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PRISON MEDICAL DEATHS AND QUALIFIED IMMUNITY

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The defense of qualified immunity for claims seeking monetary damages for constitutionally inadequate medical care for people who are incarcerated is misguided. According to the U.S. Department of Justice, medical illness is the leading cause of death of people incarcerated in prisons and jails across the United States. Qualified immunity in these cases limits accountability for carceral actors, thereby limiting incentives for improvements in the delivery of constitutionally adequate medical care. The qualified immunity defense also compounds other existing barriers, such as higher subjective intent standards and the Prison Litigation Reform Act, to asserting legal accountability of prison and jail administrators. In addition, the defense is not appropriate because medical care decisions by carceral actors are fundamentally different than traditional qualified immunity cases. Traditional qualified immunity cases usually involve discretionary decisions that are one-off, emergency, binary choices made by a single actor or unit of actors. In contrast, medical decisions in carceral settings are often serial, ongoing, and usually involve multiple decision makers, sometimes acting beyond their area of expertise. These significant differences between medical decisions in carceral settings and traditional qualified immunity decisions illustrate the practical difficulties for incarcerated plaintiffs and their families in holding prisons accountable for violating the U.S. Constitution. Recent developments refining the doctrine may lessen the negative impact of the defense on these civil rights claims, but they also do not address the core disconnect between the rationales justifying qualified immunity and its application in cases of severe injury or death from inadequate carceral healthcare.

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INTRODUCTION

Glenn Ford was released from death row in March 2014 after 29 years of wrongful conviction.[1] He only had fifteen months of freedom before his death in June 2015.[2] One month after his release, doctors diagnosed Mr. Ford with terminal cancer, a disease which he believed he developed while in prison and which went undiagnosed until he was able to obtain healthcare as a free man.[3] Mr. Ford spent much of his freedom after release undergoing radiation and chemotherapy, but his cancer was simply too advanced for successful treatment. Before his death, Mr. Ford filed a lawsuit against the warden and medical providers at Louisiana State Penitentiary, claiming

[1] Complaint at 2, Ford v. Caddo Par. Dist. Att'y's Off., No. 15-cv-00544 (W.D. La. Mar. 9, 2015), ECF No.1. The author is the executrix of the estate of Glenn Ford, and in that capacity is the substitute plaintiff in lawsuits originally filed by Mr. Ford addressing his wrongful prosecution, Order Granting Motion to Substitute Party at 1, Ford v. Caddo Par. Dist. Att'y's Off., No. 15-cv-00544 (W.D. La. Mar. 9, 2015), ECF No. 83, and the conditions of his confinement, including medical care, Order Substituting Plaintiff, Ford v. Cain, No. 15-cv-00136 (M.D. La. Sept. 9, 2015), ECF No. 84. All opinions in this essay are solely those of the author and not attributable to the estate.

[2] Mark Berman, *Innocent Man Who Spent 30 Years on Death Row Died Hours Before Supreme Court Justices Cited Him*, WASH. POST (June 29, 2015), https://www.washingtonpost.com/news/post-nation/wp/2015/06/29/innocent-man-who-spent-30-years-on-louisianas-death-row-died-shortly-before-supreme-court-mentioned-him/ [https://perma.cc/P8HX-ZS2W].

[3] Complaint at 2, 3, Ford v. Cain, No. 15-cv-00136, (M.D. La. Mar. 9, 2015), ECF No. 1.

inadequate medical healthcare.[4] Defendants answered his complaint by arguing, among other things, that their actions were "protected by qualified immunity."[5] Glenn Ford died at home surrounded by friends—his body decimated by cancer and a shell of his former robust physical self.

Criticism of the qualified immunity doctrine often focuses on how it shields government actors, especially those acting in bad faith, from legal liability for harms that occur during performance of their official duties.[6] This Article argues that for incarcerated people, the qualified immunity doctrine compounds other barriers to asserting legal accountability of prison and jail administrators. These barriers are particularly high in cases alleging inadequate medical care, including deaths due to inadequate medical care while incarcerated. In these cases, not only do incarcerated people and their families face higher and more stringent standards for proving inadequate medical care, but they must also survive qualified immunity standards to win their lawsuits against prison officials.

This Article examines qualified immunity within the context of serious medical illness and deaths in prisons and jails, as medical illnesses are the leading cause of deaths behind bars.[7] Part I discusses deaths in prison due to medical illness, including the applicable standards for allegations of constitutionally inadequate medical care. In short, plaintiffs must prove that prison officials acted with "deliberate indifference" to an incarcerated person's serious medical needs to prove constitutionally inadequate medical care. Plaintiffs must also prove that the medical care violated law "clearly established" at the time of the violation to overcome a qualified immunity defense. Part II analyzes the application of qualified immunity to claims of death and inadequate healthcare and the difficulties in establishing when

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[4] *Id.* at 3.

[5] Answer on Behalf of Dr. Thomas Demars and Dr. John D. Sparks with Jury Demand at 1, Ford v. Cain, No. 15-cv-00136 (M.D. La. June 21, 2016), ECF No. 110.

[6] *See* Joanna C. Schwartz, *How Qualified Immunity Fails*, 127 YALE L.J. 2, 66 (2017). For general background on the ways that qualified immunity doctrine fails to achieve the policy goals articulated by the U.S. Supreme Court, see Joanna C. Schwartz, *The Case Against Qualified Immunity*, 93 NOTRE DAME L. REV. 1797, 1803–14 (2018).

[7] E. ANN CARSON, BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., MORTALITY IN STATE AND FEDERAL PRISONS 2001–2018—STATISTICAL TABLES 2 (2021), https://bjs.ojp.gov/content/pub/pdf/msfp0118st.pdf [https://perma.cc/JL4Y-7D5Y] [hereinafter MORTALITY IN STATE AND FEDERAL PRISONS]; E. ANN CARSON, BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., MORTALITY IN LOCAL JAILS 2001–2018—STATISTICAL TABLES 6 tbl.1 (2021), https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf [https://perma.cc/JL4Y-7D5Y] [hereinafter MORTALITY IN LOCAL JAILS 2001–2018] (listing number of deaths per year in 2000 and 2008–2018).

medical decisions violate clearly established law. Part III focuses on cases limiting the scope of qualified immunity and their implications for medically-related deaths behind bars.

I. MEDICALLY-RELATED DEATHS IN CARCERAL SPACES

The leading cause of death in carceral spaces (including jails and prisons) is medical illness.[8] According to the Bureau of Justice Statistics, from 2001 to 2018, 86,173 people died nationwide in jails and federal and state prisons.[9] The vast majority of these deaths are due to "natural causes," such as deaths due to illnesses including "heart disease, cancer, liver disease, and AIDS-related deaths."[10] In state prisons, 87% of deaths were due to illness; in federal prisons, 90%.[11] In local jails, approximately half of all deaths of incarcerated people were due to illness.[12] In Louisiana, where Glenn Ford was wrongfully sentenced to death row, there were at least 786 deaths in prisons, jails, and detention centers 2015–2019, of which 86% were due to illness.[13] Of those deaths related to medical illness, 42% were due to heart disease and 20% were due to cancer, which appears generally consistent with national studies indicating heart disease as a leading medical cause of

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[8] MORTALITY IN STATE AND FEDERAL PRISONS, *supra* note 7, at 1; MORTALITY IN LOCAL JAILS, *supra* note 7, at 6 tbl.1.

[9] National death data was compiled from the following three resources: MORTALITY IN STATE AND FEDERAL PRISONS, *supra* note 7, at 1 (reporting 67,874 deaths in federal and state prisons); MORTALITY IN LOCAL JAILS, *supra* note 7, at 6 tbl.1 (reporting a total of 11,106 deaths from 2008–2018); MARGARET NOONAN, BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., MORTALITY IN LOCAL JAILS 2000–2007, 7 tbl.8 (2010), https://bjs.ojp.gov/content/pub/pdf/mlj07.pdf [https://perma.cc/8CZX-Q9R7] (listing total number of deaths 2000–2007; for the years 2001–2007, 7,193 people died in custody in jails). Thus, the total number of deaths in jails 2001–2018 is 18,299.

[10] MORTALITY IN STATE AND FEDERAL PRISONS, *supra* note 7, at 1.

[11] *See id.* at 2.

[12] *See* MORTALITY IN LOCAL JAILS 2001–2018, *supra* note 7, at 6 tbl.1 (noting the average percentage of deaths due to illness is 49% from 2008–2018); NOONAN, *supra* note 9, at 7 tbl.8 (noting the average percentage of deaths due to illness is 52% from 2001–2007).

