Enforced Legal Isolation Of Tuberculous Patients

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The recalcitrant tuberculosis victim always has been a thorny problem for officials charged with the conduct of tuberculosis control programs. Enforced isolation of such persons is an extremely controversial procedure. This report of California's experience is presented in the belief that it will stimulate discussion and in the hope that it will evoke comparisons with other experiments to protect the public from unnecessary exposure to infectious victims of tuberculosis.

PUBLIC HEALTH departments have long been faced with the problem of how to control tuberculous individuals who will not cooperate in isolating themselves from healthy people and who persistently continue to endanger family and community. Twenty-two States (*1*) have compulsory isolation laws, but half of these States do not make an effort to enforce them. Thus, while legal means of restricting the careless person with tuberculosis are available, in many places there has been reluctance to apply the checkrein of force. Also, the lack of even enough beds for those willing to enter a sanatorium plus the unwillingness of some sanatorium directors to admit uncooperative tuberculous individuals has placed obstacles in the way of forced hospitalization.

In some locations, the problem has been grappled with directly by establishing additional enabling regulations, usually on a local

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level, and by creating special guarded facilities for persons committed to the institutions by the counties. Columbus, Ohio (*2*), Milwaukee (*3*), Seattle (*4*), Los Angeles County, Calif. (*5*), and Philadelphia have each borne down upon the uncooperative tuberculous patients and have created practical plans of action for handling uncooperative persons with tuberculosis.

Los Angeles County's Experience

In California, the Los Angeles County Health Department pioneered in trying to bring the careless and the recalcitrant tuberculous patient under control. The first isolation order was issued in 1931. The program was pursued so energetically that in the first 10 years 800 suspects were examined under legal order, and 500 with active tuberculosis were subjected to compulsory legal isolation in institutions. More than 100 arrests and convictions attended these efforts.

There are, however, no reported decisions of the California Superior Courts and no decisions of the District Courts of Appeals or the Supreme Court of California concerning the legality of the program of enforced isolation of tuberculous patients, although there have been a number of venereal disease cases in which the courts upheld the right of health officers to quarantine a person when the health officer had reasonable cause to believe such person has a contagious or infectious disease. The most recent of these cases are *Ex parte Martin*, 83 Cal. App. 2d 164, 188 P. 2d 287; *Ex parte King*, 128 Cal. App. 27, 16 P. 2d 694; *Ex parte Clemente*, 61 Cal. App. 666, 215 P. 698; *Ex parte Arata*, 52 Cal. App. 380, 198 P. 814; and *Ex parte Johnston*, 40 Cal. App. 242, 180 P. 644. In the *Arata* case, it was found that the health officer must have reasonable cause for belief that the person is infected and may not act upon mere suspicion, and in the *Martin* case, that the county jail is an appropriate place for detention of a person whom the health officer has reasonable cause to believe infected.

In early 1943, the California State Department of Public Health called together a group of health officers, sanatorium directors, tuberculosis specialists, and representatives of the State attorney general's office and of the California Tuberculosis Association. During the conference (*6*), the subject was thoroughly discussed from the viewpoint of each discipline represented, and it was generally concluded that:

The experience in Los Angeles County has shown the practicability of enforced isolation of the tuberculous individual.

The local health officer is authorized to quarantine or isolate a person with communicable tuberculosis and may do so without consultation with or direction from the State health department.

The local health officer must be prudent in the selection of suitable cases for coercive action and must be able to show that reasonable cause exists.

Enforced isolation is to be resorted to only after persuasion and explanation have been thoroughly attempted.

A person who breaks tuberculosis isolation is guilty of a misdemeanor, for which he can and should be prosecuted.

Recalcitrant tuberculous patients frequently present complicating factors such as chronic alcoholism or borderline psychosis.

A campaign of education on the occasional necessity of enforced tuberculosis isolation is in order.

During the 1943 annual meeting of the California Tuberculosis Association, a session was devoted to the problem of recalcitrant tuberculous patients. Papers were presented (*7*) which outlined the historical, legal, and procedural aspects of the problem. The speakers were in agreement as to the necessity of action, even though they recognized the difficulties involved.

In spite of these two conferences, and the wide distribution throughout California of the proceedings of both, little progress was made in persuading other counties to follow the lead of Los Angeles County. Most local jails were unable properly to isolate a tuberculous prisoner. None of the sanatoriums had security

wards which were escape-proof. The State law was worded diffusely, merely blanketing tuberculosis with many other communicable diseases and setting the penalty for "disobeying the health officer," rather than specifically for breaking tuberculosis isolation.

