A LEGAL ANALYSIS OF HEALTH CARE FOR INCARCERATED WOMEN IN THE UNITED STATES

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ABSTRACT

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While decarceration has become fashionable, American penology remains in the throes of a penal harm movement, which posits that offenders should receive harsh punishment to deter them and others from future offending. Penal harm aims to enhance offenders' punishment during their incarceration by making conditions in jails and prisons as painful and difficult as possible. Penal harm practices include, limiting inmates' access to basic comforts such as coffee and tasty food, enhancing humiliations through chain gangs and wearing pink uniforms, and not supplying adequate health care. Given that the majority of incarcerated persons will eventually return to society, correctional health care plays an important role in public and community health. Inmates are the only population in the United States who are guaranteed a right to health care, which is important considering their health is poorer than the general population because they often do not have resources to receive medical treatment in the free-world. Research suggests, however, that the penal harm perspective influences correctional health care practices, lowering the quality of care inmates receive while incarcerated.

As the population of incarcerated women rises in the United States, researchers are focusing on how correctional facilities meet their gendered needs and challenges. Female inmates have poorer overall health compared to male inmates and unique health problems, such as the need for reproductive health services, pregnancy-related needs, and menstrual hygiene concerns. Furthermore, incarcerated women have historically received lower quality health care and limited resources compared to their male counterparts,

which limits their ability to seek treatment and to petition for legal remedies when that treatment is inadequate. The purpose of this thesis is to provide a legal discussion on the availability and quality of health services for women incarcerated in the United States to determine how penal harm influences the care they receive. This thesis uses a qualitative, inductive, doctrinal methodology to analyze United States Court of Appeals and United States District Court lawsuits brought by female offenders pursuant to Title 42 U.S.C. Section 1983, claiming violations of their Eighth Amendment rights to be free from cruel and unusual punishment.

KEY WORDS: Female offender, Incarcerated women, Correctional health care for women, Prison medical care for women, Women's health, Eighth Amendment, Deliberate indifference, Section 1983, Penal harm medicine

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CHAPTER I

The Incarceration of Women in the United States

Introduction

Although the population of incarcerated males declined from 2009 to 2017, female incarceration rates continue to rise (Carson, 2018). From 2015 to 2016, the number of women sentenced to more than one-year in federal prison alone increased by 700 women (Carson, 2018). Twenty-six states also saw a significant increase in the amount of women they incarcerated in 2016 (Carson, 2018). Due to this growth of the female offender population, criminal justice researchers, professionals, and advocates are paying more attention to incarcerated women's unique needs and challenges. Central to the conversation on caring for female offenders is ensuring they have access to adequate health care services and resources while they are incarcerated.

Prior research shows female offenders have poorer health than women in the general population and do not always have the means to seek treatment on their own (Richie, 2001). This is because a vast majority of female offenders are underprivileged women of color who come from disadvantaged communities (National Academy of Sciences, 2014); therefore, they often do not have access to health care services in the free world. Consequently, women typically enter incarceration with high rates of communicable diseases, reproductive health issues, chronic health problems, substance abuse, and mental illness that usually stems from histories of trauma and victimization (Covington & Bloom, 2003). Unfortunately, some studies suggest that incarceration might actually make these problems worse (Alves, Maia, & Teixeira, 2016) because women's correctional facilities, and resources for female offenders' in general, are

typically underfunded and underserved (Clarke et al., 2006). Since incarceration has traditionally been male-focused, correctional facilities are still learning how to handle the gendered risks, needs, and challenges that come with the female offender population boom. This means that correctional facilities often do not have the necessary resources, training, or experience to properly care for female offenders.

There is little research concerning the accessibility and quality of medical care in women's correctional facilities. The lack of research in this area is partially due to concerns of trust between correctional facilities and academic researchers and ancillary privacy issues surrounding medical information. To overcome these issues, some researchers bypass working with correctional facilities and instead examine court litigation and case law (Nolasco & Vaughn, 2020; Vaughn & Carroll, 1998). This thesis analyzes how correctional facilities meet incarcerated women's health needs through the lens of court decisions, injunctions, and settlements by organizing cases brought by female offenders who have filed medical complaints.

Literature Review

From the early criminalization of female offending to the construction of the first female correctional facilities, women who break the law have been afterthoughts at best, discriminatorily treated at worst (Chesney-Lind, 1989). Until the rise of the feminist movement and the introduction of feminist criminology in the 1970s, criminological theory did not place female offenders at the focus of their studies, and if they did, it was through a sexist lens (Smart, 1977; Chesney-Lind & Morash, 2013). Infamously, Lombrosian perspectives explained female criminality using biological determinism and cultural expectations of femininity (Lombroso & Ferrero, 1895). These perspectives were

built on the belief that female criminals were biologically flawed because their criminality contradicted a woman's natural aversion to crime (Smart, 1977). Early theorists argued that female offenders lacked maternal instincts, compassion, and passivity that were deemed essential to the female character, leading to the belief that women who commit crime are hardly women at all (Smart, 1977).

These antiquated beliefs influenced studies about female offenders until the 1980s and "retarded the development of the field [, especially in its understanding of crime committed by women,] by almost half a century" (Shoham, 1974 as cited in Smart, 1977, p. 92). Mainly, Lombroso's theories influenced research linking criminality to hormones and claims that men's higher levels of testosterone, and women's lack thereof, is to blame for the gendered difference in criminal behavior. In the 1960s, for example, researchers still argued that "the female mode of personality, more timid, more lacking in enterprise, may guard her against delinquency" (Cowie, Cowie, & Slater, 1968 as cited in Smart, 1977, p. 92).

Researchers have also blamed women's crimes on their menstrual cycles (Dalton, 1961). Moreover, some argue that women's ability to conceal their sexual arousal suggests they are deceitful in nature and would therefore be able to conceal their criminality. This latter view comes from Otto Pollak's (1950) work, which perpetuates the belief that women are manipulative and use gender stereotypes to their advantage to avoid being caught for heinous crimes. He further explains men's higher crime rates by arguing that women trick men into committing crimes using their feminine wiles, insinuating that women are the root cause of crime and the deterioration of societal values

and safety. These studies work to vilify female offenders and assume that crimes committed by women are a product of uncontrollable biology or inherent deviance.

These early failures to understand women's criminality is reflected in both formative and contemporary penologists' and corrections officials' treatment of female offenders. Before the 1820s, and even presently, female inmates were hardly treated differently from male inmates. In fact, in the late 18th century, prisoners of all ages and sexes were commonly held together in one large room (Rafter, 1983). This was likely influenced by the masculinization of female offenders and the emphasis on their lack of femininity. In her seminal work on the histories of women's penal institutions in America, Nicole Rafter (1990) identifies three steps of segregation of men and women in correctional facilities. The first step was to house women in separate rooms from the men. While this was a positive step to protect women from male inmates, female prisoners were often crammed into small rooms that were distant from the rest of the unit, effectively placing them out of sight and out of mind. Unlike male inmates, who left their cells to eat, work, and exercise, female inmates had their meals delivered to their cells, where they sat idle for the entirety of their prison sentence (Rafter, 1990). While they did not endure the same grueling physical labor or severe punishment as the men, they were forced to exist on the margins with no supervision, medical care, access to programming or other resources, or protection (Rafter, 1990).

The next step in segregating the sexes came in the form of placing women in their own individual cells. While this had advantages, such as reducing the overcrowding and improving hygienic conditions, increasing privacy, and providing safety from other inmates, there were also disadvantages, including stricter discipline, higher security, and

women being subjected to the intense regimen of harsh labor and forced silence as male inmates (Rafter, 1983). The change in treatment after switching to a single-cell model was also gendered. While the care women received was more equitable to men under this model, they were not receiving the same access to health care, religious services, or educational resources (Rafter, 1983). Additionally, women's separation from men was not, as some would like to believe, a decision made on behalf of female inmates. Instead, this separation came from the belief that female offenders were more depraved than male offenders and thus needed to be punished more harshly. This isolation, therefore, is a product of the "special disdain for—and even horror of—the female criminal" (Rafter, 1983, p. 138). The inferior care female prisoners received illustrates the societal belief that women who committed crime were more culpable and less deserving of humane treatment than men who committed the same crimes.

During this time, societal attitudes toward women proved highly influential in how they were punished. Until very recently, and some may argue this continues today, traditional gender norms dictated that women must be "pious, pure, and submissive" (Feinman, 1983, p. 13). These norms were less important for the woman herself than they were to societal hierarchy and other people's comfort. For example, in post-revolutionary America, a time of great socioeconomic change and uncertainty, women were considered the "guardian[s] of American morality, purity, goodness, nobility, and social stability" (Feinman, 1983, p. 13). The roles of wife and mother were symbolic of stability in a rapidly changing world; therefore, women who committed crimes, especially adultery or anything of a sexual nature, were seen as a threat to the social order.

Stated another way, women were not just punished for being criminals, but for defying what it meant to be a woman. This phenomenon is known today as "double deviance," which suggests that women are punished twice: once for breaking the law and again for breaking societal expectations of women (Bickle & Peterson, 1991). Some researchers have found that women receive more lenient sentences compared to men who commit similar crimes, especially in circumstances of sexual assault and intimate partner violence, stemming from their perceived vulnerability and weakness (Allen, 2010; Hodell, Wasarhaley, Lynch, & Golding, 2014; Pozzulo, Dempsey, & Maeder, 2009). Other studies have found, however, that not all women receive that same leniency (Herzog & Oreg, 2008; Wasarhaley, Lynch, Golding, & Renzetti, 2017). To explain the difference, researchers introduced a "selective chivalry" hypothesis, which posits that only women who adhere to traditional feminine gender roles benefit from chivalrous sentences and court outcomes (Farnworth & Teske, 1995). Double deviance and selective chivalry exemplify the ways the modern criminal justice system enforces gender roles and norms and attempts to control women's behaviors. Studies have found that young girls, for example, are referred to court and arrested for status offenses at higher rates than young boys (Chesney-Lind & Shelden, 2014), including behaviors such as "incorrigibility" or "waywardness" and being "a person in need of supervision" (Chesney-Lind, 1977, p. 121). Running away from home and staying out past curfew makes-up nearly a quarter of arrest rates for young girls, while these offenses count for less than 10% for boys (Chesney-Lind & Shelden, 2014). Girls are also four times more likely to be sent to a correctional facility for status offenses (Chesney-Lind & Shelden, 2014).

Thus, evidence suggests that the punishment of women is used not merely as a means to correct their criminal behavior, but also to discipline them for not conforming to gendered expectations. This is historically represented in the formation of reformatories at the end of the 19th century. Initially, female offenders, and especially female offenders of color, were thought to be incapable and unworthy of reform or rehabilitation (Rafter, 1990). This is why women convicted of crimes were kept in older penitentiaries even after male offenders were transferred to newly constructed facilities. In fact, it would take two decades after the construction of the Auburn State Prison for incarcerated women to enter the third stage of separation—moving from men's penitentiaries into the Mount Pleasant Female Prison, the first facility built specifically for female prisoners (Rafter, 1990). Mount Pleasant, while not operating from a reformatory model, was the first deviation towards gender-responsive care. It was built with a nursery and housing for matrons (female caretakers to watch over the offenders) and placed an emphasis on reform-minded practices including education, positivity, and sympathy (Rafter, 1990). The building's poor construction and New York state's apathy towards female offenders, however, did not allow for remodeling or adding cell space, which was desperately needed after a short time. Overcrowding eventually led to such poor conditions that the facility closed, and its entire female population was relocated to county penitentiaries, where New York held their female inmates for more than a decade (Rafter, 1990).

Shortly after the close of Mount Pleasant, a women's reformatory movement started to take shape. This reformation was led by white middle-class women who believed female offenders were capable of rehabilitation, but it needed to be feminized. The first objective for these reformers, driven primarily by the discovery that incarcerated

women were often sexually exploited, was to ensure that female inmates were housed in their own separate institutions (Britton, 2003). Reformers also sought to provide differential treatment to female offenders based on their gendered needs and employ other women within the facilities to control and manage the inmates (Freedman, 1981). While the idea of differential and gender-based treatment is a good one, their execution was, in hindsight, misguided and problematic. As mentioned, the leaders of this reform movement were white middle-class women. Consequently, the reform efforts were shaped by their views, which reflected the traditional, highly gendered societal norms that led to the gross neglect and mistreatment of female offenders in the first place. Reformers believed that women who committed crimes needed to return to their feminine roots and were rehabilitated to behave in the expected ladylike fashion. These rehabilitative efforts took the form of domestic training, so women could assimilate into a domestic role upon release.

The majority of women in reformatories were convicted of moral offenses, such as promiscuity, waywardness, idleness, disorderly conduct, and vagrancy, none of which were considered crimes for men (Britton, 2003). These laws were part of specific violations that were labeled as sexual misconduct but had little, if anything at all, to do with prostitution or sexual acts. For example, women could be arrested under sexual misconduct for premarital pregnancies and associating with other men besides her husband (Rafter, 1990). In fact, it was sometimes the woman's own husband who reported her behavior and could have her committed for anything from adultery to merely befriending other men (Rafter, 1990). Rafter (1990) argues that these violations worked to repress women's sexuality and were employed by the criminal justice system to

promote a double standard between the sexes. Therefore, these reformatories, while representing more of a rehabilitative method than penitentiaries, also "widened the net of social control over the lives of working-class women," creating an institutionalized method of "enforcing chastity and inculcat[ing] the values of white middle-class femininity" (Britton, 2003, pp. 40-41).

After reviewing these early responses to female offending and institutions used to house female offenders, researchers can easily draw a line to the type of treatment incarcerated women receive today. Presently, the criminal justice system remains preoccupied with controlling women's bodies and sexuality through its enforcement of traditional gender roles (Chesney-Lind & Shelden, 2014; Chesney-Lind, 1977). Additionally, some corrections officials' attitudes toward female offenders echo early sentiments that they are more difficult than male offenders, do not deserve differential treatment, and that they are failed women because they lack maternal instincts and other stereotypical feminine traits (McCorkel, 2003). Furthermore, today's female offenders do not have equal access to the same resources as men, most notably for education and job training (Lahm, 2000; Morash, Haarr, & Rucker, 1994; Tonkin, Dickie, Alemagno, & Grove, 2004). Following the example of early reformatories, most contemporary vocational training opportunities for incarcerated women are geared toward domestic work or low-paying, entry-level jobs (Morash et al., 1994). For example, in a report released by the Texas Criminal Justice Coalition (TCJC), women incarcerated in Texas only have the opportunity to earn an associate's degree, while incarcerated men can earn up to a master's degree. Men also have access to 27 additional education courses than women (Linder, 2018b). In terms of vocational training, women can earn a certification

in office administration or culinary arts/hospitality management, whereas men have access to 21 different certifications, including those for physical labor, technological work, and substance abuse counseling (Linder, 2018a).

In recent years, scholars and advocates have promoted the need for parity in the treatment of incarcerated individuals, meaning that correctional facilities should not discriminate on the basis of gender and recognize that men and women have different needs and challenges that must be considered separately. Incarcerated women have unique, gendered needs that require gender-responsive approaches to programming, care, and resources (Bloom, Owen, & Covington, 2003; Holtfreter & Morash, 2003). For example, female offenders are more likely than males to be the primary caregiver of minors (Mumola, 2000). Thus, incarcerated women need more access to parenting programs, have additional worries upon release related to childcare, and experience added pains of imprisonment from separation and poor communication with their children and families (Morash & Schram, 2002; Richie, 2001). Combined with high rates of poverty and limited access to well-paying jobs, the added pressure to care for their children increases female offenders' strain and may push them to rely on illegitimate forms of work (Richie, 2001).

Researchers have identified that incarcerated women's experiences with victimization, substance abuse, and health problems differ from incarcerated mens' experiences in that they "are not typically seen among men, are typically seen among men but occur at a greater frequency among women, or occur in equal frequency among men and women but affect women in uniquely personal and social ways" (Wright, Van Voorhis, Salisbury, & Bauman, 2012, p. 1615). Because many female offenders are

victimized before they are incarcerated, they have high rates of trauma-related mental health disorders as well as other mental health concerns, such as anxiety and depression (Belknap & Holsinger, 2006; Bloom et al., 2003). To avoid revictimization, researchers and advocates have called for implementing practices in female facilities that prioritize trauma-informed officer training and therapy over traditional security concerns (Covington & Bloom, 2003; Wright et al., 2012). Women's substance abuse may also be more directly linked to their past trauma and victimization, meaning substance abuse programs for female offenders need to address addiction itself and help women cope with the events that led to it (Covington, 2008).

One of the most pressing areas in need of parity and reform is incarcerated women's health care. Female offenders suffer from high rates of many of the same conditions as male offenders, including HIV/AIDS, respiratory illnesses, chronic illnesses, hepatitis, sexually transmitted diseases, and diabetes (Greifinger, 2007). Some studies, however, suggest that female inmates have poorer health than male inmates overall (Balis, 2007). For example, incarcerated women are 15 times more likely to be infected with HIV than women in the general population (De Groot & Cu Uvin, 2005). They are also more likely to have HIV than incarcerated men, as women are typically incarcerated for offenses that increase their risk of contracting HIV, such as drug use or sex work (De Groot & Cu Uvin, 2005). Black women specifically are the fastest growing group who test positive for HIV (Langston, 2003), and considering they also make up the majority of the female offender population, this trend has severe implications for women's health in correctional facilities.

Incarcerated women also have added concerns associated with reproductive health. Reproductive health issues disproportionately affect female offenders, possibly due to their high-risk lifestyle and limited access to preventative health care (Proca, Rofagha, & Keyhani-Rofagha, 2006). Specifically, research has found that female offenders have higher rates of abnormal PAP smears and cervical cancer than the general population (Springer, 2010). Because incarcerated women are socially disenfranchised and generally have low accessibility to routine reproductive health checkups, providing these services during their incarceration may be the only way many women will be able to receive them. The Bureau of Prisons (BOP) recommends that all female offenders receive a PAP smear on intake into prison, and nonviolent offenders should receive a mammogram every two years (Nijhawan, Salloway, Nunn, Poshkus, & Clarke, 2010). While some studies have found that most women in their sample received a PAP smear during their incarceration (Binswanger, White, Perez-Stable, Goldenson, & Tulsky, 2005; Nijhawan et al., 2010), others have had trouble with follow-up procedures and treatment options (Clarke et al., 2006; Magee, Hult, Turalba, & McMillan, 2005; Martin, Hynes, Hatcher, & Coleman, 2016; Walsh, 2016). Even if women are aware of a reproductive health issue, in some facilities, they may not be informed on or given the treatments they need (Magee et al., 2005).

Providing reproductive health care services to incarcerated women should be handled carefully considering the high rates of domestic and sexual victimization among female offenders (Knittel, Ti, Schear, & Comfort, 2017). Depending on how health care professionals perform the examination, women may be retraumatized by the procedure. In the few studies that survey female offenders on their experiences during health

procedures, participants generally describe their treatment negatively. One study conducted on the quality of PAP smears in a California state prison found that health care providers were too rough during procedures, which caused unnecessary pain and discomfort, did not provide privacy during treatment, and used unhygienic tools (Magee et al., 2005). Participants also reported that health care providers were generally unresponsive to questions or concerns, and they typically did not provide proper follow-up treatment options or recommendations.

Despite growing efforts to improve menstruation equity in prisons and jails, studies show that the quality and accessibility of menstrual hygiene products in correctional facilities also needs improvement (Crawford, Johnson, Karin, Strausfeld, & Waldman, 2020; Goodman, Dawson, & Burlingame, 2016; Kraft-Stolar, 2015). Many states provide free sanitary pads to female offenders, but surveys reveal that these pads are of such poor quality that women need to change them as often as every 30 minutes, which means they will likely need additional products before the end of their cycle (Missouri Appleseed, 2018). This is problematic because additional pads and tampons are rarely provided for free and are often unaffordable to the typical offender (Shaw, 2019). Most incarcerated women are not paid for their labor, and if they are, they need to ration their earnings for food, communication, and medical needs. Therefore, it is not uncommon for women to be forced to choose between staying clean during their period and making a phone call to their families.

Given the high prevalence of reproductive health issues among incarcerated women, it is not surprising that menstrual dysfunction is also a common problem (Allsworth, Clarke, Peipert, Herbert, Cooper, & Boardman, 2007). Incarcerated women

who suffer from conditions that give them heavier periods, more frequent periods, or severe pain and pre-menstrual syndrome (PMS) symptoms struggle to stay clean, healthy, and comfortable during their cycles. Insufficient access to hygiene products exacerbates this struggle and can lead to a number of serious health problems, including urinary tract infections, bacterial infections, and toxic shock syndrome (Shaw, 2019).

In addition to inadequate access to menstrual hygiene products creating concerns about hygiene, it also adds to the dehumanization of incarceration. One study found that around 90% of female offenders in their sample reported bleeding through their clothing, onto their bed sheets, or onto the floor (Missouri Appleseed, 2018). Without proper hygiene products, incarcerated women handmake products that increase their risk of infections (Missouri Appleseed, 2018). Additionally, female offenders often must ask correctional officers for hygiene products (Sufrin, Kolbi-Molinas, & Roth, 2015). Requesting products from correctional officers, who are typically male, is not only embarrassing, but can be degrading if the officer mocks, delays, or refuses the offender's request (Goodman et al., 2016).

Chesney-Lind and Pollock-Burne (1995) suggest that women's corrections has entered into an equality with a vengeance era, marked by female offenders suffering under policies written as gender neutral. The policies that receive the most criticism for disproportionately affecting and criminalizing women are the tough-on-crime tactics that began in the late 1970s that led to the war on drugs and mass incarceration (Bloom & Chesney-Lind, 2003). During the war on drugs, mandatory minimum sentences were created with the intention of punishing those who traffic and sell drugs in high quantities; however, laws widened the scope of who could be sentenced, targeting street dealers,

those in possession of small quantities, and users (Franklin, 2008). According to Bush-Baskette (2000), this led to an increase of women sentenced to drug offenses by 433%, compared to a 283% increase for men. Poor women of color have been disproportionately affected. Not only were they incarcerated at higher rates than white women, they also endured significant disenfranchisement and community degradation as a result of the war on drugs targeting poor black men, leaving black women behind to care for children and to pick-up the pieces (Bloom & Chesney-Lind, 2003).

Equality with a vengeance can also be seen procedurally in correctional facilities when correctional officers and staff treat women the same as incarcerated men, despite research that repeatedly shows each have different needs. For example, using strict, military-style discipline on female offenders is not only ineffective, but also retraumatizes victimized women and regresses their rehabilitation (McCorkel, 2003). Chesney-Lind (2006) refers to the correctional process of "treating women offenders as though they were men…in the name of equal justice" (p. 18) as vengeful equity. As an example, she refers to the process of shackling female inmates while they give birth. While it is clear from both a medical and commonsense standpoint that restraining a woman's movement in anyway during labor is uncomfortable and life-threatening to both mother and child, shackling at the time of labor has, until recently, been viewed as a necessary security measure. This is because male prisoners commonly use hospital visits as escape opportunities, and corrections officials assume female offenders will do the same (Chesney-Lind, 2006). This, along with other male-orientated practices, such as boot camps, chain gangs, strip searchers, and cross-gender supervision (Chesney-Lind, 2006), are examples of gender neutral procedures that are used on incarcerated women

not because they are applicable, but because they allow correctional facilities to present themselves as gender neutral.

The era of mass incarceration generated an unprecedented amount of imprisonment that drastically changed the landscape of the United States' correctional system (Alexander, 2012). By the 1990s, the criminal justice system entered into a "'mean season' in which it [became] politically correct to build prisons and devise creative strategies to make offenders suffer" (Cullen, 1995, p. 340). This emphasis of punishment over rehabilitation, vengeance over mercy, and increased punitiveness is known as the penal harm perspective, coined by scholar Todd R. Clear (1994). Clear defines penal harm as a "planned governmental act, whereby a citizen is harmed, and implies that harm is justifiable precisely because it is an offender who is suffering" (p. 4). Harsh legislation, such as three-strikes laws, mandatory minimums, and felon disenfranchisement; demeaning punishments like chain gangs, increased supervision and community control; infliction of pain through draconian conditions of confinement; and the formation of supermax prisons are all indicators that the correctional system has been undergoing a penal harm movement for the past three decades (Christie, 2007; Listwan, Jonson, Cullen, & Latessa, 2008). Moreover, the penal harm movement is reflected in a "no frills approach toward prison and jail amenities" as well as "increasingly harsh conditions of confinement and intentional shaming tactics" (Griffin, 2006, p. 210).

While prison conditions have never been comfortable, contemporary policies seem to revolve around control and limiting inmates' autonomy, restricting everyday luxuries like television access and coffee, limiting telephone calls or writing letters, and creating minimal standards for food quality, medical care, and environmental conditions

(Griffin, 2006). For example, 75 prison units in Texas, where temperatures can surpass 100 degrees in the summer, do not have air conditioning units (McCullough, 2019). Texas prison officials are currently resisting a federal court order to cool down inmates' living spaces, citing a billion-dollar expense (McCullough, 2019).