[13] *See* ANDREA ARMSTRONG, LOUISIANA DEATHS BEHIND BARS 2015–2019 19 (2021), https://www.incarcerationtransparency.org/wp-content/uploads/2021/06/LA-Death-Behind-Bars-Report-Final-June-2021.pdf [https://perma.cc/TR7J-6QYS].

death in jails, state and federal prisons.[14] Cancer is the leading cause of death for medical deaths nationwide in state and federal prisons.[15]

However, describing these deaths as due to "natural causes" obscures the carceral health providers' role in detecting, diagnosing and treating these diseases. In Louisiana, less than half of medically-related deaths (47%) were due to an illness or condition diagnosed prior to incarceration.[16] For the remaining 53%, prison and jail administrators indicated that the illness leading to death was *not* due to a pre-existing condition.[17] Indeed, 59% of all cancer deaths of incarcerated people and 52% of all heart deaths in Louisiana carceral settings were initially diagnosed by prison and jail healthcare systems.[18] Illnesses leading to death, other than cancer and heart disease, were similarly less likely to be due to a pre-existing condition, including illnesses involving the brain, respiratory systems, and deaths due to sepsis.[19] Miscellaneous deaths, described as "all other," were also less likely to be due to a pre-existing condition, and this category includes deaths due to surgical complications (hernias in particular), gastric ulcers, Alzheimer's, and ketoacidosis, among others.[20] Thus, for more than half of illnesses leading to deaths in prisons and jails in Louisiana, carceral healthcare providers were the sole source for diagnosis. For all deaths of incarcerated people, carceral healthcare providers were the sole source of treatment.

A. INCARCERATED HEALTHCARE

Local and state jurisdictions differ in how they provide healthcare for incarcerated people. Some jails and prisons contract for healthcare with

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[14] *See id*. at 20 (reviewing Louisiana deaths 2015–2019); *see also* MORTALITY IN LOCAL JAILS 2001–2018, *supra* note 7, at 12 tbl.8 (reviewing deaths 2008–2018, with heart disease the largest category of illness related deaths); MORTALITY IN STATE AND FEDERAL PRISONS, *supra* note 7, at 12 tbl.10 (reviewing deaths 2001–2018, with heart disease being the second largest category of illness related deaths).

[15] *See* MORTALITY IN STATE AND FEDERAL PRISONS, *supra* note 7, at 7 tbl.2.

[16] *See* ARMSTRONG, *supra* note 13, at 26.

[17] *See id.*

[18] *Id*.

[19] *Id*.

[20] *Id*. at 20, 26; *Louisiana Deaths Behind Bars: 2015–2019 Dataset*, INCARCERATION TRANSPARENCY, https://www.incarcerationtransparency.org/?page_id=3837 [https://perma.cc/KM6C-8BPE].

private corporations[21] such as Correct Health,[22] Corizon Correctional Healthcare,[23] and Wellpath,[24] among others. Corizon, for example, provides healthcare in the carceral settings at over 140 locations in fifteen states, covering approximately 116,000 people.[25] As of 2018, private healthcare companies are responsible for healthcare in 62% of the nation's 523 largest jails.[26] Other carceral settings create their own internal correctional healthcare system by directly hiring healthcare professionals. Louisiana's Department of Public Safety and Corrections' (DPSC) Chief Medical and Mental Health Director oversees healthcare services provided at the eight state-managed prisons.[27] Healthcare staff are employees of DPSC, but the agency also contracts with outside providers for specialty or part-time services.[28] Some jurisdictions use their existing state and local healthcare systems to provide healthcare for incarcerated people. For example, Cook County Jail in Chicago, Illinois provides healthcare through an affiliate of

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[21] *See* Jason Szep, Ned Parker, Linda So, Peter Eisler & Grant Smith, *U.S. Jails are Outsourcing Medical Care—and the Death Toll is Rising*, REUTERS (Oct. 26, 2020, 11:00 AM), https://www.reuters.com/investigates/special-report/usa-jails-privatization/ [https://perma.cc/C5VX-EEK5].

[22] *Our Clients*, CORRECT HEALTH, http://correcthealth.org/our-clients/ [https://perma.cc/2NEM-L5QQ].

[23] CORIZON HEALTH, http://www.corizonhealth.com [https://perma.cc/7ART-XLSY].

[24] *Divisions*, WELLPATH, https://wellpathcare.com/divisions/ [https://perma.cc/DX6A-7KJE].

[25] Szep, Parker, So, Eisler & Smith, *supra* note 21.

[26] *Id.*

[27] *See* Plaintiffs' Proposed Findings of Fact and Conclusions of Law at 8, Lewis v. Cain, No. 15-cv-00318 (M.D. La. Apr. 17, 2019), ECF No. 557 (noting the statewide medical director's job as "run[ning] healthcare operations" for the department); *see also* Addy Baird, *Louisiana Bars Problem Doctors from Practicing Medicine in Most Hospitals. So They Treat Incarcerated People Instead.*, BUZZFEED NEWS (May 10, 2021, 2:28 PM), https://www.buzzfeednews.com/article/addybaird/louisiana-prison-doctors-licenses-suspended [https://perma.cc/378J-YEU2].

[28] *See, e.g.*, Lewis v. Cain, No. 15-cv-00318, 2021 WL 1219988, at *6 (M.D. La. Mar. 31, 2021) ("Specialty care is provided at LSP [Louisiana State Penitentiary] in one of two ways: either a panel of specialists who come to LSP or outside specialists to whom LSP refers patients."); *see* ANDREA ARMSTRONG, BRUCE REILLY & ASHLEY WENNERSTROM, ADEQUACY OF HEALTHCARE PROVIDED IN LOUISIANA STATE PRISONS 1, 3 (2021), https://www.incarcerationtransparency.org/wp-content/uploads/2021/05/Adequacy-of-Healthcare-Provided-in-Louisiana-State-Prisons.pdf [https://perma.cc/HY4P-NZKL] (assessing the challenges for healthcare in Louisiana State prisons in study brief requested by the legislature in H. Con. R. 91, 2020 Leg., Reg. Sess. (La. 2020)).

the Cook County Bureau of Health Services and all clinical and support staff are public employees.[29]

The type of provider may impact the quality of care. A Reuters Investigation of medically-related deaths in the largest jails nationwide found higher death rates in facilities with privately managed care than publicly managed healthcare.[30] Regardless of the entity providing care, incarcerated people are not free to choose their healthcare provider, arrange for second opinions, or seek care outside of whichever system their facility has employed.

Incarcerated people may also encounter other obstacles to receiving healthcare, including requirements for medical co-pays. The majority of states charge incarcerated people a fee to see a healthcare professional, often referred to as a "co-pay" or "co-payment."[31] Prisons and jails nationwide justify imposing co-pays on incarcerated people for medical services to "raise revenue," "deter frivolous medical claims," and "teach[] them lessons in money management."[32] While there is little evidence to support these justifications,[33] correctional healthcare experts (including formerly incarcerated people) worry that co-pays can be an obstacle to obtaining healthcare behind bars.[34] In a May 2021 report, based on a review of Louisiana state policies, internal and external audits, and interviews with external health providers, the authors (including myself) calculated that the required medical co-pay of $3 was the real world equivalent of $1,087 for a sick visit.[35] For emergency medical visits, the real world equivalent of a $6

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[29] ILL. GUARDIANSHIP & ADVOC. COMM'N, HUM. RTS. AUTH.—CHI. REGION, REPORT 15-030-9002: CERMAK HEALTH SERVICES OF COOK COUNTY 1 (2015), https://www2.illinois.gov/sites/gac/HRA/Reports/2015/15-030-9002.pdf [https://perma.cc/HV9U-YELS].

[30] Szep, Parker, So, Eisler & Smith, *supra* note 21.

[31] Tiana Herring, *Prisons Shouldn't Be Charging Medical Co-Pays—Especially During a Pandemic*, PRISON POL'Y INITIATIVE: BRIEFINGS (Dec. 21, 2020), www.prisonpolicy.org/blog/2020/12/21/copay-survey [https://perma.cc/ULT6-6TEN].

[32] Rachael Wiggins, *A Pound of Flesh: How Medical Copayments in Prison Cost Inmates Their Health and Set Them Up for Reoffense*, 92 COLO. L. REV. 255, 263 (2021).

[33] *Id*. at 263–73.

