



THE ABA HEALTH LAW SECTION

# THE HEALTH LAWYER

## AN EXAMINATION OF PRISONERS' CONSTITUTIONAL RIGHT TO HEALTHCARE: THEORY AND PRACTICE

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### Introduction

More Americans than ever before are forced to forego healthcare because they cannot afford to pay for it. Although in many countries governments sponsor national health systems that provide care and treatment to all citizens, the United States Supreme Court has never deemed healthcare to be a fundamental right for all Americans, allowing the federal government to resist adopting government-subsidized healthcare for decades. There is, however, one group of Americans that *does* enjoy a constitutional right to healthcare: prisoners. Ironically, in an era where many non-incarcerated citizens lack access to even basic healthcare services, people who commit crimes serious enough to merit revocation of their freedom are entitled under the Constitution to receive necessary care and treatment.

This irony has not been lost on the general public. Many Americans bristle at the possibility that scarce healthcare

resources will be allocated first to criminals—at the expense of law-abiding citizens who also depend on the government for healthcare—in order to comply with the constitutional mandate.<sup>1</sup> Indeed, there have been notable instances of prisoners undergoing therapies and procedures they would not have been able to obtain had they not been incarcerated.<sup>2</sup> Moreover, some of these treatments were of questionable medical necessity.<sup>3</sup>

However, while it is true that prisoners are the only members of society with a constitutionally protected right to healthcare, it is unlikely that many free citizens fully comprehend the reality of that right in practice. Prison health systems are understaffed, poorly organized, and lacking in adequate equipment and facilities. Often prisoners' access to what meager services are available is limited by whether a guard chooses to allow the inmate to seek treatment. Although most non-incarcerated Americans spend little time lamenting the abhorrent state of prison healthcare, the health of our prison populations directly affects society as a whole.

This article examines the true nature of prisoners' constitutional right to healthcare. It begins by discussing the

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history of healthcare in American prisons, the landmark U.S. Supreme Court case *Estelle v. Gamble* and its progeny, and access to and quality of healthcare in prisons. After exploring Americans' attitudes toward prison healthcare and debunking some of the myths associated with care provided to prisoners, the article suggests potential modifications that could be made to improve prison healthcare.

## Healthcare in American Prisons Prior to 1976: The Cases Leading Up to the Establishment of a Constitutional Right to Healthcare for Prisoners

There is little written evidence of the manner in which medical care was delivered in prisons prior to the 1960s.<sup>4</sup> The few accounts that do exist describe archaic, unhygienic systems that operated in complete isolation from the outside world.<sup>5</sup> At the Tucker Prison Farm in Arkansas, for example, care was largely provided by an inmate without training in medicine or nursing who sold illegal drugs and medical leaves of absence and tortured other prisoners using a hand-cranked electric generator.<sup>6</sup> Beginning in the late 1960s, however, inmates in several states filed a series of lawsuits that illuminated the abysmal state of prison healthcare systems and prompted the federal courts to take action.

### Arkansas: *Holte v. Sarver*

In 1969, prisoners at the Cummins Farm Unit of the Arkansas State Penitentiary filed suit under the Eighth Amendment to the U.S. Constitution, which declares that "cruel and unusual punishments" shall not be inflicted. The plaintiffs alleged that confinement in isolation, failure to protect inmates from assaults by other inmates, and failure to provide adequate medical attention constituted cruel and unusual punish-

ment.<sup>7</sup> With little analysis or explanation, the court held that the inmates failed to meet their burden of proof with respect to medical care, stating merely that "while [prison medical and dental] facilities leave a good deal to be desired, the Court does not consider that the deficiencies are such as to raise a constitutional problem."<sup>8</sup> However, the opinion did assert that prisoners have a general constitutional right to be protected while incarcerated: "The State owes to those whom it has deprived of their liberty...[a] fundamental constitutional duty to use ordinary care to protect their lives and safety while in prison."<sup>9</sup> This decision was representative of a trend of increasing judicial recognition of the substandard conditions in prisons and heightened concern for prisoners' rights.

### Texas: *Campbell v. Beto*

In 1972, the Fifth Circuit Court of Appeals reversed a District Court ruling dismissing a Texas inmate's *in forma pauperis* complaint on the pleadings. The Circuit Court felt that the serious allegations relating to the inadequate medical care provided to the prisoner clearly warranted an opportunity to present substantiating evidence.<sup>10</sup> Although this decision did not evaluate the substance of the inmate's contentions in relation to the U.S. Constitution (since the appeal was filed to reinstate the inmate's complaint), this opinion suggested that prisoners *could* be found to have a constitutional right to be protected from "conditions which present a grave and immediate threat to health or physical well-being."<sup>11</sup> Petitioner Campbell, who was classified a "Fourth Class Medical" inmate by the prison and thus not required to do manual labor, claimed that on August 12, 1970, the warden assigned Campbell to hard physical labor in direct contravention to his medical classification.<sup>12</sup> Despite a documented heart condition, Campbell was forced to perform the work assignment

for an extended period and was allegedly denied previously-prescribed medication to treat the condition while working in the field.<sup>13</sup> On November 18, 1971, Campbell suffered a heart attack.<sup>14</sup>

In addition, Campbell's complaint purported that the Texas Department of Corrections employed "persons not licensed to practice medicine in the state of Texas," including two inmates who diagnosed prisoners' ailments and prescribed medication.<sup>15</sup> The court stated that:

Although the federal courts are very properly loathe to interfere in the internal administration of the prisons..., our constitutional duties require that the courts be ever vigilant to assure that the conditions of incarceration do not overstep the bounds of federal constitutional limitations. If the deprivation of basic elements of hygiene has consistently been held violative of constitutional guarantees, then certainly practices that result in the deprivation of basic elements of adequate medical treatment, particularly such deprivation as immediately threatens life and limb, would be equally vulnerable."

*Id.* at 767-768 (internal citation omitted).

