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**RAISING THE “CIVILIZED MINIMUM” OF PAIN  
AMELIORATION FOR PRISONERS TO AVOID CRUEL AND  
UNUSUAL PUNISHMENT**

*James McGrath\**

*This Article addresses the problems with our nation’s cultural and legal prohibitions against certain pain management treatments. The practice of pain management has not kept pace with the many medical advances that have made it possible for physicians to ameliorate most pain. The Author notes that some patients are denied access to certain forms of treatments due to the mistaken belief that addiction may ensue. Additionally, some individuals are under-treated for their pain to a greater degree than are others. This is especially the case for our nation’s prisoners. The Author contends that prisoners are frequently denied effective pain amelioration. He notes, however, that there has been improvement in medical treatment in general for prisoners due to court challenges based on the Eighth Amendment’s prohibition against cruel and unusual punishment. Yet, due to the protection of qualified immunity given to jailers and prison health care providers, prisoners cannot bring a claim for negligence or medical malpractice, they must allege a violation of their constitutional rights, a significantly higher legal standard. Prisoners must meet a subjective test showing that there was a deliberate indifference to their medical needs that violates the protection of the Eighth Amendment. The Author contends that because medical advances have made it possible to alleviate most pain suffering, withholding pain treatment or providing a less effective treatment is tantamount to inflicting pain and should be viewed as a violation of the Eighth Amendment.*

I. INTRODUCTION

Although science has advanced sufficiently to enable physicians to effectively manage almost all pain through various medicines and treatments,<sup>1</sup> our nation’s cultural and legal prohibitions against ef-

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1. See RONALD MELZACK & PATRICK D. WALL, *THE CHALLENGE OF PAIN* 52-56 (1983) (describing different types of pain and recognizing the ability of doctors to treat

fective pain management keep many people suffering needlessly. Despite the availability of effective medications, many physicians have been unwilling to effectively treat pain for many reasons that some medical experts are now labeling as irrational.<sup>2</sup> Many of the most effective pain medicines are opium derivatives ("opioid" narcotics) for which unfounded fears of patient addiction reduce, in some physicians' opinions, their potential benefit in alleviating pain.<sup>3</sup>

Although pain sufferers are generally under-treated, not all people in the United States are under-treated equally for their suffering.<sup>4</sup> People of color, women, and children receive less effective treatment for pain as compared to Caucasian men.<sup>5</sup> Patients with greater financial resources have greater access to adequate pain relief, as their financial freedom permits them to seek relief from as many providers as they are willing to pay to see. Those with greater freedom to choose their treatment options are obviously far more likely to have their pain treated effectively. Many people without these economic resources who are denied effective pain ameliorative treatment may have access to a developing cause of action that would impose liability for the under-treatment of pain.<sup>6</sup> Some legal commentators are advocating for the creation of a tort for failure to adequately treat pain and documenting its development.<sup>7</sup>

What then of sufferers who have no choice, no freedom whatsoever? Prisoners in the United States have access to health care only through their captors, through an often slow and inefficient sick call procedure.<sup>8</sup> Although the treatment of prisoners generally, and their medical needs specifically, has improved greatly with the maturing of our nation, prisoners are often denied effective pain amelioration.<sup>9</sup> Nonetheless, the invocation of the Eighth Amendment's prohibition against cruel and unusual punishment has afforded prisoners greater

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these pain types).

2. Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1, 8-9 (2000).

3. DAVID B. MORRIS, *THE CULTURE OF PAIN* 192 (1991) ("American doctors regularly refuse to prescribe effective doses of narcotic painkillers to dying patients on the grounds that the patients might become addicted").

4. See *infra* notes 45-48 and accompanying text.

5. *Id.*

6. See *infra* notes 70-78.

7. *Id.*

8. *Estelle v. Gamble*, 429 U.S. 97, 110-11 n.3 (1976) (Stevens, J., dissenting) (citing HEALTH LAW PROJECT, UNIV. OF PA., *Health Care and Conditions in Pennsylvania's State Prisons*, in AM. BAR ASS'N COMM'N ON CORR. FACILITIES & SERVS., *MEDICAL AND HEALTH CARE IN JAILS, PRISONS, AND OTHER CORRECTIONAL FACILITIES: A COMPILATION OF STANDARDS AND MATERIALS* 71, 81-82 (1974)).

9. See *infra* Section V.A. (discussing the denial of pain medication to prisoners).

access to adequate healthcare.<sup>10</sup> As our society's general view of what constitutes the humane treatment of people has changed, our law concerning what is cruel and unusual punishment has also evolved.<sup>11</sup> With this evolution, our treatment of our prisoners has slowly improved, and largely through court challenges.<sup>12</sup>

Prisoners often have no recourse for inadequate or negligent medical treatment, as their health care providers and jailers are often protected by the doctrine of qualified immunity.<sup>13</sup> This immunity often shields these state actors against claims of negligence or medical malpractice. To seek redress for failure to provide adequate medical care in federal court, prisoners' claims must meet a higher standard than negligence or malpractice; they must show a deliberate indifference to their serious medical needs in violation of the Eighth Amendment prohibition against cruel and unusual punishment.<sup>14</sup> This subjective standard of deliberate indifference is often difficult to prove, particularly in cases pertaining to inadequate treatment of a prisoner's pain.

Revelations in the medical and legal literature recognizing the generally inadequate treatment of pain, as well as medicine's advanced capacity to relieve suffering, will likely change our nation's perspective on what is a tolerable amount of pain. When it becomes common knowledge that almost all pain can be alleviated, there will be less public tolerance for enduring pain, and permitting patients to suffer. As intolerance for unnecessary pain becomes the norm, this unwillingness to permit people to suffer pain must extend to incarcerated people.

Many federal claims by prisoners seeking relief or compensation for their suffering due to a serious medical condition are dismissed on summary judgment, or for failure to state a cause of action, as their claims are "merely" of medical malpractice or negligence.<sup>15</sup> To survive summary judgment or a motion to dismiss, a claim must allege deliberate indifference to a prisoner's serious medical needs.<sup>16</sup> This deliberate indifference standard, when applied to a prisoner's case using the current, popular medical standards, is especially difficult to prove in cases of failure to adequately treat pain. By recognizing the reality of modern medicine, that almost all pain can be alleviated, it is arguable that a failure to treat a prisoner's pain for a serious medical

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10. See *infra* Section IV (discussing prisoners' constitutional rights to adequate medical care).

11. *Id.*

12. *Id.*

13. See *id.*

14. *Id.*

15. See *id.*

16. *Id.*

condition is per se cruel and unusual punishment. Failure to properly treat pain, when it can be alleviated, is tantamount to a willful infliction of pain. Withholding pain medication, or as often happens, substitution of a less effective treatment, should be considered a violation of a prisoner's Eighth Amendment rights.

Before discussing the existing legal standard applied in prisoner cases, this Article will provide an examination of some recent literature concerning our nation's cultural and medical approaches to pain. A review of the law's influence on evolving medical standards follows. This background information on the nature of pain is important to understand the implications of legal approaches to this medical issue.

As evidence that society's tolerance for pain is lessening, this Article will then examine the legal arguments that failure of a physician to adequately treat pain may be actionable in tort. As the doctrine of qualified immunity prevents most prisoners from pursuing tort claims for inadequate medical treatment, this Article will next review a prisoner's existing rights to adequate medical care. A review of prisoner cases claiming violations of the Eighth Amendment prohibition against cruel and unusual punishment for inadequate medical treatment follows, with a special focus on failure to alleviate pain.

The final section of this Article will review the current standard for evaluating prisoner cases in light of the advanced ability to treat pain and the decreasing public tolerance for the needless suffering of pain. When the reality of the principles of modern pain management are applied, the existing legal standard for litigating Eighth Amendment claims is adequate to establish that a failure to treat a prisoner's pain for a serious medical condition is per se cruel and unusual punishment. Practitioners and prisoners making their claims pro se should incorporate the literature concerning the new medical reality of effective pain management in their complaints to reveal that the existing legal standard is sufficient protection against failure to appropriately minister to a prisoner's pain.

## II. THE UNDER-TREATMENT OF PAIN

The fact that people are suffering from pain needlessly is hardly a new development. For over twenty-five years, the under-treatment of pain has been well documented in the literature of the health care professions.<sup>17</sup> Although most pain can be safely treated and relieved,<sup>18</sup>

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17. See Rich, *supra* note 2, at 8. Professor Rich discusses a 1973 article documenting physicians' unwillingness to treat pain effectively with narcotics because of excessive fear about the danger of addiction, noting they had significant misunderstandings about "the nature of addiction and the risks it posed to patients being treated for pain." *Id.* (citing Richard M. Marks & Edward J. Sachar, *Undertreatment of Medical Inpatients with Narcotic Analgesics*, 78 ANNALS INTERNAL MED. 173, 173-81 (1973)).

18. See MELZACK & WALL, *supra* note 1, at 52-56.

it often is not.<sup>19</sup> Often viewed as an inevitable part of illness, physicians often expect patients to "tough it out," forcing them to cope with pain that may be debilitating and unnecessary.<sup>20</sup>

In his exploration of the religious, philosophical, and cultural underpinnings of our attitudes toward pain, Professor Rich noted a societal willingness to endure pain as a part of the human experience.<sup>21</sup> Pain has been viewed as an essential part of being human, as man's punishment for his wickedness,<sup>22</sup> a normal part of being alive,<sup>23</sup> as well as part of a rite of passage.<sup>24</sup>

Pain has been described as:

[a]n unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life . . . . It is unquestionably a sensation in a part or parts of the body but it is also always unpleasant and therefore also an emotional experience.<sup>25</sup>

Categories of the differing types of pain have usually fallen under two rubrics: acute or chronic pain, with chronic pain subdivided further into cancer and nonmalignant pain.<sup>26</sup> Acute pain is usually that of a limited duration, which may be due to an injury, or as the

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19. See generally WORLD HEALTH ORGANIZATION EXPERT COMM., *Cancer Relief and Palliative Care*, compiled in WHO TECHNICAL REPORT SERIES No. 804.

20. Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J.L. MED. & ETHICS 28, 29 (2001).

21. Rich, *supra* note 2, at 26-31.

22. *Id.* at 26. In the Bible, pain is often a punishment for wickedness. "He is chastened also with pain upon his bed, and the multitude of his bones with strong pain . . ." *Job* 33:19 (King James).

23. Rich, *supra* note 2, at 26-31.

24. *Id.* For example, boys are encouraged to become men through fierce sports competition, and children of both sexes are conditioned with phrases such as "no pain no gain," and "big girl[s] . . . don't cry." See *id.* at 29-30; see also *id.* at 6-14, 17-21 (providing a thorough explanation of the societal implications of pain in modern western culture).

25. INT'L ASSOC. FOR THE STUDY OF PAIN, *Pain Terms: A List with Definitions and Notes on Usage*, 6 PAIN 250 (1979) (emphasis in original). Not everyone agrees that pain is always an emotional experience. See Rich, *supra* note 2, at 18 n.115 (citing DAVID B. MORRIS, *ILLNESS AND CULTURE IN THE POSTMODERN AGE* 118-28 (1998), noting that although pain is usually accompanied by suffering, there are exceptions, such as the pain of a professional athlete, or that of a woman in labor).

26. Furrow, *supra* note 20, at 29. Professor Rich discusses pain in three categories: acute, cancer and chronic nonmalignant (also known as "intractable" or untreatable). Professor Rich makes this distinction between chronic and cancer pain to acknowledge that the cancer patient must cope with her pain as a lifelong affliction, whereas a chronic sufferer's pain will likely increase with the progression of the patient's illness until they die. Rich, *supra* note 2, at 3 n.8.

result of surgery or dental work.<sup>27</sup> Chronic, nonmalignant pain is often treated with palliative care, the care of “patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is quality of life.”<sup>28</sup>

Even when a patient's disease cannot be treated, their pain often can.<sup>29</sup> Chronic pain sufferers, such as some long-term cancer patients, are candidates for long-term treatment with opioid<sup>30</sup> analgesics.<sup>31</sup> It is estimated that millions of cancer patients suffer from pain that can be adequately treated with one of the many available drug options.<sup>32</sup>

Many physicians are hesitant to prescribe appropriate levels of opioid pain medication, as they believe the medical risks of these drugs outweigh their benefit.<sup>33</sup> Physicians' concerns include: “premature death, drug addiction, respiratory depression, and compromised mental status.”<sup>34</sup> Physicians often refuse to prescribe effective doses of narcotic medications, even to dying patients, for fear they may become addicted. One researcher noted that “[t]he treatment of cancer pain, clearly, is still not based solely on scientific fact but draws on ignorance, fear, prejudice, and on an invisible, unacknowledged moral code expressing half-baked notions about the evil of drugs and the duty to bear affliction.”<sup>35</sup> Many current researchers call this fear of addiction a “myth.”

Adding to the confusion concerning adequate pain relief and the potential for addicting a chronic pain sufferer, physicians in disagreement about appropriate pain relief may not even share a similar definition of addiction.<sup>36</sup> Some physicians do not distinguish a chronic pain sufferer's physical dependence on pain medication from an addiction to that drug.<sup>37</sup> Physicians also fear running afoul of DEA

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27. Furrow, *supra* note 20, at 29.

28. *Id.* (quoting OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 3 (D. Doyle et al. eds., 2d ed. 1998)).

29. Furrow, *supra* note 20, at 29.

30. “Originally, a term denoting synthetic narcotics resembling opiates but increasingly used to refer to both opiates and synthetic narcotics.” STEDMAN'S MEDICAL DICTIONARY 1268-69 (27th ed. 2000).

31. *The Use of Opioids in the Treatment of Chronic Pain*, 6 CLINICAL J. OF PAIN 13 (1997).

32. Furrow, *supra* note 20, at 29.

33. Rich, *supra* note 2, at 20.

34. *Id.*

35. MORRIS, *supra* note 3, at 192.

36. See Mike Mitka, *Abuse of Prescription Drugs: Is a Patient Ailing or Addicted?*, 283 JAMA 1126 (2000).

37. “If significant numbers of clinicians are unable to make the most basic and fundamental distinction between addiction and physiological dependence on opioid analgesics for the relief of severe pain, then they are unlikely to be able to competently perform an appropriate risk/benefit analysis among alternative modalities treatment

regulations, for which failure to comply could result in their loss of license to prescribe controlled substances,<sup>38</sup> although this rarely happens.<sup>39</sup>

Chronic pain sufferers are very likely to have the authenticity of their claim of pain challenged by their treating physicians.<sup>40</sup> Sufferers of chronic pain do not generally exhibit objectively verifiable pathology that explains their pain.<sup>41</sup> Patients suffering from chronic pain without medically diagnosable manifestations are likely to be labeled as "drug-seeking" or malingerers.<sup>42</sup> Although this problem affects all sufferers, this effect is especially problematic for a prisoner who is actually in pain, as many prisoners do try to "work the system" in prison infirmaries to gain access to drugs.<sup>43</sup>

Even outside of prisons, the medical profession has not yet embraced the principles of pain management recommended by the experts in this field.<sup>44</sup> Moreover, not every patient is equally undertreated. A review of medical literature identifies disparities in the treatment of pain based upon a patient's race, or the physician's perception of the patient's race.<sup>45</sup> Women have a higher prevalence of

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and the default position of admonishing the patient to endure the unrelieved pain." Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Treatment*, 26 WM. MITCHELL L. REV. 35 (2000).

38. 21 C.F.R. §§ 1306.04, 1306.07, 1306.11 (2001).

39. See *Hoover v. Agency for Health Care Admin.*, 676 So. 2d 1380, 1381 (Fla. Dist. Ct. App. 1996) (reversing the Board of Medicine's restriction of the plaintiff's medical license); *In re DiLeo*, 661 So. 2d 162, 167-68 (La. Ct. App. 1995) (dismissing all charges against Doctor DiLeo for violation of the Medical Practice Act); Michael J. Reynolds, *Morphine or Malpractice: Should Courts Recognize a Legal Duty to Prescribe Opiates for Treating Chronic Pain*, 15 ST. JOHN'S J. LEGAL COMMENT. 79, 86-87 (2000).

40. ARTHUR KLEINMAN, *THE ILLNESS NARRATIVES: SUFFERING, HEALING, AND THE HUMAN CONDITION* 57 (1988).

41. DAVID B. MORRIS, *ILLNESS AND CULTURE IN THE POSTMODERN AGE* 119 (1998) (explaining that current research shows that chronic pain may often derive from "family conflict, economic stress, and a history of emotional trauma").

42. Rich, *supra* note 2, at 22. Professor Rich notes that this propensity for physicians to discount chronic pain sufferer's complaints is completely at odds with their medical training in which they are taught to listen carefully to a patient's complaints "and to resist the temptation to rely too heavily on lab tests or other diagnostic procedures." *Id.* at 22 n.134.

43. Maury J. Greenberg, *Prison Medicine*, 38 AM. FAM. PHYSICIAN 167, 167-68 (1988); see *infra* Part VI (discussing problems regarding the practice of medicine in prison).

44. The Joint Committee on Accreditation of Healthcare Organizations defines pain management as "a comprehensive approach to the needs of patients, residents, clients or other individuals served who experience problems associated with acute or chronic pain." JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORG. (JCAHO) *Guidelines*, in PAIN ASSESSMENT AND MANAGEMENT: AN ORGANIZATIONAL APPROACH 3 (2000).

45. Vence L. Bonham, *Race, Ethnicity and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J.L. MED. & ETHICS



chronic pain and are more biologically sensitive to pain than men, yet women generally receive less aggressive treatment for their pain.<sup>46</sup> Children are often perceived as unable to feel pain in the same way as adults, thereby leading to poor management of their pain.<sup>47</sup> The elderly, particularly those in nursing homes, suffer high levels of pain, which is likely to be poorly managed.<sup>48</sup>

The adequate treatment of pain is not only beneficial to a patient's comfort but it has been shown to have other medical advantages as well. Inadequate control of pain can delay recovery by impairing pulmonary function as well as gastric and bowel functions.<sup>49</sup> So not only is alleviation of suffering a humane response, but it may also lead to improved general health and healing. This may even have a potential benefit to the cost of caring for the patient.<sup>50</sup>

Even after all these potential barriers to prescribing sufficient relief have been passed, and a physician has ordered potentially effective levels of pain relief, the patient may not receive an adequate dosage. Observers of this problem find that it is widespread, noting that "clinical surveys continue to indicate that routine orders for intramuscular injections of opioids *as needed* . . . fail to relieve pain in about half of postoperative patients."<sup>51</sup> Nurses charged with providing relief based on physicians' orders are often wary of overmedicating, especially with opioid narcotics, and often fail to trust the patient in determining when additional medication is needed.<sup>52</sup>

Medical researchers have adequately documented this unwillingness of physicians and other health care workers to treat pain effectively, and the law has begun to recognize that this failure to treat pain appropriately may give rise to legal liability.<sup>53</sup> Not only prison-

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52 (2001). The author notes that although the data reveals disparities in the treatment of blacks and Hispanics as compared to white patients, that other variables were also influential, such as the type of health care facility and the physician's impression of the patient's pain. *Id.* at 60.

46. Diane E. Hoffman & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J.L. MED. & ETHICS 13, 21 (2001).

47. In a recent study by the American Academy of Pediatrics and the American Pain Society, researchers found many reasons physicians undermedicate young patients, including fear of potential side effects, and a belief that pain "builds character." Maura Kelly, *Child Pain is Poorly Treated, Pediatricians' Group Says*, PHILA. INQUIRER, Sept. 5, 2001, at A1, A5.

48. Furrow, *supra* note 20, at 29.

49. *Id.* at 37.

