Medical Treatment for Imprisoned Paraphiliacs: Implementing a Modified Standard for Deliberate Indifference

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Medical Treatment for Imprisoned Paraphiliacs: Implementing a Modified Standard for Deliberate Indifference

I. Introduction

In July, 1984, John Doe, an inmate in a Connecticut prison, filed a habeas corpus petition alleging that the prison system had denied him adequate and necessary medical treatment. Such petitions are not unusual; what distinguished Doe's was the nature of his claimed disease and the treatment he sought. Doe, incarcerated for a sex offense, claimed to be suffering from a psychosexual disorder called paraphilia and sought treatment involving both psychiatric counseling and the administration of a hormone, medroxyprogesterone acetate, better known as Depo-provera.

The constitutional obligation of prison authorities to furnish medical treatment is undisputed; failure to provide necessary and adequate medical treatment to inmates is proscribed by the Eighth Amendment. Courts have struggled, however, with implementing the obligation in cases where the issue is not a simple failure by prison authorities to provide any medical care, but rather a disagree-

1. This Comment could not have been written were it not for the courage that the Petitioner showed in pursuing his legal claims. Though every document cited in this Comment as relating to the Petitioner's legal proceedings appears in the public record, it is the desire of both the author and the Petitioner that publicity involving the identity of the Petitioner be kept to a minimum. Therefore, throughout this Comment the Petitioner's legal proceedings will be cited as Doe v. Bronson.

If more information concerning either the legal proceedings or the Petitioner is desired, the author may be contacted by way of the Yale Law & Policy Review.

2. See infra note 9.

3. Depo-provera is the trade name of a drug manufactured by the Upjohn Company. The active ingredient is medroxyprogesterone acetate, a synthetic progestin hormone normally present in low levels in the human body. See Prospectus of the Biosexual Psychohormonal Clinic, The Johns Hopkins University School of Medicine (1984) [hereinafter cited as Prospectus].


5. U.S. Const. amend. VIII.

This Comment addresses the right of prisoners to receive medical treatment. If persons incarcerated under sex offender statutes are considered involuntarily committed patients for the purpose of liberty-interest decisions, their right to treatment is more likely located in the Fourteenth, rather than the Eighth Amendment. Cf. Youngberg v. Romeo, 457 U.S. 507, 518-19 (1982) (majority endorsed trial court's determination that mental health patient had a "constitutional right to minimally adequate care and treatment," but concluded that the patient's liberty interests lay in "minimally adequate . . . safety and freedom from undue restraint").
ment between the inmate and prison authorities over the type of treatment due the inmate. In the Connecticut case, such a disagreement arose from the refusal by the Department of Correction to provide the inmate with a treatment regimen including Depo-provera, despite the recommendations of two psychiatrists not associated with the prison. The Department replied to the allegations in the habeas petition by asserting that the inmate had received adequate therapy in the form of two group therapy sessions. This Comment addresses the problems posed by implementation of a constitutional right to treatment in disputes over specific treatments by examining the case of mentally-disordered sex offenders.

II. Paraphilia and the Psycho-Organic Model

Paraphilia is a learned pattern of deviant sexual behavior. Researchers of paraphilia know that some early-life experience accounts for the type of deviant sexual behavior associated with the paraphiliac. Paraphiliac symptomatologies include persistent, intrusive sexual fantasies centered around unconventional, even bizarre, sexual conduct that result in intensive erotic cravings to act out the fantasies. When these impulses cannot be fulfilled, the


10. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders III 266-267 (3d ed. 1980) [hereinafter cited as DSM-III]. DSM-III is the official manual of mental disease and disorders, and is used for diagnoses and treatment. The entry for paraphilia follows:

The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either: (1) preference for use of a nonhuman object for sexual arousal, (2) repetitive activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners...Paraphiliac imagery is necessary for erotic arousal...In the absence of paraphiliac imagery there is no relief from nonerotic tension...[Paraphilias] are of legal and social significance. Individuals with these disorders tend not to regard themselves as ill, and usually come to the attention of
paraphiliac suffers noxious, discomforting feelings. Because a paraphiliac's fantasies and cravings are so frequent, the need to act them out is also frequent, and when not under actual physical restraint, the paraphiliac finds it extremely difficult—if not impossible—to stop behaving in a sexually deviant manner. Many paraphiliacs experience deep emotional anguish from their inability to control their deviant fantasies. Nevertheless, one distinguishing feature of paraphilia is the paraphiliac's unconcern for the social repercussions of his behavior; paraphiliacs will act out their behavior regardless of the consequences they might suffer if they are caught.

Possible consequences have become more severe as sex offenders have drawn increasing attention from the public and many legislators. Public concern, particularly in cases involving child molesters, pedophiliacs, has resulted in intensive news coverage mental health professionals only when their behavior has brought them into conflict with society. . . Specific paraphilias are (1) Fetishism (inanimate objects), (2) Tranvestitism (female clothing), (3) Zoophilia (animals), (4) Pedophilia (children), (5) Exhibitionism (public display of sexual organs), (6) Voyeurism (watching sexual activity of others), (7) Sexual masochism (the infliction of pain on self), and (8) Sexual sadism (the infliction of pain on others).

Id. Some of the best case studies of paraphilia can be found in Berlin & Meinecke, Treatment of Sex Offenders with Antiandrogenic Medication: Conceptualization, Review of Treatment Modalities, and Preliminary Findings, 138 Am. J. Psychiatry 601 (1981). These case studies indicate that the paraphiliac's fantasizing and erotic cravings are not scattered random occurrences; they are repetitive and constantly intrude on the subjects' conscious thought. See also Cordoba & Chapel, Medroxyprogesterone Acetate Antiandrogen Treatment of Hypersexuality in a Pedophiliac Sex Offender, 140 Am. J. Psychiatry 1036 (1983); Gagne, Treatment of Sex Offenders with Medroxyprogesterone Acetate, 138 Am. J. Psychiatry 644 (1981); Spodak, Zalde & Rapepeport, The Hormonal Treatment of Paraphiliacs with Depo-provera, 5 Crim. Just. & Behav. 304 (1978) [hereinafter cited as Spodak].

13. See, e.g., Testimony of Dr. Berlin, supra note 7, at 47 (discussing extent of Doe's mental anguish); Testimony of Dr. Gagne, supra note 7, at 151-52 (noting that in his opinion, approximately 95% of paraphiliacs endured less mental anguish than Doe).
14. DSM-III, supra note 10, at 267 ("Individuals with these disorders tend not to regard themselves as ill"); Berlin & Coyle, supra note 9, at 125 (describing case study in which paraphiliac behavior continued despite constant arrests).
15. The term "sex offender" is a legal classification for persons who engage in prohibited sexual behavior. States differ in their classifications of sexual offenses. Compare N.Y. Penal Law §§ 130.00-.70 (McKinney 1967 & Supp. 1986) (classifying sexual offenses into sexual misconduct; rape, first through third degrees; consensual sodomy; sodomy, first through third degree; sexual abuse, first through third degree; aggravated sexual abuse) with Tex. Penal Code Ann. §§ 21.01-.11, 22.011 & 22.021 (homosexual conduct; public lewdness; indecent exposure; indecency with a child; sexual assault; aggravated sexual assault).
16. The pedophilic is one who engages in sexual activity, or fantasizes engaging in sexual activity, with prepubertal children as the preferred or exclusive method of achieving sexual excitement. DSM-III, supra note 10, at 271.

253
age,\(^{17}\) and has sparked a variety of prophylactic measures designed to deter such conduct.\(^{18}\) Some legislatures have reacted to the public outcry by repealing special statutory treatments for the mentally-ill sex offender.\(^{19}\) Many of the repealed statutes sought to identify sex offenders whose sexual behavior was linked with a mental disorder and place them in mental health care facilities for treatment.\(^{20}\)

17. Stories dealing with sexual offenders—particularly with child molesters (pedophiliacs)—garner daily coverage. Of recent note is the controversy involving child abuse at day-care centers. Perhaps the most notorious example is the McMartin Day Care Center in Manhattan Beach, California. Everyone who worked there, including a 76-year old grandmother, was charged with criminal sexual misconduct in a total of over 115 separate counts. N.Y. Times, Mar. 23, 1984, at A14, col. 6; id., Mar. 24, 1984, at A24, col. 5.

18. One need look little further than the television set or the neighborhood supermarket to see examples of society's reaction to child abuse and the related phenomenon of missing children. CBS regularly broadcasts "Missing Children" biographies which include the last known picture and location of the child, as well as a general description (name, age, etc.). Milk cartons are routinely emblazoned with similar information. Congress has acted to provide funds for programs aimed at stopping child abuse. The most visible form of this support has been a toll-free telephone "hot-line" to help find runaways and missing children. Thompson, Congress Considers Means to Fight Sex Abuse of Children, Crim. Just. Newsletter, Nov. 15, 1984, at 4-5.


20. The mental health care centers are usually under the supervision of a state Department of Mental Health or its equivalent, e.g., D.C. CODE ANN. § 22-3508 (1981) (commitment to St. Elizabeth's Hospital, or joint supervision with the Department of Correction); MASS. GEN. LAWS ANN. ch. 123A, § 2 (West 1969 & Supp. 1985) (custodial personnel subject to control of Commissioner of Mental Health with respect to care and treatment, but subject to Commission of Correction with respect to administration, operation and discipline). Statutes authorizing commitment, supra note 19, vary regarding the point during criminal proceedings when commitment procedures are instituted. The District of Columbia, upon findings of a judge, commits sexual psychopaths to a mental hospital and stays all criminal proceedings in the interim. D.C. CODE ANN. § 22-3508, -3510 (1981). Massachusetts gives the trial judge discretion to place sex offenders with mental disorders in a mental health center in lieu of the sentence ordinarily required by law. MASS. GEN. LAWS ANN. ch. 123A, § 5 (West 1969 & Supp. 1985). Florida sentences sex offenders for their crime first, FLA. STAT. ANN. § 917.012(1) (West Supp. 1983), and then binds them over to the Department of Mental Health for evaluation and treatment if they are suspected of having a mental disorder linked to their sexual behavior. FLA. STAT. ANN. § 917.012(3) (West Supp. 1983).
Imprisoned Paraphiliacs

While public reaction to sexual crimes has resulted in fewer opportunities for mentally ill sex offenders to receive treatment, research advances have increased the effectiveness of treatment for some psychosexual disorders. One area of research into psychosexual disorders has been based on the psycho-organic model of behavior.\(^1\) This model hypothesizes that human behavior is the result of both learned and unconscious patterns of behavior, with particular behavior dependent on, or responsive to, physiological systems in the human body.\(^2\)

Researchers posit that within the neurological system controlling the mind,\(^3\) the powerful biological function of the sex drive overrides conscious attempts to restrain the deviant sexual conduct associated with paraphiliacs due to the influence of organic factors—such as testosterone on the limbic brain\(^4\)—that continually rein-

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\(^1\) The psycho-organic model of human behavior is also known by a variety of other names. These include "behavioral biology," "behavioral endocrinology," "biological psychological," "physiological psychology" and many others. See Konner, The Tangled Wing 16 (1982). This Comment focuses on the process by which the paraphiliac's behavior is shaped by psychological and organic factors and the effect recognition of this process should have on the standard for medical treatment. This Comment, therefore, chooses to use the term "psycho-organic" because it serves to highlight the model's claim that both psychological and organic factors underly mental disorders and both psychotherapy and organic therapy are required for treatment.

