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## Medicine Behind Bars: Regulating and Litigating Prison Healthcare Under State Law Forty Years After *Estelle v. Gamble*

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— Comment —

MEDICINE BEHIND BARS:  
REGULATING AND LITIGATING PRISON  
HEALTHCARE UNDER STATE LAW  
FORTY YEARS AFTER  
*ESTELLE V. GAMBLE*

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## INTRODUCTION

As of 2017, about 1,330,000 inmates are housed in state prisons in the U.S.<sup>1</sup> These inmates represent approximately 60 percent of the almost 2.3 million persons confined by various jurisdictions in the United States.<sup>2</sup>

California, Florida, and Texas are the three states with the highest prison population in absolute numbers, accounting for more than one-third of all state prisoners as of 2017.<sup>3</sup> As of 2016, the District of Columbia had the highest per-capita incarceration rate in the U.S.—with 1,196 inmates per 100,000 residents—followed closely by Louisiana.<sup>4</sup>

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1. PETER WAGNER & BERNADETTE RABUY, MASS INCARCERATION: THE WHOLE PIE 2017, at 1 (2017), <https://www.prisonpolicy.org/factsheets/pie2017.pdf> [<https://perma.cc/U9PV-8JMV>].
  2. *See id.*
  3. *See California Profile*, PRISON POL'Y INITIATIVE, <https://www.prisonpolicy.org/profiles/CA.html> [<https://perma.cc/6CSY-93W3>] (last visited Oct. 10, 2017) (reporting that California had 242,000 individuals incarcerated in 2016); *Florida Profile*, PRISON POL'Y INITIATIVE, <https://www.prisonpolicy.org/profiles/FL.html> [<https://perma.cc/6THT-8A25>] (last visited Oct. 10, 2017) (reporting that Florida had 177,000 incarcerated individuals in 2016); *Texas Profile*, PRISON POL'Y INITIATIVE, <https://www.prisonpolicy.org/profiles/TX.html> [<https://perma.cc/QVG2-VUUA>] (last visited Oct. 10, 2017) (reporting that Texas had 246,000 incarcerated individuals in 2016).
  4. Peter Wagner & Alison Walsh, *States of Incarceration: The Global Context 2016*, PRISON POL'Y INITIATIVE (June 16, 2016), <https://www.prisonpolicy.org/global/2016.html> [<https://perma.cc/JHZ8-8WHV>]. The District of Columbia rate is only slightly higher than that in Louisiana—1,143 inmates per 100,000 residents. *Id.* The average rate in the U.S. as a whole is 693 inmates per 100,000 residents. *Id.* For a global perspective, the imprisonment rate in Japan is 47 per 100,000 and that of Brazil is 307 per 100,000, which is lower than that of the state with the lowest incarceration rate in the U.S., Massachusetts—330 per 100,000. *Id.*
  5. Even with the Affordable Care Act (“ACA”) in place, access to healthcare in the U.S. remains a challenge. DONALD A. BARR, INTRODUCTION TO US HEALTH POLICY: THE ORGANIZATION, FINANCING, AND DELIVERY OF HEALTH CARE IN AMERICA 330–54 (4th ed. 2016). What is more, the future of the ACA remains uncertain. This is, in part, because of a 2014 federal lawsuit brought by the U.S. House of Representatives against the Secretary of Health and Human Services. *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 174–75 (D.D.C.), *appeal held in abeyance*, 676 F. App'x 1 (D.C. Cir. 2016) (holding that, while Congress authorized reduced cost sharings under the ACA to reimburse insurers for charging certain beneficiaries reduced “out-of-pocket” rates, Congress never appropriated any funds for it, making any such reimbursements by the Secretary unconstitutional). While the Obama Administration was engaged in defending the payments at issue on appeal, the approach of the current

The U.S. as a whole is struggling to provide reliable access to effective and affordable healthcare.<sup>5</sup> Moreover, inmates are sicker on average than the general population.<sup>6</sup>

A little over forty years ago, the Supreme Court decided *Estelle v. Gamble*,<sup>7</sup> a landmark decision concerning the constitutional standard for medical care behind bars. Since *Estelle*, most litigation<sup>8</sup> and much academic commentary<sup>9</sup> on prison healthcare has focused on the Eighth Amendment.

This Comment sets out to update older studies from around 1970 that devoted a fair deal of attention to prison healthcare under then-

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Congress and Administration is less than certain as of this writing. *House of Representatives v. Price*, HEALTH REFORM TRACKER, <http://www.healthreformtracker.org/house-of-representatives-v-price/> [<https://perma.cc/82DW-HBJD>] (last visited Oct. 20, 2017). Moreover, for the months following Dec. 31, 2018, the ACA's "shared responsibility payment" for those failing to maintain minimum essential coverage, 26 U.S.C. § 5000A(c) (2012)—commonly known as the "individual mandate"—was eliminated by the tax bill signed into law by the President on Dec. 22, 2017. Act of Dec. 22, 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2093 (to be codified at 26 U.S.C. § 5000A(c)); see Margot Sanger-Katz, *Requiem for the Individual Mandate*, N.Y. TIMES (Dec. 21, 2017), <https://www.nytimes.com/2017/12/21/upshot/individual-health-insurance-mandate-end-impact.html> [<https://perma.cc/C9A3-7N6R>] (discussing the brief history of the individual mandate and the potential impact of its repeal on healthcare markets).

6. See 1 MICHAEL B. MUSHLIN, RIGHTS OF PRISONERS § 4:1 (4th ed. 2016) (summarizing recent health statistics concerning prisoners).
7. 429 U.S. 97 (1976).
8. 1 MUSHLIN, *supra* note 6, § 4:1 (noting that, "[d]espite the availability of other approaches [on the state and federal levels], virtually all of the litigation in [the area of inmate medical care] is based on federal constitutional grounds, specifically the Eighth and Fourteenth Amendments").
9. *E.g.*, Evelyn Malavé, Note, *Prison Health Care After the Affordable Care Act: Envisioning an End to the Policy of Neglect*, 89 N.Y.U. L. REV. 700 (2014); Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME & JUST. 427 (1999); Damon Martin, Comment, *State Prisoners' Rights to Medical Treatment: Merely Elusive or Wholly Illusory*, 8 BLACK L.J. 427 (1983); Comment, *Beyond the Ken of the Courts: A Critique of Judicial Refusal to Review the Complaints of Convicts*, 72 YALE L.J. 506 (1963) [hereinafter *Beyond the Ken of the Courts*]; Note, *Prisoners' Remedies for Mistreatment*, 59 YALE L.J. 800 (1950).

existing state law<sup>10</sup> by exploring some aspects of how the provision of healthcare in state prisons is regulated and litigated at the state level today.<sup>11</sup> To achieve this goal, this Comment proceeds in two parts. Part I discusses various models for state regulation of healthcare in prisons. Part I places special emphasis on the managed-care model. The implementation of this model is discussed based on the example of Connecticut. Managed care has held out the promise of quality affordable care, but has also generated some controversy over the past decades as inimical to quality healthcare. Part II highlights a number of aspects of litigating healthcare claims by prisoners by discussing the torts and medical malpractice approach to healthcare litigation under state law. The Conclusion will summarize the findings of Parts I and II and offer some proposals for reform.

## I. REGULATING PRISON HEALTHCARE

### A. *The General Context: State Constitutions, Laws, and Regulations*

States have regulated the provision of healthcare to their prisoners beginning in the eighteenth century. For instance, Delaware's 1792 Constitution appears to be the first state constitution to do so by requiring that "in the construction of [jails] a proper regard shall be had to the health of prisoners."<sup>12</sup> In the years following the Civil War, other

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10. For a detailed discussion of state law regarding medical care for inmates circa 1970, see Michael H. Slutsky, Comment, *The Rights of Prisoners to Medical Care and the Implications for Drug-Dependent Prisoners and Pretrial Detainees*, 42 U. CHI. L. REV. 705, 706–11 (1975); Marvin Zalman, *Prisoners' Rights to Medical Care*, 63 J. CRIM. L. & CRIMINOLOGY 185, 186–90 (1972); and Barney Sneiderman, *Prisoners and Medical Treatment: Their Rights and Remedies*, 4 CRIM. L. BULL. 450, 451–56 (1968). For a summary glance at state law in this regard, see Martin, *supra* note 9, at 427–28; *Beyond the Ken of the Courts*, *supra* note 9, at 507–09 (noting that available legal remedies, including civil rights and tort law, were blunted at the time by "a conviction held with virtual unanimity by the courts that it is beyond their power to review the internal management of the prison system"); *Prisoners' Remedies for Mistreatment*, *supra* note 9, at 801 (discussing inadequate remedies for prison disciplinary abuse).

11. The familiar statement by Justice Brandeis concerning states as "laboratories" underlies this focus on the states: "[i]t is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

12. DEL. CONST. of 1792, art. I, § 11.

states—North Carolina,<sup>13</sup> Tennessee,<sup>14</sup> Wyoming,<sup>15</sup> and Georgia<sup>16</sup>—turned the condition of their prisons, including the health and general treatment of their prisoners, into concerns of constitutional magnitude.

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13. The 1868 Constitution of North Carolina appears to be the first state constitution mandating humane treatment of prisoners after Delaware's. N.C. CONST. of 1868, art. XI, § 6 ("It shall be required by competent legislation, that the structure and superintendence of penal institutions of the State . . . secure the health and comfort of the prisoners . . ."). After all, in keeping with the ideas of the prison-reform movement of the 1860s, imprisonment served "to reform the offender" to prevent crime, "not just to satisfy justice." *Id.* art. XI, § 2. *See, e.g.*, E.C. WINES & THEODORE W. DWIGHT, REPORT ON THE PRISONS AND REFORMATORIES OF THE UNITED STATES AND CANADA MADE TO THE LEGISLATURE OF NEW YORK, JANUARY, 1867, at 144–46 (1867) (noting that "the humane system [of prison discipline] . . . is more effective . . . in promoting [the inmates'] reformation, than the system of harshness and severity" and rooting in the Bible its model of a prison disciplinary system that meets out "[p]unishment . . . with reformation for its end and kindness as the means"). Article XI was completely rewritten when the state adopted its current, 1971 Constitution. *See generally* JOHN V. ORTH, THE NORTH CAROLINA STATE CONSTITUTION 32–37 (2d ed. 2011) (outlining some major developments in the state's constitutional history between 1796 and the 1970s); REPORT OF THE NORTH CAROLINA STATE CONSTITUTION STUDY COMMISSION 88–89 (1968) (stating that the 1868 provisions had "served their intended purpose or are so detailed as to be more appropriate for statutory than for constitutional treatment" and giving the state legislature the responsibility "to provide appropriate institutions and agencies to minister to the . . . correctional needs of the State"); *infra* note 21.
14. In 1870, Tennessee added language to its constitution to mandate "safe and comfortable prisons." TENN. CONST. of 1870, art. I, § 32. *See* Robert W. Lough, Comment, *Tennessee Constitutional Standards for Conditions of Pretrial Detention: A Mandate for Jail Reform*, 48 TENN. L. REV. 688, 705–06 (1981) (discussing the scarce legislative history of this provision). The Tennessee Constitution currently requires that "the erection of safe prisons, the inspection of prisons, and the humane treatment of prisoners, shall be provided for." TENN. CONST. art. I, § 32. The current wording was put in place by a constitutional amendment in 1998. *Tennessee Prisoner Treatment and Conditions, Amendment 1 (1998)*, BALLOTPEDIA, [https://ballotpedia.org/Tennessee\\_Prisoner\\_Treatment\\_and\\_Conditions,\\_Amendment\\_1\\_\(1998\)](https://ballotpedia.org/Tennessee_Prisoner_Treatment_and_Conditions,_Amendment_1_(1998)) [<https://perma.cc/X27N-J99P>] (last visited Oct. 20, 2017). The 1998 wording brings Tennessee in line with the federal minimalist formula enunciated in 1994 in *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (quoting *Rhodes v. Chapman*, 452 U.S. 337, 349 (1981)), that "[t]he Constitution 'does not mandate comfortable prisons' . . . but neither does it permit inhumane ones."
15. While Tennessee changed its original wording, the Constitution of Wyoming, adopted in 1889, is an almost verbatim echo of the 1870 Tennessee Constitution. *See* WYO. CONST. art. I, § 16 ("The erection of

Since the middle of the nineteenth century, even states that did not constitutionalize the conditions of imprisonment imposed a duty on state agencies to ensure that inmates were clothed, fed, and provided medicine and medical care.<sup>17</sup> These statutory provisions vary in form and detail.<sup>18</sup> Some statutes formulate basic requirements for prison healthcare—such as an initial physical and mental examination for all new inmates,<sup>19</sup> or that inmates are required to contribute to healthcare expenditures through co-payments<sup>20</sup>—but then delegate the authority to prescribe more detailed standards for healthcare to the state’s department of corrections.<sup>21</sup> Other statutes simply delegate all such

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safe and comfortable prisons, and inspection of prisons, and the humane treatment of prisoners shall be provided for.”).

16. Since 1868, the Georgia Constitution features an add-on to the federal version of the Eighth Amendment that provides “nor shall any person be abused in being arrested, while under arrest, or in prison.” GA. CONST. art. I, § 1, ¶ 17. See Dorothy T. Beasley, *The Georgia Bill of Rights: Dead or Alive?*, 34 EMORY L.J. 341, 380–88 (1985) (comparing the Eighth Amendment and the Georgia Constitution and discussing the legislative history of this state constitutional provision); Caroline Davidson, *State Constitutions and the Humane Treatment of Arrestees and Pretrial Detainees*, 19 BERKELEY J. CRIM. L. 1, 23 n.91 (2014) (quoting additional state constitutions with similar provisions).
17. *E.g.*, State v. McCauley, 15 Cal. 429, 432 (1860) (citing an 1856 California law that required the state to write its contracts with private prison lessees so “as will conduce to the safety and convenience of keeping, working, clothing, feeding and providing medicine and medical attendance for the convicts of the state”). For some background on the private party in this suit, John McCauley, within the context of private leases of inmate labor in the nineteenth century, see Sharon Dolovich, *State Punishment and Private Prisons*, 55 DUKE L.J. 437, 451–54 (2005).
18. This was already the observation of one commentator forty years ago. Slutsky, *supra* note 10, at 707–11.
19. *E.g.*, MD. CODE ANN., CORR. SERVS. § 9-602(f) (West 2002); 2017 N.C. Sess. Laws 2017-186; 42 R.I. GEN. LAWS § 42-56-38(a) (West 2014). As of 2015, at least 38 states had—by statute or regulation—authorized co-payments for medical services provided to inmates which are waived when inmates cannot afford the co-payments. Michael Ollove, *No Escaping Medical Copayments, Even in Prison*, PEW CHARITABLE TR. (July 22, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/07/22/no-escaping-medical-copayments-even-in-prison> [https://perma.cc/U29V-5HQQ].
20. *E.g.*, TENN. CODE ANN. § 41-4.115(d)–4.115(e) (West 2017).
21. *E.g.*, IOWA CODE ANN. § 904.108(d) (West 2017) (requiring that the standards to be established by the director of the department of corrections include the provision of “habilitative services and treatment” for inmates with intellectual disabilities); 2017 N.C. Sess. Laws 2017-186.

decisions to the state agency responsible for running state prisons while setting very general<sup>22</sup> or no parameters.<sup>23</sup>

In formulating their healthcare policies, states—acting through their legislatures or competent agencies—have addressed a number of aspects of inmate healthcare,<sup>24</sup> such as setting the community standard of care as the appropriate standard for healthcare provided to inmates.<sup>25</sup> They have also adopted and adapted elements of healthcare provision models employed in the general population, such as the continuous care model<sup>26</sup> and the managed-care model.<sup>27</sup>

