Today's Deliberate Indifference: Providing Attention Without Providing Treatment to Prisoners with Serious Medical Needs

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I. Introduction

The prison's medical staff knew what happened to Neal. Another prisoner had smashed Neal's face with a padlock. The medical providers were quick to rush him to the emergency room. They started dragging their feet later, after Neal's return to the prison.

The prison hastened Neal's return by demanding his discharge from the hospital. Housing Neal in the prison infirmary during his recovery was cheaper than paying correctional officers to stay at the hospital with him. Prison medical staff assumed responsibility for Neal's care. The hospital's discharge orders directed them to take measures to relieve the pain caused by Neal's fractured orbital socket and suggested that arrangements be made for Neal to have surgery as soon as his swelling went down. Although those were the hospital's discharge orders, those orders are mere recommendations when the patient is in the custody of a jail or prison. In Neal's case, the prison had other ideas.

For ten days, Neal suffered in the prison infirmary without being given anything to relieve his pain. The medical provider did not arrange for Neal's surgery for almost a month, despite Neal's pleas for action. Neal will never know whether a timely surgery would have saved the vision in his injured eye. He does know that had he been brought to surgery in two or three days instead of twenty-seven, his broken bones would not have already healed. His delayed surgery forced the surgeon to drill through the bone to perform the necessary repair, causing nerve damage. He knows that if not for the nerve damage, he would not have developed epilepsy, and that he would have avoided the continual disputes with prison medical staff over their failure to address his seizures. The prison medical staff delayed a consultation with a neurologist for six months and then ignored the neurologist's request for follow-up appointments and blood tests to determine whether Neal's anti-seizure medications needed to be adjusted. The prison medical staff refused to provide adequate treatment for Neal's seizures and a year and a half later accused Neal of not taking his medications and intentionally inducing his

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seizures. Neal was released from the prison a year later at the age of twenty-three.

Every day our office hears from prisoners like Neal who are looking for help with their medical care. My employer, Massachusetts Correctional Legal Services, provides advice and assistance to the 25,000 men and women in Massachusetts jails and prisons about the conditions of their confinement. Prisoners come to us with issues ranging from overcrowding to guard brutality. Health care is now the most common issue that they raise.

Health care is a civil right for the incarcerated. Thirty-four years ago, in *Estelle v. Gamble*,[1] the Supreme Court held that health care must be provided to prisoners because they cannot arrange for their own medical care.[2] Too often this right is not respected. Although the prisoners who call us, their locations, and their ailments all vary, the deficiencies in prison medical care systems they describe are similar. Neal's experience illustrates several of the recurring themes: delay in providing care; reluctance to test, diagnose, or seek outside consultation; and accusations against the patient used to justify the denial of care.

This article will share the experiences of a few other prisoners.[3] Each account is representative of one or more common practices in prison medical care;[4] practices that deny adequate care to prisoners but enable providers to claim otherwise. Those claims generally withstand scrutiny from internal grievance processes and from courts entertaining claims of Eighth Amendment violations. As a result, these practices continue.

Before describing these practices, Part II first provides some legal and historical background. Over the last thirty-three years, the Supreme Court has determined that prison medical care obligations arise under the Eighth Amendment. As that law developed, jails and prisons took on larger and older populations and the costs of health services began to rise. Jails and prisons responded to increased costs by privatizing health services. Part III describes the practices prison medical providers have used to minimize costs while still appearing to meet their Eighth Amendment obligations. Prisoners' experiences demonstrate how such practices deny adequate care. Part IV discusses the absence of effective remedies for violations of prisoner medical rights. Internal grievance systems are a study in futility and have not given prisoners access to better health care. Civil actions claiming Eighth Amendment violations run into considerable obstacles. Courts are generally reluctant to conduct thorough examinations of the alleged inade-

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[1] 429 U.S. 97 (1976).

[2] *Id.* at 103–04. *See id.* at 104 ("[I]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.") (quoting Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926)).

[3] The prisoners' names have all been changed.

[4] In the interest of simplicity, I use the term "prison" to include state prisons as well as county jails and houses of correction. The prisoners whose accounts are described in this article come from state and county facilities.

quacies in care and to determine whether they amount to deliberate indifference in violation of the Eighth Amendment. Prisoner litigants often lack the legal expertise and expert witnesses necessary to aid the court's examination. In Part V, I conclude that the widespread denial of the Eighth Amendment right to medical care is detrimental to the reputation of courts, the public interest, and prisoners. Justice would be better served by more rigorous review of alleged inadequacies in medical treatment to determine whether they reach the level of deliberate indifference. That review would be more feasible if indigent, *pro se* prisoners were provided with legal assistance or alternatively, if courts retained independent experts to investigate and report on the adequacy of treatment.

II. Legal and Historical Context

The Supreme Court recognized a prisoner's Eighth Amendment right to adequate medical care in 1976 in *Estelle v. Gamble*.[5] This result was consistent with the opinions of several circuit courts that had confronted the question in the preceding years.[6] The Supreme Court found the denial of medical care to prisoners incompatible with evolving standards of decency, by which the court determines whether a type of punishment runs afoul of the Eighth Amendment.[7]

The Court imposed the obligation of providing adequate medical care on prisons because "[a]n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."[8] To deny such care could result in "pain and suffering which no one suggests would serve any penological purpose."[9] The Court defined the scope of this obligation, holding that "deliberate indifference to serious medical needs of prisoners" violates the Eighth Amendment.[10]

Almost twenty years later, in *Farmer v. Brennan*,[11] the Court determined that the degree of intent that must be shown to establish "deliberate indifference." Until *Farmer*, Circuit courts had differed as to whether the test was objective or subjective, whether the defendant *should* have known that there was serious risk of harm to the prisoner's health, or whether the defendant *actually* knew that there was such a risk.[12] The Court chose the latter standard.[13] Accordingly, to establish deliberate indifference, a prisoner

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[5] 429 U.S. 97 (1976).
[6] *See id.* at 106 n. 14.
[7] *Id.* at 102–03.
[8] *Id.* at 103.
[9] *Id.*
[10] *Id.* at 104.
[11] 511 U.S. 825 (1994).
[12] *Id.* at 832 (emphasis added).
[13] *Id.* at 829.