50. Medical complications and infections may be avoided by a quicker healing process. *See id.*

51. AGENCY FOR HEALTH CARE POLICY & RESEARCH, ACUTE PAIN MANAGEMENT: OPERATIVE OR MEDICAL PROCEDURES AND TRAUMA 1 (1992) (emphasis added), available at <http://hstat.nlm.nih.gov/hq/Hquest/screen/contents/s/47086>.

52. *See id.*

53. *See Furrow, supra* note 20, at 29; Rich, *supra* note 2, at 2-3.

ers, but all citizens must have legal recourse to ensure that they do not needlessly suffer.

### III. THE DEVELOPMENT OF A LEGAL DUTY TO RELIEVE PAIN

The failure to adequately treat pain is considered by many medical experts to be professional negligence,<sup>54</sup> violating a physician's Hippocratic oath, and the Code of Ethics of the American Medical Association.<sup>55</sup> Many commentators are now advocating that physicians also have a legal duty of relieve pain, the breach of which may expose them to civil liability through an action for medical malpractice.<sup>56</sup>

A primary objective of medical malpractice tort law is to ensure at least a minimum standard of care among physicians.<sup>57</sup> The law sometimes intervenes when the medical profession does not act quickly enough to correct problems in health care. EMTALA was a legislative approach to extend minimum standards of patient care, creating a prohibition against "patient dumping," at least until a patient is stabilized.<sup>58</sup> The tort of medical malpractice evolved to include the doctrine of informed consent, a judicially imposed standard of care.<sup>59</sup>

Although courts are loathe to substitute their judgment for the

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54. See N.I. Cherney & R. Cataine, *Professional Negligence in the Management of Cancer Pain*, 76 *CANCER* 2181 (1995).

55. Furrow, *supra* note 20, at 29. See CODE OF MEDICAL ETHICS § 2.20 (Am. Med. Ass'n 2001). "Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death." *Id.* Note that this final sentence pertains to treatment of terminal patients. *Id.*

56. See Furrow, *supra* note 20, at 29; Rich, *supra* note 2, at 3.

57. Furrow, *supra* note 20, at 30. *But see* Lawrence Gostin, *A Public Health Approach to Reducing Error: Medical Malpractice as a Barrier*, 283 *JAMA* 1742 (2000). Although one of the goals of medical malpractice is to ensure these high standards, in practice, many non-meritorious nuisance claims are brought or settled, and for various reasons, valid claims of medical malpractice are not litigated. See *id.* at 1743.

58. The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (2001). In 1986, Congress enacted EMTALA to prevent "patient dumping," a practice of hospitals denying emergency treatment to uninsured patients or transferring them without properly stabilizing the emergency condition. In order to establish a cause of action under EMTALA, a patient with an emergency condition must show that the hospital failed in one of the following areas: 1) a thorough application of appropriate screening, 2) failure to stabilize the patient's apparent emergency condition; or 3) failure to follow appropriate transfer procedures. *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 883 (4th Cir. 1992).

59. Informed consent is a judicially imposed doctrine, requiring physicians to share information with their patients about the patient's medical condition, treatment options, risks and benefits, etc. See Christine Laine & Frank Davidoff, *Patient-Centered Medicine: A Professional Evolution*, 275 *JAMA* 152, 152-53 (1996). See *infra* notes 65-85 and accompanying text.

medical decisions of medical professionals, courts have imposed standards of care on physicians above that of the prevailing standards of care within the medical community. In *Helling v. Carey*,<sup>60</sup> an ophthalmologist failed to detect glaucoma in his patient, even though there was a simple, painless, and inexpensive test available.<sup>61</sup> The patient was thirty-two years old at the time and the standard practice was not to administer the test for persons under forty years of age.<sup>62</sup> The court held, as a matter of law, that the reasonable standard of care mandated the administration of the glaucoma test, regardless of the prevailing standard of care among ophthalmologists.<sup>63</sup> Although the patient in *Helling* did not present any expert testimony supporting glaucoma testing for persons under forty, a survey of area ophthalmologists revealed that a "respectable minority" of physicians tested younger people regularly, thus revealing an evolving standard of care.<sup>64</sup> The court's ruling mandated this already developed, but yet to be widely embraced, higher standard of care.

The evolution of the doctrine of informed consent is another example of a "[j]udicially-[i]mposed [s]tandard of [c]are."<sup>65</sup> The cause of action for failure to obtain informed consent began to appear in medical malpractice suits in the 1950's.<sup>66</sup> Courts began to find, as a matter of law, that physicians' practices of nondisclosure and silence were substandard practice.<sup>67</sup> One of the hurdles in informed consent cases was a tradition of silence from physicians that had endured for centuries. Trying to prove that it was against standard medical practice to not gain informed consent from a patient would have been impossible, as it was not widely practiced at that time.<sup>68</sup> In a seminal case on the doctrine of informed consent, Judge Robinson noted that the absence of a custom of informed consent is not the same as a custom of maintaining silence. Judge Robinson remarked that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which

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60. 519 P.2d 981 (Wash. 1974).

61. *Id.* at 981-83.

62. *Id.* at 982.

63. *Id.* at 983 (finding defendant's failure to administer the glaucoma test the proximate cause of plaintiff's injury).

64. Rich, *supra* note 2, at 74-75 (citing Jerry Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345, 383 (1981)).

65. *See id.* at 75-80 (discussing the evolution of the informed consent doctrine).

66. *Id.* at 76 (explaining the difficulty of obtaining expert medical witnesses to testify that the physician standard of care required disclosure of treatment risks and benefits, prior to 1950).

67. *Id.* at 77 (discussing *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957), the first case to mention "informed consent").

68. *Id.*

physicians . . . impose upon themselves."<sup>69</sup>

In his argument that the tort of medical malpractice must expand, Professor Rich noted that "the medical literature over the last quarter century constitutes not merely a preponderance, but clear and convincing evidence that under prevailing medical practice there is a custom of undertreating pain."<sup>70</sup> As informed consent pushed the boundaries of medical malpractice, there is now a need to legally protect patients from physicians' inability or refusal to adequately treat their pain.<sup>71</sup> There is great reluctance to permit courts to set standards of care, reaching beyond their legal expertise into the practice of medicine.<sup>72</sup> Rich argues that although clinical standards in pain management have been set, they have not yet influenced the way that physicians actually practice.<sup>73</sup>

Similarly, Professor Furrow argues that this same duty to inform patients could also be applied to situations of chronic pain.<sup>74</sup> Using this approach, a physician who is unable to effectively manage a patient's pain, or who is fearful of using opioid analgesics, has a duty to inform a patient that other treatment options are available.<sup>75</sup> Physicians already have a duty to make a referral when faced with a medical problem for which they are not experienced.<sup>76</sup> As the specialty of pain management matures, this duty to refer will likely extend to pain management specialists for physicians unable or unwilling to treat their patients' pain.<sup>77</sup> As the public becomes more aware that most medical suffering is unnecessary, it is inevitable that the failure to properly treat pain will spawn civil claims of liability against physicians unwilling, or unable to end their patient's suffering. As medical malpractice standards are not static, lawyers can introduce evidence of advancing clinical standards to show the defect in a physician's care.<sup>78</sup>

In the same way, lawyers must continue to keep abreast of changes in the law;<sup>79</sup> a physician has an obligation to avail herself of

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69. *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972).

70. Rich, *supra* note 2, at 80 (opining what a court may conclude should Judge Robinson's opinion in *Canterbury* be applied to a duty of effective pain management).

71. *Id.* (concluding that a standard of care is necessary to protect patients).

72. *Id.* at 80 n.421.

73. *Id.* at 81.

74. Furrow, *supra* note 20, at 35-36.

75. *See id.*

76. *See Johnson v. Kokemoor*, 545 N.W.2d 495, 509 (Wis. 1996). In this case, the court held that an inexperienced surgeon had a duty to offer a patient a referral to a nearby more experienced surgeon. *Id.* at 510.

77. *See Furrow, supra* note 20, at 30.

78. *Id.*

79. *See MODEL RULES OF PROF'L CONDUCT R. 1.1 cmt. 6* (1998) ("To maintain the requisite knowledge and skill, a lawyer should engage in continuing study and educa-

current treatment options for her patients.<sup>80</sup> Although the ideal of adequately treating pain has taken many years to become accepted medical practice, the fact that adequate pain management is not a regular part of most medical school's curricula does not make a physician less liable for failure to treat pain by today's medically accepted standards.<sup>81</sup> The science of medicine continues to expand, but medical school remains a four-year degree, forcing difficult curriculum decisions. It is not sufficient for a physician to meet required continuing medical education (CME) requirements of her state to meet her obligation to keep her medical knowledge current.<sup>82</sup> Although the loftier goals of medical malpractice litigation may seek to set and enforce a higher standard of care, it is not always successful in this effort.<sup>83</sup> Many malpractice errors are never litigated, and litigated cases often demonstrate no medical negligence; accordingly, these cases often have no bearing on achieving a higher standard of medical care.<sup>84</sup> Nor has everyone had a similar ability to bring such an action. Prisoners do not usually have adequate remedies in medical malpractice because the doctrine of qualified immunity shields prison officers and physicians from liability.<sup>85</sup>

#### IV. PRISONERS' ACCESS TO ADEQUATE MEDICAL CARE

The doctrine of qualified immunity often compels prisoners to pursue claims of inadequate medical care in federal court. To overcome a claim of qualified immunity to pursue an action in federal court, a claim must survive a two-part analysis. The court must determine whether the plaintiff has alleged a violation of a constitutional right and if the right was clearly established at the time of the

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tion.”)

80. “A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.” CODE OF MEDICAL ETHICS, Preamble, at V (Am. Med. Ass’n 2000).

81. *Id.* at I, VI.

82. *Id.* § 9.011.

83. Gostin, *supra* note 57, at 1742-43.

84. *Id.* at 1743 (citing P.C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993)).