### Alabama: *Newman v. Alabama*

Also in 1972, inmates filed a class-action lawsuit against several defendants within the Alabama Penal System.<sup>16</sup> In *Newman v. Alabama*, the District Court painstakingly described the barbarous conditions at several Alabama correctional institutions: medical facilities were woefully understaffed, with only three registered nurses to care for all four thousand prisoners in the penal system.<sup>17</sup> Untrained inmates often acted as "ward attendants, records clerks, and x-ray, laboratory, and dental technicians."<sup>18</sup> Unsupervised prisoners, without formal training, regularly pull teeth, screen sick

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call patients, dispense as well as administer medication (including dangerous drugs), give injections, take x-rays, suture, and perform minor surgery."<sup>19</sup> Two prisons lacked adequate laboratories or the ability to isolate contagious diseases, one facility housing eight hundred inmates had no full-time doctor, and several smaller prisons employed no medical personnel at all.<sup>20</sup> Medical care for the mentally ill was virtually non-existent, even though mental illness was the most common health problem in the Alabama penal system.<sup>21</sup> The most inexcusable deprivation, however, occurred at the hands of correctional staff. The court reported that guards routinely prevented prisoners from attending sick call and refused to dispense vital prescription medications.<sup>22</sup>

These and numerous other instances of neglect "shocked the conscience" of the court and constituted "willful and intentional violation[s] of the rights of prisoners guaranteed under the Eighth and Fourteenth Amendments," necessarily implying a constitutional right to healthcare for prisoners.<sup>23</sup> However, the decision was only binding on the Middle District of Alabama. In addition, *Newman* was ultimately overturned by the United States Supreme Court on grounds that the Alabama Board of Corrections and its employees were protected from suit by Eleventh Amendment sovereign immunity.<sup>24</sup> Nonetheless, the original District Court opinion was still important because it set the stage for the Supreme Court's decision in *Estelle v. Gamble* four years later.

## Establishment of Prisoners' Constitutional Right to Healthcare

The decisions discussed above were representative of the growing concern for prisoners' rights within the states generally, particularly with respect to medical care. Judges repeatedly averred

that society's evolving sense of decency would no longer permit prisoners to subsist in deplorable conditions and be denied basic healthcare. In 1976, the political climate was ripe for the United States Supreme Court to address the issue of healthcare in prisons.

### The Landmark Case: *Estelle v. Gamble*

J.W. Gamble, an inmate of the Texas Department of Corrections, was unloading a truck on November 9, 1973 when a bale of cotton fell on his back.<sup>25</sup> Several hours later, Gamble reported to the prison hospital with complaints of back pain.<sup>26</sup> A medical assistant examined him and sent him back to his cell, but two hours after the examination, Gamble returned to the hospital with worsening pain in his back.<sup>27</sup> A prison doctor diagnosed Gamble with a lower back injury, prescribed pain relievers and a muscle relaxant, and gave Gamble a two day "cell pass" that allowed him to remain in his cell rather than go to work.<sup>28</sup>

Over the next two-and-a-half weeks, Gamble saw the doctor three more times.<sup>29</sup> The doctor continued Gamble's muscle relaxant and pain medications and extended his cell passes at each visit, for a total of twenty-four days of work furlough.<sup>30</sup> However, on December 3, 1973, the doctor continued his prescription for pain medication, and revoked Gamble's cell pass.<sup>31</sup> When Gamble refused to work because he claimed to be "in too much pain," he was placed in "administrative segregation" and brought before the prison disciplinary board.<sup>32</sup>

The board ordered that Gamble be seen by another physician, prison medical director Dr. Gray, who diagnosed Gamble with high blood pressure in addition to his ongoing back pain.<sup>33</sup> Gamble continued to refuse to work, and therefore remained in administrative segregation for the entire month of December, 1973.<sup>34</sup> Although Gamble

returned to Dr. Gray one week following his initial examination and received a thirty-day prescription for blood pressure medication, the prescription was not filled until four days after it was written because "the staff lost it."<sup>35</sup>

Gamble did not work and was kept in administrative segregation during the month of January, 1974 as well.<sup>36</sup> During that month Gamble went to the prison hospital on three separate occasions, complaining of back pain and new-onset migraine headaches.<sup>37</sup> Each time Gamble's prescription for pain medication was renewed.<sup>38</sup> On January 31, 1974, Gamble was again brought before the disciplinary committee for his refusal to work.<sup>39</sup> Despite Gamble's insistence that his back pain remained as severe as it was the day he sustained his back injury, a prison medical assistant testified that Gamble was in perfect health.<sup>40</sup> Based on this testimony, with no further examination by a doctor, the board ordered Gamble into solitary confinement for refusing his work assignments.<sup>41</sup>

On February 4, 1974, Gamble asked at 8:00 AM to see a doctor because he was experiencing "blank outs" and chest pain.<sup>42</sup> When Gamble was finally evaluated by a medical assistant at 7:30 in the evening, he was immediately admitted to the prison hospital.<sup>43</sup> The following day, a prison physician diagnosed Gamble with an irregular heart beat and placed him on Quinidine to treat the arrhythmia.<sup>44</sup> In light of his medical condition, Gamble did not return to solitary confinement, but was instead moved to administrative segregation upon discharge from the hospital.<sup>45</sup> Nevertheless, when Gamble's chest pain recurred on February 7th and 8th, the guards denied Gamble's request to see a physician.<sup>46</sup> On February 11, 1974, Gamble filed suit under 42 U.S.C. §1983, alleging that the inadequate medical care and treatment he received following his back injury constituted cruel and unusual punishment under the

Eight Amendment, and therefore violated his civil rights.<sup>47</sup>

The Court noted that Eighth Amendment protections encompass not just physical torture, but “punishments that are incompatible with the evolving standards of decency that mark the progress of a maturing society, or which involve the unnecessary and wanton infliction of pain.”<sup>48</sup> From these principles, the Court reasoned, it follows logically that the government has an “obligation to provide medical care for those whom it is punishing by incarceration” because prisoners must rely entirely on their jailers to provide for their medical needs.<sup>49</sup> The Court warned that failure of the government to provide adequate healthcare could “produce physical torture or lingering death,” which is exactly the type of occurrence the Eighth Amendment aims to prevent.<sup>50</sup>

The Court ultimately ruled that Gamble had not pled sufficient facts to constitute a cause of action under §1983. Gamble’s claims against the medical director of the prison were not cognizable under §1983 because he was “seen by medical personnel [at the prison] on seventeen occasions spanning a three month period... [and] they treated his back injury, high blood pressure, and heart problems.”<sup>51</sup> However, the Justices did hold that, in an appropriate case, “deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eight Amendment,” and therefore violates prisoners’ civil rights.<sup>52</sup> The Court further held that, in addition to deliberate indifference to prisoners’ needs on the part of physicians, intentional denial of access to healthcare or interference with treatment by guards is also actionable under the Eighth Amendment.<sup>53</sup>

Gamble contended that more should have been done to treat his back injury, but the Court stated that, while Gamble’s allegations might support a medical malpractice cause of action, questionable medical judgment does not

rise to the level of “deliberate indifference to the serious medical needs” of prisoners.<sup>54</sup> Still, although Gamble did not succeed in his individual claim, the importance of the case cannot be overstated. The opinion in *Estelle* effectively declared that prisoners have a constitutional right to adequate medical care and treatment while incarcerated. This historic decision marked the first time in history that the Supreme Court had recognized a fundamental right to healthcare for any group of Americans.

