FEATURE

In this first of a two-part article, the authors establish the legal foundation for an inmate's right to mental health treatment, analyze questions related to how the obligation to treat may arise, and address the basic legal concepts of "serious medical needs" and "deliberate indifference." In the July-August issue, the authors will present a service delivery model which is a blueprint for compliance with such basic legal standards, and provide an example, from actual litigation, of how to use their legal analysis and compliance blueprint.

Inmates With Mental Disorders: A Guide to Law and Practice

By Fred Cohen and Joel Dvoskin*

I. Introduction

Prison inmates and jail detainees with serious mental disorders have a constitutional right to appropriate treatment.[1] For convicted inmates, this right derives from the Eighth Amendment's proscription of cruel and unusual punishment.[2] For jail detainees, the right derives from the Fourteenth Amendment's due process clause.[3]

While the legal source of the right to treatment for inmates and detainees differs (cruel and unusual punishment v. due process), the case law makes no substantive distinctions in terms of what treatment must be provided.[4] Obviously, there are differences in service delivery systems; for example, jails experience more short-term crises and suicides, and fiscal and administrative relationships may vary.[5] However, when the courts address what types of conditions entitle which persons in confinement to what type of medical or psychiatric care, the substantive entitlements are essentially the same.

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II. The Legal Scenario

A. Establishing the Right

The constitutional genesis of a prisoner's right to treatment is the Supreme Court's decision in *Estelle v. Gamble*.[6] There, the prisoner showed that he had suffered a work-related back injury, while the state showed that the inmate was seen by doctors and given some medical care. The inmate did not show, however, that the failure to perform some diagnostic tests usually associated with back injuries constituted a constitutional violation. The applicable standard derived from that decision is whether or not *deliberate indifference* to a prisoner's *serious medical needs* was shown.[7]

Deliberate indifference under the Eighth Amendment was explained in this way:

> [A]n inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton infliction of pain" or to be "repugnant to the conscience of mankind." Thus, 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.[8]

While the meaning of "serious medical needs" has been the subject of subsequent litigation, the Supreme Court in *Estelle* provided no further elaboration. Indeed, since the case involved a physical injury, it could be argued that cruel and unusual punishment applied only to physical injuries or ailments. One year after *Estelle*, however, the Fourth Circuit, in *Bowring v. Godwin*, found no reason to distinguish physical from mental illnesses for the purposes of constitutional safeguards. Since then, no reported judicial decision has rejected the Fourth Circuit's well-reasoned views.[9]

Although there are a host of complex questions in this area of law, the most important problems relate to what is a serious mental disorder and what constitutes deliberate indifference. Before elaborating on these two questions, however, it is necessary to explain the constitutional duty of care and what constitutes medical malpractice.

B. Constitutional Duty of Care; Medical Malpractice

Where the government has physical custody of a person, it must provide reasonable protection from harm as well as medical and psychiatric care. Neither the reason for custody nor the source of the medical or psychiatric problem affect these constitutional obligations.

In *DeShaney v. Winnebago County Dep't of Social Servs.*, the Supreme Court rejected a severely injured child's damages claim largely because the state did not have physical custody of the child and therefore acquired no duty to protect him from a brutalizing father.[10] When a person is in jail or prison, however, there clearly is a

duty to exercise reasonable care to preserve his or her life and health.[11]

The duty to protect requires that vulnerable individuals be shielded from harm,[12] whereas the duty to treat requires medical or psychiatric interventions designed, *inter alia*, to relieve needless pain and suffering. While both duties arise from the common ground of custody, operationally they differ dramatically.

In *Buffington v. Baltimore County, Md.*,[13] a young man was taken into police custody after his older brother called the police concerning his fears that the younger brother might commit suicide. Police apprehended the younger brother, who was drunk and armed, and placed him in protective custody. Shortly thereafter, the man committed suicide in his cell.

In a suit brought by the man's parents, the defendants argued that the Constitution does not require the state to take steps to prevent suicide when it intervenes at the family's request to protect the person from himself. The court rejected this argument, stating that nothing in *DeShaney's* "rationale for finding that some affirmative duty arises once the state takes custody of an individual can be read to imply that the existence of the duty somehow turns on the reason for taking custody."[14] Thus, regardless of who caused a serious medical or psychiatric problem or the legal basis for custody, the custodian's duty is to provide appropriate care.[15]

At times there is conceptual confusion between a custodian's obligation to provide safe conditions for those in his charge and the custodian's limited obligation to provide treatment. While there may be some overlap in a particular case – a physically vulnerable inmate who also has a florid psychosis – there is a clear conceptual and operational difference between these two duties.