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22. *E.g.*, CONN. GEN. STAT. ANN. § 18-81 (West 2016) (mandating that the state commissioner of corrections “establish rules for the administrative practices and custodial and rehabilitative methods . . . in accordance with recognized correctional standards”).
  23. *E.g.*, S.D. CODIFIED LAWS § 1-15-1.4 (2012) (“The Department of Corrections, under the direction and control of the secretary of corrections, shall govern . . . the state penitentiary, and other state correctional facilities . . .”).
  24. The healthcare manual of North Carolina’s Department of Public Safety addresses issues such as quality control measures, managed care and utilization reviews, patient’s rights, medical records, staff credentialing, intake screening of inmates, patient education, access to health services, medication administration, inmates with disabilities, dental care, continuity of care, and nutrition. *Health Care Policy Manual*, N.C. PUB. SAFETY, <https://www.ncdps.gov/Adult-Corrections/Prisons/Policy-Procedure-Manual/Health-Care-Manual> [<https://perma.cc/VC7M-WE8C>] (last visited Oct. 22, 2017).
  25. *E.g.*, STATE OF CONN. DEP’T OF CORR., ADMINISTRATIVE DIRECTIVE 8.1: SCOPE OF HEALTH SERVICES CARE 2-3 (2014), <http://www.ct.gov/doc/LIB/doc/PDF/AD/ad0801.pdf> [<https://perma.cc/8XCH-MCEL>] [hereinafter ADMINISTRATIVE DIRECTIVE 8.1].
  26. *E.g.*, D.C. CODE § 24-1401 (West 2013) (requiring the mayor to contract for provision of healthcare services “under a community-oriented healthcare services model,” i.e., “a delivery system in which one entity is responsible for managing . . . the full healthcare continuum”).
  27. *E.g.*, CAL. PENAL CODE § 5023.2(a) (West 2011) (requiring the department of corrections to “maintain a statewide utilization management program” in order “to promote the best possible patient outcomes, eliminate unnecessary medical and pharmacy costs, and ensure consistency in the delivery of health care services”); TEX. GOV’T CODE ANN. § 501.146(a), (c) (West Supp. 2015) (requiring the state’s Correctional Managed Health Care Committee to “develop and approve a managed health care plan for all persons confined” by the state and to “provide expertise to the department [of corrections] . . . in developing policies and procedures for implementation of the managed health care plan”); N.C. DEP’T OF PUB. SAFETY, ADMINISTRATIVE DIRECTIVE III-3, UTILIZATION REVIEW (UR) PLAN 1 (2014), <https://files.nc.gov/ncdps/documents/files/adIII3.pdf> [<https://perma.cc/LQ5R-SCDU>] (assigning responsibility to the department’s Prison Health Services Utilization Management Section for “[e]stablishing and maintaining an effective Utilization Review Management Program”);

*B. The Managed-Care Approach to Providing Healthcare in Prisons*

## 1. States Address the Rising Cost of Providing Medical Care to Prisoners

States have seen their expenditures for prison healthcare rise rapidly.<sup>28</sup> For example, annual healthcare expenditures per inmate ranged from \$11,793 in California to \$2,181 in Illinois in 2008.<sup>29</sup> The median growth of per-inmate healthcare expenditures was 28 percent between 2001 and 2008.<sup>30</sup> While ten states saw their overall healthcare spending mushroom by 90 percent or more, only two states saw decreased spending during this time.<sup>31</sup> The median growth in this category was 49 percent.<sup>32</sup> Healthcare expenditures in the forty-four states subject to a recent study totaled \$6.5 billion in 2008, about one-sixth of the total correctional budgets in those states.<sup>33</sup>

There are several reasons for increased cost of providing healthcare to inmates. An aging inmate population—in part due to extended sentences—is one of the main drivers of increased cost of medical care in state prison systems.<sup>34</sup> Other factors that make the provision of healthcare in a prison setting more costly than for the general pop-

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N.C. DEP'T OF CORR., ADMINISTRATIVE DIRECTIVE III-7, UTILIZATION MANAGEMENT POLICIES (2010), <https://files.nc.gov/ncdps/documents/files/adIII7.pdf> [<https://perma.cc/VUB4-S4JC>] (prescribing in detail which medical procedures require utilization management approval by whom to provide care—primarily within the network of contracted providers and vendors—that meets constitutional and community standards of care).

28. McDonald, *supra* note 9, at 451–52.

29. PEW CHARITABLE TR., MANAGING PRISON HEALTH CARE SPENDING 5 (2013), [http://www.pewtrusts.org/~media/legacy/uploadedfiles/pes\\_assets/2014/pctcorrectionshealthcarebrief050814pdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pes_assets/2014/pctcorrectionshealthcarebrief050814pdf.pdf) [<https://perma.cc/V3XM-2YCX>].

30. *Id.* at 2.

31. *Id.* The states with over 90 percent increases in overall healthcare spending were Alabama, Arkansas, California, Delaware, Maryland, Montana, New Hampshire, South Dakota, Utah, and Washington. *Id.* at 3, 29. The two states with negative growth rates were Illinois and Texas. *Id.*

32. *Id.* at 2.

33. *Id.*

34. *Id.* at 4, 8–11. While long-term inmates arrested in their youths and given extended mandatory sentences are a predictable cohort of aging inmates, there are also those inmates who were arrested at age fifty or older. Ronald H. Aday & Jennifer J. Krabill, *Aging Offenders in the Criminal Justice System*, 7 MARQ. ELDER'S ADVISOR 237, 237 (2006). Aday and Krabill go on to lay out the particular challenges faced by the elderly offender from arrest through incarceration, with special emphasis on meeting elderly inmates' medical needs. *Id.* at 238–58.

ulation are the “[p]revalence of infectious and chronic diseases, mental illness, and substance abuse among inmates, many of whom enter prisons with these problems,” as well as challenges that come with the distance of prisons from hospitals and other providers, and the need to guard inmates requiring off-site treatment.<sup>35</sup>

States have developed a number of strategies to deal with the rising cost of providing health care to their prison populations. Establishing compassionate release programs for certain elderly inmates is one approach to cost containment employed by the states that is often controversial and infrequently used.<sup>36</sup> Telemedicine is used to get inmates in, at times, remote prisons in contact with providers, obviating the need for some expensive off-site appointments and for bringing some providers to prisons.<sup>37</sup>

While these two strategies are simply aimed at saving costs, the expansion of Medicaid access under the Affordable Care Act (“ACA”) functions as both a savings device and a cost-shifting mechanism. Savings are likely to be realized because studies suggest that access to healthcare after prison is a factor when it comes to recidivism.<sup>38</sup> “[A]t

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35. PEW CHARITABLE TR., *supra* note 29, at 4, 8.

36. *See id.* at 21–25. In Ohio, for example, “compassionate release” takes the form of a revocable quasi-pardon granted by the governor for certain offenders that are “terminally ill, medically incapacitated, or in imminent danger of death.” OHIO REV. CODE ANN. § 2967.05(B)–(C) (West Supp. 2017). *See* OHIO ADMIN. CODE 5120:1-1-40 (2013) (giving guidance on implementation). Neither the statute nor the regulation requires a state agency to see that the released inmate has access to necessary medical care. *But see* MODEL PENAL CODE § 305.7(9) (AM. LAW INST., Tentative Draft No. 2 2011) (requiring the department of corrections to “identify sources of medical and mental-health care available to the prisoner after release, and ensure that the prisoner is prepared for the transition to those services”). A comment to this section of the Model Penal Code notes that “[i]t would be perverse for § 305.7 to encourage the ‘dumping’ of ex-prisoners into the community without adequate provision for the continuing care that they need.” *Id.* at cmt. j. The Ohio Department of Rehabilitation and Correction has issued a policy requiring that eligible prisoners with a serious medical condition be enrolled in Medicaid prior to release and provided with a supply of essential medication. OHIO DEP’T OF REHAB. & CORR., OFFENDER TRANSITIONAL RELEASE PLANNING 6–7 (2017), <http://www.drc.ohio.gov/Portals/0/Policies/DRC%20Policies/78-REL-01%20Feb%202017.pdf?ver=2017-02-07-140722-280> [<https://perma.cc/XXA9-ZZNN>]. This policy applies to all inmates. *Id.* at 2.

37. PEW CHARITABLE TR., *supra* note 29, at 12–14.

38. ALEXANDRA GATES, ET AL., HEALTH COVERAGE AND CARE FOR THE ADULT CRIMINAL JUSTICE-INVOLVED POPULATION 5–6 (2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8622-health-coverage-and-care-for-the-adult-criminal-justice-involved-population1.pdf> [<https://perma.cc/ZX3U-Q7FM>]; Nan Myers, *Managed Medicaid Braces for Influx of Ex-Inmates*, MANAGED CARE (Nov. 2014), <https://www.managed>

least 70% of the . . . 10 million people released from prison [and] jail each year are uninsured.”<sup>39</sup> Under the ACA’s Medicaid expansion, states are able to enroll a greater percentage of their low-income adult ex-inmate populations in Medicaid.<sup>40</sup> Thus, savings may be realized by expansion states that provide for a seamless transition of released inmates to outside services by enrolling the inmates while still in prison.<sup>41</sup> Access to Medicaid after prison obviates the need to commit crime to have access to care and prevents recidivism due to uncontrolled health issues, such as substance abuse and mental illness.<sup>42</sup> This is why it is

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caremag.com/archives/2014/11/managed-medicaid-braces-influx-ex-inmates [https://perma.cc/DEM9-EZ6F]. See also Robert B. Greifinger, *Inmates as Public Health Sentinels*, 22 WASH. U. J.L. & POL’Y 253, 261 (2006) (“Community reintegration depends in large part on successful connections with community providers for the treatment of chronic diseases, mental illness, and communicable diseases.”).

39. Myers, *supra* note 38.
40. See BARR, *supra* note 5, at 217 (noting that the ACA changes to Medicaid made the program “analogous to Medicare, in that it will provide the same level of benefits to all those in poverty,” “regardless of health status or family status”). See also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1)(C), 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012)); *id.* § 2001(a)(2)(A), 124 Stat. at 271–72 (codified as amended at 42 U.S.C. § 1396a(k)(1) (2012)); 42 U.S.C. § 1396a(e)(14)(I)(i) (cumulatively granting access to the minimum essential coverage under the Medicaid program to those whose annual income does not exceed 138 percent of the federal poverty guidelines). In 2018, 100 percent of the federal poverty guidelines is \$12,140 of annual income for a household of one. U.S. DEP’T OF HEALTH & HUMAN SERVS., *Poverty Guidelines*, ASPE, <https://aspe.hhs.gov/poverty-guidelines> [https://perma.cc/A6F5-2FWA] (last visited Feb. 14, 2018). Each additional family member raises the guideline income by \$4,320. *Id.* Accordingly, 138 percent of the poverty guidelines for a single person is \$16,753.20 in annual income. See *id.*
41. Myers, *supra* note 38. See generally *Incarcerated People*, HEALTHCARE.GOV, <https://www.healthcare.gov/incarcerated-people/> [https://perma.cc/EAM8-HUAH] (last visited Oct. 14, 2017) (explaining the modified enrollment process for former inmates). A seamless transition by pre-enrolling eligible inmates in Medicaid is not only desirable and very likely conducive to cost savings, but also, failing to do so in the case of sick inmates may represent a violation of the Eighth Amendment. Malavé, *supra* note 9, at 732–37; *id.* at 735–36 (citing *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999) (discussing *Wakefield’s* holding that the state’s duty to provide an inmate with necessary medication extends beyond the inmate’s release date for “the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply”); *Lugo v. Senkowski*, 114 F. Supp. 2d 111, 115 (N.D.N.Y. 2000) (applying *Wakefield* to the case of a parolee who “was released in the midst of an ongoing surgical process,” i.e., when he required the removal of a metal stent from his kidney within weeks of his release).
42. Myers, *supra* note 38.

important that, following passage of the ACA, Medicaid’s “essential health benefits” available also to ex-inmates now include mental health and substance-use-disorder services.<sup>43</sup>

Yet the Medicaid expansion also functions as a cost-shifting device. This is because the Social Security Act—since its 1965 amendments—allows states to shift to the federal budget between fifty percent and eighty-three percent of treatment costs incurred while an inmate enrolled in Medicaid receives inpatient services for twenty-four hours or more in a medical facility outside the prison walls.<sup>44</sup> Prior to the Medicaid expansion, this provision applied only to a small percentage of inmates and largely escaped the states’ notice.<sup>45</sup> But the shift from only covering “low-income juveniles, pregnant women, adults with disabilities and frail elders” to covering also able-bodied adults with income below 138 percent of the federal poverty guideline in expansion states makes virtually all of their inmate populations eligible.<sup>46</sup> Yet while the ACA increased the number of eligible inmates, it did not enhance the services covered, as Medicaid for inmates still only covers “inpatient health services delivered beyond prison walls.”<sup>47</sup>

Finally, another cost-saving strategy employed by states is outsourcing prison healthcare to contractors.<sup>48</sup> Some of these contractors—such as the contractor employed by the State of Connecticut discussed below<sup>49</sup>—apply the kind of managed-care strategies discussed in the following Section.

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43. Joel B. Teitelbaum & Laura G. Hoffman, *Health Reform and Correctional Health Care: How the Affordable Care Act Can Improve the Health of Ex-Offenders and Their Communities*, 40 *FORDHAM URB. L.J.* 1323, 1351 (2013) (citing 42 U.S.C. § 18022 (2012)).

44. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 352 (codified as amended at 42 U.S.C. § 1396d(a)(29)(A), (b)(1) (2012)); 42 C.F.R. § 435.1010 (2016). *See also* Ctrs. for Medicare & Medicaid Servs., State Health Official Letter to Facilitate Successful Re-Entry for Individuals Transitioning from Incarceration to Their Communities 11 (April 28, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf> [<https://perma.cc/7W77-SJV3>].

45. Christine Vestal, *Medicaid Expansion Seen Covering Nearly All State Prisoners*, PEW CHARITABLE TR. (Oct. 18, 2011), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/10/18/Medicaid-expansion-seen-covering-nearly-all-state-prisoners> [<https://perma.cc/WPB4-SEKJ>].

46. *Id.*

47. *Id.*; GATES ET AL., *supra* note 38, at 6; Teitelbaum & Hoffman, *supra* note 43, at 1346, 1346 n.129 (citing 42 U.S.C. § 1396d(a)(29)(A) (2012); 42 C.F.R. § 435.1009(b) (2012)).

48. PEW CHARITABLE TR., *supra* note 29, at 15–17.

49. *See infra* Part I.B.3.

## 2. The Rise of Managed Healthcare in the U.S.: A Brief History

State prison authorities did not invent the concept of managed care, but a number of them employ elements of the model authorized by Congress and state legislatures for the general population across the U.S. to curb healthcare expenditures.<sup>50</sup> Managed healthcare goes back to the early twentieth century where local organizations sought to provide healthcare to a defined population.<sup>51</sup> Due to opposition by the American Medical Association (“AMA”)—sanctioning any member who participated in the organizations the AMA deemed unethical—many of the early organizations went out of business.<sup>52</sup> Some, however, prospered and beginning in the 1930s became particularly popular with organized labor.<sup>53</sup>

These organizations were set up as an alternative to the traditional indemnity insurance plans that—following a fee-for-service model—reimbursed patients for the fees they had paid to a healthcare provider based on individual services performed.<sup>54</sup> The new organizations functioned as prepaid service plans where the members’ premiums provided a limited amount of money by which a set number of services and expenditures—e.g., physician salaries—needed to be covered.<sup>55</sup> As it turned out, the new organizations, initially called “prepaid group practice” based on their financing model, were able to provide services at a lower cost than the traditional fee-for-service insurance plans without lowering the quality of healthcare.<sup>56</sup>

Motivated in part by the savings achieved by the prepaid plans, Congress passed the Health Maintenance Organization (“HMO”) Act

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50. *See supra* note 27.