\(^2\) The psycho-organic model hypothesizes that neurological systems affect behavior traditionally regarded as caused only by external mental stimuli. Severe depression, for example, has its roots not merely in a traumatic, grief-filled occasion, but in several neurotransmitter systems that deepen depression and make it more acute.

Norepinephrine is a brain neurotransmitter molecule linked with depression. Studies indicate that the onset of depression causes changes behaviorally, physiologically, and biochemically. Severe, or psychopathological, depression is treated with organic-based therapy. In addition to counseling, patients are treated with "tricyclic antidepressants" which function, either by stimulating the production of norepinephrine or preventing its reabsorption by producer cells, to make more norepinephrine available to stimulate brain cells, thereby elevating the patient's mood. See Konner, supra note 21, at 339, 340.

\(^3\) An example of a neurological system which affects behavior is the *stria terminalis*, a slender compact fiber bundle connecting the amygdala with the hypothalamus and other basal forebrain regions. Stedman's Medical Dictionary 1351 (24th ed. 1982) [hereinafter cited as MEDICAL DICTIONARY]. It is hypothesized to mediate the excitatory influence of the limbic system (the "emotional" or "reptile" brain, to which both the amygdala and the hypothalamus belong) on sexual and aggressive behavior. See Konner, supra note 21, at 117.

Linked with the limbic system is the endocrinual system, which governs the secretion of testosterone by the interstitial cells of the testes. Medical Dictionary, supra, at 1431. Testosterone lowers the threshold for "firing" of the nerve fibers in the *stria terminalis*, additional evidence for the hypothesis that testosterone influences sexual and aggressive behavior. Konner, supra note 21, at 117.

\(^4\) Sexual behavior is associated with the lower, more primitive portion of the brain called the limbic system. See supra note 23. The limbic system is comprised of the hypothalamus, the amygdala, the hippocampus, the limbic midbrain, the septal area, and the regions of the neocortex associated with these lower structures. All have been impli-
force and maintain the learned sexually deviant behavior. The psycho-organic explanation of sexual behavior hypothesizes that effective treatment of deviant sexual behavior cannot result simply from attempts to alter sexual conduct through traditional psycho-
cated to some degree in the motivation and regulation of sexual activity. See Konner, supra note 21, at 280.

Testosterone is a product of the endocrinal system. It is secreted by the interstitial cells of the testes, and is classified as a sex steroid hormone. Medical Dictionary, supra note 23, at 1421, 1431. It is hypothesized to affect the development of the brain, notably in the forward portion of the hypothalamus (the portion of the brain partially responsible for sex and aggression, supra note 23), helping to account for observed differences in brain development between men and women and corresponding observations that males are innately more aggressive than females. See Field & Raisman, Sexual Dimorphism in the Neurpsil of the Preoptic Area of the Rat and its Dependence on Neonatal Androgen, 54 Brain Research 1 (1973); Clayton, Kogura & Kraener, Sexual Differentiation of the Brain: Effects of Testosterone on Brain RNA Metabolism in Newborn Female Rats, 226 Nature 810 (1970). Testosterone's influence on sexual behavior is demonstrated by its effect on sexual learning. The hypothalamus-pituitary unit of the limbic system manufactures what are called neuropeptides. These neuropeptides are involved in the formation and maintenance of new behavior. See de Wied, Bohus, Gispen, Urban, Van Wimeisne & Greidanus, Hormonal Influences in Motivational, Learning, and Memory Processes, in Hormones, Behavior, and Psychopathology 1 (Sachar ed. 1976). In sexual “learning,” that is, the development of gender awareness and the development of sexual drive, one study suggests that testosterone’s influence on sexuality can override social rearing. See Imperato-McGinley, Peterson, Gautier & Sturla, Androgens and the Evolution of the Male-Gender Identity among Male Pseudohermaphrodites with 5-alpha-reductase deficiency, 300 New Eng. J. Med. 1233 (1979) (males, raised from infants as females and exhibiting female behavioral patterns—in fact, thinking they were females—abandoned gender role upon onset of testes development and testosterone production).

The linkage of testosterone to sexual behavior is most clearly demonstrated by the effects of castration. In laboratory animals castration causes a decline of sexual activity, and also reduces aggression. Subsequent injection of testosterone into castrated males restores both sexual activity and aggression. Depo-provera, because it suppresses the production of testosterone in the testes, when administered is called “chemical castration.” Unlike castration, however, Depo-provera’s effect is temporary and reversible.

That testosterone may play a role in paraphilia is shown by one study in which 27% (6 out of 22) of paraphiliacs were found to have abnormally elevated levels of testosterone in their blood. See Berlin & Coyle, supra note 9, at 122. Contrary to popular misconception, however, elevated testosterone levels are not the only organic substrate responsible for paraphilia. What is important to remember is testosterone’s role in the organic reinforcement of sexual behavior. See supra note 23.

It is also hypothesized that deviant sexual behavior may be linked with defects in the limbic brain. All the structures of the limbic brain receive and concentrate testosterone. In the Berlin & Coyle study, 90% (18 out of 22) of paraphiliacs evidenced a variety of abnormalities including, “structural brain damage, elevated testosterone levels, genetic anomalies, seizure disorders, and pituitary hormone dysfunction.” Berlin & Coyle, supra note 9, at 122. Studies have also shown that lesions on the limbic brain can cause severe and noticeable changes in sexual activity. See Clark, Cagiula, McConnel & Antelman, Sexual Inhibition is Reduced by Rostal Midbrain Lesions in the Male Rat, 190 Science 169 (1975). Studies with epileptics have demonstrated that a majority of epileptics whose seizure focus is in or near the amygdala or hippocampus are hyposexual (suffer from a diminution or lack of sex drive); epileptics whose seizure focus is located in other parts of the brain are not hyposexual. See Blumer, Changes of Sexual Behavior Related to Temporal Lobe Disorder in Man, 16 J. of Sex Research 172 (1970).
therapeutic techniques, but must also address the organic reinforcement system.

For the mentally ill sex offender, the psycho-organic model hypothesizes that treatment must identify and address the organic substrates that influence or trigger deviant sexual behavior as well as treat the psychological aspect of the behavior. This type of treatment for psychosexual disorders, called "organic-based" therapy for the purposes of this Comment, combines the use of pharmaco-

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25. "Treatment" refers to the medical or surgical management of a patient. Medical Dictionary, supra note 23, at 1477. Palliative treatment seeks to alleviate symptoms without curing. Medical treatment is the conservative treatment of disease by hygiene and medicinal remedies. Surgical treatment involves direct physical intervention to treat disease. The term "treatment" is used interchangeably with the term "therapy" which similarly connotes the management of disease by various methods.

26. Treatment is referred to as organic therapy if it encompasses a set of procedures designed to modify human behavior by altering the chemical or neurological bases of behavior, feeling, or mentation. See Delgado, Organically Induced Behavioral Change in Correctional Institutions: Release Decisions and the 'New Man' Phenomenon, 50 S. Cal. L. Rev. 215, 217 n.3 (1977). This definition includes therapy utilizing surgical, chemical, and electronic means to modify certain types of criminal behavior by direct physical intervention into neural or physiological mechanisms. Id. at 218. For examples of the various techniques used in organic treatments, see Shapiro, Legislating the Control of Behavioral Control: Autonomy and the Coercive Use of Organic Therapies, 47 S. Cal. L. Rev. 237, 240-46 (1974). Organic therapy stands in contrast to traditional nonorganic behavior therapies, such as counseling and psychotherapy, which rely solely on persuasion, insight, and exhortation. Delgado, supra, at 217 n.3.

Organic therapists have been criticized because they have the potential to "bring about changes, even radical changes, in a patient's behavior without his cooperation." Katz, The Right to Treatment—An Enchanting Legal Fiction?, 36 U. Chi. L. Rev. 755, 777 (1969). Professor Katz warns that organic therapies can render the subject "docile and agreeable to subsequent interventions...[and] can cause alterations in behavior that are reversible and irreversible." Id. (footnote omitted).

In contrast to pure organic therapy, organic-based therapy refers to a broad-based treatment regime which includes organic therapy as a component. Organic-based therapy, therefore, differs fundamentally from pure organic therapy in that it frequently relies on a psychotherapeutic component which requires initial subject cooperation for success.

The roots of organic-based treatment may be traced back at least thirty years to the introduction of lithium salts for the treatment of manic-depression in 1939. See generally R. Johnson, The History of Lithium Therapy 94-104 (1984). Indeed, it has been noted that the explosion in the development and sophistication of the psychiatric profession can be directly correlated with the realization by the profession that therapy that included the use of drugs could result in astounding successes for the profession in treatment. One author notes that the effects of the new drug treatments "facilitated the opening of doors, full occupation, encouragement of initiative, freer communication, and the restoration of an atmosphere of hope" in the treatment of the mentally ill. A. Norton, The New Dimensions of Medicine 142-43 (1969). The effectiveness of drug treatments for the mentally ill elevated psychiatry to a new respect in medicine.

If affective disorders could be eliminated by the simple expedient of administering a chemical substance, did this not suggest that the basis of these disorders might take a chemical form? ... At a stroke, the elusive, aetherial Freudian psyche was replaced as the primary object of attention in psychiatry by the polyphasic, physico-chemical system called the brain. Psychiatry came of age, and took its place amongst the biological sciences.
logical (drug) and psychotherapeutic intervention.