85. See *Hathaway v. Coughlin*, 37 F.3d 63, 67 (2d Cir. 1994). “A prison official . . . may claim qualified immunity from suit in certain circumstances. This affirmative defense shields public officials from liability for their discretionary acts that ‘do not violate clearly established statutory or constitutional rights of which a reasonable person would have known.’” *Id.* (quoting *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)). Even where a plaintiff’s federal rights are well-established, qualified immunity is still available to an official “if it was objectively reasonable for the public official to believe that his acts did not violate those rights.” *Kaminsky v. Rosenblum*, 929 F.2d 922, 925 (2d Cir. 1991) (citations omitted).

alleged violation.<sup>86</sup> Although many state actors take refuge in the doctrine of qualified immunity to avoid liability for negligent behavior, it is not intended to protect unlawful conduct. "The purpose of the doctrine is to shield public officers from liability consequent upon either a change in law after they acted or enduring legal uncertainty that makes it difficult for the officer to assess the lawfulness of the act in question before he does it."<sup>87</sup>

This shield often acts as a complete defense to all attempts by a prisoner seeking appropriate medical treatment, or compensation for a failure to provide adequate care. The current deliberate indifference standard in claims of Eighth Amendment violations, would be sufficient to pierce this shield if adjudicated with recognition of medicines' capability to eliminate suffering.

A prisoner does not lose all of his constitutional rights when incarcerated, but keeps those rights that that can be exercised consistently with his imprisonment.<sup>88</sup> Prisoners have a constitutional right to adequate medical care that does not show "deliberate indifference" to their medical needs,<sup>89</sup> grounded in the Eighth Amendment prohibition against cruel and unusual punishment.<sup>90</sup> State prisoners pursue federal claims of cruel and unusual punishment<sup>91</sup> for many different

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86. *Siegert v. Gilley*, 500 U.S. 226, 231 (1991) (stating that threshold questions must be answered before discovery is allowed).

87. *Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999) (finding that a prison official was not protected by the doctrine of qualified immunity when the official's refusal to give the prisoner pain medication was "a gratuitous cruelty").

88. *Sampley v. Ruettggers*, 704 F.2d 491, 495 n.6 (10th Cir. 1983) ("When sentenced to a prison term, an inmate loses the portion of his liberty interest that is inconsistent with imprisonment. In particular, he loses his liberty interest in being free from his jailer's use of force that appears reasonably necessary to maintain or restore discipline.").

89. *Estelle v. Gamble*, 429 U.S. 97, 106 (1976) (explaining that "deliberate indifference" violates the Eighth Amendment).

90. The Eighth Amendment provides, "Excessive bail shall not be required, . . . nor cruel and unusual punishments inflicted." U.S. CONST. amend. VIII.

91. Professor Anthony F. Granucci argued that the framers' intent in including the clause "cruel and unusual" misinterpreted the 1689 clause of the English Puritans, which was indeed meant to curb excessive penalties. Anthony F. Granucci, "Nor Cruel and Unusual Punishments Inflicted." *The Original Meaning*, 57 CAL. L. REV. 839, 843-47 (1969). During the original congressional deliberations, including the phrase to the Bill of Rights, when Mr. Smith of South Carolina objected to the words "nor cruel and unusual punishments" as being too indefinite, Mr. Livermore of New Hampshire replied, "[t]he clause seems to express a great deal of humanity, on which account I have no objection to it; but it seems to have no meaning in it, I do not think it necessary . . . . No cruel and unusual punishment is to be inflicted; it is sometimes necessary to hang a man, villains often deserve whipping, and perhaps having their ears cut off; but are we in [the] future to be prevented from inflicting these punishments because they are cruel?" *Id.* at 842 (quoting 1 ANNALS OF CONG. 782-83 (1789)). The term was not often invoked in courts throughout the eighteenth century, and commentators of that time

reasons, including intolerable living conditions, failure to protect against attack from other prisoners or guards, and failure to provide adequate medical treatment. Although the Eighth Amendment protects prisoners from many abuses, this Article will concentrate on failure to provide adequate medical treatment for the pain of inmates.

Medical treatment of prisoners has improved since earlier recorded practices of general callousness and incompetence in treating prisoners.<sup>92</sup> Prisoners now are afforded legal protection against former practices of human experimentation<sup>93</sup> and outright neglect of their medical needs.<sup>94</sup> Claims to compel adequate care, or to seek compensation for failures to provide treatment may be brought against prison officials and physicians under 42 U.S.C. § 1983 (hereinafter § 1983).<sup>95</sup> Section 1983 permits actions against state actors for deprivations of an individual's constitutional rights.

Section 1983 is not an appropriate cause of action for medical malpractice or negligence,<sup>96</sup> the grievance must rise to a violation of a prisoner's constitutional protection, which ordinary medical malpractice does not.<sup>97</sup> A claim of inadequate medical treatment by a prisoner

thought the clause to be obsolete. *Id.* at 842. The clause was later applied to punishments that were excessive in proportion to the crime committed. *Id.* (citing *O'Neil v. Vermont*, 144 U.S. 323, 340 (1892)).

92. Michael S. Vaughn, *Section 1983 Civil Liability of Prison Officials for Denying and Delaying Medication and Drugs to Prison Inmates*, 11 ISSUES L. & MED. 47, 47-48 (1995) (noting the improvement in prison health care).

93. Protection of Human Subjects, 45 C.F.R. §§ 46.301-306 (2000).

94. Vaughn, *supra* note 92, at 48; see also Jordan B. Glaser & Robert B. Greifinger, *Correctional Health Care: A Public Health Opportunity*, 118 ANNALS INTERNAL MED. 139 (1993).

95. 42 U.S.C. § 1983 provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983 (2000).

For a discussion of the history of § 1983, see *McCray v. Burrell*, 367 F. Supp. 1191 (D. Md. 1973), *rev'd on other grounds*, 516 F.2d 357 (4th Cir. 1975). Note that jurisdiction of suits under 42 U.S.C. § 1983 is vested in United States District Courts by 28 U.S.C. § 1343 without allegation of either diversity of citizenship or of any particular sum in controversy. 28 U.S.C. § 1343 (2000).

96. *Estelle*, 429 U.S. at 106-07 (finding prisoner's claims against a prison physician not recognizable under § 1983).

97. *Id.*; see, e.g., *Floyd v. Owens*, No. 86-7176, 1987 WL 11906, at \*1 (E.D. Pa. June 2, 1987), in which a prisoner complained of inadequate pain relief when he was given Motrin, an over-the-counter medication for pain for his ulcerous leg. This claim was rejected, as complaints about medical care do not rise to constitutional claims

must rise to the level of "cruel and unusual punishment" prohibited by the Eighth Amendment.<sup>98</sup> A disagreement in proper treatment, or a negligent failure to diagnose, is also not sufficient to sustain a claim under § 1983.<sup>99</sup> Prisoners seeking relief under § 1983 for failure to provide adequate medical treatment must show "deliberate indifference" to their medical needs by a state actor in order for the claim to rise to the level of cruel and unusual punishment.<sup>100</sup>

This deliberate indifference standard was articulated by the Supreme Court in 1976 in *Estelle v. Gamble*, in which a prisoner claimed inadequate medical treatment for a back injury he had suffered while in prison.<sup>101</sup> The Court reviewed the Eighth Amendment's genesis and previous application in federal courts.<sup>102</sup> Prior to *Estelle*, the Eighth Amendment's prohibition against cruel and unusual punishment was largely interpreted as a bar against both "harsh or demeaning" punishments, and sentences that were not proportional to the crime committed.<sup>103</sup> The lower federal courts previously used various standards to determine the required scienter to pursue a prisoner's claim for failure to provide adequate medical care.<sup>104</sup>

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"even if [the] treatment is so negligent as to amount to malpractice." *Id.* In this case, the court noted that under *Estelle*, "where a prisoner has received some medical care, the alleged impropriety of that treatment will not support an [E]ighth [A]mendment claim." *Id.*

98. U.S. CONST. amend. VIII.

99. *Estelle*, 429 U.S. at 106.

100. *Id.*

101. *Id.* at 98-99.

102. *Id.* at 102-03. The Court noted in its analysis that the Eighth Amendment was originally intended to prohibit excessively brutal methods of punishment. *Id.* at 102. The Court further explained that the Eighth Amendment required courts to measure prison standards against "broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . ." *Id.* (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)); see also James J. Park, *Redefining Eighth Amendment Punishments: A New Standard for Determining the Liability of Prison Officials for Failing to Protect Inmates from Serious Harm*, 20 QUINNIPIAC L. REV. 407, 437-41 (2001) (discussing the Supreme Court's approach to protections under the Eighth Amendment).

103. Michael Wells, *Constitutional Torts, Common Law Torts, and Due Process of Law*, 72 CHI.-KENT L. REV. 617, 629 (1997); see also Park, *supra* note 102, at 434-36, for an exploration of the disconnection between the act of sentencing and the execution of the punishment. Professor Park reviews the history of early American prohibitions against cruel and unusual punishment and the excesses they were designed to prevent. *Id.* at 415-29.

104. For a detailed review of the case law concerning a prisoner's access to appropriate medication, see Vaughn, *supra* note 92, at 50-54. Courts' standards included "under exceptional circumstances," see, e.g., *United States v. Ragen*, 337 F.2d 425 (7th Cir. 1964), and "deliberate infliction of pain," see, e.g., *Runnels v. Rosendale*, 499 F.2d 733, 736 (9th Cir. 1974). However, other courts did not clearly articulate what standard was used. See, e.g., *Campbell v. Beto*, 460 F.2d 765, 767-68 (5th Cir. 1972). Prior to *Estelle*, the Second, Sixth, and Eighth Circuit Courts of Appeals had already used the deliberate indifference standard to determine the required mental state of the



The Court recognized that a prisoner must rely on prison officials to treat his medical needs, noting that a failure to do so "may actually produce physical 'torture or a lingering death.'"<sup>105</sup> *Estelle* fixed the appropriate culpable mental state of state actors in claims of cruel and unusual punishment for failure to provide adequate medical treatment.<sup>106</sup> The Court held that "such unnecessary suffering [was] inconsistent with contemporary standards of decency."<sup>107</sup> The Court noted that even "[i]n less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose."<sup>108</sup> The Court concluded that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,'" in violation of the Eighth Amendment.<sup>109</sup> For Mr. Gamble, the prisoner in this case, this meant an affirmation of the dismissal of his § 1983 claim, as the facts in his claim supported "only" an action in negligence or medical malpractice; negligence and misdiagnosis do not necessarily meet the constitutional standard.<sup>110</sup>

After *Estelle*, lower federal courts had difficulty determining exactly what constituted deliberate indifference in many differing types of claims of cruel and unusual punishment,<sup>111</sup> prompting the Supreme Court to attempt a definition in *Farmer v. Brennan*<sup>112</sup> in 1994.