51. BARR, *supra* note 5, at 118.

52. *Id.* at 119. The AMA likened the early organizations to “medical soviets.” *Id.* at 120. The AMA’s opposition to these organizations was rooted in its resistance to “contract medicine” or “corporate medicine” at the time, that is, to the practice of physicians being employed by organizations not led by physicians, e.g., corporations. Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 245–48 (2004). The AMA’s subsequent lobbying efforts resulted in licensure statutes adopted by the states. *Id.* at 249–51. And they also led to the judge-made “corporate practice of medicine doctrine.” *Id.* at 251–52. This doctrine is relevant for the matter at hand and will be discussed in some detail in Part II.E.

53. BARR, *supra* note 5, at 119–26.

54. *Id.* at 118.

55. *Id.*

56. *Id.* at 122–23.

of 1973.<sup>57</sup> The HMO Act preempted state laws outlawing HMOs, offered federal subsidies for new HMOs, and defined minimum standards for an HMO to be “federally qualified.” These standards included the requirement that HMOs had to be organized on a nonprofit basis, offer specified benefits to all members, and charge all members the same monthly premiums.<sup>58</sup> Since the 1980s, federal and state governments have contracted with HMOs to manage the provision of medical services under Medicare<sup>59</sup> and Medicaid.<sup>60</sup>

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57. Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. §§ 300e to 300e-17 (2012)). The initial passage and implementation of the Act was resisted by the AMA. Am. Med. Ass’n, 94 F.T.C. 701, 747–48 (1979). This was, at least in part, because the AMA considered the fee-for-service approach to be the only “ethical” mode of remuneration for physicians. *Id.* at 1016. Another reason was that the AMA’s ethical guidelines prohibited physicians from entering into partnerships with non-physicians that involved splitting of professional fees. *Id.* at 1017. But the Federal Trade Commission held this stance to be anticompetitive in violation of section 5 of the Federal Trade Commission Act, Pub. L. No. 63-203, § 5, 38 Stat. 717, 719–21 (1914) (codified as amended at 15 U.S.C. § 45 (2012)), and required the AMA to modify its ethical guidelines to allow physicians to accept remuneration other than fee-for-service and to participate in HMOs. *Id.* at 1017–18; see Huberfeld, *supra* note 52, at 255–56.
58. BARR, *supra* note 5, at 124, 130.
59. “Generally, Medicare is available for people age 65 or older, younger people with disabilities and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). . . . While most people do not have to pay a premium for Part A [inpatient hospital care], everyone must pay for Part B [outpatient medical services and supplies] if they want it.” U.S. DEPT. OF HEALTH & HUMAN SERVS. *Who Is Eligible for Medicare?*, HHS.GOV (Sept. 11, 2014), <https://www.hhs.gov/answers/medicare-and-medicare/who-is-eligible-for-medicare/index.html> [<https://perma.cc/ZN5R-ST8P>]; *What Medicare Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/index.html> [<https://perma.cc/5S E9-2UA4>] (last visited Oct. 27, 2017). Medicare Advantage Plans are “[a] type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations . . . .” *Medicare Advantage Plans*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html> [<https://perma.cc/446Y-6WEM>] (last visited Oct. 22, 2017). See BARR, *supra* note 5, at 161–74 (discussing, in detail, the role of HMOs in providing care for Medicare beneficiaries).
60. Medicaid, a joint federal and state program, serves “[l]ow income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI),” as well as other eligibility groups. *Eligibility*, MEDICAID.GOV, <https://www.medicare.gov/medicaid/eligibility/index.html> [<https://perma.cc/8DKY-WG7W>] (last visited Oct. 20, 2017); see also CTRS. FOR MEDICARE & MEDICAID SERVICES, NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS (2012), <https://>

By the end of the 1980s, Congress, adopting a different economic paradigm, had considerably deregulated HMOs, even allowing them to operate on a for-profit basis.<sup>61</sup> As a result, while nearly 90 percent of HMO patients were members of nonprofit HMOs in 1981, nearly two-thirds of HMO patients were enrolled in for-profit enterprises by 1998.<sup>62</sup> The broad popularity HMOs once enjoyed disappeared as a result of the paradigm shift.<sup>63</sup> And while the once dominant HMOs have been displaced by Preferred Provider Organizations (“PPOs”) that allow for greater choice among providers, the dominance of the for-profit model in healthcare remains unabated.<sup>64</sup>

In the 1990s, for-profit HMOs developed a number of strategies to control costs by controlling the utilization of healthcare services, such as using primary care physicians as gatekeepers for specialty services, utilization review, and providing a variety of financial incentives to physicians.<sup>65</sup> By adopting these strategies, for-profit HMOs seek to secure higher profits by lowering pay-out rates for medical care.<sup>66</sup> Non-

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[www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/medicaid-mc-enrollment-report.pdf](http://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/medicaid-mc-enrollment-report.pdf) [https://perma.cc/AEZ7-83AB] (summarizing the numerous state Medicaid programs using managed care as of 2012). *See also* BARR, *supra* note 5, at 204–05 (noting that by 2014, “between 50 and 75 percent of Medicaid beneficiaries, depending on the state in which they lived, were enrolled in managed care plans” and that states seek to minimize their financial liability by allocating a fixed annual payment for each beneficiary—“capitation”).

61. BARR, *supra* note 5, at 254.

62. *Id.* at 253–54.

63. *Id.* at 252–53.

64. *Id.* at 254.

65. *Id.* at 255–57.

66. *Id.* at 260 (noting that for-profit HMOs have a markedly lower “medical loss ratio” (“MLR”)—the percentage of premiums that pay for medical care—than nonprofits, 70–85 percent versus 95 percent). Since 2016, states *may* mandate an MLR of at least 85 percent for managed-care plans within their Medicaid programs. 81 Fed. Reg. 27,498, 27,862 (May 6, 2016) (codified as amended at 42 C.F.R. § 438.8(c) (2016)). For a discussion of average MLRs in Medicaid managed-care plans from 2011 to 2014, see *id.* at 27,837–38. While there does not seem to be a specific MLR for Medicaid, insurers offering a plan under Medicaid Advantage also must meet an MLR of 85 percent. This regulatory requirement goes back to a 2010 statute, but the final rule was first published in 2013. 78 Fed. Reg. 31,284, 31,307 (May 23, 2013) (codified as amended at 42 C.F.R. § 422.2410(b) (2016)); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1103, 124 Stat. 1029, 1047 (codified as amended at 42 U.S.C. § 1395w-27(e)(4) (2012)).

profit HMOs employ these strategies to a lesser extent.<sup>67</sup> Accordingly, studies have found the quality of care provided under for-profit plans to be lower than that under nonprofit plans.<sup>68</sup>

### 3. Managed Care in Prisons: The Example of Connecticut

#### a. *Background and Policy*

Connecticut has engaged in providing managed healthcare since 1997.<sup>69</sup> To do so, the Department of Correction contracted with the state university, specifically a division of the University of Connecticut Health Center called Correctional Managed Health Care (“CMHC”).<sup>70</sup> Between 2001 and 2008, Connecticut achieved below-average increases in total and per-inmate healthcare spending.<sup>71</sup> Connecticut is one of the

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67. Peter B. Jurgeleit, Note, *Physician Employment Under Managed Care: Toward A Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L.J. 255, 264 n.49 (1997).

68. BARR, *supra* note 5, at 262–64.

69. JOHN C. GERAGOSIAN & ROBERT J. KANE, AUDITORS’ REPORT: DEPARTMENT OF CORRECTION FISCAL YEARS ENDED JUNE 30, 2012 AND 2013, at 30 (2017), [https://www.cga.ct.gov/apa/reports/Correction,%20Department%20of\\_20170510\\_FY2012,2013.pdf](https://www.cga.ct.gov/apa/reports/Correction,%20Department%20of_20170510_FY2012,2013.pdf) [<https://perma.cc/32KV-GZ5Y>].

70. *Id.*

71. The total healthcare spending in Connecticut rose by 16 percent, compared to a median rise of 49 percent in the forty-four states surveyed; the per-inmate spending in Connecticut rose by 7 percent, compared to a median rise of 28 percent. PEW CHARITABLE TR., *supra* note 29, at 2, 29.

72. CONN. GEN. STAT. § 18-85a (West 2016). The departmental regulation created under this section provides that inmates are charged a fee of \$3.00 for each medical visit, each dental procedure, and each eyeglass prescription, except when medical staff determine that emergency care—as defined in the regulation—is required; when the medical / dental appointment is initiated by medical staff; when the inmate is undergoing scheduled follow-up medical treatment for chronic diseases; or when the treatment is for mental health reasons. In case of insufficient funds in the inmate’s trust account, services will be provided, but the state will create an obligation to be satisfied by funds deposited in the account in the future. STATE OF CONN. DEP’T OF CORR., ADMINISTRATIVE DIRECTIVE 3.12: FEES FOR PROGRAMS AND SERVICES 1–2 (2017), <http://www.portal.ct.gov/-/media/DOC/Pdf/Ad/ad0312pdf.pdf?la=en> [<https://perma.cc/2SGT-CHXY>]. Connecticut pays its inmate labor force between \$0.75 and \$1.75 per day. STATE OF CONN. DEP’T OF CORR., ADMINISTRATIVE DIRECTIVE 10.1: INMATE ASSIGNMENT AND PAY PLAN 6 (2015), <http://www.portal.ct.gov/-/media/DOC/Pdf/Ad/ad1001pdf.pdf?la=en> [<https://perma.cc/C6BD-FFK2>]. This pay rate makes a fee of \$3.00 for each inmate-initiated visit not

states collecting inmate co-pay for the provision of medical services in certain circumstances.<sup>72</sup> The state holds prison medical providers to the community standard of care.<sup>73</sup>

Department of Correction policy specifies which medical services are to be provided to the inmates on a routine basis and when utilization review becomes necessary.<sup>74</sup> Medical services not subject to utilization review include daily sick call, dental care including dentures, diagnostic services, pharmacy services, OB/GYN services, eyeglasses, hearing aids, prostheses, chronic care, mental health services, preventive care, and immunizations.<sup>75</sup> Utilization review comes into play

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insubstantial. Assuming an average pay of \$1.25 per day, this would correspond to a co-payment of \$193.92 for a person grossing \$80.80 in an eight-hour day under Connecticut's current minimum wage rate. Connecticut's Medicaid beneficiaries do not have to contribute any co-payments. MARY FITZPATRICK & ALEX REGER, COPAYMENTS AND DEDUCTIBLES IN MEDICAID AND HEALTH INSURANCE PLANS 2 (2015), <https://www.cga.ct.gov/2015/rpt/pdf/2015-R-0160.pdf> [<https://perma.cc/3GLC-VLTR>].

73. ADMINISTRATIVE DIRECTIVE 8.1, *supra* note 25, at 3 (“The contracted health services provider and [the Department of Correction] shall provide all inmates access to healthcare services that meet community standards.”). The regulation defines “community standard” as follows: “The scope and quality of medical, dental and mental health services . . . that is consistent with generally accepted practice parameters in the State of Connecticut as recognized by healthcare providers in the same or similar general specialty (as to typically treat or manage the diagnosis or condition . . .).” *Id.* at 2. The community standard is the standard adopted by the Connecticut Supreme Court for medical malpractice actions brought by the general population. *See, e.g.*, Jarmie v. Troncale, 50 A.3d 802, 808 (Conn. 2012) (“[P]rofessional negligence or malpractice . . . [is] defined as the failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss, or damage to the recipient of those services . . . .” (quoting Gold v. Greenwich Hosp. Ass’n, 811 A.2d 1266, 1270 (Conn. 2002))). The Department of Correction defines “community” to be coextensive with “state.” *See* ADMINISTRATIVE DIRECTIVE 8.1, *supra* note 25, at 2. But that geographic limitation was abandoned by the Connecticut Supreme Court in 1983. Logan v. Greenwich Hosp. Ass’n, 465 A.2d 294, 304–05 (Conn. 1983) (adopting a national standard of care). State law makes no reference to any geographic boundaries, as it requires medical professionals to exercise “that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.” CONN. GEN. STAT. ANN. § 52-184c(a) (West 2013). *See* Jennifer S.R. Lynn, *Connecticut Medical Malpractice*, 12 U. BRIDGEPORT L. REV. 381, 393–94 (1992).

74. ADMINISTRATIVE DIRECTIVE 8.1, *supra* note 25, at 4–11.

75. *Id.* at 4–7.

for unspecified off-site specialty services, treatment therapies such as chemotherapy and dialysis, and elective care.<sup>76</sup>

The policies of the provider, CMHC, supply additional details as to when utilization review is indicated, e.g., in the case of more complex dental surgical procedures, outpatient hospital dental services,<sup>77</sup> and transferring emergency patients.<sup>78</sup> Utilization review is also required for specialty health services, such as “[o]ff-site, [o]ut-[p]atient [h]ealth [s]ervices,” hemodialysis, prostheses, individualized wheelchairs, emergency rooms, and acute inpatient hospitalizations.<sup>79</sup>

CMHC police also sheds light on how utilization review is to be conducted: Unless the review request originates from a specialty consultation conducted outside of prison,<sup>80</sup> the practitioner in the correctional facility housing the patient examines the inmate-patient to see if there is a need for referral for specialty health services.<sup>81</sup> If there appears to be a need for referral, the practitioner submits the utilization review request to the reviewing authority.<sup>82</sup>

The reviewing authority varies depending on the priority of the request and the medical discipline involved: All specialty healthcare that is priority 1 (“emergency care and/or admission to an acute health care facility”) and priority 2 (conditions that require action within a week) are pre-authorized by CMHC’s utilization review staff, the clinical director, the dental services coordinator, or the physician utilization review panel consisting of three CMHC physicians.<sup>83</sup> Priority 1 requests are scrutinized by retrospective utilization review after the services have

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76. *Id.* at 7, 11.

77. UCONN HEALTH CORRECTIONAL MANAGED HEALTH CARE POLICY AND PROCEDURES: E 6.01 ORAL CARE SERVICES 4 (revised 2012), <https://health.uconn.edu/correctional/wp-content/uploads/sites/77/2016/12/E-Inmate-Care-and-Treatment.pdf> [<https://perma.cc/G6GZ-TVRB>].

78. UCONN HEALTH CORRECTIONAL MANAGED HEALTH CARE POLICY AND PROCEDURES: E 8.01 EMERGENCY SERVICES 1 (revised 2016), <https://health.uconn.edu/correctional/wp-content/uploads/sites/77/2016/12/E-Inmate-Care-and-Treatment.pdf> [<https://perma.cc/G6GZ-TVRB>].

79. UCONN HEALTH CORRECTIONAL MANAGED HEALTH CARE POLICY AND PROCEDURES: E 10.04 SPECIALTY HEALTH SERVICE REQUESTS 1 (2014), <https://health.uconn.edu/correctional/wp-content/uploads/sites/77/2016/12/E-Inmate-Care-and-Treatment.pdf> [<https://perma.cc/G6GZ-TVRB>] [hereinafter SPECIALTY HEALTH SERVICE REQUESTS].

80. For the process in case of such consultations, see *id.* at 3–4.

81. *Id.* at 2.

82. *Id.*

83. *Id.* at 1–2. It is not clear whether the clinical director and the dental services coordinator are employees of the department of correction or CMHC.

been provided.<sup>84</sup> Priority 2 requests are reviewed no later than the following business day after the inmate's local physician contacts the department of correction's clinical director or the dental services coordinator.<sup>85</sup> Medical requests of a lower priority are reviewed in a routine review process by the CMHC physicians review panel during its weekly meetings.<sup>86</sup> The dental services coordinator reviews all requests for dental services under utilization review, and the director of mental health and psychiatry reviews all requests mental services under utilization review.<sup>87</sup>

The officials or bodies performing utilization review approve those requests that meet "established clinical guidelines."<sup>88</sup> CMHC policy that is readily accessible to inmates or their families does not specify what these guidelines may entail in addition to, or in contravention of, recognized community standards of medical care.