must prove that the defendant was aware of a substantial risk to the prisoner's health and disregarded that risk.[14]

By adopting the subjective test for deliberate indifference, the *Farmer* Court established that not all inadequate medical treatment in a prison setting violates the Eighth Amendment and that deliberate indifference does not encompass every claim of inadequate medical treatment.[15] While the *Estelle* Court found that the Eighth Amendment prohibits more than just intentional harm, inadequate medical treatment stemming from an accident, inadvertent behavior, or ordinary negligence does not come within the definition of deliberate indifference.[16] Deliberate indifference includes only action or inaction taken in conscious disregard of a substantial risk of serious harm.[17] The *Estelle* Court noted that, "[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner."[18] Inadequate medical care that is "sufficiently harmful to evidence deliberate indifference to serious medical needs" does violate the Eighth Amendment.[19] Such indifference may be "manifested by prison doctors in their response to the prisoner's needs," including the decision to administer "easier and less efficacious treatment."[20]

Courts prefer not to delve into an examination of the adequacy of medical treatment. "Where a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims which sound in state tort law."[21] Thus, although *Estelle* and *Farmer* call for a determination of whether inadequate care resulted from accident, inadvertence, or error, or whether it resulted from deliberate indifference through the conscious disregard of a substantial risk of harm, courts are generally disinclined to make that determination.

While *Estelle* and *Farmer* were shaping the civil rights of prisoners with regard to their medical care, other forces were shaping the actual delivery of such care. The prisoner population in this country skyrocketed during this period.[22] Increased numbers of prisoners in jail and prison created more

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[14] *See id.* at 847.

[15] *Id.* at 834.

[16] Estelle v. Gamble, 429 U.S. 97, 105-06 (1976).

[17] *Farmer*, 511 U.S. at 847. *See also* Hathaway v. Coughlin, 99 F.3d 550, 553 (2d Cir. 1996) ("[C]ertain instances of medical malpractice may rise to the level of deliberate indifference").

[18] *Estelle*, 429 U.S. at 106.

[19] *Id.* The Court's statement that "not . . . every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment," *id.* at 105, implies that at least some such claims do.

[20] *Id.* at 104 & 104 n. 10 (quoting Williams v. Vincent, 508 F.2d 541, 544 (2d Cir. 1974)).

[21] Westlake v. Lucas, 537 F.2d 857, 860 n. 5 (6th Cir. 1976), cited in, *inter alia*, Layne v. Vinzant, 657 F.2d 468, 474 (1st Cir. 1981); United States *ex rel.* Walker v. Fayette County, 599 F.2d 573, 575 n. 2 (3d Cir. 1979); Harris v. Thigpen, 941 F.2d 1495, 1507 (11th Cir. 1991).

[22] According to the Bureau of Justice Statistics, in 1980 there were 503,586 people incarcerated in jail or prison. By 2008, that number had more than quadrupled to 2,304,115. BU-

demand for health care services,[23] and thus higher costs.[24] The prisoner population not only grew, it aged. Longer sentences and a decline in the number of prisoners granted parole led to a generation of prisoners who would grow old behind bars.[25] Older prisoners consume more medical services because many have chronic diseases, disabilities, and greater vulnerability to injury and infection.[26]

Due to the growing and aging prison population, spending on medical services has increased.[27] Prison health care spending continues to grow and represents approximately 10% of overall prison spending.[28] Rising costs put pressure on prison budgets, making cost containment a paramount concern.[29] In the medical arena, privatization emerged as a primary method for control-

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REAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, KEY FACTS AT A GLANCE: CORRECTIONAL POPULATIONS, *available at* http://bjs.ojp.usdoj.gov/content/glance/tables/corr2tab.cfm (last visited Feb. 22, 2010).

[23] "[P]risoners on average require significantly more health care than most Americans because of poverty, substance abuse, and because they most often come from underserved communities." JOHN J. GIBBONS & NICHOLAS DE B. KATZENBACH, CONFRONTING CONFINEMENT: A REPORT OF THE COMMISSION ON SAFETY AND ABUSE IN AMERICA'S PRISONS 38 (2006), http://www.prisoncommission.org/pdfs/Confronting_Confinement.pdf (citing James W. Marquart et al., *Health Conditions and Prisoners: A Review of Research and Emerging Areas of Inquiry*, 77 PRISON J. 184 (1997)).

[24] From 1992 to 2000, the average daily cost of health care for each state prisoner increased 31.5%, from $5.62 to $7.39. From 1997 to 2001, overall health care spending in state prisons rose by 27.1%, from $2.7 billion to almost $3.5 billion. B. JAYE ANNO ET AL., U.S. DEP'T OF JUSTICE, CORRECTIONAL HEALTH CARE: ADDRESSING THE NEEDS OF ELDERLY, CHRONICALLY ILL, AND TERMINALLY ILL INMATES 11 (2004) (citing GEORGE CAMP & CAMILLE CAMP, CRIMINAL JUSTICE INSTITUTE, THE 1992–2001 CORRECTIONS YEARBOOK (1992–2001)). By 2004, that number stood at $3.7 billion. PEW CTR. ON THE STATES, ONE IN 100: BEHIND BARS IN AMERICA 12 (Feb. 2008) (citing CHAD KINSELLA, COUNCIL OF STATE GOVERNMENTS, CORRECTIONS HEALTH CARE COSTS, TRENDS ALERT: CRITICAL INFORMATION FOR STATE DECISION-MAKERS 2 (2004), *available at* http://www.csg.org/knowledgecenter/docs/TA0401CorrHealth.pdf).

[25] One study reported that the number of state and federal prisoners over age 55 rose from 6500 in 1979 to 49,488 in 1998. NAT'L CTR. FOR INSTS. & ALTERNATIVES, ELDERLY PRISONER INITIATIVE NATIONAL SURVEY 1 (1998). From 1992 to 2001, the number of state and federal prisoners older than age 50 jumped from 41,586 to 113,358. These prisoners represented 7.9% of the overall prison population, up from 5.7% in 1992. ANNO, ET AL., *supra* note 24, at 7. This rise has been attributed to longer life expectancies in the overall population, now reflected in the prison population, and to changes in sentencing law and policy that both brought in new prisoners and kept them in prison for longer periods. KINSELLA, *supra* note 24, at 14.