The Justices did admonish, however, that inadvertent or even negligent failure to provide adequate medical care, such as may have been the case with inmate Gamble, does not run afoul of the Eighth Amendment because such an oversight is not “repugnant to the conscience of mankind. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.”<sup>55</sup> Yet, notwithstanding this qualification, the opinion could understandably stir popular resentment because it entitles imprisoned criminals to a valuable benefit that is not available to law-abiding citizens: a constitutional right to government-subsidized healthcare.

#### **Refining *Estelle*’s Holding: The Requirements for a Prisoner to Establish an Eighth Amendment Infringement of His Right to Adequate Medical Care After 1976**

In order to prove an Eight Amendment violation under *Estelle*, an inmate must satisfy an objective test and a subjective test. In the 1980s and 1990s, a string of Supreme Court decisions more clearly defined these tests, but also limited the right the Court granted in *Estelle* and fleshed out the difficult burden of proof prisoners must meet in order to establish that their right to adequate healthcare has been infringed.

##### *1. The Objective Prong*

In the 1980s, the Court expounded on the objective element of the standard

set forth in *Estelle*, holding that only deprivations denying “the minimal civilized measure of life’s necessities” could be serious enough to support an Eighth Amendment cause of action.<sup>56</sup> The First Circuit Court of Appeals later elaborated that minimal, civilized medical treatment for prisoners must be “reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards.”<sup>57</sup> In 1994, a “serious medical need” was defined by the Eleventh Circuit as “one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”<sup>58</sup> Incorporating the specific language of *Estelle*, the Second Circuit added that “a serious medical condition exists where the failure to treat a prisoner’s condition could result in further significant injury,” such that the individual’s daily activities would be significantly affected, or “the unnecessary and wanton infliction of pain.”<sup>59</sup>

In addition, the Prison Litigation Reform Act of 1995 expanded upon the objective prong of the *Estelle* standard by mandating that “[n]o federal civil action may be brought by a prisoner for mental or emotional injury suffered while in custody without prior showing of physical injury.”<sup>60</sup> For example, an incarcerated HIV patient alleged that deprivation of his medications for several days by correctional staff constituted deliberate indifference to a serious medical condition, but the inmate’s claim was denied.<sup>61</sup> Although the inmate’s underlying illness was obviously very serious, the court was of the opinion that missing a few doses of medication did not cause the inmate any additional physical harm beyond that which had already resulted from HIV infection, and did not exacerbate the disease.<sup>62</sup> However, prisoners have brought successful Eighth Amendment claims against correctional facilities where an inmate is suffering from an extremely painful condition and is denied treatment by prison staff or

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physicians.<sup>63</sup> The general trend seems to be that in order to satisfy the objective prong of *Estelle*, a prisoner's injuries must significantly decrease his quality of life, or constitute a situation where death, permanent injury, or extreme pain has occurred or appears likely.<sup>64</sup>

## 2. The Subjective Prong

In 1986, the Supreme Court began to elaborate on the subjective element of the *Estelle* standard, considerably limiting the potency of prisoners' constitutional right to healthcare in the process. In *Whitley v. Albers*, the Court reasoned that since wantonness, which requires more than mere negligence, is necessary to implicate the Eighth Amendment, the standard set forth in *Estelle v. Gamble* necessitates an inquiry into the state of mind of the prison official who allegedly inflicted cruel and unusual punishment upon the inmate.<sup>65</sup> The Court further asserted that while wantonness can have different meanings in different contexts, wantonness for purposes of determining whether the state has upheld its duty to tend to the medical needs of prisoners equates with deliberate indifference to the serious medical needs of prisoners.<sup>66</sup> In other words, unless an inmate can establish that a defendant prison official had the requisite state of mind at the time the official purportedly inflicted cruel and unusual punishment, the inmate's Eighth Amendment claim necessarily fails. This is a very difficult task in general because it is impossible to look into someone else's mind and discern his or her thoughts, but it is especially difficult for prisoners because the exigencies of prison life enable corrections officers to attribute their actions to the unique safety concerns associated with prisons, rather than a disregard for the prisoner's needs.

The burden on the inmate-plaintiff was made even more formidable by the holding in *Wilson v. Seiter*. Therein, although the Court declined to replace

the "deliberate indifference" standard for medical care with the more-stringent "malicious and sadistic" standard, the Court announced that the wantonness of a prison official's conduct is not determined by its effect on the prisoner.<sup>67</sup> Rather, it is evaluated according to the circumstances and the constraints upon the prison official at the time of the acts in question.<sup>68</sup> This theory arguably allows correctional staff to present evidence of all manner of extenuating circumstances, as well as their subjective states of mind, in order to dodge liability for infliction of cruel and unusual punishment.<sup>69</sup>

Finally, in 1994 the petitioner in *Farmer v. Brennan* challenged the subjective prong of the *Estelle* test, arguing that "deliberate indifference" should be defined as civil-law recklessness, which utilizes an objective standard.<sup>70</sup> The Court agreed with the various courts of appeals that deliberate indifference equates with recklessness, but noted that the level of culpability required to constitute recklessness had never been established.<sup>71</sup> The Court then reiterated that the Eighth Amendment prohibits cruel and unusual punishment, which necessarily requires an inquiry into whether the actor intended for his conduct to serve as a punitive measure.<sup>72</sup> "A [deplorable] act or omission unaccompanied by knowledge of a significant risk of harm might well be something society wishes to discourage..., [b]ut an official's failure to alleviate a significant risk that he should have perceived but did not...cannot, under our cases, be condemned as infliction of punishment."<sup>73</sup> Thus, the Court solidified the challenging state-of-mind requirement by adding that in order for the conduct of prison officials to violate a prisoner's Eighth Amendment right, the official must "know of and disregard an excessive risk to inmate health or safety" for the purpose of punishing the inmate.<sup>74</sup>