[34] *See, e.g.*, Charging Inmates a Fee for Health Care Services, NAT'L COMM'N ON CORR. HEALTH CARE, www.ncchc.org/charging-inmates-a-fee-for-health-care-services [https://perma.cc/4KGP-XZBG] (last updated Nov. 2017); Michelle Pitcher, *Should Prisoners Have to Pay for Medical Care During a Pandemic?*, MARSHALL PROJECT (Nov. 2, 2020, 6:00 AM), www.themarshallproject.org/2020/11/02/should-prisoners-have-to-pay-for-medical-care-during-a-pandemic [https://perma.cc/WM4J-P2BE].

[35] ARMSTRONG, REILLY & WENNERSTROM, *supra* note 28, at 4. We calculated the real world minimum wage equivalent by dividing the co-pay of $3 by the incentive wage of 2¢ an

co-pay was $2,175, while $2 prescription co-pays were $725.[36] Though state policy provides that no incarcerated person will be denied healthcare due to lack of funds, those charges become legal debts that can be deducted from future prison earnings or collected after release.[37] In light of these costs, incarcerated people may forgo healthcare until their illness more deeply impacts their daily life.[38]

Second, prison and jail healthcare systems are oriented toward sickness and symptoms, not wellness and health. Incarcerated people usually do not have annual checkups or other preventative visits with healthcare professionals that are available to free people.[39] Instead, carceral healthcare is set up to respond to "sick call" requests by incarcerated people to address urgent or immediate symptoms.[40] In Louisiana, for example, state prison policies only provide for annual checkups for adults 50 years and older and even then, state audits indicate these check-ups are not consistently completed.[41] The single largest group of incarcerated decedents in Louisiana were Black males, ages fifty-five to sixty, serving a sentence for conviction, comprising 11% of all known deaths 2015–2019.[42] Black people in particular, due to disparities in healthcare access, wealth, and healthy living

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hour paid for field labor and then multiplied the number of hours it would take to earn the co-pay by the federal minimum wage. *Id.* For example, to earn $3, an incarcerated person would have to work 150 hours in the field. *Id.* We then multiplied the federal minimum wage of $7.25 by the number of hours (150) to conclude a real world equivalent cost of $1,087. *Id.*

[36] *Id.*

[37] LA. DEP'T OF PUB. SAFETY & CORR., HEALTH CARE CO-PAYMENT 1, 2 (2009), https://www.incarcerationtransparency.org/wp-content/uploads/2021/05/HEALTH-CARE-CO-PAYMENT.pdf [https://perma.cc/9Y2N-B2NJ]; *see also* Katie Rose Quandt & James Ridgeway, *At Angola Prison, Getting Sick Can Be a Death Sentence*, IN THESE TIMES (Dec. 20, 2016), https://inthesetimes.com/features/angola-prison-healthcare-abuse-investigation.html [https://perma.cc/3XC2-ZMVN] (quoting Francis Brauner, formerly incarcerated at Angola, "If you ever do get money, they take all that money to pay toward your medical bill. And if you don't, and you leave prison, it follows you.").

[38] *See* Christopher Zoukis, *Co-pays Deter Prisoners from Accessing Medical Care*, PRISON LEGAL NEWS (Jan. 31, 2018), www.prisonlegalnews.org/news/2018/jan/31/co-pays-deter-prisoners-accessing-medical-care/ [https://perma.cc/5PN8-VL8Q].

[39] *See* Glenn Ellis, *Examining Health Care in U.S. Prisons*, PHILA. TRIB. (Mar. 25, 2017), https://www.phillytrib.com/news/examining-health-care-in-u-s-prisons/article_43520055-789e-52a9-aed5-eaf1c75c7c36.html [https://perma.cc/TJ7T-YP5R].

[40] *See* Jasmine Villanueva-Simms, *Mind the Gap—The Prisoner as an Organ Recipient: A Review of the Practical Barriers Between Prisoners and Organ Transplants*, 14 J. HEALTH & BIOMEDICAL L. 149, 156–58 (2018) (outlining federal sick call process).

[41] ARMSTRONG, REILLY & WENNERSTROM, *supra* note 28, at 4–5.

[42] ARMSTRONG, *supra* note 13, at 4.

spaces,[43] may enter incarceration with greater health needs. Thus, these annual visits are even more important for a population disproportionately impacted by incarceration.[44]

Third, many states allow healthcare professionals to practice medicine on incarcerated patients on "restricted" or "suspended" licenses.[45] These same healthcare providers are simultaneously prohibited from practicing outside of prisons and jails because of violations of their license's code of conduct.[46] One investigation found that ten out of twelve physicians hired by Louisiana State Penitentiary lost their license to practice outside of carceral settings due to disciplinary violations—including illegal distribution of narcotics, sexual misconduct, and possession of child pornography.[47] This appears to be a common practice in the United States and not just for state-managed correctional healthcare.[48] In Alabama, where healthcare is provided through a contract with Corizon, twelve out of thirty physicians "either had current or prior restrictions of their license, prior adverse reports from the medical board, or had lost privileges either entirely or on a temporary basis,"

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[43] *See generally* Dorothy E. Roberts, *The Most Shocking and Inhuman Inequality: Thinking Structurally About Poverty, Racism, and Health Inequities*, 49 UNIV. OF MEMPHIS L. REV. 167 (2018) (arguing that structural causes of racism and poverty create health inequities).

[44] *See* Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2020*, PRISON POL'Y INITIATIVE (Mar. 24, 2020) (noting Black people are 40% of incarcerated populations, but only 13% of the U.S. population).

[45] Keri Blakinger, *Disgraced Doctors, Unlicensed Officials: Prisons Face Criticism Over Health Care*, NBC NEWS (July 1, 2021, 5:00 AM), https://www.nbcnews.com/news/us-news/disgraced-doctors-unlicensed-officials-prisons-face-criticism-over-health-care-n1272743 [https://perma.cc/XG2C-3CW7].

[46] *See id*.

[47] Baird, *supra* note 27.

[48] A sample of states with documented cases hiring disciplined healthcare staff includes: Alabama, *see* MICHAEL PUISIS, S. POVERTY L. CTR., ALABAMA DEPARTMENT OF CORRECTIONS MEDICAL PROGRAM REPORT 21–22 (2016), https://www.splcenter.org/sites/default/files/documents/doc._555-3_-_expert_report_of_dr._michael_puisis.pdf [https://perma.cc/RCD6-Y77W]; Louisiana, *see* Baird, *supra* note 27; Oklahoma, *see* Andrew Knittle, *Oklahoma Corrections Department Officials Say Prison Doctors Aren't Shackled by Past Problems*, OKLAHOMAN (Sept. 27, 2016, 12:00 AM), https://www.oklahoman.com/article/5519744/oklahoma-corrections-department-officials-say-prison-doctors-arent-shackled-by-past-problems [https://perma.cc/TY9P-5HM6]; Georgia, *see* Danny Robbins, *Georgia Hires Prison Doctors with Troubled Pasts*, ATLANTA J.-CONST. (Dec. 12, 2014), https://www.ajc.com/news/state--regional-govt--politics/georgia-hires-prison-doctors-with-troubled-pasts/ihz49tyMbWg9dKLu1vt2CI/ [https://perma.cc/4ZPG-6JVW]; Illinois, *see* Taylor Elizabeth Eldridge, *Why Prisoners Get the Doctors No One Else Wants*, APPEAL (Nov. 8, 2019), https://theappeal.org/why-prisoners-get-the-doctors-no-one-else-wants/ [https://perma.cc/H5V5-SP3H].

according to the Southern Poverty Law Center.[49] This practice is specifically against guidance issued by the National Commission on Correctional Health Care, which recommends all healthcare staff in carceral settings be fully licensed.[50] More broadly, advocates and formerly incarcerated people have also argued that prisons have improperly used "nonmedical" staff to triage and treat incarcerated patients.[51]

Finally, chronic and long-term diseases,[52] such as cancer, heart and kidney disease, require ongoing care, often involving specialty healthcare that may not be available in carceral settings.[53] In these cases, correctional healthcare staff must order and then coordinate the appointments with external medical providers.[54] But in Louisiana, for example, American Correctional Association audits revealed that none of eight state-managed prisons completed 100% of the specialty consults ordered by prison physicians over a twelve-month period.[55] At one Louisiana prison, which has the largest budget for carceral healthcare relative to other prisons in the

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[49] PUISIS, *supra* note 48, at 21.

[50] NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JAILS 50 (2018) ("A license that limits practice to only correctional healthcare is not in compliance with this standard.").