At any rate, requests that do not meet these standards are rejected. Inmates or their local physicians may appeal a negative decision if they believe the rejection was not warranted.<sup>89</sup> The Department of Correction's clinical director is the sole reviewing authority; the clinical director's decision is final.<sup>90</sup> The physician is then responsible for discussing the result with the inmate.<sup>91</sup>

*b. Practice*

Policy is one thing; practice is another.<sup>92</sup> In June 2017, "eight wrongful-death [actions] [we]re pending against the [Department of

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84. *Id.* at 1, 3. While readily available provider policy does not spell out the consequences of a retrospective denial, the result for providers in the general CMHC is that they will not get paid for the services performed. Allison Faber Walsh, Comment, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 217 (1997).

85. SPECIALTY HEALTH SERVICE REQUESTS, *supra* note 79, at 4.

86. *Id.* at 4–5.

87. *Id.* at 4. It is not clear whether the director of mental health is an employee of the department of correction or CMHC.

88. *Id.* at 5.

89. *Id.* at 6.

90. *Id.*

91. *Id.* at 7.

92. Connecticut prison healthcare policy is, in part, driven by a number of federal court rulings and consent decrees. See ADMINISTRATIVE DIRECTIVE 8.1, *supra* note 25, at 1 (listing nine lawsuits in the regulation's "Authority and Reference" section). Among the suits listed are *Lareau v. Manson* and *Campos v. Manson*, two class actions that were consolidated by the court in *Lareau v. Manson*, 507 F. Supp. 1177 (D. Conn. 1980), *aff'd in part*, 651

Correction] in state or federal court, or the claims commissioner's office."<sup>93</sup> Also in 2017, a report by state auditors covering Fiscal Years 2012 and 2013 identified several significant deficiencies in Connecticut's delivery of healthcare to its inmates.<sup>94</sup>

This report found, in general, that the Department of Correction was not exercising a sufficient degree of oversight over CMHC as a result of "[v]agueness in contractual terms and a general absence of measurable performance standards."<sup>95</sup> Specifically, the contract between the Department and CMHC allowed the contractor to police itself when it came to reviewing inmate deaths.<sup>96</sup> Moreover, contrary to the terms of the contract, neither the state nor CMHC had pursued the accreditation of healthcare provided to inmates with national organizations such as the American Correctional Association<sup>97</sup> or the National

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F.2d 96 (2d Cir. 1981). The district court's memorandum decision found that the inmates' health was prejudiced by overcrowding and the absence of intake screening for communicable diseases. *Id.* at 1178. The district court had to revisit the issues of overcrowding and infectious disease, specifically HIV/AIDS, in the late 1980s and early 1990s, resulting in two consent decrees, one of which is *In re Connecticut Prison Overcrowding and AIDS Cases*, Nos. H-80-506(JAC), Civ. H-88-562(PCD), (JGM), 1990 WL 261348 (D. Conn. Dec. 6, 1990). See Deborah S. Chang & Patricia E. McCooey, *Out of the Dark Ages and into the Nineties: Prisons' Response to Inmates with AIDS*, 23 CONN. L. REV. 1001, 1003-04 (1991) (giving context of early 1990s and the positive impact of the two AIDS-related consent decrees on prison conditions in Connecticut); see also STATE OF CONN. DEPT. OF CORR., ADMINISTRATIVE DIRECTIVE NO. 8.11: HUMAN IMMUNODEFICIENCY VIRUS INFECTION/ACQUIRED IMMUNE DEFICIENCY SYNDROME 1 (2008), <http://www.ct.gov/doc/LIB/doc/PDF/AD/ad0811.pdf> [<https://perma.cc/69JV-E5JM>] (stating the department of correction's current HIV/AIDS policy).

93. Josh Kovner, *Concerns Growing Over Inmates' Medical Care; 25 Cases Flagged, Including Eight Deaths*, HARTFORD COURANT (June 15, 2017, 1:37 PM), <http://www.courant.com/news/connecticut/hc-inmate-deaths-medical-care-20170615-story.html> [<https://perma.cc/MPP6-PDFZ>].
94. GERAGOSIAN & KANE, *supra* note 69, at 30-36.
95. *Id.* at 33. Some contracts between government agencies and private healthcare providers contain indemnity clauses that require the private provider to pay for any legal costs of government agencies, thereby providing disincentives to effective government oversight. See Dan Weiss, Comment, *Privatization and Its Discontents: The Troubling Record of Privatized Prison Health Care*, 86 U. COLO. L. REV. 725, 753-56 (2015).
96. GERAGOSIAN & KANE, *supra* note 69, at 33.
97. See *Health Care Accreditation*, AM. CORRECTIONAL ASSOCIATION, [http://www.aca.org/ACA\\_Prod\\_IMIS/ACA\\_Member/Healthcare/Health\\_Accreditation/ACA\\_Member/Healthcare\\_Professional\\_Interest\\_Section/HC\\_AccreditationHome.aspx?hkey=5b21416b-fee4-47fd-9eed-2597879e7076](http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Healthcare/Health_Accreditation/ACA_Member/Healthcare_Professional_Interest_Section/HC_AccreditationHome.aspx?hkey=5b21416b-fee4-47fd-9eed-2597879e7076) [<https://perma.cc/69JV-E5JM>].

Commission on Correctional Health Care<sup>98</sup> that have developed standards for the provision of healthcare to prison inmates.<sup>99</sup>

Additionally, the state auditors perceived the relationship between the department and CMHC to be a joint venture between equals, not one where the Department set and enforced policy within the applicable constitutional and statutory parameters.<sup>100</sup> Moreover, the Department was not sufficiently staffed to monitor compliance with the complex contract governing CMHC's services to the state inmates.<sup>101</sup>

Finally, given that managed care is often touted as the way of curbing the burgeoning cost of providing care to inmates while improving the quality of care, two findings in the report are perhaps most damning. First, the report found that the medical care budget set forth in the Department's contract with CMHC impaired effective analysis and management of costs because it understated the real cost of health-care services provided by CMHC and was not detailed enough.<sup>102</sup> Second, the Department had not adequately documented whatever quality review it had performed.<sup>103</sup> The Department of Correction's response essentially agreed with the assessment and stated that it was in the process of renegotiating its contract with CMHC to address the issues identified.<sup>104</sup>

#### 4. Legal Responses to Managed Care in the Prison Context

##### *a. The Constitutional Route*

Some commentators have argued that implementing a managed-care model in the prison setting can amount to cruel and unusual punishment in violation of the Eighth Amendment as interpreted in *Estelle*

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[perma.cc/2B3P-KRTF](https://perma.cc/2B3P-KRTF)] (last visited Oct. 20, 2017) (discussing the American Correctional Association's Health Care accreditation process).

98. See *Accreditation: Pursuit of Excellence*, NAT'L COMMISSION ON CORRECTIONAL HEALTH CARE, <http://www.ncchc.org/accreditation-programs> [<https://perma.cc/R732-VS2X>] (last visited Oct. 14, 2017) (discussing the NCCHC accreditation process).

99. GERAGOSIAN & KANE, *supra* note 69, at 32.

100. *Id.* at 34.

101. *Id.* at 34–35.

102. *Id.* at 34.

103. *Id.* at 33.

104. *Id.* at 35–36. As part of its response, in May 2017, the department published a regulation specifically addressing its deficient quality review procedures identified in the report. See STATE OF CONN. DEP'T OF CORR., ADMINISTRATIVE DIRECTIVE 8.10: QUALITY ASSURANCE AND IMPROVEMENT (2017), <http://www.ct.gov/doc/LIB/doc/PDF/AD/ad0810.pdf> [<https://perma.cc/AE4M-YR2H>].

*v. Gamble* and its progeny.<sup>105</sup> They reason that this model may delay, or deny, the provision of medical care to inmates due to fiscal considerations, i.e., “non-medical reasons.”<sup>106</sup>

This problem is not new. Factoring in non-medical considerations when it comes to providing healthcare to inmates—e.g., budgetary constraints—is not a problem created by the advent of managed care in prisons. Prison officials have raised a “cost defense” in prison medical care cases beginning in the early 1990s,<sup>107</sup> even without the presence of the managed-care incentives discussed above.<sup>108</sup> And while this “cost-defense” has apparently been unsuccessful on the federal level,<sup>109</sup> in at least one state, Indiana, the standard of care for medical providers expressly allows the trier of fact to consider budgetary constraints faced by prison medical providers as one of the relevant circumstances when deciding whether the provider breached that standard.<sup>110</sup>

At the same time, what is different under managed-care approaches to prison medical care is that, in typical HMO-style contracts, the provision of less costly medical care is contractually coupled with finan-

105. *E.g.*, Ira P. Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195 (1999); Richard Siever, Note, *HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System*, 58 VAND. L. REV. 1365 (2005).

106. Robbins, *supra* note 105, at 196 (citing *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985)). *Ancata v. Prison Health Services* involved a Florida pre-trial detainee who raised the claim, among others, that he was denied medical care because he refused to pay for it, resulting in a fatal delay of care. *Ancata*, 796 F.2d at 702, 704. In general, pre-trial detainees are governed by the Fourteenth Amendment instead of the Eighth Amendment because they, by definition, cannot be subject to “punishment,” but the Supreme Court has held that this standard is at least as stringent as the Eighth Amendment. *Id.* at 703 n.5 (citing *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983)).

107. Barbara Kritchevsky, *Is There a Cost Defense? Budgetary Constraints As a Defense in Civil Rights Actions*, 35 RUTGERS L.J. 483, 529–30 (2004). Kritchevsky noted that the frequency of raising the “cost defense” increased after the Supreme Court’s decisions *Wilson v. Seiter*, 501 U.S. 294 (1991), and *Helling v. McKinney*, 509 U.S. 25 (1993), that factored a consideration of objective constraints into their analysis as to whether a defendant had the requisite mens rea. *Id.* at 495–98.

108. *See supra* Part I.B.2.

109. Kritchevsky, *supra* note 107, at 529–30.

110. *Allen v. Hinchman*, 20 N.E.3d 863, 870–71 (Ind. Ct. App. 2014). *See also* *Moss v. Miller*, 625 N.E.2d 1044, 1051 (Ill. Ct. App. 1993) (recognizing the necessary existence of constraints in the prison setting that “may well” negatively impact the delivery of medical services but should not lead to liability for the “medical arts practitioner”). For a discussion of the standard of care in medical malpractice actions brought by inmates, see *infra* notes 142–145 and accompanying text.

cial incentives benefitting those providers that use less costly medical care.<sup>111</sup> And it is here that some courts have raised a red flag. For example, in *Bowman v. Corrections Corporation of America*,<sup>112</sup> a federal case from Tennessee, the district court held a particular contract with a prison medical provider to violate “contemporary standards of decency,” not due to the existence of financial incentives per se, but because of their excessive nature.<sup>113</sup> But the Sixth Circuit reversed this finding because, due to the inmate’s death, the issue had become moot and the plaintiff—the inmate’s mother—had no standing.<sup>114</sup> Besides, the jury had found the defendant physician not liable based on expert testimony that the treatment provided to the inmate was “appropriate.”<sup>115</sup>

*b. State-Law Responses*

While the constitutional jurisprudence on managed care in prisons is emerging, state law might, at least for now, provide more promising avenues of addressing potential problems of managed care in prisons. This is especially true because a powerful obstacle to state regulation of managed-care organizations—federal preemption of state law for managed-care plans offered by employers under the Employee Retirement Security Act of 1974 (“ERISA”)<sup>116</sup>—is inapplicable to the provision of managed care to state prisoners since they are not covered by ERISA.<sup>117</sup> Moreover, the Supreme Court has identified the legislative

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111. Timothy S. Hall, *Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 S.C. L. REV. 689, 694–95 (2002).

112. 188 F. Supp. 2d 870 (M.D. Tenn. 2000), *aff’d in part, rev’d in part*, 350 F.3d 537 (6th Cir. 2003).

113. *Id.* at 890. The district court based its holding on statements by the AMA and Medicare regulations. *Id.* at 887–90.

114. *Bowman*, 350 F.3d at 549–51.

115. *Id.* at 544–45.

116. Pub L. 93-403, 88 Stat. 829 (codified at 29 U.S.C. ch. 18 (2012)). The “shifting sands of the ERISA preemption doctrine” are discussed in Hall, *supra* note 111, at 699–705, and in Thomas R. McLean & Edward P. Richards, *Health Care’s “Thirty Years War”: The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 297–315 (2004). See also Cameron Krier, Comment, *One Step Forward, Two Steps Back: The Impact of Aetna Health Inc. v. Davila on ERISA and Patients’ Rights*, 38 TEX. TECH L. REV. 127 (2005) (discussing the impact of *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), on state laws giving patients a cause of action for damages against HMOs that are administering employee benefits and are, therefore, potentially preempted by ERISA’s more modest remedial measures).

117. The HMO Act’s preemption of state law regulating managed-care organizations is more limited. Huberfeld, *supra* note 52, at 277–78.

branch as best suited to make the kind of judgments “about socially acceptable medical risk” involved in reining in non-medical considerations in the context of patient care.<sup>118</sup>

Accordingly, some states have begun regulating financial incentives when it comes to providing medical care.<sup>119</sup> And the federal government has done the same in relation to the role of financial incentives in the Medicare and Medicaid programs.<sup>120</sup>

Additionally, tort law has developed the concept of apparent agency under which hospitals and managed-care organizations may be held vicariously liable for the provider decisions they control to one degree or another.<sup>121</sup> Such organizations may also be held directly liable for negligent hiring and retention of their medical providers.<sup>122</sup> Under these and other theories, liability for the provision of defective health-

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118. *Pegram v. Herdrich*, 530 U.S. 211, 221–22 (2000).

119. Hall, *supra* note 111, at 712–15; Michael J. Miles, Note, *State Regulation of HMO Physician Financial Incentives: Finding the Proper Balance Between Motivating Financial Prudence and Protecting Quality of Care*, 36 RUTGERS L.J. 651, 663–71 (2005) (discussing several approaches taken by states, e.g., mandatory disclosure of financial incentives, prohibition of financial incentives, and prohibition of financial incentives to reduce medically necessary treatment). *But see* McLean & Richards, *supra* note 116, at 319–21 (expressing concern that state regulation of HMOs will increase the cost of medical care when it is driven more by headlines focusing on individual bad cases than a scientific approach to determining which procedure may be reasonable in a given case).

120. Hall, *supra* note 111, at 709–10 (discussing 42 C.F.R. § 417.479 (2000)). While 42 C.F.R. § 417.479 deals specifically with physician incentive plans for Medicare, managed-care organizations in Medicaid are constrained by similar limitations imposed under Medicare Advantage. 42 C.F.R. § 438.700(b)(6) (2016) (referencing Medicare Advantage regulations 42 C.F.R. §§ 422.208, 422.210). *See supra* notes 59–61 (discussing the difference between Medicare and Medicare Advantage).

121. Jane Elaine Ballerini, *The Apparent Agency Doctrine in Connecticut’s Medical Malpractice Jurisprudence: Using Legal Doctrine as a Platform for Change*, 13 QUINNIPIAC HEALTH L.J. 317, 342 (2010) (noting that for many courts applying the doctrine of apparent agency, “the touchstone . . . is control—that is, how much control the hospital or health care entity has over the physician”). But the control exercised in the managed care model, as evidenced in the Connecticut approach discussed above, typically focuses mostly on expensive forms of treatment, not on every ordinary treatment decision a physician may make. DAN B. DOBBS ET AL., *THE LAW OF TORTS* § 318 (2d ed., updated June 2017); *see also* Jenna R. Feldman, Note, *Medical Malpractice Liability and Accountability: Potential Legal Ramifications and Solutions for Florida Accountable Care Organizations*, 69 U. MIAMI L. REV. 1073, 1098–99 (2015) (discussing a 2003 Florida case where an HMO’s vicarious liability for medical malpractice turned on whether the treating physicians were agents of the HMO).

122. DOBBS ET AL., *supra* note 121, § 318.

care can also attach to state agencies employing or contracting with medical providers as well as to those providers themselves. The next Part will explore these issues within the context of litigating prison medical claims under current state medical malpractice and tort law.