## 3. The "Deliberate Indifference" Standard in Practice

Practically speaking, the decisions seem to indicate that isolated complaints from individuals, where an associated pattern of sustained deprivations is not present, are less likely to succeed.<sup>75</sup> Furthermore, as long as prison staff make some attempt, no matter how feeble, to provide treatment in response to a prisoner's complaint, it is even more difficult for an individual to prove deliberate indifference because many courts find that provision of any care converts the prisoner's grievance to a negligence claim.<sup>76</sup> In addition, courts are more likely to dismiss individual complaints arising from subjective conditions such as pain. These conditions cannot be objectively measured or quantified, thus making it more difficult for judges to determine whether the ailment is sufficiently serious to rise to the level of deliberate indifference.<sup>77</sup> In general, courts are more inclined to find an Eighth Amendment violation where institutions are sued by several inmate-plaintiffs who are able to demonstrate a trend of unacceptable healthcare practices, such as in the previously mentioned case of *Newman v. Alabama*, and the case of *Plata v. Schwarzenegger*, where so many shocking instances of constitutional violations were identified that a California federal judge placed the state's penal healthcare system under a Receivership.<sup>78</sup>

### Rationales: Why is it so Difficult to Establish Deliberate Indifference?

It is a monumental task for a prisoner to establish that his or her Eighth Amendment right to healthcare has been infringed by a correctional facility. Indeed, after *Estelle*, subsequent cases arguably appear to have narrowed the right into relative obscurity. Regardless of the perceived propriety of the Supreme Court's jurisprudence governing prisoners' constitutional right to

adequate medical care, the Court's impetus to elevate the evidentiary requirements to prove an Eight Amendment violation by corrections officers is not without justification, and is influenced by many complex factors.

First, as established in *Rhodes v. Chapman*, the Constitution does not guarantee comfortable prisons.<sup>79</sup> Conditions can be restrictive and even harsh, as long as they don't offend evolving concepts of human decency.<sup>80</sup> Incarceration is not meant to be pleasant for those who commit crimes sufficiently serious to warrant revocation of their freedom. With respect to medical care in prisons, *Rhodes* declared that provision of minimal, civilized necessities of life is all that is required by the Constitution.<sup>81</sup> The deliberate indifference standard is likely so stringent because Courts must have a detailed, sensitive, and specific test at their disposal to differentiate between actions and/or conditions that inmates oppose because they differ from the norm in the free world, and those that deviate so completely from acceptable standards that they constitute cruel and unusual punishment.

Also, the realities of the prison environment make it necessary for the court to provide legal protections for officers and healthcare providers working in prisons, and to give proper deference to their judgments. Societal norms do not necessarily apply in correctional facilities, and judges are by no means experts on the nuances of prison culture. Prisoners can be violent and may pose security risks to officers, healthcare providers, and other inmates.

Prison officials who are responsible for deciding whether a prisoner will be allowed to see a doctor must feel free to at least consider security issues when making healthcare triage decisions without fearing liability for a civil rights violation.<sup>82</sup> Likewise, courts do not want to discourage healthcare providers from working in prisons by creating a low threshold for civil liability when medical decision-making is influenced

by safety concerns.<sup>83</sup> The constraints of the "deliberate indifference" standard seem to be designed to identify truly egregious Eight Amendment violations while still allowing correctional staff to use their professional judgment in unpredictable and sometimes volatile situations without fear of undue scrutiny from judges who lack experience managing prison populations. Thus, while the *Estelle* standard is certainly difficult to satisfy, it represents an attempt to strike a balance between the government's duty to protect prisoners' rights and the desire to protect those who work in penal systems.

## The Reality of Prisoners' Constitutional Right to Healthcare

Many Americans are somewhat incredulous that prisoners have a constitutionally protected guarantee to adequate medical care and treatment. Why, they argue, should convicted criminals enjoy an invaluable benefit that the government has declined to provide to law-abiding citizens?<sup>84</sup> Though the public's indignation is understandable and perhaps even justified, in truth healthcare in the nation's prisons has not improved significantly since 1976. Unfortunately, the present condition of prison health systems could potentially silence even the most strident opponents of government-sponsored medical care for inmates.

Despite the legal mandate to provide inmates with medical care "commensurate with modern medical science and of a quality acceptable within prudent professional standards," many correctional facilities do not have adequate resources.<sup>85</sup> This deficiency is even more serious in light of the fact that prisoners have a higher rate of disease and disability than the non-incarcerated population.<sup>86</sup> For example, in one study of a large county jail in Ohio, upon admission to the facility 32 percent of inmates reported symptoms consistent with infectious diseases, 47 percent reported using

drugs and/or alcohol often enough to necessitate a substance abuse assessment, 19 percent reported symptoms of schizophrenia, 16 percent reported symptoms of bipolar disorder, 32 percent reported symptoms of depression, 38 percent reported high-risk sexual behaviors or previously diagnosed sexually transmitted diseases, and 50 percent reported a risk factor for HIV infection.<sup>87</sup> This study highlights the extreme need for diligent provision of access to specialized medical screening and treatment in prisons. Unfortunately, much work remains to be done in order to meet this goal.

### Lack of Physicians Willing to Work in Prisons

For myriad reasons, many physicians simply do not want to work in correctional settings. Prison medical facilities are frequently small, old, and crowded, and equipment and supplies are either unavailable or outdated.<sup>88</sup> Support staff is often inadequate, security protocols may interfere with the physician's medical decision making, prisoners often make for uncooperative and disrespectful patients, and some doctors fear for their own safety in prisons.<sup>89</sup> What's more, there is evidence that prison doctors may lose status among their physician-colleagues.<sup>90</sup>

As a result, many prison physicians lack specialized education, significant post-residency training, and specialty certification, thus preventing them from securing more desirable employment.<sup>91</sup> A study conducted at the University of Michigan in 1983 examined the characteristics of physicians working full-time in prisons and compared them to all physicians practicing in the United States. The study found that 33 percent of full-time prison doctors were foreign medical graduates, as opposed to 20 percent of all physicians practicing in the U.S.<sup>92</sup> This is significant because the majority of foreign medical graduates working in prisons are not board certified, do not have advanced training, do not practice in any specialty, and have restricted state licenses.<sup>93</sup> Foreign medical graduates'

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inability to speak fluent English could also affect the quality of care they provide.<sup>94</sup>

Also troubling is the lack of specialty-trained and board-certified physicians in prisons.<sup>95</sup> No specialty was declared by 42 percent of prison doctors, compared with only 16 percent in the larger physician population.<sup>96</sup> Furthermore, only 28 percent of prison physicians were board certified, as opposed to 49 percent of physicians working outside of prisons.<sup>97</sup> These statistics are especially problematic given the fact that prisoners tend to be disproportionately afflicted with mental illnesses, communicable diseases, and drug and alcohol addiction. Lack of prison physicians specializing in psychiatry, infectious diseases, and substance abuse makes it difficult for prison officials to target these specific problems and significantly decrease their incidence and prevalence.