[26] The Bureau of Justice Statistics has reported that prisoners age forty-five and over are almost twice as likely to suffer from medical problems. KINSELLA, *supra* note 24, at 14 (citing LAURA MARUSCHAK & ALLEN BECK, BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF INMATES 1997, (Jan. 2001)). *See also* LAURA MARUSCHAK, BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF INMATES 2 (2004) (over 60% of state and federal prisoners age forty-five or older report having a medical problem, defined as one of fourteen specific illnesses).

[27] *See* ANNO, *supra* note 25, at 11.

[28] KINSELLA, *supra* note 24, at 6. From 1998 to 2001, state prison corrections costs rose an average of 8% per year. Health care spending in state prisons, meanwhile, climbed 10% per year. *Id.*

[29] *See* ANNO, *supra* note 24, at vii ("The most serious challenge facing correctional administrators with regard to the elderly and infirm inmate population is containment of health care costs."); GIBBONS & KATZENBACH, *supra* note 23, at 39 ("legislatures chronically underfund correctional health care").

ling costs. Prisons and jails increasingly have allowed private outside health care entities to bid on contracts to provide prison health services.[30] The staffing, treatment, medication, supplies, and cost of referrals to outside hospitals or specialists can all be folded into a contract with an outside entity. Entities seek to underbid their competitors in order to win the contract.[31]

Through privatization, a jail or prison seeks to obtain cost savings and predictability for its health care spending.[32] The winning bidder must fulfill its contractual obligation—the provision of health services to prisoners—while trying to ensure that costs do not exceed the amount of the winning bid. The pressure to bid as low as possible, in order to win the contract in the first place, is followed by the pressure to keep costs in line with the

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[30] Paul von Zielbauer, *As Health Care in Prison Goes Private, 10 Days Can Be a Death Sentence*, N.Y. TIMES, Feb. 27, 2005, at M1 (reporting that 40% of prisoner medical care is contracted to for-profit entities, with one contractor, Prison Health Services, responsible for the medical care of about one in ten incarcerated people); Kelly Bedard & Ted Frech, Prison Health Care: Is Contracting Out Healthy? 2 (Sep. 9, 2007) (Working Paper, University of California Santa Barbara, Department of Economics), *available* at http://www.escholarship.org/uc/item/6vh3429f (citing Michael LaFaive, *Privatization for the Health of It*, *in* 4 MACKINAC CTR. FOR PUB. POL'Y, MICHIGAN PRIVATIZATION REPORT NO. 2004-02 (Winter 2005), http://www.mackinac.org/article.aspx?ID=6910 (by 2004, thirty-two states contracted with private entities for some or all of their prison health services)).

[31] Zielbauer, *supra* note 30, at M33 ("a half-dozen for-profit companies jockey to underbid each other and promise the biggest savings"). *See also* Ira P. Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195, 198–204 (1999) (describing features of managed care in prison).

[32] Zielbauer *supra* note 30, at M32 ("As governments try to shed the burden of soaring medical costs . . . [privatization of jail and prison medical care] has become a $2 billion-a-year industry."); Robbins, *supra* note 31, at 204 (describing common fee-per-offender arrangements); BEDARD & FRECH, *supra* note 30, at 7 (referring to capitated contracts, and to study suggesting that state prison systems using capitated contracts for ambulatory care had 31% lower costs per prisoner); Lawrence H. Pomeroy, *Considerations for Privatization of Health Care*, CORRECTIONS FORUM 18 (May/June 2008) ("To the governing body overseeing corrections facilities, contracting with a privatized provider has the added benefits of making costs transparent . . . .").

winning bid.[33] This reality influences all decisions about prison medical care.[34]

The practices of prison medical providers are best understood in light of the legal and historical developments of the last thirty years. Today, the Eighth Amendment requires prison authorities to provide adequate medical care, though "some medical attention" of any kind generally will satisfy this obligation.[35] An older and much larger prisoner population imposes tremendous costs on prisons. Privatization of medical services has put pressure on outside contractors to keep health care costs below their winning bids. Prison medical providers have reacted to these pressures by employing certain practices, described below, which avoid costly treatment while *appearing* to offer adequate care.

III. A Prisoner's Eye View of Medical Care

This trend in prisoner medical treatment is apparent across a variety of jails and prisons, which use many different medical service providers. Prisoners contact our office with a wide range of medical conditions or symptoms, yet their interactions with prison medical providers reveal certain common themes.

A. A Profound Lack of Curiosity

In response to a prisoner's request for treatment, a prison medical provider may resist learning too much about the patient's condition. Testing,

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[33] *See* Zielbauer, *supra* note 30, at M33 (quoting expert's observation that "the companies will take bids for amounts that you just can't do it. . . . They figure out how to make money after they get the contract"); Bedard & Frech, *supra* note 30, at M33 ("Profit-seeking firms also have better incentives to produce care more efficiently because managers are allowed to keep the residual earned by reducing costs."); Robbins, *supra* note 31, at 202–03.

This challenge has proven to be too great at times, and when this occurs, contractors are not ashamed to back out of the deal, claiming insufficient compensation. *See, e.g.*, Shay Totten, *Medical Provider Cancels Vermont Prison Contract*, Vermont Guardian, Nov. 3, 2006, www.vermontguardian.com/local/112006/PrisonContract.shtml (Prison Health Services backs out of last year of three-year contract); Joe Follick, *Prison Health Services to Sever Contract With DOC 8 Years Early*, The Ledger, Aug. 23, 2006, at MB5 (PHS backs out of contract in the first year, because contract "has underperformed financially"). Prison authorities are left to seek new bidders, who are sometimes the old bidders. *See America Service Group, Inc. announces new contract between co-operating subsidiary, Prison Health Services, and Vermont Department of Corrections*, Reuters, Jan. 29, 2007, http://www.reuters.com/article/idUSIN20070129165242ASGR20070129 (reporting that two months after its withdrawal from Vermont, PHS is rehired under new deal); Zielbauer, *supra* note 30, at 5 ("When cost-trimming cuts into the quality of care . . . governments often see no alternatives but to keep the company, or hire another, then another when that one fails – a revolving-door process that sometimes ends with governments rehiring the company they fired years earlier.").