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state actor in cases challenging the withholding of medication for serious medical conditions. See, e.g., *Massey v. Hutto*, 545 F.2d 45, 46-47 (8th Cir. 1976); *Westlake v. Lucas*, 537 F.2d 857, 860 (6th Cir. 1976); *Corby v. Conboy*, 457 F.2d 251, 254 (2d Cir. 1972). But see *Scharfenberger v. Wingo*, 542 F.2d 328, 331 (6th Cir. 1976) (relying on five different standards: "fundamental fairness," "woefully inadequate," "undue suffering," and "obvious need"); *Jones v. Lockhart*, 484 F.2d 1192, 1193 (8th Cir. 1973) (requiring "exceptional circumstances").

105. *Estelle*, 429 U.S. at 103 (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)).

106. *Id.* at 102-06; Vaughn, *supra* note 92, at 49 (noting *Estelle* established the framework for legal challenges of this sort).

107. *Estelle*, 429 U.S. at 103.

108. *Id.*

109. *Id.* at 104.

110. *Id.* at 106. Mr. Gamble received many treatments over a three month period, but the health care providers failed to appropriately diagnose and treat his back injury which kept him in "daily pain and suffering." *Id.* at 107.

111. For example, claims of brutality at the hands of guards or other prisoners.

112. 511 U.S. 825, 827 (1994). Dee Farmer was convicted of credit card fraud and was sentenced to serve time in a federal prison. *Id.* at 829. At the time of the conviction, Farmer was a preoperative transsexual who, although biologically male, had undergone breast implantation surgery and estrogen therapy. *Id.* Another prisoner raped and beat Farmer in Farmer's own cell. *Id.* at 830. Farmer filed a complaint claiming that prison officials violated the Eighth Amendment protection against cruel and unusual punishment with deliberate indifference to his safety by placing him in a violent general prison population, despite knowing that his transsexual status and the facility's history of inmate violence would make him susceptible to a sexual attack. *Id.* at 830-31.

*Farmer* established that prison officials violate the Eighth Amendment's prohibition against cruel and unusual punishment when two conditions are met, one objective and one subjective. The objective requirement is that the deprivation alleged is sufficiently serious so that the prison officials' acts or omissions result in the denial of the minimum civilized measure of life's necessities.<sup>113</sup> The subjective requirement requires a finding that the prison officials acted with "deliberate indifference," that they knew of and disregarded an excessive risk to inmate health and safety.<sup>114</sup> The Court rejected *Farmer*'s "invitation to adopt" a completely objective test for finding deliberate indifference.<sup>115</sup> The Court held that a prison official could not be held liable for Eighth Amendment violations unless such an official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."<sup>116</sup>

The objective element requires that a medical need be serious, if it presents "a condition of urgency . . . that may produce death, degeneration, or extreme pain[.]"<sup>117</sup> A court may consider "[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain. . ."<sup>118</sup> "A medical need is sufficiently serious 'if it is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."<sup>119</sup>

In satisfying the subjective element of an Eighth Amendment claim, the prisoner must demonstrate deliberate indifference on the part of prison officials.<sup>120</sup> Prison officials act with deliberate indiffer-

113. *Brown v. Nix*, 33 F.3d 951, 954-55 (8th Cir. 1994) (citing *Farmer*, 511 U.S. at 831-33, 837).

114. *Id.* at 955. (citations omitted).

115. *Farmer*, 511 U.S. at 837; *see also* *Farmer v. Brennan*, 11 F.3d 668 (7th Cir. 1992), *cert. granted*, 510 U.S. 811 (1994).

116. *Farmer*, 511 U.S. at 837.

117. *Hathaway*, 37 F.3d at 66 (quoting *Nance v. Kelly*, 912 F.2d 605, 607 (2d Cir. 1990) (Pratt, J., dissenting)).

118. *McGuckin v. Smith*, 974 F.2d 1050, 1059-60 (9th Cir. 1992), *overruled on other grounds by* *WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997).

119. *Sealock v. Colorado*, 218 F.3d 1205, 1209 (10th Cir. 2000) (quoting *Hunt v. Uphoff*, 199 F.3d 1220, 1224 (10th Cir. 1999)).

120. *Farmer*, 511 U.S. at 835-37. The courts also distinguish between the rights of a convicted prisoner and a state held pre-trial detainee, who, as a yet innocent person, has a Fourteenth Amendment right to be free from punishment altogether. *Bell v. Wolfish*, 441 U.S. 520, 535-36 (1979); *see also* *Simons v. Clemons*, 752 F.2d 1053, 1055

ence to an inmate's health if they know he faces a substantial risk of serious harm and disregard that risk by failing to take reasonable measures to abate it.<sup>121</sup> Such indifference may be proven by showing that prison officials intentionally denied, delayed access to, or interfered with an inmate's necessary medical care.<sup>122</sup> This standard requires more than a showing of negligent or inadvertent failure to provide adequate medical care and more than a mere difference of opinion between a prisoner and the prison medical staff regarding the proper course of treatment.<sup>123</sup>

The claims of prisoners under these federal actions have been based on the standard of deliberate indifference to their serious medical needs, yet, this standard is largely based on an outdated model of adequate pain treatment. As reviewed, *supra* Part II, not just prisoners, but most American citizens are largely under-treated for their pain. Next, this Article will explore the application of the current legal standard in cases of prisoner's complaints of pain.

## V. APPLICATION OF THE DELIBERATE INDIFFERENCE STANDARD IN PRISONER COMPLAINTS OF PAIN

### A. *The Objective Element in Cases of Prisoners' Pain*

The objective element of a claim of cruel and unusual punishment requires a claim for failure to appropriately treat a "serious

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(5th Cir. 1985). Simons, a former pre-trial detainee was denied access to prescription pain medication for two hours. *Id.* at 1054-55. Although Simons relied on Eighth Amendment medical care denial cases, the court found this standard was not directly applicable; instead, the court assessed whether the deprivation of medication violated Simon's Fourteenth Amendment right to be free from treatment amounting to punishment. *Id.* at 1055. The court noted that the Supreme Court, in *City of Revere v. Massachusetts General Hospital*, 463 U.S. 239 (1983), found that pre-trial detainees had, at a minimum, the same rights owed to a convicted prisoner. *Simons*, 752 F.2d at 1056 n.1. To determine whether Simon's treatment amounted to punishment, the court focused on whether there was an express intent to punish, or whether "it [was] but an incident of some other legitimate government purpose." *Id.* at 1056 (quoting *Bell*, 441 U.S. at 538). The legitimate government purpose was determined to be the need to prevent drugs from reaching other incarcerated prisoners. *Id.* The court found that the two-hour delay was not excessive, nor did Simons make any allegations that the deprivation was intended as punishment. *Id.* Federal pre-trial detainees are protected by the due process clause of the Fifth Amendment. *Duran v. Elrod*, 542 F.2d 998, 1000 (7th Cir. 1976). A prisoner may assert damages based on a constitutional violation under § 1983 against state actors, or under federal employees through an action implied in *Bivens v. Six Unknown Named Federal Narcotics Agents*, 403 U.S. 388, 395-97 (1971).

121. *Farmer*, 511 U.S. at 837-40.

122. *Estelle*, 429 U.S. at 104-05.

123. *Id.* at 105.

medical need."<sup>124</sup> In Eight Amendment prisoner claims, this is usually not the element in dispute.<sup>125</sup> Most prisoner's claims are usually denied for failure to meet the subjective requirement of deliberate indifference on the part of prison officials.

Although it may be difficult to know if a prisoner is drug seeking or actually in pain, requiring a completely objective test should never be the standard, as it may invite other potential abuses.<sup>126</sup> In the case of *Cooper v. Casey*, the prisoners were beaten by guards and requested treatment and pain medication, but were denied treatment for forty-eight hours.<sup>127</sup> The court rejected the defendants' argument that there should be some objective injury, such as "the sort of thing that might reveal itself on an x-ray, or in missing teeth, or in a bruised and battered physical appearance."<sup>128</sup> The court was concerned that this standard might provide immunity from claims of deliberate indifference to guards who might sadistically "inflict substantial and prolonged pain without leaving any 'objective' traces on the body of the victim."<sup>129</sup>

The subjective nature of pain in other litigation requires courts to look beyond objectively verifiable manifestations, such as in Social Security and Medicare claims for chronic pain.<sup>130</sup> In these claims,

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124. See *McGuckin v. Smith*, 974 F.2d 1050, 1059-60 (9th Cir. 1992), *overruled on other grounds by* *WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997) (defining a "serious' medical need" as one that, if untreated, could cause further injury or severe and unnecessary pain).

125. Obvious examples of complaints that courts have declined to deem as "serious' medical conditions" are cold symptoms and minor aches and pains. See, e.g., *Cooper v. Casey*, 97 F.3d 914, 916 (7th Cir. 1996) (noting that a prison official's refusal to "dispense bromides for the sniffles or minor aches and pains or a tiny scratch or a mild headache or minor fatigue . . . does not . . . violate the Constitution."); *Gibson v. McEvers*, 631 F.2d 95, 98 (7th Cir. 1980) (holding that failure to treat a common cold does not violate the Eighth Amendment).