## Communicable and Infectious Diseases

Prisons are hotbeds for infectious diseases, both due to the fact that entering inmates tend to have higher rates of communicable disease upon arrival in prison, and because prison conditions and high-risk behaviors common among incarcerated prisoners facilitate rapid transmission. For example, the incidence of HIV and AIDS in prison populations is many times higher than in the general population. In 1989, there were 202 cases of HIV/AIDS per 100,000 U.S. inmates, compared to 14.7 cases per 100,000 non-incarcerated Americans.<sup>98</sup> The majority of prisoners in the United States are young African American and Latino men, many of whom are under-educated and engage in high-risk behaviors prior to incarceration, such as unprotected sexual intercourse and drug and alcohol abuse.<sup>99</sup> Furthermore, there is evidence that high-risk behavior continues during imprisonment.<sup>100</sup> Lamentably, the number of Latino and African-American men infected with HIV exceeds the number of Latino and African-American men enrolled in

colleges and universities.<sup>101</sup> Prolonged confinement of these individuals in correctional facilities, combined with ever-present poor sanitation, violence, consensual and non-consensual sex, and intravenous drug use, puts uninfected prisoners at high risk for contracting HIV while incarcerated.<sup>102</sup>

Compounding the problem is the fact that prisons provide very few HIV prevention services to inmates.<sup>103</sup> Corrections officials point to a lack of funding as a major impediment, but also admit that there is institutional resistance to establishing programs that promote safe sexual practices and advocate the use of sterile syringes when anal sex and drug use are against prison policy.<sup>104</sup> In fact, only two state prison systems and five city/county jail systems make condoms available to their male prisoners.<sup>105</sup> Also, there continues to be stigma associated with discussing HIV, and many inmates avoid educational programs related to the disease because they fear that showing an interest in learning about HIV will lead other inmates and staff to believe they are HIV positive and result in negative treatment.<sup>106</sup>

Another common communicable disease in prisons is Tuberculosis ("TB"). TB is a highly contagious bacterial disease that most often affects the lungs and causes sepsis, high fevers, night sweats, and emaciation.<sup>107</sup> If left untreated, TB produces profound symptoms of toxemia and is rapidly fatal.<sup>108</sup> Although the incidence of TB in the general population is less than ten cases per 100,000 individuals, rates as high as ten times the national average have been reported in some prisons.<sup>109</sup> Studies revealing a positive correlation between length of incarceration and positive tuberculin skin tests suggest that most inmates contract TB inside correctional facilities.<sup>110</sup> This is especially significant in light of the high incidence of HIV infection in prisons, since HIV weakens the immune system and greatly increases the likelihood that a patient will contract TB.<sup>111</sup>

Conditions common to prisons, including close quarters, overcrowding, and poor ventilation contribute to the spread of TB.<sup>112</sup> In addition, because prisons are notorious for failing to dispense medication as prescribed, many drug-resistant strains of TB are common in correctional facilities.<sup>113</sup> These factors create a particularly serious public health risk for inmates and non-incarcerated citizens. First, prison conditions are ideal for facilitating explosive outbreaks of TB.<sup>114</sup> A prison-wide epidemic could devastate the inmate population, but also easily be transmitted to the general public by prison employees who become infected at work and carry the bacteria outside the prison walls when they are off-duty.<sup>115</sup> Second, if an epidemic is spurred by a drug-resistant strain of TB, the disease could prove extremely difficult to treat and exact an enormous cost in terms of government funds and loss of life.<sup>116</sup>

Viral hepatitis is also a disturbing problem in correctional facilities. Viral hepatitis is an inflammatory disorder of the liver that produces symptoms of jaundice and malaise.<sup>117</sup> Chronic viral hepatitis, caused by strains B and C of the Hepatitis virus, can ultimately lead to cirrhosis, liver failure, liver cancer, and death.<sup>118</sup> Rates of Hepatitis B and C infection are nine to ten times higher in prisoners than in the non-incarcerated population.<sup>119</sup> In 1993, 1.3 million American inmates were Hepatitis C positive upon release from prison, and 155,000 were Hepatitis B positive.<sup>120</sup> These numbers stand in stark contrast to the incidence and prevalence of hepatitis in the general population: Approximately 35,000 new cases of Hepatitis C, and 140,000 cases of Hepatitis B, are reported in the general U.S. population annually.<sup>121</sup>

Because Hepatitis B and C are transmitted through the same behaviors and practices that facilitate transmission of HIV, such as unprotected sex and intravenous drug use, and because the behaviors are common among prisoners

during incarceration, uninfected inmates run a similarly high risk of contracting hepatitis during their detention.<sup>122</sup> Also like HIV, there is no cure for Hepatitis B or C.<sup>123</sup> Therefore, inmates who contract viral hepatitis while in prison are saddled with a debilitating, potentially fatal chronic illness which requires careful medical management and treatment, and which can constitute a public health risk upon the inmate's release from prison.<sup>124</sup>

### **Substance Abuse and Withdrawal**

Substance abuse is rampant among prisoners both prior to and during incarceration. An estimated 70 percent of U.S. inmates have an addiction to an illicit substance; one in four convicts is in prison on drug-related charges.<sup>125</sup> Evidence shows that inadequately treated withdrawal from drugs or alcohol contributes significantly to deaths of newly-imprisoned individuals, yet only 28 percent of jail administrators reported that their institutions provide detoxification services.<sup>126</sup> Moreover, of the jails that reported never having provided such services, only 10 percent sent inmates to outside facilities for management of withdrawal.<sup>127</sup> If the inmate survives withdrawal, evidence shows that the best way to keep inmates from relapsing and returning to prison is to provide intensive substance abuse treatment programs while the inmate is incarcerated and following his release.<sup>128</sup> Unfortunately, due to lack of funding and lack of recognition by prison administrators of the importance of substance abuse treatment and education, such treatment programs are rare.<sup>129</sup>

### **Mental Healthcare in Prisons**

In 1988, the Center for Mental Health Services, a federal agency within the U.S. Substance Abuse and Mental Health Services Administration, reported that 6-14 percent of prisoners suffered from a major psychiatric disorder at any given time, and that 82 percent of inmates would suffer a major psychiatric disorder during their lifetimes.<sup>130</sup>