[34] Jails and prisons that do not privatize health services are not impervious to such pressures. Those who keep their health services in-house rely on an appropriation from the legislative body for health services, and then budget accordingly.

[35] *See* Westlake v. Lucas, 537 F.2d 857, 860 n.5 (6th Cir. 1976).

imaging, and other means of diagnosing an illness all have a cost, as does treatment. Providers chronically avoid gathering sufficient information about a patient in the following ways:

1. Do Not Test

Symptoms that seem to obviously require testing do not necessarily result in testing. For example, it appeared that "Cal," a prisoner, was suffering from MRSA (Methicillin-Resistant Staphylococcus Aureus), a drug-resistant Staphylococcus infection. He had sores on his legs and the antibiotics he was given failed to heal them. Still, for months the prison medical provider refused to order a bacterial culture of samples taken from Cal's sores. Such testing would have revealed whether Cal had MRSA and which antibiotics would be the most effective in treatment. The medical provider continued to give Cal ineffective treatment, only agreeing to order an MRSA test after Cal's legs deteriorated to the point where he needed to be hospitalized. The test confirmed that Cal had MRSA and the proper antibiotics were prescribed.

More remarkable than this initial refusal to test was the provider's continued inaction when Cal's infection returned. The first time, the medical provider declined to prescribe antibiotics and even refused to document the recurrence accurately, citing "orders" from above not to use the term "MRSA" in patient charts. The second time Cal sought medical treatment, a doctor told Cal that his legs were "fine" without even lifting up Cal's pants to examine the sores. On each occasion, the provider justified weeks of inaction, and the needless pain and discomfort it caused, by refusing to test Cal and confirm the infection.

Cal recovered eventually, but another prisoner, Kevin, was not so fortunate. When Kevin developed serious pain in his back and abdomen, he reported it to the prison medical provider. The provider determined that Kevin had an ulcer and prescribed medication. Kevin's pain worsened and he repeatedly sought medical attention. The provider refused to order imaging or other testing, even after Kevin lost over thirty pounds and his health deteriorated to the point where he could not walk. Finally, a group of prisoners who witnessed Kevin's agony protested on his behalf. The provider ordered testing that ultimately showed that Kevin had a tumor in his back. By the time the tumor was found, the cancer was too advanced to be treated and Kevin died.

By not testing, a prison medical provider avoids knowledge of a condition that may require treatment and thereby minimizes treatment costs. Prisoner patients are left to suffer not only from their symptoms, but also from the fear that the as-yet unidentified ailment will cause permanent harm, or even death.

2. Test Once and Stop

Some prisoners do receive testing for their symptoms. When the initial testing comes back negative, however, the provider may choose to stop there instead of pursuing further testing to discover the cause of the symptoms. This is what happened to Vernon, who for months suffered from problems urinating. Vernon developed hematuria, the presence of blood in the urine, which evolved into dysuria, a periodic inability to urinate. He was sent to see an urologist, who examined him but could not pinpoint the cause of the problem. The prison medical provider refused to do any further testing because the urologist had found nothing in initial testing, although Vernon's problems continued such that every couple of weeks he went days without being able to urinate. Months later, Vernon suffered a kidney infection and required hospitalization. A few more months passed before Vernon was hospitalized for a second time and the provider finally sent him back to the urologist for further testing. Vernon endured nearly two years of this condition before its cause was identified, and might have done so for longer had he not become so ill that he could not be ignored.

Yet another prisoner, Kurt, had initial testing that also came back with negative results. He sought treatment when he started coughing up blood and developed difficulty swallowing. Kurt eventually stopped coughing up blood, but his swallowing problems worsened. He could only swallow tiny bits of soft food or liquids and frequently choked when trying to swallow. The prison medical provider sent Kurt to see a pulmonologist who recommended that he take a bronchoscopy test. That test was never performed and Kurt's difficulties continued. When Kurt requested help, the provider pointed out that it had sent Kurt to the pulmonologist. The provider ignored the fact that Kurt's condition remained undiagnosed and that the specialist's recommendations had not been followed. After a year of struggling to swallow, Kurt received an alternative test that confirmed the existence of his condition, though it did not identify the cause or possible remedies.

By performing at least one test, a prison medical provider can claim to be providing adequate treatment, even when the test does not provide any answers. One negative finding is cold comfort for a patient whose ailment continues unidentified and untreated.

3. Do Not Listen to Others

Prison medical providers receive patient information from the patients themselves and from outside medical providers. Even when this information seems to warrant a response, there is no guarantee that the providers will acknowledge or believe the information they receive.

Michael and Brent both have a drug allergy. On separate occasions recently, prison medical providers tried to prescribe to each of them the drugs to which they are allergic. Michael and Brent informed the providers

about their respective allergies and received the identical response. The provider protested, "[t]he allergy isn't listed in your chart." Each prisoner pointed out that his drug allergy had never come up before during his incarceration. Both prisoners offered to sign releases so the provider could confirm their allergies with their community medical providers. The provider refused and informed the prisoners that alternative medications would not be prescribed. Michael and Brent were told that "refusal of care" would be documented in their records if they did not take the prescribed drugs. Both prisoners declined the drugs.

The suggestions and advice of outside medical providers may not be given any more weight than statements from prisoners. For example, Marco came to prison with diabetes controlled with insulin. His specialist contacted the prison to alert the prison medical provider about Marco's condition and treatment regimen. The provider ignored the specialist's opinion and instead offered Marco treatment that was so ineffective that he had to be hospitalized. Subsequently, the prison did not provide Marco with proper treatment. Its response was to transfer him to another facility.

As is evident from the above examples, information from a patient or an outside medical provider can lead to more efficient and effective treatment. However, such information may be disregarded if it imposes a heavier burden on the prison medical provider.

4. Do Not Consult Others

A prisoner with an undiagnosed or poorly managed condition may need to see a specialist. Prison medical providers determine whether to arrange for a specialist consultation. Such consultations have a cost, though, as do the further tests, treatment, or follow-up appointments that specialists may recommend. As a result, providers may choose to avoid outside consultations in the first place.