The penal harm perspective is clearly represented in correctional medical care, which is purposefully set at a lower standard of care than that for citizens in the free-world (Maeve & Vaughn, 2001; Vaughn & Carroll, 1998; Vaughn & Smith, 1999). Specifically, the passing of legislation aimed at limiting inmates' ability to file medical care lawsuits (Belbot, 2004), implementing fee-based copayment plans (Fisher & Hatton, 2010), and prioritizing security and custody over inmate health all represent penal harm medical practices (Vaughn & Carroll, 1998). In an article on penal harm medicine practices, Vaughn and Smith (1999) revealed that medical personnel used inmates' medical conditions to degrade and humiliate them. While the National Commission on Correctional Health Care (NCCHC) sets standards for confidentiality around health records and mandates that sensitive medical information must not be shared unless to "preserve the health and safety of the inmate, other inmates, or the correctional staff" (Vaughn & Smith, 1999, p. 194), some correctional medical professionals do not maintain confidentially with their patients, which opens the possibility for medical conditions to be made public and potentially used against an inmate. Vaughn and Smith reported that medical officials "disclosed prisoners' HIV-positive/AIDS status to everyone in the facility" (p. 194), which left them vulnerable to discriminatory treatment, stigmatization, and even physical or verbal attacks. Along with humiliation, medical personnel withheld medical care from HIV-positive prisoners. This finding has severe

implications for female offenders, who, as previously established, are diagnosed with high rates of various types of sexually transmitted and communicable diseases, including HIV/AIDS.

Vaughn and Smith (1999) also reported several examples of penal harm medical care and humiliation tactics specific to female offenders. There were several instances where women who experienced pregnancy complications, one of whom even miscarried, received delayed treatment and were met with crass, apathetic attitudes. One pregnant inmate received no treatment for symptoms she believed to be caused from chlamydia. She suffered from heavy discharge that had a strong odor, cramps, and headaches. Despite suffering from these symptoms for two months, the jail physician refused to see the prisoner, even after continuous begging. According to Vaughn and Smith (1999), forcing inmates to beg for medical care is designed to break prisoners' spirits and reinforces their helplessness and dependence on the system.

There are very few studies that examine the specific ways in which penal harm medicine negatively impacts female offenders. However, from the research on medical practices within female correctional facilities, there are clear patterns of apathy and neglect. While these studies show that incarcerated women are in need of improved medical services, it is difficult to fully assess the extent to which those improvements are really needed. This is because it can be challenging to receive full cooperation from correctional facilities to conduct research on their medical practices and procedures and even more difficult to survey inmates directly. Prior studies (Vaughn, 1999; Vaughn & Carroll, 1998; Vaughn & Smith, 1999) have avoided this problem by analyzing lawsuits filed by offenders who claim violations to their legal rights to medical care. This thesis

follows this area of inquiry to gain more insight into the quality and accessibility of health care services for female offenders in the United States.

Legal research can illuminate the responses to and provision of female inmates' medical needs in several ways. First, case law provides a unique lens into a closed and insular world. This is because case facts include detailed descriptions of events that would likely not surface in survey research. The nature of the litigation, which is to pursue violations of federally guaranteed rights under the Eighth Amendment, also offers an understanding of when, why, and how incarcerated women feel their rights have been violated. By analyzing courts' decisions, this thesis provides a discussion on how the legal system supports or hinders female offenders' access to adequate health care services. Furthermore, using cases from a variety of courts in multiple states across a broad timeline helps to understand how incarcerated women's medical needs are being and have been handled across the country, not just in one state or unit at one given time.

This thesis consists of five chapters. The first and current chapter provides an introduction and review of literature on incarcerated women's unique experiences in the United States. Chapter two describes the goals of the current study, explains the standard of deliberate indifference and how it applies to correctional medical care, explains doctrinal methodology, and includes basic descriptions of the court cases this thesis will analyze. These cases will be organized into themes and discussed in chapter three, which will also provide a short summary for each theme. An in-depth discussion on how these cases and their themes fit within contemporary correctional policy will be provided in chapter four, along with recommendations for improvement. Chapter five will conclude thesis.

CHAPTER II

The Current Study

The type and quality of medical care that correctional facilities must provide to prisoners originates from the U.S. Supreme Court's decision in *Estelle v. Gamble* (1976). The facts show that J.W. Gamble, a Texas inmate, injured his back during a work assignment. He did not believe he received proper medical care for the injury, which led to a Title 42 United States Code Section 1983 lawsuit (hereafter, Section 1983). A prison medical professional diagnosed Gamble with lower back strain, prescribed him pain relievers and muscle relaxers, and ordered that he be moved to a lower bunk bed. Prison authorities expected Gamble to return to his work duties before he believed he was ready to do so. When Gamble refused these duties because of pain, he was disciplined and placed into administrative segregation. While in administrative segregation, Gamble began experiencing pain in his chest, left arm, and back, and requested to see a doctor. When the correctional officers refused, Gamble filed a Section 1983 lawsuit against the officers and up the chain of command to the Director of the Texas Department of Corrections, W.J. Estelle, Jr., claiming his Eighth Amendment rights were violated.

The United States Supreme Court held that the officers did not cause "unnecessary and wanton infliction of pain" (*Estelle v. Gamble,* 1976, p. 103). In other words, though Gamble believed he was provided substandard care, state officials were not liable since under Section 1983. Conversely, the Court held that to have an actionable claim, the medical care provided must be deliberately indifferent to the inmate's serious medical needs. The care Gamble received might have been medical negligence or malpractice, but those standards do not rise to the culpability required to invoke a

constitutional violation; the standard of review that governs prison medical litigation under Section 1983 is deliberate indifference. The Court recognized that, because inmates are reliant on the prison system to care for their basic needs, the government has an obligation to provide medical care to incarcerated populations. If correctional facilities do not provide that care, they are directly causing undue suffering and wanton infliction of pain. The Court likened denying medical care to torture, as it prolongs pain and discomfort and, in extreme cases, can lead to death. Therefore, when correctional and/or medical staff are deliberately indifferent to offenders' serious medical needs, they are violating the Eighth Amendment's prohibition against cruel and unusual punishment.

Estelle v. Gamble had a big impact on correctional practices (Wright, 2008). Ironically, *Estelle* mandated that the only persons in the United States who are guaranteed medical care are those who are incarcerated. Because of *Gamble,* inmates can now seek relief for care that is deliberately indifferent to their serious medical needs, which holds correctional health care providers accountable in how they treat and care for inmates. Furthermore, *Estelle* brought changes to prison budgets, insomuch as medical care now is one of the largest parts of prisons' budgets (McKillop, 2017).

Incarcerated individuals typically sue correctional officers and other correctional staff members under Title 42 of the United States Code Section 1983 (42 USCA § 1983). This remedy for deprivation of rights grants all people in the jurisdiction of the United States, inmates included, the right to sue local and state government employees, municipalities, and counties who are acting under color of the law for violating their federally guaranteed rights. Acting under color of law refers to acts that are conducted by a state or local official who is acting under the authority granted to him or her by the

government, whether or not they adhere to the law (United States Department of Justice [DOJ], 2015; Vaughn & Coomes, 1995). If an official violates an individual's federal rights while acting under the authority granted to them by the state, it does not matter if the acts are "done while the official is purporting to or pretending to act in the performance of his/her duties" (DOJ, 2015, para. 2). Section 1983 lawsuits are litigated by incarcerated populations because they allow plaintiffs to apply "legal norms developed with regard to the conduct of public institutions and officials into the private sphere" (Beermann, 2004, p. 10). In other words, Section 1983 claimants can bring lawsuits against prison health care providers, doctors, officers, administrators, as well as other correctional staff, which would not be possible to do under general malpractice claims (Beermann, 2004).

Methodology

This thesis uses inductive, grounded theory, doctrinal methods to analyze how lower courts have interpreted the standard of deliberate indifference in medical care cases for incarcerated women in the United States. Inductive and qualitative in nature, doctrinal research is similar to grounded theory in that themes are created by analyzing multiple judicial opinions (Nolasco, Vaughn, & del Carmen, 2010). As in grounded theory, themes are generated based on commonalities within litigation, such as the details of a plaintiff's complaints, the facts of the case, what party prevails, or judicial reasoning. These themes are the product of observable patterns in litigation that deepen understanding of how Supreme Court standards are applied in lower cases. These patterns also provide insight into how particular cases can alter legal doctrine. After themes are created, cases are grouped into a legal framework that creates the structural organization

of the thesis. This framework becomes a principle around which courts apply legal doctrine to specific legal issues (Nolasco, del Carmen, Steinmetz, Vaughn, & Spaic, 2015).

As a form of qualitative research, doctrinal research is beneficial in exploring areas of interest that are underdeveloped or difficult to access through quantitative methods. Because doctrinal research revolves around analyzing court application of legal precedent in multiple decisions, it also applies grounded theory, which provides "a valuable set of procedures for thinking theoretically about textual materials" (LaRossa, 2005, p. 838). In other words, doctrinal studies are unique in that they are driven and influenced by legal doctrine, which allows researchers to deeply understand and explain complex litigation through digestible patterns. Using these patterns, doctrinal researchers can develop themes around litigation that explain how and why courts interpret legal standards in certain ways. This ultimately makes litigation more easily accessible to the public, policymakers, and other researchers so that they can be informed on not only the legal precedents on a specific issue of law, but also of the patterns in litigation.

In this thesis, United States Court of Appeals and United States District Court cases are analyzed because these lower courts flesh out the operational realities of Supreme Court standards. The lower courts' interpretation of the standard of review and subsequent litigation is then used to develop grounded observations about the application of legal standards and to analyze precedents about specific legal issues. All the following lower court cases discuss and interpret the deliberate indifference standard, specifically focusing on medical care lawsuits brought by female offenders. All cases in this thesis

are litigated under Section 1983 and consider whether the defendants are liable for violating female offenders' constitutional rights to adequate medical care.

The cases were collected using the online legal database WestlawNEXT, which was available through Sam Houston State University's Newton Gresham Library. Specific search terms were used to ensure the cases met the parameters of the analysis. The search parameters included "'"section 1983" /50 "jail! OR "prison!" medical!" & "female" or "women"'." Using these search terms, 151 cases were included in the initial analysis. After screening these cases, 39 met the criteria for female offenders in jail or prison suing pursuant to Section 1983, claiming violations of the Eighth Amendment right to basic medical care. Of these 39 cases, 34 were heard by district courts, and five were reviewed by a Circuit Court of Appeals. All of these cases were interlocutory appeals during the pretrial stage, meaning that the issue on appeal had to be decided before the merits could be litigated. The cases are divided into six different categories, representing the themes around which the thesis is organized: system failures (n=6), delays in treatment (n=7), medication errors (n=7), failure to treat chronic or preexisting illnesses (n=5), mistreatment of pregnant offenders (n=8), and mismanagement of reproductive health (n=6).

The following chapter is separated into six sections corresponding with these themes. Each section contains a synopsis of the cases, a summary of the litigation, the court's reasoning for their decision, and a discussion of the specific theme. System failures refer to systemic or systematic policies and procedures that led to plaintiffs' complaints, such as staff training, security concerns, or issues with medical delivery methods. The section on delays in treatment discuss litigation on female offenders not

receiving their medical care in a timely manner and what courts have said about wait times in correctional medical settings. Cases pertaining to medication errors include delays or failures to deliver medications as well as correctional facilities' reactions when female inmates suffered adverse side effects to prescribed medication. The fourth theme covers failures to provide treatment to offenders with chronic or preexisting illnesses, meaning any illness an inmate was diagnosed with prior to incarceration. The section on mistreatment of pregnant offenders discusses cases where plaintiffs suffered miscarriages or had treatment that resulted in negative health outcomes while pregnant, such as being shackled during labor and delivery. Finally, mismanagement of reproductive health refers to instances where facilities or corrections personnel failed to provide women with reproductive health services or menstrual hygiene products.

CHAPTER III

Case Summaries

Cases Related to Systematic Failures to Deliver Correctional Medical Care

The goals of custody officers and health care providers are frequently at odds with one another. One is focused on control, while the other aims to heal. When jails and prisons operate from a custody perspective, even the most basic health care services may exist in a culture of penal harm. Before the penal harm movement gained popularity, Departments of Corrections focused on correcting inmate deviant behavior rather than creating additional punishments, leaving medical staff to focus on "prisoners' welfare and treat[ing] them with compassion, dignity, and humanity" (Vaughn & Smith, 1999, p. 177). Under a penal harm framework, however, correctional health care workers are expected to adopt a custodial emphasis, prioritizing security concerns over the health of their patients and placing their ethical obligations secondary to correctional security.

When correctional health care providers operate under a penal harm framework, they practice what some scholars refer to as "penal harm medicine" (Aday & Farney, 2014; Deaton, Aday, & Wahidin 2009-2010; Maeve & Vaughn, 2001; Vaughn, 1999; Vaughn & Smith, 1999). Penal harm medicine practices mainly result from blurred responsibilities and the conflicting goals between custodial staff and medical personnel. Flanagan and Flanagan (2001), for example, found that nurses in correctional facilities are pressured to adopt a "primacy of security" mindset that overshadows the wellbeing of their patients (p. 76). Additionally, medical practices lead to penal harm when medical staff delay or deny medical care, act apathetically towards inmates' needs, minimize inmates' conditions or injuries, disregard their medical histories, or provide grossly

incompetent or reckless care. These practices all lead to a systematic failure to supply adequate medical care and resources to those incarcerated. The following cases discuss systematic failures of correctional health care, specifically focusing on adverse conditions of confinement, poor delivery systems, failure to provide routine services, and improperly trained staff.

Cases Related to Systematic Failures Where Plaintiffs Prevail

When inadequate medical care is so widespread and recurring that multiple inmates have the same complaints, they may consolidate their complaints into one single lawsuit (Collins, 2010). This is known as a "class action lawsuit," which allows a small group of plaintiffs to represent a class of people who have experienced, or will perhaps experience in the future, similar injustices. *Todaro v. Ward* (1977) was a class action lawsuit that challenged the conditions and delivery of medical care for female inmates at the Bedford Hills Correctional Facility in New York. *Todaro* was decided a year after *Estelle v. Gamble*, meaning that it is one of the first cases to apply the deliberate indifference standard to female facilities. Plaintiffs' complaints centered around the accessibility and delivery of medical services, including intake health screenings, which are critical for proper subsequent care (Fitzgerald, D'Arti, Kasl, & Ostfeld, 1984). As a consequence of poor record keeping, inadequate facilities, and poor procedures, the inmates also experienced frequent delays or denials of access to primary care physicians; were not properly observed when they were seriously ill; and did not receive test results, diagnostic work, follow-up treatment, or outside consults when necessary. Moreover, ill inmates did not receive proper monitoring, record keeping, or follow-up; hence, sick and injured inmates were often given inappropriate work assignments.

The U.S. District Court for the Southern District of New York stated that "the prison health care system must provide the full gamut of health care services, from treatment for minor, routine instances of illness to more esoteric specialty care" (*Todardo v. Ward*, 1977, p. 1132). The plaintiffs in this case showed that Bedford Hills did not meet basic standards and was not actively trying to correct longstanding problems. Therefore, the district court found the medical care at Bedford Hills grossly inadequate, ordering counsel to reach a settlement that would remedy the plaintiffs' complaints.

On appeal, the U.S. Court of Appeals for the Second Circuit affirmed, stating that the proposal for a settlement was necessary so that Bedford Hills would provide constitutional medical care to the female inmates. This case presents an example of correctional health care providers operating from a penal harm perspective; such widespread and grossly inadequate conditions existed because corrections officials and medical staff were indifferent to female inmates' needs. As proof, on their appeal to the Second Circuit, the corrections officials argued they were not liable under the Eighth Amendment because "procedures utilized at Bedford Hills were no worse than those in force at other correctional facilities" and were not "defective in the maximum degree" (*Todaro v. Ward*, 1977, p. 53). In denying their appeal, the Second Circuit held that systematic failures to provide adequate treatment constituted cruel and unusual punishment, and facilities need to do more than provide the "lowest common denominator" (*Todaro v. Ward*, 1977, p. 53) of healthcare.

Litigation on conditions of confinement and sanitation shows that incarcerated populations have the right to a "reasonably sanitary environment…that does not offend accepted standards of decency" (see Scheihing, 1983, p. 998). This includes the need to

provide inmates with clean, sanitized conditions (*Ramos v. Lamm,* 1980), cleaning supplies and laundry services (*Green v. Ferrell,* 1986; *Howard v. Adkison,* 1989), and personal hygiene items such as soap, toothbrushes, and toothpaste (*Board v. Farnham,* 2005; *Whitington v. Ortiz,* 2007). Female inmates have unique hygiene requirements during their menstrual cycles. Denying access to tampons, sanitary pads, and other menstrual hygiene products adds to incarcerated women's pains of imprisonment by stripping them of their ability to stay clean. Through a penal harm lens, denying these products systematically dehumanizes female offenders.

There is scant litigation on whether menstrual hygiene products are required under the Eighth Amendment. A case example was *Dawson v. Kendrick* (1981), in which female offenders brought a class action suit, alleging their constitutional rights were violated due to the jail's failure to supply them with feminine hygiene products. While some courts have concluded that menstrual hygiene products are a luxury, not a necessity required under the Eighth Amendment (*Vaughn v. Day,* 2018), the *Dawson* court ruled that access to sanitary napkins is essential. Specifically, *Dawson* held that a denial of sanitary napkins during a woman's period invoked an Eighth Amendment violation because it qualifies as an infringement of "personal hygiene and sanitary living conditions" (p. 1289).

In addition to these hygienic concerns, system failures also affected the cleanliness of the bedding, which plaintiffs in *Dawson* alleged was so inadequate that they contracted parasitic skin conditions, such as crab and lice infestations. Even worse, once they were infected with lice, they would often wait long periods of time before being treated, even though medical staff were aware of the problem. Female offenders

also did not have regular access to showers, which made them more prone to skin diseases, parasitic infections, and pararectal disease. These deplorable conditions of confinement at the *Dawson* facility occurred alongside malfunctioning plumbing, inadequate lighting, diets that contained insufficient amounts of nutrition, restricted ability to exercise, confiscation of books, and the use of solitary confinement as discipline; these types of deprivations have been identified as penal harm punishments in previous literature (Curriden, 1995; Griffin, 2006). The plaintiffs further alleged that the jail did not offer routine examinations upon intake, and the jail also had no sick call or preventative medical treatment because they did not have medical supplies or a medical examination room, which demonstrates a level of systematic and institutional culpability that implicates penal harm.

The *Dawson* court ruled that these conditions "…severely… subject[ed the inmates] to the specter of physical and emotional damage by their experiences in the substandard, debilitating environment of the jail" (p. 1280). Consequently, the court ordered the jail to make several changes. First, the court held that the jail must improve the basic hygiene of the facility, issues with respect to bedding, access to showers, general cleanliness, and supplying menstrual hygiene products. Second, the court ruled that the jail must screen offenders upon intake to uncover any serious medical needs. Finally, the court found that the jail was grossly deficient in its provision of medical care and services due to its absence of any classification system, medical supplies, or a medical examination room, no sick call, inaccurate medical records, and improperly dispensing prescription drugs. Accordingly, the jail was ordered to remedy these constitutional defects.

Correctional medical staff and facilities are often too overworked to directly tend to every inmates' medical need, particularly simpler needs like answering questions or scheduling appointments. When medical professionals are not available, inmates frequently ask correctional officers to handle their immediate concerns or questions (Hemmens & Stohr, 2000). While many facilities rely on correctional officers to identify inmates' medical problems, custody officials are not adequately trained to diagnose or triage inmates' medical needs. The case of *Flynn v. Doyle* (2009) illustrates that when facilities rely too heavily on correctional officers to perform medical duties, this practice can lead to widespread failures to provide adequate care. In *Flynn*, plaintiffs alleged that the facility's indifference to their medical needs caused delays in medication or post-operative treatment, denial of screenings or consultations for a variety of illnesses, including female-specific health care concerns, and issues with receiving prescription medications. The plaintiffs attributed these issues to the facility's "convoluted and archaic" (p. 989) medication delivery process, which was handled not by trained medical staff, but by correctional officers. This led to prescription and dosage errors, incredibly long delays, and prolonged suffering for the inmates in need of specific medications.

The U.S. District Court for the Eastern District of Wisconsin certified this case as a class action lawsuit, ordering the defendants to propose plans to improve the medication delivery system. In 2009, the plaintiffs filed for preliminary injunction to "protect them from the serious, ongoing risks to their health posed by a chaotic medication ordering and administration system" (p. 989). The court granted the motion, ordering the Wisconsin facility to ensure prescription medications and delivery of those medications would be handled by licensed practical nurses, not correctional officers. Furthermore, to improve

the organization and timeliness of medication distribution, the facility was ordered to adopt an updated, computerized medication order process.

As in *Flynn*, the conflicting responsibilities between custodial and medical staff can lead to the implementation of penal harm medicine practices because correctional health care providers are forced into the penal harm role. The consequences of prioritizing security over health care was litigated in *Scott v. Clarke* (2012), where female offenders in the Virginia Department of Corrections suffered due to the way the facility handled sick call procedure, medication errors, delays and callous responses from medical staff, and mismanagement of patients. According to the plaintiffs, these issues were related to improperly trained or underqualified staff as well as an emphasis of security over health care. Nurses in the correctional center, for example, reported having difficulty visiting patients during lockdown, and the plaintiffs alleged that security staff's decisions often limited their access to health care opportunities.

The case started in 2012, where all inmates incarcerated in Fluvanna Correctional Center for Women sought a court order to improve its medical services. The district court ruled for the plaintiffs, and in 2014, the plaintiffs were granted class action status. In 2016, the court entered a final settlement between the parties. In 2017, however, the plaintiffs moved to hold the defendants in contempt. In January of 2019, the Fourth Circuit found that the defendants were in violation of parts of the settlement agreement. The court ruled that sick calls were not being responded to in a timely manner, medical personnel were significantly understaffed, the facility was not providing timely emergency care transportation, medical staff failed to provide vaccines or give inmates their test results, and the correctional center did not provide staff with written training

material on the specifics of the settlement agreement. This case is not uncommon in that prior research shows it often takes years or decades to remedy constitutional violations in correctional facilities (Carroll, 1998; Crouch & Marquart, 1989). As these cases illustrate, systematic failures resulting from penal harm practices are prevalent in dysfunctional prisons.

Cases Related to Systematic Failures Where Defendants Prevail

Free-world citizens, with few exceptions, are granted full access to their medical records under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which is crucial for keeping track of one's medical conditions. In the free world, having access to medical records is also important if someone suffers a case of medical malpractice, as these records can be used to prove liability. HIPAA does not extend this same access to incarcerated populations, which can be described as a penal harm method to remove inmates' autonomy and hinder their ability to oversee their own health care. While every correctional facility has different policies on when and how inmates can access their records, they also have the right to deny that access if they believe it would jeopardize the health and safety of others within the facility (Chandler, 2003).

Denial of medical records to inmates can result in an inmate not being able to show that health care staff were deliberately indifferent to their serious medical needs. This occurred in *August v. Caruso* (2015), where Tracy August, a prisoner in Michigan, sued regarding the medical care she received after she injured her shoulder. Specifically, August alleged health care staff minimized her injury, delayed treatment, and limited access to her medical records. The injury occurred when the plaintiff was following orders to restrain an inmate who was having a seizure. In the original medical report, the

defendants wrote that the plaintiff was injured after her arm was pinned against a railing. August claimed that this report minimized the seriousness of her injury, as "her arm was caught between two railings and ripped upwards as she fell to the ground" (p. 2). Although the defendants agree that the injury was caused by a traumatic event, August argued that the report minimized her injuries, which subsequently led to inadequate treatment. She alleged it took three days to see any medical professional, during which she "could not move her left arm and her pain was exacerbated by" (p. 3), having to climb to her top bunk. Her requests for a bottom bunk were delayed, which worsened her injury, as were the cortisone injections that were ordered by the prison doctor. She continued to experience delays, resistance to treatment, and retaliation when requesting treatment over the course of three years.

August alleged that part of the reason her medical care was handled so poorly was because the facility underreported the filing of medical complaints to "protect their interests and profits" (p. 4). In other words, she accused the correctional facility of falsifying her medical records, which negatively impacted her ability to seek adequate treatment. She also alleged that she was not able to access the medical records she needed to support her lawsuit. Moreover, when she sought the appointment of counsel, she was denied[1] because she had proven her ability to debate in a court of law from her experience with previous complaints. In granting the defendant's motion for summary judgment, the court stated that August failed to name any correctional officers that were present on the day she injured her shoulder or were directly involved in deliberately denying and delaying her medical care. The court also said that August was given access

[1] The "[a]ppointment of counsel in a civil case is not a constitutional right. It is a privilege that is justified only by exceptional circumstances" (*Lavado v. Keohane*, 1993, pp. 605–606).

to her medical information through the defendants' motion for summary judgment; however, whether August knew the records she requested access to were included in the motion is unclear. The court concluded that August failed to prove any individuals acted deliberately to cause wanton infliction of pain.

As it is difficult for offenders to have access to their medical records, it can also be a challenge for correctional medical officials to obtain inmates' full medical histories, which often means that correctional medical staff are unaware of inmates' previous diagnoses, test results, and prescription medication (MacDonald, Parsons, & Venters, 2013). Without access to these records, medical staff cannot make informed decisions regarding inmates' health and wellbeing. Even with inmates' medical histories, however, medical staff operating under a penal harm perspective might not consult patients' histories or take them seriously before making medical decisions. This issue was illustrated in *Popoalii v. Correctional Medical Services* (2008), where Leiloni Popoalii claimed that Correctional Medical Services (CMS) and the Missouri Department of Corrections violated her Eighth Amendment rights to adequate medical care.

Despite complaining of headaches for an extended time period and telling medical staff and several officers that they were immobilizing, Popoalii received several conduct violations when the headaches rendered her unresponsive to certain orders, such as sitting-up during count time. Without treatment, the plaintiff suffered from blurry vision to the extent that she could not sign documents and spilled her food because she could not see the tray, which resulted in conduct violations. As the pain worsened, she screamed loudly, hallucinated, and progressively lost her vision. At one point, Popoalii's hallucinations caused her to bang her head against the wall. After an officer alerted

mental health officials, Popoalii was placed in a padded cell and kept on 24-hour suicide watch.

