HEALTH CARE IN JAILS:

Inmates' Medical Records & Jail Inmates' Right to Refuse Medical Treatment

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In these papers, an attempt is made to set forth the general principles of law which govern the rights of the confined. With respect to specific issues not addressed by the United States Supreme Court, the reader will note that court decisions and statutory law do vary somewhat from state to state and that differences do exist among the various Federal Circuits. For authoritative legal advice on specific problems, competent local legal counsel should be consulted.

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Inmates' Medical Records: Legal and Ethical Concerns

Introduction

In order to discuss the rights of the confined with respect to their medical records, it is necessary first to understand the principles applicable to medical records in general. The medical record made by a physician when he examines a patient is essentially a compilation of that physician's notes. The doctor records the results of his examination and the treatments he has prescribed in order to assist him in rendering proper care to the patient.

While the medical record is used primarily by the physician, information contained therein may be of use to other persons. Insurers, employers, other physicians, sometimes even family, may wish to obtain information from a patient's medical record. Because of the personal nature of such information, certain protections must be observed. In general, no information should be released to third parties without the authorization of the patient. Exceptions to this general rule, the principles behind it, and its applicability to the confinement situation are the subject of this paper.

I. The Doctrine of Confidentiality

> When a patient seeks out a doctor and retains him, he must admit him to the most private part of the material domain of man. Nothing material is more important or more intimate to man than the health of his mind and body. Since the layman is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health. As a consequence, he must disclose all information in his consultation with his doctor — even that which is embarrassing, disgraceful or incriminating. To promote full

> disclosure, the medical profession extends the promise of secrecy . . . . The candor which this promise elicits is necessary to the effective pursuit of health; there can be no reticence, no reservation, no reluctance when patients discuss their problems with their doctors. But the disclosure is certainly intended to be private. If a doctor should reveal any of these confidences, he surely effects an invasion of the privacy of his patient. We are of the opinion that the preservation of the patient's privacy is no mere ethical duty on the part of the doctor; There is a legal duty as well.

So spoke a Federal Court sitting in Ohio in 1965.[1] This opinion sets forth clearly and directly the reasons that the relationship between a physician and his patient has long been considered a confidential one. For these same reasons, the physician's entries into his patients' medical records are considered to be deserving of some protection.

Confidentiality is an ethical duty, subject to certain exceptions, not to make extrajudicial disclosures of private patient information. It is not to be confused with privileges granted by law, which will be discussed below. Nevertheless, as the *Hammonds* Court indicated, this ethical duty is indicative of a legal duty.

The *Principles of Medical Ethics*, the code of professional conduct applicable to all American physicians, states the doctrine thus:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or

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[1] *Hammonds* v. Aetna, 243 F.Supp. 793 (N.D. Ohio, 1965).

> unless it becomes necessary in order to protect the welfare of the individual or of the community.[2]

While the ethical standards of the medical profession are not legally enforceable *per se,* many states have made "unprofessional conduct" grounds for revocation or suspension of a medical license.[3] "Unprofessional conduct" can include noncompliance with the ethics of the profession.

In addition, the above ethical principle has been cited by several courts as an excellent expression of the physician's legal duty to his patients. This provision was the "promise of secrecy" referred to in *Hammonds, Supra.* In a case involving the unauthorized disclosure of a patient's medical history to his life insurers, the Supreme Court of New Jersey quoted this ethical provision and continued:

> The above ethical concepts, although propounded by the medical profession under its own code, are as well expressive of the inherent legal obligation which a physician owes to his patient. The benefits which inure to the relationship of physician-patient from the denial to a physician of any right to promiscuously disclose such information are self-evident. On the other hand, it is impossible to conceive of any countervailing benefits which would arise by according a physician the right to gossip about a patient's health.[4]

A third case involved a physician's unauthorized disclosures to a patient's employers.[5] The court noted that

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[2]American Medical Association, *Principles of Medical Ethics,* Section 9 (1957). see also: American Medical Association, *Judicial Council Opinions and Reports,* §5.62 (1977).

[3]See, e.g. California BPC §2379, Illinois Annotated Statutes 91 §16a(4), Code of Virginia 54 §317(11).

[4]*Hague* v. *Williams,* 181 A.2d 345 (N.J., 1962).

[5]*Horne* v. *Patton,* 287 So.2d 824 (Ala., 1973).

"willful betrayal of a professional secret" is grounds for license revocation in Alabama. Reading this together with the ethical principle cited above, the court concluded that public policy in Alabama requires the physician to maintain patient information in confidence. Again, the physician is under a general fiduciary duty not to make extra-judicial disclosures of patient information.