Such was the case with Hugh, who was attacked by another prisoner. He appeared to have a broken nose after the assault and the nurse wanted to send him to a hospital immediately. The prison doctor, who was not on site, overruled the nurse and ordered that an x-ray be taken the next day. The x-ray confirmed the nurse's suspicion that Hugh had a fracture, but the doctor still rejected any further testing or treatment. Nothing was done for weeks despite the fact that Hugh's pain continued and he developed clicking in his jaw. After weeks of requesting medical treatment, Hugh was begrudgingly referred to an ear, nose, and throat specialist who advised him that it was too late to fix the clicking in his jaw and the dent in his nose.

Unlike Hugh, Sam never even saw a specialist for the constant ringing in his ears, which persisted for months. Sam sought relief from the prison medical providers. One individual provider recommended that Sam see a specialist to diagnose and treat his problem, but the contractor refused this request. When pressed for a reason, the contractor simply denied that Sam

had any serious ringing in his ears. Sam was never treated before his release from prison.

The failure to provide specialist consultations and testing, coupled with the failure to acquire patient information from other sources allows prison medical providers to keep their heads buried in the sand. Denying treatment for a known problem would be difficult to justify. Providers instead may simply avoid learning enough about a prisoner's condition to ascertain their specific treatment needs. This profound lack of curiosity ultimately harms patients, as does delayed treatment, which is discussed next.

B. Delay as Denial

A client with an undiagnosed problem described the medical care in prison by stating that things only happen in multiples of three months. An initial request for help may elicit a timely response. However, it then takes three months to be referred to a specialist, another six months to get a test done, three more months to return to the specialist so that she can interpret the test results, and so on. Without expressly denying care, the prison medical provider can postpone diagnosis and treatment, and therefore evade the cost, at least for a time, of a serious condition.

The frustration mounts, meanwhile, for the prisoner who is subjected to indefinite delay in treatment. Scott was one such prisoner. Twice, within a year, Scott was assaulted by prisoners who broke bones in his face. The initial response to each assault was prompt. Scott was taken to the emergency room after one of the assaults and allowed a consultation with a specialist to assess the damage to his face. The specialist requested a return visit if Scott's pain did not go away within a few weeks. At that point, the specialist would determine whether surgery was necessary. Although Scott's pain did not subside, prison medical providers delayed his return visit to the specialist and failed to provide him with treatment in the interim. After a year of suffering, Scott was still waiting for a follow-up appointment with the specialist.

Although delay is a familiar concept to many prisoner patients, two types of delay merit special mention due to their prevalence. First, delay sometimes takes the form of repeatedly ordering the same ineffective treatment, rather than doing nothing. Second, for prisoner patients whose release or transfer is imminent, their medical care gets delayed until their departure.

1. Running in Place

Prisoners with unsolved medical problems can find themselves stuck, with prison medical providers ordering a test or treatment repeatedly, even when that test or treatment has failed to remedy the problem. Although repeating a futile exercise appears wasteful, that course may still be less expensive than the alternatives.

Steven found himself stuck in just such a cycle. Steven is an HIV-positive prisoner whose teeth were in terrible shape. He had multiple cavities, several fillings that had fallen out, and some visibly dying teeth. Tooth decay poses risks, including the possibility of infection, for anyone, but such risks are particularly serious for those with HIV. When Steven requested dental treatment, it took five months just to be examined. The dentist noted Steven's many problems but did not treat any teeth. When no return appointment was made, Steven resumed making requests for further care. Four months later, he received another routine exam at which the dentist again acknowledged the poor state of his teeth but did not treat them. The dentist only prescribed antibiotics for a possible abscess. Two months later, Steven's HIV specialist requested immediate intervention to repair Steven's teeth. That request led to a dentist appointment at which one tooth was extracted but no work was performed on the others. The specialist again requested intervention, pointing out that Steven's necrotic teeth were at significant risk of infection. That request only led to another routine dental exam, at which the problems in Steven's teeth were again duly noted but not treated.

For prisoners like Steven, the frustration of delayed effective treatment is compounded by the repeated ordering of the same ineffective treatment. Steven spent over a year going back and forth to the dentist's chair but he did not get any relief, despite the seriousness of his condition. However, because Steven was allowed to make multiple visits to the dentist, one could not say that the provider denied all medical attention.

2. Running Out the Clock

While some prisoners experience delay as a series of repetitious, fruitless appointments, others are simply ignored until they are released or transferred. At that point, their problems become the responsibility of another provider, usually another prison or the community.

Will discovered firsthand how reluctant providers are to provide care to a prisoner nearing release. Will's teeth had deteriorated to the point that they could not be saved. The provider instead performed a full mouth extraction. This surgery not only removed all of Will's teeth but also left a hole in the roof of his mouth, one that eventually reached his sinus. Will suffered from repeated infections and substantial pain as a result. After weeks of recurring infections, the prison sent Will back to the oral surgeon, who recommended a second surgery to close the hole. At the time, Will had one year remaining on his sentence. Despite Will's multiple requests for treatment and continuing infections, the provider did not arrange for the second surgery. When Will was transferred to a minimum security facility, the doctor there refused to look at the oral surgeon's report, though Will had a copy in hand, or to look in Will's mouth at all. The implicit message was that no surgery would be forthcoming for a patient on the verge of release.

To add insult to injury, Will never received dentures. He only consented to the full mouth extraction after the prison medical provider promised that it would provide dentures. That promise was never fulfilled. Upon his release, Will tried to get dentures, but his insurer denied coverage for them because he had a preexisting condition.

Delaying the treatment of prisoners soon to be released or transferred is an obvious way to save costs. Such delays are not exclusively visited upon this group, however. Any prisoner with a serious ailment may end up waiting indefinitely for treatment from a provider who has not denied the treatment outright but who has not offered it either.

C. Blaming the Patient

The aforementioned practices—refusing to test or obtain important information and delaying treatment—often leave prisoners with the choice of either continuing to request treatment or giving up. Those who persist in seeking treatment may find the prison medical provider turning its attention not to the treatment but to the patient's character. In order to justify the delay in or denial of adequate care, providers accuse the prisoner either of exaggerating his condition or of purposefully bringing it about.