In some quarters, efforts were made to promote the establishment of a State tuberculosis sanatorium, which, in addition to other categories of patients, could also care for the committed recalcitrant in specially planned wards. But the existence of a satisfactory chain of county-owned sanatoriums, partly State-supported, and other factors defeated the proposal.

In 1948, the California Conference of Local Health Officers, which is a consultative and advisory body to the State department of public health, requested that legislation be introduced to create a State facility for tuberculous recalcitrants which would take committed persons from smaller counties, particularly where even one florid recalcitrant patient could negate much of the effectiveness of a tuberculosis control program.

Acting on this request, the State public health department prepared a bill that was passed without debate by the legislature, becoming law in late 1949. This act empowered the State department of public health to "lease" facilities, and money was provided for this purpose. At the same legislative session, two sections (*8*) which set up procedures and penalties specifically for the enforcement of tuberculosis isolation were added to the California Health and Safety Code. These were drawn up especially to smooth the way of the local health officer who would need to send patients to the proposed facility for recalcitrants.

Sections 2559.5 and 2600.5 of the revised code (*8*) make it mandatory for the local health officer to issue a quarantine and isolation order in writing when he determines that segregation of any patient afflicted with infectious tuberculosis is necessary for the preservation of the public health. The local health officer is also required to advise the district attorney of the county, in writing, when the order of quarantine and violation has been violated. Any patient found guilty of violating the order is guilty of a misdemeanor, and upon conviction, may be ordered by any court of local jurisdiction to be confined for a period up to 12 months on a subsequent conviction.

A Temporary Medical Facility

In California, which has almost 80 tuberculosis institutions, it would seem to be an easy task to find an institution which would be willing and able to set aside a wing, a floor, or a building, to put such area under proper security arrangements, and then lease it to the State public health department. But it proved to be otherwise. Most of the institutions were overcrowded; many had waiting lists; and almost nowhere was there enough bed space available. One of the larger sanatoriums, which was located after much seeking, offered an older isolated building on condition that the State health department recondition it in a major way and make all the security arrangements. However, relative remoteness made the location somewhat less than ideal, and before the negotiations had crystallized, it was learned that the California State Department of Corrections might be able to help.

During the early period of California prison history, almost 100 years ago, it was customary for each institution to care for its own tuberculous patients. At first, this practice affected only San Quentin, since for a long time it was the only prison in California. Later, as the number of prisons was increased, efforts were made to segregate patients in a single prison only. At times, the prison would be San Quentin, and at others it was Folsom.

A significant reorganization of California prisons began in 1944 when the Governor appointed Richard A. McGee to the newly created position of director of corrections. Since then, the California State Department of Corrections has been actively concerned with the establishment of a classified correctional program (*9*) involving, among other things, a diversification of institutions to meet the needs of offenders. Recognized and approved at an early date was the urgent need for an adequate facility for treatment of the many disabled inmates, particularly those afflicted with long-lasting physical and mental illnesses. The basic justifications for such an institution have not

been seriously questioned at any time. Construction of such a treatment facility is now under way on a site of some 900 acres near Vacaville, Calif.

In the meantime, the former Navy Disciplinary Barracks at Terminal Island, San Pedro, Calif., was loaned to the department of corrections in 1950 and is being used as a temporary California Medical Facility. During 1938, it had been opened for use by the Federal Bureau of Prisons as a correctional institution for short-term, medium-custody inmates, and some 4 years later it was transferred to the Navy.

Although the temporary medical facility is not a regular hospital, efforts are being made to meet the basic standards. It really serves as an intermediate type of institution halfway between a prison and a hospital. One thousand and one hundred inmates are cared for by an average number of 200 employees. According to three major medical categories of disabilities, the current population is 150 tuberculous, 400 chronic infirm (including the aged), and 550 neuropsychiatric patients.

When the California State Department of Public Health became aware of the plans to care for tuberculous felons at Terminal Island, the thought grew that here might be the facility to care for the tuberculous recalcitrants. The State department of corrections was sympathetic to the idea and plans were accordingly made to receive both types of tuberculous individuals—felons and recalcitrants. The tuberculous felons were transferred to Terminal Island from other institutions, particularly from Folsom Prison, during the summer of 1950. They were a large group, approximately 90, and because of the obvious difficulties involved in properly segregating and treating so many patients with tuberculosis in the regular institutions, it was decided at the outset to give them transfer priority over other patients. Subsequently, active cases detected in the regular prison population and more recently in the reception and guidance centers have also been promptly transferred to Terminal Island. Many of these are discovered by routine admission X-ray films; others are found by the periodic small-film surveys made by the California State Bureau of Tuberculosis Control.