If the physician breaches this obligation to his patient, the patient does have legal recourse. The *Hammonds* Court, *Supra.*, made it clear that

> The unauthorized revelation of medical secrets, or *any* confidential communication given in the course of treatment, is tortious conduct which may be the basis for an action in damages.[6]

Numerous grounds have been proposed for such legal action. Invasion of privacy was successfully claimed in *Hammonds, Supra.* and in numerous other cases.[7] The law of defamation has been invoked as a basis for recovery where an improper or reckless disclosure by a physician has harmed a patient.[8] The unauthorized release of information can also be seen as a breach of a duty owed to the patient, causing injury to him.[9] In such a case, the physician would be liable for negligence. Finally, the physician who releases confidential information could be held liable for breach of contract. As reasoned by the Court in *Hammonds, Supra.*:

> Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compen-

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[6]*Hammonds, Supra.* at 802.

[7]See cases collected at 20 A.L.R.3d 1109 at 1114-1115.

[8]*Berry* v. *Moench*, 331 P.2d 814 (Utah, 1958), *Vigil* v. *Rice*, 397 P.2d 719 (N. Mex., 1964).

[9]*Felis* v. *Greenberg*, 273 N.Y.S.2d 288 (N.Y., 1966); c.f. *Steeves* v. *United States*, 294 F.Supp. 446 (D.S.C., 1968), where breach of another ethical principle was held to constitute negligence.

> sated. As an implied condition of that contract, this Court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission.[10]

Regardless of which legal action could be taken, invasion of privacy, defamation, negligence or breach of contract, maintaining confidentiality is clearly a legal as well as an ethical duty. All courts recognize, however, that this duty is not absolute, but is subject to certain exceptions.

The ethical principle cited above sets forth these exceptions:

> [A physician may make disclosure when] required . . . by law or . . . it becomes necessary in order to protect the welfare of the individual or the community.[11]

Therefore, there is no violation of patient confidentiality when a physician discloses information intended to protect the individual or the community. In the past, physicians were not held liable for disclosures to a hotel keeper, or even an employer, that a patient had venereal disease.[12] Today, most states have impressed upon the physician an affirmative duty to report venereal disease, child abuse, etc. Civil immunity is provided by statute to the physician so reporting.

Finally, the right to confidentiality may be waived when the patient himself puts his medical condition in issue, as where filing a claim for insurance benefits.[13] In such

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[10]243 F.Supp. at 801. See also *Horne* v. *Patton, Supra*, at 831-832.

[11]See footnote 2, *Supra*.

[12]*Simonsen* v. *Swenson*, 177 N.W.831 (Neb., 1920), *Cochran* v. *Sears-Roebuck*, 34 S.E.2d 296 (Ga., 1945).

[13]*Quarles* v. *Sutherland*, 389 S.W.2d 249 (Tenn., 1965), *Hammer* v. *Polsky*, 233 N.Y.S.2d 110 (N.Y., 1962), *Collins* v. *Howard*, 156 F.Supp. 322 (S.D. Ga., 1957).

cases, where a privilege might have existed, courts have held that by raising the issue, the patient waived any right to keep records confidential, if they were pertinent to the condition at issue.

II. Privilege

Recognizing the need to encourage full disclosure by patients to their physicians, forty-seven states and the District of Columbia have enacted statutes providing for a physician-patient privilege.[14] For the most part, these statutes give the patient the right to prevent his physician from testifying to confidential information in court. Some statutes are broader, however, and are, in effect, codifications of the doctrine of confidentiality.[15] In dealing with the physician-patient privilege, it must be remembered that no privilege exists apart from the statutes enacted by the legislatures. These vary greatly in their terms and scope. In all cases, however, the privilege is that of the patient, not of the physician. If the patient waives the privilege, the physician may not refuse to disclose the information.

Legal recognition of the doctrine of confidentiality does not necessarily depend on the existence of a physician-patient privilege statute in the state. Of the cases discussed *above*, *Hague* v. *Williams* preceeded the enactment of a physician-patient privilege in New Jersey, and there is still no privilege statute covering all physicians in Alabama, where *Horne* v. *Patton* was tried. As the Court stated in *Hague:*

> By analogy the history and thinking behind [the physician-patient] privilege bear a direct relationship to the present problem . . . . Our policy is to

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[14]Citations to statutory provisions, and major limitations thereon, are attached as Appendix A. No statutes creating a physician-patient privilege were found in Rhode Island, South Carolina, or Vermont.