Organic-based therapy for paraphilia utilizes Depo-provera, the synthetic form of a human anti-androgen that suppresses the production of testosterone in the testes. The reduction in testosterone levels neutralizes one of the key factors in the sexual drive system and results in the immediate diminution of the symptoms and behavior associated with paraphilia; specifically, the administration of Depo-provera is unique in reducing the constant erotic fantasizing of paraphilia. In addition to administration of Depo-provera, the psycho-organic model requires psychotherapeutic intervention to address the psychological components of paraphilia.

R. Johnson, supra, at xiv.

Organic-based therapies for sex offenders have been studied and used for over a decade. The first reported studies utilizing Depo-provera in conjunction with psychiatric counseling as a treatment for paraphilia were performed by Dr. John Money at the Johns Hopkins University in Baltimore, Maryland in 1965. See Money, Wiedeking, Walker & Gain, Combined Antianodrogen and Counseling Program for the Treatment of 46,XY and 47,XYY Sex Offenders, in HORMONES, BEHAVIOR AND PSYCHOPATHOLOGY 104 (Sachar ed. 1976) [hereinafter cited as Money & Gain]; Money, Wiedeking, Walker, Migeon, Meyer & Borgaonkar, 47,XXY and 46,XY Males with Antisocial and/or Sex-Offending Behavior: Antiandrogen Therapy plus Counseling, 1 PSYCHONEUROENDOCRINOLOGY 165 (1975) [hereinafter cited as Money & Borgaonkar].

27. The level of serum testosterone (testosterone in the bloodstream) is reduced in antianandrogen therapy to that of a normal prepubescent boy (from approximately 575 nanograms/100 milliliters to 125 nanograms/100 milliliters). The "average" starting dosage of Depo-provera for an adult male is an intramuscular injection ranging from 400 mg. to 600 mg. per week. See Berlin & Coyle, supra note 9, at 119 (use of 500 mg./week); Berlin & Meinecke, supra note 10, at 603 (400 mg./week); Gagne, supra note 10, at 644 (400-600 mg./week).

An antianodrogen is any substance capable of preventing full expression of the biological effects of androgenic hormones on responsive tissue. MEDICAL DICTIONARY, supra note 23, at 86. Medroxyprogesterone acetate inhibits the release of luteinizing hormone (LH) from the pituitary gland. LH is the chemical messenger which normally stimulates the testes to produce androgens, especially testosterone. This results in the lowering of the level of testosterone in the bloodstream. See PROSPECTUS, supra note 3 (describing antianidrogenic effect and mode of endocrine action of Depo-provera).

28. Clinicians report that the frequency and intensity of erotic fantasizing decreased substantially. See Berlin & Meinecke, supra note 10, at 603; Gagne, supra note 10, at 645; Cordoba & Chapel, supra note 10, at 1038; Spodak, supra note 10, at 309.

29. All the researchers used psychotherapy in conjunction with Depo-provera therapy. Berlin & Coyle, supra note 9, at 123; Cordoba & Chapel, supra note 10, at 1039; Money & Gain, supra note 26, at 105; Gagne, supra note 10, at 646.

Dr. Gagne analogizes Depo-provera to a "brain relaxant"—by allowing the brain a respite from the paraphiliac's constant fantasizing and craving, the paraphiliac is made more accessible to psychotherapeutic methods. Nonorganic methods are then used to assist the individual to "unlearn" the pattern of behavior associated with his paraphilia. Petitioner's Exhibit 25, Doe v. Bronson, supra note 1. See also PROSPECTUS, supra note 3 (counseling necessary to help the patient cope with problems that have developed as a consequence of his prior life style). Others have noted that when "the threshold or barrier to sexual arousal is strengthened by the hormone [Depo-provera] the individual is metaphorically on vacation from the demands and insistence of his sexual drive, and so is able to experience an erotic or psycho-sexual realignment in conjunction with counseling." Money & Gain, supra note 26, at 119.
Imprisoned Paraphiliacs

Usually, psychotherapy treats the deeply rooted early-life traumas that produced the deviant behavior and attempts to readjust the patient away from focal points of unnatural or proscribed behavioral patterns.30 In addition to attempting to “unlearn” the deviant behavior, psychotherapy also addresses the social adjustment problems the paraphiliac will confront.

An organic-based treatment regimen is recognized as one of the few, if not the only, effective treatment for paraphilia.31 At present, any physician can prescribe Depo-provera for a diagnosed paraphiliac.32 Depo-provera thus is one of the treatments that must be at least considered in a treatment-specific33 dispute between an

30. Psychotherapy most commonly involves psychological treatment of mental disorders without the use of physical or chemical means. As one source defines it:

[P]sychotherapy [is] a form of psychological treatment in which a trained person (psychotherapist) establishes a professional relationship with a person (patient, client) suffering from emotional problems for the purpose of alleviating, or modifying troublesome symptoms or patterns of behavior. . . . All forms of psychotherapy are based on common psychological principles of operating in any helping relationship, including comfort, support, guidance, reason, guilt-reduction through confession, and hope. . . . [I]t represents a more or less systematic effort to help a patient achieve maturity, autonomy, responsibility, and skill in adult living.


31. The data is generally anecdotal in the form of case studies. See Berlin & Meinecke, supra note 10; Spodak, supra note 10. Where a large number of individuals have been tested, however, the effectiveness of Depo-provera in reducing the symptomologies of paraphilia has been consistently high. See Berlin & Meinecke, supra note 10, at 604-05 (noting 17 out of 20 responded favorably to treatment); Money & Giauq, supra note 26, at 120 (17 out of 17 sex offenders received beneficial effect from treatment); Gagne, supra note 10, at 645 (40 out of 48 responded favorably). It should be noted that this Comment does not seek to argue that treatment including Depo-provera and psychotherapy is either appropriate or necessary for all paraphiliacs—rather, this Comment uses the current research into treatment for sex offenders to illustrate the implementation of the modified Estelle standard this Comment proposes. See infra notes 62-85 and accompanying text.

32. Depo-provera is approved for use as a treatment for cancer in the United States. Rosenfield, The Food and Drug Administration and Medroxyprogesterone Acetate, 249 J. A. M. A. 2922, 2924 (1983). Physicians, however, have great discretion in the uses they may make of drugs approved for only limited purposes:

Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling. Such “unapproved” or, more precisely, “unlabeled” uses may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature. . . . [A]ccepted medical practice often includes drug use that is not reflected in approved drug labeling.

Use of Approved Drugs for Unlabeled Indications, 12 FDA DRUG BULLETIN 1 (April 1982).

33. For the purposes of this Comment, “treatment-specific” will refer to a particular method of treatment or therapy; thus, it can encompass a category of treatment as broad as organic-based therapy or a type of treatment within a category as specific as Depo-provera/psychotherapy. While treatment-specific disputes involving alternative treatments from different categories might raise a stronger case of deliberate indifference, see infra notes 62-85 and accompanying text, as in the case where an inmate seeks organic-based therapy while the prison offers only psychiatric counseling, this need not suggest
inmate and a prison physician. Indeed, a few states have explicitly recognized Depo-provera’s importance as a treatment for paraphilia.\textsuperscript{34}

III. The Constitutional Right to Treatment

A. Estelle v Gamble

In Estelle v Gamble,\textsuperscript{35} the Supreme Court held that prison officials were obligated to provide adequate medical care to prisoners. The constitutional duty arises because inmates are completely dependent on prison authorities to meet their medical needs. Failure to meet these needs violates the inmates’ rights under the Cruel and Unusual Punishment Clause of the Eighth Amendment:\textsuperscript{36}

In the worst case, such a failure [to treat medical needs] may actually produce physical torture or lingering death . . . [i]n less serious cases, denial of medical care may result in pain and suffering which no one suggests could serve any penological purpose.\textsuperscript{37}

The Court enunciated a two-part standard for determining violations of a prisoner’s right to adequate medical treatment. Prison authorities violate the Eighth Amendment if: i) a prisoner has serious medical needs, and ii) by act or omission, officials demonstrate deliberate indifference to those needs.\textsuperscript{38}

The Supreme Court has not heard any cases to clarify the standard articulated in Estelle. Lower courts have interpreted “serious medical needs” to require only a disease or injury that has been diagnosed or can be diagnosed and is amenable to treatment.\textsuperscript{39} This requirement is met relatively easily and is used largely as a threshold test to weed out patently frivolous claims. For example, if a pris-
Imprisoned Paraphiliacs

oner were suffering from a slight cold, or perhaps a bruised knee, either of which would run its course in a few days and cause only minor discomfort, it would be difficult to sustain a claim under the *Estelle* standard. However, were the prisoner suffering from a rare respiratory illness which the cold could trigger, or were he a hemophiliac to whom the bruised knee might prove fatal, denial of treatment would rise to constitutional levels. The *de minimis* considerations underlying the “serious medical needs” standard simply do not apply when dealing with the mental disorder of a paraphiliac, whose behavioral aberrations have been recognized as having serious legal and social significance.

Lower courts have struggled with the “deliberate indifference” standard, particularly in handling treatment-specific disputes, that is, when forced to choose between alternative treatments for a recognized medical need. Courts recognize that treatment-specific disputes can result in deliberate indifference when an easier but less efficacious treatment is consciously chosen, or when the care actually provided is so inadequate as to constitute a refusal to provide essential care. At the same time, however, courts are reluctant to intervene solely on the basis of a disagreement over the desirability of a form of treatment between the inmate and the prison physician.

Two concerns underlie judicial reluctance to enter treatment-specific disputes. The first is a judicial reluctance to second-guess med-

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40. See, e.g., Thomas v. Pate, 493 F.2d 151, 158 (7th Cir. 1974) (only treatment “so blatantly inappropriate as to evidence intentional mistreatment likely to seriously aggravate the prisoner’s condition” gives rise to a constitutional claim).

41. DSM-III, supra note 10, at 267.

42. See, e.g., Williams v. Vincent, 508 F.2d 541 (2d Cir. 1974) (prison doctor’s decision to amputate inmate’s ear and sew up the stump rather than attempt a more difficult but much more efficacious procedure to preserve the ear found to result in an “easier, and less efficacious treatment” proscribed by the Eighth Amendment). Although Williams was decided prior to *Estelle*, it was cited with approval in the *Estelle* opinion. 429 U.S. at 106 n.14.