As alluded to earlier, one of the most basic rights of a detainee or inmate is to be held under conditions which assure personal safety; that is, freedom from physical and sexual assault. In *Youngberg v. Romeo*,[16] the Supreme Court dealt with a complex set of issues related to the care of civilly confined persons with mental retardation. As a predicate for determining that such persons have a constitutional right to some minimal training, the Court noted that prisoners have a protected liberty interest in personal safety. Viewing incarcerated persons convicted of crime as occupying the lowest rung on the ladder of legal rights, the Court reasoned that persons in state confinement who are entirely innocent of wrongdoing must enjoy at least the same rights.[17]

This duty to provide protection is much less demanding than the duty to provide treatment. Protection, or safety, simply requires insulating potential victims from threatened harm. Parenthetically, at least one court has taken cognizance of the duty to protect prisoners who do not have mental illnesses from potentially violent inmates with mental illnesses.[18] Whatever else the word treatment implies, at its core is professional judgment and conduct designed to relieve pain and prolong life by appropriate interventions. The duty to protect inmates, then, should be viewed as an insulating function, whereas the duty to provide treatment is an affirmative obligation to relieve pain or suffering which may, in turn, include efforts to change a person's ideas and behavior.[19]

The legal obligation to treat a detainee or a convict is different from the obligation to treat someone who has been civilly committed. Any person who is involuntarily hospitalized may reasonably claim that the rationale for a noncriminal confinement must include an obligation to provide treatment. Where the commitment is exclusively based on a *parens patriae* rationale, as opposed to the police power rationale which undergirds commitments for dangerousness to others, then the demand for treatment is especially compelling.[20]

As one of us has written elsewhere,

> Whatever the rationale or legal source relied upon, ultimately a civil patient's legal claim to treatment faces outward from the institution: Treat me or release me. I'm here without benefit of full criminal procedures and without the moral opprobrium of having committed a crime. Therefore you cannot punish me, and if you fail to treat me, you are punishing me. . . . I'm here because you (or a court) said I needed treatment. You, therefore, owe me treatment and if you will not or cannot deliver, then you must let me go.[21]

There is, of course, no ready analogue for prison inmates' claims to psychiatric care. The legal basis for an inmate's incarceration is the conviction of a crime and a sentence.[22] Indeed, the Eighth Amendment, which protects an inmate from cruel and unusual punishment, is also the constitutional foundation for "ordinary" punishment which is *not* cruel and unusual. The legal basis for holding an inmate or detainee does not evaporate even when minimally appropriate psychiatric care is not provided. In an individual case, the remedy will be damages and possibly a form of injunctive relief, while in a class action case involving a challenge to the entire delivery system, the remedial action will focus on system repair and reform, but not the release of those in confinement.

While federal courts applying federal law have led the way, state law may also provide a basis for an inmate's claim to mental health services in the form of a lawsuit claiming a failure to deliver adequate and appropriate care. For example, a New York prisoner injured his knee while in jail and during the next three and one-half years continually complained about his knee.[23] Evidence showed that the state failed to properly diagnose a torn meniscus and ligament injury, despite the inmate's display of classic symptoms and the fact that an arthrogram would have revealed the injury. The state provided special shoes, pain killers, braces and the like, but the delay in making a proper diagnosis and providing appropriate care was found to constitute medical malpractice.[24] A $100,000 damages award was upheld.

There is a striking resemblance between the back injury which was the subject of *Estelle v. Gamble* and the knee problem involved in the instant decision. Gamble received

some medical treatment, but certain tests which might have more accurately disclosed the nature of his low back injury were not done. The state law claim in the New York case is based on a finding of medical malpractice, whereas Gamble's claim was decided according to the deliberate indifference standard, which is far less demanding of the practitioner than negligence or medical malpractice.

III. Serious Medical Needs Standard: Physical Versus Mental Conditions

While serious medical need is one of the major prongs of the *Estelle* test for constitutionally mandated care, there is no real certainty concerning what is or is not serious. Indeed, there continues to be lively debate about what constitutes a medical or psychiatric disorder.[25] While civil commitment law has a strong legislative component, the law of prisoners' rights is basically judicially made and enforced.[26] Definitions of serious disorder often are tucked away in consent decrees or stipulations and court orders, and are difficult to study systematically.

A Massachusetts case dealing with physical injuries sustained in a bar altercation and then additional injuries allegedly inflicted later by the arresting officers is an instructive case with which to begin.[27] The plaintiff claimed that he was unlawfully beaten by the police and that necessary treatment was delayed by at least 10 hours. In reviewing – and upholding – a grant of summary judgment for the defendants, the court states: "At most, the medical record suggests that Gaudreault suffered a 'blow out fracture' of the right orbit, resulting in a deviated septum, a cyst in his sinus and some transient nerve damage."[28]

No one seriously questioned the detainee's general right to treatment for serious injuries. One of the basic questions, however, is whether the above-described injuries were serious. The reviewing court stated that:

> A medical need is "serious" if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention. . . . The "seriousness" of an inmate's needs may also be determined by reference to the effect of the delay of treatment.[29]