[15]See, e.g. N.Y. Consol. Laws Ann. CPLR §4504.

> expose such information to view when it is relevant to the resolution of litigation . . . . However, the same philosophy does not apply with equal rigor to non-testimonial disclosure.

Consequently, even where no privilege exists, or where the statutory privilege is extremely limited, the physician still has a duty to protect confidential information disclosed to him by his patient. While he may be compelled to disclose such information in court if no privilege exists, he may still be liable to his patient, as discussed above, for indiscriminate, *extra*-judicial disclosure.

III. Medical Confidentiality in Prison

Given the reasoning behind judicial acceptance of the confidentiality of medical information, it is difficult to see any difference of application in the confinement setting. If anything, the detainee or the convict may have more reason than the average citizen to disclose certain information to a physician. Why should a detainee, for example, relate symptoms of drug withdrawal to a jail physician if he fears the physician's testimony will help convict him on a drug charge? By failing to provide confidentiality between physician and patient, jail officials could effectively deny him the treatment he needs.

Such an issue was discussed in a recent Michigan case.[16] The Court concluded:

> The state, whether intentionally or not, was able to condition defendant's power to obtain medical care upon his willingness to incriminate himself.
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> By placing defendant in the situation that it did, the state, through the jail authorities, was allowed to

[16]*Michigan* v. *Bland*, 218 N.W.2d 56 (Mich., 1974).

> profit from its ability to play off one of defendant's constitutional rights against another. Defendant had to choose between adequate medical care and the Eighth Amendment or silence without medical care and the Fifth Amendment. Such tactics in themselves have long been held to be unconstitutional.[17]

The Court reasoned that medical testimony regarding the patient's drug withdrawal unfairly prejudiced the jury where the patient was accused of sale of narcotics.

To obtain maximal security of confidential patient information, the medical treatment record should not be a part of the general confinement record. Whether the inmate is confined awaiting trial or serving a sentence, correctional officials have a duty to provide medical care.[18] The actual treatment by the physician is directed toward the health of the inmate, however, not his retention or punishment. This was made clear in a recent case, where an escaped mental patient-prisoner murdered a man.[19] The dead man's heirs sought to obtain all the prisoner's medical records. The court held that this claimant was entitled only to nonmedical information in the records, saying:

> Claimant asserts that the physician-patient privilege is not applicable because [inmate's] communications were not intended to be confidential since he was not in the hospital voluntarily, but incarcerated therein as a part of his punishment . . . We do not agree. [He] was in the hospital for treatment, not punishment, and information conveyed by him, whether or not willingly, was confidential.[20]

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[17]*Id.* at 59-60.
[18]*Estelle* v. *Gamble*, 97 S.Ct. 285 (1976).
[19]*Dowling* v. *State of New York*, 374 N.Y.S.2d 148 (N.Y., 1975).
[20]*Id.* at 150.

It should make no difference that the patient is confined. The principles of open and honest communication with one's physician apply equally to all patients. The exceptions which are part of the doctrine of confidentiality also apply, of course. In brief, the notes made by a physician in treating a confined person should be kept confidential subject to the interests of the patient, the welfare of the community, and any applicable laws.

A. The Duty of the Physician

What then is the obligation of the physician employed by a state or county to render medical service in a correctional institution? First, the fact of his contractual relationship with the institution should have no effect on his relationship with patients. Irrespective of who pays the physician, any treatment rendered establishes a relationship between the physician and the person treated.[21] Therefore, it is conceivable that the physician may have to protect his patients' confidentiality from disclosure to confinement personnel if they have no legitimate reason to see the patient's records.

There are, however, a number of legitimate reasons why personnel responsible for inmates' overall care may need access to information in their medical records. Obvious examples parallel the exceptions to the confidentiality doctrine: communicable disease which could imperil the welfare of the community; medical conditions which could endanger the welfare of the inmate (e.g. heart or back problems, dietary restrictions, etc.); statutory directives to report medical conditions of inmates to correctional authorities.

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[21]Compare *Maben* v. *Rankin*, 358 P.2d 681 (Cal., 1961) where it was determined the physician's duty was to the person treated, not to her spouse, who engaged the physician's services. See also *In Re Smith*, 295 A.2d 238 (Md., 1972). Mere examination, as opposed to treatment, may not create a sufficient relationship. See: *Lotspeich* v. *Chance-Vogt Aircraft*, 369 S.W.2d 705 (Tex., 1963). To the contrary, see: *Beadling* v. *Sirotta*, 176 A.2d 546 (N.J., 1961); *Union Carbide Corp.* v. *Stapleton*, 237 F.2d 229 (C.A.6, 1956).