## II. LITIGATING PRISON HEALTHCARE AS STATE MEDICAL MALPRACTICE AND TORT CLAIMS

### A. *The Background: Common-Law Duty of Care for Prisoners and Obstacles to Inmate Suits*

For at least three quarters of a century before the Supreme Court articulated a constitutional right to adequate medical care in prison,<sup>123</sup> the common law had held that prison officials owed a duty of “ordinary and reasonable care for [the inmate’s] life and health.”<sup>124</sup> After all, “[i]t is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself.”<sup>125</sup> In fact, after striking down the civil-rights claim of inadequate medical treatment brought by a Texas inmate under the Eighth Amendment

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123. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).

124. *Indiana ex rel. Tyler v. Gobin*, 94 F. 48, 50 (C.C.D. Ind. 1899). The court in *Tyler* recognized a dual duty of the sheriff as the custodian of the inmate: He owed a duty to the state to produce the prisoner “in court at the time of the trial.” *Id.* He also owed a duty of reasonable care to the prisoner, as noted. *Id.* *Accord* *Kusah v. McCorkle*, 170 P. 1023, 1025 (Wash. 1918) (citing *McPhee v. U.S. Fid. & Guar. Co.*, 100 P. 174, 175 (Wash. 1909)). *Tyler* arrived at this conclusion by reasoning from analogy: as it is established that the sheriff has a duty to safeguard property and animals seized by virtue of his office, “why should not the law impose the duty of care upon him in respect of human beings who are in his custody by virtue of his office?” *Id.* Under this duty, sheriffs and similar officials were held liable under the then relatively new wrongful-death statutes enacted by the states following English precedent. *E.g.*, *Asher v. Cabell*, 50 F. 818, 827 (5th Cir. 1892) (holding that a U.S. marshal owed his prisoner the duty “of safe-keeping and protection from unlawful injury” and that Texas wrongful-death statute entitled prisoner’s widow to pursue a wrongful-death action against the defendant). William Blackstone commented that sheriffs had the duty to keep prisoners in “safe custody” and remarked that “[t]he abuses of goalers and sheriff’s officers toward the unfortunate persons in their custody are well restrained and guarded against.” 1 WILLIAM BLACKSTONE, COMMENTARIES \*332, \*335.

125. *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926). *See supra* note 13 (discussing North Carolina’s 1868 Constitutional provision on inmate health). *Tyler* agrees: “Is a helpless prisoner in the custody of a sheriff less entitled to his care than a bale of goods or a dumb beast? The law is not subject to any such reproach.” *Tyler*, 94 F. at 50.

and 42 U.S.C. § 1983, the Supreme Court noted that the inmate could pursue a medical malpractice claim under Texas law.<sup>126</sup>

Thus, it would appear the most natural course of action for state prisoners who believe their medical care in prison was inadequate to file a claim under the state's tort laws or the state's medical malpractice laws. While this course may appear natural, it is by no means easy. To be sure, some of the earlier obstacles to bringing such claims have been removed, such as the notion that certain inmates were civilly dead and, thus, could not sue at all.<sup>127</sup> Other obstacles have become attenuated, such as the requirement to demonstrate malice or gross negligence to prevail in any suit against prison officials.<sup>128</sup>

But it still is often no easy feat for an inmate to pursue a claim of medical injury. This is not only because prisoners attempting to sue state prison agencies or physicians under these causes of action still face a number of obstacles members of the general population typically do not face when seeking a legal remedy for a medical injury. Among these additional obstacles are sovereign immunity and the concomitant requirement to exhaust administrative remedies, as will be discussed below.

Filing state claims that seek redress for medical injury is also difficult because new obstacles have emerged since the 1970s. For example, states have followed the federal government and enacted prison litigation reform legislation that seeks to curb a perceived excess of frivolous inmate suits. Moreover, medical malpractice litigation in general has gone through several waves of reform that have aimed at curbing what the medical community perceived to be excessive damage

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126. *Estelle*, 429 U.S. at 107 (referencing the 1969 Texas Tort Claims Act, TEX. REV. CIV. STAT. ANN. art. 6252-19, § 3 (Supp. 1976)). The section referenced in *Estelle* was repealed and amended in 1985, effective September 1, 1985. TEX. CIV. PRAC. & REM. CODE § 101.021 (2011); 1969 Tex. Gen. Laws 874; 1985 Tex. Gen. Laws 3303, 3322.

127. Zalman, *supra* note 10, at 187–88 (discussing New York law in effect circa 1970 and its judicial attenuation). Currently, “civil death laws . . . impose no significant disability on inmates” when it comes to the right to sue and be sued. 3 MUSHLIN, *supra* note 6, § 16:2.

128. Sneidman, *supra* note 10, at 451–53. Sneidman cites an eighteenth-century English treatise to the effect that jailers had a duty to avoid the spread of contagious diseases and placing prisoners in unhealthy accommodations, so they were prevented from behaving “with the least degree of wanton cruelty to their prisoners.” *Id.* at 450–51 (citing WILLIAM HAWKINS, A TREATISE OF THE PLEAS OF THE CROWN, ch. 31, § 10, at 119 (Thomas Leach ed., 6th ed. 1788) (1716)). The current constitutional standard for medical injury under the Eighth Amendment is, in part, “deliberate indifference,” i.e., “subjective recklessness as used in the criminal law.” *Farmer v. Brennan*, 511 U.S. 825, 839–40 (1994). This formulation seems to have grasped the “original meaning” of the Eighth Amendment quite well.

awards and an avalanche of frivolous suits that allegedly led to an unreasonable increase in liability insurance premiums.<sup>129</sup> While some have lauded and promoted such efforts, others have pointed out that the problem underlying the symptom of spiking medical malpractice insurance premiums appears to be largely rooted in economic realities, not in excessive lawsuits.<sup>130</sup>

But limiting access to the courts to litigate medical torts in particular comes at a price in terms of justice and quality assurance: Absent viable alternatives in the U.S.,<sup>131</sup> such limitations interfere with “the primary regulatory vehicle for compensating wrongfully injured patients and deterring future medical error.”<sup>132</sup> While this sentiment was formulated in view of the impact of “tort reform” on the general population, it appears particularly apt in view of prisoners and other populations with little to no choice when it comes to their medical providers.

These and other difficulties in pursuing state claims may be among the factors that have led to a “dearth of state court litigation” of prisoners’ medical claims.<sup>133</sup> Nonetheless, this Comment will set forth the basic elements of tort and medical malpractice claims and shed light on some of the challenges inmates face when it comes to litigating their medical tort and malpractice claims. It will use published state court opinions as guides through this legal landscape.

*B. Distinguishing Tort and Medical Malpractice Claims and  
Establishing the Standard of Care*

A basic decision every plaintiff has to make is which cause of action to pursue to obtain appropriate relief for the alleged injury. This is also the case for inmates contemplating a suit regarding inadequate medical care. Specifically, they may pursue a regular tort claim or a medical malpractice claim. Which of these actions to pursue is not left to the

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129. Scott DeVito & Andrew W. Jurs, “*Doubling-Down*” for Defendants: The Pernicious Effects of Tort Reform, 118 PENN. ST. L. REV. 543, 549–54 (2014) (outlining the main features of, and rationales behind, the three waves of tort reform in the 1970s, 1980s, and 2000s).

130. Douglas A. Kysar et al., *Medical Malpractice Myths and Realities: Why an Insurance Crisis Is Not a Lawsuit Crisis*, 39 LOY. L.A. L. REV. 785, 787 (2006) (“[C]areful inquiries into insurance industry dynamics have identified insurers’ business practices, rather than malpractice payouts, as the primary source of premium volatility.”); see *id.* at 794–99 (discussing the insurance industry dynamics leading to spiking premiums); *id.* at 800–13 (illuminating the “lawsuit crisis”).

131. *Id.* at 790–92.

132. *Id.* at 794.

133. 1 MUSHLIN, *supra* note 6, § 4:1.

plaintiffs' choice, but is determined by the nature of the claim they wish to bring. Ohio law, for example, requires plaintiffs to bring a claim for medical malpractice if the claim is asserted against a medical provider employed by the state or a hospital and arises out of medical diagnosis, care, or treatment.<sup>134</sup> This requirement also applies to inmates in state prisons.<sup>135</sup>

The selection of the proper cause of action leads to a number of consequences. For instance, the elements a plaintiff must establish in a medical malpractice action<sup>136</sup> are different from those in a claim of ordinary negligence.<sup>137</sup> Moreover, if inmate plaintiffs are required to bring a malpractice claim, they must ordinarily provide expert testimony to establish the elements of their claim.<sup>138</sup> In fact, state law may

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134. *Estate of Stevic v. Bio-Med. Application of Ohio, Inc.*, 905 N.E.2d 635, 637 (Ohio 2009) (citing OHIO REV. CODE ANN. § 2305.113(E)(3) (West 2004)). Importantly, both requirements need to be met in each case. For example, a claim asserted against a medical provider not engaged in medical diagnosis, care, or treatment does not sound in medical malpractice, but in ordinary negligence. *Franks v. Ohio Dep't of Rehab. & Corr.*, No. 12AP-442, 2013 WL 1632101, at \*4-5 (Ohio Ct. App. Apr. 16, 2013); *Foster v. Dep't of Rehab. & Corr.*, No. 12AP-503, 2013 WL 988056, at \*8 (Ohio Ct. App. Mar. 12, 2013). On the other hand, a claim of medical malpractice will not lie against a non-medical professional, as defined by state law. *McKuchen v. TransformHealthRX, Inc.*, 790 S.E.2d 122, 130 (Ga. Ct. App. 2016), *reconsideration denied* (July 28, 2016), *cert. denied* (Apr. 17, 2017) (holding that defendant who was trained as an emergency management technician and dispensed medication on the weekend shift was not among medical professional listed in GA. CODE ANN. § 9-11-9.1(g) (West 2011)); *Randall v. Tex. Dep't of Criminal Justice Emps.*, No. 01-97-00649-CV, 1999 WL 681918, at \*6 (Tex. App. Aug. 31, 1999).
135. *E.g.*, *Foy v. Ohio Dep't of Rehab. & Corr.*, Nos. 16AP-723, 16AP-724, 2017 WL 1091587, at \*6 (Ohio Ct. App. Mar. 23, 2017); *Johnson v. Ohio Dep't of Rehab. & Corr.*, No. 06AP-196, 2006 WL 3517998, at \*3 (Ohio Ct. App. Dec. 7, 2006) (holding that, because the state agency had not carried its burden of showing it was a "hospital" within the meaning of OHIO REV. CODE ANN. § 2305.111(E)(1) (West 2004), summary judgment in its favor was inappropriate on the theory of medical malpractice).
136. The standard elements of a medical malpractice action are "(1) the standard of care within the medical community; (2) the defendant's breach of that standard of care; and (3) proximate cause between the breach and the plaintiff's injuries." *Foy*, 2017 WL 1091587, at \*7.
137. The standard elements of an ordinary negligence claim are "(1) the existence of a duty owed to [plaintiff] by the defendant, (2) a breach of that duty, and (3) injury proximately resulting from that breach." *Franks*, 2013 WL 1632101, at \*5.
138. "Unless a matter is within the comprehension of a layperson, expert testimony is necessary" to establish all three elements. *Ramage v. Cent. Ohio Emergency Servs., Inc.*, 592 N.E.2d 828, 833 (Ohio 1992); *Foy*, 2017 WL 1091587, at \*7 (citing *Ramage* as applicable in prison context). *Accord Hertz v. Beach*, 211 P.3d 668, 680-81 (Alaska 2009) (requiring expert

require that an “affidavit of merit” or similar document by a qualified expert witness accompany the complaint, although a failure to provide such an affidavit may not cause a dismissal on the merits.<sup>139</sup> At the summary judgment stage, however, the absence of plaintiff’s medical expert testimony will lead to an adverse judgment on the merits, even where defendants provided only their personal medical expert testimony.<sup>140</sup>

The standard of care in malpractice actions<sup>141</sup> is established by medical expert testimony.<sup>142</sup> The standard for inmates is no different

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testimony where the actions required involve “specialized medical care, skill, or judgment”); *Bryant v. Harrington*, F067290, 2014 WL 5392967, at \*7 (Cal. Ct. App. Oct. 23, 2014) (discussing the relationship between summary judgment and expert testimony in medical malpractice claims); *McKuhlen*, 790 S.E.2d at 128–30 (rejecting testimony of expert who did not meet statutory qualifications); *McCool v. Dep’t of Corr.*, 984 A.2d 565, 571–72 (Pa. Commw. Ct. 2009) (stating that without expert testimony the prisoners claim for medical malpractice cannot survive summary judgment); *Denson v. T.D.C.J.-I.D.*, No. 12–02–00099–CV, 2003 WL 21254862, at \*20–21 (Tex. Ct. App. May 20, 2003) (holding that a fellow inmate could not serve as a medical expert because he, though otherwise qualified, was not practicing medicine when the claim arose, as required under state law).

139. *E.g.*, OHIO CIV. R. 10(D)(2)(a), (d).

140. *Montanez v. Questcare, Inc.*, 675 So. 2d 466, 467 (Ala. 1996).

141. Since the 1960s, the standard of care has broadened from the “strict locality rule” to a national standard. *See, e.g.*, *Shilkret v. Annapolis Emergency Hosp. Ass’n*, 349 A.2d 245, 247–54 (Md. 1975) (discussing the development of various standards of care in the nineteenth and twentieth centuries nationally and in Maryland for both physicians and hospitals). In fact, the “strict locality rule” is itself a physician-sponsored reaction to the very first U.S. medical malpractice crisis of the mid-1800s when it displaced the reasonableness standard. Maxwell J. Mehlman, *Professional Power and the Standard of Care in Medicine*, 44 ARIZ. ST. L.J. 1165, 1177, 1180–81 (2012). The locality rule made it difficult for plaintiffs to secure expert witnesses. *Id.* at 1181. *Accord* Glen O. Robinson, *The Medical Malpractice Crisis of the 1970’s: A Retrospective*, LAW & CONTEMP. PROBS., Spring 1986, at 5, 16–17. While there was some reaction to the geographically broadened standard from those who sought to implement tort reform via restrictive legislation, it was not thorough or widespread during the first wave of reform. *Id.* at 23.