Before her incarceration, Popoalii was hospitalized for viral encephalitis, a serious medical condition that could result in blindness if untreated, which she reported to correctional medical professionals at intake. During an appointment regarding her headaches, Popoalii mentioned to a correctional physician that she was sensitive to light. At this point, correctional officials had not requested access to her medical records, so they were unaware of her history with encephalitis. If the prison doctor had been aware of her full medical history, hearing that Popoalii was experiencing light sensitivity would have been a "red flag" (p. 494). Correctional medical staff treated the plaintiff's headaches with ibuprofen and rest; however, her condition continued to progress and eventually prompted a visit to an outside hospital, where she was diagnosed with cryptococcal meningitis.

Since her condition had gone untreated for so long, she developed permanent blindness. In her lawsuit, Popoalii alleged that her blindness could have been prevented had CMS staff requested her medical history and sent her to the hospital sooner. The defendants moved for summary judgement, saying that even if they had obtained medical records sooner, there was nothing to suggest Popoalii had cryptococcal meningitis. The Eighth Circuit affirmed the grant of summary judgement, stating that even though CMS could have acted more diligently, their behavior did not constitute deliberate indifference.

Section Summary of Cases Related to Systematic Failures

Systematic failures in providing adequate medical care to incarcerated populations can occur for a variety of reasons. Prioritizing security and custody over

inmate health and wellbeing can decrease the quality of correctional health care. Custodial personnel push prison medical staff to follow safety and security measures over everything else. While correctional medical staff are trained as health professionals, working in a correctional environment has led some to compromise their oath to do no harm to their patient's health (Coyle, 2014). This could lead to correctional staff mishandling inmates' medical needs, as demonstrated in the *Scott* and *Flynn* cases.

Relying on correctional staff to carry out medical duties jeopardizes inmates' health because officers are not trained medical professionals and are likely to make errors. The emphasis on security means that inmates are not given the same quality treatment available to free-world patients. In the cases of *Popoalii v. Correctional Medical Services* and *August v. Caruso,* for example, the plaintiffs demonstrated that correctional officers and medical staff significantly delayed their care to the point that they suffered additional medical complications. In the free-world, these cases would likely qualify for medical malpractice litigation, but negligence is not actionable in a Section 1983 claim under the standard of deliberate indifference. The limited access to medical records in these cases further illustrates offenders' lack of control and autonomy in their health care decision-making, which is indicative of the penal harm perspective. By restricting offenders' access to medical records and taking away their ability to manage their own health care, correctional administrators add to their pains of imprisonment, making it more difficult to seek legal remedies for inadequate medical care.

The cases in this section create two other important trends. First, in *Dawson v. Kendrick,* the district court ruled that menstrual hygiene products are a necessary item

that the correctional facility must provide to female offenders (Barchett, 2017). This case is important because prior research shows that access to menstrual hygiene products in prisons is largely inadequate (Shaw, 2019; Winkler & Roaf, 2014). This inadequacy stems from the fact that there are no nationwide standards or guidelines stating that correctional facilities are required to supply adequate menstrual hygiene products or how much they can charge for them (Shaw, 2019). The lack of guidance results in a patchwork of policies that hold no one accountable for the absence of menstrual hygiene products (Montano, 2018).

Second, *Todaro v. Ward* was important for making medical intake screenings part of female inmates' medical needs. High rates of preexisting illnesses and communicable diseases among female offender populations makes preventative care in jails and prisons a priority (Magee et al., 2005). Without theses initial screenings, inmates are themselves at risk and place other inmates and correctional staff at risk of contracting contagious illnesses. Furthermore, since incarcerated persons generally come from disadvantaged backgrounds and may not have access to health care, screening women upon intake is crucial to prevent diseases from spreading within the correctional center as well as in the free world once the offender is released (Restum, 2005). Incarcerated women are especially susceptible to adverse reproductive health risks (Knittel et al., 2017; Sufrin, Kolbi-Molinas, & Roth, 2015) and should therefore have access to reproductive health screenings.

Moreover, these cases illustrate that penal harm practices are not always intentional. Penal harm practices are represented in these cases through systematic neglect and apathy towards female inmates and their needs. Apathy towards female

inmates exists in correctional facilities as well as in the legal system, evidenced by the fact that the only cases where plaintiffs prevailed within this section were class action lawsuits. The benefit of class action lawsuits, especially those involving system-wide errors, is that strength in numbers seems to increase the chances of prevailing. Class action suits make inadequate medical care and deliberately indifferent treatment more difficult to ignore because it occurs on a continuous, systematic level. Overall, this suggests that courts are more inclined to hand down judgments against correctional personnel when widespread problems occur and cannot be ignored or passed off as mere negligence.

Cases Related to Delays in Treatment

While the Supreme Court established in *Gamble* that deliberate indifference can result in delays of medical treatment, the lower courts vary in what establishes an unconstitutional delay, both in the reasoning and timeframe of the delay (Nolasco & Vaughn, 2020; Vaughn, 1995). Lower courts have found correctional officials liable for delaying care for three weeks (*Fields v. Gander*, 1984), several months (*Board v. Farnham*, 2005; *Gevas v. Mitchell*, 2012), and even for delaying emergency dental care by several hours (*Maddox v. Davis*, 2005). Without set rules or guidelines for what constitutes a deliberately indifferent delay of medical care, it is difficult to enforce proper standards or assign civil liability to correctional staff when they delay care to sick or injured inmates. Delays in care may stem from the fact that inmates' medical requests are often lost or ignored because corrections officials do not take them seriously (Vaughn, 1999). Studies on delays in correctional medical treatment point out that delays of care ultimately result in denial of care (Neisser, 1977). This is because medical delays may be

a strategy to avoid providing care, as facilities sometimes continuously push back medical treatment until the offender is released or transferred (Thompson, 2010). This unfortunately forces inmates into a frustrating cycle of submitting requests for medical attention only to be denied, meaning they must make the choice to persistently seek medical care from apathetic correctional staff or, most likely, give up and go without (Thompson, 2010).

Delays demonstrate penal harm medicine mainly through medical staff's apathy towards female inmates' medical needs. Despite research showing that incarcerated women have more serious health concerns than incarcerated men and therefore require more serious medical treatment, female inmates are commonly viewed as malingerers (Barry, 2001). Consequently, their health care requests are not taken seriously. The following section analyzes lower court cases brought by female offenders that involve the denial or delay of medical treatment to determine under what circumstances correctional officials can be held liable for delaying care to incarcerated women.

Cases Related to Delays in Treatment Where Plaintiffs Prevail

In severe instances of treatment delays, inmates have died as a result of not receiving timely medical care for their serious illnesses. Such was the case in *Shultz v. Allegheny County* (2011), brought by Luann Shultz on behalf of her deceased daughter, Amy Gillespie, who died while in the custody of Allegheny County Jail. Gillespie was serving time because she violated her work release by falling pregnant. While Gillespie entered the jail in good health on December 2, 2009, she soon developed bacterial pneumonia and, along with her unborn child, died on January 13, 2010—just over a month into her sentence. According to Shultz, Gillepsie's death was a result of

correctional officials ignoring and downplaying her medical needs. Shultz brought allegations of Eighth Amendment violations against 10 correctional staff and the senior policy maker.

Gillespie reportedly tried to tell correctional officers multiple times that "something was wrong with her health" (p. 18). Specifically, she complained that she could not breathe and had discharge from her lungs. Her condition was not taken seriously until December 29, 2009, when she reported symptoms of nausea, vomiting, aches, fever, and sleeplessness to the infirmary staff at the jail. The medical staff members incorrectly diagnosed her with influenza at this time and treated her with IV fluids, Tylenol, and Benadryl. Her condition worsened until she was eventually transferred to a nearby university hospital, where she was correctly diagnosed with bacterial pneumonia. Because her condition was improperly treated for so long, however, she could not breathe on her own and required intubation. Three days after she arrived at the hospital, her family members decided to withdraw care to end her suffering.

The defendants sought dismissal since, as they argued, Gillespie did receive medical care while at the jail. They argued that the misdiagnosis and subsequent improper treatment was merely medical negligence or malpractice, not deliberate indifference. The district court, however, held that this case presented more culpability than negligence. Specifically, the court said that the correctional officers' failure to note Gillespie's condition as serious despite her prolonged inability to breathe and the medical staff's diagnosis of influenza despite not having an outbreak in the jail constituted "sufficient facts and reasonable inferences to suggest the existence of and ability to prove

deliberate indifference" (p. 23). Thus, the defendants' motion to dismiss the claims of deliberate indifference for the correctional staff was denied.

The Estate also alleged that Gillespie's death resulted from a "policy and/or practice of not providing adequate medical care" to inmates that is "driven by financial concerns" (p. 19). Shultz brought this claim against the senior policy maker, who invoked qualified immunity as grounds for dismissal. However, qualified immunity can only be granted if no clearly established constitutional right was violated. Indeed, Shultz succeeded in proving that the jail's reaction to her daughter's medical needs constituted a violation to her federally guaranteed rights, thus striking the policy maker's defense of qualified immunity. Additionally, the court concluded that there was evidence to suggest Gillespie's treatment was "a result of custom, practice or policy of denying essential testing and diagnosis due to measures designed to produce cost-savings" (p. 25). This case was approved to move to trial.

Gillespie's death was preventable. Had the corrections officials reacted appropriately to her symptoms and performed necessary diagnostic tests, her condition would not have progressed to the point where she needed intubation. Gillespie died as a result of correctional personnel cutting costs by avoiding expensive diagnostic and treatment procedures, a delay strategy that researchers have reported in other correctional health care practices (Chandler, 2003). Delaying medical care for serious medical needs; although the medical staff did not intentionally deny treatment, their hesitance to take appropriate steps to provide a proper diagnosis caused unnecessary harm and a preventable death.

Cases Related to Delays in Treatment Where Defendants Prevail

Although delays in diagnoses can pose serious risks, courts have held that those delays do not produce civil liability if the defendants provide adequate medical care while an inmate is awaiting a diagnosis. Such was the case in *Barnett v. Suryadevara* (2010), where a woman incarcerated in California brought allegations of deliberate indifference to her serious medical needs regarding her treatment and diagnosis of Kienbock's Disease, a serious condition that affects bone health. The plaintiff met with a correctional medical staff member in 2006 for wrist pain. Two months later, the plaintiff had an MRI done on her wrist. Four months after that, the plaintiff was referred to the University of California Davis for a consultation, which happened three months later in September of 2007, a full year after her initial appointment regarding her wrist pain. The hospital physician diagnosed the plaintiff with stage four Kienbock's disease. At this progressive stage in the disease, the plaintiff's only treatment option was surgery, which she underwent in January of 2008. Post-operation, the plaintiff was prescribed pain medication that she was allergic to, but her initial request to switch to a different medication was denied. The plaintiff filed this suit because she feared that her rehabilitation, follow-up care, and physical therapy were at risk of being denied or delayed due to her treatment experience.

The plaintiff alleged the defendants were aware that her treatment and diagnosis was being delayed and did nothing to speed up the process. She contended that they were responsible for inflicting additional, unnecessary pain, and she believed their deliberate indifference to her serious medical needs caused further harm to her wrist and impeded her recovery process. However, the district court disagreed, stating that Barnett's

complaints demonstrated “a difference of opinion between a prisoner-patient and prison medical” staff (p. 3), and that she did not link the defendants to a clear denial of her rights. The court further said that the defendants were not liable because they provided medical resources to the plaintiff—whether she believed that the health care was delivered in a timely manner is not enough to establish an Eighth Amendment violation.

Injuries during incarceration are often the result of preventable accidents that occur due to officials’ negligence or hazardous conditions of confinement (Sung, 2010). The fact that injuries are avoidable and yet are still fairly common is indicative of penal harm. Since correctional personnel do not always ensure conditions are safe, inmates regularly fall or injure themselves while following orders or while performing their work duties (Sung, 2010). Caselaw shows that when inmates are frequently injured during incarceration, their injuries are not always properly treated. This was exemplified in *Morris v. Correct Care* (2012), where Chevelle Morris brought a Section 1983 action after treatment was delayed for a hand injury she sustained while incarcerated in a Delaware correctional facility. Morris slammed her hand in a shower door, which she alleged happened because the door was warped and hard to close. Her injury was so severe that it required the partial amputation of her ring finger.

According to Morris, the physicians of Correct Care, the medical provider for the Delaware Department of Correction, refused to redress her wound. When they finally did provide treatment, it was done in an unsanitary manner. Morris brought her allegations against Correct Care as the sole defendant, prompting them to move for a motion to dismiss since Morris failed to “provide evidence that there was a relevant…policy or custom” (p. 4) that led to Morris’s inadequate medical care.

Granting the defendant's motion, the district court stated that Morris's complaint demonstrated a "mere disagreement as to…proper medical treatment" (p. 3), not a delay to her serious medical needs. Additionally, because Morris named Correct Care as the defendant rather than individual medical staff, she needed to be able to draw a connection between Correct Care's policy and her negative treatment. Since she could not do this, the district court dismissed her case; however, the court gave Morris the opportunity to amend her claim to name specific individuals as defendants. Morris requested counsel, as she could not financially afford to navigate the issues by herself, but the court denied this request on the grounds that this case was "not so factually or legally complex that requesting an attorney is warranted" (p. 5). Apparently, Morris was unable to file additional affidavits.

Proving that correctional officials are liable for delaying inmates' access to pain medications have mixed rulings, but courts have held under certain circumstances that inmates have a constitutional right to prescription medications when they sustain serious injuries (Vaughn, 1995). Similar litigation occurred in *Mouton v. Villagran,* (2015), when Joann Mouton injured her knee and back after falling out of a correctional facility bus. Immediately following the fall, correctional officers on scene called the on-duty physician to examine Mouton's injuries. Because Mouton could move her extremities without difficulty, did not complain of head pain or nausea, and had no other visible injury other than scrapes and bruises, the physician ordered her to ice it for three days. Mouton requested a prescription for pain medication and an x-ray, but her requests were denied.

Her Section 1983 complaint alleged that the physician was deliberately indifferent to her medical needs because he delayed ordering an x-ray and did not prescribe her pain medication. The physician contended that Mouton's injuries were not serious enough to require an x-ray, and he did not prescribe pain medication because she was already taking some for an unrelated injury. The defendants moved for summary judgement on the grounds that Mouton's medical needs were not serious, and even if they were, that the physician was not deliberately indifferent to them. The district court agreed, saying that Mouton did not prove her injury was serious enough to warrant an x-ray or more timely care; therefore, the court did not find that Mouton's federally guaranteed rights were violated, prompting the dismissal of this case.

When inmates injure themselves and believe their injury requires hospital visitation or refers to specialists, they are not given autonomy to make those decisions and can be denied specialist attention. In *Qualls v. Manoharon* (2010), for example, a woman serving time in the California Institute for Women (CIW) sued, alleging that the facility's acting physician provided inadequate medical care after she injured her finger playing volleyball. Specifically, the plaintiff claimed that the physician was deliberately indifferent because he did not refer her to a hospital for further treatment. The physician in question moved for summary judgement on the basis that the plaintiff did not offer any admissible evidence to show deliberate indifference to her serious medical need.

The physician argued that, while they did not refer the plaintiff to a hospital, she received emergency treatment in the facility's triage center immediately following the injury. In this appointment, the physician took x-rays of the plaintiff's hand, examined the injury, and diagnosed a small fracture. The plaintiff's finger was placed in a splint

and given pain medication, and the defendant recommended she see her primary care physician in the next five days. At this facility, when the physician makes a recommendation to see a primary care physician, it is the primary care doctor's job to contact the offender. Therefore, even if the inmate does not see their primary care physician, it is not the correctional facility physician's fault. They only need to recommend a check-in with a primary care physician to ensure they are complying with medical standards. The court held that the physician's actions did not invoke an Eighth Amendment violation, as the doctor provided the plaintiff with substantial treatment for her injury. Therefore, the district court granted the defendants' motion for summary judgement dismissing the case.

While legal studies have found courts generally rule that delays resulting in permanent damage are unconstitutional (Nolasco & Vaughn, 2020), this does not always appear to be the case for female inmates. In *Walker v. California Department of Corrections and Rehabilitation* (2011), Florence Walker experienced significant delays in treatment for an undiagnosed rash that caused permanent scarring and elevated blood pressure. Walker alleged she visited a correctional physician in May of 2008 for a skin condition they identified as a spider bite or ringworm. No treatment was given after this appointment. In August, the plaintiff saw a different doctor regarding a wound on her hand that was oozing pus. A rash had also appeared on Walker's hand and arms that was beginning to spread to her neck and face. The doctor examined the wound, but they did not believe it warranted follow-up care, treatment, or even bandages or anti-bacterial medication.

A week later, the rash spread into the plaintiff's ears and eyes, caused her blood pressure to rise, and had formed watery blisters. She also developed more open wounds that oozed pus, which is a sign of infection. The correctional doctor said there was nothing he could do and told Walker to submit a request to see a different correctional doctor for follow-up. Sometime after that appointment, the plaintiff initiated a medical emergency because she was having trouble breathing and had elevated blood pressure. Instead of seeing her, the same doctor she saw about the progressing rash threatened her with disciplinary action for initiating a medical emergency. A couple days after that, Walker vomited after breakfast and was taken to the medical infirmary, but she was given no treatment.

Walker's complaint alleged that she was deliberately and continuously delayed treatment for a serious medical need that resulted in permanent scarring and elevated blood pressure. While the court agreed that Walker was suffering from a serious medical need, it also said that she failed to prove the defendants deliberately delayed her care. When alleging deliberate indifference, inmates need to specify acts, or failures to act, by correctional personnel that signify they were aware of the inmate's serious medical need and knowingly disregarded the inmate's health and safety by ignoring that need. The court held that Walker's complaint demonstrated negligent care, not deliberately indifferent care, and that Walker failed to show how any individual person or action caused her undue harm.

Even though Walker's care was continuously delayed, and she suffered permanent consequences, her claim was not actionable under Section 1983 because she did not prove the corrections officials acted with a culpable state of mind. The culpable

state of mind requirement of deliberate indifference creates a high burden for inmates to overcome, resulting in the dismissal of many medical care lawsuits, which ultimately lowers the standard of care that correctional facilities provide. The culpable state of mind of deliberate indifference cases works to enhance the penal harm perspective, as both are based in the idea that inmates are deserving of lesser treatment than the general population and should not receive higher-quality treatment during incarceration compared to the free world.

Delays in care can also refer to inmates' requests for special testing or procedures. In *Hall v. Herdner* (2008), for example, Carrie Hall sued pursuant to Section 1983 correctional medical providers, saying that they provided untimely medical treatment. Hall was prescribed pain medication and antibiotics by staff at a free-world hospital when developed an ear infection and Mastoiditis. Once she returned to the correctional facility, the correctional physician discontinued the plaintiff's pain medication. Hall stopped taking the antibiotics shortly thereafter because, without the pain medication to mitigate adverse side effects, the antibiotics were too rough on her body and made her hair fall out. The plaintiff also alleged that her request for a culture test on her Mastoiditis infection was denied, even though it was draining out of her ear and causing severe headaches. In addition to the ear infection and Mastoiditis, Hall developed a MRSA infection in her left arm and crotch area. Allegedly, the defendants did not put her on antibiotics for this infection or drain the infected areas on her body to relieve the pain and pressure.

Hall's suit said that the defendants were deliberately indifferent to her serious medical needs by delaying her access to medical services while she was suffering from

these various infections. The defendants argued that Hall's allegations were merely disagreements about her treatment and were not deliberately indifferent to her treatment needs. Granting the defendants' motion for dismissal under qualified immunity, the district court said that, although Hall demonstrated she was in need of serious medical care, the defendants were entitled to qualified immunity because they acted appropriately and reasonably in their treatment decisions based on the knowledge they had of Hall's condition.

Section Summary of Cases Related to Delays in Treatment

Allegations under the deliberate indifference standard are more successful if the case involves an inmate's death. In this section, the *Shultz* court ruled for the plaintiff and held that the circumstances surrounding Gillespie's death was far more than negligence—the failure to provide a timely proper diagnosis and treatment resulted in an unavoidable death of a pregnant woman and thus invoked Eighth Amendment violation. This case outcome may suggest that finding correctional officials liable does not depend as much on the facts of the case as much as the outcome. In these instances, the more severe the consequences of the delay, the more likely the court will rule for the plaintiff. The fact that courts in this section did not find defendants liable in cases that involved permanent damage (*Walker*) or delayed diagnosis of a serious condition (*Barnett*) further suggests incarcerated women must suffer extraordinarily to satisfy deliberate indifference.

The tendency for courts to rule in defendants' favor invokes the "Principle of less eligibility" (Vaughn & Carroll, 1998), and reveals that incarcerated women's litigation is heavily affected by the penal harm perspective (Maeve, 1999; Maeve & Vaughn, 2001). Corrections officials usually argue, and the courts generally agree, that they are not liable

for inmates' inadequate medical treatment because the case represents negligence or malpractice, not deliberate indifference. This implies that both correctional facilities and the courts operate under the penal harm belief that conditions and treatment during incarceration should not be pleasant or comfortable. Additionally, corrections personnel and the courts believe that incarcerated populations do not need the same standard of medical care as free-world populations. In many circumstances, female offenders' claims of inadequate medical treatment are likely to fail unless that care results in their death.

Cases Related to Medication Errors

After diagnostic errors or delays, medication error is the second most frequent type of lawsuit in medical malpractice among free-world citizens (Wallace, Lowry, Smith, & Fahey, 2013). Claims on medication errors also occur among incarcerated populations, who experience negative medical outcomes from delays in receiving medication, receiving the wrong medication, being prescribed improper dosages, suffering adverse side effects from medications, or not receiving their prescriptions at all (Dabney & Vaughn, 2000; Vaughn, 1997). The difference between medical malpractice cases in the free-world and deliberate indifference cases, however, is that the degree of culpability that must be shown in Section 1983 litigation is much higher for incarcerated plaintiffs. Rather than needing to show that the standard of care they received was negligent, as in malpractice, inmates are required to prove medical professionals' deliberate indifference led to their medication error (Vaughn, 1997). Therefore, as the cases in this section will demonstrate, it can be much more difficult for inmates to prevail on claims of medication errors.

As mentioned above, female offenders' top complaint of receiving inappropriate medical care while incarcerated involves errors with medications (Stoller, 2003). This is also reflected in research on correctional health care across genders (Vaughn, 1997; Stern, Greifinger, & Mellow, 2010). Inmates commonly report problems with receiving their medications due to correctional officers delaying or denying their prescriptions, either directly or through the prioritization of custodial cocnerns (Stern et al., 2010; Vaughn, 1997; Vaughn & Collins, 2004). In some situations, officers have even denied inmates their medication as a form of punishment (Vaughn, 1995).

Security procedures that restrict inmates' access to their medication revolves around the fact that inmates often need to travel to and stand in medication distribution lines to receive prescriptions (Stoller, 2003). There are problems with medication distribution lines: inmates with disabilities, inmates who are very ill and may not be able to ambulate, and inmates in court, lockdown, at work, or attending vocational/educational programs may not receive medications. Studies also suggest that corrections personnel do not take necessary precautions to ensure inmates receive proper medications, and if an inmate is given the wrong prescription or has negative side effects, corrections staff do not always provide adequate medical attention (Vaughn, 1997). Female inmates in Stoller's (2003) study, for example, reported that they were sometimes forced to take medicine that was incorrectly labeled and given medication prescribed to a different inmate.

Cases Related to Medication Errors Where Plaintiffs Prevail

Burn wounds require frequent monitoring and consistent changes of medicated dressings (Daristotle et. al., 2019). In *Richmond v. Huq* (2018), Melisa Richmond was

arrested, and while on the way to the police station, Richmond set her seatbelt on fire in an attempt to free herself. As a result, she suffered second degree burns and was taken to the hospital for treatment. The physician who treated Richmond at the hospital prescribed a topical ointment that needed to be applied twice a day. Back at the jail, Richmond alleged that nursing staff did not clean the wound or change the dressings daily, as ordered by the hospital physician. Evidence showed that jail records indicated Richmond went multiple days without having her dressing changed.

Richmond sued under Section 1983, and the district found for jail officials, stating that the plaintiff failed to identify any individual who did not provide her the prescribed treatment. The Sixth Circuit reversed, holding that jail medical staff logs revealed six occasions where no staff members changed Richmond's dressings, which constituted a disregard to serious risk of infection and demonstrated deliberate indifference. Therefore, on the complaints regarding the correctional medical staff's treatment for Richmond's burn, the Sixth Circuit found the defendants were deliberately indifferent to Richmond's medical need.

Prior to her arrest, Richmond was taking Prozac and Xanax to help manage her bipolar disorder, a fact that she made clear to the psychiatrist who handled her intake screening. This psychiatrist diagnosed her as bipolar, suffering from depression and anxiety, and experiencing auditory hallucinations. Despite this diagnosis, and the knowledge that she was currently off her prescribed medication, the jail psychiatrist ordered her to go without medication until she received a follow-up psychiatric appointment. Consequently, Richmond went 17 days without her medication. The district court found this did not constitute a serious psychological need, but the Sixth Circuit

reversed, holding that the delay in providing prescription medication despite the jail's own psychiatrist's diagnosis showed she was suffering from a serious medical problem.