In such situations, the physician would have a duty to provide adequate information to those having the responsibility for inmates' care. Regular reports could be made to responsible authorities (warden, sheriff, etc.) indicating which inmates need hospitalization, which should be isolated due to infectious diseases, which need special diets or cannot participate in heavy work details, etc. Such reports need not include the entire medical record.

Medical records may also be important in emergency situations. In the event of a stabbing or other altercation, for example, access to an inmate's medical data would be necessary. Data such as blood type, known allergies, etc. could be crucial. In institutions where 24-hour medical attendance is provided, there would be little difficulty getting such data. Where only outside coverage (such as a local hospital) is available, however, some responsible official should have access to the medical records.

Very few state legislators have directly addressed the question of how inmates' medical records are to be maintained. Only fourteen state statutes can be found requiring that records be kept, even of initial screening examinations.[22] Of these, Illinois, Maryland and Nebraska deal only with the record of the initial examination. Kansas, Maine, Oregon and Pennsylvania require that physicians keep medical records, and make them accessible to specified correctional personnel. Louisiana and New Jersey require that medical records be kept, not by the physician, but by the person in charge of the institution. Missouri requires that the physician keep a daily record, but only make biennial reports on the general condition of health in the institution. Arizona and New Mexico make the physician solely responsible for the medical records. Hawaii and Massachusetts merely require that records be kept.

In the majority of states, there are no such statutory requirements. In the absence of statutes or regulations of

[22]Citations to statutory provisions are attached as Appendix B.

state agencies such as a Department of Corrections, it would seem that any reasonable system of keeping medical records could be established. Care must be taken, however, to maintain patient confidentiality, while protecting the health and welfare of both the inmate-patient and the inmate-community.

In a situation where two or more physicians provide medical care to inmates, it would seem to be in the inmates' best interests to maintain the records of the inmates "in a safe and secure place" within the institution.[23] This would also seem advisable where allied medical personnel assist physicians in providing medical services. All personnel rendering medical care to inmates should have ready access to needed medical records.

When either the inmate or the physician permanently leaves the institution, medical records should be provided to the successor physician. Many states recognize the great importance of continuity of care, and require that medical records be provided to succeeding physicians upon the demand of the patient.[24] Like confidentiality, this is also a matter of ethical medical practice.[25] No rule can be established as to the manner in which such records are to be transmitted. In some instances, a summary may be sufficient; in others the complete medical records may be needed. Much depends on the circumstances of the particular institution.

B. Duties of Correctional Personnel

As has been discussed above, there are times when the sheriff, warden or other person in responsibility will legitimately have access to inmates' medical records. How often or under what circumstances will depend on how medical care is provided in the individual institution.

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[23]See Ariz. Rev. Stat. Ann. §31-201.010.

[24]See, e.g., Ill. Ann. Stat. 51 §73.

[25]American Medical Association, *Judicial Council Opinions and Reports* §5.61 (1977).

Medical information may be needed by correctional officials to provide for the needs of the individual inmate or the confined community as a whole. As seen above, when medical information is so used, these interests outweigh the inmate's interest in confidentiality.

Of more concern is the transmission of medical information by the inmate directly to confinement personnel. It is common, for example, for a jail guard to be the first person alerted to an inmate's need for medical care. Even if medical personnel are present at an institution at all times, it is generally a guard who must summon them at an inmate's behest. At many institutions, an outside physician or hospital is "on call" and an inmate's request for medical care must go "through channels." In these situations, the correctional personnel who are asked to obtain medical care are, in effect, the inmate's agents in securing such care. As such, they owe the inmate just as much a duty of confidentiality as does the physician who is ultimately contacted.

Such was the ruling in the case of *Michigan* v. *Bland, Supra*. There, a pre-trial detainee wrote to an official requesting hospital care. The court held:

> Here the communication was made to the hospital doctors through defendant's agent, Officer Immos, "with a veiw to establishing the relation" of physician and patient, and "securing professional aid for the principal." Not only was the use of Officer Immos "reasonably necessary," it was the only means by which defendant could contact the hospital doctors to receive the medical care he needed. Therefore, defendant should be protected against a betrayal of this confidence by his agent to the same extent as he would be protected against such betrayal by his physician.[26]

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[26]218 N.W.2d 56 (Mich., 1974) at 59.