142. *Ramage*, 592 N.E.2d at 833. Experts may draw in their testimony on the standards promulgated by non-governmental prison accreditation organizations such as the American Correctional Association and the National Commission on Correctional Health Care. *E.g.*, *District of Columbia v. Wilson*, 721 A.2d 591, 598 (D.C. 1998). But these standards do not establish the constitutional standard for healthcare under the Eighth Amendment. *Bell v. Wolfish*, 441 U.S. 520, 543 n.27 (1979).

than the one for the general population in a particular state.<sup>143</sup> However, under the reasonable physician standard, constraints typical in the prison setting may be considered by the fact finder when determining whether the standard of care has been breached.<sup>144</sup>

While non-medical defendants are not subject to medical malpractice suits, they may be found liable—for instance, under a duty of custodial care—in a claim of ordinary negligence.<sup>145</sup> Similarly, medical staff not engaged in medical care, diagnosis, or treatment may be found liable under the general duty of custodial care the state owes its inmates in a claim for ordinary negligence.<sup>146</sup> An alternative theory of liability—ministerial neglect—was extended by a New York court to prison staff when it found that both medical and non-medical defendants breached administrative medical protocols that had been put in place in the wake of a federal lawsuit and left them with no discretion in attending to plaintiff's medical needs.<sup>147</sup> Additionally, a California court held that a

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143. *E.g.*, Jameson v. Desta, 155 Cal. Rptr. 3d 755, 772 (Cal. Ct. App. 2013); District of Columbia v. Mitchell, 533 A.2d 629, 648 (D.C. 1987); Pisacano v. State, 188 N.Y.S.2d 35, 40 (N.Y. App. Div. 1959); *Foy*, 2017 WL 1091587, at \*7; Shea v. City of Spokane, 562 P.2d 264, 270 (Wash. Ct. App. 1977), *aff'd*, 578 P.2d 42 (Wash. 1978).
144. *E.g.*, Moss v. Miller, 625 N.E.2d 1044, 1051 (Ill. Ct. App. 1993) (recognizing that “constraints necessarily exist in correctional institutions which may well have a negative effect on the ability to deliver medical services,” such as “limitations on direct referrals”); Allen v. Hinchman, 20 N.E.3d 863, 870–71 (Ind. Ct. App. 2014) (noting that the finder of fact may take security and budget concerns facing prison physicians into account under the general standard of care articulated in Vergara *ex rel.* Vergara v. Doan, 593 N.E.2d 185, 187 (Ind. 1992) (abandoning the modified locality rule in favor of “that degree of care, skill, and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances.”).
145. *E.g.*, Watson v. State, 26 Cal. Rptr. 2d 262, 265–66 (Ct. App. 1993) (discussing the scope of the statutory duty of public entities or public employees to summon medical care in case of obvious medical conditions requiring immediate care under CAL. GOV'T CODE § 845.6 (West 2012)); Darling v. Palm Beach Cty. Sheriff, 2 So. 3d 368, 369 (Fla. Dist. Ct. App. 2008).
146. Franks v. Ohio Dep't of Rehab. & Corr., No. 12AP-442, 2013 WL 1632101, at \*5 (Ohio Ct. App. 2013).
147. Kagan v. State, 646 N.Y.S.2d 336, 338 (App. Div. 1996). The federal lawsuit referenced in *Kagan* is *Todaro v. Ward*, 431 F. Supp. 1129 (S.D.N.Y. 1977), which involved the same women's prison, Bedford Hills, in which the plaintiff in *Kagan* was incarcerated. *Id.* at 1131; *see also* Howard v. City of Columbus, 521 S.E.2d 51, 68 (Ga. Ct. App. 1999) (holding licensed practical nurses liable for failure to perform their ministerial duties); *infra* note 162 and accompanying text (discussing the distinction between ministerial and discretionary functions in the context of sovereign immunity).

prison physician owed the fiduciary duty of obtaining an inmate's informed consent prior to performing a medical procedure.<sup>148</sup>

*C. Sovereign Immunity*

Historically, governmental entities and their agencies—for example, a department of corrections running the state's prisons or the hospital run by a state university—enjoyed complete sovereign immunity from suit.<sup>149</sup> But over time, this absolute immunity came to be replaced by limited immunities that vary from state to state.<sup>150</sup> These limited immunities are realized either by abolishing immunity altogether and carving out certain exceptions from this rule or by maintaining general immunity and carving out certain exceptions from that rule.<sup>151</sup> And while governmental agents in their individual capacity historically were liable to suit, they now are afforded a variety of immunities.<sup>152</sup> In some states, the liability of a governmental entity is tied to whether an individual governmental agent is liable.<sup>153</sup>

Like the general population, prisoners have to navigate the issues raised by sovereign immunity and its partial waivers set forth in state tort law if they wish to sue the state for claims related to the provision of healthcare. For instance, in several Texas cases, the inmates' claims turned on whether the alleged governmental conduct fell within one of the exceptions from sovereign immunity under the Texas Torts Claims Act and whether their claims were asserted against the governmental unit, not individual government employees.<sup>154</sup> Conversely, California

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148. *Jameson*, 155 Cal. Rptr. 3d at 771 (citing *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990)). “The elements of a cause of action for breach of fiduciary duty are: (1) the existence of a fiduciary duty; (2) breach of the fiduciary duty; and (3) damage proximately caused by the breach.” *Id.* (quoting *Stanley v. Richmond*, 41 Cal. Rptr. 2d 768, 776 (Ct. App. 1995)).

149. DOBBS, ET AL., *supra* note 121, § 334.

150. *Id.*

151. *Id.* § 342.

152. *Id.* § 334.

153. *Id.* § 350.

154. *E.g.*, *Denson v. T.D.C.J.-I.D.*, No. 12-02-00099-CV, 2003 WL 21254862, at \*16-17 (Tex. App. 2003) (noting that the Texas Tort Claims Act “does not provide for recovery against individuals employed by the state,” and that claims against governmental units must fall within one of the “three specific areas of liability” set forth in TEX. CIV. PRAC. & REM. CODE ANN. § 101.021 (West 2011), i.e., employee use of motor-driven vehicle; condition or use of tangible personal or real property; premise liability); *Roberson v. Univ. of Tex. Med. Branch at Galveston*, No. 14-99-00493-CV, 2000 WL 1262525, at \*7 (Tex. App. 2000); *Randall v. Tex. Dep’t of Criminal Justice Emps.*, No. 01-97-00649-CV, 1999 WL 681918, at \*6 (Tex. App. 1999).

law provides a blanket exception from sovereign immunity for public employees “lawfully engaged in the practice of one of the healing arts under any law of this state.”<sup>155</sup> Accordingly, medical malpractice suits must be brought against the individual employee, not the agency, while general negligence suits may be brought against both the governmental agency and the employee.<sup>156</sup>

Pennsylvania statutory law provides that sovereign immunity is not a defense available to medical professionals employed by the state in the prison context.<sup>157</sup> Illinois achieves the same result based on its case law because state courts inquire about the source of a duty that was allegedly breached while the state defendants were acting within the scope of their employment to determine whether a state employee enjoys sovereign immunity.<sup>158</sup> Thus, if the duty originated in the employment relationship with the state, immunity attaches. But if the duty originated independently of state employment, immunity does not attach.<sup>159</sup> This means that state-employed prison medical providers cannot claim a sovereign-immunity defense if “[t]he duties . . . [they] allegedly breached were those every physician owes one’s patient, rather than obligations incurred solely by virtue of holding a public office.”<sup>160</sup>

At least one Georgia appeals court pursued a similar line of reasoning. It held that state-employed prison physicians are not shielded by official immunity when functioning as physicians due to the professional relationship of trust that exists between patient and physician.<sup>161</sup> The court so held because the professional relationship

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155. CAL. GOV’T CODE § 845.6 (West 2012).

156. *Watson v. State*, 26 Cal. Rptr. 2d 262, 265 (Ct. App. 1993). *See also supra* note 145 (discussing liability for failure to summon medical care that extends to both governmental units and employees under California law).

157. *Williams v. Syed*, 782 A.2d 1090, 1095 (Pa. Commw. Ct. 2001) (citing 42 PA. STAT. AND CONS. STAT. ANN. § 8522(b)(2) (West 2017)). *Pisacano v. State*, 188 N.Y.S.2d 35, 41 (App. Div. 1959), held that the broad scope of the state’s waiver statute—N.Y. Ct. Cl. Act § 8, as construed in *Becker v. City of New York*, 140 N.E.2d 262, 267 (N.Y. 1957)—even exposed the state to vicarious liability for its medical prison employees. *See infra* Section II.E. (discussing the issue of vicarious liability for state medical employees).

158. *Currie v. Lao*, 592 N.E.2d 977, 980 (Ill. 1992).

159. *Id.*

160. *Moss v. Miller*, 625 N.E.2d 1044, 1049 (Ill. Ct. App. 1993).

161. *See generally* Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1 (2015) (discussing the potential legal role of trust in the patient-physician relationship, and the importance of trust between physicians and patients). Equity courts traditionally recognized a fiduciary relationship between physicians and patients. 1 JOSEPH STORY, COMMENTARIES ON EQUITY JURISPRUDENCE 321 (13th ed. 1886).

effectively creates an exception from immunity.<sup>162</sup> The Georgia Supreme Court has since eliminated this judge-made exception for medical defendants acting within the scope of their government employment.<sup>163</sup>

*D. Meeting Administrative Requirements*

Related to the concept of sovereign immunity is the requirement that those who wish to sue the state as prisoners may have to meet certain administrative requirements prior to filing a complaint. For example, in Texas, a “governmental unit is entitled to receive notice of a claim against it” within six months of the complained conduct.<sup>164</sup> Texas prisoners may meet this requirement by filing a grievance with the state agency in charge of prisons.<sup>165</sup> Specifically, before inmates can

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162. *Howard v. City of Columbus*, 521 S.E.2d 51, 68–69 (Ga. Ct. App. 1999) (citing *Keenan v. Plouffe*, 482 S.E.2d 253, 255–57 (Ga. 1997), *overruled*, *Shekhawat v. Jones*, 746 S.E.2d 89 (Ga. 2013)) (granting sovereign immunity for LPNs performing discretionary acts and to medical doctor acting as county medical director but not to same medical doctor when acting as physician due to the latter’s professional relationship of trust to his patients). The *Keenan* court limited its holding to cases where patients choose their treating physician; it did not “consider whether immunity is appropriate for state-employed physicians who are required to treat particular patients.” *Keenan*, 482 S.E.2d at 257 n.17. Arguably, then, immunity would be appropriate for prison physicians even under *Keenan*. *Howard*, as well as *Keenan*, also relied on a case involving the medical care of a physician employed by a corporation who had alleged immunity from suit based on co-employee immunity under Georgia’s Workers’ Compensation Act, GA. CODE ANN. § 34-9-11(a) (West 2017). *See Davis v. Stover*, 366 S.E.2d 670, 671 (Ga. 1988) (holding that “it is the [defendant’s] professional standing that creates a trusting relationship that cannot be breached with impunity,” regardless of statutory immunities). On the defense of discretionary acts—as opposed to ministerial acts—in the context of sovereign immunity raised in *Howard* and *Keenan*, see DOBBS ET AL., *supra* note 121, §§ 344, 350.

163. *Shekhawat*, 746 S.E.2d at 93.

164. TEX. CIV. PRAC. & REM. § 101.101(a) (West 2011). California inmates must also comply with a similar statutory requirement. CAL. GOV’T CODE §§ 910, 915(b), 945.4, 950.2 (West 2012); *Watson v. State*, 26 Cal. Rptr. 2d 262, 266–68 (Ct. App. 1993) (holding that the variance between plaintiff’s required notice filed with state alleging failure to *summon* medical care and his amended complaint alleging failure to *provide* adequate treatment was fatal because these claims are not equivalent under CAL. GOV’T CODE § 845.6 (West 2012)); *see also State v. Superior Court*, 90 P.3d 116, 122 (Cal. 2004) (discussing the historical background of California’s current claim presentation statutes).

165. *E.g.*, *Roberson v. Univ. of Tex. Med. Branch at Galveston*, No. 14-99-00493-CV, 2000 WL 1262525, at \*6–7 (Tex. App. 2000).

file a claim, they must exhaust the administrative remedies available within the prison system.<sup>166</sup>

A number of states have enacted a variety of generally applicable pre-trial screening requirements specifically as a response to a perceived medical malpractice crisis.<sup>167</sup> For instance, as already noted, those alleging medical malpractice in Ohio must file “one or more affidavits of merit relative to each defendant named in the complaint for whom expert testimony is necessary to establish liability.”<sup>168</sup> These affidavits “shall be provided by an expert witness . . . .”<sup>169</sup> Accordingly, inmates who fail to produce these affidavits cannot prevail in a medical malpractice action but may be able to proceed on general-negligence grounds.<sup>170</sup> Similarly, Delaware law requires all claimants, including prisoners, to file an expert affidavit of merit with their medical malpractice complaint.<sup>171</sup>

Louisiana law provides that medical malpractice claims against the state raised by the general population must ordinarily go through a “medical review panel procedure” before they become “susceptible of judicial recognition or adjudication.”<sup>172</sup> Prisoners can satisfy the administrative review prerequisite by submitting their malpractice claims first to the hearing procedures “in the correctional environment or established in accordance with express law.”<sup>173</sup>

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166. TEX. CIV. PRAC. & REM. CODE § 14.005 (West 2017); TEX. GOV'T CODE § 501.008 (West 2012); *Brown v. Talley*, No. 08-02-00397-CV, 2003 WL 22283271, at \*1 (Tex. App. Oct. 2, 2003).

167. *Robinson*, *supra* note 141, at 25.

168. OHIO CIV. R. 10(D)(2)(a).

169. *Id.*

170. *E.g.*, *Franks v. Ohio Dep't of Rehab. & Corr.*, 958 N.E.2d 1253, 1255–57 (Ohio Ct. App. 2011).

171. *Stedley v. Surdo-Galef*, No. 499, 2013 WL 1228019, at \*1 (Del. Mar. 26, 2013) (quoting DEL. CODE ANN. tit. 18, § 6853(a) (West 2017)) (holding that the affidavit requirement is not unconstitutional as applied to inmates).

172. LA. STAT. ANN. § 40:1237.1(E)(1) (2016); *see* Leonard J. Nelson, III et. al., *Medical Malpractice Reform in Three Southern States*, 4 J. HEALTH & BIOMED. L. 69, 98–112 (2008) (discussing the broader context of medical malpractice reform in Louisiana that included several features in addition to medical review panels). Medical review panels were first introduced as part of the 1970s medical malpractice reforms in the states. PATRICIA MUNCH DANZON, *THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS* 43 (1982) (discussing the prevalence of this procedure in the states in 1982); Patricia Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 27 J.L. & ECON. 115, 146–47 (1984) (dating the adoption of the panel procedure, “PAN,” across the fifty states).

173. LA. STAT. ANN. § 40:1237.1(E)(1) (2016); *Walker v. Appurao*, 29. So. 3d 575, 576–77 (La. Ct. App. 2009).

Similarly, Massachusetts law requires the general population, as well as inmates,<sup>174</sup> to present their medical malpractice claims to a tribunal consisting of a superior court justice, a licensed physician, and an attorney prior to seeking judicial relief.<sup>175</sup> Within thirty days of the tribunal's finding, claimants must post a bond of \$6,000 that is payable to the defendants if the plaintiff does not prevail in the final judgment.<sup>176</sup> Upon motion by the claimant, the amount of the bond may be decreased for indigent claimants.<sup>177</sup> This provision is particularly relevant for prisoners "since most inmate [plaintiffs] are indigent."<sup>178</sup>

Resisting the usually defendant-friendly trend of malpractice reform, Connecticut, in 1998, amended its general statute authorizing actions against the state to make the filing of medical malpractice actions easier. This is particularly relevant for state prisoners because, as seen above,<sup>179</sup> Connecticut not only houses them, but also, via the state university, provides medical care to them. Prior to the change, the State Claim's Commissioner held a trial-like hearing to determine whether to allow the claim to go forward.<sup>180</sup> After the change, the Commissioner was required to allow a medical malpractice suit against the state or medical provider employed by the state if the plaintiff submitted a certificate of good faith.<sup>181</sup> For a prisoner who was injured prior to the effective date of the statute, the simplified procedure was not available

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174. *Lanza v. Mohamed*, 1995 Mass. App. Div. 53, 53 (Dist. Ct. 1995).

175. MASS. GEN. LAWS ANN. ch. 231, § 60B (West Supp. 2015).

176. *Id.*

177. *Id.*

178. 3 MUSHLIN, *supra* note 6, § 17:29.

179. *See supra* Part I.B.3 (discussing how Connecticut provides managed healthcare to inmates).

180. *D'Eramo v. Smith*, 872 A.2d 408, 416 (Conn. 2005) (discussing a pre-1998 scenario involving a medical malpractice claim and noting that "the effect of the [1998] statute was to convert a limited waiver of sovereign immunity to medical malpractice claims . . . to a more expansive waiver subject only to the claimant's compliance with certain procedural requirements."); *see* 1998 Conn. Acts 334 (Reg. Sess.) (containing the session law amending the pre-1998 statute by inserting the paragraph that is now CONN. GEN. STAT. ANN. § 4-160(b) (West Supp. 2017)).

