard "must be granted at a meaningful time and in a meaningful manner." We reject also respondent's contention that the hearing must be conducted in accordance with the rules of evidence or that a "clear, cogent, and convincing" standard of proof is necessary. This standard is neither

\textsuperscript{84} \textit{Id.} at 229.
\textsuperscript{85} \textit{Id.} at 231.
\textsuperscript{86} \textit{Id.} at 232 (quoting Parham v. J.R., 442 U.S. 584, 607-08 (1979)).
\textsuperscript{87} \textit{Id.} (quoting Parham v. J.R., 442 U.S. 584, 609 (1979)).
\textsuperscript{88} \textit{Id.}
\textsuperscript{89} \textit{Id.} at 233.
required nor helpful when medical personnel are making the judgment required by the regulations here. 90

The Court went on to state that "the fact that the medication must first be prescribed by a psychiatrist, and then approved by a reviewing psychiatrist, ensures that the treatment in question will be ordered only if it is in the prisoner's medical interests, given the legitimate needs of his institutional confinement." 91 These procedures, which recognize both the prisoner's medical interests and the state's interests, meet the demands of the Due Process Clause. 92

As discussed above, the prisoner hunger strike has also raised the issue of forced medical treatments in prison. 93 There is a long history of prisoner hunger strikes as a means of protest, both political and against the prison system itself, or in an attempt to commit suicide. 94 Unlike some of the cases discussed above, 95 steps have usually been taken to end the hunger strike. 96 Forced feeding has been employed in many of these cases 97 although prison officials and doctors usually only intervene when the inmate's life could be in danger. 98 A majority of courts have held the right

90. Id. at 235 (internal citations omitted).
91. Id. at 222.

[T]reatment is permissible after the inmate has received notice and a hearing before an administrative panel. Accordingly, BOP policy mandates that psychiatric medication be used only for a diagnosable psychiatric disorder for which such medication is the most acceptable treatment. Psychiatric medication may be administered involuntarily in emergency situations (i.e., when a person becomes a danger to self, including grave disability, and/or a danger to others due to mental illness). This may be done only if psychiatric medication is the appropriate treatment for the illness, and if less restrictive alternatives (such as seclusion, physical restraint, and minor tranquilizers) would not be effective. Inmates who are given emergency treatment of this type will be considered for referral to a psychiatric referral center.

Id. at 33 (internal citations omitted).
93. See Ohm, supra note 9; see also supra Part I.
94. Ohm, supra note 9, at 151-52.
96. Ohm, supra note 9, at 152.
97. Id. at 153-54 (noting instances where hunger strikes have been given notoriety, such as suffragists employing hunger strikes in 1917; D.C. sniper John Allen Muhammad; and even Saddam Hussein when he was in U.S. custody).
98. Id. at 152.
of an inmate to continue a hunger strike is outweighed by the interest of the state and the prison itself, permitting the forced-feeding based on the determination that "[a] prison regulation, even one that impinges on an inmate’s constitutional right, is valid if it is reasonably related to a legitimate penological interest." The Federal Bureau of Prisons (BOP) has adopted regulations that permit force-feeding of inmates who are on a hunger strike. These regulations specifically provide that "the physician shall give consideration to forced medical treatment of the inmate" who refuses to eat. These inmates are to be observed by prison staff for a period of seventy-two hours before the inmate is considered to meet the definition of a hunger strike. At that time, it is within the discretion of the prison physician to determine when and if to intervene by forcibly feeding the inmate, and only the physician may discontinue the treatment.

101. 28 C.F.R. § 549.60 (2007) ("It is the responsibility of the Bureau of Prisons to monitor the health and welfare of individual inmates, and to ensure that procedures are pursued to preserve life.").
102. Id. § 529.65(a).
103. 28 C.F.R. § 549.61 states:

As defined in this rule, an inmate is on a hunger strike: (a) When he or she communicates that fact to staff and is observed by staff to be refraining from eating for a period of time, ordinarily in excess of 72 hours; or (b) When staff observe the inmate to be refraining from eating for a period in excess of 72 hours. When staff consider it prudent to do so, a referral for medical evaluation may be made without waiting 72 hours.

Id. § 549.61 (emphasis added).
104. Subsections (c) and (d) of 28 C.F.R. § 549.65 state:

(c) When, after reasonable efforts, or in an emergency preventing such efforts, a medical necessity for immediate treatment of a life or health threatening situation exists, the physician may order that treatment be administered without the consent of the inmate. Staff shall document their treatment efforts in the medical record of the inmate.

(d) Staff shall continue clinical and laboratory monitoring as necessary until the inmate's life or permanent health is no longer threatened.

Id. § 549.65(c)-(d).
105. Id. § 549.66 ("Only the physician may order that an inmate be released from hunger strike evaluation and treatment. This order shall be documented in the medical record of the inmate.").
Another situation that can require forcible medical treatment is medical screening and testing for infectious diseases. Here, there is less controversy because of the clear need to protect other inmates and prison staff from harm. However, the rights of those who may be carrying an infectious disease must be respected, and this is an issue that prison officials have had to confront in recent years.106 For example, courts have ordered mandatory testing for tuberculosis (TB) in prisons.107 In Massachusetts, the state courts have used the Myers test108 rather than the Turner test109 to uphold mandatory administration of TB tests on an inmate.110

The Massachusetts Appeals Court ruled in 1993 that the administration of the TB and control tests was a proper exercise of the prison’s authority over its population.111 In addition, the inmates had no constitutional right to refuse the TB tests.112 The court cited Myers for the proposition that “[a]lthough an inmate’s incarceration does not divest him of his right of privacy and his interest in preserving his bodily integrity, it does limit those constitutional rights when the State’s interest in prison security and administration is at risk.”113 A prison’s interest in “the preservation of internal order and discipline, the maintenance of institutional security, and the rehabilitation of prisoners” may outweigh an inmate’s privacy rights.114 Prison staff would initially counsel an inmate who refused to submit to the test.115 If he still refused to cooperate, a disciplinary report would be made for failing to obey a direct order and the inmate would then be disciplined.116 This process may result in “loss of good time credit, segregation, isolation, loss of visitation privileges, transfer to a higher level of custody, and confinement to a punitive unit within the correctional facility.”117 Whether the risk to internal order is a lone inmate on a hunger strike or other inmates contracting a disease, such as TB, the interests of the prison can outweigh the individual inmate’s autonomy.118