[51] *See, e.g.*, JC Canicosa, *In Five Years, 786 People Died in Louisiana's Jails and Prisons, a New Report Finds*, LA. ILLUMINATOR (June 2, 2021, 1:25 PM), www.lailluminator.com/2021/06/02/in-five-years-786-people-died-in-louisianas-jails-and-prisons-a-new-report-finds/ [https://perma.cc/4G8S-QKA9] (quoting Norris Henderson, who was formerly incarcerated at Angola); *see also* Complaint at 3, 22, 40, Lewis v. Cain, No. 15-cv-00318 (E.D. La. May 20, 2015), ECF No. 1; *Norris Henderson*, VOICE OF THE EXPERIENCED, https://www.vote-nola.org/norris-henderson.html [https://perma.cc/4344-GSBS] (introducing Norris Henderson, founder of Voice of the Experienced, who was wrongfully incarcerated for 27 years).

[52] This discussion does not include mental health diseases, which can also be long-term illnesses and can result in suicide. *See generally* Louise Brådvik, *Suicide Risk and Mental Disorders*, 15 INT'L J. ENV'T RSCH. & PUB. HEALTH 2028 (2018). The data collected do not allow for determinations of whether suicides are deemed to be the result of a pre-existing condition, which is the focus of this Article.

[53] *See* KIL HUH, ALEX BOUCHER, STEPHEN FEHR, FRANCES MCGAFFEY, MATT MCKILLOP & MARIA SCHIFF, PEW CHARITABLE TRUSTS, STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE 2 (2018), https://www.pewtrusts.org/-/media/assets/2018/07/prisons-and-hospital-care_report.pdf [https://perma.cc/EMY3-PTSZ].

[54] *See id.* at 6–8 (discussing different state approaches to approval and review processes for external hospital treatment).

[55] ARMSTRONG, REILLY & WENNERSTROM, *supra* note 28, at 7.

state,[56] only 50% of ordered specialty consults were completed.[57] Obstacles for ensuring proper specialty care include receiving approval from headquarters for budgetary purposes, lack of availability for transport staff, and communication between medical and security staff.[58] These challenges are even more important given that approximately half of these illnesses in Louisiana develop after admission to jail or prison.[59] Interviews with external health providers, conducted as part of a 2021 legislative study of prison healthcare in Louisiana, underscore the gravity of the data. Interviewees agreed that incarcerated patients initially present more advanced stages of disease at earlier ages than their non-incarcerated patients.[60]

B. STANDARDS FOR INCARCERATED HEALTHCARE CLAIMS

Amongst these significant challenges to access and quality healthcare services, litigation to address wrongful deaths and inadequate healthcare must surmount higher than normal legal standards.

Incarcerated people have a constitutional right to adequate medical and mental healthcare consistent with the level of care provided outside of prisons.[61] In 1976, the U.S. Supreme Court held that the government is obligated "to provide medical care for those whom it is punishing by incarceration" in *Estelle v. Gamble*.[62] Mr. J.W. Gamble, who was convicted and incarcerated in Texas, was injured while forced to work unloading bales of cotton.[63] After being punished with solitary confinement for refusal to work after continued medical complaints, he sued claiming the refusal to

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[56] The medical operating budget for Louisiana State Penitentiary (LSP) for FY 2020 is $24,647,905, the highest listed for all prisons. *See* LA. DEP'T PUB. SAFETY & CORR., BUDGET, FISCAL YEAR 2020 (2019) (on file with author). Similarly, medical expenditures are also the highest among all state prisons at $26,048,831. *Id.*

[57] ARMSTRONG, REILLY & WENNERSTROM, *supra* note 28, at 3.

[58] *See generally* HUH, BOUCHER, FEHR, MCGAFFEY, MCKILLOP & SCHIFF, *supra* note 53, at 6, 11 (discussing different state prison approaches to providing healthcare and identifying challenges).

[59] *See* ARMSTRONG, *supra* note 13, at 26.

[60] *See* ARMSTRONG, REILLY & WENNERSTROM, *supra* note 28, at 4–5.

[61] *See e.g.*, Estelle v. Gamble, 429 U.S. 97, 103 (1976); Farmer v. Brennan, 511 U.S. 825, 832 (1994); Brown v. Plata, 563 U.S. 493, 510–11, 545 (2011); *see also* Edmo v. Corizon, Inc., 935 F.3d 757, 786 (9th Cir. 2019), *cert. denied sub nom.* Idaho Dep't of Corr. v. Edmo, 141 S. Ct. 610 (2020) ("Accepted standards of care and practice within the medical community are highly relevant in determining what care is medically acceptable and unacceptable.").

[62] 429 U.S. at 103.

[63] *Id.* at 99.

provide adequate medical care violated the U.S. Constitution's prohibition on "cruel and unusual punishment" under the Eighth Amendment.[64] Though Mr. Gamble's specific claim failed,[65] the Court subsequently affirmed the broader government obligation to provide medical and mental healthcare in *Farmer v. Brennan*[66] and *Brown v. Plata*,[67] among other cases.

Unfortunately, the courts have not clearly defined a standard for "adequate" medical treatment. Instead, medical services available to incarcerated individuals are merely required to be at a level "reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards."[68] Moreover, courts are often reticent to "second guess" medical decisions and "constitutionalize" medical claims.[69]

To enforce the right to constitutionally-adequate healthcare, incarcerated people must overcome a series of hurdles created by the Prison Litigation Reform Act (PLRA).[70] The PLRA erects several barriers to litigation, including requiring exhaustion of administrative complaint procedures and limiting attorney's fees.[71] Research by Professor Margo

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[64] *Id.* at 99–101.

[65] *Id.* at 107–08. Mr. Gamble's claim failed because the actions taken by the prison, including seventeen medical visits, did not establish that the state was "deliberately indifferent" to his medical need. *Id.*

[66] 511 U.S. at 825, 832 (noting obligation to provide medical care under the Eighth Amendment while addressing Eighth Amendment claim of failure by prison officials to protect petitioner, an incarcerated preoperative transwoman, from assault).

[67] Brown v. Plata, 563 U.S. 493, 511 (2011) ("A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.").

[68] United States v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987); *see also* Kosilek v. Maloney, 221 F. Supp. 2d 156, 160 (D. Mass. 2002) ("Adequate care requires treatment by qualified personnel, who provide services that are of a quality acceptable when measured by prudent professional standards in the community. Adequate care is tailored to an inmate's particular medical needs and is based on medical considerations.").

[69] Joel H. Thompson, *Today's Deliberate Indifference: Providing Attention Without Providing Treatment to Prisoners with Serious Medical Needs*, 45 HARV. C.R.-C.L. L. REV. 635, 638 (2010) (citing Westlake v. Lucas, 537 F.2d 857, 860 n.5 (6th Cir. 1976)).

[70] *See* 42 U.S.C. § 1997; *see also* Andrea C. Armstrong, *No Prisoner Left Behind: Enhancing Public Transparency of Penal Institutions*, 25 STAN. L. & POL'Y REV. 435, 461 (2014) (describing PLRA restrictive requirements generally). *See generally* Margo Schlanger, *Trends in Prisoner Litigation, as the PLRA Enters Adulthood*, 5. U.C. IRVINE L. REV. 153 (2015) (analyzing the impact of the PLRA on civil rights filings by incarcerated people).

[71] Andrea Fenster & Margo Schlanger, *Slamming the Courthouse Door: 25 Years of Evidence for Repealing the Prison Litigation Reform Act*, PRISON POL'Y INITIATIVE (Apr. 26,

Schlanger demonstrates that the PLRA has been highly effective at reducing civil rights litigation by incarcerated people since its passage in 1996.[72] In addition to these general hurdles to litigation, both incarcerated people and families of incarcerated decedents face more demanding standards when asserting claims of inadequate healthcare than non-incarcerated people.