A section of the tuberculosis building was made ready for the reception of tuberculous misdemeanants. The first misdemeanant, one from Santa Clara County, was admitted in December 1950. The 25 beds available were rapidly filled from counties in all parts of the State.

According to the present agreement between the State departments of public health and corrections, the number of misdemeanants at Terminal Island shall not exceed 25 at any one time; and they shall receive no more or no less treatment than other patients, but shall be separated as much as possible from other types of patients. Since the medical facility is a unit of the department of corrections, there is an interchange of State prisoners between it and other penal institutions in California, and it is governed by the same general laws and rules as the others.

No significant questions have been raised concerning the legal rights or privileges of the felons or regular State prisoners. Procedures relating to segregation, reporting of active cases, and other matters were well established long before the temporary California Medical Facility came into being. But questions were soon raised concerning the status of the group committed for breaking tuberculosis isolation—the recalcitrant misdemeanants.

Legality of Enforced Isolation

The evident intent of the provision (*8*) in the health and safety code which authorizes the State department of public health to lease any facilities it considers necessary to care for such misdemeanants (section 3300.4) is to authorize confinement when necessary in a place other than a county jail.

According to section 17 of the California Penal Code, "A felony is a crime which is punishable by death or by imprisonment in the state prison. Every other crime is a misdemeanor. . . ."

It was inevitable that the legality of the public health department's selecting the Terminal Island medical facility as a place for the incarceration of recalcitrant tuberculous patients would be questioned. Is it legal to confine misdemeanants in a specialized institution

established for the treatment of felons? An opinion was requested of the State attorney general regarding this matter. He responded in August 1951 in part as follows (*10*):

"The fact that, traditionally, misdemeanants are not confined in State prisons does not necessarily or legally prohibit such confinement. The fact that the legislature has by statute directed the State Department of Public Health to select and obtain facilities it deems necessary to care for recalcitrant persons infected with active contagious tuberculosis who are convicted of violation of Section 2600.5 of the Health and Safety Code, would appear to make such confinement legal by courts which have misdemeanor jurisdiction. This is particularly true where, as here, we are concerned with recalcitrant active contagious tuberculosis patients and such confinement is necessary to protect the public from infection. The average hospital is incapable of furnishing the necessary restraint or guards for such patients, and county jails are inappropriate places for treatment. The fact that the place selected by the State Department of Public Health is a part of the State prison system would appear to be immaterial."

The attorney general concluded:

"Judges of Justices' Courts, both Class A and B, and of Municipal Courts have the power and authority, under Sections 2600.5 and 3300.4 of the Health and Safety Code to commit recalcitrant tuberculosis patients for violations of Section 2600.5 of the Health and Safety Code, to the Terminal Island Medical Facility."

Pertinent Sections of the California Health and Safety Code Which Apply to Enforced Legal Isolation of Tuberculous Patients

2554 Directs health officers and coroners to take necessary measures to prevent the spread of contagious and infectious diseases, including, among others, tuberculosis.

2559.5 Directs local health officers to use every available means to ascertain the existence of and to investigate all reported and suspected cases of infectious tuberculosis; and authorizes isolation and quarantine of persons suspected to be infected, the service of notice of quarantine upon such persons, and in case of violation of quarantine, notification of such violation to the district attorney.

2562 Requires obedience to the health officer's orders in cases of quarantine.

2563 Requires a quarantined person to remain on the premises.

2600 Provides that violation of any State department rule, order, or regulation respecting quarantine is a misdemeanor.

2600.5 Provides that any person who fails to comply with the health officer's order concerning his isolation is guilty of a misdemeanor, and upon conviction may be ordered by the court confined for not more than 6 months.

2600.6 Provides a 12-month sentence for violators who are repeaters.

2601 Provides that willful exposure of self or another to a communicable disease is a misdemeanor.

2602 Provides the penalty for violation of Section 2601.

2603 Requires the district attorney to prosecute in the case of a violation of sections 2559.5 and 2600.5.

3300.4 Authorizes the State department of public health to lease facilities necessary for the care of tuberculous misdemeanants.

3300.46 Makes it mandatory for the local sheriff's office to transport tuberculous misdemeanants to and from the facilities leased by the State health department for their care.

Problems in Maintaining Isolation

In the face of great need for space in all the penal institutions and the necessity of making maximum use of all available beds, there is seldom any margin or reserve for flexibility within the Terminal Island institution. This is an unfavorable situation, which at times has caused considerable annoyance.