This approach to defining serious medical need is flawed in several respects. First, physicians diagnose minor ailments as calling for minimal care, as in headaches and aspirin, all the time. Thus, a medical diagnosis and prescription for care by itself is hardly determinative of seriousness. Second, even if one doctor diagnoses something as serious, that does not prevent a second medical opinion to the contrary and one upon which a correctional decisionmaker reasonably might choose to rely.[30] Third, there is no mention of a key ingredient from *Estelle v. Gamble*, i.e., preventable pain; the greater the pain and the longer it is endured, the more likely is a supportable diagnosis of "serious." Fourth, the obvious-to-a-layman factor is oft repeated but little explained. A bone protruding through the skin is one kind of layman's call, while a mental illness is very different. Behavior that one person views as "bad" another characterizes as "mad" and, without more, who may say who is correct?[31]

In the context of sex offenders and the possibility of their having a mental disease, Fred Cohen has stated:

> Clearly, the medical profession serves as the gatekeeper for entry into the world of disease. Although the term "disease" is traditionally associated with pathology of tissue, in the context of mental disease (or illness) it more nearly resembles a logical or theoretical construct which is not demonstrably valid or invalid. Thus, the various diagnostic categories of mental disease and disorders, as well as individual diagnosis, are in the hands of doctors and other mental health professionals."[32]

With detainees and inmates there often is a threshold question whether disturbing or damaging behavior may be attributed to mental disorder. Dozens of variables ranging from the availability of resources to the personal perspectives of clinicians will enter into the decisionmaking process. Inmates who, for example, argue for treatment due to their claimed dysthymic disorder or transsexualism will first have to establish the existence of a serious mental disorder before arguing for appropriate treatment.[33]

In truth, what is or is not viewed as a disorder, and then as serious, will be the subject of the battle of experts. The courts will announce a few oft repeated formulations, but the experts will be the key. Among those judicial formulations are:

> 1. The (diagnostic) test is one of medical or psychiatric necessity.
>
> 2. Minor aches, pains, or distress will not establish such necessity.
>
> 3. A desire to achieve rehabilitation from alcohol or drug abuse, to lose weight to simply look better or in order to feel better, will not suffice.[34]
>
> 4. A diagnosis based on professional judgment and resting on some acceptable diagnostic tool, e.g., D.S.M.-III(R), is presumptively valid.

If a mental health professional – especially a psychiatrist or clinical psychologist – diagnoses a malady as a bona fide mental disorder, and if that expert determines that it is serious, that is the threshold requirement for a claim under *Estelle v. Gamble*. The bona fide exercise of professional judgment is accorded great deference by the courts.[35] In making an initial diagnosis, then, the clinician will first refer to his or her professional training and norms, but should also realize that constitutional requirements for treatment relate only to serious disorders, and that among the critical components of that decision, are the amount of pain associated with the disorder and the consequences of a delay in providing appropriate care.

Courts have also determined that while "mere depression" or behavioral and emotional problems alone do not qualify as serious mental illness,[36] acute depression, paranoid schizophrenia, "nervous collapse," and suicidal tendencies do qualify.[37]

In accepting or rejecting such diagnostic categories, courts are strongly influenced by accounts of the inmate's behavior. For example, in a Massachusetts prison suicide case, a federal appeals court held that "the record contains sufficient evidence that Torraco had a serious mental health need."[38] In support of this conclusion, the court referred to an earlier suicide attempt while in confinement, assault on a prison official later attributed to impaired mental health, and overdosing on T.H.C. pills somewhat later.[39] Thus, clinical diagnosis supported by incidents supportive of those judgments are at the core in determining serious disorders.

IV. Deliberate Indifference

The "deliberate indifference" standard for determining constitutional liability, as noted, was born in the context of an inmate's complaint about the quality of the medical care he received. The reach of the deliberate indifference standard has been greatly expanded in a recent landmark Supreme Court decision.

In *Wilson v. Seiter*,[40] the Court was asked to determine the proper standard by which federal courts should resolve inmates' so-called general conditions lawsuits – overcrowding, excessive noise, inadequate heating and cooling, improper ventilation, unsanitary bathroom facilities and food preparation, and similar matters. The common thread in such litigation is the general living environment.

The Court claimed it had three choices: (1) adopt the "malicious and sadistic for the very purpose of causing harm" standard from *Whitley v. Albers*;[41] (2) decide only whether the inmates' claims are serious without regard to any mental element; or (3) require the deliberate indifference standard borrowed from medical and psychiatric claims.

The Court adopted the deliberate indifference standard to govern the resolution of general conditions lawsuits. In doing so, the Court rejected a good deal of case law which had required only that inmates show life or health-threatening conditions, without regard to whether prison officials had some culpable mental state in creating or maintaining those conditions. The resolution of general conditions cases, then, will depend on the courts' understanding of the meaning and application of deliberate indifference. Thus, the decisions on point reviewed here are likely to have wider application than medical or psychiatric issues.

In our effort to convey some shared understanding of this term, *Estelle* itself provides an important initial reference point: deliberate indifference requires something more than poor judgment, inadvertence or failure to follow the acceptable norms for practice in a particular geographic area.[42] Deliberate indifference is not, however, coextensive with the intentional infliction of needless pain and suffering. Looked at another way, deliberate indifference requires more culpability than malpractice but need not reach the more demanding criteria for intentional conduct; that is, consciously acting to achieve a preconceived result.

