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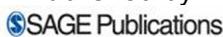
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# Health Care in Prison Thirty Years After *Estelle v. Gamble*

Lester N. Wright, MD, MPH

Raising access to health care for incarcerated people to a constitutional right radically changed correctional health care. It also established a constantly changing standard of required care because the right is based on evolving standards of health care in the general community. A prison system must continually monitor new health care possibilities and attempt to determine what is required. Correctional health care must consider access, quality, and cost together as part of a system; this may be easier to do in a clearly defined setting such as corrections than in the community. *Estelle* also taught incarcerated people that lawsuits can be used to improve care and to attempt to force the prison system to provide the care they want.

**Keywords:** correctional health care; *Estelle v. Gamble*; prisons; standard of care

In a recent week, as chief medical officer of a large prison system, I dealt with requests for medical parole (compassionate release); approvals for short-course treatment of latent tuberculosis infection and hepatitis C; the question of whether we should begin offering the new human papillomavirus vaccine to young female inmates; developing guidelines for bariatric surgery; hiring decisions on physicians, dentists, and pharmacists; approval for an inmate to donate one of his kidneys to his mother; approval for another inmate to be evaluated for a heart transplant for himself; oversight of a spectrum of mental health and behavioral health care; a quality improvement question about why emergency trips had doubled at one of our prisons; and preparation for defense in lawsuits filed about health care.

How has the Supreme Court's ruling in *Estelle v. Gamble* 30 years ago affected health care in a large state prison system? Thirty years ago, I had recently returned from a term working in Ethiopia and was a county health officer. Correctional health care was far from my mind and many years away from my work, so I can only reflect on what I read about the subject then and compare it with what I experience it is now.

In 1972, the results of a survey conducted by the American Medical Association documented that in some jails the only care available was first aid, and even that was not available everywhere. Physicians were not available. Unlicensed health care providers, some of whom were graduates of foreign medical schools, and untrained "nurses" provided care. The only dental care was emergency care (Arnold, 2004).

Lester N. Wright, MD, MPH, is the deputy commissioner and chief medical officer for the New York State Department of Correctional Services, directing a health services division that provides health care for approximately 64,000 inmates in 70 facilities. He is certified by the American Board of Preventive Medicine, and has held leadership roles public health departments at the state and county levels. He also has done significant work in African nations on numerous health-related projects.

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Address correspondence to: Lester N. Wright, MD, MPH, New York State Department of Correctional Services, 1220 Washington Avenue, Building 2, Albany, NY 12226-2050; e-mail: [LNWright@docs.state.ny.us](mailto:LNWright@docs.state.ny.us).

When an uprising occurred at Attica Correctional Facility in Western New York in September 1971, one of the major sources of inmate complaints was health care (New York State Special Commission on Attica, 1972). The tragic loss of life that occurred during the retaking of Attica got attention in New York. It is quite possible that, even without the *Estelle* ruling, health care would have significantly improved in New York State prisons. I say that it is quite possible, but it is not clear how much improvement would have occurred because more than a decade later, an unacceptable level of health care was cited in two prisons and court monitors were accepted to improve care. In 1990, a class action suit was filed by inmates with HIV/AIDS to enjoin acceptable care for their disease, a disease that had not been identified at the time of *Estelle*. More recently, a class action lawsuit was filed regarding mental health care of inmates with serious mental illness who are in disciplinary housing.

## **Changing Standards of Care**

My point is that the principle enunciated in *Estelle*—that deliberate indifference to the health care needs of inmates with serious medical conditions is a violation of constitutional rights of incarcerated persons—is only a principle and one that has been further defined in many later cases. In one of these, *Rhodes v. Chapman* (1981), the court noted that deliberation as to whether conditions of confinement are “cruel and unusual, for the Eighth Amendment, ‘must draw its meaning from the evolving standards of decency that mark the progress of a maturing society” (Frank, 2005). In other words, the level of health care required, the target for a prison system, is a shifting target. Thus, an acceptable, expected standard of health care in 2007 is not the standard that was in place when *Estelle* was decided, it is not the standard that was in place when I began my work in corrections in 1995, and it is not the standard that will be in place in 2010.

The effect of *Estelle* continues to be defined year by year. Having a system for care of those dying of AIDS was the cutting-edge issue 15 years ago. That situation has radically changed, with today’s standard being a system for management of HIV as a chronic illness that requires very extensive, very expensive therapy for what can be decades of life.

Fifteen years ago, it was clear that staff who might come into contact with hepatitis B should be offered immunization against the disease. Now we offer the immunization series not only to staff but also to all inmates who are not already immune.

Twelve years ago, it was expected that renal transplant would be available to some of the inmates who were being maintained on renal dialysis, therapy that was not universally available even to everyone in the community when *Estelle* was decided. Now inmate-patients who would not survive otherwise are being provided with other major organ transplants, such as liver.

Ten years ago, the issue was relatively newly recognized and sometimes treatable hepatitis C. Now more effective treatment is available, but that treatment takes months and costs thousands of dollars. To make it possible for treatment, even though the inmate-patient may be released before that treatment is completed, a continuity program has been developed in collaboration with medical centers throughout New York.

Thirty years ago, most seriously mentally ill people were in mental hospitals, where they received major tranquilizers, and many hoped they could be released back into the community to be maintained on those medications with the support of community mental health centers. Now there are two or three times as many seriously mentally ill people in prisons as there are in mental hospitals. Providing appropriate care for their mental health needs wherever they are in a prison system has become not only essential to maintaining good order and safety in the prisons but also a constitutional issue.