43. See, e.g., Ramos v. Lamm, 639 F.2d 559, 578 (10th Cir. 1980), cert. denied, 450 U.S. 1041 (psychiatric care facilities were so “ridiculously pathetic” as to constitute denial of treatment).

44. See, e.g., Wright v. Collins, No. 84-6001 (4th Cir. Jan. 7, 1985) (disagreement over treatment of injuries sustained in fall would, at most, constitute claim of negligence) (available as of Jan. 15, 1985, on WESTLAW DCT database); Ferranti v. Moran, 618 F.2d 888 (1st Cir. 1980) (refusal to provide plaintiff with second opinion from his own back specialist reflected a “mere disagreement” between the prison physician and patient, not deliberate indifference); Penn v. Starks, 575 F. Supp. 1240 (N.D. Ind. 1983) (after decision on other grounds, court noted that even sincere disagreement over the type and quality of treatment would not state constitutional claim).

Courts have relied on language in *Estelle* stating that an inadvertent failure to provide adequate medical care, through negligence or accident, does not violate the Eighth Amendment. 429 U.S. at 105-06.
The judiciary attaches deference to a single physician’s presumed expertise in diagnosis and treatment to an extent unheard of in other circumstances provoking judicial intervention. The second concern is the difficulty involved in attaching improper motives to physicians’ actions. Where deliberate indifference is interpreted as creating an intent requirement, courts have

45. Judge David Bazelon, commenting on those who criticized his opinion in Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) (holding that the right to treatment established by District of Columbia statute was guaranteed to those involuntarily committed to mental hospital by reason of insanity and that failure to treat violates the patients’ rights under the law), has written:

Pundits both legal and medical were swift to point out that adequate treatment is a quicksilver concept. Different psychiatrists have radically different ideas of what constitutes good treatment either in general or for a specific patient. Judges have little basis to choose among the varieties of treatment, and certainly cannot formulate for themselves standards for adequate treatment....[This had] led many critics toward the conclusion that courts should leave doctoring to the doctors.


46. Imagine that the Social Security system were set up so that in reviewing the termination of benefits, a single person would conduct the review, the review would be limited to a few questions, no opportunity would be given for a discussion of alternatives or a full explanation of the circumstances, and the decision would be essentially immune to higher review. Of course, the Social Security system no longer works this way following the “procedural due process revolution of the early 1970’s.” G. Gunther, Cases and Materials on Constitutional Law 647 (10th ed. 1980) (discussing such cases as Goldberg v. Kelly, 397 U.S. 254 (1970), which held that due process required that welfare recipients be afforded an evidentiary hearing before the termination of benefits, and Mathews v. Eldridge, 424 U.S. 319 (1976), which held that due process, while flexible, called for procedural protections matching the demands of the particular situation).

The present system for reviewing prison provision of medical services, however, is not unlike Social Security review in the pre-Goldberg period. Typically, inmate petitions are filed pro se (only rare class-action lawsuits possess the force and expertise of real lawyers). In these cases, the pleadings may be “indecipherable,” Ferranti v. Moran, 618 F.2d at 889, or state conclusions of law, Wright v. Collins, supra note 44, at n.2 (pleadings alleged “denied me any sufficient (sic) med. treatment. . . denied adequte (sic) med treatment. . . denied proper (sic) medical treatment). Judge Bazelon has noted that inmate’s deficiencies in intelligence and literacy affect the ability of judges to understand writs of habeas corpus or other pro se filings, especially those raising medical claims, and may result in a general lack of review. Bazelon, supra note 45, at 746. Inmates are also generally denied access to physicians who might contradict the prison physician’s recommendation. Compare, Lee v. McManus, 543 F. Supp. 386 (D. Kan. 1982) (plaintiff had two doctors contradict the prison doctor’s treatment recommendation; plaintiff had private counsel), with, Partee v. Lam, 528 F. Supp. 1254 (N.D. Ill 1981) (inmate had only “mere depression” which the court, for lack of evidence, refused to believe; petition was filed and argued pro se).

47. One reason for the general unwillingness of the courts to attribute improper motives to prison physicians may lie in what one physician has described as the prevailing perception of the prison physician:

[Physicians are still, by and large, expected to be compassionate, concerned for man’s pain and suffering, and at least tolerant, if not accepting, of man’s perversity. This is expected even if the physician is one of the prison’s key-keepers.


It is difficult to find the interpretive basis for an intent standard in the Eighth Amendment. See Estelle, 429 U.S. at 116 (Stevens, J., dissenting) (“whether the constitutional standard has been violated should turn on the character of the punishment rather than
been generally unwilling, except in clearly egregious circumstances,\textsuperscript{48} to find that physicians have displayed an intentional indifference to an inmate’s medical needs by denying his treatment-specific requests.

As to the first concern, it seems no more difficult for a judge to evaluate and compare the efficacy of medical treatments than to make other comparisons routinely required of judges in other contexts. Judges are commonly called upon to assess, evaluate and compare in cases requiring expertise not within the judge’s domain of knowledge.\textsuperscript{49} Today’s judiciary possesses sufficient competence to make treatment-specific comparisons and choose the treatment required for a particular disease. The judge must decide only whether the patient is receiving carefully chosen therapy which respectable professional opinion regards as within the range of appropriate treatment alternatives.\textsuperscript{50}

The second concern also appears to be rooted in a tradition of deference to the medical profession. Unlike the situation where the judgment of a physician is in question, courts are quick to find deliberate, intentional indifference in cases where non-medical prison personnel are involved in denying treatment,\textsuperscript{51} or where procedures

\textsuperscript{48}. See, e.g., Boyce v. Alizaduh, 595 F.2d 948 (4th Cir. 1979) (prescription of eye drops that inmate had told physician he was allergic to, causing a serious and painful aggravation of inmate’s condition); Thomas v. Pate, 493 F.2d 151 (7th Cir.), \textit{cert. denied}, Thomas v. Cannon, 419 U.S. 879 (1974) (injection of penicillin with knowledge that prisoner was allergic, and refusal of doctor to treat the allergic reaction); Williams v. Vincent, 508 F.2d 541 (2d Cir. 1974) (doctor threw away prisoner's ear and stitched the stump).

\textsuperscript{49}. Judge Bazelon has further commented: Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. . . . No judge would claim the ability to prescribe a particular therapy for a 'chronic and undifferentiated schizophrenic.' But neither would any judge allocate AM frequencies to avoid interference. That is not his task in either case; his role rather is to determine whether a capable expert has studied the problem fully and reached a defensible result.

Bazelon, \textit{supra} note 45, at 743.

\textsuperscript{50}. \textit{Id.} at 745. Even though Judge Bazelon, in his article, was defending a decision that ultimately rested on statutory, not constitutional grounds, his defense of the competence of the judiciary is surely appropriate to this context—it dealt with a right to treatment and with the tricky question of whether a court can enter the realm of the doctor-patient relationship to implement that right.

\textsuperscript{51}. See, e.g., West v. Keve, 571 F.2d 158 (prison personnel denied inmate access to
have been implemented such that access to medical services is routinely limited.52

What courts overlook in deferring to physicians' presumed expertise is the context within which prison physicians operate. The diagnosis, or treatment, in question is the product of a prison health care system that, in many cases, borders on the totally inadequate and often may even violate constitutional requirements.53 The inadequacy of medical care facilities and support personnel shifts more of the burden of routine tasks to the prison physician.54 In addition, the prison physician is called upon to perform many other duties related more to prison security and discipline than to medical care; these include body cavity searches, initiation of forced feedings and performance of physical examinations for prisoners being admitted, transferred or paroled.55 Furthermore, inmates generally have more medical problems than unconfined populations.56

52. See, e.g., Ramos v. Lamm, 639 F.2d at 577-78 (no on-site psychiatrist for prison population in which 10-25% of inmates required psychiatric treatment); Todaro v. Ward, 565 F.2d 45, 52 (2d Cir. 1977) (procedures for access to prison mental health services so cumbersome as to constitute a denial of mental health services for inmates).

53. Beginning in 1969, attention was drawn to the woeful state of hospital facilities and medical attention in the nation's prisons. One author pointed out that in a New Orleans jail, inmates with chronic diseases who should have been confined to bed were kept on open tiers; that prescribed medication frequently never reached the inmate who needed it; and that access to medical care was dependent on the whims of guards or trustees, who allowed access if the bribe were high enough. Goldsmith, Jailhouse Medicine: Travesty of Justice?, 87 HEALTH SERV. REP. 767 (1972). Despite such publicity, and the decision in Estelle, a 1981 American Medical Association program report on correctional institutions revealed that 42.5% of jails had no medical examining room and 71% had no medical bed space. Further, 29.5% had no medical staff to serve inmates and 31.2% had no responsible physician or medical authority serving in an advisory capacity. Lessenger, Health Care in Jails: A Unique Challenge in Medical Practice, 72 JAIL HEALTH CARE 131, 132 (1982).

54. There are many reasons for this inadequacy. The first, and most obvious, is that there is simply a shortage of funding necessary to maintain adequate prison health services which frequently are a low priority for state budget planners. See E. BRECHER & R. DELLA PENNA, HEALTH CARE IN CORRECTIONAL INSTITUTIONS 61-63 (1975).


56. One study of New York correctional facilities found that three-fifths of those admitted were diagnosed as suffering from at least one type of disease, the most common being drug abuse, psychiatric disorders, trauma and alcohol abuse. Novick, Della Penna, Swartz, Remmlinger & Loewenstein, Health Status of the New York City Prison Population, 15 MED. CARE 205, 215 (1977). One author posits that incarceration makes an inmate more sensitive to his health, and thereby increases the number of physician visits per individual as compared with physician visits of similarly situated unincarcerated persons. Neisser, supra note 55, at 942 (citations therein). Another problem is that physicians find that the normal doctor-patient relationship does not exist in prisons; cooperation may be replaced by the con. Thus, subjective medical data may be unreliable, and the physician may require more than one visit to render a diagnosis of the

264
Imprisoned Paraphiliacs

The physicians called on to perform the varied tasks required by prison administrators may be those least able to handle them. One study has concluded that prison physicians are divided into two distinct groups—physicians who work full-time in prisons and those who work both inside and outside prisons. The majority of physicians in prisons do only part of their work there, yet full-time prison physicians account for 73% of the physician hours spent in prison. The problem is that the full-time prison physicians display characteristics associated with a lower quality of health care. A high proportion (33%) of the full-time prison physicians are foreign medical school graduates with a much lower than average proportion of additional postgraduate medical training and specialization; 84% are not board certified; 56% lack advanced training; 47% have no specialty; and 25% have restricted licenses (licensed to practice only in that specific institution).

