Equivalency of Care Difficult to Attain in U.S. Prisons

Gregory J. Dober

To cite this article: Gregory J. Dober (2014) Equivalency of Care Difficult to Attain in U.S. Prisons, The American Journal of Bioethics, 14:7, 17-19, DOI: 10.1080/15265161.2014.922370

To link to this article: http://dx.doi.org/10.1080/15265161.2014.922370

Published online: 30 Jun 2014.
CRITICAL ASSESSMENT

Despite its claimed benefits, I think the reconceptualization of health as well-functioning in prison will hit a snag, if not furnished with a further criterion of what counts as well-functioning. Without such a criterion, as I mentioned in the introduction, a prisoner with excessive cholesterol might well be regarded as “well-functioning” in the current unfriendly prison environment and thus denied access to medical care.

This leads to a more fundamental issue with regard to the motivation for reconceptualization. I think that it can be challenged why we should reconceptualize health as well-functioning in prison in the first place. Just because the notion of health, understood traditionally as normal functioning, is an unachievable goal in the current prison context doesn’t mean that it should be reconceptualized so as the goal becomes more achievable. Consider an analogy. The World Congress on Poverty (WCP), an imaginary entity deeply devoted to the eradication of poverty, decides that the goal of eradicating poverty by 2050, as the notion of poverty is currently understood, is practically unachievable. So the group decides that it will reconceptualize the notion of poverty, lowering the poverty line, so that fewer people will remain below it and the group’s task becomes much more achievable. If the readers can detect any irony in this analogy, this is certainly because reconceptualizing the notion of poverty does not really substantially improve the situations of those who originally fall below the poverty line. Likewise, reconceptualizing the notion of health as well-functioning in prison does not really address the health needs of those prisoners whose health is endangered by health risk factors such as excessive cholesterol or obesity.

MY PROPOSAL

For the record, I do not disagree entirely with Jotterand and Wangmo’s proposal to reconceptualize the notion of health as well-functioning in prison. It does help to focus our gaze upon the prisoners themselves in their special circumstances. However, this is not to say that we have to discard the traditional notion of health, which might still serve a functional role in defining what the risk factors are. For instance, excessive cholesterol or obesity certainly poses a threat to the notion of health traditionally understood as normal functioning, for, as is well known, these factors are confirmed to increase the risks of inducing cardiovascular diseases. So my proposal is this. It is well and fine to reconceptualize the notion of health as well-functioning in prison; it does help to develop a medical care program suitable for prisoners’ special circumstances. Yet to prevent undue negligence of prisoners’ health needs, the reconceptualized notion of health has to be supplemented with a clear criterion of “well-functioning.” This idea of “well-functioning” should at least be understood in such a way as to be sensitive to those health risk factors as traditionally conceived in the original conception of health as normal-functioning. By incorporating the idea of sensitivity to health risk factors into the criterion of well-functioning in prison, Jotterand and Wangmo’s proposal to reconceptualize the notion of health, I contend, is made much more plausible, for it will be enabled to reduce the risk of aggravating the negligence of prisoners’ health in an unfriendly environment while enacting a medical care program specifically for the prisoners.

FUNDING

This research is partly funded by NSC 102-2628-H-194-002-MY2.

REFERENCES


Equivalency of Care Difficult to Attain in U.S. Prisons

Gregory J. Dober, Correctional Healthcare Advocate

Jotterand and Wangmo (2014) note that many international guidelines stipulate that the principle of equivalency of care is a minimum standard of care for providing health care to prisoners. They conclude that the principle of equivalency of care cannot be a realistic and achievable goal in prison medicine and that future efforts should...
focus on improving health care delivery in the prison environment.

From a theoretical standpoint, I concur with Jotterand’s and Wangmo’s essay and conclusion. From a pragmatic perspective, their concepts of delivery and outcomes of health care, as it pertains to the equivalency of care standard, are not achievable in the United States for incarcerated individuals. Despite the United States being accountable for approximately 23% of the world’s known incarcerated population (Walmsley 2013), a conceptual framework defining health care and health in prison has neither been consistently defined nor universally applied. The current decentralized judicial and economic policies prohibit attaining an ethical equivalency of care and defining health care norms and values in prisons.

International guidelines and national guidelines in the United Kingdom and Switzerland are more specific in defining equivalency of care in prisons than current guidelines in the United States. As Jotterand and Wangmo (2014) indicate, “In the American context, no principle is explicitly mentioned as the basis for prison medicine.” Unfortunately, in the United States, principles or standards for the care of prisoners are either undefined or vague. Rather than definitive doctrines, declarations, or a legislated definition of prison health care standards, providers in U.S. prisons and jails rely predominantly on case law for guidance regarding delivering minimal and/or adequate care. However, case law is used to generally determine violations of cruel and unusual punishment under the Eighth Amendment of the U.S. Constitution. The courts have been remiss in providing specific direction in defining adequate care or a principle of equivalency of care. Often the cases are brought by inmates to remedy a specific grievance as it relates to constitutionality, rather than to design an overarching health care system for the delivery of adequate healthcare outcomes.

Case law is decided across the United States through various courts and jurisdictions. These case law decisions, via court opinions, can originate at a federal, state, local, or tribal jurisdictional level. A hierarchical relationship exists within and between the various courts. A decision in a specific jurisdiction can be appealed to a higher court in the same jurisdiction. For example, state common pleas court decisions can be appealed to a higher state supreme or superior court. Similarly, the decision of a specific jurisdiction can be appealed to a higher jurisdiction. For example, decisions from state courts can be appealed to the federal courts. As a result of the preceding, case law opinions have not defined what constitutes a universal standard for equivalency of care for delivery in prisons. The consequence of this obscurity, in the court rulings, is inadequate health care in prisons and poor health outcomes for prisoners.