126. See *Cooper*, 97 F.3d at 917 (emphasizing that an objective inquiry "would confer immunity from claims of deliberate indifference on sadistic guards").

127. *Id.*

128. *Id.*

129. *Id.* (citing *Williams v. Boles*, 841 F.2d 181, 183 (7th Cir. 1988)).

130. Ann K. Wooster, Annotation, *Standard and Sufficiency of Evidence When Evaluating Severity of Claimant's Pain in Social Security Disability Case Under § 3(a)(1) of Social Security Disability Benefits Reform Act of 1984*, 42 U.S.C.A. § 423(d)(5)(A), 165 A.L.R. FED. 203, 203 (2000). "The majority of courts require only subjective evidence of the severity of a claimant's pain; courts in the minority require objective evidence to support any subjective testimony of the severity of pain experienced by a claimant." *Id.* In *Light v. Social Security Administration*, 119 F.3d 789 (9th Cir. 1997), the Ninth Circuit Court of Appeals noted that if the government concludes that a claimant for Social Security disability benefits suffers from infirmities that may cause pain, then the claimant cannot be denied benefits merely because there is no objective medical evidence to support the severity of that pain. See *id.* (citations omitted).

courts may use purely subjective evidence, or a combination of both subjective and objective indicia on which to base their determinations.<sup>131</sup>

*Ralston v. McGovern*,<sup>132</sup> reversed a case in which a prisoners' claim was denied for not meeting the objective element's requirement of a serious medical condition. In *Ralston*, a prisoner, who suffered from cancer, complained that he could not swallow and was spitting blood.<sup>133</sup> A guard denied the prisoner his prescribed pain medication.<sup>134</sup> His claim was dismissed by the district court, because although there was sufficient support in the complaint to show deliberate indifference, the court found that the prisoner failed to present a serious medical condition that constituted cruel and unusual punishment.<sup>135</sup> The appellate court noted that a medical need could be as serious as treatment needed immediately to save a patient's life, to a need so inconsequential such as "trivial discomforts" and "cosmetic imperfections."<sup>136</sup> The court found these poles to be obvious examples of Eighth Amendment violations and non-violations respectively.<sup>137</sup> The court noted that drawing the line "is a matter of determining the civilized minimum of public concern for the health of prisoners, which depends on the particular circumstances of the individual prisoner."<sup>138</sup> This is the part of the test that the court found difficult to generalize, but added that the "civilized minimum" analysis might be further reduced to an examination of the costs and benefits of the treatment.<sup>139</sup> The court noted that *Ralston*, the prisoner, was not demanding costly treatment, not anything esoteric or unconventional, only the pain medication already prescribed for him. The court found the guard's denial of *Ralston's* pain medication to be gratuitous cruelty.<sup>140</sup> "The lower the cost, the less need has to be shown, but the need must still be shown to be substantial. It seems to us that to refuse to treat, at trivial cost, the pain caused by cancer and cancer treatments borders on the barbarous."<sup>141</sup> The court noted that the "terror which cancer inspires magnifies the pain and discomfort of the frequent side effects of cancer treatments," calculating the par-

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131. *Wooster*, *supra* note 130, at 239-40.

132. *Ralston v. McGovern*, 167 F.3d 1160 (7th Cir. 1999).

133. *Id.* at 1161.

134. *Id.*

135. *Id.*

136. *Id.* (quotations added)

137. *Id.* at 1161-62.

138. *Id.* at 1162.

139. *See id.* (noting that the lower the cost of the requested treatment, the less need the prisoner is required to show).

140. *Id.*

141. *Id.*

ticular circumstances of Ralston's illness in its analysis.<sup>142</sup>

Some medical problems are easier to identify objectively than others. A broken bone can often be seen even without an x-ray, and thus is verifiable even when not visible to the naked eye. These claims generally pass the subjective element easily. Courts are likely to find that delay or avoidance in treatment for a prisoner's broken bone is deliberate indifference to a serious medical need. In a pre-*Farmer* case, *Brown v. Hughes*,<sup>143</sup> the court found that with a painful injury, such as a broken foot,

it may be that deliberately indifferent delay, no matter how brief, would render defendants liable as if they had inflicted the pain themselves. Deliberately inflicted pain, as with an electrical cattle prod, does not become unimportant and unactionable under the [E]ighth [A]mendment simply because the pain produced is only momentary.<sup>144</sup>

The court noted that even if they found that delays of minutes or seconds were de minimus delays, the delay "on the order of hours," in providing treatment for a broken foot is sufficient for a constitutional claim.<sup>145</sup>

In another pre-*Farmer* case, the pain of a broken arm was found to have the potential of such an excruciating injury as to mandate expedited attention of a doctor's care.<sup>146</sup> In *Loe v. Armistead*, a delay of eleven hours for an inmate to see a doctor was considered a sufficient pleading to survive a motion to dismiss of the prisoner's claim of cruel and unusual punishment.<sup>147</sup> This ruling was made in spite of the fact that the prisoner was provided pain medication soon after the accident causing the break.<sup>148</sup> In a footnote, the court in *Loe* clarified its holding, so as to correct a dissenting judge's characterization.

[O]ur holding is that the complaint of a prisoner under § 1983 against responsible state and federal officials is not subject to summary dismissal when he alleges that, *with deliberate indifference*, the defendants failed to have his painful and obviously broken arm examined until [eleven] hours after his injury and failed to have it x-rayed until [twenty-two] hours after his injury.<sup>149</sup>

The court noted that unusual length of the delay supported an inference of deliberate indifference, noting that "an indigent could

142. *Id.*

143. 894 F.2d 1533 (11th Cir. 1990).

144. *Id.* at 1538.

145. *Id.*

146. *Loe v. Armistead*, 582 F.2d 1291, 1296 (4th Cir. 1978).

147. *Id.*

148. *Id.* at 1297 (Hall, J., dissenting).

149. *Id.* at 1296 n.3.

reasonably expect faster treatment at a hospital emergency room."<sup>150</sup>

Claims of deliberate indifference by prisoners for pain due to broken bones are rare post-*Farmer*.<sup>151</sup> Cases which are more likely to be appealed are claims of delay or substitution of a prisoner's prescribed pain medication.

### B. *The Subjective Element in Cases of Prisoners' Pain*

As with other standards that include a subjective component, various courts apply the standard of deliberate indifference diversely. The clearest example of deliberate indifference would be the case in which it was possible to show that a prison official withheld treatment to intentionally inflict pain.<sup>152</sup> This is almost never the case in claims of cruel and unusual punishment. However, even before *Farmer* refined the definition of deliberate indifference, courts found deliberate indifference in particularly egregious cases of neglect.<sup>153</sup>

In a pre-*Farmer*, First Circuit case, a prisoner had been denied pain medication by the prison nurse, "because the injury had occurred before [the inmate] went to prison."<sup>154</sup> The nurse felt that because the injury had nothing to do with what happened to him in the prison, she "was not responsible for care or treatment [of his injured] hand."<sup>155</sup> The prisoner was also denied the opportunity to go outside the prison and see another health care provider concerning the injury.<sup>156</sup> In finding that the nurse had indeed been deliberately indifferent to the prisoner's pain, the court explained the difficulty in making this determination, noting that the "obvious case would be a denial of needed medical treatment in order to punish the inmate."<sup>157</sup> But the court found that "deliberate indifference may also reside in

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150. *Id.* at 1296.

151. However, in *Senisais v. Fitzgerald*, 940 F. Supp. 196 (N.D. Ill. 1996), an inmate brought an action against prison physicians for failure to treat his broken hand. *Id.* at 198. Although the prisoner stated he experienced excruciating pain for eight days, he did not claim this suffering as his reason for pursuing a 42 U.S.C. § 1983 action alleging inadequate medical care. *Id.* at 200. The court held that allegations that the inmate's broken hand was not set in a cast until nine days after the fall were sufficient to state claim of deliberate indifference to prisoner's serious medical needs. *Id.* at 199; see also *Ruvalcaba v. City of Los Angeles*, 167 F.3d 514 (9th Cir. 1999), in which a failure to diagnose a prisoner's broken ribs was characterized as possibly negligent, but not deliberately indifferent. *Id.* at 525.

152. See *Watson v. Caton*, 984 F.2d 537, 540 (1st Cir. 1993) ("The obvious case would be a denial of needed medical treatment in order to punish the inmate.")

153. *Id.* at 539-40.

154. *Id.* at 539.

155. *Id.*

156. *Id.*

157. *Id.* at 540.

'wanton' decisions to deny or delay care<sup>158</sup> . . . where the action is recklessness, 'not in the tort law sense but in the appreciably stricter criminal-law sense, requiring actual knowledge of impending harm, easily preventable.'<sup>159</sup> The prisoner later received treatment and "another round of surgery" was recommended.<sup>160</sup> The court ruled that although the nurse was obviously aware of the prisoner's pain, she did nothing to treat it and vacated dismissal of the prisoner's § 1983 claim and remanded it for further proceedings.<sup>161</sup>

In *Johnson v. Hardin County*,<sup>162</sup> the Court of Appeals concluded that a reasonable jury could find deliberate indifference in the actions of prison guards for not properly providing a prisoner his prescribed pain medication.<sup>163</sup> Johnson was permanently disabled as a result of a prior motorcycle accident and had persistent problems with his legs, leading him to request a small cell and a lower bunk, both of which were denied.<sup>164</sup> Johnson's guards did not always provide him with his prescribed doses of medication, and when they did, they would often throw his pills into his cell, where they would sometimes roll out of his reach.<sup>165</sup> The prison officials' refusal to alter the prison policy of distributing drugs every six hours to every four hours, as to accommodate Johnson's prescription for Tylenol-3, was not found to be deliberate indifference.<sup>166</sup> Proving a systemic mistreatment of prisoners, rising to the level of deliberate indifference is a higher standard, which had not been met in this case.<sup>167</sup>

The above cases were appeals of lower court rulings dismissing the prisoners' claims prior to the ruling in *Farmer*. After *Farmer*, with the deliberate indifference standard more clearly articulated, prisoners' appeals have not generally been for circumstances so blatantly cruel.