It appears, therefore, that most prison physicians simply have neither the time nor the skill to meet the special diagnostic needs of prisoners with psychological problems, much less those whose problems stem from psycho-organic roots. In addition, physicians' treatment decisions are often limited by the policies or practices of prison administrators to whom they must account, limitations that, were the inmate at liberty, would have no place in the treatment decision of the physician.

The above factors weigh heavily against judicial deference to
prison physician diagnoses or treatment-specific decisions. It is difficult to employ a "reasonable physician" standard, as one lower court has suggested,\(^6\) when reasonable standards of practice cannot exist in prisons without either seriously limiting the scope of health care by devoting more time to individual patients or expanding the resources and personnel of prison health care. Neither alternative seems a likely occurrence. A different standard for deliberate indifference, one less heavily weighted in favor of deference to prison physicians, is necessary to guarantee adequate care in treatment-specific disputes involving complicated diagnoses.

**B. A Modified Test for Deliberate Indifference**

The *Estelle* Court’s opinion provides judicial guidance for formulating a modified standard for deliberate indifference. The *Estelle* Court explicitly stated that the conditions and treatment of prisoners must embody the "contemporary" and "evolving standards of decency that mark the progress of a maturing society."\(^6^2\) The use of the words "evolving" and "contemporary" incorporates the notion that outdated medical practices, even if previously considered adequate treatment, will not pass constitutional muster.\(^6^3\) This comports with ethical standards promulgated by physicians’ groups—the ethical physician has a duty to keep abreast of developments in medical care, particularly if she has an area of specialization, a duty independent of either the physician’s or the patient’s environment.\(^6^4\) The ethical duties of a physician also include prescribing

\(^{61}\) Bowring v. Godwin, 551 F.2d at 47 (prison physician held to the standard of a physician exercising reasonable care in diagnosis).


\(^{63}\) This is especially true in the area of modern psychiatric practice. Before 1950, drug therapy was the exception rather than the rule in psychiatric treatment, and the use of custodial care, physical restraint and the isolation of patients from their normal environment were the primary, and sometimes the only tools used by psychiatrists. See R. JOHNSON, *supra* note 26, at xiv.

\(^{64}\) This principle is embodied in physicians’ ethical rules:

> A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated. . . . Psychiatrists are responsible for their own continuing education and should be mindful of the fact that their’s must be a lifetime of learning.

**AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 5** [hereinafter cited as **MEDICAL ETHICS**].

Chapter 8, Section 1 of the By-Laws of the American Psychiatric Association states, "All members of the American Psychiatric Association shall be bound by the ethical code of the medical profession, specifically defined in the Principles of Medical Ethics of the American Medical Association." *Id.* at 1.
Imprisoned Paraphiliacs

for her patient treatment appropriate to remedy diagnosed injuries. The appropriate treatment, called the "treatment of choice" by some physicians, is a standard of care which ties the physician to the state of present medical knowledge in prescribing treatment. Appropriate treatment does not mandate the best possible available treatment, but rather one which adequately addresses the diagnosis the physician has reached. For example, if the psychiatrist has constructed a diagnostic model of the inmate that indicates a paraphilic disorder and concluded that the inmate suffers mental distress as a result of that disorder, organic-based treatment consisting of Depo-provera and psychotherapy is the appropriate treatment regardless of its availability.

That constitutional obligations may hinge upon the state of medical knowledge is confirmed by the Supreme Court's decision in Roe v. Wade. There, the Court relied on "present medical knowledge" and "established medical fact" in determining that the end of the first trimester marked the beginning of the state interest in regulating a woman's pregnancy. Moreover, faced with conflicting opinions as to when the state's interest in life began, the Court

65. "Treatment of choice" refers only to the treatment developed according to the diagnostic model the physician constructs from his interview with the patient. See infra note 67.
66. Cf. Medical Ethics, supra note 64, at § 5 (psychiatrists shall continue to apply and advance scientific knowledge, and be responsible for their own continuing education).
67. The diagnostic model is completed through a thorough evaluation of the patient through the psychiatric interview:
   In the psychiatric interview, like all medical interviews, one person is suffering and desires relief; the other person is expected to provide that relief.
The diagnostic model includes differential diagnosis, which aims at distinguishing the various conditions which may have similar symptoms. An accurate diagnosis is required as a basis for specific treatment. Lewis, Differential Diagnosis, in 2 Basic Handbook of Child Psychiatry 144 (1979). The psychiatrist then develops a treatment plan. The treatment decision takes into account the needs of the patient who is suffering; usually, these needs include the patient's most acute and major problems. A treatment plan (or plans) is then proposed to the patient—not imposed on him—although the patient does expect the psychiatrist to advise him concerning the treatment best suited for him. MacKinnon, supra note 59, at 903. "'Best suited' is a complex notion that includes not only the subtleties of diagnosis but the patient's emotional, financial, and life situational resources as well." Id.
68. Dr. Berlin, in Doe v. Bronson, outlined his differential diagnosis process, as well as his reasons for recommending Depo-provera and psychotherapy treatment, at the habeas hearing. Testimony of Dr. Berlin, supra note 7, at 23-47. A more formal diagnosis is found in Petitioner's Exhibit 25, Doe v. Bronson, supra note 1, at 4.
70. 410 U.S. at 163.
71. Id.
72. Id.
chose a medical standard—"viability"—to delineate the boundaries of that interest. Ten years later, in Akron v Akron Center for Reproductive Health, Inc., the Court reaffirmed its decision in Roe and required, for the "full vindication of the woman's fundamental right," that the physician be allowed to exercise her professional medical judgment, without regulation by the state, until the point at which the state's interest becomes compelling. Toward this end, the state has been required to give the physician "the room he needs to make his best medical judgment." The Court's willingness to rely on evolving medical knowledge suggests a modified test for deliberate indifference in treatment-specific disputes. Where alternative treatments are proposed, lower courts should not automatically defer to the prison physician's choice of treatment, but should instead compare the alternative treatments in light of present medical standards. The comparison

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73. Id.
75. Id. at 427.
76. Id. (quoting Doe v. Bolton, 410 U.S. 179, 192 (1973)).
77. While many find fault with the application of such a shifting scale in the abortion decision, it makes perfect sense if there are, indeed, different levels of medical care inherent in the constitutional right to treatment. If particular treatments are dependent on the validity of medical facts, the possibility that another, more sophisticated treatment may be invented in the future should not preclude the founding of a constitutional right to receive treatment upon the present existence of the lesser treatment so long as it remains the treatment of choice. For example, although a cure for diabetes that does not require insulin injections may be discovered in ten years, that should not preclude diabetics from grounding a constitutional claim to insulin on its current status as the treatment of choice for diabetes.

Similarly, the status of Depo-provera/psychotherapy as the only known effective treatment for chronic paraphilia should strengthen paraphiliacs' ability to raise a constitutional claim for its application. The currently favored medical hypothesis is that deviant sexual behavior has, as part of its component behavior, reinforcement in the limbic system of the brain. Present medical fact links testosterone with the limbic, or sex and aggression system; medical fact demonstrates that reducing or eliminating testosterone has the effect of reducing or eliminating sexual behavior; and present medical practice involving the administration of anti-androgens and psychotherapy has a 95% chance, in some cases, of controlling paraphilic behavior. See supra note 24. The possibility that a newer, better theory and treatment may appear in five years should be irrelevant—until it occurs. Justice O'Connor, echoing the critics of Judge Bazelon, see Bazelon, supra note 45, at 742, stated that:

[It is] difficult to believe that this Court...believes itself competent to make...inquiries and to revise these standards every time the American College of Obstetricians and Gynecologists (ACOG)...revises its views about what is and what is not appropriate medical procedure in this area. Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 456 (O'Connor, J., dissenting). Justice O'Connor further warned against the Court serving as an "ex officio medical board with powers to approve and disapprove medical and operative practices and standards throughout the United States." Id. (quoting Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 99 (1976) (White, J., concurring in part and dissenting in part)).

268
Imprisoned Paraphiliacs

should focus on the demonstrated efficacy of the treatments at issue. Included in this evaluation of efficacy should be an examination of the symptoms the treatment seeks to alleviate; the treatment’s success in controlling or curing the disorder; the behavior it seeks to alter (in the case of mental disorders); the side-effects of the treatment, including any intrusive effects upon fundamental rights of the individual; and its acceptance among the medical community. The credentials of the recommending physician and the prison physician providing the treatment should be examined, where appropriate. If the goals of each treatment are the same and the success of

78. Particular attention should be paid to those symptoms which produce the greatest anguish, either physical or emotional. The search for symptoms should not be confined to those listed under a textbook heading for the individual’s disease; diseases affect individuals in different ways, and it may, therefore, be necessary to address different symptoms even for individuals with the same disease.

79. By “control,” one means the restraint or direct influence of the symptoms and behavior associated with psycho-organic diseases. “Cure” is more problematic in its definition and application to psycho-organic disease. It may mean the restoration of a healthy or normal condition. Remission of signs of a disease may also be called a “cure.” Webster’s Third New International Dictionary 496-97, 555-56 (Unabridged ed. 1981). This Comment will use “cure,” in the context of psycho-organic disease, to refer to the complete remission of the disease; the “cured” paraphiliac would require no pharmacological or psychological maintenance. “Control” will be used to refer to the remission of psycho-organic disease under the restraint of continuing pharmacological and/or psychological maintenance. For the most part, comparisons between treatments will be made by evaluating the relative amounts of “control” they exert over an inmate’s paraphiliac symptoms and behavior. Again, superiority of “control” may vary with the diagnostic and therapeutic needs of the inmate.

80. This requirement focuses on the effect the mental disorder has on the inmate’s well-being, not on the specific behavioral deviations responsible for his incarceration. To require the latter would create a right to treatment that simply does not exist in the Constitution. See O’Connor v. Donaldson, 422 U.S. 563 (1975) (Burger, C.J., concurring). Thus, unless the diseased behavior poses significant stigmatic problems for the inmate (that is, he cannot confine it to his cell and maintain as “normal” a prison life as possible) and/or poses a threat to his mental or physical well-being in the prison, behavioral alteration does not assume a position of great importance in the comparison to be made by the court. Insofar as behavioral change is demonstrative of the alleviation of symptoms which affect the mental and physical well-being of the inmate, it becomes a necessary component of the comparison.