106. LEGAL RESOURCE GUIDE, supra note 92, at 31-32.
110. Langton, 614 N.E.2d at 1006.
111. Id.
112. Id.
113. Id. (citing Myers, 399 N.E.2d at 457).
114. Myers, 399 N.E.2d at 457; see also Langton, 614 N.E.2d at 1006.
115. Langton, 614 N.E.2d at 1004.
116. Id.
117. Id.
118. See Turner v. Safley, 482 U.S. 78, 81 (1986); Langton, 614 N.E.2d at 1006; Myers, 399 N.E.2d at 453; Ohm, supra note 9, at 152.
The prison system has also had to deal with the risks of HIV transmission among its population. The BOP has adopted policies to balance the rights of HIV-positive individuals against those of uninfected staff and inmates, including a “multi-faceted program of testing, treatment, and education.” These tests are random and include multiple HIV tests during commitment and just prior to release from prison, as well as when it is clinically indicated. Importantly, these HIV tests are mandatory:

Any inmate refusing one of the mandatory HIV testing programs shall be subject to an incident report for failure to follow an order. All inmates are tested prior to release to ensure they are fully informed about their health and the implications of a positive test for them and others with whom they will come in contact. Inmates are also tested for the presence of HIV antibodies when they ask to be tested, when they display clinical signs of HIV infection, and for other administrative reasons, such as when an inmate displays predatory or promiscuous behavior. This random testing program enables the BOP to monitor the rate of viral transmission within the prison system. HIV-positive inmates in BOP institutions are housed in the general population. Following a hearing, the BOP segregates only those HIV-positive inmates who demonstrate predatory or promiscuous behavior in order to protect other inmates from becoming infected.

However, this only begins to address the problem. The Federal BOP reported that “[a]s of February 2002, there were 1525 HIV-positive infections in the BOP (approximately 0.9 percent of the inmate population).” In the entire United States, including federal and state prisons, and county and local jails, two million people have been incarcerated and roughly twenty percent have been sexually assaulted by other inmates or corrections staff. Since the rate of HIV in the prison population is ten times higher than in the population at large, these sexual assaults are more likely to lead to the transmission of HIV, other sexually transmitted diseases, or communicable diseases such as TB and hepatitis B and C.


120. LEGAL RESOURCE GUIDE, supra note 92, at 31.

121. Id. (internal citations omitted).

122. Id. at 32.


124. Id. at 160.
Many state prison systems also require mandatory HIV testing, and courts have upheld challenges to such testing based on the Turner test. Forced blood tests of prisoners have been found constitutional because of the penological interest in diagnosing a serious disease and preventing its transmission among the prison population, as well as mandatory HIV screening of all prisoners in light of the legitimate penological objective of protecting prisoner health and preventing the spread of the virus that causes AIDS. Courts have also upheld the segregation of HIV-positive inmates.

An additional and ongoing controversy comes from recent advances in the use of DNA in criminal investigations. The DNA Analysis Backlog Elimination Act of 2000 (DNA Act) requires certain officers to collect a DNA sample from each individual who is, or has been, convicted of a qualifying federal offense. This is also the case upon the supervised release of an inmate, which may also include testing for controlled substances. Several states have considered Fourth Amendment challenges to the DNA Act and found it constitutional because the government interest in protecting the public from criminals outweighed the minimal intrusion of extracting a DNA sample from a convicted offender. Inmates who refuse to provide a DNA sample have their release revoked; then they are fined and are guilty of a Class A misdemeanor punishable by up to one year in custody.

126. Id. at 1287; see also Turner v. Safley, 482 U.S. 78, 89-90 (1987).
127. See Thompson v. City of Los Angeles, 885 F.2d 1439, 1447 (9th Cir. 1989).
129. Id. at 1521 (holding that although segregation is a more extreme approach to reducing the transmission of HIV, it passes the Turner test and is therefore constitutional).
131. DNA Analysis BacklogElimination Act of 2000, 42 U.S.C. § 14135a(a)(1)(B) (Supp. V 2000). The relevant portion states: "The Director of the Bureau of Prisons shall collect a DNA sample from each individual in the custody of the Bureau of Prisons who is, or has been, convicted of a qualifying Federal offense." Id. (emphasis added). These offenses include violent crimes, felonies, and conspiracies to commit those offenses. Id. § 14135a(d).
132. 18 U.S.C. § 3583(d) (2000) (stating that "[t]he court shall order, as an explicit condition of supervised release, that the defendant cooperate in the collection of a DNA sample from the defendant, if the collection of such a sample is authorized pursuant to section 3 of the DNA Analysis Backlog Elimination Act of 2000") (emphasis added).
133. United States v. Reynard, 473 F.3d 1008, 1021 (9th Cir. 2007); United States v. Conley, 453 F.3d 674, 680-81 (6th Cir. 2006).
134. 42 U.S.C. § 14135a(a)(5).
Although inmates can completely refuse medical treatment in some limited circumstances, it is clear that there are many more situations in which an inmate must comply with intrusive medical treatment, either to protect the health of those who have contact with them in the prison or to help preserve order in the prison. However, there are situations that fall in between the two extremes of refusing medical treatment and forcing medical treatment in which an inmate should have some ability to make decisions for himself.

C. The Middle Ground: Making Health Care Decisions and Directing the Course of Medical Treatment

What happens when an inmate disagrees with a decision made by a prison physician? The United States Supreme Court has held that the Eighth Amendment prohibits prison officials from being "deliberately indifferent" to an inmate's "serious medical needs." This principle also extends to mental health care needs. However, as long as prisons have complied with the "deliberate indifference" standard, courts across the United States have held that an inmate has no right to choose his own doctor, to get a second opinion, or to choose what medical treatment he is to receive—the doctor's decision is final. This does not mean that a prisoner never gets a second opinion, or that prison physicians are not responsive to prisoner requests for certain medical treatment. However, it does mean that a difference of opinion as to the course of treatment between an inmate and his doctor, or a disagreement between two treating physicians, does not establish a viable claim on behalf of the inmate. For

135. Legal Resource Guide, supra note 92, at 30; see also Estelle v. Gamble, 429 U.S. 97, 104-05 (1976) (holding deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain ... proscribed by the Eighth Amendment").

136. Legal Resource Guide, supra note 92, at 30; see also Smith v. Jenkins, 919 F.2d 90, 92-93 (8th Cir. 1990); Greason v. Kemp, 891 F.2d 829, 834 (11th Cir. 1990).

137. Marc J. Posner, The Estelle Medical Professional Judgment Standard: The Right of Those in State Custody to Receive High-Cost Medical Treatments, 18 Am. J.L. & Med. 347, 361 & n.101 (1992) ("In essence, Estelle holds that a prisoner is constitutionally entitled to the treatment prescribed by a medical professional. This right would not seem to encompass second opinions or choice of doctors or treatments.").