Generally, a non-incarcerated person must prove that a healthcare professional acted "negligently" in the provision of care for a successful claim of medical malpractice.[73] Negligence only requires that a physician act contrary to what a "reasonable" physician would have done and is usually proven by showing the care provided was below the generally accepted standard of care.[74] A doctor does not have to intend to provide substandard care per se, but rather a non-incarcerated person must prove that the doctor acted inconsistently with accepted practices, policies, and standards.[75]

In contrast, incarcerated patients and families of decedents must prove "deliberate indifference."[76] Deliberate indifference is more akin to a standard of "recklessness," which requires that a healthcare professional subjectively and actively knew of the "substantial risk of serious harm" and nevertheless failed "to take reasonable measures" to avoid the harm.[77] "[W]hen some medical care is administered by officials, even if it arguably falls below the generally accepted standard of care, that medical care is often sufficient to rebut accusations of deliberate indifference."[78] The Fifth Circuit arguably established an even higher standard by requiring proof that "prison officials refused to treat him, ignored his complaints, intentionally treated him incorrectly, or engaged in any similar conduct that would clearly evince a wanton disregard for any serious medical needs."[79] "Unsuccessful medical

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2021), www.prisonpolicy.org/reports/PLRA_25.html [https://perma.cc/65GB-229J]; *see also* Easha Anand, Emily Clark & Daniel Greenfield, *How the Prison Litigation Reform Act Has Failed for 25 Years*, APPEAL (Apr. 26, 2021), www.theappeal.org/the-lab/explainers/how-the-prison-litigation-reform-act-has-failed-for-25-years [https://perma.cc/B9JK-BFNA].

[72] *See* Fenster & Schlanger, *supra* note 71.

[73] 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 331 (2021).

[74] *See id.*

[75] *Id.*

[76] Estelle v. Gamble, 429 U.S. 97, 104–06 (1976).

[77] Farmer v. Brennan, 511 U.S. 825, 836, 847 (1994) ("It is, indeed, fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk.").

[78] Burgos v. Phila. Prison Sys., 760 F. Supp. 2d 502, 508 (E.D. Pa. 2011).

[79] *See* Thomas v. Carter, 593 F. App'x 338, 342 (5th Cir. 2014) (quoting Gobert v. Caldwell, 463 F.3d 339, 346 (5th Cir. 2006)).

treatment, acts of negligence, or medical malpractice" are not sufficient to prevail in litigation challenging healthcare provided by correctional authorities.[80]

While Glenn Ford's lawsuit for inadequate medical care was ultimately voluntarily dismissed,[81] other federal cases illustrate the difficulty of establishing "deliberate indifference" for carceral healthcare for serious illnesses. These cases often fall into two categories: 1) failure to timely screen or diagnose and 2) failure to adequately treat post-diagnosis.

At least one circuit has held that the failure to timely screen or test can be a violation of the Eighth Amendment when it comes to communicable diseases.[82] However, that failure is often examined within the context of the impact of the delayed diagnosis.[83]

Yet, for other types of chronic illnesses, a "failure to timely diagnose" claim will be construed as a "failure to adequately treat" claim, which then fails. For example, in California, an incarcerated patient was diagnosed with hypertension in 2003 and complained of symptoms consistent with heart failure in 2015 but was treated for acid reflux.[84] In 2019, while incarcerated at a different prison, he was diagnosed with heart failure and scheduled for heart surgery.[85] In 2020, he sued alleging a "failure to diagnose and treat his heart condition" based on the 2003 and 2015 diagnoses.[86] The court instead treated his claim as a misdiagnosis, rather than a failure to timely screen, writing "[t]o the extent CDCR medical staff misdiagnosed Balderrama's condition in 2003 and 2015, even negligence constituting medical malpractice is not sufficient to establish an Eighth Amendment violation."[87] Similarly, in the Seventh Circuit, a plaintiff alleged failure to timely diagnose bladder cancer after sixteen months of treatment for complaints of blood in

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[80] Rogers v. Boatright, 709 F.3d 403, 410 (5th Cir. 2013) (quoting *Gobert*, 463 F.3d at 346).

[81] Order of Dismissal at 1, Ford v. Cain, No. 15-cv-00136 (M.D. La. June 13, 2017), ECF No. 140.

[82] Lareau v. Manson, 651 F.2d 96, 109 (2d Cir. 1981).

[83] *See* Andrew Brunsden, Comment, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform*, 54 UCLA L. REV. 465, 491 (2006) ("For the most part, courts have avoided the question of deliberate indifference by asking whether a delay in HCV diagnosis caused actual harm to the inmate.").

[84] *See* Balderrama v. Cal. Dep't of Corr. & Rehab., No. CV 20-6052-JGB, 2020 WL 4260965, at *1 (C.D. Cal. July 24, 2020).

[85] *Id.*

[86] *Id.*

[87] *Id.* at *3.

his urine.[88] While the court acknowledged that it may be "regrettable" that prison doctors did not perform the diagnostic test earlier, the court relied on evidence that doctors provided treatment based on their hypotheses at the time, and that those hypotheses were not gross departures from the standard of care.[89]

Incarcerated people may develop serious life-threatening illnesses, but carceral healthcare systems are often ill-equipped to detect, diagnose, and treat these conditions. When carceral systems fail to provide adequate care, the consequences can be deadly, as incarcerated people are not free to arrange for their own healthcare or treatment. Litigation is less likely to be successful due to barriers like the PLRA and more onerous standards of proof for claims of inadequate medical care. Superimposed on top of these more stringent standards for claims of inadequate healthcare for serious medical needs, courts also impose the qualified immunity doctrine when the plaintiff seeks monetary damages as a remedy.

II. APPLYING QUALIFIED IMMUNITY TO WRONGFUL MEDICAL DEATHS AND SERIOUS MEDICAL NEEDS

Qualified immunity is a legal doctrine that protects government actors from monetary liability for harms that occur during performance of their official duties. The qualified immunity doctrine for civil rights violations emerged from cases primarily dealing with police and individual discretionary decisions. In 1967, the U.S. Supreme Court applied the defense of good faith to civil rights actions under 42 U.S.C. § 1983 in *Pierson v. Ray*.[90] In *Pierson,* which involved the arrest of religious ministers violating Mississippi segregation laws, the Court held that the defense of "good faith" was available to police officers alleged to have committed an unconstitutional arrest.[91] Subsequent cases applying *Pierson* to executive branch actions (as distinct from judicial or legislative branches) involve school administrator disciplinary decisions,[92] state hospital administrator

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[88] Duckworth v. Ahmad, 532 F.3d 675, 677 (7th Cir. 2008).

[89] *Id.* at 680–81.

[90] 386 U.S. 547, 557 (1967).

[91] *Id*.

[92] *E.g.*, Wood v. Strickland, 420 U.S. 308, 316–19 (1975) (clarifying the intent standard and applying immunity defense to school board decisions), *abrogated by* Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982) (adjusting the defense to require proof of violation of a "clearly established" law or right).

decisions rejecting petitions for release from indefinite civil commitment,[93] and prison official decisions on mail.[94] Two issues arise from a review of these early qualified immunity cases for claims of constitutionally inadequate medical care in carceral settings.

These early qualified immunity cases are premised on binary decisions and time-sensitive decision-making. First, these early cases concern individual binary decisions, such as the decision to arrest or the decision to refuse to mail a letter sent by an incarcerated person.[95] The deciding government actor must choose whether or not an action (arrest, school discipline, confinement) should be taken.[96] However, medical decisions are different. They are rarely binary yes/no decisions. Instead, medical decisions are more akin to a decision tree. Each medical question, once answered, leads to a different decision point for additional action. Once diagnosed, the decision is often what types of treatment follow, not whether or not to treat. Moreover, the challenged healthcare is often a series of missed or failed decisions culminating in serious harm, compared to an individual binary choice.

Second, police qualified immunity cases in particular focus on the need for swift, in the moment, decision-making. Those decisions are protected, in part, because in time-pressured situations, courts have held that officials should be given the benefit of the doubt.[97] Accordingly, one of the aims of qualified immunity is to provide immunity where officials did not have prior notice that certain actions are prohibited.[98] However, many non-emergency medical decisions, particularly decisions on testing and diagnosis, are not similarly time pressured. Decisions on which tests to order for a non-emergency medical condition can be made after the healthcare visit is complete since the patient remains incarcerated (and therefore available) for future appointments. Diagnoses need not be immediate, but can evolve over

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[93] *See, e.g.*, O'Connor v. Donaldson, 422 U.S. 563, 576–77 (1975).

[94] *E.g.*, Procunier v. Navarette, 434 U.S. 555, 557, 561 (1978).

[95] *See Pierson*, 386 U.S. at 551–52 (describing the claim for unconstitutional arrest); *Procunier*, 434 U.S. at 557 (describing the claim that prison officials refused to mail specific letters from Mr. Navarette).

[96] *See Pierson*, 386 U.S. at 551–52; *Procunier*, 434 U.S. at 557; *Wood*, 420 U.S. at 312–14 (describing a school board member decision to expel students).