In the context of a suicide case, a federal court explained:

> The deliberate indifference standard implicitly requires assessment of states of mind in order to determine the constitutional adequacy of inmate medical care. Isolated negligence or malpractice is insufficient to state an *Estelle* claim. Deliberate indifference exists when action is not taken in the face of a "strong likelihood, rather than a mere possibility" that failure to provide care would result in harm to the prisoner.[43]

The *Estelle* approach to deliberate indifference, as noted earlier, arose where the inmate claimed that he received improper and inadequate treatment. In the definition set out above, reference is to an omission, i.e., to a failure to provide care when there was a duty to do so.

The mental state of deliberate indifference, which typically is inferred from conduct, may apply to how treatment was provided or to a failure to provide treatment when it was mandated. The significance of the *Estelle* rule is that it creates a constitutional duty of care which is the *sine qua non* of a legal claim in this area of law. Without some legal duty to do something, the consequences of a failure to interrupt a course of events are not legally attributable to a particular person or entity. That is why the earlier discussion of *Estelle v. Gamble* is central to this article.

A recent case involving a Nevada state prison inmate is instructive on the difference between deliberate indifference and mere negligence.[44] Inmate Wood arrived at the prison with a shoulder injury which had been repaired by inserting two pins in his damaged shoulder. The treating physician also prescribed a sling to prevent dislodging the pins. Over Wood's protests, a prison guard confiscated the sling as a security threat, without any access to Wood's medical file. Wood promptly broke one of the shoulder pins and experienced intense pain. After several days, the prison physician saw Wood and prescribed medication and recommended referral to an outside orthopedic specialist. Two months later, the orthopedic specialist removed the floating pin. The nub of Wood's complaint is deliberate indifference to his medical needs based in part on the unavailability of his medical records and an inadequate course of treatment during the two-month period.

The Court of Appeals for the Ninth Circuit stated:

> We agree with the district court that, while the prison officials' treatment of Wood may have been negligent, it did not rise to the level of deliberate indifference.
>
> Wood's strongest claim is that the prison officials failed to provide the inmate's medical records when he arrived at Nevada State Prison. This failure caused the confiscation of Wood's sling, which in turn caused the harm Wood complains of. This conduct, though apparently inexcusable, does not amount to deliberate indifference. While poor medical judgment will at a certain point rise to the level of constitutional violation, mere malpractice, or even gross negligence, does not suffice. . . .

> Nor does the delay in treatment . . . constitute an eighth amendment violation; the delay must have caused substantial harm. Given the seriousness of his condition and the treatment Wood actually received such harm was not present here.[45]

This analysis creates a significant hurdle for inmates' medical claims. Consider, for example, the unavailability of Wood's medical records despite the fact that he injured his shoulder in jail just prior to being transported to prison. Inexcusable, says the court, but not deliberate indifference.[46]

In addition, courts have also disagreed as to whether gross negligence equates to deliberate indifference.[47] On the other hand, in reviewing a "failure to train" claim, the Supreme Court has implied that deliberate indifference just might be a more rigorous standard than even gross negligence.[48]

Without pretending that there is certainty in this area, gross negligence probably refers to an act or omission where there is a high degree of risk-creation (e.g., if a sling is not worn then a pin will likely break), with conscious realization of such risk ("My doctor said to tell you guys that if I didn't wear this sling, something bad would happen to my shoulder"). Gross negligence and deliberate indifference, after all, are hardly scientifically valid or objective terms.[49] They are descriptive and subjective and seem to be very close neighbors.

The final point from the *Wood* excerpt relates to the requirement that the delayed treatment cause substantial harm. Again, there are several ways to look at that requirement. First, harm can – and should – include needless pain or suffering, and need not be limited to the medical sequelae associated with the mending of the broken bone. Indeed, we strongly believe that the original *Estelle v. Gamble* formulation intended to encompass the prolongation of relievable pain, as well as consequent mental suffering.

The *Wood* court uses the term "substantial harm" in a way that also raises some questions. One might argue that since a serious medical condition is a threshold requirement, then delay always results in substantial harm and, therefore, ought not to be a separate proof of liability requirement. Implicit in the *Wood* opinion, however, is that *Estelle* is explicitly a three-prong test: (1) serious medical or mental disorder; (2) deliberate indifference; and (3) substantial harm. Prior to *Wood*, we thought of *Estelle* as a difficult two-prong test: deliberate indifference and serious disorder. *Wood* suggests that an independent third prong may exist, requiring a separate showing of substantial harm.[50]

In a significant New York case, *Langley v. Coughlin*,[51] female inmates confined at Bedford Hills Correctional Facility complained that prison officials routinely placed inmates with severe mental illnesses in the Special Housing Unit (SHU) without proper screening, without even marginally adequate treatment, and then failed to safeguard the rights of other inmates from a long list of horrible conditions created by the disturbed inmates.[52]

The appropriate state agencies resolved the injunctive claims on the issues of diagnosis, treatment, and a tolerable environment.[53] That left the plaintiffs' claim for damages. In considering the possibility of damages, the magistrate clarified the meaning of deliberate indifference.