181. CONN. GEN. STAT. § 4-160(b). The certificate of good faith is the result of "a reasonable inquiry . . . to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant." *Id.* § 52-190a(a). The certificate is to be based on "a written and signed opinion of a similar health care provider . . . that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion." *Id.*

because the state supreme court deemed the change enacted by the legislature to be substantive in nature, not merely procedural.<sup>182</sup>

*E. Direct and Vicarious Liability of State Agencies for Medical Malpractice*

Beginning in the early twentieth century, courts created what is called the “corporate practice of medicine doctrine,” which was intended to shield physicians from being controlled in their medical practice by non-medical, corporate considerations.<sup>183</sup> While this was a noble sentiment at the time, it also created an effective shield from vicarious liability for hospitals. For example, the New York high court held, in a 1914 opinion written by Justice Cardozo, that a hospital was not vicariously liable for the tort of trespass<sup>184</sup> committed by a physician serving the hospital because the “relation subsisting between a hospital and its physicians . . . is not one of master and servant, but the physician occupies the position . . . of an independent contractor . . . liable, of course, for his own wrongs.”<sup>185</sup> After all, the “hospital does not undertake to act through them, but merely to procure them to act upon their own responsibility.”<sup>186</sup> Thus, under this theory, a hospital could be held liable for the conduct of the physicians it “procured” for patients only directly, meaning, for instance, if the hospital itself had also acted negligently when hiring the negligent physician.<sup>187</sup>

This theory, abrogated in 1957, became known in New York as the “*Schloendorff* rule” and barred vicarious liability of any hospital em-

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182. *D'Eramo*, 872 A.2d at 416–18.

183. Huberfeld, *supra* note 52, at 251–53.

184. “In early common law, battery claims were pursued by an action for trespass to the person and thus fell under the rule that trespass actions would lie only if the harm was done directly.” DOBBS ET AL., *supra* note 121, § 33.

185. *Schloendorff v. Soc’y. of N.Y. Hosps.*, 105 N.E. 92, 93 (N.Y. 1914). The court’s primary rationale for hospital immunity in this particular case was that the hospital was a charitable corporation. *Id.*; see Ballerini, *supra* note 121, at 321–25 (discussing the rise and fall of charitable hospital immunity from vicarious liability).

186. *Schloendorff*, 105 N.E. at 94.

187. *Id.* (quoting *Glavin v. R.I. Hosp.*, 12 R.I. 411, 424 (1879)). In *Glavin*, the court also stated: “A patient has a right to rely on the exercise of such [reasonable] care” in selecting physicians “skillful and trustworthy in their professions,” “and consequently if, through the neglect of the hospital to exercise it, he receives an injury, he is entitled to look to the hospital for indemnity . . . .” *Glavin*, 12 R.I. at 424. Accord *McDonald v. Mass. Gen. Hosp.*, 120 Mass. 432, 436 (1876) (holding that corporations must use reasonable care when selecting its agents). *But see* Ballerini, *supra* note 121, at 328 (claiming that hospitals became liable for negligent hiring first in the 1960s).

ploying medical providers.<sup>188</sup> However, this rule was held inapplicable in medical claims against the state based on negligent conduct of state employees because the state's sovereign immunity legislation put state institutions beyond the scope of the rule.<sup>189</sup>

But this does not mean that hospitals are always liable for the negligent conduct of all medical staff working in the hospital. While negligent conduct of hospital employees could lead to vicarious liability of the hospital, negligent conduct of independent contractors is not necessarily attributable to the hospital.<sup>190</sup> In New York, a critical element here is that of "control in respect to the manner in which the work is to be done."<sup>191</sup> In other words, considering "the actualities" of the employment relationship, not simply the contractual designation of a member of the hospital staff,<sup>192</sup> the hospital will be found vicariously liable for the negligent conduct even of an "independent contractor," if the contractor was required to treat patients according to the hospital's rules and regulations.<sup>193</sup>

In addition to the "agency or control in fact" just described as a basis for vicarious liability, a hospital or corporation can be held vicariously liable in a malpractice action based on "apparent or ostensible agency."<sup>194</sup> Under this theory, vicarious liability would attach where the hospital or corporation held out a medical provider as its agent, creating reliance on this representation in the patient who contracts with the medical provider.<sup>195</sup>

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188. *Bing v. Thunig*, 143 N.E.2d 3, 3, 7 (N.Y. 1957).

189. *Becker v. City of New York*, 140 N.E.2d 262, 268 (N.Y. 1957) (citing N.Y. CT. CL. ACT § 8).

190. *See generally* DOBBS ET AL., *supra* note 121, §§ 425, 431.

191. *Mduba v. Benedictine Hosp.*, 384 N.Y.S.2d 527, 529 (App. Div. 1976) (citing *In re Susan Messer Assoc.*, 306 N.Y.S.2d 842, 842 (App. Div. 1970)).

192. *Id.* (citing *In re Fidel Ass'n of N.Y.*, 259 A.D. 486, 487 (N.Y. App. Div. 1940)).

193. *Id.* at 453.

194. *Hill v. St. Clare's Hosp.*, 490 N.E.2d 823, 827 (N.Y. 1986).

195. *Hannon v. Siegel-Cooper Co.*, 60 N.E. 597, 597-98 (N.Y. 1901) (holding a department store liable for malpractice of a dentist owning a dentistry clinic in the store where the injured patient had relied on the store's representation that the store was running a dentistry business although it was prohibited to do so under state law). *Accord* RESTATEMENT (THIRD) OF AGENCY § 2.03 (AM. LAW INST. 2003); RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 65(a) (AM. LAW INST. 2012); *see also* DOBBS ET AL., *supra* note 121, § 433 (noting that a plaintiff's "reliance" can be replaced by plaintiff's "reasonable belief").

These rules also apply to New York state prison agencies employing or contracting with medical providers.<sup>196</sup> Accordingly, under the theory of “ostensible agency,” the state would be vicariously liable for medical malpractice if, for instance, “the plaintiff could have reasonably believed, based upon all of the surrounding circumstances, that the treating physician was provided by the defendant . . . or was otherwise acting on the defendant’s behalf.”<sup>197</sup> Especially important are the state’s own words or conduct “that give rise to the appearance and belief that the doctors were acting on its behalf.”<sup>198</sup>

Other states operate with similar distinctions, in part as an extension of sovereign immunity. For example, the Texas Court of Appeals held that a county was not vicariously liable for the negligent conduct of physicians employed by the state university but working for the county as independent contractors over which the county had “no right to control.”<sup>199</sup> This was because the state law waiving sovereign immunity for certain state employees’ negligent conduct expressly excepted independent contractors and their agents not legally controlled by the state.<sup>200</sup> The court agreed with the plaintiff that the county, under state law, had a “nondelegable duty to provide adequate health care . . . to its inmates,”<sup>201</sup> but found that the county had “discharged that duty by entering into a contract with a reputable health care provider.”<sup>202</sup> And because the agreement between the county and the provider set only very broad parameters for medical care, the court held that the county did not sufficiently control their independent contractors to bring the county into the scope of the state law’s waiver of sovereign immunity.<sup>203</sup> In fact, the court noted that “the very nature of practicing medicine makes it *impossible* for Harris County” to “control[] the details of the physicians’ work.”<sup>204</sup>

The doctrine of nondelegable duties also featured prominently in a prison healthcare case before the high court of the District of

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196. *Garofolo v. State*, 23 N.Y.S.3d 667, 669 (App. Div. 2016).

197. *Id.* (quoting *Soltis v. State*, 568 N.Y.S.2d 470, 471 (App. Div. 1991)).

198. *Id.* (citing *Hallock v. State*, 64 N.Y.2d 224, 231 (1984)).

199. *Thomas v. Harris Cty.*, 30 S.W.3d 51, 54 (Tex. App. 2000).

200. *Id.* at 53 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 101.021 (West 1997)).

201. *Id.* at 54 (citing TEX. CODE CRIM. PROC. ANN. art. 16.21 (West 1997)).

202. *Id.*

203. *Id.*

204. *Id.* (emphasis added).

Columbia.<sup>205</sup> One of the court's panels held that the District of Columbia owed a nondelegable duty to provide non-negligent medical care to its inmates both under the U.S. Constitution<sup>206</sup> and the laws of the District.<sup>207</sup> As a corollary, the court held that the employees of the contractor were, in fact, agents of the state for purposes of vicarious liability.<sup>208</sup> The court also recognized a direct basis for liability that required the plaintiff to establish by expert testimony that the District's supervision of the medical provider was negligent.<sup>209</sup>

The rehearing of the case en banc focused solely on the question of the District's nondelegable duty under District law.<sup>210</sup> The full court reversed the panel's holding on this issue.<sup>211</sup> The full court held that, while the District had a nondelegable duty to provide medical care under the Eighth Amendment, it did not have such a duty under the District's common law and statutory obligations to provide medical care to its inmates.<sup>212</sup>

Two Supreme Court decisions caused the full court to arrive at this split characterization of the District's duty. For the constitutional question, the court referenced *West v. Atkins*.<sup>213</sup> In *West*, the Court established that the Eighth-Amendment duty to provide adequate medical care cannot be contracted away.<sup>214</sup> For the common-law and

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205. *Herbert v. District of Columbia (Herbert I)*, 691 A.2d 1175 (D.C.), *reh'g en banc granted, judgment vacated*, 698 A.2d 1017 (D.C. 1997), *opinion reinstated in part on reh'g*, 716 A.2d 196 (D.C. 1998).

206. *Id.* at 1180 (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (noting that a violation of the nondelegable duty to provide adequate medical care under the Eighth Amendment requires a showing of more than mere negligence or medical malpractice, i.e., a showing of "deliberate indifference to serious medical needs of prisoners").

207. *Id.* at 1182–83.

208. *Id.* at 1183 (citing *Medley v. N.C. Dep't of Corr.*, 412 S.E.2d 654, 659 (N.C. 1992)).

209. *Id.* at 1184. Following the leading case, *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253 (Ill. 1965), liability for negligent supervision is part of the institution's own corporate liability for its own negligent acts. DOBBS ET AL., *supra* note 121, § 316 (citations omitted) (stating that under the doctrine of corporate liability a hospital may be held liable for its own failure to supervise its medical staff). The older cases, cited *supra* note 187, already recognized a hospital's direct liability for negligent hiring.

210. *Herbert v. District of Columbia (Herbert II)*, 716 A.2d 196, 197 (D.C. 1998).

211. *Id.* at 200–01.

212. *Id.*

213. 487 U.S. 42 (1998).

214. *Herbert II*, 716 A.2d at 200 (quoting *West*, 487 U.S. at 56 (1988)).

statutory question, the court cited *Logue v. United States*.<sup>215</sup> In *Logue*, the Court declined to impose a nondelegable duty to provide adequate medical care on the Federal Bureau of Prisons because the same 1948 public law that imposed on the Bureau the duty to provide “care” for its inmates also authorized the government to contract with the states and its subdivisions for such “care.”<sup>216</sup>

One of the cases the District’s high court had relied on in its panel decision finding a nondelegable duty,<sup>217</sup> but which it declined to find persuasive in its en banc decision,<sup>218</sup> was the North Carolina Supreme Court case *Medley v. North Carolina Department of Correction*.<sup>219</sup> *Medley* also involved negligent conduct by independent medical contractors but came to a result opposite from that reached by the Texas Court of Appeals and the District of Columbia high court.<sup>220</sup>

This was in part because North Carolina law—unlike Texas law<sup>221</sup>—did not expressly exclude independent contractors from the state’s waiver of sovereign immunity. And unlike District of Columbia law,<sup>222</sup> it referenced the general principle of agency.<sup>223</sup> Additionally, the North

215. 412 U.S. 521 (1973).

216. *Herbert II*, 716 A.2d at 199 (quoting *Logue*, 412 U.S. at 531–32). The federal statutes at issue in *Logue* were 18 U.S.C. §§ 4002, 4042 (2012)). *Logue*, 412 U.S. at 528–29. Both sections were enacted as part of an act revising and codifying title 18 of the U.S. Code. Act of June 25, 1948, Pub. L. No. 80-772, §§ 4002, 4042, 62 Stat. 683, 847, 849. Evidently, a nondelegable *duty* is not the same as a nondelegable *task*. Rather, the former presupposes delegation of the task to non-employees, but disallows delegation of liability for non-employee conduct in certain circumstances. 5 FOWLER V. HARPER ET AL., HARPER, JAMES AND GRAY ON TORTS § 26.11, at 101 (3d ed. 2006) (“In all these cases [where courts found a nondelegable duty] the employer is as liable for the conduct of the contractor as though it were his own.”). This is why the District of Columbia high court ultimately declined to apply the nondelegable-duty doctrine in the *Herbert* case beyond the context of the limited requirements imposed by the Eighth Amendment. *Herbert II*, 716 A.2d at 200–01.

217. *Herbert v. District of Columbia (Herbert I)*, 691 A.2d 1175, 1181–82 (D.C.), *reh’g en banc granted, judgment vacated*, 698 A.2d 1017 (D.C. 1997), *opinion reinstated in part on reh’g*, 716 A.2d 196 (D.C. 1998).

218. *Herbert II*, 716 A.2d at 201 n.7 (referencing the opinion-writer’s dissent in *Herbert I*).

219. 412 S.E.2d 654 (N.C. 1992).

220. *Id.* at 659.

221. *Thomas v. Harris Cty.*, 30 S.W.3d 51, 53 (Tex. App. 2000) (citing TEX. CIV. PRAC. & REM. CODE ANN. § 101.021 (2017)).

222. As the *Herbert I* court noted, the District of Columbia did not have a tort claims act. *Herbert I*, 691 A.2d at 1182.

223. *Medley*, 412 S.E.2d at 657 (quoting N.C. GEN. STAT. § 143-291(a) (2017)).

Carolina high court also seemed to have a better understanding than the Texas appellate court of what the concept of nondelegable duty means for liability purposes. After all, when a nondelegable duty is recognized, this means that the duty—and the resultant liability in case of a breach of that duty—cannot be contracted away.<sup>224</sup> Thus, the North Carolina court found that the state’s nondelegable duty to provide adequate medical care—established primarily by the state’s statutory and decisional law<sup>225</sup>—turned an independent medical provider into an agent of the state within the meaning of North Carolina’s State Tort Claims Act and resulted in the Department of Correction’s vicarious liability for the negligent conduct of that contract physician.<sup>226</sup> Similarly, the Washington Court of Appeals, in *Shea v. City of Spokane*,<sup>227</sup> held that a city’s duty to provide healthcare for its prisoners was nondelegable so that the city “cannot be relieved of liability for the negligent exercise of that duty by delegating it to an ‘independent contractor’ physician.”<sup>228</sup>

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224. *Id.* at 657–58; *see also* *Hardaker v. Idle Dist. Council* (1896), 1 Q.B. 335, 340 (distinguishing a district council’s inevitable liability for a nondelegable duty negligently performed by a contractor from the contractor’s collateral negligence for which the council is not liable); DOBBS ET AL., *supra* note 121, § 432 (defining “collateral negligence” as a “risk that is not a usual or inherent part of the work” contracted for).

225. *Medley*, 412 S.E.2d at 657–58 (citing N.C. GEN. STAT. § 148-19(a) (2017), *amended by* Act of June 29, 2017, N.C. Laws S.L. 2017-186); *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926)).

226. *Id.* at 659. The *Medley* court—in support of its holding that the state had a nondelegable duty to provide adequate medical care to its inmates—also noted that the U.S. Supreme Court held that states cannot avoid their duty to provide adequate medical care under the Eighth Amendment by contracting out medical care. *Id.* at 658–59 (citing *West v. Atkins*, 487 U.S. 42, 56 (1988)). *Medley* responded to the objection that, under the Eighth Amendment, mere negligence is not sufficient to support liability by reasoning that “[t]he United States Supreme Court seems to interpret the Eighth Amendment to impose on states a broad duty—to provide ‘adequate medical care’ to inmates—while at the same time allowing actions under section 1983 only for deliberate breaches of that duty.” *Id.* at 659. Outside the context of nondelegable duty, the U.S. Supreme Court, highlighting the importance of “control” discussed above, has held that government contractors, if acting within reasonably precise specifications supplied by the government, share in the government’s immunity. DOBBS ET AL., *supra* note 121, § 352 (discussing *Boyle v. United Techs. Corp.*, 487 U.S. 500, 501 (1988)).