[97] *See, e.g.*, Donovan v. City of Milwaukee, 17 F.3d 944, 946, 951 (7th Cir. 1994) (noting the qualified immunity doctrine "gives public officials the benefit of legal doubts" and applying it to a police decision to engage in a high-speed chase resulting in the death of motorcyclists).

[98] *See* Butz v. Economou, 438 U.S. 478, 497–98 (1978).

time based on symptom prevalence or change and testing results. Treatment plans may be revised or adjusted based on a patient's response. None of these medical decisions are the traditional split-second decisions, particularly those involved in police use of force or arrest cases.

Furthermore, qualified immunity doctrine itself has changed over time, including shedding the requirement that a defendant prove the subjective element of "good faith."[99] Currently, to overcome a defendant prison official's claim of qualified immunity, a plaintiff must show 1) violation of a constitutional or statutory right and 2) that the right was clearly established at the time of the offense. The U.S. Supreme Court held that courts have discretion on the order of inquiry for the two prongs of qualified immunity analysis.[100] Thus, courts may look to whether a right was clearly established at the time of the harm without determining whether in fact there was a violation of the claimed right.[101]

Lower courts are increasingly taking up the Supreme Court's invitation to avoid unnecessary decisions on constitutional questions[102] by focusing on the second prong of the qualified immunity doctrine, namely whether a claimed right is "clearly established." "To be clearly established, a right must be sufficiently clear 'that every reasonable official would [have understood] that what he is doing violates that right.'"[103] In other words, "existing precedent must have placed the statutory or constitutional question beyond debate."[104] Courts examining whether a right is clearly established compare "the factual circumstances faced by the defendant to the factual circumstances of prior cases to determine whether the decisions in the earlier cases would have made clear to the defendant that his conduct violated the

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[99] *Compare Wood*, 420 U.S. at 1000–01 (indicating that the qualified immunity standard requires good faith), *with* Pearson v. Callahan, 555 U.S. 223, 231 (2009) (omitting the reference to good faith in the qualified immunity standard).

[100] *Pearson*, 555 U.S. at 236.

[101] *See, e.g.*, Reichle v. Howards, 566 U.S. 658, 664 (2012) (applying this approach and holding the right was not clearly established without addressing whether the right exists or was violated).

[102] *Pearson*, 555 U.S. at 241; *see* Karen M. Blum, *Qualified Immunity: Time to Change the Message*, 93 NOTRE DAME L. REV. 1887, 1893, 1896 (2018) (identifying cases in the Fourth, Fifth, Seventh, Eighth, Ninth, Tenth, and Eleventh Circuits).

[103] *Reichle*, 566 U.S. at 664 (quoting Ashcroft v. al-Kidd, 563 U.S. 731, 741 (2011)).

[104] *Id.*; *see also* Zach Lass, *Lowe v. Raemisch: Lowering the Bar of the Qualified Immunity Defense*, 96 DENV. L. REV. 177, 187–88 (2018) (noting this is a higher standard than the "fair warning" standard articulated by the U.S. Supreme Court in Hope v. Pelzer, 536 U.S. 730 (2002)).

law."[105] In addition,U.S. Supreme Court has said that precedent "must be 'particularized' to the facts of the case."[106]

A. QUALIFIED IMMUNITY APPLIED TO WRONGFUL DEATH FOR ILLNESS

If families can successfully prove deliberate indifference for inadequate healthcare, they have usually satisfied the first prong of the qualified immunity analysis. The second prong, however, requires more than a showing of deliberate indifference; instead, plaintiffs must prove that the right was clearly established at the time of the violation. Put another way, a claim for inadequate medical treatment can be found deliberately indifferent, in part because "contemporary standards and opinions of the medical profession also are highly relevant in determining what constitutes deliberate indifference to medical care."[107] But to be clearly established, a prison's medical provider must also have notice that courts or other authoritative bodies have previously held those same professional standards to be legally binding or required, since one of the key rationales of qualified immunity is prior notice for defendants of the care required.[108] Additionally, some courts have actively required evidence of "bad faith."[109]

In the Tenth Circuit, the failure to identify prior decisions from the Supreme Court or the Tenth Circuit was fatal for the plaintiff's claim of inadequate healthcare because of a seven day delay in the diagnosis of toxic

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[105] Sandoval v. Cnty. of San Diego, 985 F.3d 657, 674 (9th Cir. 2021); *see also Hope*, 536 U.S. at 741 ("Although earlier cases involving 'fundamentally similar' facts can provide especially strong support for a conclusion that the law is clearly established, they are not necessary to such a finding. The same is true of cases with 'materially similar' facts."); *id.* at 741–42 (reversing the circuit court grant of qualified immunity because prior cases gave "fair warning" that the conduct at issue violated the Constitution).

[106] White v. Pauly, 137 S. Ct. 548, 552 (2017) (quoting Anderson v. Creighton, 483 U.S. 635, 640 (1987)).

[107] Howell v. Evans, 922 F.2d 712, 719 (11th Cir. 1991), *vacated pursuant to settlement*, 931 F.2d 711 (11th Cir. 1991), *opinion reinstated sub nom.* Howell v. Burden, 12 F.3d 190 (11th Cir. 1994).

[108] *See, e.g.*, Roe v. Elyea, 631 F.3d 843, 858 (7th Cir. 2011) ("The basic question is whether the state of the law at the time that Dr. Elyea acted gave him reasonable notice that his actions violated the Constitution.").

[109] *See, e.g.*, Est. of Hammers v. Douglas Cnty., Kan. Bd. of Comm'rs, 303 F. Supp. 3d 1134, 1151 (D. Kan. 2018) ("While it is indeed clearly established that correctional facilities must provide adequate medical care to its inmates, it is not 'clearly established'—for purposes of qualified immunity—that Undersheriff Massey's policies and procedures [to address substance abuse withdrawal and protocols for medical assistance] violated this right.").

metabolic encephalopathy.[110] The plaintiff was treated by jail healthcare providers for symptoms of drug or alcohol withdrawal until his rapid deterioration led to hospitalization, where he received the correct diagnosis.[111] At issue was the decision to diagnose and treat Mr. Crowson without "first obtaining the results from a previously ordered blood test."[112] The blood test could have revealed a metabolic imbalance, which is consistent with symptoms of encephalopathy.[113] The Tenth Circuit held that the doctor's actions fell into a "grey area" among prior cases, and therefore could not "conclude that every reasonable official would have known it was a violation" to diagnose and treat without test results.[114]

Qualified immunity doctrine also shields prison-based healthcare from damages where advances in medical professionals' understanding of certain diseases is not reflected in prior cases. By relying on facts and decisions from prior cases instead of expert understanding at the time of the challenged actions, courts ensure that advances in knowledge and/or treatments are irrelevant to qualified immunity analysis. For example, in California, a plaintiff sued claiming that his 2009 placement in a prison within a region suffering a Valley Fever outbreak constituted deliberate indifference given his history of asthma and higher vulnerability to the disease as an African-American person.[115] At the time of his placement, California did not have restrictions on who could be placed in those facilities, but the guidelines that would have prohibited his placement were added in 2013.[116] The court held that it was not clearly established that plaintiff should be excluded from those facilities at the time of his placement.[117]

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[110] Crowson v. Washington Cnty., 983 F.3d 1166, 1183–84 (10th Cir. 2020); *see also* Karthik Kumar, *What is Metabolic Encephalopathy?*, MEDICINENET (Oct. 1, 2020), https://www.medicinenet.com/what_is_metabolic_encephalopathy/article.htm [https://perma.cc/5JXD-2TCN] ("Metabolic encephalopathy or toxic metabolic encephalopathy is a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body. Metabolic encephalopathies may be reversible if the preexisting disorders are treated. If left untreated, they may result in brain damage.").

[111] *Crowson*, 983 F.3d at 1173.

[112] *Id.* at 1182–84.

[113] *Id.* at 1175.

[114] *Id.* at 1183.

[115] Hines v. Youssef, No. 1:13-CV-0357, 2015 WL 2385095, at *1 (E.D. Cal. May 19, 2015), *aff'd in part, rev'd in part sub nom.* Hines v. Youseff, 914 F.3d 1218 (9th Cir. 2019).

[116] *Id.* at 4.

[117] *Id.* at 10.

The "clearly established" prong may also invite courts to construe asserted rights more narrowly in the qualified immunity context than they would for the primary constitutional claim. Though the general right to adequate healthcare is well acknowledged, in some cases the right asserted is broken down into constituent pieces. Plaintiffs in these courts must prove that certain diagnostic tests or treatments are embedded in the generally acknowledged right or that the delay in treatment caused serious harm. Put another way, plaintiffs have to prove the content of the right just as much as the existence of the right itself.