Cases Related to Medication Errors Where Defendants Prevail

Research from the institute of medicine shows medication errors kill thousands of Americans each year (Kohn, Corrigan, & Donaldson, 1999). Combined with the high-stress environment of correctional settings and overworked staff, apathetic attitudes for inmates' health and wellbeing has led to medication errors and an unwillingness to acknowledge errors at all. Medication error was the issue in *Silvas v. Chowchilla State Prison* (2012), when Maria Silvas alleged she was given the wrong medication and was thereafter not given adequate medical treatment. Silvas said that she was given the wrong medication for her mental illness, and that after the corrections medical staff realized their mistake, they simply gave her the correct medication and did not monitor her for any side effects. Silvas suffered adverse side effects for nine days, which escalated from nausea and dizziness to intense, paralyzing pain. In fact, 10 days after she had been given the incorrect medication, correctional staff called a medical emergency because Silvas was paralyzed. Even after this episode, a doctor never evaluated Silvas; instead, she was given Aleve and sent back to her cell.

Silvas did not see a doctor until two months later. Her condition worsened because nurses failed to report that they gave her the wrong medication. When the plaintiff questioned the correctional staff on their failure to report, one correctional officer allegedly mocked Silvas by responding, "I sure am fucking up aren't I? That's false documentation isn't it?" (p. 2). The plaintiff identified four unnamed correctional staff members as defendants, but she did not state in her claim how they were involved

with her medication errors and subsequent adverse side effects. Consequently, the district court dismissed her complaint.

As the *Silvas* case suggests, corrections personnel do not always respond appropriately when inmates suffer adverse side effects from medications. In *Andreasik v. Danberg* (2012), Linda Michelle Andreasik believed she was not given adequate medical care after she showed adverse symptoms after a correctional physician overprescribed Lithium. She alleged that several correctional facility employees, including officers and medical staff, were negligent in prescribing Lithium and failed to intervene when she presented symptoms of Lithium intoxication. Andreasik did not receive medical attention until she was unable to walk or write. For relief, she requested an attorney, compensatory damages, release from prison, physical therapy, and proper medical care. While Andreasik named several correctional staff as defendants, her complaint did not mention anyone by name. The district court dismissed her suit since she could not name specific individuals. More to the point, the court held that these allegations fell under the aegis of medical malpractice, which is not a violation of incarcerated persons' Eighth Amendment rights in Section 1983 cases.

Medication errors, in both correctional and free-world primary care settings, may stem from diagnostic errors. There has been significant research on correctional facilities' inability to diagnosis and treat mental health issues, but less attention has been paid to misdiagnosing, resulting in prisoners taking incorrect medication (Martin, Hynes, Hatcher, & Coleman, 2016). Misdiagnosis could result in inmates being classified and treated as mentally ill when they are not, ultimately leading to inmates being wrongfully housed in psychiatric wards and forced to take unneeded psychiatric medication. In *Smith*

v. Burgdorff (2018), Lillian Smith, a California inmate in a women's prison, was misdiagnosed with a mental illness, housed in a mental health crisis unit, and involuntarily given psychiatric medication. Smith alleged that one day, seemingly out of nowhere, two correctional physicians came to her cell and informed her she would be moved to the mental health crisis unit. When she asked why, she was not given an answer. Smith did not understand why she was being treated as a psychiatric patient, as she did not express suicidal ideations or act aggressively toward correctional staff.

In addition to being held in the mental health crisis unit, Smith further alleged that correctional medical staff failed to change her adult diaper in a timely manner. Smith believed this treatment amounted to cruel and unusual punishment and caused her to suffer from physical pain and emotional distress. The district court held that Smith's claim was based on her disagreement with the correctional doctors' assessment of her mental state, not that they were deliberately indifferent to her medical needs. In dismissing her Eighth Amendment claims, the court stated that Smith did not produce evidence to demonstrate the treatment she received posed an excessive risk to her health. The court granted Smith leave to file an amended complaint, and one month later, she filed a motion for reconsideration. The district court denied this motion because she did not provide any evidence for the court to revise its previous decision.

Correctional health care has struggled with respect to continuity of care for persons arrested while taking medications and continuing those medications once the person is incarcerated (Abbott, Magin, Lujic, & Hu, 2017). Reports show that 61% of federal inmates and 59% of jail detainees were taking prescription medications 30 days prior to their incarceration (Maruschak, Berzofsky, & Unangst, 2015). The transition

from free-world to correctional medical care may disrupt medication since correctional physicians often alter prescription dosages or substitute prescriptions for formulary medications. This occurred in *Estes v. Danberg* (2009), when Sheletta Estes sued under Section 1983, alleging that correctional medical personnel in Delaware violated her Eighth Amendment rights to be free from deliberately indifferent medical care. Before entering the correctional facility, Estes' psychiatrist had prescribed Seroquel, an antipsychotic drug. The correctional physician continued this prescription for a few weeks before switching Estes to an "equivalent medicine" (p. 2). At this time, she was diagnosed with Bell's palsy by another correctional medical official and was prescribed a different medication. Months later, while housed at a separate probation center, Estes developed an ear infection. The probation facility prescribed antibiotics and Robitussin, which the plaintiff claims were inadequate and left her "totally deaf in her right ear" (p. 2). Additionally, the plaintiff alleged that the substitute medication for Seroquel damaged her mental health by exacerbating other mental health problems.

During incarceration, Estes suffered a medical episode resembling a stroke. Correctional physicians informed her that she was having a negative reaction to medications, and that once her ear infection was treated, she would return to normal. Estes' request for an outside hospital visit for further testing was denied. She claimed that the correctional medical staff were deficient in providing her proper care because they did not quickly approve her request for outside medical attention. The courts have, however, repeatedly made it clear that prisoners have no constitutional right to choose a particular medical treatment and cannot raise a Section 1983 claim solely because they disagree with the doctor's treatment decision (Nolasco & Vaughn, 2020). Additionally,

disagreeing with prison doctors' professional judgement is not actionable under Section 1983. In this case, the district court dismissed Estes' claims since the care she received was merely negligent, not deliberately indifferent.

Studies report that female inmates' medical complaints are not taken seriously by medical professionals, and communication with inmates about treatment plans or options is minimal (Magee et al., 2005). Consequently, inmates may develop serious conditions due to medication errors since correctional physicians do not always inform female offenders of the risks or side effects of medication. In *Darden v. Singh* (2012), for example, Geraldine Darden was diagnosed with multiple sclerosis (MS) while incarcerated in a California women's prison. While in the hospital, a physician prescribed Avonex, a drug used to treat MS that has been shown to increase one's risk of cancer. The plaintiff had a history of cancer that she disclosed to both the prescribing doctor and the correctional physician, who treated her with Avonex without warning her of the increased cancer risk. Darden later developed breast cancer, which she contested was a direct result of taking Avonex.

In her Section 1983 lawsuit, Darden alleged that the physicians' failure to inform her of the risks despite knowing she had cancer history subjected her to a serious risk of harm, which led to her breast cancer. The district court said while Darden's case demonstrated negligence, the culpable state of mind for negligence falls under medical malpractice and does not possess enough blameworthiness to invoke an Eighth Amendment violation. Darden's cancer may have developed from taking Avonex, but the court held that Darden did not demonstrate that the defendants were deliberately indifferent to her serious medical needs or had malicious motives when treating her. This

case provides yet another example of female inmates suffering penal harm at the hands of neglectful correctional medical personnel. Although the prescribing physician and correctional doctor knew of Darden's medical history and the risks of Avonex, they failed to disclose those risks to her.

In another example of how correctional medicine can cause harm through the handling of inmate's medical histories, Chandler (2003) reported that female inmates are not always informed of their own medical conditions. One of the women in Chandler's study was not told that she had been diagnosed with Hepatitis C. Chandler also revealed that this was only one case out of many where women had not been informed of their diagnoses, where correctional personnel withheld those diagnoses to avoid paying for treatment. Given that correctional physicians may not always have access to inmates' full medical histories, combined with the fact that they do not communicate with inmates about their health, incarcerated populations may be more at-risk of medication complications (Chandler, 2003; MacDonald et al., 2013). In extreme cases, these complications can lead to the development of serious and chronic illnesses. Such was the case in *Ayobi v. Adams* (2017), when a female inmate developed diabetes after being prescribed Lipitor to help lower her cholesterol. According to the magistrate judge, the physician knew that Ayobi was at high-risk for developing diabetes due to her family history and was deliberately indifferent to this risk by prescribing a medication that can lead to diabetes.

In *Ayobi v. Showalter* (2019), Ayobi's amended complaint, the U.S. District Court said that the defendant, Showalter, produced evidence to show she did not examine Ayobi on the day in question and that she began working at the correctional facility after

Ayobi claimed she was prescribed Lipitor. Additionally, Showalter moved for summary judgement since Ayobi's allegations amounted to a difference of opinion in treatment, not deliberate indifference. In granting the defendant's summary judgement, the district court said Ayobi failed to prove that Showalter was employed at the correctional facility when she was prescribed Lipitor or that Showalter was the prescribing physician.

Inmates cannot prevail unless they demonstrate deliberate indifference, which sets a high bar of guilty mindedness or culpability. An example can be found in *Williams v. Danberg* (2012), where Sherrhonda L. Williams, incarcerated in a women's correctional facility in Delaware, claimed she was subjected to a wrongful operation, was not prescribed necessary medication, and had ongoing problems with receiving her prescriptions. Williams claimed that Correct Care Services (CCS) failed to address her multiple chronic medical needs. Upon entrance into the correctional facility, she was taken off all her medications and was concerned that medical staff did not make that decision with sound medical judgement. However, the plaintiff failed to specify the medical conditions from which she suffered and did not specify allegations against individual defendants. Because she did not show that any individual person was deliberately indifferent to her medical needs, the district court dismissed the case.

Summary of Cases Related to Medication Errors

These cases reveal that even when plaintiffs suffer adversely from medication errors and develop chronic conditions, such as diabetes and cancer, they are not protected under the Eighth Amendment unless they can prove those errors were made with deliberate indifference or with intent to cause harm. While plaintiffs in free-world medical malpractice litigation can prevail by showing a medical professional was

negligent, Eighth Amendment claims brought under Section 1983 must show that correctional personnel acted with culpability equivalent to "subjective recklessness as used in criminal law" (*Farmer v. Brennan,* 1994, p. 834). The principle of less eligibility refers to the multitude of ways in which disenfranchised populations, such as the poor, racial and ethnic minorities, and incarcerated persons are provided lower quality services in various aspects of society (Sieh, 1989). Case law clearly shows the principle of less eligibility is in play in offenders' lawsuits since inmates are not eligible for the same recompense when suing medical officials as free-world citizens because of their inmate status. Thus, from a legal perspective, female inmates can suffer the consequences of medical malpractice and medical negligence without a constitutional remedy (Vaughn & Carroll, 1998). Donald Black's (2010) differentiation of law perspective is also at work in female offenders' lawsuits. According to this theory, litigation outcomes vary with respect to how integrated a person is in social circles, with those who are more successfully integrated in society being more successful in litigation. It is predictable, therefore, that incarcerated populations, who are pushed to the margins of society and are viewed as less deserving of quality medical care under the penal harm perspective (Clear, 1994), are less successful in their legal pursuits (Vaughn & Carroll, 1998).

Cases Related to Failure to Treat Chronic and/or Preexisting Conditions

Due to mass incarceration and an increased use of mandatory minimum sentences, the United States is currently experiencing a rise in the average age of prisoners (Auerhahn, 2002). The aging incarcerated population places a strain on correctional health care services because elderly persons typically have health concerns that require extra care. Compared to free-world elderly patients, elderly inmates suffer

disproportionately from serious and chronic illnesses (Skarupski, Gross, Schrack, Deal, & Eber, 2018). Specifically, 46% of elderly inmates report some kind of health problem at the time of their incarceration (Beckett, Peternelj-Taylor, & Johnson, 2003). These health problems are often comorbid, as elderly inmates have on average three co-occurring chronic illnesses (Aday, 2005-2006). Chronic conditions also adversely impact inmates at a younger age than those in the free-world, as incarcerated individuals are physiologically older than their actual age (Aday, 2005-2006).

Despite female offender populations rising faster than any other demographic, and considering that the average age of incarcerated women is also going up, there has been little research on the care of chronic illnesses in female correctional facilities (Lemieux, Dyeson, & Castiglione, 2002). Available research shows, however, that women enter incarceration with a multitude of preexisting illnesses and disproportionately suffer from chronic illnesses (Aday & Farney, 2014; Lindquist & Lindquist, 1999). The most common reported chronic illnesses among this population are arthritis, hepatitis, hypertension, asthma, cancer, diabetes, kidney problems, and heart conditions (Aday & Farney, 2014; Leigey & Hodge, 2012). While it is well-documented that incarcerated women are a high-risk population with serious health concerns, studies on the care of chronically ill female inmates show that chronic care is inadequate (Dinkel & Schmidt, 2014; Harner & Riley, 2013).

Cases Related to Failure to Treat Chronic and/or Preexisting Conditions Where Plaintiffs Prevail

Some of the most severe cases of failing to treat chronic illnesses can result in an inmate's death. *Estate of Perez by Perez v. Morgan County Sheriff* (2018) exemplifies the

dangers of failing to understand chronically-ill inmates' medical needs. While serving time in a county jail in Indiana, Tammy Perez died from complications of adrenal hyperplasia, a disease that compromised her hormonal balance, which required daily hormone replacement therapy. Those who have this condition become very ill when they do not receive proper medication, developing symptoms of dehydration and electrolyte imbalance that often result in death (National Institute of Child Health and Human Development, 2016).

The facts in *Perez* showed that on the day Tammy was sentenced to jail for drug possession, the plaintiff and Tammy's mother, Sheryl Perez, brought Tammy's medication to the jail and gave explicit directions to the medical staff on how they were to be administered. The medical staff on duty assured Sheryl that her daughter would have the medication daily and that they understood the seriousness of her condition. In reality, the jail officials and medical staff failed to give Tammy her medication, resulting in her death just three days after intake.

During her intake interview, Tammy disclosed to a jail officer that she used heroin the previous night. When Tammy became suddenly and violently ill, the jail nurse assumed that she was suffering from heroin withdrawal. The medical staff made the decision to administer a common withdrawal treatment that involved oral medication, but both the nurse and the other inmates expressed concerns for Tammy as she was not able to keep down a sip of water, much less oral medication. Tammy's condition deteriorated rapidly—she lost control of her bowel movements, threw up anything she ingested, and was severely dehydrated. Tammy and the other inmates repeatedly told staff that Tammy

needed to go to a hospital, but the medical staff continued to give Tammy oral medication, fluids, and Pepto Bismol, all of which she immediately involuntarily purged.

The second night, Tammy reportedly laid on the floor of her cell and repeatedly said, 'help me' loud enough for the officers and jail staff to hear throughout the night. She was unable to control her bowel movements, was still vomiting, and she was allowed to shower twice. The officers who were in charge of taking her to the showers allegedly became frustrated after two showers and told Tammy that "[she was] an adult" and "[needed] to try to make it to the toilet" (p. 7) because they did not want to supervise her showers. Tammy continued to soil herself and vomit in the middle of the night, but she was not allowed to clean herself until the next day. Tammy attempted to call her mother on her third day in the jail, what would be her last day alive, but she could not because her mother had not yet paid for Tammy's phone account so that Tammy could receive calls. On this day, the women incarcerated with Tammy testified that:

> [they] had seen and heard Tammy beg the Jail staff to go to the hospital, and had told Jail staff the same. They had both observed Tammy's inability to keep down any of the medications she was given and had both informed Jail staff of this inability. They had both observed Tammy repeatedly soiling herself with vomit and feces. It was obvious to both women that Tammy's treatment by the Jail was not effective. (p. 7)

At this point, Tammy had been without food, water, and her medication for two days. When she was finally examined by a doctor on the third day, the physician described Tammy as "a little upset" (p. 8) and continued to prescribe oral medication. On this day, the jail officers attempted to move Tammy from one cell to another, but she

reportedly stopped, collapsed, and said she could not continue. In her final hours, Tammy asked for a shower after soiling her jail uniform with urine, vomit, and feces. While in the shower, she could not stand. It took Tammy several attempts to get back to her cell after her shower, all the while being yelled at by the on-duty officers. Tammy eventually made it back to her cell, laid down on her bunk, and did not get up again. Her cause of death was officially identified as complications of her hormonal disorder, not heroin withdraw as the medical staff and officers believed.

Tammy's Estate sought to hold all individuals involved in Tammy's care personally liable for violating her Eighth Amendment rights as well as claims of negligence under state law. The Estate also sought to hold the county Sheriff and the medical organization that oversees medical operations at the jail vicariously liable for their employees' actions. The Seventh Circuit ruled in favor of the plaintiff on some claims, but granted defendants summary judgement on others. The individual jail staff sought summary judgement on all of the claims, arguing that their behavior and treatment were consistent with what any reasonable person would do in the same situation. The motion was granted for six individuals who were not involved in or aware of Tammy's treatment. The county sheriff was also granted summary judgement under qualified immunity. The medical organization that contracted with the jail was granted summary judgement since the plaintiff could not produce a specific policy that led to Tammy's death.

Denying defendants' motion for summary judgement, the Seventh Circuit held that several of the named jail nurses and medical officers who were personally involved in or aware of Tammy's treatment were deliberately indifferent to her serious medical

needs. The defendants also sought summary judgement for the jail's doctor, who oversaw Tammy's care and made the decision to treat her orally for heroin withdrawal. The defendants argued that the doctor did not act with deliberate indifference because he provided Tammy with some care. The Seventh Circuit, however, cited precedent (*Berry v. Peterman*, 2010; *Roe v. Elyea*, 2011), ruling that "the easier and less efficacious treatment for an objectively serious medical condition can still amount to deliberate indifference" (*Estate of Perez by Perez v. Morgan County Sheriff,* 2018, p. 13) and "failure to consider an individual inmate's condition in making treatment decisions is…precisely the kind of conduct that constitutes" (p. 13) deliberate indifference. The court concluded that several of the doctor's decisions met the culpability threshold of deliberate indifference.

This case illustrates the consequences of medical and custodial personnel operating under a penal harm framework, where inmates receive deficient health care. The custodial and medical staff were aware of Tammy's needs, but reacted with incompetence and callousness. When Tammy first fell ill and was obviously not getting better with the oral medication, or even keeping the medication down due to excessive vomiting, the medical staff chose to continue the same ill-advised treatment instead of seeking more serious medical aid. Furthermore, even though the correctional nurse told Tammy's mother she knew how important Tammy's medication was, none of the medical staff made sure that Tammy received her medication. Despite the begging from Tammy and other female offenders in the jail, custodial and medical staff not only failed to take Tammy to the hospital, but dismissed her complaints, downplayed her condition and treated her symptoms as malingering. Evidence showed that Tammy was treated this

way because the medical and custodial personnel assumed that she was just another drug user going through withdrawal; this assumption shows that corrections and medical officials' biases and ignorance toward inmates' medical conditions can have dire consequences.

Cases Related to Failure to Treat Chronic and/or Preexisting Conditions Where Defendants Prevail

Free-world patients with chronic illnesses need regular specialists' visits, and so do chronically ill inmates. It can be difficult, however, for incarcerated women to receive this specialty care since it requires transportation to outside facilities (Deaton et al., 2009-2010; Young & Revere, 2001). This issue arose in *Nash v. Nevada Department of Corrections* (2016), where Nancy Nash alleged several staff at Nevada Department of Corrections denied her request to see specialists for her numerous chronic conditions. In an amended complaint, Nash reiterated that defendants failed to provide medication for her autoimmune diseases and severe pain, did not operate to ease severe, ongoing vaginal bleeding, and did not prescribe vaginal cream for an infection.

The defendants produced evidence showing that at the time the events occurred, the plaintiff was housed in a hospital ward in which she had fulltime access to correctional medical professionals. When she was not residing in the medical ward, evidence showed the plaintiff met with doctors on numerous occasions. While these doctors were not specialists, the defendants argued they provided Nash with adequate care. The Ninth Circuit agreed, not finding the defendants were deliberately indifferent to Nash's serious medical needs. In other words, the court concluded that denying a prisoner's request for a referral to be treated by a specialist in the medical community is

not enough to establish deliberate indifference. The Ninth Circuit granted the defendants' summary judgment motion since the plaintiff merely showed that she disagreed with her prescribed treatment.

In addition to needing specialized care, inmates with chronic conditions have medical needs that require vigilant monitoring and higher diagnostic consideration. Unfortunately, studies have found that some correctional facilities do not regularly monitor chronic illnesses the way they should (Young & Revere, 2001). In *Fraher v. Heyne* (2014), the plaintiff believed that a correctional physician overlooked complications with her heart condition. Fraher entered a women's facility in California with a history of cardiac health issues and an aortic valve problem, making her vulnerable to illnesses and infections. Fraher alleged that, despite knowledge of her condition, the medical staff did not take quick action when she repeatedly complained of flu-like symptoms, which could indicate heart valve infection.

Specifically, Fraher reported seeing the named defendant, a correctional doctor, multiple times for chest pain, cough, night sweats, blood in her urine, a continual low-grade fever, and foot pain. The defendant diagnosed Fraher with a urinary tract infection and believed that her symptoms were related to either her menstrual cycle or menopause, even though the plaintiff previously had a hysterectomy. After persistent symptoms, the plaintiff was transferred to a community hospital, where doctors discovered her aortic valve was deteriorating and required immediate replacement. Fraher argued that the correctional doctors should have taken her symptoms more seriously given her history of cardiac health problems. She believed if they had done so, she would have avoided the health risks surrounding surgery. Granting defendants' motion for summary judgement,

the Ninth Circuit held defendants did not cause, nor could they have prevented, Fraher's valve-replacement surgery. Because of the plaintiff's particular type of cardiac health issue, she would have eventually needed surgery regardless of the defendants' actions.

Incarcerated women also are not taken seriously about their chronic conditions because stereotypes of malingering inmates persist in correctional health care circles (Fisher & Groce, 1985; Vaughn, 1999). These stereotypes led to complications with Wilma Kilpatrick's chronic condition, which she claimed correctional health professionals minimized in *Kilpatrick v. Mekkam* (2005). Kilpatrick was incarcerated with sickle cell disease, a blood disease that can cause harm to organs, bones, and joints if left untreated. While incarcerated, Kilpatrick had medical orders to drink Pedialyte, as it is crucial for those with sickle cell disease to remain hydrated to avoid complications; she was also placed in the Chronic Care Program in her unit. In June of 2002, she met with one of the defendants, a correctional physician, who eliminated Pedialyte and removed her from the Chronic Care Program on the basis that he did not believe she had sickle cell disease. In August of 2003, Kilpatrick went to the emergency room for pain and distorted vision in one of her eyes. She was sent to an optometrist who examined Kilpatrick and diagnosed her with a detached retina. A week later, she had eye surgery.

Kilpatrick alleged that the correctional physician incorrectly categorized her sickle cell disease as trivial, which made treatment of her eye injury more difficult. The prison doctor argued that he made a medically-informed decision using the plaintiff's medical history. The district court found that her complaint stated a cognizable claim for relief against one of the defendants. The court granted the defendants' summary judgement since Kilpatrick did not meet her burden to show the detached retina resulted

from the denial of Pedialyte or removal from the Chronic Care Program. The Ninth Circuit also stated that Kilpatrick's complaint focused more on being upset at the classification of her disease, not on the actual treatment she received. The court concluded that no evidence was offered to demonstrate that the defendant acted with deliberate indifference or knowingly delivered harmful treatment.

Correctional facilities' spatial organizations do not always lend themselves to ensuring inmates have necessary access to medical services (Stoller, 2003). Specifically, inmates with chronic illnesses sometimes struggle to receive their medications in a timely manner because they have to travel across the facility, which proves difficult for inmates with disabilities or chronic conditions that leave them weak or in pain (Stoller, 2003). In *Schoenwandt v. Karan* (2014), Lori Schoenwandt alleged defendants denied and delayed medical care related to a preexisting neuromuscular condition that affected her back, neck, left hand, and right arm. Specifically, Schoenwandt stated that the medical staff were deliberately indifferent to providing her with disability accommodations, as her condition affects her ability to walk, work, and function.

The plaintiff's allegations on the delay in medication stemmed from the failure for someone to deliver her medicine to her, as she could not walk by herself to the medication lines. Schoenwandt alleged that the prison's doctor waited three and a half months to approve the medication for delivery to her unit. Additionally, this same doctor delayed for 17 months recommending the plaintiff be transferred to disability housing. Consequently, the plaintiff suffered abuse and taunting from correctional officers and other inmates in her unit, where her disabilities were not understood. The defendants moved to dismiss Schoenwandt's accusations since there was no proper claim against

them. In granting the motion, the district court ruled that Schoenwandt did not demonstrate that the defendants were deliberately indifferent to her serious medical needs.

Section Summary of Cases Related to Failure to Treat Chronic and/or Preexisting Illnesses

In one of the few studies on incarcerated women's perspectives on dying in prison, Deaton, Aday, and Wahidin (2009) found that women are afraid of getting sick while incarcerated because they believe they will die from lack of care. As *The Estate of Perez by Perez* case shows, these worries are not unfounded. *Perez* shows the dangers of neglecting chronic illnesses and failing to consider an inmate's unique chronic health needs. Additionally, the plaintiff's death was indirectly linked to the actions of correctional physicians, who assumed the plaintiff was just another inmate suffering from drug withdrawal. This is problematic for the treatment of female offenders, in general, but proved fatal when the doctor's biases outweighed the inmate's medical needs. Correctional health personnel need to be vigilant in diagnosing, prescribing, and treating an inmate's chronic or preexisting conditions.