> [A]n isolated and inadvertent error in treating even a serious medical need would not constitute a violation since the Eighth Amendment does not constitutionalize the law of medical malpractice. On the other hand, a serious failure to provide needed medical attention when the defendants are fully aware of that need could well constitute deliberate indifference, even if they did not act with a punitive intent. . . .
>
> [W]hile one isolated failure to treat, without more, is ordinarily not actionable it may in fact rise to the level of a constitutional violation if the surrounding circumstances suggest a degree of deliberateness rather than inadvertence, in the failure to render meaningful treatment. Moreover, the inference of such indifference may be based upon proof of a series of individual failures by the prison even if each such failure – viewed in isolation – might amount only to simple negligence.[54]

Two key points are to be discerned from the above excerpt. First, deliberate indifference may be shown by a series of negligent acts or omissions which then may cumulate to become a constitutional violation. No single act or omission need attain deliberate indifference, but if seriously ill inmates are consistently made to wait for care while their condition deteriorates, or if diagnoses are haphazard and records minimally adequate then, over time, the mental state of deliberate indifference may be attributed to those in charge.

Note that the judge referred to being "fully aware" of the serious medical needs. Repeated acts of negligence or poor practice should also constitute the requisite proof of knowledge. Medical directors cannot turn their backs to that which they must face and then claim ignorance. And, the more often their backs may be turned, the more likely there may be a finding of deliberate indifference.

Second, *Langley* carefully develops the professional judgment standard of care. In *Youngberg v. Romeo*, the Supreme Court dealt with the habilitation-training claims of state facility residents with mental retardation.[55] The Court stated that decisions regarding appropriate care (training, in this instance) would be presumptively valid if made by a mental health professional. Such decisions might be challenged, but only in the absence of reasonable professional judgment.[56]

While the Supreme Court did not state – and as yet has not stated – whether this extreme deference to professional judgment applies to all individuals in governmental custody, the *Langley* opinion cites a number of lower court decisions finding the rule applicable, and adopts this approach for itself.[57] We believe that the Court's general deference to the real or presumed expertise of correctional officials in general, and health care providers in particular, supports the *Langley* view that *Youngberg's* rule of "professional judgment" ap-

plies in the context of jail and prison cases which call for deliberate indifference analyses.[58]

There is a touch of irony here, in that at a time when social trust and deference to doctors has seriously eroded, legal rules supportive of such deference are at a new high.[59]

Langley also provides an exhaustive list of the type of specific claims that indicate constitutionally inadequate mental health care. We simply will list a representative sample of those items here, and later incorporate them into our model for legally adequate service delivery. Remember, all of these items must be linked with the mental element of deliberate indifference.

1. Failure to take a complete medical (or psychiatric) record.
2. Failure to keep adequate records.
3. Failure to respond to inmates' prior psychiatric history.
4. Failure to at least observe inmates suffering a mental health crisis.
5. Failure to properly diagnose mental conditions.
6. Failure to properly prescribe medications.
7. Failure to provide meaningful treatment other than drugs.
8. Failure to explain treatment refusals, diagnosis, and ending of treatment.
9. Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a prior diagnosis existed.
10. Personnel doing things for which they are not trained.[60]

Lawyers who are pursuing or defending a claim in this area, and administrators who seek to assure compliance with the law, would do well to use this as a checklist.

Chambers v. Ingram [61] also illustrates the scope and meaning of deliberate indifference. Inmate Chambers faked being mentally ill and suicidal.[62] He was interviewed by the prison's supervising psychologist, Dr. Ingram, who, in turn, reported to Dr. Ali, a contract psychiatrist, that the inmate was a danger to himself. Without seeing Chambers, Dr. Ali prescribed Sinequan and Atarax. Thereafter, Dr. Ingram noted that Chambers was less anxious but still thinking of harming himself. After a discussion with Ingram and a short visit with the inmate, Dr. Ali prescribed Haldol, which has a number of well-known, serious side effects, including seizures. The inmate experienced grand mal seizures and claims to have continuing seizures, blackouts, and the like. His suit was for damages based on the side-effects of Haldol.

Dr. Ali settled and the case against the psychologist continued "because she failed to obtain information, failed to record information, and failed to apprise Dr. Ali (accurately) of Mr. Chambers' condition."[63] Dr. Ingram failed to tell Dr. Ali that the inmate seemed much improved, and this failure led to the continuing misdiagnosis, the continued injection of Haldol, and the consequent seizures.