139. Feeney v. Corr. Med. Services, Inc., 464 F.3d 158, 162-63 (1st Cir. 2006) ("The correctional center's medical staff was responsive to appellant's complaints, expended substantial resources trying to get to the root of his problem, and adopted other measures in an effort to alleviate his discomfort.").

140. See Norton v. Dimazana, 122 F.3d 286, 292 (5th Cir. 1997); Watson v. Caton, 984 F.2d 537, 540 (1st Cir. 1993); Smith v. Marcantonio, 910 F.2d 500, 502 (8th Cir. 1990).
example, in a recent decision, the Eighth Circuit Court of Appeals summed up its previous holdings on this issue, stating that "inmates have no constitutional right to receive a particular or requested course of treatment, and prison doctors remain free to exercise their independent medical judgment."\textsuperscript{141} "[A] prisoner's mere difference of opinion over matters of expert medical judgment or a course of medical treatment fail[s] to rise to the level of a constitutional violation."\textsuperscript{142}

Prisoners can question the decisions of doctors but they have no recourse to challenge these decisions on constitutional grounds; a difference of opinion can only rise to the level of a claim of medical negligence, which, as we shall see in Section III, is not the standard applied to physicians who are treating inmates.\textsuperscript{143} Therefore, an inmate must completely rely on the doctor to make decisions and the inmate has no recourse until there is a breach of the standard of care that rises to the level of a violation of the constitutional right to adequate health care in prison—deliberate indifference to a serious medical need—which is a very high bar to reach.\textsuperscript{144}

A 1993 case from Maine, \textit{Watson v. Caton}, provides a good example of an inmate's disagreement with health care providers.\textsuperscript{145} Watson was incarcerated at Maine's Downeast Correctional Facility when he filed a claim for lack of medical treatment for a hand injury that occurred prior to his imprisonment and a back injury that occurred while working at the prison.\textsuperscript{146} A nurse treated his back injury with medication and bed rest and insisted he would be fine; Watson insisted he needed more treatment, perhaps physical therapy.\textsuperscript{147} Watson eventually did have surgery on his back.\textsuperscript{148} However, the court refused to recognize a viable claim for Watson because some treatment had been given, even if Watson did not agree with the treatment and even if it turned out to be ineffective.\textsuperscript{149} The nurse also refused to provide treatment for his hand simply because the injury

\begin{footnotes}
\item[141.] Meuir v. Greene County Jail Employees, 487 F.3d 1115, 1118 (8th Cir. 2007) (emphasis added) (quoting Dulany v. Carnahan, 132 F.3d 1234, 1239 (8th Cir. 1997)).
\item[142.] \textit{Id.} at 1118-19 (emphasis added) (quoting Taylor v. Bowers, 966 F.2d 417, 421 (8th Cir. 1992)).
\item[143.] Estelle v. Gamble, 429 U.S. 97, 106 (1976); Meuir, 487 F.3d at 1118-19; \textit{Watson}, 984 F.2d at 540.
\item[144.] Estelle, 429 U.S. at 106; \textit{Watson}, 984 F.2d at 540.
\item[145.] \textit{Watson}, 984 F.2d 537.
\item[146.] \textit{Id.} at 539.
\item[147.] \textit{Id.}
\item[148.] \textit{Id.}
\item[149.] \textit{Id.} at 540.
\end{footnotes}
happened before he arrived in prison.\textsuperscript{150} Watson knew the hand required surgery, and he subsequently attempted to contact a specialist, but no specialist would come to the prison and the prison would not arrange for him to go to a specialist.\textsuperscript{151} Watson continued to suffer, and eventually a prison doctor examined the hand and recommended the surgery.\textsuperscript{152} The court held that this was not simply a disagreement over the course of treatment, but that it could possibly rise to the level of deliberate indifference if Watson provided more facts at trial; therefore, summary judgment was not warranted for this claim.\textsuperscript{153}

A recent federal case from Massachusetts illustrates a common situation in which two doctors disagreed over the course of medical treatment, leaving the inmate with no recourse. In \textit{Feeney v. Correctional Medical Services, Inc.}, the First Circuit Court of Appeals found that there was a disagreement in the course of treatment between two doctors that caused a delay in treatment—though it did not rise to the level of a constitutional violation.\textsuperscript{154} Feeney was suffering from a painful foot condition and was prescribed orthotic insoles by a podiatrist within the prison.\textsuperscript{155} Feeney refused to allow the podiatrist to examine his feet because he was in too much pain, but he was prescribed orthotic walking shoes anyway.\textsuperscript{156} Another physician countermanded the podiatrist’s orders after consulting with him because he felt that without proper examination the prescription was not appropriate.\textsuperscript{157}Shortly thereafter the podiatrist did examine Feeney and doubt arose as to the cause of his pain and whether the orthotics would resolve the problems he was having prompting many months of expensive testing—and misdiagnosis.\textsuperscript{158} After twenty-two months of treatment, Feeney finally received the orthotics, but he had already filed his claim.\textsuperscript{159}

Had he not been a prisoner, Feeney may have had a claim against a doctor based on medical negligence, but here he did not have such a claim. Feeney could certainly not complain that he had not received any health care, which may have risen to the level of a constitutional violation.\textsuperscript{160} In

\begin{itemize}
\item \textsuperscript{150} \textit{Id.} at 539.
\item \textsuperscript{151} \textit{Id.}
\item \textsuperscript{152} \textit{Id.}
\item \textsuperscript{153} \textit{Id.}
\item \textsuperscript{154} \textit{Feeney v. Corr. Med. Serv., Inc.}, 464 F.3d 158, 162 (1st Cir. 2006).
\item \textsuperscript{155} \textit{Id.} at 160.
\item \textsuperscript{156} \textit{Id.}
\item \textsuperscript{157} \textit{Id.}
\item \textsuperscript{158} \textit{Id.}
\item \textsuperscript{159} \textit{Id.} at 160-61.
\item \textsuperscript{160} \textit{Id.} at 162-63.
\end{itemize}
fact, the delay in getting his orthopedic shoes resulted while receiving a
great deal of expensive medical care and consultation.\textsuperscript{161} The court found
that during the course of treatment, Feeney was examined by medical
professionals on multiple occasions.\textsuperscript{162} He had numerous diagnostic tests,
including blood work, x-rays, and MRIs; he saw outside specialists,
including a podiatrist, a neurologist, a neurosurgeon, and a physical
therapist; and he was given pain medications, generic shoe inserts, steroid
injections, and physical therapy.\textsuperscript{163} Although all of this medical treatment
was ineffective and prolonged Feeney's suffering, he was still at the mercy
of his well-intentioned doctors, one of whom had ultimately chosen the
wrong plan of care.