Until recently, almost any attempt at treatment, no matter how futile or feeble prevented a prisoner from successfully claiming deliberate indifference.<sup>168</sup> Courts often stated that these claims may have

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158. *Id.* (citing *Wilson v. Seiter*, 501 U.S. 294, 303 (1991)).

159. *Id.* (citing *DesRosiers v. Moran*, 949 F.2d 15, 19 (1st Cir. 1991)).

160. *Id.* at 539.

161. *Id.* at 540-41.

162. 908 F.2d 1280 (6th Cir. 1990).

163. *Id.* at 1284.

164. *Id.* at 1282.

165. *Id.* at 1284.

166. *Id.* at 1286-87.

167. *See id.* at 1287. This implicates the *Farmer* requirement of knowledge.

168. *See, e.g., Floyd v. Owens*, No. 86-7176, 1987 WL 11906, at \*1 (E.D. Pa. June 2, 1987). In *Floyd*, the court noted that under *Estelle*, "where a prisoner has received some medical care, the alleged impropriety of that treatment will not support an [E]ighth [A]mendment claim." *Id.*



been valid claims of medical malpractice, but did not rise to constitutional violations of a prisoner's rights.<sup>169</sup> After *Farmer*, some courts were willing to look at the quality of the treatment given to determine whether the medical care was adequate to avoid a constitutional violation.

In a Seventh Circuit case, a prisoner, Sherrod, complained of severe abdominal pain and was seen by prison doctors on many occasions over a two-week period.<sup>170</sup> Although Sherrod continued to suffer severe abdominal pain and high temperatures, the cryptic phrase "rule out appendicitis" was repeatedly entered into his medical record by the prison's medical staff.<sup>171</sup> It was not clear if the phrase was an instruction to actually rule out appendicitis, or if it was stating that indeed appendicitis had been ruled out.<sup>172</sup> Finally, Sherrod was taken to the hospital where it was revealed he had a ruptured appendix and a gangrenous bowel.<sup>173</sup> The district court ruled that the prison medical staff did not show deliberate indifference because Sherrod received continuous medical treatment.<sup>174</sup> Based on its resolution of questions of material fact in favor of the defendants, the district court found that Sherrod's symptoms "did not match those of appendicitis" on the second day he requested medical assistance.<sup>175</sup> The appeals court concluded that the lower court's findings of fact constituted reversible error, because it was clear that Sherrod had symptoms of appendicitis on the first day he sought treatment.<sup>176</sup> The appeals court also found that the lower court should have examined the entire period of time when he was complaining of pain.<sup>177</sup> With all of the evidence available, the appeals court found that a jury could reasonably find that the prison health care workers acted with deliberate indifference towards Sherrod.<sup>178</sup> The appeals court noted that "[t]he question mandated by *Farmer* is whether the official knew of and disregarded an excessive risk to the inmate's health, not whether the inmate was ignored."<sup>179</sup> The appeals court found that Sherrod had presented sufficient evidence "that the prison staff knew of and dis-

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169. See, e.g., *id.* For many of these state prisoners, a claim of medical malpractice was without value as the prison officials at fault were protected by qualified immunity. See *supra* note 85 and accompanying text.

170. *Sherrod v. Lingle*, 223 F.3d 605, 608-09 (7th Cir. 2000).

171. *Id.* at 608.

172. *Id.*

173. *Id.* at 609.

174. *Id.* at 611.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.* at 612.

regarded a serious risk to his health . . . ."<sup>180</sup>

Another recent case in the Seventh Circuit also showed a court's unwillingness to accept any treatment as proof that the treating officials were not deliberately indifferent.<sup>181</sup> The Seventh Circuit reversed the dismissal of a prisoner's complaint of a refusal to provide him surgical treatment for pain prescribed by a physician.<sup>182</sup> A physician at the prison examined the prisoner who complained about wrist pain, and referred him to a specialist at a local hospital.<sup>183</sup> The prisoner was diagnosed as having calcium overgrowths, requiring surgery to alleviate his pain.<sup>184</sup> Before surgery occurred, the prisoner was transferred to another prison where the attending physician examined him and agreed that he needed the surgery, but told him that the prison did not provide such treatment.<sup>185</sup> Two other doctors gave him similar advice.<sup>186</sup> After repeatedly requesting treatment for a period of three years, he filed a grievance, which was denied, after which he filed a § 1983 claim.<sup>187</sup> The Court of Appeals noted that "[t]he subjective element of deliberate indifference encompasses conduct such as a refusal to treat a prisoner's chronic pain."<sup>188</sup> The court below dismissed the prisoner's claim because the prisoner had failed to establish that the prison officials' alleged refusal to treat his condition was more than mere negligence or dissatisfaction with his treatment.<sup>189</sup> The Court of Appeals did not accept the defendant's argument that because the prisoner was seen by prison doctors, he was receiving treatment and merely disagreed with the diagnosis. The court found that the prisoner's acknowledgment that he saw the doctors did not negate his claim, noting "[p]risoners are not required to show that they were completely ignored by prison medical staff to demonstrate deliberate indifference."<sup>190</sup>

In *Sanocki v. Reno*,<sup>191</sup> a prisoner received many treatments for non-malignant tissue growth, but was given a different pain medica-

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180. *Id.*

181. *Adams v. Detella*, No. 98-1613, 2000 WL 1763342, at \*4 (7th Cir. Nov. 22, 2000).

182. *Id.* at \*4.

183. *Id.* at \*1.

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.* at \*2.

188. *Id.* at \*3 (citing *Jones v. Simek*, 193 F.3d 485, 490 (7th Cir. 1999), *aff'd sub nom.* *Jones v. Lopez*, No. 01-1798, 2001 U.S. App. LEXIS 22880, at \*6 (7th Cir. Oct. 18, 2001)).

189. *Adams*, No. 98-1613, 2000 WL 1763342, at \*2.

190. *Id.* at \*3 (citing *Sherrod*, 223 F.3d at 612).

191. *Sanocki v. Reno*, No. 96-3603-KHV, 1998 WL 184460, at \*1 (D. Kan. Mar. 16, 1998).

tion than the one prescribed by a consultant surgeon.<sup>192</sup> Although there was a question of adequacy of the pain relief given, the court also noted that the prisoner had received many different treatments, and that any delays in the treatment did not rise to the level of constitutional violations.<sup>193</sup>

The difficulties of treating patients in a prison environment often lead to delays in treatment.<sup>194</sup> These delays in treatment can be especially devastating to a prisoner in pain, who has no other source of aid. How long is too long to suffer? The answer is not uniform in the various courts, and may employ a calculus that includes the length of the delay and the severity of the pain.

Even prior to *Farmer*, a prisoner's complaint that a nurse denied him prescribed pain medication, as well as dressing changes, for five days was sufficient grounds to state an Eighth Amendment cause of action.<sup>195</sup> In *Boretti v. Wiscomb*,<sup>196</sup> a nurse refused to treat an inmate or contact a doctor over a holiday weekend to verify the inmate's pain prescription.<sup>197</sup> The patient suffered a gunshot wound, incurred while he was an escapee, and was treated surgically at a hospital and sent to a holding cell at Oakland County Jail. The cells at the jail had no beds, so the inmate slept on the floor, which he complained made his pain worse. Despite being prescribed 800 mg of Motrin, he was denied any pain medication by his captors. The court observed that the nurse could have verified the legitimacy of the prisoner's pain prescription with one phone call.<sup>198</sup> In answer to other defenses the nurse proffered, the court also noted that simply because the wound eventually healed, this did not mean that the prisoner did not suffer damages.<sup>199</sup> The court also ruled that the prisoner could recover "for any injury caused by the delay in care and any concomitant pain, suffering, or mental anguish."<sup>200</sup>

A year after *Boretti*, the Seventh Circuit reversed a dismissal of a claim for failure to treat a prisoner's pain for four months.<sup>201</sup> The

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192. *Id.* at \*2.

193. *Id.* at \*4.

194. See *infra* Part IV (discussing some of the problems of providing medical care in prisons).

195. *Boretti v. Wiscomb*, 930 F.2d 1150, 1152 (6th Cir. 1991), *reh'g en banc denied*, No. 90-1427, 1991 U.S. App. LEXIS 1759, at \*1 (6th Cir. July 9, 1991), *rev'd on remand*, No. 92-2203, 1993 U.S. App. LEXIS 20608, at \*7-8 (6th Cir. Aug. 3, 1993).

196. 930 F.2d 1150 (6th Cir. 1991).

197. *Id.* at 1152.

198. *Id.* at 1154.

199. *Id.* at 1155.

200. *Id.* (quoting *Parrish v. Johnson*, 800 F.2d 600, 611 (6th Cir. 1998)) (emphasis omitted).

201. *Jones*, 193 F.3d at 490-92.

district court was reversed for drawing conclusions of fact in favor of the prison officials.<sup>202</sup> In an affidavit, the prisoner alleged the doctor had refused to prescribe him pain medication when needed, as well as failing to provide him access to a specialist for a six-month period.<sup>203</sup> The court ruled that, if proven, these actions meet the definition of deliberate indifference to serious medical needs required under *Estelle* and *Farmer*.<sup>204</sup>

### C. Substitution of Prescribed Medication

As noted above, pre-*Farmer*, almost any attempt at treatment would undermine a prisoner's claim of deliberate indifference to his medical needs. This has still been largely true for claims in which a prisoner's pain was not treated successfully by drugs that were substituted for stronger, often narcotic prescriptions. In cases in which prisoners were given aspirin, Excedrin, or Ibuprofen (Motrin), when a stronger pain medication had been prescribed and refused to the prisoner, courts generally have not found deliberate indifference on the part of prison officials.<sup>205</sup>

In *Zigmund v. Walsh*,<sup>206</sup> a prisoner who had been prescribed both Excedrin and Ativan, a stronger pain relief medication, lost a summary judgment appeal finding that the prison officials' refusal to give him the stronger drug, as well as failure to provide even Excedrin for periods of three and a half hours was a violation of the Eighth Amendment.<sup>207</sup> In denying the prisoner's claim, the court noted that the prisoner did not claim that "he was in *serious* pain" in his declarations to the court.<sup>208</sup> This appears to be evidence of the court's unwillingness to protect the rights of a pro se litigant in navigating the appeals process. In other cases, courts are very liberal in their reading of prisoners' pro se claims when analyzing whether the claim states a valid cause of action. Failure to state that he was in *serious* pain may have been an inadvertent omission on his part, or he may have assumed that a reasonable person would know his requests for medication, especially for narcotics, were for serious pain.