Young and Reviere (2001) found that only seven out of 67 correctional facilities in their sample regularly monitored female inmates' chronic illnesses. This same study reported that incarcerated women with chronic illnesses have difficulty self-monitoring or managing their health conditions due to the lack of control over their diets, stress levels, and medication schedules. While inmates with chronic illnesses know that their health is declining and are in need of specialized treatment, which the plaintiffs expressed in *Fraher, Nash, Kilpatrick,* and *Schoenwandt,* it can be difficult to receive specialized

medical care due to correctional personnel's rejection of specialty care. Thus, chronically ill female inmates see their health declining but have trouble navigating the prison health care system, adding stress, fear, and anxiety to their incarceration experience (Aday & Farney, 2014). Legally speaking, if a prison doctor diagnoses and treats an inmate condition—even if it is outside the physician's area of expertise—courts consider inmates' requests for specialists as a mere disagreement with the treating doctor's orders, which is not actionable under Section 1983.

In their study, Deaton et al. (2009) concluded that health professionals treated chronically ill and elderly inmates poorly and that penal harm medical practices increased chronically ill and elderly inmates' anxieties about death. Inmates reported correctional personnel did not take their conditions seriously and operated under the principle of less eligibility, where inmates' medical needs are not as serious as free-world patients', and inmates are not privy to free-world standards of health care. Taken as total institutions (Goffman, 1961), correctional facilities deprive incarcerated populations of certain resources and autonomy, leaving them reliant on correctional personnel for necessities and safety (*Estelle v. Gamble, 1976*). Since these institutions are often driven by the penal harm perspective, which advocates "no frills" austere prisons with few comforts that emphasize misery for offenders, custodial staff need to value inmate lives. The litigation from these cases demonstrates that it is difficult for incarcerated women to prevail on Eighth Amendment lawsuits under Section 1983 based on the mismanagement of their chronic illnesses. Denying prisoners relief is a symbol of penal harm ideology—where basic care that is not deliberately indifferent to serious needs is the acceptable standard, a minimalistic approach to health care.

Cases Related to Pregnancy

It is estimated that up to 10 percent of female offenders are pregnant when they enter incarceration (Kelsey, Medel, Mullins, & Dallaire, 2017; Maruschak, 2006). Some researchers (Knight & Plugge, 2005) argue that incarceration may improve pregnancy outcomes. This is because, when compared to women from similar backgrounds as the average female offender, correctional facilities provide structure and care that may benefit pregnant offenders more than similarly situated free-world pregnant women. Other studies, however, (Kelsey et al., 2017; Ferszt & Clarke, 2012; Tapia & Vaughn, 2010) have produced findings that suggest pregnant inmates suffer at the hands of correctional health providers.

One of the most pressing concerns associated with pregnant offenders is the use of shackling or other harsh disciplinary measures, especially in later trimesters or during labor and delivery. Indeed, recent research and news stories on this practice shows that it is still prevalent despite attempts to ban it (Southall, 2019; Sussman, 2009; Thomas & Lanterman, 2019). Pregnant offenders also face challenges in receiving adequate prenatal care, including balanced diets, extra food, and vitamins (Ferszt & Clarke, 2012; Goodman, Dawson, & Burlingame, 2016). Research also finds that correctional facilities do not always provide special accommodations to pregnant offenders, such as bottom bunks, extra pillows, breaks from work assignments, or extra time to rest (Ferszt & Clarke, 2012). Finally, pregnant offenders are also in need of perinatal and postnatal care as well as access to parenting, birthing, and family planning classes (Alirezaei & Roudsari, 2020; Bard, Knight, & Plugge, 2016; Hotelling, 2008).

Cases Related to Pregnancy Where Plaintiffs Prevail

News reports on the experiences of pregnant female inmates have helped to illuminate their widespread neglect. The Washington Post, for example, tells the story of Diana Sanchez, who gave birth in her jail cell without any medical attention despite telling on-duty correctional officers she was in labor (Chiu, 2019). Case law shows Sanchez is far from the only incarcerated woman who has been ignored during labor. *Coleman v. Rahija* (1997) provides an example, in which the plaintiff, Gloria Coleman, brought Eighth Amendment violation allegations against Ruth Rahija, a prison nurse, for being deliberately indifferent to her medical needs during labor. Coleman, who was seven months pregnant, began experiencing spotting with back and stomach pain. When she notified the correctional health staff, they contacted a university hospital and were told to monitor the situation. Specifically, a doctor informed them that increased bleeding would be cause for concern. Despite this direction, when Coleman alerted the medical staff her bleeding worsened and showed them a sanitary napkin as proof, they threw the napkin in the trash. Hours later, Coleman began to experience labor pains and went to the medical unit for an examination. Rahija sent Coleman back to her cell without taking vital signs, performing a vaginal examination, or checking the baby's heart tones.

Later the same day, Coleman reported to Rahija that her pain was worsening, she was still bleeding, and she had contractions that were six minutes apart. In response, Rahija simply touched Coleman's abdomen and, despite thinking Coleman might have been in "possible early labor" sent her back to her cell because Rahija "was unable to feel any contractions" (p. 782). That night, Coleman's labor progressed to the point where she was expelling significant amounts of blood, was screaming in pain, and had the urge to

push. At no point did she receive a vaginal examination, which likely would have proven she was dilated and in premature labor. Coleman had complications in all of her previous pregnancies, which had also been early, quick deliveries, which was recorded in her medical records. Despite her medical history and repeated reporting of labor pains, Coleman was not sent to a hospital for medical attention until she could not stand from the pain and informed the prison medical staff she felt like she needed to push her baby out. Coleman delivered a premature baby boy shortly after arriving at the hospital with no complications. She filed this suit almost two months after her son's birth.

The district court found that nurse Rahija's actions were deliberately indifferent and awarded Coleman compensatory and punitive damages amounting to $3,500. Rahija appealed to the Eighth Circuit on the grounds that courts have previously established pregnancy alone is not a serious medical need (*Boswell v. County of Sherburne*, 1988) and that Coleman failed to present clear evidence that her symptoms warranted medical attention. The court of appeals held that, while pregnancy alone is not a serious medical need, Coleman provided evidence that she was at substantial risk of pregnancy complications such that a layperson would have recognized as necessitating medical attention. The Eighth Circuit also held that there was enough evidence to show Rahija was deliberately indifferent to Coleman's medical needs and placed Coleman and her child in substantial risk of harm by not taking Coleman's labor complaints seriously. Furthermore, the court held that Rahija's deliberate indifference caused extensive physical and psychological damage that would have been avoided had the nurse acted sooner. The court let stand the compensatory damages but vacated the punitive damages since Rahija's actions, while deliberately indifferent, were not malicious or callous; thus,

the Eighth Circuit concluded that punitive damages are only appropriate when there is a clear evil motive or intent to cause harm.

Researchers, advocates, and health professionals have challenged the use restraints or shackles on pregnant women for decades (Alexander, 2010; Amnesty Internation, 2000; Griggs, 2011). Despite a broad body of research from social scientists and medical experts, reports from incarcerated women show that correctional facilities are still shackling women during their pregnancies and even during labor (Southall, 2019). In *Brawley v. Washington* (2010), Cassandra Brawley sued Washington State, the Washington State Department of Corrections, and two named correctional officers for being shackled to a hospital bed while she gave birth in 2007. Brawley stated that anytime she was transported to a hospital for prenatal care, she was placed in full restraints, including handcuffs that attached to a metal chain around her waist. Once it was confirmed by a jail nurse that Brawley was in labor, with contractions three minutes apart and lasting 30 seconds, she was strip-searched and put in full restraints to prepare her for transportation. When they arrived at the hospital and entered the examination room, the officers removed her restraints only to chain her to the hospital bed by her ankle. This ankle chain did not allow her to get up and walk or give her full mobility, which is essential for pregnant women to move to different positions to ease labor pains.

At one point during early labor, the hospital staff needed to transfer Brawley from the examination room into a delivery room. At this point, the hospital staff confirmed she was having contractions and vaginal spotting and were concerned that something was wrong with her child, possibly an infection. The correctional officer was informed of Brawley's condition, but she still chained Brawley to a wheelchair during the room

transfer and once again chained her to the bed in the delivery room. As her labor complications progressed, it was decided that she needed an emergency cesarean (c-section). The officer unchained Brawley's leg just before the surgery, but re-applied the restraint immediately afterwards, "before she could even feel her legs" (p. 1213). When Brawley recovered enough to see her child in the NICU hours later, she was again chained to a wheelchair and could only walk one or two steps away from it. Although the nurses wanted her to walk around after the c-section, Brawley reported that she had difficulty doing so because she was placed in leg restraints.

Brawley was given a "medium security" (p. 1211) classification because of two outstanding warrants on her record for felonies in other counties. This classification, along with a history of failing to report while on community supervision, earned her the label of "escape status" (p. 1211). The plaintiff argued that this status, which was based on pre-incarceration behavior and technicalities, was not enough to prove that Brawley was a flight risk. In fact, one of the named defendants who transported the plaintiff to the hospital admits that she was not told Brawley posed any type of risk or escape; the officer knew Brawley was in her third trimester and was not feeling well. Furthermore, at the time of her birth, The Washington State Department of Corrections had a policy that "female offender[s] will not be restrained during labor and delivery" (p. 1213), which was clearly not followed. In *Brawley*, correctional officers did not have any security-related justification for the use of restraints, and their actions violated departmental policy.

The defendants sought dismissal on the grounds of qualified immunity, stating that the two named correctional officers were not fully aware of Brawley's medical needs

and thus did not violate the Eighth Amendment. While the defendants argued that it was not clear when Brawley went into labor and they could not be certain whether her condition constituted as a serious medical need, there is evidence from the jail's own medical records that Brawley was having contractions before she was transported. Brawley filed a motion for partial summary judgement against the officer who shackled her to the hospital bed, but the court ruled that there was a genuine issue of fact as to whether this officer was aware of Brawley's rights in that moment, and so denied Brawley's motion against this officer. However, the Ninth Circuit also denied the defendants' motion for dismissal, stating that Brawley succeeded in demonstrating she had serious medical needs and her rights were clearly established.

As researchers and health professionals have contended, shackling during labor and birth can not only negatively affect the delivery, but can also have lasting physical and psychological effects on the pregnant woman (Amnesty International, 2000). The consequences of shackling was illustrated in *Nelson v. Correctional Medical Services* (2009). In this case, Shawanna Nelson sued under Section 1983 the Director of the Arkansas Department of Corrections (ADC) and one named correctional officer after Nelson's legs were shackled to a hospital bed while she was in the final stages of labor. Specifically, Nelson alleged that the director placed her, and other pregnant inmates, at serious risk of harm by not following appropriate policies and practices when dealing with pregnant inmates. Furthermore, she claimed that the named defendant, Officer Turensky, acted against medical professionals' recommendations and violated prison regulations that required officers to "balance any security concern against the medical needs of the patient" (p. 525) when the officer shackled her during labor. Finally, Nelson

argued that a layperson could discern that she did not pose a security risk while "on the verge of giving birth" (p. 525); thus the use of shackles were not only unnecessary, but cruel and unusual. The district court denied the defendants' motion for summary judgement based on qualified immunity.

Nelson, a nonviolent offender, went into labor at the ADC and was immediately transported to a hospital for her delivery. Turensky was tasked with riding with and guarding Nelson to the hospital and during the hospital visit. Despite testifying that she never felt threatened by Nelson and had no reason to believe she was a flight risk, Turensky shackled Nelson's legs to a wheelchair once they arrived at the hospital and shackled both of her ankles to the hospital bed when she was in the maternity ward. At the time that Turensky made the decision to use shackles on Nelson, it was clear that she was having contractions and that her cervix had dilated to seven centimeters, meaning she was "well into the final stage of labor…" (p. 526). A nurse requested that Turensky remove the shackles, but she did not comply. As a result of the shackles, Nelson testified she could not move her legs or change positions during the most painful part of her delivery. Additionally, she reported that the shackles caused mental anguish, a permanent hip injury and deformation that would likely cause lifelong pain, torn stomach muscles, an umbilical hernia, and damage to her sciatic nerve.

The ADC policies on shackling inmates during labor or delivery stated that shackles should only be used "when circumstances require the protection of inmates, staff, or other individuals from potential harm or to deter the possibility of escape" (p. 527). By Turensky's own admittance, she did not think any of those circumstances applied to Nelson at the time of her labor or delivery. Despite this admission and reports

in her testimony that she personally believed shackling pregnant inmates was wrong and could lead to complications or injury, Turensky and the director of ADC both argued that their actions did not violate any of Nelson's clearly established constitutional rights and thus moved for qualified immunity. On the decision of Turenky's qualified immunity defense, the Eighth Circuit held that evidence showed Turensky was aware of the serious risk shackling posed to Nelson and applied shackles regardless of that risk, constituting violations to Nelson's Eighth Amendment rights. They also held that Turensky was aware of Nelson's clearly established right to not be shackled during birth, which discounted her qualified immunity defense. However, because the director of the ADC had no personal part in Nelson's delivery and had no knowledge of the care she received, the circuit judge granted him summary judgement based on qualified immunity. The appeals court remanded this case to the district court for trial. In *Nelson v. Turensky* (2010), a jury awarded Nelson $1.00 in damages.

Although shackling pregnant prisoners is widely considered barbaric and condemned, corrections officials often justify this practice based on safety, custodial, and security concerns, arguing that inmates attempt to escape during hospital visits, thus justifying the use of restraints as a precaution (Smith, 2016). Researchers have pointed out, however, that these types of escape attempts are more common among male inmates, and it is rare for a female inmate to attempt to escape or cause harm during her labor and delivery (Clarke & Simon, 2013). Therefore, while restraining pregnant inmates is, on its face, a gender-neutral security precaution, from a security perspective, this practice is unnecessary. Moreover, this is yet another penal harm strategy to create additional degradation and humiliation, inflict pains of imprisonment on incarcerated pregnant

women, and can lead to complications that can harm the child and mother (Kalmanson, 2016).

Many states now have policies that limit the use of shackling pregnant inmates to situations in which the inmate poses a danger to themselves or others (Thomas & Lanterman, 2019). The problem, however, is that individual facilities and security staff do not always act in accordance with these policies (Goodman et al., 2016). In *Mendiola-Martinez v. Arpaio* (2016), leg and handcuffs were applied to the plaintiff during early labor while she was transferred to the hospital, post c-section while she was in the recovery room at the hospital, where she was attached to her hospital bed via a six foot long chain that she had to drag on the floor when she went to the restroom, and on her way out of the hospital. Mendiola-Martinez sued Maricopa County, Arizona, Sheriff Joe Arpaio, the medical center where she had her baby, and John and Jane doe defendants. The district court granted summary judgement for Maricopa County, Arpaio, and the medical center and ordered that the plaintiff pay $1,971 to the medical center and $936 to the county. Mendiola-Martinez appealed to the Ninth Circuit.

Correctional policy required restraining pregnant inmates in labor when they were being transported to the hospital. Additionally, prisoners were required to be restrained while they were in the hospital unless medical professionals requested otherwise. These policies did not have an exception for pregnant women. Four days before Mendiola-Martinez delivered her baby, the correctional facility released a memorandum that stated officers should “remove the restraints…during the stage of active labor” as to prevent injury to mother or child during delivery (p. 1245). The plaintiff argued that the officers’ decision to restrain her during her transportation to the hospital, when she was

experiencing labor pains and was thus in active labor, was in violation of the memorandum and constitutional protections against cruel and unusual punishment.

The plaintiff had to show that shackling during her labor and recovery constituted a substantial risk of harm; to do this, Mendiola-Martinez had expert report from a gynecologist, who stated that shackling "'at any point in pregnancy…and during postpartum recovery' poses a threat to the mother" (p. 1251). The gynecologist said restraints limit the ability of medical professionals to evaluate women and assist with the delivery, may cause injury while she moves her body in response to contractions, increases the risk pre- and post-labor, and limits a woman's ability to walk, which is essential after a c-section to decrease the risk of blood clots. The Ninth Circuit concluded that since the plaintiff was a nonviolent offender, the restraints inflicted a substantial risk, and thus met the culpability threshold of deliberate indifference. Furthermore, given that Mendiola-Martinez did not pose a threat or danger to others, was visibly in pain on her way to the hospital that would prevent her from fleeing, and was constantly supervised by an armed officer, the court also stated that the use of restraints was an "exaggerated" response (p. 1255). The court vacated the summary judgement for Maricopa County and Sherriff Arpaio on the claims that the plaintiff was shackled during labor and transportation to and from the hospital. In conclusion, the Ninth Circuit remanded for a jury to determine county and sheriff's liability. The court affirmed summary judgement for the medical center and the $1,971 cost award in its favor because the court did not find the medical center abused its discretion.

Studies suggest that incarcerated women are more vulnerable to pregnancy complications, miscarriages, and stillborn deaths (Ferszt & Clarke, 2012; Fogel, 1993).

These complications may be due in part to female offenders' socioeconomic disadvantage and limited access to health care in the free world (Hotelling, 2008). Pregnant women's health concerns are exacerbated in correctional settings, where corrections personnel do not always give them the attention and care they need. A particularly tragic case, *Pool v. Sebastian County, Ark.* (2005), illustrates the experience of miscarriage while incarcerated. Talisa Pool alleged that corrections personnel at Sebastian County Detention Center (SCDC) were deliberately indifferent to her serious medical needs, causing her to miscarry four months into her pregnancy.

Pool informed a nurse she was spotting and requested Tylenol and sanitary pads, but the nurse told Pool to go back to her cell and rest. Pool was able to get pads from a fellow inmate, which she quickly bled through and onto her clothing. At one point, Pool was transported to Benton County jail, where she would serve the remainder of her sentence. During transportation, she bled through her clothes and onto the seat of the vehicle. When officers at the jail saw her clothes, they immediately took her to see a nurse, who expressed concern that she had not seen a doctor. Pool was transported back to SCDC and placed in an observation cell to monitor her condition. Pool spent one night in the observation cell, during which she alleged that no one came to check on her except for a female officer who delivered her food through the door window.

Throughout the night, Pool continued to cramp so badly she could not eat and continued to pass blood clots. She screamed and banged on the door to get the officers' attention, but when they came to check on her, they simply told her to lie down and that there were no doctors available to see her. Pool miscarried her child over the toilet in the observation cell sometime after midnight, catching her child in her shirt. When the

officers came to check on her, having seen her miscarry over the observation camera, she was crying and holding her fetus in her lap. They reportedly stood at the window and asked "Is a child really there?" (p. 939) and directed Pool to hold the fetus up so they could affirm. Pool told them she could not do that because the cord was still attached to her, at which point the officers finally called paramedics and had her transferred to a hospital. One of the officers on duty, Deputy Griffin, wrote an affidavit that illuminated the level of neglect and indifference other officers engaged in while Pool miscarried alone in the cell. Her affidavit said:

> [Deputy Griffin] was aware that Pool had been bleeding prior to miscarrying. Two days before Pool miscarried, Deputy Griffin delivered a used sanitary pad to her supervisor and was told to get it off the desk [and]…to quit being an inmate-lover, to toughen up, and to 'not let these people get to you.' The supervisor also commented: "Fuck her [Pool], she's going to prison and doesn't need a baby anyway… (p. 940)

In response to Pool's lawsuit, the district court denied the defendant's motion for summary judgement based on qualified immunity. On appeal to the Eighth Circuit, the court held that the plaintiff proved she was suffering from a serious medical need and that the officials acted with deliberate indifference. The Eighth Circuit rejected the officials' argument that Pool failed to demonstrate the miscarriage posed a serious threat to her own health since she was not "showing (p. 944). The officials contended that Pool failed to demonstrate that the miscarriage posed a serious threat to her own health, merely her unborn child's, and that her medical needs were not obvious because she was not "showing" (p. 944). The court held that Pool had a serious need for medical attention that

would have been obvious to a medical official. Moreover, Deputy Griffin's affidavit revealed that "everyone on her shift was aware of what was happening to Pool because they had talked about it…and [they believed] that Pool just wanted attention" (p. 940). The Eighth Circuit concluded that it was clearly established that being pregnant is a serious medical need, that the defendants were aware of this need, and it required appropriate treatment.

Cases Related to Pregnancy Where Defendants Prevail

Complications with pregnancy or the development of a fetus can create health problems with women living in the free world, but even more so among incarcerated populations, who often feel as though they have limited options and are pressured into decisions by correctional physicians (Goodman et al., 2016). In *Pohlman v. Stokes* (1987), Denise Pohlman allegedly had her pregnancy terminated without informed consent. When she was admitted into the correctional facility, Pohlman informed staff that she was four months pregnant, which was confirmed by the intake physical examination.

Two months into her sentence, the plaintiff received an ultrasound that revealed the fetus was anencephalic, meaning that it was not developing parts of its brain or skull (Centers for Disease Control and Prevention, 2019). After a sonogram confirmed the anencephaly, Pohlman met with her chaplain, a doctor, and the baby's father to discuss terminating the pregnancy. In these meetings, it was decided that medical professionals would induce labor to deliver the baby early, and it died shortly afterwards. While the defendants claim this was a meeting to discuss potential options for the delivery, Pohlman alleged that the health professionals did not properly explain what would

happen if she induced labor and that she consented without fully understanding the procedure's outcome.

After the procedure, Pohlman experienced continuous heavy menstrual bleeding. She returned to the correctional facility and was placed on a health plan that was intended to stop the bleeding. She was told by nurses and a gynecologist that her bleeding was normal, and it did not require treatment; however, she was transferred to a different unit a month later, where a different gynecologist diagnosed her with an infection from prolonged bleeding. One month after her release, Pohlman got pregnant again, but she was forced to undergo emergency surgery for an ectopic pregnancy and was told that she had suffered substantial damage to her reproductive organs and would never be able to have children. Pohlman believed that the damage to her reproductive organs stemmed from the delayed prison diagnosis of her infection and inappropriate health care regarding the earlier pregnancy's termination. Granting the defendants summary judgement, the court said Pohlman's argument more resembled a difference of opinion in treatment and medical malpractice, not deliberate indifference. Additionally, the court stated that Pohlman's complaint revealed that she had access to medical care, and merely disagreeing with the course of treatment does not constitute an Eighth Amendment violation.

Even though Pohlman received poor treatment, negligence does not generate enough culpability to violate the Eighth Amendment in a Section 1983 lawsuit. In free-world medical malpractice cases, plaintiffs need to shows doctors were negligent, Constitution claims pursuant to Section 1983 must show that defendants acted with deliberate indifference to serious medical needs. Free-world patients are also granted

higher degrees of autonomy in their health care decisions, whereas incarcerated persons must accept the treatment they receive. Generally speaking, inmates cannot sue under Section 1983 for disagreeing with the medical provider's treatment decision as long as it is based on the medical officials' professional judgement. From a penal harm lens, this emphasizes inmates' powerlessness and dependence on custodial and medical officials. For pregnant inmates, having little control over their pregnancies and health care choices adds to their stress, fear, and to the pains of imprisonment.

In addition to lacking control over decisions about their pregnancies, pregnant inmates also commonly express frustration in not being able to maintain a balanced diet (Goodman et al., 2016). Although many facilities have policies specifying that pregnant inmates receive a diet designed for their prenatal or perinatal needs, they often do not specify what that diet looks like and have no way to hold facilities accountable for actually providing it (Ferszt & Clarke, 2012; Goodman et al., 2016). This issue is explored in *Patterson v. Carroll County Detention Center* (2006), where Elizabeth Patterson sued under Section 1983 after she miscarried while incarcerated because the detention center did not provide her with adequate nutrition and vitamins. While the Carroll County Detention Center (CCDC) provided prenatal vitamins, they denied Patterson's verbal requests for milk, snacks, and vitamins to increase her consumption of calcium and protein and delayed her access to medical attention.

The night before she miscarried, Patterson experienced severe cramping. She knew from previous pregnancies that her pain was unusual and cause for concern, so she alerted the on-duty jail staff. While their actual responses are unclear, Patterson said that the officers did not take her request seriously and delayed her medical care because they

"believed that the cramps were merely a symptom of pregnancy" (p. 1), which does not itself qualify as a serious medical need. After a restless night of worrying and cramping, Patterson's water broke. At this time, she was only six months pregnant. After removing Patterson from her cell, officers had her wait in an office while they determined which hospital was authorized to transport inmates. They decided on a hospital 30 miles away, even though there was another hospital in their county.

Patterson went into labor at the hospital only to deliver a nonviable fetus. According to the OB/GYN, the state of the fetus at birth indicated that Patterson had likely miscarried days or weeks earlier. Because of this finding, the Eighth Circuit concluded that the officers' actions during Patterson's labor would not have made a difference in her delivery outcome. Furthermore, Patterson's claims that the Center refused to provide her with additional sources of protein and calcium was dismissed since she could have purchased these items from commissary.

On the issue of whether jail officers violated the plaintiff's Eighth Amendment rights by not taking her cramps seriously and acting accordingly, the court stated "no reasonable jury could find that a guard who brushes off an inmate…that is four to five months pregnant…but had not experienced *any* prior complications…was 'deliberately indifferent…'" (p. 4). Additionally, the mere "knowledge that Patterson was indeed pregnant…did not place the CCDC on notice that [she] had a serious medical condition requiring 'immediate attention'" (p. 4); rather, Patterson's condition was only considered serious after her water broke, at which time, the court concluded, the officers reacted appropriately.

The *Patterson* court said that pregnancy itself is not a serious medical need. According to this decision, pregnant inmates are only considered to be in serious need of medical attention when they are in labor or experiencing severe and obvious complications. This is problematic considering that complications in pregnancy are not always obvious, which could lead to inmates miscarrying and not receiving needed medical attention because correctional personnel do not regard their condition as serious. Additionally, because many female inmates are considered to have high-risk pregnancies (Sufrin, 2018), custodial and medical staff should treat all pregnant inmates' medical needs seriously. The idea that pregnancy itself does not constitute a serious medical need in correctional environments is consistent with penal harm practices, where security and custody are prioritized over health and wellbeing.