227. 562 P.2d 264 (Wash. Ct. App. 1977), *aff’d*, 578 P.2d 42 (Wash. 1978).

228. *Id.* at 268. The *Herbert* case also relied on and distinguished *Shea*. *See supra* notes 205–216 and accompanying text.

*F. Remedies*

Following the adoption of the federal Prison Litigation Reform Act of 1995 (“PLRA”),<sup>229</sup> a number of states adopted similar, at times virtually identical, provisions on remedies.<sup>230</sup> In addition to setting forth which remedies are available to inmate litigants, these laws require that any compensatory damages an inmate might win must first be applied to satisfy a variety of the inmate’s obligations, such as court-ordered payments including victim’s compensation and child support.<sup>231</sup>

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229. Pub. L. No. 104-134, tit. VIII, 110 Stat. 1321-66 to 1321-77 (1996) (codified as amended in scattered sections of 18 U.S.C., 28 U.S.C., and 42 U.S.C.). The PLRA was enacted to stem a perceived tide of frivolous inmate litigation. Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1633-34 (2003) (quoting, among others, *Porter v. Nussle*, 534 U.S. 516, 524-25 (2002)); *see also* Mark Tushnet & Larry Yackle, *Symbolic Statutes and Real Laws: The Pathologies of the Antiterrorism and Effective Death Penalty Act and the Prison Litigation Reform Act*, 47 DUKE L.J. 1, 64 (1997) (noting that, by the mid-1990s, “conservatives won the battle of sound bites: law suits focusing on peanut butter sandwiches and premium cable became the central images [in the prison litigation reform debate] rather than lawsuits that attempted to keep cells free of raw sewage”). Tushnet and Yackle also shed light on the political dynamics that, beginning in the 1980s on the state and federal levels, resulted in the adoption of the PLRA in the mid-1990s. *Id.* at 12-22.
230. Like their federal counterpart, state PLRAs are broader than the portions on remedies discussed here. They also include, e.g., administrative exhaustion requirements. *See supra* Part II.D. The administrative exhaustion requirement in the federal PLRA has been called that law’s “most damaging component.” Schlanger, *supra* note 229, at 1650. The states adopted their versions of the PLRA to stem an anticipated flow of prisoner suits from federal to state courts. *Id.* at 1635; *see also* *Gibson v. Tolbert*, 102 S.W.3d 710, 713 (Tex. 2003) (noting that the Texas PLRA was enacted “to curb this particular area of litigation excess”).
231. *E.g.*, ARK. CODE ANN. § 12-29-601 (West 2014) (providing that compensatory damages awarded to prisoner in suit against correctional facilities, after attorney’s fees and costs, will be applied to satisfy outstanding restitution orders); LA. STAT. ANN. §§ 15:1182, 15:1189 (2015) (discussing available remedies; damage awards and pending restitution orders); MD. CODE ANN. CTS. & JUD. PROC. § 5-1006(a)(1), (b) (West 2011) (providing that compensatory or punitive damages awarded to inmate in civil action “shall be paid directly to satisfy any outstanding judgment of restitution or child support order pending against the prisoner” and that the prisoner’s custodian is to notify inmate’s victims and child support recipient when such damages are awarded); MICH. COMP. LAWS ANN. §§ 600.5511(2)-(3), .5517-.5527 (West 2013) (discussing damage awards in relation to restitution orders and victim notification as well as the conditions and scope of prospective relief); MO. ANN. STAT. §§ 506.387-.390 (West 2003) (discussing monetary damage awards in relation to inmate’s cost of incarceration, outstanding court orders regarding victim compensation, restitution, costs, bail, etc., and requiring attorney general to send notice to victim of crime regarding pending payment of compensatory damages); N.J. STAT. ANN. § 30:4-16.4

State-law litigants already face the prospect of rather meager damage awards because their loss of income and medical expenses in case of an injury caused by simple negligence or medical malpractice are typically not very significant. This is because inmates do not have any significant income while incarcerated<sup>232</sup> and their medical expenses, at least while in prison, are covered by the state.<sup>233</sup> Unlike in the case of civil-rights violations brought under 42 U.S.C. § 1983, general or presumed damages are not available to supplement damage awards in these actions, except in cases of intentional torts such as assault and battery.<sup>234</sup> Moreover, some state PLRAs—like their federal counterpart<sup>235</sup>—provide for limitations on attorney fees recoverable by inmate litigants.<sup>236</sup> Considering these factors, even inmates with a meritorious

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(West 2008) (mandating use of money judgments for inmates to satisfy outstanding court-ordered obligations or claims for reimbursement of medical costs); OHIO REV. CODE ANN. § 2969.27 (West 2006) (providing for deductions from any judgment for damages awarded to inmates in civil action against government entity or employee); 42 PA. STAT. AND CONS. STAT. §§ 6604-6608 (West 2017) (discussing conditions and scope of prospective relief and the disbursement conditions of monetary damages awarded to inmates); W. VA. CODE ANN. § 25-1A-7 (West 2002) (mandating that compensatory damages awarded to inmate must be used first to satisfy outstanding court-ordered payments such as restitution or child support).

232. Prison pay rates vary widely depending on the state and the type or time of labor an inmate performs: Some states pay nothing (e.g., Arkansas and Georgia). A pay of more than \$2 per hour is high and only offered for select assignments by a few states, e.g., North Carolina and Washington. *State and Federal Prison Wage Policies and Sourcing Information*, PRISON POL'Y INITIATIVE (Apr. 10, 2017), [https://www.prisonpolicy.org/reports/wage\\_policies.html](https://www.prisonpolicy.org/reports/wage_policies.html) [<https://perma.cc/RZ9E-SR5P>].
233. See Schlanger, *supra* note 229, at 1622 (noting that, given that low to no wages and state-paid medical expenses form the basis of damage awards for inmates, “it is simply not surprising that damages are low even in cases involving very serious injury”). While Schlanger’s article discussed the data for federal litigation under 42 U.S.C. § 1983, her data are also representative for state-law litigants because the Supreme Court, in *Smith v. Wade*, 461 U.S. 30, 34 (1983), has construed remedies for constitutional violations in analogy to those for common-law torts.
234. DOBBS ET AL., *supra* note 121, §§ 47, 479.
235. 42 U.S.C. § 1997e(d) (2012). The background, impact, and constitutionality of this provision is discussed in greater detail in Karen M. Klotz, Comment, *The Price of Civil Rights: The Prison Litigation Reform Act’s Attorney’s Fee-Cap Provision as a Violation of Equal Protection of the Laws*, 73 TEMP. L. REV. 759 (2000).
236. *E.g.*, LA. STAT. ANN. § 15:1185 (2015) (mirroring the federal limitations); W.VA. CODE ANN. § 25-1A-8 (West 2002) (mirroring the federal limitations except for the 25 percent/150 percent provisions).

malpractice claim will likely not be able to find an attorney to represent them and an expert to provide the expertise that is often required simply to get into court.

Courts at times have discretion to appoint representation for indigent litigants in a civil case, including a malpractice action.<sup>237</sup> But they may be dissuaded from doing so based on the analogue of a malpractice action in the general population where lawyers routinely represent indigent clients on a contingency basis.<sup>238</sup> Yet because an inmate's compensable injury is small compared to a typical tort suit brought by a non-inmate,<sup>239</sup> this analogue is highly questionable to the point of being cynical.

## CONCLUSION

### A. *Summary of Findings*

As seen in Part I, states regulate the provision of medical care in a number of ways. While some legislatures provide little to no guidance to the state agencies in charge of their prison populations, others provide more direction, e.g., by setting forth fundamental parameters involving the principles of managed care. While managed care has the potential of providing financially stressed state prison systems more affordable care for their inmates without sacrificing the quality of care, it also has the potential to lead to too little care too late when the goal of cost savings is not properly balanced with that of providing medically necessary care.

Federal courts, in suits brought under 42 U.S.C. § 1983, have rejected a "cost defense" advanced by states to defend in medical care suits brought by inmates under the Eighth Amendment. Thus, managed care plans that are too fiscally ambitious should be well within the scope of this jurisprudence. But some states have built a "cost defense" into their standard of care. At the same time, other states have been implementing a variety of measures seeking to tame managed care by balancing the containment of costs and the provision of adequate medical care for the general population, for instance by prohibiting

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237. *E.g.*, TEX. GOV'T CODE ANN. § 24.016 (West 2004).

238. *E.g.*, *Gibson v. Tolbert*, 102 S.W.3d 710, 713 (Tex. 2003) ("[P]laintiffs in medical malpractice cases are routinely represented by counsel on contingent fee contracts. As long as his claims against Gibson were meritorious, [the inmate's] indigency should not have prevented him from employing able counsel.").

239. In 1993, state tort trials resulted in a mean verdict of about \$430,000 for non-inmate litigants, while inmates who prevailed in trials realized a mean verdict of \$18,800. Schlanger, *supra* note 229, 1603. In 2012, inmates won a mean award of just under \$22,000. Margo Schlanger, *Trends in Prisoner Litigation, as the PLRA Enters Adulthood*, 5 U.C. IRVINE L. REV. 153, 167 (2015).

financial incentives for physicians outright or requiring their disclosure to patients.

As seen in Part II, state tort and malpractice law has changed over the past four decades. But this change has not been an unequivocally positive one from the prisoner's perspective. First, litigating medical claims now is at least as cumbersome for inmates as it is for the general population. This is due to several waves of "tort reform" that have sought to fix the problem of costly malpractice insurance by limiting plaintiffs' access to the courts. Moreover, compared to damages recoverable by the general population, inmate damages are typically quite low, even where the physical injury suffered is the same. This reduces the likelihood that inmates will be able to afford competent legal representation and the necessary medical experts.

Second, some states have added a layer of litigation disincentives aimed at inmate plaintiffs by enacting statutes that in one way or another echo the federal Prison Litigation Reform Act of 1995. These two obstacles that limit access to the courts are troublesome because access to litigation has—for better or worse—proved to be the most effective way to enforce standards of medical care in the U.S.

#### *B. Proposals for Reform*

"Criminals are not popular. No politician in recent memory has lost an election for being too tough on crime."<sup>240</sup> This dual reality seems to make meaningful reform in this area difficult to achieve. Still, the discussion above has indicated a number of possible areas of reform. In fact, the time to raise such proposals seems favorable, as there is, at least on the state level, an emerging bipartisan consensus that incarcerating more people for longer periods of time is not sustainable.<sup>241</sup>

First, state legislatures should revisit the issue of prison litigation reform. States now have at least two decades worth of experience with attempts to roll back inmate access to the courts in the form of prison litigation reform legislation. A candid assessment of what such legislation has accomplished is needed as the foundation for such an assessment. Evidently, the citizens of the states, through their elected representatives, must make the final decisions here that balance costs and benefits.

Importantly, there is evidence showing that providing quality medical care to inmates while they are in prison and connecting them with medical care after their release is good public policy also in that it actually saves money by keeping ex-inmates out of prison. Giving in-

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240. Tushnet & Yackle, *supra* note 229, at 1.

241. Lorelei Laird, *States Featuring Bipartisan Support Rally for Criminal Justice Reform*, A.B.A. J. (Dec. 2017), [http://www.abajournal.com/magazine/article/criminal\\_justice\\_reform\\_louisiana\\_alaska](http://www.abajournal.com/magazine/article/criminal_justice_reform_louisiana_alaska) [https://perma.cc/M5EA-527K].

mates more liberal access to the courts when it comes to litigating medical claims can play an important role when it comes to improving the medical care they receive.

Second, states that seek to realize cost savings by implementing principles of managed care in their prisons should enact measures that limit financial incentives for providers also for that particular group of their populations the law has placed under their special care, their prisoners. In a way, adopting such measures should prove easier for the inmate population than for the general population because the typical managed care plan for the general population is offered through employment and, thus, often removed from state action by ERISA preemption. This preemption provides no obstacle for regulating managed care plans implemented to facilitate affordable care among prisoners.

Once again, states should realize that they have an interest in providing quality medical care to their inmates in that sick inmates, once released, often reoffend because they are sick or in order to avail themselves of healthcare. In other words, working in prison to release prisoners who are healthy and connected to needed medical care in their communities should actually save states money.

Third, states have an understandable interest in shielding themselves and their medical employees and contractors from claims of vicarious or direct liability. And they also have a legitimate interest in requiring administrative procedures of claim resolution before allowing access to the courts. At the same time, states also have a duty to provide for their inmate populations' medical needs.

Several states—by statutory or decisional law—exempt physicians from liability protections and immunities available to other state employees or contractors. By doing so, these states recognize that the patient-physician relationship is different from—and primary to—a citizen's relationship to the government in general and a prisoner's relationship to the remaining prison staff in particular. Equally noteworthy are those states that recognize that they have a nondelegable duty to care for their inmates, even if they employ private contractors to provide the medical care.

Removing medical professionals from the shield of immunities and liability protections as well as recognizing a nondelegable duty are commendable because these measures hold the promise of justice and accountability. They are, in the limited area of prison medical care, meaningful reforms of a "tort reform" that appears to have brought less justice and accountability. States should have an interest in exposing themselves and their medical employees and contractors to this whole-some risk to fulfill the duty of care they have in relation to their prisoners.

Fourth, the ACA remains under siege. The House of Representatives' suit relating to certain reimbursements is merely held in abeyance. The ACA's "individual mandate" has been rescinded by

Congress. These two measures put the Medicaid expansion in jeopardy. States have an interest in keeping this expansion in place, also because it allows them to offer basic medical insurance to more inmates and more former inmates. As noted earlier, ex-inmates that are provided a range of medical services are less likely to reoffend, thereby saving the states scarce financial resources.

Fifth, students of the American healthcare system, who have compared it with the way healthcare is provided in comparable countries abroad, have identified an important reason as to why healthcare is more costly here than there. And that is that, e.g., European countries provide other social welfare programs in addition to healthcare, so that not every social issue finds its way into the healthcare system, thereby raising the amount of money spent on healthcare.<sup>242</sup> And while residents of European countries may pay more in social security taxes—including payments for healthcare—their American counterparts may actually end up paying more for healthcare without getting better healthcare in return.<sup>243</sup>

This observation is relevant for the discussion of the burgeoning costs of providing medical care for inmates. Here, too, one cause of increased healthcare spending in prisons appears to be that the provision of healthcare and other social services is forced onto the institutions that by law must provide them, i.e., jails and prisons. Instead of addressing the social and medical causes of criminality and recidivism proactively, society seems to have opted for ignoring those causes and now lets the prisons “handle” the fallout. But given that, as stated above, prisoners are not popular and politicians are not voted out of office for sending too many people to prison, this strategy can easily result in chronic underfunding for inmate healthcare.

Moreover, the way society accounts for those prevention programs is often in the same way it does in the general healthcare field, i.e., by adding, not by subtracting.<sup>244</sup> This is to say, the savings that are realized by engaging in preventive measures—both in view of crime and disease—are never highlighted. What remains are the costs of prevention that are added to the costs of incarceration. States should take note of this reality and invest more in meaningful preventive measures to save more on remedial measures—including incarceration—that are often socially disruptive.

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242. McLean & Richards, *supra* note 116, at 327.

243. *Id.*

244. “Interestingly, when society does benefit from providing medical treatment for social conditions, the avoidance of future medical treatment, and hence costs, is never contemplated. Any benefits to society in rehabilitating drunks or drug addicts are not subtracted from the medical budget, so the net result is always more costs with no credit for the benefits.” *Id.* at 294.

The last proposal goes beyond the scope of this Comment in that it points to the societal context of medicine behind bars. It is nonetheless important to raise it, lest the discussion of prison healthcare misses the forest for the trees.

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