A 2006 case from the Supreme Court of New York, Appellate Division,
\textit{Matter of Scott v. Goord},\textsuperscript{164} is an example of an inmate being denied a
particular course of medical treatment. Scott was an inmate who had
sustained an injury to his shoulder while incarcerated and was scheduled
for surgery.\textsuperscript{165} The procedure was intended to relieve Scott's persistent
pain, but he refused to have the operation.\textsuperscript{166} He was permitted to confer
with another doctor who offered an alternative surgical procedure that was
intended to repair the injury rather than merely relieve the pain.\textsuperscript{167} Scott
filed a grievance with the prison in an attempt to request the alternative
surgery, but it was denied on the basis that it constituted a second opinion
and was unnecessary treatment.\textsuperscript{168} Scott filed his claim seeking to compel
the prison to provide him with the treatment intended to repair the injury
rather than the treatment intended to merely relieve his persistent pain.\textsuperscript{169}
The Appellate Division held that Scott had offered no proof that the
surgery was medically necessary and that because he received medical
treatment, even if it was not the procedure he wanted, this was not a breach
of the standard of care in the prison setting.\textsuperscript{170}

The BOP has policies in place that are similar to the state prison systems
discussed in the cases above. The BOP's health care professionals make
determinations regarding what is "medically mandatory" or "presently

\begin{footnotesize}
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\item[161.] \textit{Id.} at 162.
\item[162.] \textit{Id.}
\item[163.] \textit{Id.}
\item[165.] \textit{Id.} at 619.
\item[166.] \textit{Id.}
\item[167.] \textit{Id.}
\item[168.] \textit{Id.}
\item[169.] \textit{Id.}
\item[170.] \textit{Id.} at 620.
\end{itemize}
\end{footnotesize}
"medically necessary" using their clinical judgment. The BOP's policy is to provide only the care that is medically necessary, not treatment that is simply for the convenience of the inmate. The policy also excludes some specific procedures, such as routine hernia repair, noncancerous skin lesion and tattoo removal, or cosmetic surgery. The medical director of the prison can make exceptions on a case-by-case basis. Despite following this standard, however, officials are entitled to exercise their medical judgment regarding appropriate care. Accordingly, a difference of medical opinion as to treatment or an inmate's disagreement with the course of medical care does not establish "deliberate indifference."

If an inmate disagrees with the decisions of a prison doctor, the only recourse available seems to be the prison's grievance procedure. All state prison systems and the Federal BOP have inmate grievance procedures in place. For example, by statute, Massachusetts requires that the Commissioner of Corrections provide a procedure for inmates to file a grievance against the prison. Although Massachusetts has a grievance procedure in place, the Commissioner does not allow the DOC grievance

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171. LEGAL RESOURCE GUIDE, supra note 92, at 30. The terms "medically mandatory" and "presently medically necessary" are defined in section 10(d) of the Guide, subtitled "Voluntary Medical/Mental Treatment."

The health care mission of the BOP is to provide necessary medical, dental, and mental health services to inmates by professional staff in a manner consistent with community standards. The principles "medically mandatory" and "presently medically necessary" are used to determine what health care is necessary.

"Medically mandatory" is defined as immediate, urgent, or emergency care required to maintain or treat a life-threatening illness or injury. "Presently medically necessary" is defined as routine care or treatment provided to maintain a chronic or non-life threatening condition that cannot be reasonably delayed without the risk of further complication, serious deterioration, significant pain or discomfort.

Id.

172. Id.

173. Id.

174. Id.

175. Id. at 30-31; see also White v. Farrier, 849 F.2d 322, 327 (8th Cir. 1988).

176. LEGAL RESOURCE GUIDE, supra note 92, at 31; see also Snipes v. DeTella, 95 F.3d 586, 591-92 (7th Cir. 1996) (holding a prison doctor who removed an inmate's toenail without anesthesia was not deliberately indifferent though the inmate disagreed with the doctor's decision); Smith v. Marcantonio, 910 F.2d 500, 501 (8th Cir. 1990) (holding a doctor was not deliberately indifferent though the inmate patient was not satisfied with the doctor's care).


system to be used for questions about the type or quality of medical treatment; a prisoner may only file a grievance for access to medical care.\textsuperscript{179} The medical contractor used by the DOC, who employs the prison doctors, is supposed to have its own grievance procedure in its system.\textsuperscript{180} So, the state DOC’s own grievance procedure is not helpful to the inmate who disagrees with his particular medical treatment. The Federal BOP also provides for inmate grievances to be heard; procedures for most grievances are provided by the BOP’s Administrative Remedy Program.\textsuperscript{181} However, personal injury claims must be brought under the Federal Tort Claims Act, which has a separate statute describing these procedures.\textsuperscript{182} The grievance procedures must be exhausted before a claim can be brought in court,\textsuperscript{183} but this process does not seem to be the solution to an inmate’s problems.

There is a glimmer of hope for inmates. In \textit{Thor v. Superior Court}, the California Supreme Court discussed at length that the right to make one’s own medical decisions falls within the scope of those rights that an inmate retains.\textsuperscript{184} While the inmate in \textit{Thor} was refusing all medical treatment, the logical conclusion of the court’s assertion that inmates can make their own medical decisions would lead to a holding that inmates should be able to direct the course of their health care, just like any other citizen.\textsuperscript{185} An amicus brief filed in \textit{Thor} questioned whether the inadequacy of prison health care could lead to an inmate deciding to refuse medical treatment because he had simply given up.\textsuperscript{186} The amicus brief advocated for a judicial review to assess the situation and determine the rationality of the prisoner’s decision to refuse treatment in these types of cases.\textsuperscript{187} The Court stated its position as follows:

\begin{quote}
[W]e are reluctant for several reasons to formulate any particular procedure for determining a competent prisoner’s right to control
\end{quote}