A similar situation occurred in *Cooper v. Rogers* (2013), where Brittany Cooper alleged that correctional officers' deliberate indifference to her serious medical needs caused her miscarriage. Cooper was placed in the Bullock County Jail in 2009 after violating the terms of her probation, where she waited to be transferred to the Alabama Department of Corrections. While waiting for this transfer, Cooper was taken to a doctor, where she tested positive for pregnancy during a standard urinalysis test. The doctor ordered a follow-up appointment with an OB/GYN that Cooper would never receive, although she informed jail officials that she tested positive for pregnancy. Sometime after she was admitted to the Bullock County Jail, Cooper was released on house arrest.

Shortly after her release, she violated the terms of the house arrest and was reincarcerated; on the day she returned, she informed the officer on duty she was pregnant. She began experiencing extreme cramping and spotting, which made her

concerned for the health of her child. Although she made daily verbal requests for medical attention, correctional officers did not oblige. Her pain continued and worsened for several weeks until she was finally allowed to visit an emergency room. Hospital doctors tested her for pregnancy, but the results were negative, meaning Cooper miscarried before arriving at the hospital.

The district court made several conflicting rulings surrounding this case. First, the court held that the defendants were deliberately indifferent to Cooper's serious medical needs, violating her Eighth Amendment rights. Specifically, Cooper repeatedly informed correctional officers that she was spotting with pain and requested medical attention. Instead of providing medical care, the named correctional officer reportedly told Cooper that he would "send her to Tutwiler, a state women's prison, because the county did not have any money to pay for her care" (p. 28). The same officer told Cooper to "act like he was invisible and that he was not responsible for what happened on the weekends while he was 'off duty'" (p. 26). Another officer allegedly ordered Cooper to "keep the baby inside her until she went back to court" (p. 26) when her bleeding and pain worsened. The court held that this inaction and denial of Cooper's request to see an OB/GYN were enough to show deliberate indifference.

The court, however, did not find the defendants responsible for causing Cooper to miscarry. According to the court, there was no evidence that the defendants' actions were enough to cause a miscarriage, so there was no certainty that if the defendants had taken Cooper to the doctor that the baby would have survived. Additionally, the court stated it could not rule out the possibility that Cooper herself did something that caused harm to her unborn child in the short time period that she was on house arrest. Therefore,

although there is no disagreement that the defendants were deliberately indifferent to Cooper's serious medical needs, they were not held liable for Cooper's miscarriage.

Summary of Cases Related to Pregnancy

The most important precedents in this section of the thesis are those on shackling pregnant offenders. The courts in *Brawley, Nelson,* and *Mendiola-Martinez* held that using shackles or restrains on inmates at any point during labor or delivery, including during transportation, is a violation of the Eighth Amendment. Additionally, the *Coleman* court established that correctional health professionals need to consider pregnant inmates' previous labor complications when making treatment decisions. Because the plaintiff in *Coleman* had problems with past deliveries and demonstrated current complications, the court found the defendant failed to adequately treat the inmate's serious medical needs by ignoring her symptoms and delaying medical attention. The *Pool* case demonstrates that correctional medical staff can also be held liable when they knowingly delay or deny care to an inmate who miscarries. Though the *Pool* defendants argued they could not be held liable because the plaintiff was not visibly pregnant, the court held that her prolonged symptoms of bleeding and cramping constituted serious medical needs and required appropriate care.

The cases in which plaintiffs did not prevail reveal that care for pregnant inmates remains in need of improvement. Particularly concerning is the *Patterson* court's decision that pregnancy itself is not a clearly established serious medical need. Pregnant women require special medical treatment and accommodations that even a layperson would recognize; therefore, it should be clear that pregnant offenders automatically have a clearly established right to medical attention even if they are not experiencing

complications or are not in active labor. The fact that corrections officials argue pregnant offenders do not automatically have this medically necessary right is indicative of penal harm ideology. Under this view, pregnant inmates must be visibly suffering or in active labor to receive medical attention, which suggests healthcare personnel deprive medical care until inmates' absolutely need it.

Cases Related to Reproductive Health

Under *Estelle*, plaintiffs must prove that correctional personnel "[had] absolute knowledge of [inmates' serious] medical needs, as opposed to an awareness of, or a reasonable expectation to perceive, than an inmate's need has not been addressed" (Weatherhead, 2003, p. 438). This standard places a high burden of proof on incarcerated individuals, especially female inmates, who must not only prove that correctional personnel acted deliberately, but also that their medical needs are serious enough to invoke Eighth Amendment protections. Some researchers believe that the male-centered perspective of prisons and jails makes it so that female offenders' needs are minimized (Swavola, Riley, & Subramanian, 2016; Weatherhead, 2003). The standard of deliberate indifference is itself based on a male-model of care, which some argue results in courts not viewing certain aspects of female offenders' health care as necessities (Weatherhead, 2003).

The penal harm perspective is also reflected in the widespread neglect of providing reproductive health care to incarcerated women despite research that repeatedly shows they are vulnerable to reproductive health issues and are in dire need of these services (Clarke et al., 2006; Knittle et al., 2017). This includes preventative screenings, such as pap smears, gynecological examinations, mammograms, and STD/STI testing.

Along with reproductive health care, the systemic absence of providing female inmates adequate access to menstrual hygiene products, an obvious necessity to feminine hygiene, suggests that some of correctional health care officials are not sufficiently focused on women's needs (Shaw, 2019; Walsh, 2016). Restricted access to these products dehumanizes female inmates and sometimes forces them to live in unsanitary, unhygienic conditions; thus, denying women access to feminine hygiene products exemplifies the penal harm agenda to increase pains of imprisonment, humiliate, shame, and demoralize female offenders. The following cases discuss litigation on female inmates' access to reproductive health care services and menstrual hygiene products and courts' decisions on when their denial or delay constitutes a constitutional violation under Section 1983.

Cases on Reproductive Health Where Plaintiffs Prevail

Although researchers and advocates have demonstrated that incarcerated women have different health care needs than incarcerated men, correctional facilities struggle to address these needs (Swavola et al., 2016). These differing needs include the most important: access to preventative reproductive health care screenings. The responsibility of correctional facilities to provide these services was litigated in *Women Prisoners of the District of Columbia Department of Corrections v. District of Columbia* (1994), a class action suit brought by female inmates from various correctional facilities within the District of Columbia. Plaintiffs outlined many problems associated with policy and procedure, conditions of confinement, and medical services. Here, the focus is on allegations pertaining to reproductive health care services.

In addressing the plaintiffs' complaints, the district court recognized that female inmates, as a "high-risk" population, need to be examined much more frequently than the

general population. Therefore, gynecological services, such as pelvic examinations, pap smears, culture testing for sexually transmitted diseases, thyroid examinations, breast examinations, and rectal examinations should be provided to all female inmates. The plaintiffs stated that these examinations were not performed in a timely or routine manner, and some were not given upon intake. This was in direct violation of a District of Columbia Department of Corrections policy that stated all arrivals would be given a medical examination within 24 hours of intake. The plaintiffs also complained that when they did receive medical tests and services, the follow-up care procedures were inadequate, and they often waited for long periods of time before receiving necessary treatments or medicine.

To remedy these complaints, the U. S. District Court for the District of Columbia proposed several orders that would improve preventative reproductive health care services as well as OB/GYN care. These orders included hiring midwives and additional nurse practitioners or physician's assistants with training in OB/GYN services, establishing a prenatal clinic, adding inquiries about use of contraceptives, taking a history of pregnancy, and documenting women's last known period at intake screenings, as well as providing gynecological examinations within 14 days of admission. Furthermore, the court ordered defendants to implement changes to the way they cared for pregnant inmates, including prohibiting the use of shackles in labor, during delivery, or in recovery. These orders were made in 1994, and the district court finalized them in 1997. On remand, the only health care orders that remained were eliminating shackling pregnant women during labor and during the last trimester.

While *Women Prisoners of the District of Columbia* recognized female offenders are a high-risk population and require gender-specific medical care, the final ruling only addressed a small part of their needs. The plaintiffs' complaints about reproductive health care, such as hiring trained OB/GYN staff, prenatal care, and providing routine gynecological examinations, were not rectified in the class action, so the court did not consider these services necessities. Researchers on the importance of preventative reproductive health care for incarcerated women would disagree (Clarke et al., 2006; Walsh, 2016). This issue was raised in *Laube v. Campbell* (2004), where women incarcerated by the Alabama Department of Corrections (ADOC) filed a class-action lawsuit, alleging that state officials denied health care to female prisoners' serious medical needs, which amounted to deliberate indifference. When the case was originally heard in 2002, the parties came to a settlement agreement. The state proposed remedial and supplemental plans that were later approved by the U. S. District Court.

Importantly, the settlement stated that new policies must be implemented to improve intake screenings, tuberculosis testing, and regular physical examinations that included annual pap tests, cervical screenings, and pregnancy testing. The district court recognized that incarcerated women are entitled to periodic mammograms, as is outlined by the American Cancer Society (ACS) (ACS, 2019). If any of these tests yielded abnormal results, then the correctional health care system would be required to inform the patient about their results. The patient would then need to receive timely, adequate follow-up care. The settlement also included mandated improvements to women's specific health concerns, such as osteoporosis, menstrual abnormalities, ovarian and

cervical abnormalities, and menopause, in accordance with the American College of Obstetricians and Gynecologists (ACOG) (ACOG, 2012).

These cases show that correctional facilities can be found liable for failing to provide female-specific health care services. These rulings are certainly groundbreaking, considering that correctional facilities have always been androcentric, and prove that female inmates' unique health concerns are protected under the Eighth Amendment. Unfortunately, as will be seen in the cases where the plaintiffs did not prevail, reproductive health care and access to menstrual hygiene products must still be improved. The inadequacies of these services are likely a product of the penal harm mindset and the permeating belief among corrections officials that female inmates are more difficult to care for than male inmates, which could create an attitude of reluctance and indifference to their medical services (McCorkel, 2003).

Cases on Reproductive Health Where Defendants Prevail

Gynecological services and routine preventative reproductive health care are needed to provide early diagnoses for conditions such as cancer, pelvic inflammatory disease, ovarian cysts, sexually transmitted diseases, among many others (Clarke et al., 2006). Studies have found, however, that correctional facilities often do not have on-site gynecology care or OB-GYN specialists, meaning that incarcerated women face barriers in receiving timely and competent treatment (Kraft-Stolar, 2015). Not providing these services constitutes deliberate indifference to female inmates' serious medical needs, as is outlined in *Laube v. Campbell* (2002). Limited access to gynecological care stems from penal harm medicine in that correctional officials may not take these needs seriously, as correctional health care systems generally focus on treating immediate health threats, not

providing proactive health care. Due to the punitive nature of correctional facilities, in other words, preventative reproductive care may not always be a priority or a necessary health service. While not providing preventative reproductive health care or gynecological examinations does not necessarily result from malicious intent, it does suggest that correctional health care programs are either indifferent toward or ill-informed on incarcerated women's specific health care needs.

Snyder v. Lakin Correctional Center (2019) exemplifies the dangers of delaying treatment for reproductive health issues. The plaintiff, Sarah L. Snyder, alleged that defendants, Lakin Correctional Center in West Virginia, violated her constitutional rights based on medical deliberate indifference. While incarcerated at Lakin in May 2016, Snyder began experiencing severe menstrual bleeding. Snyder reported the condition to prison staff and requested to be seen by the medical unit, but she was repeatedly denied. When Snyder was eventually sent to the medical unit, the correctional officers in the medical unit ordered her to return to her cell without receiving any care. While still requesting medical attention, Snyder fell ill from progressive blood loss. On June 9, 2016, medical staff checked her blood count and, upon discovering it was abnormally low, sent her to the hospital for a blood transfusion. Snyder was eventually transferred to a different prison, where she was diagnosed with cervical cancer, which was causing her heavy menstrual bleeding.

Under Section 1983, Snyder brought a $1.5 million lawsuit for pain and suffering due to the lengthy delay in her diagnosis and the officer's denial to address her cancer. In response, the Lakin Correctional Facility filed a motion to dismiss, citing the Eleventh Amendment, saying that "arms or agencies of [the state] are entitled to sovereign

immunity in federal court from claims seeking money damages" (p. 2). In other words, state agencies in their official capcities, such as correctional facilities, are not eligible to be sued under Section 1983, as they are not persons as defined in the statutory language of Section 1983 (*Monell v. New York Department of Social Services*, 1978). Inmates are often unaware of this rule and commonly make the mistake of suing facilities, resulting in case dismissal. Rather, inmates should sue officials in their individual capacities; meaning, individuals who work for the state are considered "persons" for purposes of Section 1983 (*Monroe v. Pape*, 1961). Since Snyder did not name specific individuals who denied her care, the court granted the defendants' Eleventh Amendment defense.

One of the consequences of poor medical care is that inmates' serious medical conditions are not taken earnestly unless correctional personnel believe the inmate is in immediate danger or visible, serious pain (Weatherhead, 2003). This is especially a concern for female offenders, whose unique health needs have been and continue to be overlooked by correctional personnel and the court system (Marquis, 2018; Weatherhead, 2003). Reproductive health problems, which sometimes have no visible symptoms, result in delays in treatment as some correctional officers do not believe female inmates when they complain of symptoms.

This might have been why Tandy Brown-Rogers, an inmate in Tennessee, was denied medical attention for two-and-a-half months after she informed correctional staff that she was experiencing abnormal vaginal discharge (*Brown-Rogers v. Bradley County Jail Medical Department*, 2007). She was not examined by medical personnel until after she started having severe abdominal pain, at which time she was taken to a health department and was placed on antibiotics. However, Brown-Rogers alleged that the

medication she was prescribed at the health center and the medication correctional staff gave her were different. Correctional staff also did not give these antibiotics to her consistently, nor did they ever tell her the test results. She was eventually transferred to another unit, where she was given another PAP smear, and finally learned that she had Pelvic Inflammatory Disease and trichomoniasis. Only after the transfer was she placed on the proper medications.

Brown-Rogers sued the Bradley County Jail Medical Department pursuant to Section 1983. Under Section 1983, however, plaintiffs must be able to identify individual people in their complaints. Therefore, just as in *Snyder*, the district court dismissed Brown-Rogers' allegations without prejudice, citing her failure to state a claim against a suitable defendant. Moreover, the court stated that the county jail was not liable since the plaintiff failed to identify a policy or custom that led to the delay in her treatment and diagnosis. Because her only legitimate complaint was that these services were delayed, not that they were deliberately delayed, it was insufficient to constitute an Eighth Amendment violation.

Research on incarcerated women's health care experiences reveal that seeking medical attention is a stressful, degrading process (Harner & Riley, 2013; Magee et al., 2005). Prior research on penal harm medicine shows that inmates need to beg correctional officials for medical care, and even then may still experience delays or inadequate treatment (Vaughn & Smith, 1999). Female offenders report that correctional medical staff are dismissive, insulting, rough, and rush through medical appointments, often leaving women with more questions than answers (Harner & Riley, 2013; Magee et al., 2005). After going through hurdles to receive medical attention, such as repeatedly

requesting sick call and offering proof that their medical need is serious (Harner & Riley, 2005), medical staff have been implicated in not communicating with inmates about their treatment options or follow-up care (Clarke et al., 2006). This makes the process of receiving medical care confusing, and poor communication or an unwillingness to take time to explain treatment options have serious consequences. This is demonstrated in *Thomas v. Hickman* (2006), where the prisoner, Kelli Thomas, experienced chronic pelvic pain stemming from ovarian cysts over the course of six months.

Thomas met with a correctional physician, one of the named defendants, about the pain in a brief appointment, who suggested surgically removing the cysts to ease the pain and checking for signs of cancer. During this meeting, which lasted between five and 10 minutes, the plaintiff alleged the physician did not inform her that this surgery would possibly compromise her future ability to have children. Plaintiff stated that if she had been aware of this risk, she would not have had the surgery; nevertheless, a surgeon at a private hospital performed the surgery. Although Thomas only agreed to a cystectomy, a surgery to remove cysts or damaged tissue, the defendant performed an oophorectomy, a procedure to remove the ovaries and part of the fallopian tubes. The plaintiff alleged that not only did she not consent to the removal of her ovaries, but that she was not told by the surgeon or any other medical staff that they had been removed. Consequently, she was not informed about or prepared for the side effects of ovary-removal, including premature menopause, hormonal imbalances, and infertility.

Thomas did not consent to the oophorectomy as it would have prevented her from having children; thus, the surgeon essentially forcibly sterilized her. After the surgery, Thomas alleged she did not receive proper post-operation care and was given no

explanation or medical attention for the extreme side effects she was having. She suffered premature menopause at 25 years of age, which resulted in hot flashes, amenorrhea (absence of a woman's period), rapid weight loss, anxiety attacks, and depression so severe she contemplated suicide. These symptoms remained for years after the surgery. Furthermore, the correctional medical staff did not request her post-operative medical records, so they were unaware that her ovaries had been removed and believed that Thomas was feigning her symptoms. Thomas did not receive confirmation that her ovaries were removed until she was able to independently review her medical records with the help of her attorneys.

Thomas sued several named defendants as well as the private hospital where she had her surgery. The named correctional staff filed a motion for dismissal since Thomas failed to directly link any correctional personnel to her medical procedure. In granting the motion to dismiss, the court said that the surgeon who operated was not a correctional medical staff member, but an employee of a private hospital, and only state agents acting under color of law can be sued under Section 1983 (Vaughn & Coomes, 1995).

One of the most glaring areas in need of improvement for incarcerated women's health is the provision of menstrual hygiene products, which has recently captured the public's focus and become a topic of debate among advocates, researchers, lawmakers, and corrections officials (Shaw, 2019). For example, in one of the largest campaigns for menstrual equity in prisons, Arizona politicians, activists, and female inmates revealed that women incarcerated in Arizona were only receiving 12 thin pads per month and would have to purchase additional pads, a financial burden that they could not meet given their 15-cents-an-hour salary (Noori Farzan, 2018). As a result, correctional facilities in

Arizona increased the amount of sanitary pads inmates received per month threefold (Held, 2018). The courts have provided mixed rulings on whether menstrual hygiene products are an essential item for health under the Eighth Amendment. In *Vaughn v. Day* (2018), for example, plaintiff Amber Vaughn took legal action against defendant Jason Day, the administrator of the Boone County Detention Center in Arkansas, after going without menstrual hygiene products.

During her detention, Vaughn began her period and was denied sanitary pads because she could not afford them. Sanitary pads at this facility costed ten cents, but Vaughn had no money in her jail commissary account. An officer told Vaughn that the only way to receive sanitary pads was to purchase them. Consequently, she went without sanitary pads for three days, which she alleged was "demoralizing, degrading, and inhumane" (p. 1). As relief, Vaughn sought monetary damages for her humiliation and requested that the detention center update their policy so that sanitary pads would be provided at no charge.

The district court ruled that Vaughn's accusations did not amount to deliberate indifference. Since Vaughn did not "allege that she was routinely denied sanitary pads, that she lacked access to other hygiene supplies, or that there was an immediate danger to her health" (p. 2), she did not invoke Eighth Amendment protections. Whether corrections officials deprive incarcerated women of menstrual hygiene products intentionally or as a result of policy, such as requiring women to pay for products as in *Vaughn*, limited access to sanitary pads and tampons is a punitive practice that dehumanizes female inmates. Menstrual health is a misunderstood area even among free-world medical providers, suggesting that correctional officials may not grasp the

importance of supplying adequate products or the consequences of not doing so. Additionally, since there are no specific guidelines or accountability measures, facilities can decide individually how to handle suppling these products. Therefore, restricting female inmates' access to menstrual hygiene products is a penal harm tactic and results from indifference, ignorance, and willful disregard toward women's menstrual hygiene.

The absence of defined standards and accountability also applies to the constitutionality of the provision of menstrual hygiene products. As demonstrated in *Vaughn*, adequate access to feminine hygiene products is not guaranteed under the Eighth Amendment. To support this ruling, the district court cited several cases that have held that "the temporary denial of bedding, exercise, clothes, showers, or hygiene products is not unconstitutional" (p. 3). All of the decisions cited, however, dealt with male inmates' sanitary needs and conditions of confinement, which are vastly different from females' menstrual hygiene. The court also held that because correctional officer Day was not directly involved in denying or withholding Vaughn's access to sanitary pads, he could not be held liable for any harm that came to the plaintiff.

Summary of Cases Related to Reproductive Health

Trends in these cases appear in the *Laube* court's ruling that preventative reproductive care screenings are a necessary service that correctional facilities must provide to female inmates. Moreover, in *Women Prisoner's of District of Columbia*, the litigation required that incarcerated women who experience adverse reproductive health problems have access to preventative care, and the court recognized that high-risk female offenders have different needs from their male counterparts. Despite the decision in *Laube*, however, correctional facilities struggle to provide reproductive health care

screenings and follow-up treatment to incarcerated women (Magee et al., 2005), suggesting that some facilities are not providing the basic necessities for female reproductive health and menstrual hygiene.

Case outcomes demonstrate that even when facts show delays or indifferent care, it is still difficult for individual female offenders to prove correctional officers or medical staff acted with deliberate indifference. Due to their limited access to legal resources, inmates often sue the wrong person or entity, which leads to case dismissal. Female inmates may be especially prone to this problem, as research suggests they have less access to programming compared to male inmates (Morash et al., 1994), which may also include legal resources and law libraries. Plaintiff Vaughn's claim of deliberate indifference in *Vaughn v. Day*, for example, was dismissed not because she did not receive appropriate menstrual hygiene products, but because of how she worded her complaint. Because Vaughn claimed that she was forced to go without sanitary pads, not that the correctional officers denied or delayed them, the court ruled that she did not provide enough evidence to satisfy a claim of deliberate indifference. Although prior cases have held that menstrual hygiene products are constitutionally required (*Dawson v. Kendrick*, 1981), neither the correctional officer nor the correctional facility was found liable in *Vaughn*.

Similarly, in *Snyder v. Lakin Correctional Center* and *Brown-Rogers*, it is clear that the correctional center's delay of medical care prolonged the plaintiffs' pain and suffering. Although plaintiffs continuously requested medical care, the correctional officers and medical staff did not follow to see that care was provided. In *Snyder*, the delay in diagnosing cervical cancer constituted a serious risk to the plaintiff's overall

health and wellbeing and could have been identified sooner had the correctional center provided routine PAP smears or taken action when Snyder complained of abnormal bleeding. Discovering reproductive health conditions after they have progressed to a non-treatable state may not be uncommon, as research finds incarcerated women are discouraged from requesting routine examinations (Harner & Riley, 2013). This likely stems from an attempt to cut costs and, from a penal harm perspective, indicates that corrections officials do not believe female inmates' reproductive health care is necessary.

CHAPTER IV

Discussion

Case analysis in this thesis reveals that female inmates in the United States are sometimes being harmed by correctional health care practices, and they rarely succeed in their Section 1983 lawsuits for deliberately indifferent medical care. Female prisoners are more successful in their Section 1983 lawsuits when facilities have years of inadequate medical care that sometimes take the form of a class action lawsuit. Also, where defendants' culpability is greatest is when plaintiffs are more likely to succeed on Eighth Amendment claims, such as cases involving inmate's deaths and cases where pregnant inmates experienced odious and callous treatment. Litigation by individual women prisoners were not found to be as successful, even when many of them resulted in significant adverse health outcomes. This suggests that penal harm practices are impacting female inmates' medical care, and the principle of less eligibility influences courts' decisions on what constitutes unlawful medical treatment. The discussion, which follows, examines the six themes identified by the case analysis and recommends practice, policy, and legislation to improve the quality and accessibility of health care for incarcerated women in the United States.

Discussion on Systematic Failures to Deliver Correctional Medical Care in Female Correctional Facilities

Penal Harm

The consequences of the punitive nature of correctional philosophy are most visible when correctional health care systems as a whole fail their incarcerated patients (Christie, 2007; Nolasco & Vaughn, 2020). Systematic failures occur often, as research

has documented inadequate access to medical services, psychiatric care, and prescription medications across federal and state prisons and jails (Wilper et al., 2009). One explanation for such widespread and recurring inadequacies is that the penal harm movement that has gripped the United States' criminal justice system for the past four decades has a strong toehold in correctional medicine (Vaughn & Smith, 1999). From this perspective, corrections officials justify providing bare-minimum acceptable conditions, essentially poor health care, under the belief that the incarceration experience should make pains of imprisonment as arduous and onerous as possible (Vaughn & Smith, 1999; Wolff & Greifinger, 2020). While some researchers have suggested penal harm practices may soon be replaced by more progressive policies (Listwan et al., 2008), others are not as sanguine (Webster & Doob, 2008; Zimring, 2008).

As prior research on penal harm medicine practices shows, however, these practices do not always stem from individual intent to cause harm and cruelty. On some occasions, poor correctional health care is the result of administrative breakdowns and managerial disorganization, in which every part of the medical delivery system is dysfunctional (Dias & Vaughn, 2006; Easley, 2011). Thus, it is unfair and inaccurate to assume that all individual corrections officials and medical personnel are indifferent or intentionally harming prisoners. In fact, research finds that many correctional nurses express frustration toward the barriers they face in providing inmates quality medical care (Ammar & Erez, 2000). More accurately, correctional health care workers are constrained by the custodial and punitive nature of correctional facilities and the expectation for their care to cut costs, which means they must adapt their medical procedures to fit the goals of their facility (MacDonald et al., 2013).