Chambers filed a civil rights action in federal court alleging both a violation of his federal constitutional rights and a pendent state law claim for medical malpractice.[64] The district court directed a verdict for the defendants on the federal claim, leaving intact a $17,000 judgment on the state law claim against Dr. Ingram noting:

> The circumstances of the forced . . . ingestion of Haldol were not done with deliberate or wilful neglect but, perhaps, were done with gross negligence in misdiagnosing a patient who superficially might have appeared to be a psychotic, suicidal person, perhaps, with greater standard of medical evaluation and care would not have been properly diagnosed in that manner. I think what we simply have here is a medical malpractice case.[65]

The Seventh Circuit found that Dr. Ingram's failure to provide Dr. Ali with accurate diagnostic information resulted in a misdiagnosis which, in turn, led to treatment with a more severe drug, establishing medical malpractice.[66] There was expert testimony as to the applicable standard of care and that the defendant negligently deviated from that standard, the gist of a malpractice claim.

Once again, we observe poor practice, the infliction of preventable harm upon one who is owed a duty of care. Still, one must contrast the very demanding standard of deliberate indifference with the rigorous, but certainly less demanding, standard of medical malpractice. We also note the potential legal hazards involved in "telephone medicine" practices, even though it was the doctor who "wrote" the prescription and a nurse who administered the drug. The poor diagnostic-information-sharing function of the psychologist led to her legal downfall.[67]

Greason v. Kemp [68] is one of several recent cases involving the abrupt termination of anti-depressant medication. Dr. Frank Fodor was charged with discontinuing Greason's medication without reviewing the inmate's clinical file or conducting a mental status exam. Greason had an extensive history of schizophrenia along with numerous hospitalizations, and his records indicated that he was a substantial suicide risk.[69] Even after Greason's parents warned the mental health team leader, there was no monitoring, and within two months, Greason committed suicide. The court found evidence that Greason received grossly inadequate psychiatric care, and that Dr. Fodor acted in a grossly incompetent manner.[70]

Dr. Fodor was not required to agree with an earlier diagnosis and prescription of care and, he certainly could disagree in the exercise of his professional judgment. What is at issue, is a clinical judgment based on a few minutes contact with Greason, which totally ignored medical data and failed to require post-termination monitoring.[71]

This case also involved supervisory liability. The court noted that the clinical director of the Georgia facility, Dr. Oliver, knew of a severe, clinical staff shortage but did nothing about it. He also knew of an earlier abrupt termination incident involving an inmate-patient of Dr. Fodor and took no action.[72]

The court applied a three-prong test to the supervisory liability claim:

> 1. Whether, in failing to train and supervise subordinates, he was deliberately indifferent to an inmate's mental health needs.
>
> 2. Whether a reasonable person in the supervisor's position would know that his failure to train and supervise reflected deliberate indifference.
>
> 3. Whether his conduct was causally related to the constitutional infringement by his subordinate.[73]

The court concluded that a reasonable jury could find that Dr. Oliver's failure to act satisfied this three-prong test. The court also noted, "if the supervisory officials can show that they attempted to remedy the staffing problems [in Georgia prisons] but were unable to do so because of lack of funds, then they can escape liability."[74]

One of the better explanations of deliberate indifference involves the Eleventh Circuit's prison suicide case, *Rogers v. Evans*.[75] The court noted that while systemic deficiencies may equate with deliberate indifference, there must be a series of incidents, e.g., delayed or denied care, causing resultant suffering.[76] Here, non-medical personnel tried to report on the inmate's symptoms and kept records of his behavior, which was enough to rebut claims of "callous indifference" directed at them.[77]

In the same case, however, there was a triable issue of "callous indifference." Dr. Smith who is not board certified and holds only an institutional permit to provide psychiatric services, used placebos to treat a suicidal inmate. An expert testified that Dr. Smith's diagnosis "was so wide of the mark as to be far below the minimum standards of medical care, and no psychiatric or medical basis exists for the prescription of a placebo for Rogers' symptoms."[78]