However, the study found that mental health services available to inmates had decreased between 1988 and 2000.<sup>131</sup> Furthermore, services appear to be concentrated in certain facilities, with others providing few or no services.<sup>132</sup> Moreover, psychotropic medication is not regularly prescribed. In a small study of prisoners in Ohio, "over half reported being diagnosed with depression, but only 38 percent of the sample reported receiving treatment or taking prescription medication for depression."<sup>133</sup> Insufficient state government funding is blamed for this lack of available mental healthcare, as more money is directed toward security than to treatment of underlying psychiatric disorders that may be contributing to prison violence.<sup>134</sup>

### **An Illustration: the California Penal Healthcare System Receivership**

Perhaps the best example of how little progress has been made toward improving access to quality healthcare for prisoners is described in the case of *Plata v. Schwarzenegger*.<sup>135</sup> On April 5, 2001, several California inmates filed a class action alleging that all California prisons were providing "constitutionally inadequate medical care."<sup>136</sup> In response, the California Department of Corrections ("CDC") agreed to implement comprehensive new policies and procedures within a specified time frame.<sup>137</sup> As part of a Stipulation for Injunctive Relief, in June of 2002 State medical experts inspected nine prisons that were supposed to have instituted the changes set forth in the injunction. Far from finding improvements, the experts concluded that there was "an emerging pattern of inadequate and seriously deficient physician quality in CDC facilities," and that failure to address the problem placed prisoners "at serious risk of harm or death."<sup>138</sup>

The experts found that medical care often went beyond gross negligence and progressed to outright cruelty, directly resulting in a disturbing six to seven inmate deaths per week.<sup>139</sup> For

example, in one instance a prisoner was diagnosed with treatable endocarditis (an infection of the membranous sack surrounding the heart), but did not receive the necessary antibiotics.<sup>140</sup> When his infection progressed to septic shock, the inmate went to the prison emergency room and should have been immediately transferred to an acute care hospital.<sup>141</sup> Despite the objections of a nurse, however, the inmate was instead sent by the prison physician to the facility's Outpatient Housing Unit, where he died shortly after arrival from cardiac arrest.<sup>142</sup>

In another instance, a prisoner reported to a prison clinic after a fight unable to move his legs.<sup>143</sup> The patient had suffered a neck injury, but instead of immobilizing his neck to prevent further injury, as is the standard of care for a patient with such an injury, a physician assumed the inmate was faking the injuries and moved the inmate's head from side to side.<sup>144</sup> The patient is now permanently paralyzed.<sup>145</sup> An additional case involved a prisoner with shortness of breath, fatigue, and elevated blood pressure.<sup>146</sup> After several hours in the infirmary for observation, a doctor decided that no further treatment was necessary and discharged the inmate back to his housing unit, despite the fact that the inmate's symptoms had not improved.<sup>147</sup> The inmate stumbled and fell to his knees once while attempting to walk to a transportation van, and again upon exiting the van to return to his unit.<sup>148</sup> The inmate's first collapse was ignored by medical staff at the infirmary and inappropriately dismissed as a manifestation of sleep deprivation.<sup>149</sup> However, when the inmate collapsed outside his housing unit for the second time, he became unresponsive and died of undiagnosed congestive heart failure thirty minutes later.<sup>150</sup>

These and countless other examples of "the most reckless and grossly negligent behavior" the court experts had ever seen led the district court to employ a drastic remedy: the entire California penal healthcare system was placed under a receivership.<sup>151</sup> This

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remedy brought the entire system under control of the federal court until such time as the CDC demonstrates that it is capable of independently providing prisoners with constitutionally-adequate healthcare.<sup>152</sup> Receiverships are rarely imposed because, although the court can appoint a receiver to "act in the name of the Court as the Court's officer," they require long-term judicial oversight to which most courts are not eager to commit.<sup>153</sup> However, in this case the violations were so egregious that the court felt it had no other alternative.<sup>154</sup> As of July, 2008, the California Penal Health System remains under the control of receiver J. Clark Kelso, whose "Turnaround Plan of Action" for developing a constitutionally adequate system of delivering healthcare to California inmates was submitted to the federal court in June of 2008.<sup>155</sup>

The Court identified a multitude of reasons for the abhorrent state of healthcare within the CDC: The system had virtually no medical leadership, both centrally and within individual prisons, and lacked the tools to maintain even minimally acceptable medical records.<sup>156</sup> Furthermore, CDC physicians and nurses were, more often than not, shockingly incompetent, under-qualified, and indifferent; they were also rarely counseled or disciplined for providing sub-standard medical care to the inmates.<sup>157</sup> In fact, many physicians and nurses worked without any supervision whatsoever.<sup>158</sup> In addition, inmates did not have adequate access to medical care, often because custodial staff actively prevented prisoners from obtaining even basic treatment.<sup>159</sup> What's more, once inmates actually received clearance to see a physician, they were often forced to wait days to see a primary care doctor, and weeks or months to see a specialist.<sup>160</sup> Although California is the only state in which a federal court has been compelled to resort to the extraordinary remedy of receivership to improve prison health-

care, California's predicament demonstrates that, thirty years after *Estelle v. Gamble*, at least one state (and likely many others) has a long way to go in order to fulfill prisoners' constitutional right to healthcare.

## Ethics and Prevailing Societal Attitudes: Should Law-Abiding Citizens Advocate for Improvements in the Prison Healthcare System?

Many Americans do not harbor much sympathy for convicted criminals. After all, confinement in jail is the entirely avoidable result of the inmate's personal decision to violate the law. Public protest has become even more intense in response to several highly-publicized incidences of inmates receiving healthcare that is of questionable medical necessity or to which they would not have had access had they not been incarcerated.<sup>161</sup> These cases have spurred much debate about the definition of "deliberate indifference" to the healthcare needs of inmates and what treatments, exactly, are guaranteed to prisoners by *Estelle v. Gamble*.

The issue of whether society believes convicted criminals should have more, or even equal, access to healthcare compared to non-incarcerated citizens is multi-faceted and ethically complex. However, regardless of public sentiment regarding this issue, one thing is certain: the consequences of poor healthcare in prisons do not fall exclusively on prisoners. Failure to provide adequate medical treatment to inmates violates the principle embodied in the phrase "let the punishment fit the crime," has a detrimental effect on public health, and has the potential to eliminate able-bodied people from the work force.