On arrival at the medical facility, the patients are assigned immediately to the tuberculosis section and placed in single cells, if available, pending classification. Such medical treatment as appears to be indicated is begun without delay. The classification procedure is based on the standard method prescribed by the State department of corrections but with emphasis on the clinical factors.

While the effort is made to keep the two types of tuberculous prisoners apart, the physical limitation of the wards and lack of flexibility have proved to be an obstacle which unfortunately cannot be fully overcome until the patients can be transferred to the new institution at Vacaville. Generally, the misdemeanants are accommodated in single cells. Those in both categories who are more critically ill are also kept in single cells.

Twenty years ago, prison tuberculosis wards consisted largely of toxic, bedfast men with limited life expectancy. Today, the tuberculosis section of the California Medical Facility consists largely of ambulatory patients with a promising expectation of life, even though the disease is usually moderately or far advanced. This change is at least partly due to the use of modern drugs which, while they do not always produce miracles with respect to cure, certainly prolong life. Most of the recalcitrant tuberlous group have a fibroid type of disease which remains clinically nonprogressive under favorable conditions with occasional relapse under adverse conditions.

That tuberculosis is frequently superimposed on other disabilities is another significant problem which often is given insufficient attention. Minor mental disorders are exceedingly prevalent, at times reaching psychotic proportions. The misdemeanants, of course, bring their inner conflicts, anxieties, and other troubles with them, all in addition to tuberculosis. Many are chronic alcoholics who have been arrested and jailed numerous times; a few have used narcotic drugs. Many of them suffer from the loneliness and the boredom of the situation in which they find themselves. Some feel guilty, inhibited, and depressed. Others are convinced that the world in general is wrong and the institution especially is wrong and that they are justified in doing as they please.

So, in addition to medical and surgical measures, it is necessary, both from an administrative and scientific point of view, to prevent the development or worsening of psychological deviations and to do something about them as they are detected, for often they are the cause of more difficulty than the tuberculosis per se. To combat the tension, restlessness, hostility, worries and fears, a group psychotherapy program has been made available to the patients in the tuberculosis section. Other auxiliary services are also brought to bear on the problem—education, religion, occupational therapy, social service, bibliotherapy, and hobby work. These and allied services are essential for the peace and health of mind of the average man who is segregated and restricted for a prolonged period of time, whether for a criminal offense, tuberculosis hospitalization, or both.

Administrative Difficulties

The medical staffing is adequate. In residence is a full-time physician who for one afternoon a week is assisted by a visiting tuberculosis specialist. A visiting thoracic surgeon assisted by the resident surgeon devotes a half day each week either to review cases proposed for surgery or to operate. Because of the active medical and surgical therapy, some of the recalcitrant group have left after the relatively short term with a negative sputum for the first time in many years.

The physicians of the State bureau of tuberculosis control act as consultants to the facility and visit the patients periodically. When a tuberculous prisoner is discharged, whether a recalcitrant or a felon, a summary of treatment and status is sent to the health officer of the originating county to which the patient is returned. Basic data concerning the facts pre-

ceding commitment of the recalcitrants and their medical course during residence are forwarded to the bureau of tuberculosis control.

Transportation of the misdemeanants to and from the facility presented difficulties at times. Some sheriffs' offices, failing to find specific instructions in the penal or health and safety codes, refused to go out of the county with a misdemeanant. Others pleaded lack of funds for this specific purpose. However, transportation was ultimately arranged in most areas. Two patients had to be discharged without transportation because the home county would not come for them. They had to be released temporarily into the custody of the Los Angeles City Health Department, which provided hospitalization while other transportation could be arranged. In the spring of 1953, the California Legislature passed an act (*8*) making it mandatory for the local sheriff's office to transport patients to and from the facility (Health and Safety Code, sec. 3300.46).

Other legislation (*8*) passed at the same time permits a maximum of 12 months on a second or subsequent commitment to the facility (Health and Safety Code, sec. 2600.6). This may act in a twofold way, permitting a longer segregation of the worst recidivists, and correspondingly longer protection for the community, but tying up some of the few beds and resulting in a smaller turnover of patients. The increase in beds hoped for at the new institution at Vacaville may help in expanding these services. As of mid-1953, 8 patients had been returned a second time, and 1 for a third time.

A local obstacle was presented by those county prosecuting attorneys and judges who were reluctant to send sick tuberculous patients to a prison. Circular letters were sent to all health officers, prosecuting attorneys, and local judges by the California State Department of Public Health and the attorney general's office, quoting and outlining the law and its procedures and reassuring them of the adequate nature of the medical treatment provided at the facility. The medical officers of the State bureau of tuberculosis control visited counties on occasion to assist health officers in persuading prosecuting attorneys who did not wish to take action. On the whole, whenever an adequate explanation was made to the legal fraternity, cooperation followed. The main point at issue was whether the right of the individual to be free in his movements was to override the community welfare. The judgment in this matter is left to the local health officer, with the judge of local jurisdiction making the decision regarding disposition.