Dual Loyalties

The conflicting roles and duties of medical staff within correctional settings stems from the "bifurcation of allegiance" (MacDonald et al., 2013, p.1229) that correctional health care workers have to their patients and to the security staff that employ and protect them, a concept referred to as "dual loyalty" (MacDonald et al., 2013, p. 1229; Pont, Stover, & Wolff, 2012). Requiring medical staff to balance their loyalties between patients can create unethical conundrums where medical personnel perform custodial duties, such as searching inmates for contraband, observing or participating in use of force against patient-inmates, and medically clearing an inmate for solitary confinement (MacDonald et al., 2013; Venters, 2019). Medical staff can also be placed in uncomfortable situations when they are asked to determine whether inmates are malingering. Indeed, custodial staff pressure medical officials to confirm security's belief that inmates are faking their medical conditions (Galanek, 2014; Human Rights Watch, 2003). Participating in solitary confinement procedures and denying care to patients contradicts medical professionals' oath to cause no harm, but in correctional facilities, medical staff are forced to make ethically suspect decisions on a regular basis (Human Rights Watch, 2003).

The problem of dual loyalty not only affects medical staff's duties, but also their attitudes and perceptions of their roles (Venters, 2019). In studying the ways correctional nurses adapt to correctional environments, Hardesty, Champion, and Champion (2007) found that nurses who prioritized patient health and wellbeing over security concerns had poorer working relationships with custodial staff. Prison custody staff called these nurses "idealists" (p. 200) and were viewed by custodial officials as "dysfunctional in the jail

setting" (p. 200). This demonstrates that to be accepted into the custodial culture and foster better working relationships with correctional officials, medical staff are encouraged to become cautious, skeptical, and pessimistic toward patient-inmates (Conover, 2010; Wolff & Greifinger, 2020). Research shows that nurses generally have negative attitudes toward inmates (Shields & de Moya, 1997) and report that a wide portion of their job stress comes from the pressures from custodial personnel to prioritize security (Flanagan & Flanagan, 2001). By some personal accounts, correctional health care workers are even stigmatized by friends and family for working in a correctional facility (Dabney & Vaughn, 2000; Hardesty et al., 2007), which may add to their negative view of their clientele.

Accreditation

Many correctional health care programs, including private managed care operations and health care systems provided by the state, are accredited by the National Commission on Correctional Health Care (NCCHC, 2018a, 2018b). To receive accreditation, correctional health care systems must develop written policies and procedures that conform to NCCHC standards and suggested care practices. Following a national standard of care is optimal for producing uniform practices as well as ensuring that correctional medical professionals perform their duties ethically and within their area of specialty. While accreditation "provides companies with a seal of approval to help them attract business" (Robbins, 1999, p. 204) and reduces liability if the guidelines are implemented correctly, it is voluntary and holds no legal significance. Because correctional facilities are not required to have accredited health programs or follow any national guidelines, the actual implementation of medical care varies greatly throughout

the country and is not always delivered with patient-inmate health as a priority (Maeve & Vaughn, 2001). Therefore, accreditation should be the subject of more research, and the process to achieve accreditation should be more connected to the actual delivery of health care to prisoners.

In addition to accreditation being optional, some have claimed that the process through which it is achieved is "not stringent" enough (Robbins, 1999, p. 205). The accreditation process consists of "completing a Self-Survey Questionnaire and having an accreditation site visit" that examines "facility governance and administration, managing a safe and healthy environment, personnel training, health care services support, inmate care and treatment, health promotion and disease prevention, special [inmates'] needs and services, health records, and medical legal issues" (Robbins, 1999, p. 205). Moreover, critics have argued that NCCHC accreditations only amount to a basic level of care and do not provide enough oversight to ensure health officials treat inmates accordingly (Robbins, 1999). Without random reviews or the constant presence of on-site representatives to increase accountability, even correctional health programs that are accredited can easily provide health services that are below recommended standards, leading to deliberately indifferent medical care and malpractice (Vaughn & Smith, 1999). For this reason, legislation should be enacted that outlines specific standards for medical care in correctional facilities and includes consequences for medical personnel and corrections officials who do not comply with those standards.

Recommendations Concerning Systematic Failures

To reduce the number of medical complaints that occur due to systematic failures, one of the most needed reforms is also one of the hardest to achieve: shifting corrections

officials' attitudes from a perspective of penal harm to one of compassion and rehabilitation (Birmingham, Wilson, & Adshead, 2006). Ideally, American penology and its correctional health care systems should undergo a paradigm shift toward health promotion, a health perspective that involves treating existing illnesses in patient-inmates while also "offering the knowledge, skills, and referrals that incarcerated people need to protect their health inside the prison or jail and after release" (Ramaswamy & Freudenberg, 2007, p. 229). According to the WHO, which adopted health promotion strategies in 1986, there are five critical activities involved in this health care framework (Ramaswamy & Freudenberg, 2007):

- developing personal skills for health,
- creating supportive environments,
- strengthening community action for health,
- reorienting health services, and
- building healthy public policy.

While this concept is difficult to implement in correctional settings, much of it can be achieved by partnering with community medical organizations whose missions already align with health promotion. Even if corrections officials' attitudes and actions shift from punitive practices, some argue that correctional health care cannot improve as long as medical services are connected with the correctional system itself (Birmingham et al., 2006). For this reason, researchers have recommended that facilities utilize community medical resources and implement treatment programs that involve teaching hospitals, community health clinics, and outside medical experts (Barry, 2001). Merging correctional health care services with those offered in the community would also aid in

continuity of care, which is a pressing need among all incarcerated populations and especially female inmates (Sered & Norton-Hawk, 2013).

In addition, special considerations should be given to the various ways women's gender impacts their health needs during their incarceration experiences (Maeve, 1999). Given that female inmates are incarcerated with more complex and higher rates of illnesses than men, the model of care they receive should not be based on male inmates' needs (Fearn & Parker, 2005). Gender-responsive methods of care consider women's unique needs, experiences, and concerns (Guthrie, 2011). When asked how their medical care could be improved, for example, incarcerated women emphasize their desire for health care workers to be more empathetic, patient, trustworthy, and who will answer their questions without judgement or malice (Dinkel & Schmidt, 2014). Female inmates also expressed interest in learning about their health conditions, so they could be more involved in their treatment plans and care processes (Dinkel & Schmidt, 2014).

Prior research indicates that the majority of female inmates are victimized in some way prior to incarceration (Lorenz & Hayes, 2020). Moreover, women continue to experience trauma while incarcerated through a variety of pains of imprisonment and the threat of physical and sexual assault by other inmates and correctional staff (Blackburn, Mullings, & Marquart, 2008). Exposure to trauma, especially sexual trauma or abuse, can negatively impact the survivor's physical and mental health (Harner & Burgess, 2011). Given this link between victimization, trauma, and health concerns, health care services in female correctional facilities should use trauma-informed methods (Levenson & Willis, 2019). To act from a trauma-informed framework means to understand and consider a patient's victimization and its role in their health "to design service systems

that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment" (Harris & Fallot, 2001, p. 4). Rather than simply noting an inmate's past experiences of victimization, correctional health care providers should understand their "symptoms and diagnosis in the context of…[their] traumatic experiences" (Harner & Burgess, 2011, p. 472). Trauma-informed methods involve:

- understanding how trauma impacts the survivor mentally and physiologically,
- understanding the survivor's unique experiences and adopting a treatment plan catered to those needs,
- providing open communication, acceptance, and patience,
- refraining from judgement or callous behavior, and
- ensuring the survivor is comfortable at all times.

Trauma-informed methods also impact the way routine examinations are performed. In the free world, it is recommended that women receive a cervical examination every three-to-five years (ACOG, 2019); however, among incarcerated women, many of whom have experienced trauma, the NCCHC (2020) has recognized that forcing incarcerated women to undergo such an invasive procedure may retraumatize those who have been sexually victimized in the past or make female inmates feel violated. Hence, the NCCHC recommends that incarcerated women only receive cervical examinations when they are having symptoms that indicate an examination is required (NCCHC, 2020). Importantly, this should not be used as a reason not to provide preventative reproductive health care services; rather, correctional facilities should listen

to female inmates, and ensure they have access to reproductive health services when they are needed.

Implementing trauma-informed care in correctional facilities is challenging for several reasons. First, correctional health care providers and corrections officials may argue that there are simply too many inmates to be able to provide the individualized care trauma-informed methods requires. Second, switching to a trauma-informed model requires widescale retraining for both custodial and medical staff about trauma, its consequences, and the ways in which it impacts inmates' health. The third and perhaps most pressing challenge is that trauma-informed practices are in direct contrast to the current system that operates on penal harm and increasing the pains of imprisonment. It may prove difficult to convince custodial personnel that trauma-informed methods are beneficial to them, in addition to the idea that female inmates are deserving of compassionate medical treatment.

Discussion on Delays in Medical Treatment for Incarcerated Women

Women's medical problems are not taken as seriously in free-world or correctional health care settings (Barry, 2001), resulting in the delay or denial of treatment. When health care personnel are skeptical of women's medical care, it shows their apathy and lack of interest in female's health needs (Werner & Malterud, 2003). While medical delays occur frequently in male correctional facilities, researchers and advocates on women's incarceration experiences argue that correctional personnel regard female inmates as "complainers, malingerers, or drug seekers who have more psychosomatic than actual illnesses" (Barry, 2001, p. 39). These attitudes lead to the assumption that incarcerated women have fewer legitimate medical complaints than their

male counterparts. Contrary to this belief, research repeatedly shows female inmates have more health concerns than male prisoners, meaning they have more health care needs than male prisoners (Acoca, 1998; Ahmed, Angel, Martel, Pyne, & Keenan, 2016). Since health care in women's facilities is often modeled after what is provided to male inmates (Ross & Lawrence, 1998), inadequate resources, policies, and procedures can lead to treatment delays and other forms of negligence and maladministrative care (Fearn & Parker, 2005).

Staffing Issues

Insufficient medical staff in female correctional facilities leads to delays in treatment (Fearn & Parker, 2005). While there are fewer incarcerated women than incarcerated men, female inmates use more medical services (Ammar & Erez, 2000). Since inmate-to-staff ratios in female units are generally equivalent to what is used in male units, medical staff may be overwhelmed by the volume of requests they receive when working in a women's facility. In one study on health care in a women's institution, a nurse explained that "staffing of the women prisons follows the male model: 200 men to three nurses. But women in prison go to doctors two-and-a-half times the rate of men…" (Ammar & Erez, 2000, p. 20).

Incarcerated women also have more difficulty gaining access to doctors (Lindquist & Lindquist, 1999) because staffing and resources are determined by "a healthy, young male as [the] model prisoner" (Hill, 2002, p. 232). Moreover, correctional personnel who are not properly trained or informed on women's health needs also cause delays by being unintentionally ignorant to certain medical conditions (Tapia & Vaughn, 2010). When corrections officials ignore early symptoms of female-specific

health concerns, such as vaginal bleeding, discharge, or breast lumps, these can develop into serious medical problems (Fearn & Parker, 2005).

Proactive Versus Reactive Medical Treatment

Medical professionals in the free-world operate under the mentality that prevention is easier than treatment, but punitive and cost-cutting strategies in correctional health care programs often mean that inmates are not given medical attention until it borderlines an emergency (Nolasco & Vaughn, 2020; Robbins, 1999). Correctional personnel may view preventative measures, such as annual check-ups or providing wellness aids, such as vitamins, adequate nutrition, and exercise programs, as luxuries or unnecessary expenses (Craig, 2004; Garneau, 1961; Vaughn & Smith, 1999; Willmott, 1997). Incarcerated women, for example, have reported that correctional personnel discourage them from taking advantage of routine cervical examinations, with some women saying they are made to feel guilty for requesting preventative reproductive health care services (Harner & Riley, 2013). Additionally, studies have found that correctional facilities delay and deny inmates preventative health screening measures, such as testing for communicable diseases, to avoid paying for treatment should an inmate test positive (Chandler, 2003). Therefore, correctional health care can be classified as reactive rather than proactively seeking to maintain inmates' health and wellbeing (Nolasco & Vaughn, 2020).

While reactive care may appear to save money, correctional facilities may actually spend more in the long-run by delaying screening mechanisms and prolonging treatment protocols. First, if a serious medical condition is diagnosed early, the treatment options for that condition may not be as costly (Acoca, 1998). For this reason, researchers

have stressed the importance of providing intake health screenings for every individual admitted to a correctional facility (Fitzgerald, D'Arti, Kasl, & Ostfeld, 1984). Second, if a medical delay violates an inmates' rights against cruel and unusual punishment, correctional personnel may face monetary repercussions if that inmate prevails in a court of law (Vaughn & Collins, 2004). Finally, in facilities that use managed care and in those organizations that contract their medical services to private companies, noncompliance with that company's standards, perhaps including timely medical care, could result in financial penalties (Robbins, 1999).

Recommendations Regarding Delays in Treatment

Aside from adopting policies and procedures that emphasize proactive care, forgoing punitive and cost-cutting strategies, and attempting to change indifferent attitudes, there are steps facilities can take to lessen negative medical outcomes caused by delays in treatment. Some recommendations include:

- train custodial and medical staff on women's specific health needs to ensure symptoms of serious medical needs are not ignored or minimized,
- hire adequate numbers of medical staff to meet the demands of incarcerated women's unique health needs,
- implement external review processes that score correctional health care programs on the timeliness of their medical services, and
- pass legislation that specifies what is meant by 'timely' health care and require correctional facilities to comply with this legislation.

Discussion on Medication Errors with Incarcerated Women

Mistakes occur in the practice of medicine (Gawande, 2003), with medication errors being one of the leading causes of medical malpractice. Indeed, there has been a high priority put on reducing medication errors since the Institute of Medicine (Kohn, Corrigan, & Donaldson, 1999) identified that medical errors in general injure and/or kill over 100,000 people per annum in the U. S. Van Den Bos and colleagues (2011, p. 599) estimated that medical errors that harm patients cost $17.1 billion in 2008, of which medication errors are a sizeable subset. Free-world research on medication errors shows that they stem from preventable moments of lack of communication, negligence, or incompetence (Lehmann & Kim, 2005; Pearl, 2017). Research shows that "medication-related adverse events are the single leading cause of injury" to patients seeking medical care (Bates, 2007, p. S3).

Incarcerated populations have a federally guaranteed right to health care and are generally—free of co-pays—not expected to pay for that care; thus, correctional facilities are responsible for the cost. In fiscal year 2016, the Federal Bureau of Prisons spent $111.7 million on inmates' pharmaceuticals (U.S. GAO, 2017). Similar to the free-world, medication errors also occur in jails and prisons. Research suggests that, in some correctional facilities, medications are withheld as punishment and that some prison staff and medical providers deny and delay medication to prisoners (Vaughn, 1995) and may prescribe inadequate medication for "punitive, nonmedical reasons" (Vaughn, 1997, p. 342). For the most part, medication errors in correctional facilities result from improperly diagnosing an inmate and consequently prescribing improper medication, denying an inmate medication after transfer to a different prison, delaying an inmate medication

because of a lack of follow-up care, replacing a prescribed medication with one that is on the prison formulary but not efficacious, giving an inmate medication to which they are allergic, or supplying an inmate medication that is contraindicated with their health status.

The Problem of Prescription Medications

Prescribing medication to inmates poses a unique challenge for correctional medical staff. The focus on inmate malingering and the unyielding belief among correctional officials that inmates lie about the seriousness of their medical conditions to receive medication negatively impacts inmates who are truly in need of certain prescriptions (Tamburello, Kathpal, & Reeves, 2017). Research has found that although antipsychotic medications are not considered to have high abuse potential in free-world populations, inmate populations misuse medications such as Seroquel, Neurontin, Zyprexa, and other common antipsychotics (Del Paggio, 2012). The widespread closure of state psychiatric facilities has resulted in large numbers of mentally ill prisoners being funneled into correctional facilities (Parsons, 2018). This means that a good portion of inmates may be in serious need of antipsychotic medications; however, abuse of those medications by malingering inmates or those with unresolved substance dependencies makes correctional medical professionals hesitant to prescribe antipsychotics and may even result in certain medications being removed from a facility's formularies (Del Paggio, 2012; Glancy, Tomita, Waldman, Patel, Booth, Cameron, & et al., 2019). When medications are removed from correctional facilities' formulary, they are not readily stocked, must be approved before the inmate can receive them, and then must be delivered directly by medical staff (McKee, Penn, & Koranek, 2014). This process may

result in delays in prescribing necessary medication or substitution for an equivalent, yet less effective, medication.

A commonly litigated issue is providing pain medication to inmates who suffer diseases, illnesses, or injuries while incarcerated (McDermoh, Dualan, & Scott, 2013; Vaughn, 1995, 1997). When this occurs, correctional medical staff may not prescribe pain medication due to the malingering inmate stereotype, to not exacerbate substance dependency (Gill, Metts, & Ugwueze, 2019), or for punitive, non-medical reasons (Vaughn, 1995). Furthermore, pain medications are considered a commodity in the facility's underground economy, meaning inmates have more reason to request them (McKee et al., 2014). While instances of malingering to receive pain medication are prevalent, courts have ruled that inmates have a constitutional right to adequate medication to relieve pain when they suffer serious injuries, such as broken bones (Vaughn, 1995, 1997). These issues pose challenges for female inmates, who have higher rates of mental illnesses and addiction than their male counterparts.

Medication Delivery

Once a medication has been prescribed and the inmate is approved to receive it, barriers remain that may prevent its timely and proper delivery. Some facilities have in-house pharmacists, others use a centrally located correctional pharmacist who coordinates delivery services to nearby prisons, and some facilities contract out their pharmacy services to independent contractors or to private companies (Hussain, Tayyab, Hassali, Patel, & Babar, 2019). Medication delivery methods vary between correctional facilities, as some prefer a centralized method in which medication is distributed from a centrally located warehouse due to its ability to cut costs and enable administrators to actively

supervise medication prescribing patterns (Vaughn, 1997). Other common medication delivery methods include distribution through an in-unit pharmacy and/or contracting medication-related services to private companies (Vaughn, 1997). In some facilities, inmates are required to travel to and stand in medication lines to receive their scheduled dosages. While this system is helpful to maintain dosage routines, observe inmates taking their medications to guard against cheeking or hoarding, and is more convenient for medical staff, it can be challenging for inmates with mobility issues (Stoller, 2003). Moreover, custodial policies, such as count times, court dates, rehabilitation and educational schedules, or lock downs, have been known to disrupt dosage schedules.

Recommendations Regarding Medication Errors

While it is understandable that correctional medical systems must take necessary steps to ensure inmates do not abuse prescription medications, it is important that these precautions do not interfere with the treatment of inmates' serious medical needs. Finding a balance can be difficult, as preventing medication misuse can inadvertently lead to policies and practices that violate the Eighth Amendment and result in deliberately indifferent medical care. The standards for medication management under the NCCHC require facilities to act in compliance with state and federal laws regarding medications, allows self-carry medication programs for certain prescriptions, mandates that facilities without on-site pharmacists provide opportunities to consult with a pharmacist, and emphasizes that inmates should only be prescribed medications when there is a recognized clinical need (Knox, 2015). The NCCHC also emphasizes continuity of care, stating that inmates who are routinely taking a prescribed medication at the time of their incarceration continue to receive that medication in a timely manner (NCCHC, n.d.b).

Using electronic medication systems has led to decreases in medication errors in both free-world and correctional medical settings (Carmenates & Keith, 2001; Lehmann & Kim, 2005). Research on medication errors in the free-world strongly recommends switching to electronic medication systems to solve the problem of illegible handwriting and abbreviations that may lead to incorrect prescriptions as well as implementing a drug database that will automatically alert medical professionals of adverse drug combinations (Wittich, Burkle, & Lanier, 2014). Moreover, free-world medical organizations emphasize educating both patients and health care professionals to reduce medication errors, including providing patients with information on how to maintain accurate medication lists, the side effects and potential interactive effects of their medications, and involving pharmacists in the patient education process (Wittich et al., 2014). Finally, disclosing medication errors is a crucial step in reducing future errors, as this can "provide data for broader, systemic insights into any recurring patterns of errors" (Wittich et al., 2014, p. 1121).

To reduce medication errors, correctional facilities should consider these free-world recommendations as well as adopt the following suggestions outlined by case law, prior research, and medical professionals:

- provide evidence-based rehabilitation and substance abuse services to decrease inmates' medication-seeking behavior,
- avoid prescribing cheaper, less effective substitutes for medications,
- ensure that prison medical staff are the sole providers of inmates' prescriptions; security staff should not distribute medications or make decisions about medication delivery,

- educate custodial staff, medical staff, and inmates on inmates' rights to adequate medication,
- ensure that inmates who cannot travel to medication lines are approved for medication delivery or for possession of bulk-supply of medication in a timely manner,
- provide telemedicine options and consultations in facilities that do not have an on-site pharmacy,
- educate prescribers and correctional medical staff about any new medications that are added to facilities' formularies, and
- create legislation that:
    - standardizes routine evaluations of medication delivery systems and
    - requires facilities to perform quality checks on medications to ensure they are not expired, contaminated, or faulty.

Discussion on Failures to Treat Chronic and/or Preexisting Illnesses

As illustrated in the cases on chronic illnesses, incarcerated women do not always receive adequate treatment regarding their serious and chronic health conditions. Caring for inmates with chronic conditions is a pressing concern for correctional health care workers as the United States is experiencing a rise in the average age of prisoners (Auerhahn, 2002). In their guide to prison health, the World Health Organization (WHO) recognizes that incarcerated populations commonly suffer from chronic conditions such as epilepsy, conditions that affect the heart and lungs, and chronic reproductive health issues for incarcerated women (Gatherer, Jürgens, & Stöver, 2007). To provide proper

treatment for these individuals, the WHO recommends that correctional facilities employ primary care teams that are knowledgeable in chronic care. Facilities should also work with prisoners to develop fact sheets to track chronic illnesses as well as provide information on inmates' treatment options and medical resources (Gatherer et al., 2007). This strategy is similar to those used in free-world medical settings, where health professionals have found that involving patients with their treatment plans and strategies and developing specific chronic care models can improve outcomes of chronic conditions (Bodenheimer, Wagner, & Grumbach, 2002).

Granting inmates more autonomy in their health decisions contests with the current treatment that chronically ill inmates receive, given that studies on chronically ill inmates find that inmates do not feel they have control over their health (Deaton et al., 2009-2010). Notably, incarcerated women with chronic illness and elderly incarcerated women report that correctional medical personnel present callous and indifferent attitudes, making female inmates feel unsafe and as though their health needs are not taken seriously (Deaton et al., 2009-2010). Moreover, women with chronic conditions or disabilities also allege that correctional health providers delay treatment if the inmate is being released soon. In Harner and Riley's (2013) study, for example, one woman who sought treatment for a disability stated, "[t]he first thing [medical professionals] ask…is how much time you have left…If you don't have a lot of time left, they blow you off and won't take care of you. It's not worth it to them" (p. 792). This obvious indifference to inmates' health and wellbeing creates additional barriers and inadequate treatment practices for chronically ill female inmates, including delays or denials in treatment (Harner & Riley, 2013), a lack of monitoring of their conditions (Young & Revere,

2001), mishandling of inmates medical records, medical tests, or medical histories (Chandler, 2003), problems with receiving prescription medications (Stoller, 2003), minimizing the seriousness of chronic conditions (Aday & Farney, 2014), and limiting access to qualified medical professionals (Acoca, 1998).

While some studies suggest that correctional health care services offer better treatment for chronically ill women than they would receive in the free-world given their poor socioeconomic backgrounds (Alves et al., 2016), the death of Tammy Perez, the multitude of plaintiffs' complaints in this thesis, and prior research on chronic care in female correctional facilities reveals widespread problems. Due to adherence to the penal harm perspective, ill treatment of female inmates with serious health needs is not only carried out by custodial and medical personnel but is also not reprimanded by supervisors. Consider, for example, a recent case in which a female inmate with a history of bipolar disorder died after four days of grossly negligent treatment. The facts show that Damaris Rodriguez was in custody at a detention center in Seattle when she began exhibiting symptoms of ketoacidosis, a metabolic disorder that caused her to drink excessive amounts of water (Carter, 2019). She vomited the water continuously and was clearly in need of medical treatment, but instead of providing care, a group of correctional officials "covered the window of her cell so they did not need to look at her, put towels in front of the door so her vomit would not leak into the hallway, and then ignored her" (Carter, 2019, para. 2). They also falsified check-ins, with one officer initialing "a log entry claiming that Damaris was offered and refused water almost an hour after she had stopped breathing" (Carter, 2019, para. 4). She died after four days of her symptoms being ignored, naked and alone in her jail cell.

Recommendations Regarding Incarcerated Women's Chronic and/or Preexisting Conditions

Improving the care that chronically ill female inmates receive is complex and would ultimately require systemic changes to the care, policies, and practices in correctional facilities and the adjustment of attitudes and behaviors of correctional personnel. Altering specific procedures, however, may increase incarcerated women's quality of and access to care. Along with the WHO's recommendations about hiring specialized teams, creating fact sheets, and involving inmates with their treatment plans, facilities should consider the following recommendations:

- implement scheduled, routine check-ups with chronically ill inmates to ensure their conditions are being monitored,
- record chronic conditions and document treatment history and prescriptions for their conditions during intake health screenings,
- stop requiring inmates to travel to a medical unit or medicine line to receive their medications, particularly if they are infirm or elderly,
- prioritize dose schedules over security concerns to ensure inmates receive their prescriptions regardless of court dates, educational/vocational opportunities, count times, or lockdowns,
- provide on-site chronic care to reduce the amount of traveling, and
- offer telemedicine services if on-site care cannot be provided.