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\item \textsuperscript{179} 103 MASS. CODE REGS. 491.08 (2001).
\item \textsuperscript{180} \textit{Id.}
\item \textsuperscript{181} 28 C.F.R. \textsuperscript{\textsection} 542.10 (2007).
\item \textsuperscript{182} \textit{Id.} \textsuperscript{\textsection} 543.30.
\item \textsuperscript{183} Prison Litigation Reform Act (PLRA) of 1995, 42 U.S.C. \textsuperscript{\textsection} 1997e(a) (2000) (requiring that an inmate exhaust all administrative remedies before bringing an action under federal law).
\item \textsuperscript{184} \textit{Thor v. Superior Court}, 855 P.2d 375, 378-79 (Cal. 1993); \textit{see also} CAL. PENAL CODE \textsuperscript{\textsection} 2600 (1994) (“A person sentenced to imprisonment in a state prison may during that period of confinement be deprived of such rights, and only such rights, as is reasonably related to legitimate penological interests . . . . Nothing in this section shall be construed to overturn the decision in \textit{Thor v. Superior Court}.’’); Parker & Paine, \textit{supra} note 7, at 248.
\item \textsuperscript{185} \textit{See Thor}, 855 P.2d at 388.
\item \textsuperscript{186} \textit{Id.} at 389.
\item \textsuperscript{187} \textit{Id.}
\end{itemize}
decisionmaking with respect to his or her own health care. First, as a general proposition, judicial intervention of the type proposed tends to denigrate the principle of personal autonomy, substituting a species of legal paternalism for the medical paternalism the concept of informed consent seeks to eschew.188

The Court seems to indicate here that neither courts nor doctors should be making health care decisions without an inmate’s permission.189 It appears the court believes inmates should be making these decisions for themselves. While Thor recognized that an inmate retains some right to make medical decisions for himself,190 the Court never states whether an inmate actually should make these decisions independently or to what extent he can make them independently. It appears a physician must determine what the inmate’s choices are, and it is within the physician’s discretion to determine which course of treatment is to be followed. Therefore, the relationship between the inmate and his doctor is extremely important.

III. THE STANDARD OF CARE APPLIED TO THE PRISON PHYSICIAN—DELIBERATE INDIFFERENCE TO A SERIOUS MEDICAL NEED RATHER THAN MEDICAL NEGLIGENCE

If an inmate alleges that he was harmed by his physician in the course of his medical treatment, he is usually unsuccessful in proving that the physician breached the higher standard of care that is applied in these cases, “deliberate indifference to a serious medical need,” rather than mere medical negligence.191 Therefore, the physician-patient relationship in the prison setting is different from that in the rest of society—the doctor is less accountable to the patient, and as we have seen, the patient has almost no ability to control the medical treatment he receives.192

The United States Supreme Court set the standard of care applicable to

188. Id.
189. See id. at 387-88.
190. Id.
192. Id. at 106 (“[A] complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.”); Meuir v. Greene County Jail Employees, 487 F.3d 1115, 1118-19 (8th Cir. 2007); Watson v. Caton, 984 F.2d 537, 540 (1st Cir. 1993) (“The courts have consistently refused to create constitutional claims out of disagreements between prisoners and doctors about the proper course of a prisoner’s medical treatment, or to conclude that simple medical malpractice rises to the level of cruel and unusual punishment.”); see supra Section II.C.
prison doctors in _Estelle v. Gamble_.\textsuperscript{193} The Court held that prison officials are prohibited under the Eighth Amendment from showing "deliberate indifference" to an inmate's "serious medical need."\textsuperscript{194} This principle has also been extended to mental health care needs.\textsuperscript{195} In following this standard, however, officials are entitled to exercise their judgment regarding medical care.\textsuperscript{196}

Gamble, an inmate at a Texas prison, claimed he did not receive adequate care from prison doctors after he was injured on a prison work assignment.\textsuperscript{197} Gamble complained of a back injury and was prescribed pain medication by the doctors, who saw him on multiple occasions.\textsuperscript{198} The pain medication was apparently ineffective; when Gamble could not return to work he was disciplined, and he ultimately filed a claim against prison officials.\textsuperscript{199} The Court decided that a decision by a prison doctor not to order x-rays or other diagnostic tests for the inmate was a medical judgment that, at most, amounted to medical malpractice, but that this was not the standard of care in the prison setting.\textsuperscript{200} The standard applied in this situation is that a doctor showed "deliberate indifference to serious medical needs" of the prisoner, which constitutes a violation of the Eighth Amendment as it creates an "unnecessary and wanton infliction of pain."\textsuperscript{201}

Since _Estelle_, the Court has decided important cases that have further defined the ability of an inmate to challenge the health care he has received in prison.\textsuperscript{202} In 1991, the Court revisited the deliberate indifference standard in _Wilson v. Seiter_.\textsuperscript{203} In that case, the Court extended the _Estelle_ deliberate indifference standard for prison health care to claims of cruel and unusual punishment regarding all conditions of confinement.\textsuperscript{204} _Wilson_ also confirmed that there is an objective and subjective element to a finding of deliberate indifference on the part of prison officials; there must be a

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  \item \textsuperscript{193} _Estelle_, 429 U.S. at 104.
  \item \textsuperscript{194} Id.
  \item \textsuperscript{195} See Smith v. Jenkins, 919 F.2d 90, 93 (8th Cir. 1990); Greason v. Kemp, 891 F.2d 829, 834 (11th Cir. 1990).
  \item \textsuperscript{196} White v. Farrier, 849 F.2d 322, 327 (8th Cir. 1988).
  \item \textsuperscript{197} _Estelle_, 429 U.S. at 98.
  \item \textsuperscript{198} Id. at 99-101.
  \item \textsuperscript{199} Id. at 100.
  \item \textsuperscript{200} Id. at 107-08.
  \item \textsuperscript{201} Id. at 104 (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976)).
  \item \textsuperscript{203} _Wilson_, 501 U.S. at 294.
  \item \textsuperscript{204} Id. at 303.
\end{itemize}
serious deprivation, measured objectively; and a subjective state-of-mind requirement. After acknowledging the objective standard articulated in previous cases, the Court said that "Eighth Amendment claims based on official conduct that does not purport to be the penalty formally imposed for a crime require inquiry into state of mind." Three years later, Farmer v. Brennan reaffirmed the test in Wilson, holding that the subjective standard was correct; the Court would not allow a showing of recklessness to be sufficient to show deliberate indifference. The Court stated that the liability of a prison official cannot be established unless (1) the official "knows of and disregards an excessive risk to inmate health or safety;" (2) the official is "aware of facts from which the inference could be drawn that a substantial risk of serious harm exists[;]" and (3) the official has to actually draw the inference. The Court thought this subjective standard was "somewhere between the poles of negligence at one end and purpose or knowledge at the other." The Court concluded that:

[P]rison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability if they responded reasonably to the risk, even if the harm ultimately was not averted. A prison official's duty under the Eighth Amendment is to ensure "'reasonable safety,'" a standard that incorporates due regard for prison officials' "'unenviable task of keeping dangerous men in safe custody under humane conditions.'"