In a case involving the death of an incarcerated patient during withdrawal from narcotics, a district court in Oklahoma found that while "the right to custodial medical care is clearly established," the court also found that "there is no clearly established law that there is a constitutional requirement of a maximum time a person can be held for purposes of detoxification before they must be referred for physical or mental medical care."[118] Similarly, a district court in California concluded "although the law requires access to minimally adequate medical care, given that there is no precedent specifically on point the contour of the law does not 'clearly establish' a prisoners [sic] right to medivac services."[119] That court also denied qualified immunity without prejudice on a different count of the complaint alleging that the prison lacked appropriate emergency staffing.[120] In a different California case, the Ninth Circuit upheld the lower court's grant of qualified immunity, concluding "the specific right that the inmates claim in these cases—the right to be free from heightened exposure to Valley Fever spores—was not clearly established at the time."[121]

Cases concerning the treatment of Hepatitis C behind bars in the Third and Fourth Circuits indicate that not all courts apply this narrow approach requiring an exact precedent to prove the right was clearly established. In the Third Circuit, the prison defendant argued the right at stake for qualified immunity purposes was the "right to receive immediate treatment with direct-acting antiviral medication rather than monitoring and treatment under a

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[118] Grizzle v. Christian, No. CIV-16-254-SPS, 2018 WL 4286187, at *7, *8 (E.D. Okla. Sept. 7, 2018).

[119] Provencio v. Vazquez, 258 F.R.D. 626, 636 (E.D. Cal. 2009).

[120] *Id.* at 637.

[121] Hines v. Youseff, 914 F.3d 1218, 1229 (9th Cir. 2019), *cert. denied*, 140 S. Ct. 159 (2019).

prioritization protocol" for treatment of Hepatitis C.[122] The appellate court upheld the denial of summary judgment on qualified immunity grounds, construing the right as to be free of "delay[ed] necessary medical treatment for non-medical reasons."[123] Similarly, a district court in the Fourth Circuit rejected the narrow definition of the right advanced by the defendant.[124] Mr. Pfaller died of liver cancer while incarcerated in Virginia.[125] The defendant argued the right at issue was "the right of inmates with Hepatitis C to receive treatment with DAAs [direct acting antiviral drugs]."[126] The district court, relying on Fourth Circuit precedent in *Scinto*,[127] instead defined the right broadly as the right to "receive adequate medical care and to be free from officials' deliberate indifference to his known medical needs."[128]

B. UNIQUE BARRIERS CREATED BY QUALIFIED IMMUNITY FOR WRONGFUL DEATH OR ILLNESS

Applying qualified immunity to cases of serious medical needs with a high risk of death creates additional barriers for plaintiffs seeking damages. First, in medical care cases, as compared to police use of force cases for example, plaintiffs are often attempting to prove the absence of government action, such as constitutionally-required healthcare.[129] In many cases, plaintiffs' claims of deliberate indifference to serious medical needs are not botched services, but the failure to timely diagnose or treat an illness in the first place. Delays in treatment, standing alone, do not establish a violation

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[122] *See* Abu-Jamal v. Kerestes, No. 3:15-CV-967, 2018 WL 2166052, at *16 (M.D. Pa. May 10, 2018), *aff'd in part, dismissed in part*, 779 F. App'x 893 (3d Cir. 2019).

[123] *Abu-Jamal*, 779 F. App'x at 900.

[124] *See* Pfaller v. Clarke, No. 3:19cv728, 2021 WL 1776189, at *10 (E.D. Va. May 4, 2021).

[125] *Id.* at *1.

[126] *Id.* at *10.

[127] Scinto v. Stansberry, 841 F.3d 219, 235–36 (4th Cir. 2016).

[128] *Pfaller*, 2021 WL 1776189, at *10.

[129] *See* Thompson, *supra* note 69, at 642–47 (describing how prison health providers "do not test," or "test once and stop," or "delay" to implicitly deny care). *Compare* Brosseau v. Haugen, 543 U.S. 194, 194–97 (2004) (upholding qualified immunity for the defendant police officer accused of excessive use of force in shooting a suspect fleeing in an automobile because it was not clearly established), *with* Lewis v. Cain, No. 15-cv-318, 2021 WL 1219988, at *5–17, *39–40 (M.D. La. Mar. 31, 2021) (detailing the findings of the absence of constitutionally-mandated care in clinical care, specialty care, infirmary/in-patient care, sick call, emergency care, and chronic care, and finding prison officials failed to provide meaningful access to care).

of a known constitutional right.[130] Thus, plaintiffs must prove that *Estelle* and its progeny require, for example, early detection or testing for certain diseases, preventative healthcare, and certain types of treatments for chronic illnesses, to survive a defense of qualified immunity.

Second, decisions being challenged in carceral medical care cases are often not single, isolated decisions, but instead a series of decisions. The typical qualified immunity case is focused on affirmative and single acts by a government actor.[131] In contrast, for carceral medical care cases, a plaintiff must prove that a series of failures to act by a government actor creates liability.[132] For example, the one-time decision whether or not to arrest is very different than the multiple medical decisions required to adequately diagnose and appropriately treat a serious medical decision.

Third, traditional qualified immunity is often focused on the decisions by a single actor or a unit of actors with similar expertise.[133] In medical care cases, healthcare is often delivered by various individuals, including physicians, nurses, physician assistants, and in some cases, custodial staff trained as emergency management technicians.[134] The actors may be more diffuse, involving multiple decision makers with different areas of expertise such as medical personnel like triaging healthcare staff and treatment staff, and non-medical decisionmakers such as security officials or administrative officials with budgetary decision making.

Fourth, the doctrine, as a policy matter, removes incentives for prisons and jails to proactively ensure their actions adhere to latest known advances in disease understanding and treatment. Overcoming qualified immunity

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[130] *See, e.g.*, Citrano v. Allen Corr. Ctr., 891 F. Supp. 312, 322 (W.D. La. 1995) (noting a delay of four days for injuries sustained by beatings by security guard did not lead to substantial harm).

[131] *See* discussion *infra* Part II.

[132] *Id.*

[133] *See, e.g.*, Pierson v. Ray, 386 U.S. 547, 551–52 (1967) (noting a claim against two police officers and one police captain allegedly acting in concert)); Wood v. Strickland, 420 U.S. 308, 312–14 (1975) (describing a claim against school board members acting together as a unit to render expulsion decision); O'Connor v. Donaldson, 422 U.S. 563, 567–70 (1975) (detailing a claim against hospital administrator who repeatedly made the same decision to deny release to a person involuntarily committed).

[134] *See e.g.*, Complaint at 38–41, Lewis v. Cain, No. 15-cv-00318 (M.D. La. May 20, 2015) (describing medical care staffing at Louisiana State Penitentiary and arguing staffing and qualifications are insufficient); *see also* Crowson v. Washington Cnty., 983 F.3d 1166, 1174 (10th Cir. 2020) ("Dr. LaRowe was responsible for diagnosing and treating inmates, but he visited the Jail only one or two days a week, for two to three hours at a time. Dr. LaRowe relied heavily on the Jail's deputies and nurses.").

depends on being able to prove that the law—and not necessarily best practices of a profession—which requires certain decisions for medical treatment through an examination of prior cases. However, emerging best practices, based on new understandings of science and disease progression, will not be reflected in prior cases. Since carceral healthcare remains protected until courts hold those emerging practices to be legally required, prisons and jails may choose to avoid incorporating those best practices into their healthcare systems.

Last, traditional qualified immunity usually involves a government actor making discretionary decisions within their area of expertise or training. This idea is arguably implicit in one of the rationales underlying qualified immunity, which is that the decision maker has prior notice that their act is illegal.[135] The rationale of prior notice assumes that the person is acting within the area that they have expertise or training in and it is through their familiarity with the subject matter in which they are making the decision, that they have prior notice. In the traditional police wrongful arrest case, the officer has been trained in arrest and therefore their decision to arrest is based on their prior training and expertise.[136] In carceral medical cases, there are examples of qualified immunity being granted for decisions made outside of their area of expertise or training.[137] This could also hypothetically be the case where, for example, a prison only employs general medicine doctors, who then are responsible for diagnosing and treating specialized diseases of incarcerated patients.