Currently, the NCCHC standards on chronic disease services mandates that any inmate with a chronic condition or condition that requires multidisciplinary treatment should be given an individual treatment plan and receive regular, ongoing care (NCCHC,

n.d.a). These standards do not, however, outline any particular guidelines of care; rather, the NCCHC directs correctional facilities to follow national clinical guidelines on treating chronically ill inmates. Additionally, the NCCHC's standards do not specify a certain timeframe that facilities need to initiate chronic care or what type of health care professional should be administering chronic care treatment. In terms of who can deliver treatment to chronically ill inmates, the NCCHC merely states that health care providers must have proper credentials to carry out any tasks they perform, which may vary between states (NCCHC, n.d.a). To strengthen these guidelines and lower the variability between federal, state, and local facilities, national standards outlining the specific expectations for chronic care should be created. New standards should include the length of time inmates with chronic conditions must wait before their care begins after being admitted to a facility, who is permitted to perform chronic care duties, how chronically ill inmates will receive updates on their treatment, and a requirement for correctional medical staff to be trained in the complexities of chronic care treatment. Once improvements are made, external oversight and internal accountability would need to be strengthened to ensure new practices are being followed.

Discussion on Pregnancy During Incarceration

Three to five percent of female inmates report being pregnant at the time of incarceration, and approximately 1,400 babies are born to incarcerated women in the United States every year (Sufrin, 2018). Pregnant women face many risks and challenges during incarceration, such as being exposed to higher amounts of stress, having inadequate access to dietary needs or prenatal care, not receiving timely medical attention, and having limited opportunities to visit health care specialists, such as

obstetricians and gynecologists. Due to the punitive nature of correctional facilities, pregnant inmates are not always provided with accommodations that some corrections personnel may view as unnecessary luxuries, such as being moved to a bottom-bunk or being placed on light-duty work assignments (Ferszt & Clarke, 2012). Caring for pregnant inmates requires modifications to correctional facilities' normal practices and routines, placing the health and wellbeing of mother and child over security concerns, and following national health standards to ensure female inmates have healthy pregnancies and deliveries.

Specific Needs of Pregnant Inmates

Medical Testing

According to the NCCHC, inmates should be offered a pregnancy test upon intake, specifically within 48 hours of admission (Sufrin, 2018). If that test is negative and the inmate believes she may be pregnant, an additional test should be offered two weeks later. Pregnancy tests should also be offered to female inmates who receive conjugal visits or are granted a furlough. Although it is important to identify pregnancy early to initiate prenatal care, some women have reported that mandatory pregnancy testing is invasive and humiliating (Goodman et al., 2016); therefore, it is important that women are given the option to take a test but are not forced to do so.

Incarcerated women who are confirmed to be pregnant should be tested for a variety of communicable and sexually transmitted diseases, most notably HIV. The American Public Health Association (APHA, 2003) also suggests that pregnant women receive prenatal care that reflects national standards, which includes frequent visits with a prenatal care provider, diagnostic tests to identify complications or illnesses in either the

mother or fetus, and a prenatal visit that includes a physical examination, comprehensive medical history, laboratory screenings for a complete blood count, and tests for common illnesses among incarcerated populations, such as hepatitis and tuberculosis (Sufrin, 2018). Pregnant inmates are also in need of genetic screenings, ultrasounds, and procedural tests throughout the first and second trimesters as well as a screening for gestational diabetes (Sufrin, 2018). If any of these tests generate abnormal results, the inmate should receive counseling, diagnostic testing, and information about their treatment options (Sufrin, 2018).

Diet and Nutrition

While the ACOG (2011a) and the APHA (2003) have written standards addressing pregnant women's dietary and nutritional needs, studies find that incarcerated women do not receive enough food or adequate levels of proper nutrients (Ferszt & Clarke, 2012; Kelsey, Medel, Mullins, Dallaire, & Forestell, 2017; Kraft-Stolar, 2015). In one study, for example, all pregnant women sampled reported they were not receiving enough food, with many claiming that they went to bed hungry most nights (Kraft-Stolar, 2015). This study revealed that inmates are generally fed three times a day: once early in the morning, once in the middle of the day, and once in the evening, with pregnant women sometimes receiving a snack during meals that they stated was not enough in either sustenance or nutritional value. In some facilities, meals come pre-packaged and are not altered to fit the needs of pregnant women (Kelsey et al., 2017). The lack of strict legislation on pregnant women's nutritional needs lead to varying policies, practices, and procedures (Rebecca Project for Human Rights, 2010); consequently, some facilities lack

written policies on nutrition for pregnant women, which makes it difficult to assess facilities' performance (Kraft-Stolar, 2015).

Work Assignments

Given the extreme physiological changes women experience during pregnancy, coupled with the fact that most pregnant inmates have high-risk pregnancies (Sufrin, 2018), it is crucial for incarcerated women to be placed on lighter work assignments or removed from work assignments while they are pregnant. While studies have pointed out that it is discriminatory to restrict an inmate's access to work only because she is pregnant (Kraft-Stolar, 2015), reasonable work accommodations should be made to ensure the nature of the work does not cause harm to the woman or her pregnancy. Work assignments, for instance, that have physical responsibilities or require pregnant women to stand for long periods of time could result in preterm delivery (ACOG, 2011a). Furthermore, the ACOG (2011a) recommends that women continue to be placed on lighter work duty four-to-six weeks after giving birth. Again, due to a lack of legislation, some studies find that pregnant inmates are not always given modified work assignments nor are they allowed extra rest (Ferszt & Clarke, 2012).

Shackling of Pregnant Inmates

The FIRST STEP Act forbids the practice of shackling women who are pregnant or who have just given birth, with two important exceptions (Wyse, 2019). The Act gives discretion to corrections officials to shackle a woman who is pregnant, in labor, during delivery, or immediately postpartum if she is considered a flight risk or poses an immediate and serious threat to herself or others (Wyse, 2019). This is problematic for several reasons. First, these exceptions create a loophole in which corrections officials

can justify using restraints on pregnant women by claiming they are acting in the name of security. Officers used the flight-risk excuse in *Brawley v. Washington* (2010), where the plaintiff was chained to a hospital bed during labor and immediately following an emergency c-section, as well as to a wheelchair while she was recovering postpartum. While the court decided in this case that the officer's actions were unconstitutional and found them liable for deliberately indifferent medical care, Brawley still suffered great trauma and physical injuries from the restraints, which may have been avoided if clearer policies and guidelines were in place.

Second, allowing the use of shackles on pregnant inmates for security-related concerns is an example of what Chesney-Lind (2006) describes as equality with a vengeance, which refers to practices or policies that disparately impact female inmates but appear to be gender-neutral on their face. Specifically, Chesney-Lind explains that shackling during inmates' pregnancies is based on security protocols used in male facilities, without considering women's unique needs or wellbeing. Because male inmates have used hospital visits to attempt escape, corrections officials assume female inmates will use their labor and delivery for the same opportunity, thus justifying restraints. As Clarke and Simon (2013) state, however, using a custodial argument to shackle women is not viable given the rare instances of escape attempts by female inmates during labor or delivery, their limited physical capacity to escape, and the fact that the majority of female inmates are incarcerated for nonviolent crimes. Finally, the FIRST STEP Act's shackling exception may disproportionately affect female inmates of color, who make up the majority of the incarcerated female population. Furthermore, black women already suffer from disparate access to medical care, high rates of mortality, and generally receive lower

quality medical treatment compared to women of other races (DuMonthier, Childers, & Milli, 2017), and are three times more likely to die from childbirth than white women (Centers for Disease Control and Prevention, 2018).

Recommendations on the Use of Shackles against Pregnant Inmates

Like many other issues in correctional health care, shackling still occurs because of the decentralized nature of the U. S. correctional system, creating a great deal of variability between laws and policies (Rebecca Project for Human Rights, 2010). The FIRST STEP Act, for example, only applies to federal prisoners and is inapplicable to the majority of female offenders who are incarcerated in local jails (Kajstura, 2019). Without creating a standardized form of accountability in carrying out anti-shackling legislation, correctional staff will continue to prioritize custody over the wellbeing of pregnant inmates and justifying the use of restraints based on security concerns. The following recommendations, which are based on case law and prior research, should be considered to diminish shackling:

- Eliminate the use of shackles during pregnancy, including during transportation to outside health care facilities,
- Expand the FIRST STEP Act so that it applies to state facilities and jails and make the following amendments:
    - Eliminate security loopholes by removing the language allowing shackling in certain circumstances,
    - Train corrections officials, including custodial staff, medical staff, and officials who contract with correctional facilities, on anti-shackling procedures,

    - Require corrections officials and free-world medical officials to report instances of shackling or violations of the law, and
    - Outline specific reparations for the unnecessary use of restraints on pregnant inmates.
- Increase enforcement of anti-shackling legislation and policies,
- Educate corrections personnel and female inmates about inmates' rights with respect to shackling during pregnancy, and
- Educate free-world medical providers on their rights to remove patients' restraints.

Discussion on the Reproductive Health Care of Incarcerated Women

Reproductive health care and menstrual hygiene are intrinsic to women's health and wellbeing. Because this area of healthcare is so specific to women, the way correctional facilities handle these services are metaphorical of how women are viewed and treated by the criminal justice system. In other words, analyzing how criminal justice officials react to reproductive health care reveals their perspective on incarcerated women's needs. The cases of *Snyder, Brown-Rogers, Thomas,* and *Vaughn* show that correctional facilities do not consider reproductive health care or menstrual hygiene as a serious medical need, nor did the courts in these cases reprimand the facilities for providing deficient care. Women's health needs are misunderstood and minimalized, even in free-world medicine (Tuana, 2006), which means women must act as their own health advocates (Shieh & Halstead, 2009). Due to their lack of autonomy over their health decisions, incarcerated women cannot advocate for themselves and are thus more vulnerable to having these conditions mistreated, misdiagnosed, or minimized.

Reproductive Health Care Services

As was decided in the *Laube* case, incarcerated women should receive reproductive care that aligns with the recommendations and standards of free-world medical organizations. Free-world medical standards state that women should:

- receive annual mammograms after turning 40, while women between the ages of 20 and 39 should receive them every one-to-three years (ACOG, 2011b; Susan G. Komen, 2013),
- have cervical examinations every three years (ACOG, 2019),
- be tested for the human papillomavirus (HPV) every five years (ACOG, 2019), and
- periodically undergo well-woman examinations conducted by OB-GYN professionals, where they can discuss how to maintain overall health (ACOG, 2012).

Researchers have also identified several other services crucial to maintaining female inmates' health and wellbeing, including:

- comprehensive intake health screenings that record gynecological health concerns (NCCHC, 2020),
- routine vaccinations in compliance with national free-world guidelines (Knittel et al., 2017),
- education on reproductive health care and treatment options, contraceptives, and family planning (Clarke et al., 2006; Dinkel & Schmidt, 2014), and

- notification systems to alert women of their test results and treatment options after they are released (Knittel et al., 2017).

Plaintiffs' complaints in the cases on reproductive health reveal similar barriers to those identified by research on incarcerated women's access to reproductive health care. First, facilities often do not have an on-site OB-GYN or a woman's health professional, meaning that if inmates have a pressing concern or would like a consult regarding a reproductive health issue, they need to wait to be transported to an outside facility (Kraft-Stolar, 2015). In the same vein, correctional medical staff are notoriously understaffed and overworked, meaning that they cannot provide the individualized care that women need (Clarke et al., 2006). The third barrier stems from correctional facilities' expectations for medical providers to keep costs low, which results in the provision of bare-minimum treatment (Kraft-Stolar, 2015). Fourth, female inmates experience delays in receiving test results due to slow-moving lab work and lackadaisical attitudes toward reproductive health testing (Magee et al., 2005). Finally, due to the punitive nature of facilities, a lack of sympathy for offenders' needs, and minimal external oversight, custodial officials and correctional health staff act as barriers themselves because they do not believe their actions, or lack thereof, will result in serious consequences (Kraft-Stolar, 2015).

Recommendations Regarding Reproductive Health Care for Incarcerated Women

The following recommendations should be considered to improve some of these barriers:

- hire more OB-GYN and women's health professionals and ensure these professionals are on-site regularly,

- utilize telemedicine strategies for facilities that do not have on-site OB-GYN nurses,
- improve external oversight by assigning task forces from the NCCHC or state-level equivalents to investigate instances of inadequate medical care,
- allocate state funds for correctional facilities to hire adequate numbers of medical staff and to ease the pressure of cutting costs,
- ensure proper training of medical and custodial staff to respond to female inmates' medical needs in an appropriate, timely manner, and
- educate custodial and medical staff on the seriousness of reproductive health issues and women's needs.

Menstrual Hygiene for Incarcerated Women

Leaving the delivery of menstrual hygiene products up to correctional officials is problematic considering the penal harm and carceral framework under which American penology currently operates (Michaels, 2019). Placing correctional officers in charge of women's hygienic needs humiliates and shames women during their periods, as female inmates have reported needing to show male officers their bloody menstrual products to prove that they need new ones (Goldberg, 2018). From a penal harm perspective, necessities such as menstrual hygiene products are viewed as luxuries by the custodial staff. This is evidenced by emerging research and news articles that show facilities provide the bare minimum of products, which are often inadequate in both quantity and quality, if they provide anything at all (Bozelko, 2015; Polka, 2018; Ronan, 2015; Shaw, 2019). Moreover, facilities charge inmates for additional products at marked-up prices,

supporting the notion that feminine hygiene is a commodity, not a necessity, in the eyes of the criminal justice system (Seibold & Fienberg, 2019; Greenberg, 2017).

Recommendations Regarding Menstrual Hygiene for Incarcerated Women

Although the federal government passed legislation that requires federal facilities to provide free menstrual hygiene products in a bill titled The FIRST STEP Act, this law does not provide guidelines for how many products facilities should provide, meaning that access is still restricted by arbitrary monthly quotas (Samant, 2018). This legislation also does not impact state facilities, of which only four provide free products to female inmates (Polka, 2018; Seibold & Fienberg, 2019). Therefore, it is recommended that the federal guidelines provided by the FIRST STEP Act be adopted at the state and local levels and to specify what is required. This Act states that the Bureau of Prisons (BOP) is required to "provide tampons and sanitary napkins that meet industry standards to prisoners for free and in a quantity that meets the healthcare needs of each prisoner" (James, 2019, p. 20). While this states clearly that products should be provided for free, the remaining language is vague. It is unclear what quality of product meets "industry standards," and there is subjectivity on how many products women will actually receive. To ensure women receive adequate access to fair-quality products, the FIRST STEP Act should be strengthened in the following ways:

- specify what is meant by "industry standards,"
- outline how facilities can quality-check items,
- address how supplies are distributed,
- clearly eliminate the use of quotas on menstrual hygiene products,

- standardize the price at which additional products can be purchased, ensuring that prices are reasonable compared to market prices and affordable for incarcerated women's income, and
- include a wider variety of menstrual hygiene options, such as menstrual cups or menstrual underwear.

After these improvements are made, similar laws should be enacted by state legislators and county commissioners so menstrual products are available in state and local correctional facilities, where the majority of female offenders are incarcerated. Furthermore, steps should be taken to improve oversight and accountability in correctional facilities. Currently, due to a lack of oversight, especially in county jails, corrections officials are free to decide for themselves when, or if, female offenders should be supplied hygiene products. This leads to jails overcharging women for products, providing poor quality products, or even denying women access to products, leaving them to bleed onto their clothes or their own bodies (Michaels, 2019; Swavola, Riley, & Subramanian, 2016).

Even if a facility has a written policy detailing the provision of menstrual hygiene products, implementation of that policy is not guaranteed, and reports have shown that facilities still charge women for menstrual hygiene products despite being instructed to provide them for free (CAN-DO Foundation, 2017; Dolven, 2017). This may be because violations of departmental policy result in internal investigations that do not produce the same consequences as breaking the law (Shaw, 2019). Thus, it is not enough for individual departments to create a policy. In order to achieve menstrual equity and provide adequate reproductive health services for incarcerated women, legislation must

be enacted that creates national standards and specific guidelines for the delivery of these services and penalties for correctional facilities and their actors who fail to meet those standards.

CHAPTER V

Conclusion

Findings and Implications

This thesis focuses on lawsuits pursuant to Section 1983 brought by female inmates claiming deficient health care. Due to the historic neglect of female offenders' experiences in the criminal justice system, less is known about the challenges women face during incarceration. Therefore, this thesis explores an aspect of female inmates' experiences with correctional health care to fill some of the gaps in the literature, as there are few studies that focus solely on legal issues on correctional health care for women. The findings speak to the negligent, and at times cruel, humiliating, and deliberately indifferent, care that women are subjected to behind bars.

One significant finding shows that there were fewer cases brought by female offenders than their male counterparts that alleged deliberate indifference to inmates' serious medical needs. While this may be due to the lower numbers of incarcerated women than incarcerated men, it could also imply that incarcerated women do not have equal access to legal resources and are less able to seek legal redress when their rights are violated. A second finding suggests that the penal harm perspective influences correctional medical care practices as well as court decisions. Evidence shows there is a heightened level of *mens rea* when showing the culpable state of mind (deliberate indifference as opposed to negligence) placed on offenders suing under Section 1983 compared to free-world medical malpractice litigants who only show negligence. The legal difference in culpability leads to fewer victories for Section 1983 female plaintiffs for their adverse medical outcomes for incarcerated women. Penal harm is the result

whether inflicted with a high degree of intent, through malign neglect, or mere negligence. Indeed, the majority of cases analyzed were dismissed, with the exception of class action lawsuits challenging widespread failures to deliver even basic medical care to female inmates, lawsuits pertaining to female inmates' deaths due to deficient health care, and cases brought by pregnant offenders who experienced odious and callous behavior from custodial staff or prison health care personnel.

The high dismissal rates and the legal justifications behind them reflects the courts finding that the medical care merely negligent, not deliberately indifferent, reveals that correctional administrators and correctional health personnel are not found legally responsible for providing inadequate, harmful medical care unless it is proven they did so with a high degree of culpability. In other words, this thesis reports that courts justify penal harm medical practices, making it more difficult for female offenders to seek legal remedies for the poor medical care they receive. Since the baseline for adequate medical care under *Estelle v. Gamble* is so low to begin with, the courts' complacency in cases on penal harm medicine also makes it more challenging to improve the state of medical care for incarcerated women.

For medical treatment to improve, correctional administrators, health care officials, state legislators, and local politicians who allocate financial resources to correctional medical systems need to embrace the "principle of equivalence," where inmates are entitled to the same level of health care as practiced in the free-world (Vaughn & Carroll, 1998). The "principle of equivalence" is an aspirational goal of many countries in the European Union and United Kingdom as well as international entities, which include the Council of Europe, the World Medical Association, the World

Health Organization, and the United Nations. While perhaps falling short of the "principle of equivalence," all these entities have been striving to provide prisoners with the same level of medical care available to the non-incarcerated public (Charles & Draper, 2012; Jotterand & Wangmo, 2014; Niveau, 2007). The United States, however, with the largest jail and prison populations in the world, makes no pretense about its correctional health care reaching the "principle of equivalence," with its differing legal standards for prisoners suing under Section 1983 (deliberate indifference) and for free-world citizens who sue pursuant to medical malpractice (negligence). Rather, as this thesis documents, the courts and correctional systems across the U.S. are collectively more focused on the "principle of less eligibility" and on the practice of penal harm medicine.

Limitations

While analyzing the state of health care services for incarcerated women in the United States through their legal complaints produced an illuminating case study on inadequate medical treatment and courts' responses, there are some shortcomings to using this particular method. First, this thesis only reports cases appearing in Westlaw. Westlaw only publishes cases the courts decide to publish. Moreover, settlements and many trials are omitted from cases in Westlaw, so the most frivolous cases and the most egregious cases are likely not included. In addition, litigation rarely provides information on a plaintiff's race, ethnicity, socioeconomic status, or any other demographic variables relevant to their medical treatment. This in turn limits the generalizability of the findings. Another limitation is that most of the cases reported here are interlocutory appeals, which settle pretrial procedural disputes, thus many cases presented are not litigated on the

merits and do not report the final disposition of the litigation. Finally, relying on doctrinal research may limit the pool of data as most instances of neglectful or deliberately indifferent medical care are never litigated, and if they are, their decisions may not be made available to the public.

Recommendations for Future Research

Moving forward, researchers should use doctrinal methods in conjunction with other fields and methodologies to produce findings that consider litigation in a broader context. Doctrinal research is beneficial in providing insight for legal research and litigation, but these methods can also be constricting. This is because doctrinal findings are limited to the facts of particular cases, which critics argue leads to a lack of generalizability, unclear methodology, and reduces replicability (Hutchinson, 2015). Contemporary doctrinal studies, however, often infuse interdisciplinary methods into their analyses, such as secondary survey results, statistical analysis, and interviews (Hutchinson, 2015). Additionally, doctrinal researchers are choosing interdisciplinary co-authors, and comparative research methods are becoming more common within the legal research field (Hutchinson, 2015).

Improving the accessibility and quality of incarcerated women's health care is not limited to court proceedings; it also involves public policy, correctional policy, sentencing laws, budgetary allocations, and attitudinal changes from criminal justice actors and the public at large. Therefore, future research on this topic should consider using interdisciplinary methods to provide the best recommendations for change. For example, using doctrinal methods alongside conducting a survey in a women's correctional facility could help illustrate and contextualize which lawsuits are filed. The

significance of a court's decision may be lost among the thousands of cases filed each year; thus, for doctrinal methods to make a bigger impact, demonstrating that the facts of one case describe ongoing situations in a facility through a survey of female inmates' experiences would directly link case law to facility practices and highlight the need for stronger legal action.

Although it is important to study women's experiences in their own capacity, it is equally important to compare their experiences with those faced by men, as a comparison would determine the extent to which sex and gender discrimination plays a role in incarcerated women's health care needs. Because this thesis did not include lawsuits filed by male inmates, it cannot speak to inequitable treatment between male and female offenders. Therefore, next steps should include comparing similar cases brought by men and women to analyze the differences in legal outcomes. Comparisons should also be made between extralegal factors, such as race, ethnicity, sexual orientation, gender identity, socioeconomic status, religion, and offense type to uncover any other potentially discriminatory practices in court decisions.

Another avenue of comparative research could involve comparing free-world medical malpractice claims to female prisoners' claims of deliberate indifference. According to Black's theory of differential law, which posits that litigation success is dependent on social integration and stratification, marginalized populations receive fewer legal benefits. Prior research (Vaughn & Carroll, 1998) has found support for Black's theory by comparing legal standards for correctional health care with those of the free world; findings reveal that inmates are not privy to the same legal remedies when they suffer poor and inadequate medical care as free-world populations. While this thesis

examines the high degree of culpability required in Section 1983 claims, which rely on the legal standard of deliberate indifference when applied to female prisoner' medical care lawsuits, a more direct comparison between free-world malpractice as opposed to Section 1983 health care lawsuits would illustrate this inequity more clearly.

This thesis was written when the COVID-19 pandemic was raging in the United States. Of the populations affected most by this virus are those who are incarcerated, who have limited options to socially distance, do not have widespread or equal access to testing, and are not granted full autonomy of their medical care or decisions. As of June 9th, 2020, there have been approximately 44,000 cases of COVID-19 in correctional facilities and 522 inmate deaths (The Marshall Project, 2020). Correctional staff are also at an increased risk of contracting the coronavirus (Montoya-Barthelemy, Lee, Cundiff, & Smith, 2020). Like inmates, correctional officers are subjected to environmental factors that promote the spread of respiratory illnesses, such as dense populations, poor ventilation, limited personal protective equipment (PPE) and hygiene supplies, as well as making direct contact with inmates who may be infected (Montoya-Barthelemy et al., 2020).

Since inmates and correctional staff each have an increased risk of contracting the coronavirus, there is an additional concern that they may spread the virus to the community. Researchers have established that public health is directly affected by correctional health and vice versa (Restum, 2005). The health of incarcerated populations impacts public health through offender release and recidivism; communities that have high concentrations of previous inmates, for example, suffer from health disparities and higher rates of communicable diseases (Wildeman & Wang, 2017). Due to racial

disparities in sentencing and inmate populations, these communities are generally comprised of minorities of low socioeconomic status who do not have adequate access to health care resources. Thus, while correctional facilities can provide an opportunity for these populations to receive preventive care and treatment, correctional health care is only one part of the solution. For incarcerated populations' health to improve and to improve the overall health of communities heavily affected by mass incarceration, more resources should be allocated to these communities, and correctional facilities should consider partnering with community health centers.

Limited attention has been given to the specific ways that incarcerated women have been impacted by the pandemic. As some authors state, "women are the less visible victims of COVID-19 behind bars—as they are often overlooked in a criminal justice system that was not designed for them" (Aspinwall, Blakinger, & Neff, 2020, para. 3). While more male inmates have died from the coronavirus than female, female inmates have higher rates of preexisting conditions that would make them more vulnerable. In fact, reports show that corrections officials highlight these conditions after women die in their care, explaining that their health problems made them more susceptible to complications of COVID-19 that could lead to their death (Aspinwall et al., 2020). Moreover, further research is needed on the risks of developing serious diseases after contracting COVID-19 while pregnant, as preliminary studies suggest pregnant inmates are at higher risk of complications and thus need additional protections (Montoya-Barthelemy et al., 2020).

Correctional health care scholars will likely be studying the effects of COVID-19 in jails and prisons for years to come. Undoubtedly, there will be a plethora of litigation

on wrongful inmate deaths, inadequate medical care, and facilities' failure to provide clean, safe, and healthy conditions during this tragedy. As the world continues to learn about how the coronavirus has been managed in correctional facilities and more incarcerated individuals share their stories via news reports, studies, and litigation, special care should be taken not to ignore or minimize incarcerated women's experiences.

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Safe Streets and Second Chances Reentry Project: Five Key Models
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Publications

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Conference Experience

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