## "Let the Punishment Fit the Crime"

Society has pre-determined the severity of the punishments it believes should accompany particular crimes. The majority of offenses do not, in society's opinion, merit sentences as harsh as the death penalty or even life in prison. Yet by confining prisoners in an environment where they are at high risk for contracting communicable diseases, and where they lack access to care that would allow them to manage chronic health problems and avoid preventable consequences of certain diseases, society effectively imposes much stiffer penalties than were originally deemed appropriate by the legislature. If an inmate contracts HIV or Hepatitis C in prison, for example, he has potentially received the equivalent of a death sentence, regardless of the crime for which he was imprisoned. This inadvertent result of sub-standard healthcare in prisons seems contrary to a reasonable sense of justice and morality.

## Public Health Concerns

The majority of prisoners do not remain incarcerated for life.<sup>162</sup> After serving their sentences, inmates are released back into society and are free to engage in all of the activities in which free citizens partake. Once they leave prison, inmates who have contracted tuberculosis, an airborne pathogen, can transmit the disease to any number of unsuspecting citizens if the disease becomes active.<sup>163</sup> Prisoners infected with HIV, Hepatitis C, or other sexually transmitted diseases can pass these viruses on to sexual partners in the general population.<sup>164</sup> Moreover, because HIV and Hepatitis C are blood-borne, if an infected ex-prisoner engages in I.V. drug abuse, he or she may transmit these diseases to anyone with whom a needle is shared.<sup>165</sup> Notwithstanding Americans' personal feelings about whether inmates deserve state-of-the-art medical treatment, the

effect of poor prison healthcare on the public health should not be disregarded.

### **Preventable Disability and Inability to Work**

Many people have chronic medical conditions which, if monitored and managed properly, do not interfere with their daily lives. However, common ailments such as diabetes, high blood pressure, and elevated cholesterol can lead to severe disability if left untreated. If inmates in correctional facilities lack access to regular healthcare and are unable to monitor and manage their chronic conditions the way they did before they entered prison, preventable consequences of these diseases may significantly debilitate the inmate. If the disability renders the inmate unable to work after he has served his sentence, two adverse consequences may result: First, society could be responsible for supporting the inmate through social programs such as welfare and government-sponsored health plans such as Medicaid.<sup>166</sup> Second, if the former inmate is unable to provide for his or her own needs, (s)he may resort to committing crimes to support himself, thus increasing the likelihood that (s)he will return to prison.<sup>167</sup> Consequently, helping inmates maintain or improve their health while incarcerated appears to be an economically efficient and socially valuable endeavor.

### **Elective vs. Medically Necessary Treatments**

Although it is in the public's best interest to advocate for better prison healthcare, in this modern era of complex and amazing medical capabilities, a debate has arisen regarding just how much care the Eighth Amendment guarantees for prisoners.<sup>168</sup> For example, in the case of *Maggert v. Hanks*, Plaintiff, who was a transsexual, sued under §1983, claiming that the prison's refusal to authorize estrogen therapy and provide sex-reassignment surgery violated the Eighth Amendment.<sup>169</sup> Hormone therapy and surgery, while usually necessary to "cure" transsexualism, would have been protracted and

extremely costly.<sup>170</sup> The Court found that while "the Eighth Amendment forbids prisons to ignore the serious medical [and psychiatric] afflictions of prisoners," the state is not under a constitutional obligation "to give a prisoner medical care that is as good as he will receive if he is a free person, let alone an affluent free person."<sup>171</sup> This is especially true where there are viable alternative treatments or therapies, such as psychiatric counseling, in which Plaintiff was already participating.<sup>172</sup>

However, a significantly more complex ethical dilemma is implicated when prisoners need organ transplants. In 2001, a thirty-one-year-old California inmate who was serving a fourteen year sentence was diagnosed with terminal heart failure, the only cure for which was a heart transplant.<sup>173</sup> The inmate received a transplant at Stanford University in 2002 because a federal district judge ruled that the "deliberate indifference" standard set forth in *Estelle* required the state to provide the inmate with a transplant.<sup>174</sup> The surgery and subsequent hospitalization cost taxpayers and estimated \$2 million dollars, and the inmate passed away less than a year after his transplant, reportedly at least partially due to non-compliance with his post-transplant medications.<sup>175</sup>

This angered many Californians, including *Los Angeles Times* writer Steve Lopez, who lamented in a 2002 column, "What is this telling people?...You know, you had two robbery convictions, you're in jail, you get sick, you're going to the top of the [transplant] line, buddy. I mean, that's the problem here."<sup>176</sup> The waters are muddied even further by the specific situations of each potential incarcerated transplant recipient. In order to develop a workable standard for deciding which prisoners, if any, should receive transplants, courts will have to grapple with the questions of whether the age, type of crime, and/or length of sentence (especially in the case of prisoners who are condemned to death) should factor into the decision. This is complicated even more by evidence that a fair number of inmates who were

wrongfully convicted have been exonerated, especially since the advent of DNA technology.

## **Suggestions for Improving the Delivery of Healthcare in American Prisons**

While many solutions have been proposed to remedy the problem of constitutionally inadequate medical care in prisons, the following two possibilities stand out as holding the most potential in terms of degree of benefit and feasibility of implementation:

### **Prisons Should Partner With Healthcare Providers Within Their Communities**

As discussed above, prison doctors and nurses are often incompetent and under-qualified. However, partnerships with community healthcare providers and public health agencies expand the number of competent providers from which to choose, increase the chance that providers will be available who understand particular inmates' cultures, and provide a connection to the community health system the prisoners can retain upon release from prison.<sup>177</sup> Utilizing community providers can also increase prisoners' access to specialists in relevant fields of medicine.<sup>178</sup> In addition, universities with medical schools and affiliated teaching hospitals should be approached regarding provision of care to prisoners.<sup>179</sup> Admittedly, relationships between teaching institutions and prisons have historically involved some ethically questionable instances of medical research using prisoners as subjects, thus making these affiliations appear risky to prison administrators. But if proper safeguards are instituted to protect inmates from improper experimentation, medical students and residents can benefit from the learning opportunities presented by the unique health problems of prisoners, and inmates can obtain higher-quality care.

### **Correctional Healthcare Must Be Viewed as a Public Health Opportunity**

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The majority of American inmates are poor and uneducated, and are disproportionately black and Latino. Often they come from underprivileged communities that offer limited access to health education and medical care. However, incarceration provides an opportunity to teach this population about health maintenance and prevention of communicable diseases, and to diagnose and properly treat mental illnesses.