Consequently, jail guards and other officials who have access to medical information, from whatever source, must treat it confidentially. To the extent that the physical and/or mental condition of an inmate is a private matter between the inmate and his physician, such privacy must be respected. This is particularly true with regard to those incarcerated awaiting trial. But even those convicted and sentenced do not sacrifice all rights and human dignity. To recall the words of the Federal Court in *Hammonds, Supra.*, "Nothing material is more intimate to man than the health of his mind and body." Respect for the human dignity, even of the convicted prisoner, must still be observed.

IV. Conclusion

Medical records and information are of a confidential nature. Certain considerations, such as the welfare of the patient, the welfare of the community, or the dictates of law, can outweigh the need for confidentiality. Nevertheless, unauthorized disclosure of a person's medical record is legally actionable.

Most states have enacted statutes protecting physician-patient confidentiality even in the courtroom. Where this privilege exists, patients can prevent their physicians from testifying to information obtained in confidence.

The fact of confinement does not limit a patient's need for discussions with his physician to be kept confidential. Physicians providing medical care in correctional institutions must protect inmates' confidences as they would any patient's. Such physicians do have certain duties, however. They must safeguard the health and welfare of both the individual and the community. Disclosures of medical information which are so directed do not violate the physician's duty of confidentiality.

Confinement personnel, too, have responsibilities in this regard. Because of their peculiar relationship to persons confined under their care, they may be unavoidably in-

volved in the inmate's medical care. When such is the case, the duties of confidentiality rest no easier on such personnel than on physicians. While the inmate's right to confidentiality of medical information clearly is not absolute, it must be carefully observed by all persons involved in his care.

APPENDIX A

Code of Ala. 46 §297 (36) (psychotherapist only)
Alas. Stat. §18.20.090
Ariz. rev. State Ann. §§12-2235 (civil cases) 13-1802 (criminal cases)
Ark. Rev. Stat. §28-607;
Cal. Evid. Code §992
Colo. Rev. Stat. §13-90-107(d)
Conn. Gen. Stat. Ann. §52-146(d) (psychiatrists only)
Del. Code Ann. 24 §1741(12) (violation of privileged communication grounds for license revocation)
D.C. Code §14-307
Fla. Stat. Ann. §90.242 (psychiatrists only)
Ga. Code Ann. §38-418(5) (psychiatrists only)
Hawaii Rev. Stat. §621-20.5 (civil cases only)
Idaho Code §9-203(4) (civil cases only)
Ill. Ann. Stat. §51-5.1, 5.2
Ind. Stat. Ann. §34-1-14-5(4)
Iowa Code Ann. §622.10
Kan. Stat. Ann. §60-427 (civil & misdemeanor cases only)
Ky. Rev. Stat. §213.200
Me. Rev. Stat. Ann. §32.3295, (psychotherapist only)
Md. Ann. Code C.J. §9-109
Ann. Laws of Mass. §233:20B (psychotherapist only)
Mich. Stat. Ann. §27A.2157
Minn. Stat. Ann. §595.02(4)
Miss. Code Ann. §13-1-21
Mo. Ann. Stat. §491.060(5)
Mont. Rev. Code §93-701-4(4) (civil only)
Neb. Rev. Stat. §25-1206
Nev. Rev. Stat. §49-215 to 245
N.H. Rev. Stat. Ann. §329:26
N.J. Stat. Ann. §2A:84A-22.2
N.M. Stat. Ann. §20-4-504 (psychotherapist only)
N.Y. Consol. Laws Ann. CPLR §4504
N.C. Gen. Stat. §8-53
N.D. Cent. Code Ann. §31-01-06
Ohio Rev. Code Ann. §2317.02(B)
Okla. Stat. Ann. §12-385

Ore. Rev. Stat. §44.040(d) (civil cases only)
Pa. Stat. Ann. §28-328 (civil only)
S.D. Comp. Laws §19-2-3
Tenn. Code Ann. §24-112 (psychiatrists only)
Tex. Stat. Ann. CCP §38.101 (drug abusers only)
Utah Code Ann. §78-24-8 (civil only)
Va. Code §8-289.1
Wash. Rev. Code Ann. §5.60.060 (civil only)
W. Va. Code §50-6-10
Wisc. Stat. Ann. §905.04
Wyo. Stat. §1-139