It must be recognized that in practice only the worst of the recalcitrants in a community are ever presented to the prosecuting attorney for action. Only after all customary efforts to gain cooperation have repeatedly failed, and the patient in an obvious fashion continues to endanger the community, will the health officer finally take this legal step.

A Controversial Area

Any kind of a program in so controversial an area cannot hope to escape criticism. The one most frequently heard is that a prison is no place for an ill tuberculous person. This criticism has been met by emphasizing the danger to the community and by providing as good medical service as would be available elsewhere.

Some have objected that 6 months is too short a period for the isolation of most of the uncooperative tuberculous individuals, and that a more elastic law should be created permitting incarceration until the sputum is negative. The law permitting a 12 months' term for repeaters is a step in this direction. At times, lack of room has meant nonadmittance of a recalcitrant, to the understandable discomforture of the local health officer.

Some have objected to calling these patients "recalcitrants." They feel that the individuals are basically disturbed "psychopathic personalities," usually alcoholic addicts. That these individuals are also tuberculosis patients is a happenstance, they believe. They suggest that this type of patient be committed to a State mental hospital.

There is no denying that the majority of the group require more than a little psychiatric care. However, most of the recalcitrants are not "insane" and cannot legally be committed under present laws. Also, there is great overcrowding in the State hospitals. Then, too, the security arrangements should be tighter than

those currently available at State hospitals. Possibly in the future, a wing especially for this category of patient could be built at a designated State hospital. For the present, the new facility under construction at Vacaville should meet the situation satisfactorily.

Another criticism of considerable validity is that insufficient psychological services have been offered. Effort is being made to improve these services by increasing the amount of professional time that can be devoted to the misdemeanants. It is hoped eventually to provide a full-time specialist to work specifically with the misdemeanant group.

Paradoxically, two patients were so pleased with their treatment that they asked to be sent back. This not being possible, they deliberately broke their isolation orders in order to be committed again. The local authorities obliged in both cases. This episode is told not for its humorous implication, but to throw light on the mixed feeling on the part of some of the recalcitrants that the protected environment of a prison offers not only a psychological haven but one that assures proper physical treatment. This phenomenon has been noted by criminologists in other categories of law-breakers.

More than 100 patients have been received at the facility since it opened in December 1950. A followup review (*11*) was made of the first 27 patients who were discharged. As of November 1, 1952, 11 were properly isolated in local hospitals; 1 was isolated satisfactorily at home; 6, having become noninfectious, had been reclassified as arrested or inactive; 1 had died, and 8 were still infectious and not properly controlled. Some of the last group had dropped out of sight. While this speaks well of the immediate effects of the incarceration, it offers no guarantee against future misbehavior of the offenders.

There seems to be little call for similar beds for women who are tuberculous recalcitrants. During the 3 years of this program, only 2 requests to admit women were received. However, since the California Institution for Women is building an additional medical wing, 1 or 2 beds in it can be used for this purpose in the future.

In viewing this program from a 3-year perspective, it is evident that imperfections exist, that many thorny problems have arisen, and that some have not found solution. Most local health officers and sanatorium directors are in agreement with our view that in a State as large and populous as California, there is a need for a central facility for the reception of the seriously uncooperative tuberculous male patients, which will be available to all the counties in the State.

The pattern outlined here is one that has worked: It has found acceptance far beyond the meager number of beds available, so that it has been necessary to set up a quota for the larger counties. The California Medical Facility has spared the people of California from spread of tuberculosis by heavily infected individuals who had a contagious potential many times that of the average cooperative tuberculous person. The existence of the institution has given the health officer a specific weapon for the restriction of the very worst offender and is even more valuable as a threat than it is in use. Once it becomes known in the community that an individual has been defying the law in this respect despite repeated and futile efforts to convert him and that he has been sent to a State prison facility, the effect sometimes is very noticeable. The health officer now finds previous recalcitrants more willing to obey his orders or enter local tuberculosis institutions and remain there.

Of long-term results, it is too early to speak. In such a group, a large number will be recidivists. Some will reach arrestment of disease; some will attain personality rehabilitation. A few of the most heedless could justifiably be held under restriction for the remainder of their lives. In any event, however, the program will result in the reduction of the exposure of the public for a significant number of man-years, and it is helping the local health officers in one of their most difficult problem areas.

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