Prison medical care cases differ significantly from the traditional qualified immunity cases. Traditional qualified immunity cases usually involve discretionary decisions that are one-off, emergency, binary choices made by a single actor or unit of actors. In contrast, medical decisions in carceral settings are often serial, ongoing, and usually involve multiple decision makers, sometimes acting beyond their area of expertise. These

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[135] *See e.g.*, Saucier v. Katz, 533 U.S. 194, 206 (2001) (noting prior notice as rationale for qualified immunity), *modified*, Pearson v. Callahan, 555 U.S. 223, 227 (2009).

[136] *See, e.g.*, Kennedy v. City of Villa Hills, 635 F.3d 210, 215–16 (6th Cir. 2011) (noting the officer could not "reasonably believe that he had probable cause" for the arrest and affirming the district court denial of qualified immunity defense); *see also* Malley v. Briggs, 475 U.S. 335, 345–46 (1986) (requiring "reasonable professional judgment" in an application for an arrest warrant to invoke qualified immunity).

[137] *See Crowson*, 983 F.3d at 1174, 1180 (affirming a grant of qualified immunity where a nurse, who was not authorized to diagnose, only requested a psychological evaluation instead of a physiological evaluation, consistent with the nurse's belief that the incarcerated plaintiff's symptoms were "caused by the ingestion of illicit drugs or alcohol." The plaintiff was later diagnosed with toxic metabolic encephalopathy.).

significant differences between medical decisions in carceral settings and traditional qualified immunity decisions illustrate the practical difficulties for incarcerated plaintiffs and their families in holding prisons accountable for violating the U.S. Constitution. Furthermore, qualified immunity for these types of decisions also creates perverse incentives for administrators of carceral healthcare systems to only provide care recognized as constitutionally necessary in prior cases.

III. QUALIFIED IMMUNITY IN DISTRESS

In recent years, advocates, courts, and policy makers have increasingly criticized the scope and breadth of the qualified immunity doctrine. Several state legislatures considered legislation to reduce the applicability of the qualified immunity doctrine in *state courts*, particularly as it relates to police decisions, though few of the bills were actually adopted.[138] For federal civil rights claims, congressional efforts to abolish or limit qualified immunity have not yet been adopted.[139]

The U.S. Supreme Court, as well as most circuit courts, has also acted to limit the potential breadth of the qualified immunity defense as applied to prison and jail officials. In *Taylor v. Riojas*, a 2020 per curiam opinion, the U.S. Supreme Court overruled a Fifth Circuit opinion affirming the lower court's grant of qualified immunity for inhumane conditions of confinement.[140] The Fifth Circuit, similar to the Ninth Circuit,[141] had defined the right at issue narrowly for qualified immunity purposes.[142] The petitioner-plaintiff in *Taylor v. Riojas* claimed that jail officials forced Mr. Taylor to

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[138] *See e.g.*, H.R. 1727, 102d Gen. Assemb., Reg. Sess. (Ill. 2021); H.R. 609, 2021 Leg., Reg. Sess. (La. 2021). *But see* S.B. 20-217, 72d Gen. Assemb., 2d Reg. Sess. (Colo. 2020) (removing qualified immunity for civil rights claims in state court under the Colorado Constitution); H.R. 4, 2021 Leg., Reg. Sess. (N.M. 2021) (barring the qualified immunity defense for claims of violations of civil rights under the New Mexico Constitution).

[139] *See e.g.*, George Floyd Justice in Policing Act of 2021, H.R. 1280, 117th Cong. (2021); Ending Qualified Immunity Act, H.R. 1470, 117th Cong. (2021).

[140] Taylor v. Riojas, 141 S. Ct. 52, 53 (2020).

[141] *See* Hines v. Youssef, No. 1:13-CV-0357, 2015 WL 2385095, at *1 (E.D. Cal. May 19, 2015), *aff'd in part, rev'd in part sub nom.* Hines v. Youseff, 914 F.3d 1218 (9th Cir. 2019).

[142] Taylor v. Stevens, 946 F.3d 211, 222 (5th Cir. 2019), *cert. granted, judgment vacated sub nom.* Taylor v. Riojas, 141 S. Ct. 52 (2020) ("Though the law was clear that prisoners couldn't be housed in cells teeming with human waste for months on end . . . we hadn't previously held that a time period so short violated the Constitution.") (internal citations omitted).

sleep naked in a cell caked with excrement and later in a cell with flooded with raw sewage over a six day period in 2013.[143] The Fifth Circuit held that it was not "clearly established" that housing Mr. Taylor in "extremely dirty cells for only six days" was constitutionally prohibited, and accordingly affirmed the district court's ruling of qualified immunity for the correctional officers from Mr. Taylor's civil rights claim."[144] Though the Fifth Circuit found that there is a constitutional right to not be housed in "truly filthy, unsanitary cells,"[145] the Fifth Circuit also found that no prior case provided sufficient notice that a six-day stint—as compared to months on end—would violate the Constitution.[146]

The U.S. Supreme Court reversed in a per curiam opinion. Where the Fifth Circuit had focused on the number of days (and lack of cases identifying six days as the constitutional threshold), the Supreme Court looked instead to lack of emergency or necessity for being housed in such conditions in the first place.[147] The Supreme Court also noted the lack of efforts to mitigate the obvious unsanitary conditions, either by improving conditions or shortening the time frame.[148] While *Taylor* should help courts avoid the trap of finding an exact factual match from prior case law, the opinion, by referencing derogatory statements by the defendant prison guards,[149] also seems to invite additional inquiries into defendant's state of mind during the violation.

A second area of narrowing is also apparent in opinions deciding who may invoke qualified immunity for incarcerated healthcare. Jails in particular are increasingly contracting out healthcare services to private medical corporations such as Centurion, Correct Health, and Corizon Correctional Health Care.[150] A majority of circuits decided that these private corporations cannot claim qualified immunity for providing the same services as a state

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143 *Taylor*, 946 F.3d at 218–19; *Riojas*, 141 S. Ct. at 53.

144 *Stevens*, 946 F.3d at 217, 222.

145 *Id.* at 220.

146 *Id.* at 222.

147 *Riojas*, 141 S. Ct. at 54.

148 *Id.*

149 *Id.* (referencing remarks that "Taylor was 'going to have a long weekend'" and that "he hoped Taylor would 'f***ing freeze'") (citation omitted).

150 Szep, Parker, So, Eisler & Smith, *supra* note 21 (noting that the expansion of privatization of incarcerated healthcare in jails began in the 1990s and that the percentage of jails with privately managed healthcare rose from nearly half of all jails nationwide in 2010 to 62% by 2018).

entity.[151] In these states, private medical corporations risk greater liability and financial exposure than the state would if it provided the same services itself. This immunity preference for state actors over private actors, in light of the trend towards contracting with privately healthcare providers, may serve to at least limit the applicability of the qualified immunity doctrine for claims of constitutionally inadequate medical care by private medical providers.

The qualified immunity doctrine was developed and justified for a different set of circumstances than those involving carceral healthcare decisions. Recent developments, including adopting a broader approach for assessing whether a right was clearly established and prohibiting the defense for private actors, may lessen the obstacles for accountability for incarcerated plaintiffs and their families in cases of carceral deaths. Significant challenges remain, however, for claims of constitutionally inadequate medical care against prison-based medical providers, particularly for novel illnesses.

CONCLUSION

Qualified immunity in the context of carceral healthcare does not make sense. While legislative bodies reassess the doctrine due to increased attention to police misconduct, little attention has been paid to the expansion of the doctrine from its origins in street law enforcement to carceral healthcare. Adding qualified immunity is an unnecessary layer of legal protection atop already onerous legal standards governing inadequate healthcare under the Eighth Amendment. It also goes beyond the original intentions of the qualified immunity doctrine.

To the extent that the qualified immunity defense continues to be available, it should be limited to its original context. Medical care decisions behind bars are not usually single, emergency, affirmative, and binary decisions. As such, decisions by carceral healthcare providers should be categorically exempt from qualified immunity analysis.

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[151] Tanner v. McMurray, 989 F.3d 860, 864–65 (10th Cir. 2021) (citing Est. of Clark v. Walker, 865 F.3d 544, 551 (7th Cir. 2017)); McCullum v. Tepe, 693 F.3d 696, 704 (6th Cir. 2012); Jensen v. Lane Cnty., 222 F.3d 570, 580 (9th Cir. 2000); Hinson v. Edmond, 192 F.3d 1342, 1347 (11th Cir. 1999); *see also* Sanchez v. Oliver, 995 F.3d 461, 467 (5th Cir. 2021) (noting circuit alignment and denying qualified immunity to private a healthcare corporation providing healthcare services).