APPENDIX B

Ariz. Rev. Stat. Ann. §31-201.010
Hawaii Rev. Stat. §353-10
Ill. Ann. Stat. 38 §1003-8-2
Kan. Stat. Ann. §76-2415
La. Rev. Stat. §15:829
Me. Rev. Stat. Ann. 34 §§1-B, 912
Md. Ann. Code 27 §§691-697
Ann. Laws of Mass. §§127:16, 17
Mo. Ann. Stat. §216.255
Neb. Rev. Stat. §83-179
N.J. Stat. Ann. §26:8-5
N.M. Stat. Ann. §42-1-31.2
Ore. Rev. Stat. §179.495
Pa. Stat. Ann. 61 §372

Jail Inmate's Right to Refuse Medical Treatment

It is a well-established principle of law that a competent adult has a right to refuse medical treatment. It makes no difference that such refusal might be to that individual's detriment. The classic statement of this principle was made by Justice Benjamin Cardozo in 1914:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body. *Schloendorff* v. *Society of New York Hospital*, 105 N.E. 92 (New York, 1914).

More recently this principle has been further clarified:

> The keystone of this doctrine is every competent adult's right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession or even the community. *Wilkinson* v. *Vesey*, 295 A.2d 676 (R.I., 1972) at 687.

These statements clearly recognize that *every* competent adult has this right. If there is to be any exception with respect to inmates, it must be due to some overriding interest of the State. Where the patient is incompetent to consent to treatment, of course, someone else must be able to act in his behalf.

I. State Statutes

A few states have provided statutory protection of the inmate's right to refuse treatment.[1] The State of Missouri provides:

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[1]See footnotes 2-5 below, also Opinion of the Attorney General (Florida) #075-28 (1975) and Opinion of the Attorney General (Texas) #C-124 (1963).

> The administrative officer of any state mental institution or any division of the department of corrections may order such standard medical, surgical, and psychiatric treatment as may be necessary for the welfare of a patient or inmate.
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> In the event that a patient or inmate is competent to give informed written consent for any surgical or other procedure necessary or advisable, but not an immediate matter of life or limb, the administrative officer may accept and rely upon the consent, if given; *but if not given, may not proceed with such surgical or other procedure.*[2]

Missouri's neighbor, Illinois, approaches the question from a different perspective. Recognizing the need to obtain consent to treatment from a competent individual, that state provides for the situation where an inmate is incompetent to consent.

> A person committed to the Department [of Corrections] who becomes in need of medical or surgical treatment but is *incapable* of giving consent thereto shall receive such medical or surgical treatment by the *chief administrative officer* consenting on his behalf. Before the chief administrative officer consents, he shall obtain the advice of one or more physicians licensed to practice medicine in all its branches in this State. If such physician or physicians advise:
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> (1) that immediate medical or surgical treatment is required relative to a condition threatening to cause death, damage or impairment to bodily functions, or disfigurement; and

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[2]*Vernon's Annotated Missouri Statutes* §105.700, emphasis added.

> (2) that the person is not capable of giving consent to such treatment; the chief administrative officer may give consent for such medical or surgical treatment, and such consent shall be deemed to be the consent of the person for all purposes, including, but not limited to, the authority of a physician to give such treatment.[3]

Still another approach has been taken by the State of Virginia. That State addresses only the concern of persons under 18 years of age who have been sentenced or committed to the custody of the Department of Corrections or Board of Corrections. In such cases, authority commensurate with that of a parent is conferred on the Director of Corrections for purposes of giving consent to needed medical or surgical treatment.[4]

II. Case Law

Although such statutes are few, judicial reasoning also supports the inmate's general right to refuse treatment. Such was the position of the court in *Runnels* v. *Rosendale,* 499 F.2d 733 (C.A.9, 1974). In *Runnels,* a prison physician performed a hemorrhoidectomy on a state inmate who allegedly refused to consent to the procedure. The court remarked:

> Because of a prisoner's peculiar dependence and vulnerability in respect to medical treatment, the right to be secure in one's person could be violated by the substantial threat to physical security necessarily involved in major surgery, when such surgery is neither consented to nor required for purposes of imprisonment or security.

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[3]*Smith-Hurd Illinois Annotated Statutes,* 38 §1003-6-2(e), emphasis added.
[4]*Code of Virginia* §32-137(2a).

The court found no "compelling state interest" to justify violation of the inmate's "constitutionally protected right" of security and privacy. Therefore, it reversed the trial court's dismissal of the inmate's complaint.