1. No Treatment for the Faker

Providers sometimes defend the decision not to treat a prisoner by alleging that the prisoner is feigning illness or exaggerating the problem. Prisoners as a group start from a baseline of limited credibility, so even those patients with no history of faking symptoms may be targeted.

Ben was one such prisoner. He suffered from kidney stones and was waiting for surgery to remove a stone. The procedure had been delayed indefinitely. One day Ben became very sick. He had blood in his urine and was vomiting. He was brought to the prison infirmary, where instead of being immediately examined, he was sent to a holding cell to wait. The provider, perturbed by Ben's unforeseen arrival in an already busy infirmary, accused him of faking his symptoms and refused to examine him even though the provider was well aware of Ben's kidney stone and the fact that he had been waiting a long time for surgery. Ben continued to suffer for hours in the infirmary. Finally, a correctional officer saw Ben dry heaving on the floor and demanded that he be evaluated. Upon examination, Ben was immediately taken out to a hospital where he had the kidney stone removed.

The provider in Ben's case never disclosed just what he thought Ben was hoping to gain by faking his illness. The same can be said for Walker, who was accused of trying to manipulate his way into an endoscopy. Walker had an undiagnosed stomach ailment, for which he was sent to a gastroenterologist who recommended an endoscopy. The prison medical

provider declined to order the procedure without providing any explanation. Walker continually made verbal and written requests to have the endoscopy performed. He was then accused by the doctor of feigning his symptoms and "angling" to get an endoscopy. The doctor offered no theory as to why Walker would want to undergo an intrusive and unnecessarily, uncomfortable procedure.

Skepticism about certain patient complaints is part of the practice of medicine. As the above examples demonstrate, however, in prison such skepticism can be too quickly and liberally applied.

2. No Care for the Self-Inflicted Wound

A prisoner's condition may be so obvious that she cannot be accused of lying. Instead, she may be blamed for bringing about the illness. Such allegations seem to be leveled most frequently against the patients who are the most steadfast in their pursuit of adequate treatment.

Kurt was one such prisoner. At the onset of his symptoms, when he started coughing up blood and finding it difficult to swallow, he made repeated requests for testing and treatment. His requests were rejected by the prison doctor, who ultimately accused Kurt of coughing up blood by cutting the back of his throat. The doctor never explained the basis for this theory nor why he believed that Kurt would do such a thing.

Dan had suffered from high blood pressure for several years. His prescribed medication, once effective, was no longer working and his blood pressure was high whenever it was checked. Minor adjustments to his medication regimen had failed to solve the problem. After a year with elevated blood pressure, Dan pleaded for more aggressive treatment to bring his blood pressure back down. The prison doctor rejected Dan's entreaties, and instead accused Dan of raising his own blood pressure. The doctor accused Dan of being able to make his blood pressure higher when it was being checked at the infirmary, claiming that it was otherwise normal. For the provider, the doctor's conclusion justified the decision not to offer further treatment.

Prison medical providers may not always make such curious accusations, but they frequently fault prisoners for purposefully making themselves ill or for "sabotaging" their health. The alleged behavior is regarded as a justification for denying or limiting care.

IV. Inadequate Remedies for Inadequate Medical Care

As suggested by the practices described above, prison medical providers may appear to be attentive to patient needs while simultaneously failing to provide adequate care. When inadequate care is serious enough to warrant action, the prisoner's options are limited in number and effectiveness.

Prisoners cannot get a second opinion or choose another provider.[36] They are therefore left with two options: follow the prison's medical grievance process to seek adequate treatment or bring an action against the jail or prison for violating the Eighth Amendment. Neither option fully protects a patient's rights.

A. The Prison Medical Grievance Process—A Giant Feedback Loop

Many prison medical systems have a grievance process for prisoners to report their problems.[37] A medical grievance system suggests that prisoners have recourse when they are not provided with adequate care, but too often the system lacks independence. The person reviewing a medical grievance is either an employee of the medical contractor, such as a colleague of the individual providers whose actions are being reviewed, or a prison administrator whose interests, particularly in controlling costs, are closely aligned with the contractor's interests. Furthermore, the reviewing officials often are not medical professionals. Thus, they are not qualified to question the individual provider's actions and usually defer to the provider's medical judgment.

Isaiah has witnessed the ineffectiveness of the medical grievance process. Isaiah suffered from chronic testicular pain for years. His pain limited his physical activities and drove him to drop out of an educational program because he was too distracted to concentrate. As the cause of his pain had not been identified, Isaiah sought further testing, or a referral to a specialist. The prison medical provider took no action except to tell Isaiah to learn to live with the pain. Isaiah dutifully followed the medical grievance process. He related the provider's refusal to act and requested further efforts to diagnose his condition. The response to his first-stage grievance advised him to "discuss this with your medical provider"—the one with whom he had just met and whose inaction was the cause of his complaint. The response to Isaiah's second-stage grievance referred to a previous test, which was negative, and told him "that specialty care or further testing is [not] medically necessary at this time." At the third and final stage, an administrator again referred Isaiah back to his individual provider, scolding him for "not submit[ing] a sick slip for testicular pain since November 16." November 16 was the date that Isaiah's provider refused to take action and told him to live with the pain.

A four-month-long grievance process sent Isaiah right back to his original provider and chided him for not going to the provider for further care

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[36] *See* Estelle v. Gamble, 429 U.S. 97, 103 (1976) ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.").

[37] Such systems are a response to the Prison Litigation Reform Act's exhaustion requirement, 42 U.S.C. § 1997e(a) (2006), which turns prisoner lawsuits away if the plaintiff has not fully exhausted his or her available administrative remedies.

while he was pursuing a grievance based on that person's refusal to act. His experience is shared by others whose medical grievances land them in, as one client put it, a giant feedback loop. The grievance process consumes prisoners' time and energy. They write to several different authorities, in many cases only to be referred right back to the provider whose actions prompted the grievance.

B. Individual Eighth Amendment Claims: A Tough Sell

Prisoners who find no relief in the grievance system may attempt to bring suit against the medical provider for violating the Eighth Amendment. However, they face an uphill battle. If the provider has taken any action at all, a court may not be willing to find deliberate indifference. Even if a court undertakes an examination of the adequacy of care, the examination is typically one-sided, pitting a prisoner without legal counsel or any expert witnesses against a medical provider armed with its own records and expert opinions.