The effect of these holdings is that an inmate cannot file a lawsuit against his doctor based on mere negligence. The doctor's actions must rise to the level of a breach of constitutional rights—a very high standard to

205. Id. at 297, 302.
206. Id. at 302.
207. Farmer, 511 U.S. at 837. As noted in Farmer, the Courts of Appeals have routinely equated deliberate indifference with recklessness. The Supreme Court cited as examples:
Id. at 836.
208. Id.
209. Id. at 836.
210. Id. at 844-45 (citations omitted).
211. Id. at 835; Estelle v. Gamble, 429 U.S. 97, 106 (1976).
The inmate has the burden of proving that, objectively and subjectively, the doctor caused, and intended to cause, the harm suffered by the inmate. The standard says that prison officials are supposed to defer to the physician’s opinion once the doctor has defined the medical need as “serious.” Once a physician has characterized an illness or injury as serious and has ordered a particular treatment, prison officials cannot violate or ignore the order—the prisoner is constitutionally entitled to the treatment that the medical professional decides is necessary.

Other courts have decided what constitutes reasonable health care in order to comply with the standards set by the United States Supreme Court in Estelle and subsequent cases. Courts have held that a prison must provide “reasonable health care or [] care that is reasonably designed to meet the[] routine and emergency medical needs” of its inmates. This appears to include both preventive health care as well as other medical treatment, and it seems that access to health care must be available twenty-four hours a day.

However, inmates are only entitled to health care that complies with the Eighth Amendment. Inmates have no right to perfect health care, treatment from top medical providers, or to every potential medical procedure. Inmates may not determine what treatments are necessary for themselves, and a difference of opinion between an inmate and a physician does not rise to the level of a violation of the Eighth Amendment. Therefore, an inmate is relying on his physician to make the right choices for him.

The physician-patient relationship in the prison setting is different from the rest of society in other ways. In addition to the entirely different standard of care that applies to prison doctors, inmates frequently

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212. Id. at 834.
213. Id. at 837.
215. Estelle, 429 U.S. at 104-05.
217. Id.
218. Id. at 931-32.
219. Id. at 933-34.
220. Id.
221. Id. at 934.
222. Estelle v. Gamble, 429 U.S. 97, 106 (1976) ("Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a
mistrust their doctors because the doctors are sometimes placed in an adversarial role in relation to them.\textsuperscript{223} For instance, prison doctors may have to administer medications or provide other medical care against an inmate’s wishes or may even be required to perform forced body searches.\textsuperscript{224} So, just as the inmate is not completely autonomous in health care decisions, there are times when the prison physician is not really autonomous in the treatment of the inmate and must take into consideration other factors that may affect the course of treatment.\textsuperscript{225} Prison physicians have historically been employees of the prison system; therefore, an inmate may be suspicious of a doctor’s actions and motives because he assumes prison officials are influencing the doctors.\textsuperscript{226} An inmate may also suspect that the doctor has other considerations in mind, such as the cost of treatment.\textsuperscript{227}

IV. RISING COSTS OF HEALTH CARE AND THE REACTION OF PRISON SYSTEMS

The costs of health care are an important consideration in any discussion about prisons.\textsuperscript{228} \textit{Estelle} established that inmates have a constitutional right to health care—making them the only individuals who have such a right.\textsuperscript{229} However, the problem of cost allocation, that is who has the duty to pay for these medical services, remained unresolved.\textsuperscript{230} This issue, untouched in \textit{Estelle}, was not addressed by the courts until 1983 in \textit{City of Revere v. Massachusetts General Hospital}.\textsuperscript{231} The importance of this case, and its eventual impact on states’ enactment of payment and co-payment provisions, warrants closer study.

\textsuperscript{223} Parker & Paine, supra note 7, at 245.
\textsuperscript{225} Id. at 438.
\textsuperscript{226} Parker & Paine, supra note 7, at 245.
\textsuperscript{227} Siever, supra note 3, at 1399-1404 (discussing the possibility of inmate claims of deliberate indifference to serious medical needs based on a prison’s managed health care cost cutting incentives for physicians).
\textsuperscript{228} Friedman, supra note 216, at 934.
\textsuperscript{229} McDonald, supra note 224, at 430.
A. Paying for Health Care

In *Revere*, police shot and wounded a suspect named Kivlin when he attempted to flee a robbery.\(^{232}\) The police called an ambulance and Kivlin was taken to Massachusetts General Hospital and treated for his gunshot wound.\(^{233}\) When the Revere police refused to pay Kivlin’s medical bills, the hospital sued the City of Revere in state court.\(^{234}\) The Massachusetts Supreme Judicial Court (SJC) held that the Eighth Amendment required the responsible government entity—Revere in this case—to pay the costs of medical care.\(^{235}\) However, the United States Supreme Court decided that, while the Eighth Amendment requires states to ensure that medical care is provided, how the medical care is paid for is a matter of state law and not a federal question.\(^{236}\) The Supreme Court reversed the portion of the SJC’s decision that applied the Eighth Amendment as a basis for recovery, but it upheld the part of the decision requiring governmental entities to “ensure[] that the medical care needed is in fact provided.”\(^{237}\) However, the Supreme Court warned that “if [a] governmental entity can obtain the medical care needed for a detainee only by paying for it, then it must pay.”\(^{238}\) Therefore, the states can decide on any system of payment, as long as they provide medical care to all inmates.\(^{239}\)

States reacted to *Revere* in various ways. Since courts have consistently stated that a lack of funds cannot justify withholding constitutional medical care for inmates,\(^{240}\) enormous problems may result for prison systems trying to deal with the rapid growth of prison populations, aging inmates, rising health care costs, shrinking budgets, and frustrated taxpayers.\(^{241}\) In
1997, the United States Department of Justice’s National Institute of Corrections conducted a survey that inquired about the special issues confronting prison medical services across the country. Specifically, the study examined the state DOCs’ efforts toward service efficiencies and cost reduction when dealing with inmates with special medical needs. This comprehensive study found that at least twenty-seven state DOCs had consolidated their specialized medical care at one or more sites for these populations. Consolidation of services was common for terminally ill populations in twenty-three DOCs and somewhat less common for elderly inmates. Consolidation was rarely used as an approach for chronic care; those inmates were still treated in the regular prison system. The study also found that the number of DOCs using “telemedicine, inmate fees for medical care, and use of computers to manage medical services was increasing rapidly” as prison systems were looking for new and creative ways to deal with cost issues. More than forty of the DOCs were then using or planning to use “managed care, privatization of medical services, and/or centralization or regionalization of medical services.”