A. Communicable Disease

There are cases where a "compelling state interest" has been found to override the individual's right to refuse treatment. Where treatment is required in order to prevent the spread of communicable disease, society's interests can supersede those of the individual. The United States Supreme Court upheld on this basis a state statute requiring smallpox vaccination of all citizens. *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). On the same basis, a requirement that a chest X-ray be taken of all students entering a state university was upheld. The objections of a Christian Scientist were overridden by the interest of the state in preventing the spread of tuberculosis to its citizens. *State ex rel. Holcomb* v. *Armstrong*, 239 P.2d 545 (Wash., 1952). In light of these decisions it should be clear that the state has an interest in preventing the spread of communicable diseases. That interest is particularly strong in an institution such as a jail, where close contact among inmates is unavoidable. One state has recognized this exception. The State of Louisiana provided, as early as 1948:

> Except as to compliance with the sanitary laws and all reasonable regulations relating to contagious and infectious diseases, any sane patient or sane inmate of the Louisiana State Penitentiary may decline any medical care or treatment offered or provided by the institution and provide other care for himself at his own expense.[5]

The statute does not address the question of how the inmate

[5] *Louisiana Revised Statutes*, 15:860.

is to be adjudged "sane," however. It is also curious that Louisiana provides this protection for inmates of the State Penitentiary only.

B. Security Purposes

The *Runnels* case alludes to an additional interest which might override the inmate's right to refuse treatment. The Court allows for compulsory medical treatment whenever "required for purposes of imprisonment or security." It is unclear which treatments might be so required. From other cases it is clear that medical treatments intended to punish or "rehabilitate" are not permissible without the inmate's consent. For example, the injection of emetic drugs as "aversive stimuli" is considered a medical treatment which can be refused by the inmate. *Knecht* v. *Gillman,* 488 F.2d 1136 (C.A.8, 1974). Similarly, *Mackey* v. *Procunier,* 477 F.2d 877 (C.A.9, 1973) held that psychosurgery intended to correct an inmate's sexual psychopathology requires his consent.[6] Apparently neither of these procedures are "required for purposes of imprisonment or security" in the sense intended by the *Runnels* case. Indeed, at least one commentator questions whether any medical treatment could be so required.[7]

C. Self-Inflicted Injury

Because the inmate is restrained by the authority of the state, the state does have certain duties, however. According to *Fitzke* v. *Shappel,* 468 F.2d 1072 (C.A.6, 1972) at 1076, the state must provide whatever is necessary for sustaining life and health. This duty may come into conflict with the inmate's right to refuse treatment in certain circumstances.

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[6]See also: *Scott* v. *Plante,* 532 F.2d 929 (C.A.3, 1976); *Souder* v. *McGuire,* 423 F.Supp. 830 (M.D. Pa., 1976).

[7]Ginsberg, "A New Perspective in Prisoner's Rights: The Right to Refuse Treatment and Rehabilitation," 10 *John Marshall Journal of Practice and Procedure* 173 (Fall, 1976) at 185.

A very recent decision took the position that such necessary medical care cannot be withheld even in instances of deliberate self-injury. *Scharfenberger* v. *Wingo*, 542 F.2d 328 (C.A.6, 1976) at 330. Thus, the state has a duty to protect inmates from self-inflicted injury or suicide. Clearly, the suicidal inmate could be expected to reject medical treatment designed to save him. Nevertheless, this situation would be an exception to the general rule that a person has a right to refuse treatment in two respects. First, the right to refuse is limited to mentally competent individuals. It is not likely that the suicidal inmate would be considered competent. Secondly, the provision of medical treatment in such a case would seem sufficiently related to the security or correctional interests of the institution. Such would conceivably be the sort of interest referred to in *Runnels*.

The legislature of the State of North Carolina has enacted a statute dealing with just such a situation. The approach taken by North Carolina carefully balances the inmate's general right to refuse treatment with the special problems surrounding self inflicted injury:

> When a board comprised of the Secretary of Correction, the chief medical officer of a prison hospital or penal institution, and a representative of the State or county social services department of the county where the prisoner is confined, shall convene and find as a fact that the injury to any prisoner was wilfully and intentionally self-inflicted and that an operation or treatment is necessary for the preservation or restoration of the health of the prisoner and that the prisoner is competent to act for himself or herself; and that attempts have been made to obtain consent for the proposed operation or treatment but such consent was refused and the findings made by this board have been reduced to writing and entered into the prisoner's records as a permanent part

> thereof, then the local health director . . . or in the event a local health director is not immediately available then the local health director of any adjoining or nearby area, shall be authorized to give or withhold, on behalf of the prisoner, consent to the operation or treatment.
>
> In all cases coming under the provisions of this Article, the medical staff of the hospital or institution shall keep a careful and complete medical record of the treatment and surgical procedures undertaken. The record shall be signed by the chief medical officer of the hospital or institution and the surgeon performing any surgery.[8]

D. Emergencies

Finally, in emergency situations, consent may be implied. Justice Cardozo, in establishing the "right to refuse treatment," qualified it thus:

> 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. 105 N.E. at 93.