81. This includes any intrusion on any of the rights encompassed by the individual’s right to privacy, particularly those relating to the autonomy of thought and ideas. For example, in one case, psychiatric patients at a state institution were asked to consent to experimental psychosurgery which produced irreversible effects often including “the blunting of emotions, the deadening of memory, the reduction of affect, and limit[s on] the ability to generate new ideas.” Kaimovitz v. Michigan Department of Mental Health, 42 U.S.L.W. 2063, 2064 (Mich. Cir. Ct. Wayne County July 10, 1973). The court stated that “if the First Amendment protects the freedom to express ideas, it necessarily follows that it must protect the freedom to generate ideas. Without the latter protection, the former is meaningless.” Id.

82. This requirement would not be met by a Gallup poll of physicians. Instead, the court should, as in many other situations, look to the opinion of experts and leading practitioners and researchers in the field.

83. In light of the statistics regarding the qualifications of prison physicians, supra note 58 and accompanying text, this is not an insignificant factor.
each appears roughly equivalent, such that no “needless infliction of pain”\textsuperscript{84} would result from the choice of one treatment over the other, the court should dismiss the inmate’s complaint and defer to the prison physician’s choice of treatment. If, however, there are significant differences in the alternative treatments’ goals and efficacy, such that it is clear that the treatment of choice is that sought by the inmate, a presumptive right to \textit{that} treatment should be established. This presumptive right to treatment must then be weighed against any interests the state asserts for not providing the requested treatment. If the state’s asserted interests are insufficient to justify denial of the treatment, failure to provide the treatment must be held to be the result of deliberate indifference by the prison.\textsuperscript{85}

IV. \textit{Applying the Modified Test for Deliberate Indifference}

A. \textit{The Efficacy of Depo-provera/psychotherapy Treatment}

The prison psychiatrist who has diagnosed the paraphiliac is confronted with an inmate suffering from chronic erotic fantasizing that inhibits his participation in therapy requiring mental attention. Although at present, the medical community is still debating whether or not organic-based therapy is the treatment of choice for paraphilia, a treatment involving Depo-provera would be highly recommended for the paraphiliac who has undergone other forms of conventional psychotherapy and not responded. Depo-provera is the only treatment available that restricts and suppresses the erotic fantasies and sexual compulsions that are the symptomologies of paraphilia.\textsuperscript{86} It thus has the capacity to alleviate any mental suffering the paraphiliac experiences as a result of his inability to control his behavioral and psychological urges and may be the only effective way to enable the paraphiliac to participate in psychiatric counseling.\textsuperscript{87}

The lack of either Food and Drug Administration (FDA) label approval or an overall consensus in the medical community should not hinder the recognition of Depo-provera’s efficacy. One need look

\textsuperscript{84} Estelle, 429 U.S. at 103.  
\textsuperscript{85} Prior to this stage, but after a presumptive right to treatment had been established, it might be appropriate for the reviewing court to continue the case to give the state the opportunity either to grant the treatment or to find reasons why it should not be granted. Such a procedure would clear any ambiguity remaining from possible application of an intent standard; denial of treatment, after the court had found a right to that treatment, without a statement of reasons, should suffice to demonstrate intent.

\textsuperscript{86} See supra note 28 and accompanying text.

\textsuperscript{87} Testimony of Dr. Berlin, supra note 7, at 47; Testimony of Dr. Gagne, supra note 7, at 136. See also supra note 67 (describing diagnostic procedures and treatment plans).
Imprisoned Paraphiliacs

only to the history of lithium therapy for an example of a treatment regimen which became the treatment of choice before receiving official sanction. The use of lithium to treat manic depressives was initially resisted by most clinicians; however, once even skeptical clinicians began to use lithium, they found it so effective that many circumvented the double blind trials in which they were engaged (in which a control group of patients was given placebos while the test group was given lithium carbonate) and gave all their patients lithium. The fact that FDA approval was required (which is not the case for Depo-provera) did not stymie medical practitioners. A large number of psychiatrists during this time employed lithium therapy without FDA permission because of its efficacy, and the FDA, though well aware of the practice, did nothing to stop it.

The major side-effects of Depo-provera include weight gain, increased blood pressure, lethargy, sweats, cramps, dyspnea, hyperglycemia and hypogonadism. All the effects are fully reversible after the administration of Depo-provera ceases, usually within two weeks. As with any pharmacological treatment, some monitoring is required, and informed consent is usually obtained.

Thus, while current medical consensus may not have labeled

88. R. Johnson, supra note 26, at 100.
89. Id. at 101. The FDA required physicians to file an investigative therapy form with their office for approval; however, as word of lithium's effectiveness in treating manic behavior spread, the FDA routinely granted investigative clinical trials and, indeed, paid no attention to those who did not file an investigative therapy form.
90. Berlin & Meinecke, supra note 10, at 603. Critics of Depo-provera have attempted to link it with possible carcinogenicity in tests with female beagles. See Rosenfield, The Food and Drug Administration and Medroxyprogesterone Acetate, 249 J. A. M. A. 2922, 2924 (1983). However, several researchers refute this correlation. See Liang, Risk of Breast Uterine Corpus and Ovarian Cancer in Women Receiving Medroxyprogesterone Injections, 249 J. A. M. A. 2909, 2912 (1983) (study indicated that there is not likely to be a strong association between MPA injections and cancer of the breast, uterine corpus or ovary); Rosenfield, supra, at 2923 ("there appear to be absolutely no contraindications to medroxyprogesterone acetate use other than pregnancy").
91. The changes attributed to the medication are reversible upon cessation of treatment, usually within seven to ten days. Prospectus, supra note 3. See also Berlin & Meinecke, supra note 10, at 603 ("Effects appear to be fully reversible within a few months after the medication is stopped."); Gagne, supra note 10, at 646 (absence of irreversible side effects is one characteristic that may make MPA the drug of choice in treating patients with a history of deviant sexual behavior).
92. Monitoring can take the form of blood tests to gauge the effectiveness of the drug in lowering testosterone levels. Typically, a brief hospitalization period is needed as treatment begins to monitor for side-effects. Berlin & Meinecke, supra note 10, at 603; Prospectus, supra note 3; Gagne, supra note 10, at 644-645.
93. "...[A] subject's informed consent must be competent, knowing, and voluntary. The integrity of the individual must be protected from invasion into his body and personality not voluntarily agreed to. Consent is not an idle or symbolic act; it is a fundamental requirement for the protection of the individual's integrity." Kaimowitz v. Michigan Dept. of Mental Health, 42 U.S.L.W. 2065, 2064 (Mich. Ct. App. 1973).
Depo-provera the treatment of choice for paraphilia, under a present medical knowledge standard, Depo-provera must be recognized as the most effective treatment currently available for paraphilia. When a prison physician has proposed an ineffective alternative treatment, such as treatment consisting only of group counselling sessions, even though the physician's diagnostic model requires an organic-based treatment, the paraphiliac inmate must be found to have established a presumptive right to Depo-provera treatment.

B. State Interests

No right, of course, is absolute. State interests of a compelling nature can be raised to justify an abridgement or encroachment upon almost any right. Several state interests are likely to arise in the context of a right to medical care including concern for costs, concern for additional administrative burdens and a desire to avoid judicial entanglement with state authorities.

The cost consideration is not insubstantial. The development of the modified test for deliberate indifference has rested in part upon an indictment of the inadequacy of prison medical services. Any attempt to improve the quality and availability of medical services in any prison as a whole would be very expensive. Such institutional considerations, however, have not proven to be obstacles to court injunctions requiring improvements in individual medical care. Furthermore, it is not always the case that the inmate's requested therapy is significantly more costly than that chosen by the prison. The implementation of Depo-provera therapy, for example, does not impose any additional significant cost to the state. Indeed, the bulk of the expense associated with Depo-provera treatment is incurred in treating the psychological component of the disorder; in Doe's case, most such costs were already being incurred in provid-
Imprisoned Paraphiliacs

ing the psychiatric counselling recommended by the prison doctor. In Connecticut, the Department of Correction has apparently abandoned the cost rationale for denying treatment and has announced that any inmate may request and receive Depo-provera/psychotherapy treatment so long as it is clinically appropriate. 98

Interference and entanglement with prison administrators does not appear to be a major concern in medical treatment cases since medical care does not directly interfere with the normal day-to-day functions of prison administrators, namely, prison security and discipline. 99 Furthermore, most, if not all, of the additional procedures imposed on the prison by the right to treatment—such as psychological screenings to determine appropriate treatment-specific recommendations for psycho-organic disorders or ensuring that informed consent is present—would be performed by medical care personnel. Interference has become a superficially valid concern only because prison administrators themselves have interfered with the medical process, invoking security or discipline reasons. 100 The answer is not to limit treatment but to limit this unnecessary interference through the development of institutionally independent medical services within the prison. 101

Another objection which states might raise against implementing a right to treatment focuses on the disparity such a right might create between the level of care of inmates and that of the general population. In other words, states might claim that a right to treatment endows the inmate with better health care than his counterpart at

mental health unit does not require advanced degrees and, to a limited extent, can rely on less expensive interns to assist in psychotherapeutic counseling.


99. Todaro v Ward, 565 F.2d at 47.

100. See supra note 60.

101. This idea is not unique. See Neisser, supra note 55. Its practicality, however, remains open to question. Requiring the prisons and the courts to rearrange their schedules to accommodate physician appointments, as Neisser proposes, is perhaps too burdensome a task to impose. However, the idea that medical and correctional lines of authority and supervision be separated has merit. Such a separation would help ensure that incarceration does not frustrate the delivery of health care services; moreover, it would ensure that health care services are delivered according to considered, independent medical judgment, not according to the needs of the prison. Of course, such a change would obviate the necessity for the standard of review proposed in this Comment, since the standard is premised, at least in part, on the current poor state of medical care in prisons. If this Comment becomes obsolete, however, due to the advent of adequate funding, adequate staffing and bureaucratic divisions that allow competent medical judgment—so be it.
liberty who, due to financial or other circumstances, cannot acquire appropriate treatment.