Prison systems increasingly use managed care, or Health Maintenance Organizations (HMOs), to deal with rising health care costs. HMOs are designed to provide cost effective access to health care. This is done through limiting a patient’s access to services, restricting a patient’s choices, fixing rates for services, and leveraging the buying power of a large group of individuals to cut costs. Essentially, an HMO is a group insurance plan, making a prison an appropriate situation in which to utilize this system. HMOs attempt to reduce the use of health care by charging a co-payment for each visit or charging in full if the service is not covered under the client’s plan.

In the prison setting, the HMO provides the medical care for the inmates,
oversees all the medical decisions, and hires and trains the medical staff.\textsuperscript{254} HMOs solve many problems that a government-run correctional health agency cannot.\textsuperscript{255} While government-run health care in prisons may contribute to less patient advocacy, which could affect the quality of care,\textsuperscript{256} HMOs are private companies and could not only save the public money, but they could also increase the quality of care for the inmates.\textsuperscript{257} HMOs offer management of on-site health care in prisons, contractual agreements with prison systems on the prices charged for services, and hiring and training of medical staff, which is much more efficient than a government bureaucracy.\textsuperscript{258}

B. Inmate Co-Payments

In response to the decisions in \textit{Estelle} and \textit{Revere}, states instituted policies that required inmates to contribute to their health care expenses.\textsuperscript{259} States have typically offered three justifications for prisoner payment statutes concerning health care in state correctional institutions: (1) they reduce the number of unnecessary medical visits; (2) they hold inmates partly responsible for their own health care costs; and (3) they raise revenue for the prison system.\textsuperscript{260}

A 2003 survey found that thirty states had some form of co-payment policy in place.\textsuperscript{261} The majority of those states, including California,\textsuperscript{262} Florida,\textsuperscript{263} and Illinois,\textsuperscript{264} have co-payment systems in which the state

\begin{itemize}
\item \textsuperscript{254} Siever, supra note 3, at 1377-78.
\item \textsuperscript{255} Id. at 1378-79.
\item \textsuperscript{256} Id. at 1380.
\item \textsuperscript{257} Id.
\item \textsuperscript{258} Id. at 1379.
\item \textsuperscript{260} Id. at 699-700.
\item \textsuperscript{261} Health Care Part I, \textit{Corrections Compendium}, Oct. 2003, at 10.
\item \textsuperscript{262} Cal. Penal Code § 5007.5 (West 2004). California charges inmates a five-dollar fee for each inmate-initiated medical visit which is deducted from the inmate’s account. Id.
\item \textsuperscript{263} Fla. Stat. Ann. § 945.6037 (West 2001 & Supp. 2009). Florida charges inmates a four-dollar co-payment for each non-emergency visit to a health care provider, which is deducted from the inmate’s account. Id. If there is not enough money in the account, fifty percent of any subsequent deposit to the account must be used to reimburse the state for the co-payments. Id.
\item \textsuperscript{264} 730 Ill. Comp. Stat. Ann. 5/3-6-2(f) (West 2007). Illinois charges inmates a two-dollar co-payment for non-emergency medical visits, which are deducted from the inmate’s account. Id.
\end{itemize}
legislatures have set the dollar amount of the co-payment. Colorado, Nevada, and Pennsylvania require co-payments but leave the amount to be charged per visit up to the DOC. Massachusetts leaves the decision whether or not to charge a co-payment completely up to the discretion of the DOC. Texas requires that inmates reimburse the state for the total cost of their health care expenses. New York—by statute—does not allow inmates to be charged a co-payment for any health care visits or treatment. The need to deal with health care costs is a concern for the federal prison system as well. The BOP may require inmates to pay some or all of their health care costs. Federal inmates are charged a two-dollar co-payment per health care visit. Approximately 90% of inmates

267. Colo. Rev. Stat. Ann. § 17-1-113 (West 2004). Colorado leaves the exact amount of the co-payment up to the Department of Corrections, but the statute states that the co-payment cannot exceed five dollars per visit.
270. Mass. Gen. Laws ch. 127, § 16A (2006). In Massachusetts, the reimbursement of inmate medical expenses is left entirely to the discretion of the commissioner of the Department of Corrections. The statute, entitled “Reimbursement of Medical Expenses by Persons Incarcerated in Pre-Release Facilities,” states in its entirety: “The commissioner may include in the rules and regulations promulgated pursuant to the provisions of section forty-eight provisions for the reimbursement of medical expenses by persons incarcerated in department of correction pre-release facilities.” Id.
274. 28 C.F.R. § 549.70 (2007). The regulation states:

(a) The Bureau of Prisons (Bureau) may, under certain circumstances, charge you, an inmate under our care and custody, a fee for providing you with health care services.

(b) Generally, if you are an inmate as described in § 549.71, you must pay a fee for health care services of $2.00 per health care visit if you:

(1) Receive health care services in connection with a health care visit that you requested, (except for services described in § 549.72); or

(2) Are found responsible through the Disciplinary Hearing Process to have
in the federal prison system make some contribution toward the cost of their confinement.\textsuperscript{275} The funds collected from these prisoners are not returned to the BOP, but rather are paid to the United States Treasury.\textsuperscript{276} As the BOP's \textit{Legal Resource Guide} says, "requiring such payments is an effective means for the government to recover some of the costs of operating the criminal justice system . . . ."\textsuperscript{277} Another reason given for the co-payment policy is to reduce the unnecessary use of health care services by federal prisoners.\textsuperscript{278} After this policy was implemented in 2005, the BOP found a 33\% decrease in the use of prison health care by inmates in the first six months.\textsuperscript{279}

Not everyone agrees with the basic premise that inmates should be required to make some contribution to their health care costs. Claims have been brought against these policies based on both Eighth Amendment cruel and unusual punishment and Fourteenth Amendment due process grounds without success.\textsuperscript{280} A group called the "Commission on Safety and Abuse in America's Prisons" (Commission) recently completed a study that recommended states revoke existing laws that authorize prisoner co-payments for medical care.\textsuperscript{281} The Commission claims that "[m]any short-term cost-saving measures imposed by local, state, and federal legislatures have long-term negative consequences."\textsuperscript{282} The Commission believes that, in an attempt to drive down the costs, legislators "pressure" corrections administrators to require prisoners to make co-payments for their medical care.\textsuperscript{283} They believe that co-payments may cost more in the long run by discouraging sick prisoners from seeking care early on, when it is easier to
prevent deterioration or transmission and the treatment is less expensive.\footnote{284} The Commission worries that “even small fees can be insurmountable for sick prisoners who have no control over the jobs and wages available to them.”\footnote{285}