The practices of prison medical providers described in Section III would seem to meet *Farmer*'s definition of deliberate indifference: they reflect a conscious disregard of a substantial risk of harm to the prisoner.[38] They do not suggest, however, a denial of all treatment or an interference with treatment,[39] either of which would be readily apparent Eighth Amendment violations. Providers can use their own records and affidavits to argue that they did not deny all care to the prisoner patient and that they did not interfere with any prescribed treatment. However, neither directly addresses the prisoner's claim, which is that the medical care was so inadequate that it constituted deliberate indifference.

Measuring the adequacy of a prisoner's care would seem to necessitate a review of the available evidence, whether through a summary judgment motion or trial. Given the general "reluctan[ce] to second guess medical judgments,"[40] however, such claims may be dismissed at the pleading stage.[41] Many courts share the view that a prisoner's disagreement with the

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[38] *See* Farmer v. Brennan, 511 U.S. 825, 847 (1994).

[39] *Estelle*, 429 U.S. at 104–05.

[40] *Westlake*, 537 F.2d at 860 n.5.

[41] The usual vehicles—a motion to dismiss for failure to state a claim or motion for judgment on the pleadings—are joined in prisoner cases by the initial screening required by the Prison Litigation Reform Act. 28 U.S.C. § 1915A (2006). The statute calls for federal courts to screen prisoner complaints sua sponte as soon as practicable after docketing, and to dismiss those that are frivolous, malicious, or fail to state a claim, and to dismiss claims for monetary relief against defendants who are immune from such relief. *Id.* Early screening of prisoner cases predates the PLRA, though; in fact, *Estelle v. Gamble* was one such case. *Estelle*, 429 U.S. at 98 ("The District Court, *sua sponte*, dismissed the complaint for failure to state a claim upon which relief could be granted."). Though the Court in *Estelle* recognized and defined the right to adequate medical care, it ultimately agreed with the lower court's dismissal of the complaint based solely on the allegations therein, before the defendants had even filed a response. *Id.* at 108 n.16 (court is able to dismiss for failure to state a claim because complaint

type of treatment he or she receives does not state an Eighth Amendment claim,[42] and that prisoners, while entitled to adequate medical care, are not entitled to their choice of treatment.[43] Neither of these phrases come from *Estelle* or *Farmer*, and neither answers the question of whether a provider acted with a knowing disregard of a substantial risk of harm,[44] but they are invoked as a sort of shorthand test for deliberate indifference. An early dismissal of the case at the pleading stage gives the prisoner no opportunity to prove that the alleged inadequacy was more than an accident, inadvertence, or error.[45]

Even when the claim survives the pleading stage, the prisoner plaintiff is unlikely to survive summary judgment. Most prisoner plaintiffs are pro se litigants. Unskilled in discovery matters, they may not be able to secure the production of supportive documents or testimony.[46] More importantly, they almost always need an expert witness to offer an opinion about the adequacy of the care and to rebut the provider's claims.[47] Prisoners generally lack the

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"provides a detailed factual accounting. . . . By his exhaustive description he renders speculation unnecessary. It is apparent from his complaint that . . . the doctors were not indifferent to his needs."). Justice Stevens disagreed. *Id.* at 110 (Stevens, J., dissenting) ("On the basis of Gamble's handwritten complaint it is impossible to assess the quality of the medical attention he received.").

[42] *See, e.g.*, Ciarpaglini v. Saini, 352 F.3d 328, 331 (7th Cir. 2003); Watson v. Caton, 984 F.2d 537, 540 (1st Cir. 1993); Massey v. Hutto, 545 F.2d 45, 46 (8th Cir. 1976); Smart v. Villar, 547 F.2d 112, 114 (10th Cir. 1976).

[43] *See, e.g.*, Layne v. Vinzant, 657 F.2d 468, 473 (1st Cir. 1981) ("The right to be free from cruel and unusual punishment does not include the right to the treatment of one's choice."); U.S. *ex rel.* Hyde v. McGinnis, 429 F.2d 864, 867–68 (2d Cir. 1970).

[44] It seems obvious that the Eighth Amendment does not entitle a prisoner to her choice of treatment. That said, the fact that the prisoner had a treatment preference should not automatically result in her claim being dismissed. The question remains whether the treatment was constitutionally adequate. A prisoner filing suit over her medical treatment *always* disagrees with the treatment offered. To say that such disagreement does not entitle her to relief does not further the deliberate indifference analysis. Such disagreement alone should not be cause for dismissal; it should not exempt providers from a review of the adequacy of their care.

[45] *See* Estelle v. Gamble, 429 U.S. 97, 105–06 (1976). In fact, no matter how the complaint is drafted, the deliberate indifference claim is at risk of being dismissed. If the complaint does not contain enough detail about the provider's wrongful conduct, it may be dismissed under *Ashcroft v. Iqbal*, 129 S.Ct. 1937 (2009). If the complaint contains detailed allegations about the provider's wrongdoing, it may be dismissed at the initial screening phase or by a motion to dismiss, as in *Estelle*, if the court assumes that the allegations contain all of the relevant information. This denies the prisoner an opportunity to develop factual support. *See Estelle*, 429 U.S. at 107–08, 108 n.16; *Ciarpaglini*, 352 F.3d at 331 (sua sponte dismissal) ("Ciarpaglini has simply pled himself out of court by saying too much").

[46] Supportive information might be obtained from the defendants, such as internal policies for the treatment of certain diseases, or facts surrounding the role of financial considerations in treating an illness. *See* Johnson v. Wright, 412 F.3d 398, 406 (2d Cir. 2005) (reliance on blanket policy, when put on notice that medically appropriate choice may be to depart from policy, may amount to deliberate indifference); Robbins, *supra* note 31, at 214–15 (citing cases holding that it is deliberate indifference to place financial considerations ahead of prisoners' medical needs).