Endnotes

1. *See generally* F. Cohen, *Legal Issues and the Mentally Disordered Prisoner* (Nat'l. Inst. of Corrections, 1988) [hereinafter, Cohen, *Legal Issues*).
2. *Estelle v. Gamble*, 429 U.S. 97 (1976), 1 MDLR 265.
3. *See Bell v. Wolfish*, 441 U.S. 520 (1979).
4. *See Inmates of Allegheny County Jail v. Wecht*, 699 F. Supp. 1137 (W.D. Pa. 1988).
5. L. Teplin, "Detecting Disorder: The Treatment of Mental Illness Among Jail Detainees", 58 *J. of Consulting & Clinical Psychology* 233, 235 (1990). *See Belcher v. Oliver*, 898 F.2d 32, 34-35 (4th Cir. 1990), "the general right of pretrial detainees to receive basic medical care does not place upon jail officials the responsibility to screen every detainee for suicidal tendencies."
6. 429 U.S. 97 (1976), 1 MDLR 265.
7. *See* Jamelka, Trupin & Chiles, "The Mentally Ill in Prisons: A Review," 40 *Hosp. & Community Psychiatry* 481, 485-86 (1989), where the clinician authors mistakenly interpret legal decisions as entitling inmates to mental health care which is equal to that available in the community.
8. 429 U.S. at 104-05.
9. 551 F.2d 44 (4th Cir. 1977), 1 MDLR 331. *See Greason v. Kemp*, 891 F.2d 829, 839 (11th Cir. 1990), 14 MPDLR 163, noting that every reported decision after *Estelle* equates physical and mental health claims, yet defendants continue to challenge that position.
10. 489 U.S. 189 (1989), 13 MPDLR 104. For application of this decision to a jail suicide, *see Buffington v. Baltimore County, Md.*, 913 F.2d 113 (4th Cir. 1990) (rehearing denied), 15 MPDLR 43.
11. *See e.g., Brogsdale v. Barry*, 926 F.2d 1184, 1190-91 (D.C. Cir. 1991), discussing the problems of dangerous overcrowding, inmate safety, and medical care without sharp distinction. For an excellent analysis of the duty to protect from harm *see Purvis v. Ponte*, 929 F.2d 822 (1st Cir. 1991).
12. *See* Cohen, *Legal Issues, supra* note 1, at 115-19. There also is a duty to take reasonable steps to prevent suicide, particularly if there is a past history or current threat. *See, e.g., Torraco v. Maloney*, 923 F.2d 231 (1st Cir. 1991), 15 MPDLR 243.
13. 913 F.2d 113 (4th Cir. 1990) (rehearing denied), 15 MPDLR 43.
14. *Id.* at 119.
15. In *Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239 (1983), the Court held that where police officers justifiably wound a fleeing suspect, the appropriate governmental agency must provide treatment to minimize the impact of the resulting harm. The decision rests on the Fourteenth Amendment's due process clause.
16. 457 U.S. 307 (1982), 6 MDLR 223. The Court made it very clear that considerable deference is to be given to judgments concerning an inmate's conditions of confinement; as long as a reasonable professional judgment was rendered, it does not have to be proven right.
17. *Id.* at 319. Interestingly, inmates probably do not have a right to be placed in protective custody. Thus, liability arises only where government officials are deliberately indifferent to the plight of vulnerable inmates. *See Lovell v. Brennan*, 566 F. Supp. 672 (D. Me. 1983), *aff'd*, 728 F.2d 560 (1st Cir. 1984).
18. *See Langley v. Coughlin*, 715 F. Supp. 522, 533 (S.D.N.Y. 1989), 13 MPDLR 511, *aff'd*, 888 F.2d 252 (2d Cir. 1989), 14 MPDLR 132, specifically dealing with issues related to the commingling of inmates who do and do not have mental illnesses in a segregation unit.
19. The duty to provide protection is essentially an obligation imposed on uniformed staff, while the duty to provide treatment is essentially an obligation imposed on medical and mental health professionals.
20. *See* R. Reisner & C. Slobogin, *Law and the Mental Health System: Civil and Criminal Aspects*, Chs. 8 and 10 (2d ed. 1990).
21. Cohen, *Legal Issues, supra* note 1, at 3.
22. *See Salerno v. United States*, 481 U.S. 739 (1987).
23. *Stanback v. New York*, 557 N.Y.S.2d 433 (N.Y. App. Div. 1990).
24. *Id.* at 434.
25. S. Shah, "Mental Disorder and the Criminal Justice System: Some Overarching Issues," 12 *Int'l J. of L. & Psychiatry* 231, 235 (1989).
26. Jamelka, Trupin & Chile, *supra* note 7, at 485. The authors write, "Mentally ill persons [in prison] are almost entirely dependent on the courts for legal protection of constitutional rights to treatment and due care."
27. *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203 (1st Cir. 1990). *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir.

1980), *cert. denied*, 450 U.S. 1041 (1981), is one of the earlier formulations of this test.

28. 923 F.2d at 209.

29. *Id.* at 208. This definition may be found in a number of judicial decisions.

30. This situation occurs with some regularity when an inmate's outside physician has reached a particular diagnosis calling for a given course of treatment, and a prison physician then totally disagrees with the diagnosis and prescription.

31. *See* Cohen, *Legal Issues, supra* note 1, at 6-7. Chief Justice Rehnquist once compared homosexuality with measles in an effort to establish their shared contagious qualities. *See Ratchford v. Gay Lib*, 434 U.S. 1080 (1978) (dissenting from Court's refusal to review a lower court's requirement that a university recognize a gay rights group).

32. F. Cohen, "The Right to Treatment," in *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender* 155, 157 (B.K. Schwartz, ed., Nat'l Inst. of Corrections, 1988) [hereinafter *Guide to Treating the Male Sex Offender*].

33. *See Farmer v. Carlson*, 685 F. Supp. 1335, 1339 (M.D. Pa. 1988), where the argument was over estrogen treatment demanded by the inmate or the psychotherapy prescribed by the prison physicians. *See also Phillips v. Michigan Dep't of Corrections*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), holding that transsexualism is a serious medical disorder regardless of cause.