However, most states do not require indigent inmates to make a co-payment and no inmate is denied necessary medical treatment in any case. Additionally, in the Third Circuit case of Reynolds v. Wagner, when an inmate sued a Pennsylvania prison over a policy that required a co-payment, the Court of Appeals found that although the inmate claimed he could not afford the small co-payment fee and therefore delayed seeking medical care, he did have a subscription to a newspaper, several magazines, bought snacks and candy, received money from his family, and made a car payment during the period of time in question.\footnote{286} Then Judge Alito, speaking for the court, said:

It is apparent that the Berks County Prison Program does not force inmates to choose between necessary medical care and other essentials. Rather, it forces them to choose between, on the one hand, the payment of a small fee for certain types of non-emergency medical care and, on the other hand, the use of these funds for non-essential expenses.\footnote{287} This clearly does not violate the Eighth Amendment.\footnote{288}

Also, the Commission never discusses the fact that there are other important aspects to charging an inmate a co-payment. Teaching an inmate personal responsibility is also a consideration for prison systems when the decision is made to require an inmate to contribute to the cost of his health care.\footnote{289} For example, the stated purpose of the co-payment in Reynolds was not to raise revenue, but rather to discourage the abuse of sick calls and “instill inmate responsibility.”\footnote{290} The rationale behind the BOP’s co-payment requirement is also to encourage inmates to be more responsible for themselves.\footnote{291} The BOP’s Legal Resource Guide says that the inmate co-payment requirement “assists offenders in becoming responsible, law-

\footnotesize{\begin{itemize}
\item \footnote{284}{Id.}
\item \footnote{285}{Id. at 456.}
\item \footnote{286}{Reynolds v. Wagner, 128 F.3d 166, 177-78 (3d Cir. 1997).}
\item \footnote{287}{Id. at 178.}
\item \footnote{288}{Id.}
\item \footnote{289}{See generally id. at 175.}
\item \footnote{290}{Id.}
\item \footnote{291}{FEDERAL BUREAU OF PRISONS, U.S. DEPT. OF JUSTICE, PROGRAM STATEMENT P6031.02, INMATE COPAYMENT PROGRAM 1 (2005), available at http://www.bop.gov/policy/progsstat/6031_002.pdf (stating that one of the expected outcomes of the inmate co-payment program is that “[i]nmates will be encouraged to be more responsible for their own health care”).}
\end{itemize}}
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abiding members of the community." 292

Additionally, discouraging the overuse of health care is one of the basic theories of all managed care, inside or outside of prison. 293 A co-payment requirement is simply a means of preventing inmates from abusing what would otherwise be free health care. There is no constitutional bar to the prison HMO unless it is demonstrated that managed care leads to ineffective health care which rises to the level of "cruel and unusual punishment" due to a violation of the deliberate indifference standard. 294 Indeed, the United States Supreme Court has stated that the Eighth Amendment "must draw its meaning from evolving standards of decency that mark the progress of a maturing society." 295 For this reason, an inmate can and should be required to make a co-payment when that is the standard for the rest of society. 296

V. CONCLUSION

State and federal prison systems struggle to deal with the competing concerns of providing inmates with adequate health care, rising health care costs, and maintaining order in our prisons. Providing an inmate more control over his health care decisions should be a greater concern. An increase in inmate autonomy in health care decisions is a logical extension to the trends of the privatization of prison health care and inmate co-payments for health care.

It appears that managed health care in prisons is here to stay. This relatively recent development in criminal confinement modifies many aspects of health care in prisons. HMOs are private companies, and inmates are more likely to trust a doctor who works for an HMO than a doctor who works directly for the prison, strengthening the doctor-patient relationship. The addition of a right to a second opinion as a member of an HMO gives an inmate some ability to control his medical care and question a doctor's decision. While considerations of cost are inescapable, the cost of medical treatment as part of an HMO plan has specific costs for specific treatments; arbitrary decisions are unlikely. The financial costs of treatment are one factor that is balanced with other factors, just like in the rest of society where the patient and doctor, together, decide on a reasonable course of treatment. 297 This creates a situation in which the physician-patient relationship in the prison setting begins to appear more like the rest of

292. LEGAL RESOURCE GUIDE, supra note 92, at 18.
293. Id. at 1378-79.
294. Siever, supra note 3, at 1403.
297. Shields, supra note 230, at 301.
Increased physician autonomy in giving medical advice strengthens the physician-patient relationship in the prison setting and makes inmates less suspicious of the doctor’s motives, making the relationship less adversarial.

Inmate co-payments for medical care are also a growing trend and should continue. While raising revenue and discouraging the overuse of health care in an attempt to deal with rising costs are important aspects of inmate co-payments, one of the commonly stated goals of these policies is to teach inmates personal responsibility, preparing them for life outside of the prison setting. Teaching good work habits and self-discipline to prisoners is a legitimate and proper goal. Inmates will probably not contribute to their health care costs willingly, but courts have held that as long as due process requirements are met, charging prisoners for health care may be considered part of the process of rehabilitation and reform. Prisons should attempt to develop citizens who will be able to lead a law abiding and responsible life upon release. Individual responsibility is an important part of American culture, and it is appropriate for prisoners to receive instruction on this issue while they are subject to confinement.

Most importantly, since there has been an increase in the privatization of prison health care and since inmates are increasingly required to contribute to their health care costs, inmates should therefore have proportionately greater control over health care decisions, as would any consumer who is paying for medical services. An inmate has an interest in personal bodily integrity and personal autonomy, even while in prison, and an inmate should retain as many of these rights as possible during confinement. Health care decisions are too fundamental and important to human existence to be discarded so easily in the prison setting. Of course, courts will always have to balance the various state interests with the inmate’s liberty interests whenever an individual is criminally confined, but the increased privatization of health care in prisons should be reflected by an increase in an inmate’s personal autonomy in health care decisions.


299. Shields, supra note 230, at 298; Prows, 704 F. Supp. at 275; see also Turner, 624 F. Supp. at 322.

300. Shields, supra note 230, at 298-99; Prows, 704 F. Supp. at 275.


302. Id.


Some supervision should still be required to ensure that the rights of the inmate are not being sacrificed in favor of other concerns, and the person in the best position to direct the course of the inmate’s medical treatment is the inmate himself.

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305. Shields, supra note 230, at 297.