[47] *See, e.g.*, Boudreau v. Englander, No. 09-cv-247-SM, 2009 WL 4952490, at *6–7 (D.N.H. Dec. 14, 2009) (denying preliminary injunction to prisoner) ("For his part, and this is critical, Boudreau did not offer any expert medical opinion evidence tending to question or contradict [Defendant's] professional treatment decisions. . . . This court lacks the medical

wherewithal to locate a willing expert and the funds to retain her as an expert witness.[48] A plaintiff's sworn statement about how she was treated, without more, stands little chance against the records, affidavits, and expert opinions that the prison medical providers can generate.

A few prisoners are fortunate enough to obtain a full airing of their deliberate indifference claims. Usually, this occurs when the prisoners have secured counsel, expert witnesses, or a piece of evidence that undercuts the prison medical providers' positions. The rest are not so fortunate. Their Eighth Amendment claims, based on inadequate care, rather than denial of or interference with care, are generally disfavored. In addition, these plaintiffs are either unable to obtain the necessary evidence or find that their claims are dismissed before they can do so. As a result, the medical practices that prisoners encounter today are largely insulated from Eighth Amendment scrutiny.

V. Conclusion

For too many prisoners, the Eighth Amendment does not ensure adequate medical care. Prison medical providers may be aware of their constitutional obligations, but they are also well aware of the conflicting need to limit costs. They employ practices that functionally deny adequate care while appearing to address the medical concerns that prisoners have. Prisoners lack effective remedies. They are unable to secure a second opinion or select a different medical provider. The medical grievance system amounts to a rubber stamp for the provider's choices. The only independent authority to which prisoners can turn is the judiciary, but individual claims for violating the Eighth Amendment are likely to be dismissed without a full airing of the question of adequacy of care.

The right to adequate medical care established by the Supreme Court in *Estelle* loses its meaning when it is not enforced. A prison medical system that lacks accountability benefits no one. The Eighth Amendment jurisprudence in this area has harmed courts because their authority to enforce prisoners' constitutional rights has been diminished. The public interest is also negatively affected because the public health consequences of inadequate prison medical care do not remain behind prison walls. Diseases are communicated to family members, other visitors, and prison staff, who bring them into outside communities. Moreover, the overwhelming majority of

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training and expertise necessary to determine, in the absence of expert opinion evidence, whether the medical judgment exercised by the defendant physicians . . . was so substandard as to implicate the Eighth Amendment."). An expert may not be essential in cases of interference with prescribed treatment, or the denial of any care, but it is hard to envision a case based on inadequate care that can be made without an expert.

[48] The need for expert witnesses also applies to medical negligence (malpractice) claims, and it explains why such claims are not a feasible alternative to civil rights litigation. A medical malpractice plaintiff typically must have an expert opinion supporting the claim. *See* 61 Am. Jur. 2d *Physicians, Surgeons, Etc.* § 321 (2009).

prisoners will someday be released.[49] Serious medical needs that go unmet leave prisoners less able to reintegrate into society. Their illnesses or disabilities may limit their work and housing options. Their continuing medical needs will be costly to them. The public will also shoulder some of the costs of inadequate treatment, as many former prisoners rely on public insurance programs through the Veterans Administration, Medicare, Medicaid, or on free care provided in emergency rooms. With one in every 100 American adults in a jail or prison,[50] the financial and public health impact of inadequate prison medical care cannot be ignored.

Not surprisingly, prisoners also lose. A provider's deliberate indifference obviously affects the patient's physical health. This injustice also colors prisoners' perceptions of medical providers and courts. Support for this proposition is only anecdotal but important nonetheless. Many prisoners start out viewing prison medical providers in a different light than the other members of the prison staff. They believe that these providers have ethical responsibilities to their patients that set them apart and insulate them from the pressures that influence the behavior of prison authorities. This positive view of prison medical care erodes when prisoners are subjected to unfair medical practices or disingenuous medical decisions. Their inability to obtain relief from courts confirms the impression that they cannot get fair treatment or justice from any institutional actor.

The Eighth Amendment right to adequate medical care should be enforced more vigorously. The Constitution requires that prison medical providers be held accountable for inadequate care if the inadequacy amounts to deliberate indifference. Early dismissals of inadequate care claims based on deliberate indifference, as opposed to the complete denial of or interference with care, should be the exception, not the rule. Instead of characterizing claimed inadequacies as disagreements about the choice of treatment, which are suitable only for negligence actions, courts should examine the claimed inadequacies to determine whether they evidence deliberate indifference. The practices of prison medical providers described in this article, which produce inadequacies in care, potentially emanate from conscious disregard of a substantial risk to prisoner health.

The courts' examination of whether alleged inadequacies in care amount to deliberate indifference would be easier and more accurate if prisoner patients had the means to obtain and submit evidence in support of their claims. Legal representation, through a legal aid office like ours, the appointment of a pro bono attorney, or some other avenue, would improve the plaintiff's prospects of gathering support for her claim through discovery.

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[49] In 1998, approximately 11.5 million people were released from jails and prisons into the community, with "high rates of communicable disease, chronic disease, and mental illness." NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES, VOLUME 1 ix (Mar. 2002).

[50] PEW CTR. ON THE STATES, *supra* note 24, at 3.

Similarly, retaining an expert witness is often necessary for a prisoner plaintiff to establish that the provider's action or inaction meets the threshold of deliberate indifference.

The challenges here are significant. Many, if not most, prisoner plaintiffs cannot afford to pay an expert witness. Even a plaintiff with sufficient financial resources likely would have difficulty locating and retaining an expert witness. Nevertheless, justice would be better served if the presentation of evidence on the question of deliberate indifference were not completely one-sided. Especially where counsel cannot be located for a prisoner, some means of providing an expert to prisoners with meritorious medical claims—for example, payment of costs, the development of a pro bono panel tantamount to a federal court's pro bono attorney panel—is necessary to ensure that Eighth Amendment medical care obligations are met.

Alternatively, courts examining the claimed inadequacies to determine whether they amount to deliberate indifference could retain their own medical experts. A court-appointed medical professional could play an investigatory role. The medical professional might review records, policies, and standards of care. She also could examine the plaintiff before reporting to the court about the adequacy of care. Such a system would at least ensure independent scrutiny of the provider's actions and representations, even where the prisoner lacks an expert witness.