What will be the next issue of care to arise? Will it be yet another more expensive but more effective treatment for an existing disease? Will it be another emerging infection? Will it be screening for early detection of another disease, perhaps screening for lung cancer? Will it be another immunization against disease such as human papillomavirus to prevent cervical cancer or HIV to prevent infection? Although it is impossible to know what the next issue will be, it is clear that there *will be* a next issue and that prison systems must be constantly aware of developing medical care issues in the community.

## Changing Systems of Care

But even more significant than the developing issues for which correctional health will be held responsible to provide care is the need for a system through which health care is provided in corrections. In a large corrections system, such as the one in which I work, inmates are moved, on average, two or three times a year among the prisons, and it is not acceptable to provide care to differing standards at the various prisons. If health care in each prison is provided according to the interests and expertise of the providers who work there, then the care provided in some of the prisons will not be up to the constitutional standard. In others, nonessential care may be provided based on the interests of a physician or the persistence of some inmate-patients who demand until it is easier to say "yes" than to have the inmate in your face every day.

Three decades ago, the American Medical Association survey found unlicensed physicians caring for inmates, and even half that many years ago, it was not uncommon to find physicians who were licensed only to provide care to those in state institutions. Now it is rare for my system to hire physicians who do not have specialty boards. The percentage of physicians who work in my system who are board certified or board eligible is now greater than 91%, slightly higher than the rate among physicians in New York state as a whole.

Three decades ago, treatment might have been ordered by an unlicensed provider. Now we reflect the community in using a mix of physicians, physician assistants, and advanced practice nurses to diagnose and treat our inmate-patients. All are licensed in their profession and expected to maintain their knowledge and expertise.

Continuing professional education is required by many licensing boards, but it is also recognized as essential to keep current on rapidly evolving care. A system such as mine now not only requires continuing education for its providers but also offers many educational programs using newly developed media. Fifteen years ago, traveling lecture programs were provided in various parts of the state. Now much of the education is done through two-way video, satellite-broadcast televised conferences, and videotapes. Educational programs may be provided by the system directly, by arrangement or contract with specialists from medical centers in the community, or by national experts.

Three decades ago, little quality assurance was done in prisons. In the intervening years the business world has gone through many generations of management systems. From them has come the concept of continuous quality improvement (QI), with its understanding that many of the problems in care can be avoided through changes in the system and that care should be constantly studied to find how to improve the outcomes. When the Institute of Medicine published its study "To Err is Human" (Institute of Medicine, 2000), QI became expected in the community. As this is expected in the community, it is expected in correctional health care also. Accreditation standards such as those of National Commission on Correctional Health Care (2003) and the American Correctional Association (2004) require not only QI in each prison but also peer review of providers.

## Consequences of *Estelle*: Cost and Litigation

With the expectation that community-level care will be provided in corrections has come the resultant issue of cost. It is recognized in health care policy that access, quality, and cost must be addressed together. They are interrelated. In effect, correctional health care has become not merely a "health insurance program" but in reality a "managed care system." Managed care has earned itself a bad name in the community because in too many cases it is the bottom line that is being managed rather than the health care. In corrections, there are a number of technical factors that make it possible to use the tools of management to improve care, including mandatory enrollment, relatively low turnover in enrollees, limited provider choice, and a universal budget. However, *Estelle* results in one essential difference from the community: A constitutional guarantee of fulfillment of all required health care needs will outweigh management of the bottom line.

Using the tools of management to improve care means, for example, that computerized systems are used to schedule the 130,000 specialty consults needed last year across New York using regional clinics, most of which are based in prisons, with services provided by more than 1,000 specialists on contract to us. It means that we choose to pay the specialist the same amount for his/her time whether the consult is provided in person or through the use of telemedicine, because we consider the security cost of the medical trips as well as the cost of the specialist's encounter. It also means that primary care practice guidelines are developed or adapted in an attempt to achieve uniformity of care systemwide.

One other effect of *Estelle* is the litigation. Although inmates file suits about many aspects of their criminal justice experience, one of the most common aspects is their health care. *Estelle* provides the foundation for their suits charging "deliberate indifference." In the community, suits against medical providers usually allege "malpractice," which is really professional liability for unacceptable outcomes. In correctional health care, most of the lawsuits are filed in federal courts alleging Eighth Amendment violations, not in state courts alleging malpractice. And federal courts, while enunciating the distinction between deliberate indifference and malpractice, do issue judgments based on malpractice even though they are described as deliberate indifference.

## Conclusion

So 30 years later, how has *Estelle* affected health care in a large prison system? It has radically changed nearly everything about health care. It has resulted in the expectation by prisoners that they have the right to care, often the care that they want or demand rather than what they need. It has resulted in informed budget authorities understanding that medical needs must be met or there will be court judgments to pay. It has meant that health care in prisons is no longer provided by gentlemen retiree physicians and unlicensed providers but rather by qualified physicians who find it is interesting and challenging to care for inmates who have endured medical neglect in the community and present with conditions rarely seen in the community. And many of those providers come to practice in corrections where they do not have to fight with insurance company rules. It has meant the opportunity to develop efficient systems to provide the care. It has meant that correctional health care has moved from a backwater behind the walls to some of the most clearly transparent health care in the country. It has meant that we in a large prison health care system have the opportunity to provide high-quality care to those in custody simply because they need that care, and not having to turn someone away from care they need because they do not have the insurance coverage.

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