Reviewing various landmark cases and decisions in prison health care does not clarify the specifics needed to adhere to the principle of equivalent care. In the state court decision and affirmed at the federal level, *Newman v. Alabama* (1972), the federal court found that the state does have a constitutional responsibility to provide medical treatment to prisoners. The court ruled: “The quality of medical care afforded inmates of the Alabama Prison System transgressed the interdictions of the cruel and unusual punishment clause of the Eighth Amendment.” In *Newman*, the court specifically limited its role by stating, “While it is not our function to expect or demand alchemy of prison officials, it is our role to ensure that the plight of inmates is not constitutionally forsaken.” A landmark U.S. Supreme Court decision in 1976, *Estelle v. Gamble*, held that deliberate indifference by prison personnel to a prisoner’s serious injury or illness constitutes cruel and unusual punishment under the Constitution. Confusion on what may constitute adequate care was perpetuated in the court’s opinion: “Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.” The court opined that inmate Estelle was a victim of malpractice rather than of deliberate indifference resulting in cruel and unusual punishment and that malpractice can be settled in a civil (state jurisdiction) damage suit. The court did not define adequate care or equivalency of care and ruled that malpractice care is not unconstitutional. Employing this opinion, one could construe that the court implicitly applied a malpractice criterion as meeting a “minimum and adequate” standard for health care in prisons. However, it is unlikely that a society would endorse malpractice-type standards as a “gold standard” for ethical health care delivery for all its general population. Rather than define the standards in the court’s opinion, *Estelle* suggested five varying sources from which standards might be sought. These sources were varied and ranged from the National Sheriffs Association to the United Nations. It should be noted that these sources are not recognized as mandated standards for the ethical delivery of health care to prisoners.

In a 2009 landmark case, *Plata v. Schwarzenegger*, the California state court noted: “For years the medical and mental health care provided by California’s prisons has fallen short of minimum constitutional requirements and has failed to meet prisoners’ basic health needs.” As in *Estelle* and *Newman*, the court in *Plata* agreed that inadequate health care delivery could violate the Eighth Amendment of the U.S. Constitution. *Plata* reiterated that inmates should receive “minimal and adequate care.” However, the court’s remedy was to reduce health care delivery chaos through the release of prisoners from the overcrowded facilities into the general population. Similar to *Estelle* and *Newman*, *Plata* did not define the type of or specific care necessary to comply with adequate care or an equivalency of care standard.

Jotterand and Wangmo (2014) indicate, “Hence, when the state imprisons convicted offenders it takes on the responsibility of their care, well-being, and medical treatment” (4). In the United States, as in other Western countries, the state has the responsibility and oversight of
caring for prisoners. However, it is not always the state that operates the prison or delivers health care services to inmates. The structure of prison oversight, facility management, and health care management is highly fragmented and diverse within the U.S. correctional system. The decentralized organizational structure of incarceration in the United States makes it challenging to integrate the principle of equivalence of care within the delivery of health care to prisoners. First, the oversight of corrections facilities is within the federal, state, local, or tribal jurisdictions. These various jurisdictions have separate and distinct legislation, regulations, and case law. Second, though the responsibility for the incarceration of inmates is the responsibility of each state, the state can choose to either manage the prison operations or delegate the responsibility through contracts to private for-profit prison operators. Currently, some for-profit-sector prison operators are listed on the U.S. capital market exchanges, primarily the New York Stock Exchange. Lastly, the delivery of health care to inmates is a separate function in prison and is often distinct from the primary management or oversight of the facility. For example, the state may be responsible for oversight, a private for-profit company responsible for facility operations and security, and another private for-profit operator, contracted by the state or facility operator, responsible for health care services. As with prison operators, some of these health care providers are listed on U.S. capital markets exchanges. Without a government legislative definition of equivalent care, for-profit private health care providers can produce profitability by decreasing delivery costs, sometimes by withholding adequate health care services to inmates, leading to poor health outcomes for prisoners (Dober 2014).

The authors indicate that a new perspective is needed to improve health care in prisons. They remark that primary care must be tailored specifically to the needs of inmates in the prison environment (Jotterand and Wangmo 2014). My concern is that a fair determination of a prisoners’ needs, norms, values, and notions of health in prison may not be justly applied. For example, the Centers for Disease Control and Prevention (CDC) indicates that one out of three individuals incarcerated in the United States is positive for hepatitis C (CDC 2013). Despite hepatitis C being a prevalent disease in prison, prisoners are routinely denied the expensive hepatitis C virus (HCV) treatments. Many departments of correction consider the inmate’s sentencing term and parole eligibility before considering administration of the treatments. In Pennsylvania, during 2013, a prisoner filed a class action suit because he and others similar to him were denied treatments despite having prison sentences up to 3 years. The prisoner was offered HCV treatments in exchange for waiving his annual parole hearings (Dober 2013). Also, in Colorado, the Department of Corrections (DOC) HCV treatment policy states that an inmate will not be treated for HCV if the inmate’s sentence is less than 24 months (Colorado DOC 2002). This policy does not consider the length of the specific HCV treatment. For example, treatments can range from 24 to 48 weeks based upon the specific HCV genotype. Conversely, a newly diagnosed diabetic prisoner is treated without consideration of sentencing term, even if the chances of noncompliance are high after his or her release. In addition, mortality tables, to determine the odds of completion, are not used by oncologists to determine whether chemotherapy should be started for patients in the general population of society. Therefore, if Jotterand and Wangmo’s (2014) new perspective on tailoring specific health care needs to inmates is to be successful, a fair determination and just application of these needs must be consistently applied.

REFERENCES