34. *See* Cohen, *Legal Issues, supra* note 1, at 58-63, and *Guide to Treating the Male Sex Offender, supra* note 32, at 155-62. Alcohol or narcotics addiction is not viewed as a disease for the purposes of a constitutional right to treatment.

35. *Youngberg v. Romeo*, 457 U.S. 307 (1982), 6 MDLR 223, put the Supreme Court's seal of approval on such deference.

36. Cohen, *Legal Issues, supra* note 1, at 59-60.

37. *Id.* It is the clinician's use of the right diagnostic terminology which actually moved these cases from discretionary care to mandatory care.

38. *Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991), 15 MPDLR 243.

39. *Id.* at 235, n. 4.

40. 111 S. Ct. 2323 (1991).

41. 475 U.S. 312 (1986). *See infra* note 51.

42. 429 U.S. at 105-06.

43. *Guglielmoni v. Alexander*, 583 F. Supp. 821 (D. Conn. 1984) (citations omitted), 8 MPDLR 475.

44. *Wood v. Housewright*, 900 F.2d 1332 (9th Cir. 1990).

45. *Id.* at 1334-35.

46. Plainly, Wood could have retained the sling after it was closely examined, and he could have been held in some special form of custody pending verification of his medical necessity claim.

47. *See, e.g., Villante v. Dep't of Corrections of City of New York*, 786 F.2d 516, 519-20, 522 (2d Cir. 1986).

48. *City of Canton v. Harris*, 109 S. Ct. 1197, 1204, and n.7 (1989).

49. *See* W.R. LaFave and A.W. Scott, Jr., *Criminal Law* 209 (1972).

50. How much pain or loss is suffered clearly speaks to the amount of damages. We are arguing only that given "serious condition" and deliberate indifference, that a violation of rights has been proved. *See Phillips v. Michigan Dep't of Corrections*, 731 F. Supp. 792, 801 (W.D.Mich. 1990). Also, *Hudson v. McMillian*, 112 S. Ct. 995 (1992), held that a prisoner's injury need not be "significant" in order to establish an Eighth Amendment claim of excessive force by a corrections officer. The Court did require, however, "malicious and sadistic" behavior to establish liability.

51. 715 F. Supp. 522 (S.D.N.Y. 1989), 13 MPDLR 511, *aff'd*, 888 F.2d 252 (2d Cir. 1989). The magistrate's masterful report was adopted by the trial judge as his opinion.

52. New York uses SHUs as a combination of disciplinary and administrative segregation.

53. A crucial factor in such stipulations/agreements is the time for monitoring compliance along with easy access to the court to assure compliance. Here, a two-year period was agreed upon. 715 F. Supp. at 532.

54. 715 F. Supp. at 537. *See also* the leading case of *Todaro v. Ward*, 565 F.2d 48, 52 (2d Cir. 1977).

55. 457 U.S. 307 (1982), 6 MDLR 223.

56. *Id.* at 321-23.

57. 715 F. Supp. at 538.

58. *See Turner v. Safely*, 482 U.S. 78 (1987) and *O'Lone v. Shabazz*, 482 U.S. 342 (1987).

59. On the general erosion of deference, *see* David Rothman's brilliant new book, *Strangers at the Bedside* 10 (1991).

60. 715 F. Supp. at 540-41.

61. 858 F.2d 351 (7th Cir. 1988).

62. The "One Flew Over the Cuckoo's Nest" syndrome is omnipresent in the criminal justice system. While there often may be a secondary gain from acting "mad" (e.g., transfer to a hospital, removal from segregation, etc.), no one is likely to act "bad" for some secondary gain, except perhaps to seek isolation without the stigma of requesting protective custody.

63. 858 F.2d at 357.

64. For an excellent summary of the pendent law claims, *see* S.H. Steinglass, *Section 1983 Litigation in State Courts* Sec. 614(b) (1988).

65. 858 F.2d at 355 (ellipsis in the original). The trial judge gave this ruling from the bench, which may account for the awkward language.

66. *Id.* at 359.

67. *See Rogers v. Evans*, 792 F.2d 1052, 1061 (11th Cir. 1986), 10 MPDLR 387, for a brief discussion of different duties imposed on a *consulting* psychiatrist and an *attending physician.*

68. 891 F.2d 829 (11th Cir. 1990), 14 MPDLR 163. The case is appealed on a refusal to grant summary judgment.

69. *Id.* at 835.

70. *Id.*

71. The same court indicated that "grossly incompetent medical care or choice of an easier but less efficacious course of treatment can constitute deliberate indifference." *Waldrop v. Evans*, 871 F.2d 1030, 1035 (11th Cir. 1989), 13 MPDLR 342.

72. 891 F.2d at 838. The earlier case referred to in the text is that which is described in *Waldrop v. Evans, supra*, note 71.

73. 891 F.2d at 836-37.

74. 891 F.2d at 838, n. 19.

75. 792 F.2d 1052 (11th Cir. 1986), 10 MPDLR 387.

76. *Id.* at 1058-59.

77. *Id.* at 1059.

78. *Id.* at 1060.