In a case where a federal prisoner underwent surgery for internal hemorrhaging, the Court disallowed his contention that treatment was rendered without his consent. *Owens* v. *Alldridge*, 311 F. Supp. 667 (W.D. Ok., 1970). The Court did not comment at length on the emergency nature of Owens' condition. Nevertheless, this factor was seen by the *Runnels* Court (Supra. at 735 n.2) as a major distinction. *Runnels* noted clearly that, in a medical emergency, consent may be implied.

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[8]*General Statutes of North Carolina* §130-191.1.

III. Juveniles

Although competent adult inmates may refuse treatment, the law is unclear as to the rights of confined minors. As mentioned above,[9] the State of Virginia clearly places the Director of Corrections *in loco parentis*. What is the rule with respect to treatment of juveniles elsewhere, however? Need physicians obtain the consent of the parent, guardian or legal custodian in order to provide medical treatment to juvenile inmates?

The general common law rule with respect to minors is that a physician may not treat a minor patient without parental consent.[10] There are exceptions to this rule, however, the most significant of which is the doctrine of emancipation. A minor is considered "emancipated" when the parents have surrendered parental duties and responsibilities and all rights to custody of the minor. Such circumstances as marriage[11] and military service[12] are clear instances of emancipation of a minor. Some states have codified the doctrine of emancipation in their statutes.[13]

When arrested or convicted, a minor is removed from his parents' custody for confinement purposes. Whether such removal would constitute emancipation for purposes of consent to medical treatment is unclear. The better rule would seem to be that reflected in the Virginia statute referred to above. Namely, those responsible for his care (i.e. the Director of Corrections, Sheriff, warden, etc.) should be able to consent to such medical treatment as is needed to safeguard the minor's health.

Another exception to the requirement of parental consent is the emergency situation. As with the adult inmate, the

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[9]See footnote 4, *Supra*.

[10]See, e.g., *Bonner v. Moran*, 126 F.2d 121 (CADC, 1941).

[11]*Bach v. Long Island Jewish Hospital*, 267 N.Y.S.2d 289 (N.Y., 1966).

[12]*Swenson v. Swenson*, 227 S.W.2d 103 (Mo., 1950).

[13]See, e.g. *Ariz. Rev. Stat.* §44-132; *Cal. Civ. Code Ann.* §34.6; *Illinois Ann. Stat.* §91-18.1, *Ind. Stat. Ann.* §16-8-3-1; *Miss. Code Ann.* §41-41-3; *Nev. Rev. Stat.* §129.030, *N.M. Stat. Ann.* §12-25-1; *Penna. Stat. Ann.* §35-10101.

physician may proceed with treatment in an emergency without obtaining the parent's consent.[14] An emergency exists where the physician determines that the obtaining of parental consent is not reasonably feasible under the circumstances without adversely affecting the condition of a minor's health.[15]

In all events, refusal of consent to treatment is subject to the same conditions set out above with regard to adult inmates. Irrespective of whether the parent's consent is required, consent to treatment for contagious disease or self-inflicted injury, for example, cannot validly be refused.

Conclusion.

In conclusion, the right of any competent adult to refuse medical treatment applies equally to jail inmates. Likewise the exceptions to this right which apply generally apply also in jails. Treatment may not be refused where the state's interest in protecting its citizens conflicts with the patient's (inmate's) desires. Such is the case with treatment of contagious or venereal diseases. Treatment may not be refused where it is offered in satisfaction of a duty to protect the patient (inmate) against self-inflicted injury or death. This duty is no less for the jail than for the general hospital. Finally, a patient's (inmate's) consent to treatment can be implied in emergency situations. In short, jail physicians must observe the same principles of informed consent as apply when treating the civilian population.

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[14] See: *Luka* v. *Lowrie*, 136 N.W. 1106 (Mich., 1912); *Sullivan* v. *Montgomery*, 279 N.Y.S. 575 (N.Y., 1935).

[15] Such a provision is codified in many states. See, e.g. *Illinois Annotated Statutes*, §91-18.3.

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