There are several responses to this objection. First, courts have already rejected a similar argument based on a state claim that improving medical conditions at one prison would create a disparity of treatment among the state’s prisons.\(^{102}\) The courts have focused solely on the medical needs of the individual inmate and not on whether, by comparison, he is better or worse off than another inmate similarly situated. Second, prisoners are denied Medicaid benefits.\(^{103}\) When combined with other cost considerations, this creates huge incentives for state officials to ensure that while the inmate receives appropriate treatment, he receives only the minimum treatment at the minimum cost from a physician of the prison’s choosing. Unlike his counterpart on the outside, the inmate has no choice as to who administers what treatment where. Any fear that inmates will receive comparatively luxurious treatment is simply unfounded.

Third, denial of equivalent health care cannot be justified as additional punishment. Punishment is the loss of liberty. As Estelle recognized, the Cruel and Unusual Punishment Clause would have little meaning if punishment were allowed to justify deprivations reaching every aspect of a prisoner’s life, especially were it allowed to extend to denials of medical care.\(^{104}\) Fourth, treatment of the inmate will not divert health care from those at liberty. For example, an inmate requiring major, unique surgery—such as an organ transplant—would not have a special or preferred claim for the limited supply of organs. Implementation of a right to treatment would require only that prison officials ensure that an inmate has an opportunity equal to that of a free person, however limited, to be considered for the surgery.\(^{105}\) Finally, concerns over disparity of treatment are particularly invalid for paraphiliacs, the majority of whom will seek no treatment until incarcerated.

\(^{102}\) Todaro v Ward, 565 F.2d at 53. The state argued that the district court had erred in ordering injunctive relief because care at the institution in question was no worse than that at other correctional facilities. The Second Circuit dismissed this argument, saying that institutional practices were not required to be defective to a maximum degree before a violation of constitutional rights could be found.

\(^{103}\) 42 U.S.C. § 1396d(a) (1970).

\(^{104}\) "The [Eighth] Amendment embodies 'broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . . .'" Estelle, 429 U.S. at 102 (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)).

\(^{105}\) Of course, if donor banks or surgeons refused to consider convicts for transplants because they considered inmates to be undeserving, a problem of a different sort would arise, a problem, however, which would not implicate prison medical authorities. Special difficulties might also be posed by an inmate condemned to death who required an organ transplant. Neither problem will be addressed by this Comment.
Imprisoned Paraphiliacs

C. Inmate Interests

One danger of implementing the right to treatment as proposed in this Comment is that legitimizing the use of organic-based therapies carries with it possibilities of abuse by prison officials. One prison official has already gone on record as advocating general use of Depo-provera for the purpose of eliminating sexual assaults and aggressive behavior among inmates. If the right to treatment is to serve only the desired purpose of insuring adequate medical care, inmates must be able to protect themselves from overzealous and undesired application of treatments for reasons unrelated to their well-being. Courts should be prepared to counter state attempts to coerce unwanted treatment.

1. The Duty to Treat

In seeking to impose unwanted or unnecessary treatment, states might assert that, once an illness is diagnosed, the state has a duty to provide treatment in order to fulfill its constitutional obligation. Indeed, states might assert that in treatment-specific disputes where the alternative treatments are roughly equivalent, the state has the right to choose the "better" treatment. For paraphiliacs, this would justify the imposition of organic-based therapy without the paraphiliac's consent.

106. Larry Meachum, Corrections Director of Oklahoma "would like to see Oklahoma become a 'frontrunner' in studying the use of 'chemical castration' to control sex offenders in overcrowded prisons." Meachum has also declared that "the future of corrections in this country is going to be in incarceration, chemistry and electronics." United Press International, Press Release (March 19, 1984) (available on NEXIS).

107. While the nature of the constitutional obligation demands that the state provide treatment where the medical need is serious and the treatment necessary, one commentator has stated that a reciprocal duty to submit to treatment exists in the person claiming a right to treatment. Katz, supra note 26. The duty to be treated resolves the dilemma posed to the state by a patient who is incompetent or unable to accept or appreciate the need for treatment. If treatment is necessary, then the questions that "must be posed and answered are: Why, for whom, and within what limits?" Katz, supra note 26, at 767. The solution Katz proposes is to limit both the right and duty of treatment, thereby creating "a right to treatment only for those who wish to exercise it or who after a [limited] period of time have come to appreciate such a right and can benefit from it." Katz, supra note 26, at 775. Katz views the latter limit as allowing for a limited period of coerced treatment which may give an individual the ability to acquire, if possible, the capacity to decide for or against treatment. Katz, supra note 26, at 773.

108. If the state were to argue a position similar to Katz, supra note 26, it would claim the right to coerce organic-treatment for paraphiliacs, since its immediate effect would be to enable the paraphiliac to feel what it is like to be "normal" and free from the intrusive fantasies and urges associated with the disease. This position has certain merit when one recalls that one aspect of paraphilia is the subjects refusal to believe that the conduct he engages in is at all deviant. See supra note 10. If this is the case, the paraphiliac would be naturally hostile to treatment that sought to change his "normal" behavior patterns. Coerced therapy would be required.
Situations in which an inmate's ability to assert a right to receive treatment does not allow the state to assert a duty to treat over the inmate's objections can be distinguished on several grounds: the degree of physical or mental discomfort treatment causes the inmate, the degree of risk associated with the side-effects of treatment, and the intrusiveness of the treatment. The greater the impact of treatment upon the inmate, the greater the need to ensure voluntary election of therapy. In Depo-provera treatments for paraphiliacs, for example, extreme physical discomfort is associated with the side-effects of the drug. This discomfort is not inconsequential, even if reversible. The degree of risk of physical side-effects depends on the physiology of the individual. For all individuals, however, Depo-provera has a major intrusive effect on brain functions—mentation is substantially altered. The intrusiveness of Depo-provera treatment suggests that the patient's consent should be required. Moreover, voluntary election of therapy is essential in any organic-based regime precisely because one component of the regime is psychotherapy. The goals of the psychotherapeutic techniques employed are effectively thwarted and nullified if the patient is unwilling.

This is an arbitrary line, to be sure, but it speaks to the issue of whether informed consent to a procedure should be required. If informed consent is made a prerequisite to a particular therapy, then election of that therapy should be completely voluntary.

The intrusiveness of a given therapy is often raised in conjunction with a claimed right to refuse treatment. The right has been frequently invoked by mental patients who refuse psychotropic medication which can leave the patient in a state of near catatonia. See Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978).

The Supreme Court has declined to face the issue of the right to refuse treatment, remanding a case which originated in Massachusetts and argued that the right to refuse treatment was encompassed in the right of privacy. Mills v. Rogers, 457 U.S. 291 (1982). The ostensible reason for the remand was that in the interim between granting certiorari and delivering judgment, the Massachusetts Supreme Court, in Guardianship of Roe v. Mass., 421 N.E. 2d 40 (1981), held that, under the Massachusetts constitution, a right to refuse treatment existed, primarily because thought processes were protected as a corollary of the right to express one's self.

Whether a right to refuse treatment will be found in the federal constitution remains an open question. However, it seems clear that current interpretation of the right to refuse treatment is an important factor in delimiting the duty to be treated, especially in the context of an organic-based therapy that utilizes Depo-provera. There is little doubt that Depo-provera affects mentation; it produces a "calming" effect on the brain, and it disrupts the normal chain of biochemical processes that make up the testosterone-limbic brain system. See Petitioner's Exhibit 25, Doe v. Bronson, supra note 1.

But see Katz, supra note 26, at 772-75. While psychotherapy requires the establishment of a collaborative relationship between patients and therapists, the quality of the relationship required can vary. The relationship need not be an unequivocally positive one. Id. at 772 n.55. In implementing a duty to be treated, for example, the relationship would be required to exist even while treatment was being coerced. Id. As a general rule, however, Katz acknowledges the need for cooperation and trust if psychotherapy is to be successful. Id. at 772 n. 54.
Imprisoned Paraphiliacs

2. **Coercion of Inmates: Tying Care to Benefits**

To support the imposition of unwanted treatment, prison officials can create circumstances such that inmates will accept treatment without proper regard for its associated risks. The simplest method of coercing treatment is to tie participation in treatment to liberty interest decisions such as the granting of parole or goodtime. Prison officials might attempt to use such ties to coerce all those eligible for Depo-provera treatment, with its institutionally desirable side-effect of reduced aggressiveness, to participate in treatment.¹¹¹

Because coercion in a prison environment is so likely, its possibility should be averted by forcing liberty interest decisions to be made without the knowledge of whether an inmate has elected or refused an organic-based therapy.¹¹² This is easily accomplished by keeping medical records confidential. Such a practice has the additional benefit of furthering physician/patient confidences which might aid diagnosis and treatment in the first instance. The merits of such a system are evident. It promotes self-selection among inmates who desire organic-based therapies without forcing drastic changes in the present practice of medical care delivery. Guards and other personnel, such as counselors, could continue in their present roles, but would no longer be privy to the medical files or medical information regarding the inmate. Even though they might suspect an inmate was undergoing organic-based therapy, they would be unable to obtain confirmation from the medical file. Inmates too would be instructed by prison physicians that their files are confidential and inaccessible to any persons with control over liberty interests. This suggests another desirable side-effect of confidentiality, namely discouraging the inmate who seeks to make

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¹¹¹ “Liberty interests” refers to the spectrum of mechanisms that allow inmates to leave prison before the expiration of their imposed sentence, the deprivation of which cannot be accomplished without due process. Examples of liberty interests include goodtime, parole, pardons, furloughs, half-way house eligibility, sentence modifications/commutations, or transfers to a minimum security, “open” facility. Even judges are not immune from the temptation to coerce treatment. One judge attempted to do so to an heir of the Upjohn fortune (the pharmaceutical corporation that manufactures Depo-provera, an irony lost neither on the press nor the judge). The judge ruled that the convicted heir had a choice between a five year prison sentence and a one year jail term with probation subject to the condition that he undergo “chemical castration.” The Court of Appeals of Michigan overturned the sentencing judge’s decision as imposing an unlawful condition of probation, citing allegations that Depo-provera was unsafe and not widely accepted. People v. Gauntlett, 184 Mich. App. 737, 352 N.W. 2d 310 (1984).