A 1993 study suggested that prisons should institute the following procedures and programs to decrease the incidence and prevalence of communicable diseases in prisons: Prisoners should undergo an initial examination within twenty-four hours of arrival at the facility.<sup>180</sup> There should be aggressive promotion of voluntary, confidential HIV testing, increased pre-symptomatic treatment, and mandatory educational programs for inmates and prison staff.<sup>181</sup> Information on methods of preventing sexual transmission of HIV should be explicit, and condoms should be distributed by prison healthcare workers.<sup>182</sup> To decrease TB infection, prisons should mandate annual tuberculin skin testing for inmates and staff.<sup>183</sup> In addition, because immune-compromised HIV patients are at high risk for contracting TB, prisons should consider administering prophylactic antibiotics to HIV-infected inmates.<sup>184</sup>

The study also made several general recommendations: Rigorous infection control programs must be instituted in correctional institutions.<sup>185</sup> Sources of infections must be carefully traced, suspected cases of airborne communicable diseases must be promptly isolated, and inmates afflicted with airborne pathogens should not be transferred to other facilities until their infections have been properly treated.<sup>186</sup> Furthermore, educational materials should be presented in a culturally sensitive manner and in languages other than English if necessary.<sup>187</sup> Finally, prison

health systems must be designed to focus on the ailments most common in prison populations: infectious diseases, substance abuse, and mental illness.<sup>188</sup> The authors of the study present a large amount of statistical evidence that, if these health problems are aggressively addressed in prisons, their incidence and prevalence will significantly decrease in the general population as well.<sup>189</sup>

## Conclusion

While prisoners do have a constitutionally protected right to adequate medical care and treatment while incarcerated, in reality the establishment of that right in 1976 has not stimulated much improvement in access to quality healthcare in prisons. This is partly due to the stringent burden of proof required for a prisoner to show that his or her Eighth Amendment right to adequate healthcare has been infringed. However, this difficult burden was by no means arbitrarily imposed by the Supreme Court, and is necessitated by the unique environment in which correctional officers work each day. While the ethical questions surrounding prison healthcare are complex, it behooves the non-incarcerated public to advocate for reform, taking into account the distinction between medically necessary and unnecessary treatments. Improvements in the state of prison medical care can be accomplished through partnership between prison health systems and community-based healthcare providers, and by conceptualizing incarceration as an opportunity to educate prisoners and improve individual prisoners' health specifically, and the public health generally.



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## Endnotes

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- <sup>2</sup> See, e.g., Julie A. Shinn, *Heart Transplantation for a Prisoner*, 17(2) PROGRESSIVE CARDIOVASCULAR NURSING 99-100 (2002).
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- <sup>4</sup> Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME AND JUST. 426, 431 (1999).
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- 41 *Id.*
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- 44 *Id.*
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- 47 *Id.*
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- 49 *Id.* at 103 (emphasis added).
- 50 *Id.*
- 51 *Id.* at 107.
- 52 *Id.* at 104, 105 (emphasis added).
- 53 *Id.*
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- 55 *Id.* at 105-106.
- 56 *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).
- 57 *United States v. DeCologero*, 821 F.2d 39, 43 (1987).
- 58 *Hill v. DeKalb Regional Youth Detention Center*, 40 F.3d 1176 (11th Cir. 1994).
- 59 *Chance v. Armstrong, et. al.*, 143 F.3d 698, 702 (1998) (internal citations omitted).
- 60 42 U.S.C. §1997(e)
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- 63 *See, e.g., Hemmings v. Gorczyk*, 134 F.3d 104, 109 (2nd Cir. 1998).
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- 65 *Whitley v. Albers*, 475 U.S. 312, 319 (1986).
- 66 *Id.* at 320.
- 67 *Wilson v. Seiter*, 501 U.S. 294, 303 (1991).
- 68 *Id.*
- 69 *See, e.g., Hudson v. McMillan*, 503 U.S. 1, 5-7 (1992). The Supreme Court held that three prison guards had not violated the Eighth Amendment in refusing to allow the prisoner to seek medical care after the guards beat the prisoner, resulting in bruises, facial swelling, loosened teeth, and a broken dental plate. Although the district court previously found that the officers' use of force was "objectively unreasonable..., clearly excessive, and occasioned unnecessary and wanton infliction of pain," the evidence was sufficient to establish that the guards used the unnecessary force "in a good faith effort to maintain or restore discipline," rather than to "maliciously and sadistically cause harm."
- 70 *Farmer v. Brennan*, 511 U.S. 825 (1994).
- 71 *Id.* at 836.
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- 73 *Id.* at 837-838.
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- 75 *See, e.g., Estelle, supra* note 25; *Smith, supra* note 51.
- 76 *See, e.g., Estelle, supra* note 25 (while Plaintiff's medical condition was perhaps improperly managed and treated, his Eighth Amendment complaint was denied because he saw a prison physician on numerous occasions); *Floyd v. Owens*, No. 86-7176, 1987 WL 11906, at 1 (E. D. Pa. June 2, 1987) (Court stated that under *Estelle*, where a prisoner has received some medical care, the alleged impropriety of that care sounds in negligence and will not support a constitutional claim.)
- 77 *Compare Estelle, supra* note 25 (no constitutional violation found where inmate's suit arose from complaints of severe back pain); *with Campbell, supra* note 10 (dismissal by summary judgment of inmate's complaint was reversed where the inmate had a documented history of a heart condition and high blood pressure requiring prescription medication) *and Chance, supra* note 59 (dismissal of prisoner's Eighth Amendment claim for inadequate dental care was reversed where prisoner's contentions of severe pain were accompanied by evidence that the prisoner was unable to chew properly, and delay in provision of dental care resulted in extraction of two of the prisoner's teeth.)
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- 172 *Id.*
- 173 CBS News, *Change of Heart* (2003), <http://www.cbsnews.com/stories/2003/09/12/60minutes/printable572974.shtml>.
- 174 *Id.*; Shinn, *supra* note 2.
- 175 Pamela J. Podger, *Prisoner with Transplanted Heart Dies* (December 18, 2002), <http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2002/12/18/BA46334.DTL&type=printable>.
- 176 CBS News, *supra* note 170.
- 177 John J. Gibbons & Nicholas de B. Katzenbach, *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons*, 40.
- 178 *Id.*
- 179 *Id.* at 41.
- 180 Glaser, *supra* note 97, at 143.
- 181 *Id.*
- 182 *Id.* at 144.
- 183 *Id.*
- 184 *Id.*
- 185 *Id.*
- 186 *Id.*
- 187 *Id.* at 143.
- 188 *Id.* at 145.
- 189 *Id.*

## REMINDER:

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