¹¹² One problem with this neutralization technique is that it seems unfair to deprive an individual who has willingly sought, is undergoing, and is responding well to organic-based treatment, from being able to take advantage of that fact in liberty interest decisions. The response to this, though perhaps unsatisfactory, is that objective observations will bear out the improvements and changes in the affected person’s behavior, and reflect favorably in liberty interest decisions.
the physician an ally in attaining favorable liberty interest considerations.

3. Coercion of Physicians: Tying Care to Employment

Prison physicians hold their positions at the discretion of the prison (or the state). They are subject to directives and requests from the administrative staff of the prison. As members of an institutional workforce, prison physicians may internalize the policies and goals of the institution.113 State officials seeking to impose unwanted treatment can, therefore, either directly, by issuing directives or threatening to discontinue the physician's employment, or indirectly, by establishing general prison policies, pressure physicians to disregard inmate objections to treatment.

The prison physician can resist state pressure by raising the medical profession's ethical canons. These canons dictate that a physician's concern, first and foremost, must be for her patient.114 The ethical physician has an obligation to prescribe only the appropriate treatment which, according to her considered medical judgment, is warranted by her patient's medical needs. She must act without consideration for the general level of health care in the prison, limitations on available facilities at the prison, administrative desires to treat for non-medical reasons or any social or political concerns.115

The ethical physician, therefore, can guard against coerced treatment. A mechanism is required, however, to insure that prison phy-

113. Bazelon, The Prison Doctor and the Patient, 5 MAN & MED. 77, 79 (1980). One author has also expressed his feeling that some prison physicians seek to stay as far away from their patients as possible, "Jails are often smelly, and [a prisoner's] appearance and personal habits may seem repulsive (e.g., unwashed hair, foul odor, offensive tattoos, obscene speech)." Lessenger, supra note 53, at 141.
114. The starting point for a survey of the ethics governing physician duties is the Hippocratic Oath. "For twenty five centuries it has been the 'credo' of the profession," W. Osler, THE EVOLUTION OF MODERN MEDICINE 63-64 (1921). The Oath states in relevant part:

I swear by Apollo the physician and Aesculapius and Health (Hygieia) and All-Heal (Panacea) and all the gods and goddesses, that, according to my ability and judgment, I will keep this oath and this stipulation. . . . I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. . . . Into whatsoever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption. . . .

Id. In addition, there are principles of medical ethics which decree that the first duty of the physician is to the well-being of his patient. MEDICAL ETHICS, supra note 64.
115. "[T]he physician should not delegate ... to any nonmedical person any matter requiring the exercise of professional medical judgment." MEDICAL ETHICS, supra note 64, at § 5. Furthermore, though psychiatrists are encouraged to participate in social and political activities and remain free from penalty for protesting social inequities, they "should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine." Id. at §§ 3, 7.
Imprisoned Paraphiliacs

Physicians act as ethical physicians. One such mechanism might be an independent review board authorized to scrutinize prison physicians to determine whether they are in fact fulfilling their ethical obligations toward their patients.  

D. The Problems of Rehabilitation

Quite apart from those concerns related to implementation of treatment-specific duties in prisons, the increasing use of organic-based therapies for diseases such as paraphilia will create a second set of problems for the state if treatment proves successful. Prison administrators, legislators and the public at large will be forced to confront the "creation" of what has been called the "new man"—someone whose psycho-organic problems are cured or controlled, resulting in a person free of the impulses and behavior that identified him both for punishment and for organic-based therapy. This is, with little dissent, "rehabilitation" in the truest sense of the word. For the paraphiliac, it means freedom from the compulsions and drives that were manifested through deviant behavior. Should the rehabilitation of a prisoner through organic-based ther-

116. See Neisser, supra note 55, at 961 (advocating the use of courts to establish standards for licensing, competence and professional judgment); Lichtenstein & Rykwaler, supra note 57, at 596 (calling for the use of medical audits to supervise prison physicians).

117. The term "new man" was first used to describe a British criminal, jailed for numerous uncontrollable violent episodes, who was operated on for a bone chip that was lodged in his brain. Immediately after surgery, the man sought release, claiming that he no longer felt the violent urges that had made him commit crimes—that he felt like a "new man." See Delgado, supra note 26, at 216. A similar, if not as spontaneous, reaction has been noted among paraphiliacs when Depo-provera succeeds in lowering testosterone levels. The case studies reported in Berlin & Meinecke, supra note 10, at 605, indicate that subjects treated with Depo-provera experienced "considerable relief from obsessive erotic urges." Similarly, Gagne reported that his patients felt a "sense of freedom accompanied the diminution in the frequency of sexual fantasies." Gagne, supra note 10, at 645.

118. "Rehabilitation," in the classical penological sense, involves the use of therapeutic measures employed and designed to effect changes in the behavior of the convicted in the interests of his own happiness, health and satisfaction, and in the interest of social defense. See Allen, Criminal Justice, Legal Values and the Rehabilitative Ideal, 50 J. CRIM. L. CRIMINOLOGY & POLICE SCI. 226 (1959). The objective is to produce an individual whose propensity to violate societal norms has been reduced to acceptable levels. Delgado, supra note 26, at 256. Others suggest that true rehabilitation further requires self-reform and self-restraint. Note, Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients, 45 S. CAL. L. REV. 616, 657-658 (1972). This of course raises the question of whether rehabilitation has really been effected if the physical substrates responsible for behavior have been removed without any effort required of the inmate, as in the case of organic therapy. However, in successful organic-based therapy, the psychological component—reform and restraint—is necessary, and rehabilitation, therefore, may be said to have occurred. It should be noted, however, that maintenance of the rehabilitation through continuing treatment is required.

279
apy, however, force a review of the prisoner's sentence? This section does not attempt to answer this question definitively; instead, it seeks to target the major areas of inquiry that should develop as organic-based therapies become more sophisticated, and more inmates may be said to be rehabilitated.

One way of approaching the propriety of continued incarceration is to examine how rehabilitation affects accepted rationales for incarceration. There are four generally accepted rationales: specific deterrence, general deterrence, retribution and rehabilitation.119 Specific deterrence—deterrence resting on the premise that confinement will reduce the propensity of a given inmate to commit another crime120—is thoroughly undermined through successful organic-based therapy. The paraphiliac's propensity to commit deviant sexual acts is either wholly eliminated through successful treatment with Depo-provera, or at least reduced to the extent that, statistically, there is little likelihood of it recurring.121

The general deterrence rationale focuses on the ability of punishment to set an example for society as a whole.122 It may be that punishment of the rehabilitated paraphiliac remains justified by this rationale. Because the majority of the population will be unable to distinguish between the aggressive, violent sexual offender and the paraphiliac, incarceration of those who committed sex crimes because of a now-cured disease may deter those who are able to choose whether or not to commit sex crimes.

Another rationale for incarceration is that it serves as retribution to society for the crime committed. Retribution satisfies a societal need for revenge, a need that remains unsatisfied even if a penal system deters or rehabilitates the individual and even if the criminal shows remorse or accepts responsibility for his actions. The creation of a "new man" probably has no effect on society's desire for

119. The "four classic principles" representing the goals of incarceration have been characterized as deterrence, retribution, rehabilitation and protection of the public. Delgado, supra note 26, at 251 and n.234. This Comment substitutes the term "specific deterrence" for "protection of the public" because it more clearly portrays the principle's focus on the inmate himself; incarceration under this principle is designed to deter the individual inmate from further crime by giving him a taste of the penalty he can expect.

120. Specific deterrence consists of after-the-fact inhibition of the person punished. Specific deterrence rests on the assumption that the individual will avoid future conduct which is likely to subject him to imprisonment again. Delgado, supra note 26, at 259-60.

121. Dr. Berlin claims an 85% success rate in treating paraphiliacs with Depo-provera and psychotherapy. AP Press Release, supra note 34.

122. General deterrence involves inhibition in advance by the threat of punishment. Delgado, supra note 26, at n.237. For an excellent discussion of the deterrence interest and the "new man," see Id., at 251-257.
revenge. However, insofar as retribution depends on an identity between the punishment and the individual as a focus for the community’s moral outrage, organic-based therapies successfully destroy any such connection because the individual who committed the crime, the uncured paraphiliac, ceases to exist.\(^\text{123}\)

This section can only conclude that whether to continue incarceration of the rehabilitated paraphiliac remains an unresolved issue. On the one hand, the desires of society for general deterrence and retribution may best be served by the continued incarceration even of those inmates treated successfully with organic-based regimens. On the other hand, society’s concern for the individual, and perhaps the moral decency associated with a maturing society, might weigh on the side of sentence reconsideration and a refocussing on rehabilitation as an acceptable goal.\(^\text{124}\) Whatever the approach to the treatment of the “new man,” it is clear that the issue can arise only after implementation of a right to treatment. Whatever the concerns of the state in this area, they should play no part in the constitutional balancing involved in choosing between alternative treatments.

V. Conclusion

Advances in medical science have produced a model of the underlying causes of paraphilia. Formation of the model, which posits that the paraphiliac’s deviant sexual behavior has both psychological and organic roots, has suggested the use of organic-based therapy. Depo-provera in combination with psychotherapy has been used with great success in treating paraphiliacs.

Unfortunately, legal advances have not matched medical advances. Lower court application of the “deliberate-indifference” prong of the Supreme Court’s \textit{Estelle} standard has left most imprisoned paraphiliacs unable to obtain organic-based therapy. This Comment has suggested that the deliberate-indifference test be recast to account both for medical advances and for inadequacies in prison medical care. Application of the modified standard would

\(^{123}\) See \textit{id.}, at 259-60.

\(^{124}\) Recently, the goal of rehabilitation has undergone a renaissance: When we, as society, place a person behind walls and bars, we take on a moral obligation—not a legal obligation, not a constitutional obligation—a moral obligation, to do everything within our resources to make that person better able to cope when he comes out and rejoins the mainstream of society.

allow inmates to establish a presumptive right to treatment where denial of a recognized medical treatment could be premised only on the inadequacy of the prison’s medical facilities or other non-medical concerns.

Of course, creating a presumptive right to treatment will not in itself resolve the problems society faces in treating imprisoned sex-offenders. For example, care must be taken lest prison officials abuse the inmate’s right and coerce undesired treatments. Nevertheless, recognizing that paraphiliacs can be treated while imprisoned, and making that treatment available, are at least first steps towards a coherent policy on medical treatment, and prison conditions in general, for all inmates.

—Michael Yaki