As mentioned above, in *Sanocki*,<sup>209</sup> a prisoner received many treatments for non-malignant tissue growth, but was given a different pain medication than the one prescribed by a consultant sur-

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202. *Id.* at 491-92.

203. *Id.* at 490.

204. *Id.* at 489.

205. *See, e.g., Zigmund v. Walsh*, No. 98-2862, 1999 WL 491869, at \*1 (2d Cir. July 8, 1999).

206. *Id.*

207. *Id.* at \*2.

208. *Id.* (emphasis added).

209. *Sanocki*, No. 96-3603-KHV, 1998 WL 184460, at \*1.

geon.<sup>210</sup> The prison physician substituted Tylenol-3, for the prescribed medication, Propoxephene, for which there was no "direct equivalent" approved for prescription to federal inmates.<sup>211</sup> The court found no deliberate indifference, as the prisoner had been seen by various physicians on multiple occasions. The substitute of medication could have been characterized as negligent, or an inadvertent failure to properly treat, but did not rise to the level of a constitutional violation.<sup>212</sup>

Similarly, in *Holleman v. Duckworth*,<sup>213</sup> the court found no deliberate indifference in a substitution of a less potent pain medication. The prisoner in *Holleman* had been given Tylenol for his pain associated with his treatment for hepatitis. Physicians at a hospital later recommended he be given Darvon instead of Tylenol, as they believed the Tylenol stressed his liver, undercutting his liver treatment.<sup>214</sup> Because Darvon is a mild narcotic, the prison was unwilling to dispense it and instead substituted aspirin, Ibuprofen, and salasate.<sup>215</sup> The court found that this substitution did not rise to the level of indifference to the prisoner's medical needs.<sup>216</sup> Finding that the prison had a legitimate interest in limiting the use of narcotics by prisoners, the court found no constitutional violation, as the prisoner had been treated for his pain.<sup>217</sup> As will be discussed below, prisons have found ways to reduce the abuse of prescription methods, especially those drugs used for chronically ill patients.<sup>218</sup>

Cases in which prescribed narcotics are not made available to a prisoner are not rare. In *Thomas v. O'Haver*,<sup>219</sup> a nurse confiscated a prisoner's pain medication for back pain upon his arrival to the prison.<sup>220</sup> The court found that the prisoner's failure to communicate the extent of his pain, and the nurse's reasonable belief that his condition might not be necessarily serious was sufficient to sustain the lower court's summary judgment for the defendants against the prisoner's § 1983 claim.<sup>221</sup> In an Arizona case concerning the substitution

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210. *Id.* at \*2.

211. *Id.*

212. *Id.* at \*4.

213. *Holleman v. Duckworth*, No. 99-1004, 1999 WL 1082511, at \*1 (7th Cir. Nov. 15, 1999).

214. *Id.* at \*1.

215. *Id.* at \*1.

216. *Id.* at \*1.

217. *Id.*

218. *See infra* notes 250-51 and accompany text.

219. No. 97-1877, 1998 WL 171270, at \*1 (7th Cir. Apr. 2, 1998).

220. *Id.* She also confiscated his medication for erectile dysfunction, but the prisoner's § 1983 claim for denial of this medication, Yohimbine, was also quashed. *Id.* at \*3.

221. *Id.* at \*2.

of pain medication, the court found no deliberate indifference when the prison physician prescribed Darvocet, a milder narcotic than Percoset, which a physician in a specialty clinic had originally prescribed for the pain the prisoner suffered after an automatic cell door severed the tip of his finger.<sup>222</sup>

Other cases have illuminated prison officials' concerns about prescribing narcotic pain relief. In *Logan v. Clarke*,<sup>223</sup> a prisoner who had a history of narcotic abuse was offered other types of pain medication, none of which successfully alleviated his pain.<sup>224</sup> The prisoner did not claim that the painkillers he received had no effect, prompting the court to opine, "[h]e cannot expect them to eliminate all pain—painkillers usually do not."<sup>225</sup> This lack of awareness of the capabilities of effective pain management is not isolated in the Eighth Circuit.

In a recent case in New York, because there was no evidence presented that would show that the prison doctor's decision to substitute a non-narcotic drug was based on anything other than her medical judgment, the claim failed to survive an analysis of deliberate indifference required of an Eighth Amendment claim.<sup>226</sup> In *Douglas v. Stanwick*, the prisoner had been treated outside of the prison for a fracture in his hand, and had been given a prescription for Darvocet, a narcotic pain medication, by the treating physician.<sup>227</sup> The prison doctor, sensitive to problems of dispensing narcotics in prison, substituted Tylenol for the prisoner's pain.<sup>228</sup> Even after the prisoner was again prescribed Darvocet at his follow up visit with the outside physician, the prison doctor would permit him only Tylenol when he complained of pain.<sup>229</sup> The court noted that when two physicians disagree on the course of treatment, it does not follow that one of them is acting with deliberate indifference to the prisoner's needs.<sup>230</sup> The court found that this is especially relevant when one of the physicians is "more familiar with the jail or prison environment, and therefore more sensitive to the need to restrict narcotics use."<sup>231</sup> A

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222. *Ransom v. Arizona*, No. 94-16427, 1995 WL 608438, at \*1, 4-5 (9th Cir. Oct. 16, 1995).

223. 119 F.3d 647, 650 (8th Cir. 1997) (finding that prison doctors "were not deliberately indifferent" because the prisoner's failure to cooperate led to a delay of medical treatment and the doctors made a reasonable effort to cure the prisoner).

224. *Id.* at 649.

225. *Id.* at 650.

226. *Douglas v. Stanwick*, 93 F. Supp. 2d 320, 324-25 (W.D.N.Y. 2000).

227. *Id.* at 322.

228. *See id.*

229. *Id.*

230. *Id.* at 325.

231. *Id.* (quoting *Thomas v. O'Haver*, No. 97-1877, 1998 WL 171270, at \*4 (7th Cir. Apr. 2, 1998)).

disagreement between a physician and a prisoner or between physicians does not give rise to an Eighth Amendment violation.<sup>232</sup> The court found that this type of disagreement may give rise to a medical malpractice action, when available, but not to a constitutional claim.<sup>233</sup> Given that most Americans are ignorant of the fact that most pain suffering is unnecessary, and that most physicians have not yet embraced modern principals of modern pain management, this result seems understandable. But as it becomes common knowledge that almost all suffering caused by pain is avoidable, is a willingness to permit a prisoner to endure pain not only deliberately indifferent, but tantamount to deliberate infliction of pain?

As effective pain management becomes the norm, a twenty-four hour delay of a patient's prescribed medication as seen in a recent case in Texas, *Augustus v. Dallas County Jail*,<sup>234</sup> should trigger Eighth Amendment protections. In *Augustus*, a prisoner was forced to wait twenty-four hours for pain medication following an accident to his hand, as the medication did not arrive with him back from the hospital where he was treated.<sup>235</sup> Although a recent case, the court curiously relied on cases cited in *Estelle*<sup>236</sup> to find that this delay was not a deliberate indifference to the prisoner's suffering.<sup>237</sup>

## VI. PROBLEMS OF PRACTICING MEDICINE IN PRISON

Practical and logistic problems inherent in the practice of medicine in prisons make diagnosis and treatment of prisoner pain difficult. The constantly growing population of prisoners adds to these problems. The total numbers of prisoners in federal or state adult correctional facilities continues to rise, most recently to include about one out of every 137 U.S. residents.<sup>238</sup> Most of the incoming population has had little access to health care, and comes to the prison with a higher rate of disease than the general population.<sup>239</sup> Obviously,

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232. *Snipes v. DeTella*, 95 F.3d 586, 588-89 (7th Cir. 1996) (concerning an inmate's claim of an Eighth Amendment violation when his toenail was removed without anesthesia and he was forced to shower in standing water).

233. *Id.* at 590-91.

234. No. 3:00-CV-2451-R, 2001 WL 363053, at \*3 (N.D. Tex. Mar. 16, 2001) (finding that a twenty-four hour delay in providing pain medication was not deliberate indifference).

235. *Id.*

236. *Estelle v. Gamble*, 429 U.S. 97, 106 (1976).

237. *Augustus*, No. 3:00-CV-2451-R, 2001 WL 363053, at \*2.

238. ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 1999 at 1 (Aug. 2000), available at <http://www.ojp.usdoj.gov/bjs/abstract/p99.htm>. Over 71,000 of the 1,366,721 prisoners were held in privately operated prisons. *Id.* at 6. For the purposes of Section 1983 claims, the prison workers and physicians are still considered state actors.

239. Prisons have higher incidents of many communicable diseases, including HIV,

prisons are unattractive places to live, but they are also depressing, often frightening places in which to practice medicine.<sup>240</sup> Although there are exemplary clinicians working in prisons in the United States, prisons are also known to hire unlicensed physicians and others with questionable backgrounds.<sup>241</sup> Abusive doctor-patient relationships at prison hospitals are thought to be somewhat common.<sup>242</sup>

Correctional facilities may accredit both their medical facilities and health care workers through the National Commission on Correctional Health Care, which sets standards through voluntary accreditation.<sup>243</sup> These prisons that take advantage of this voluntary accreditation are not likely to be the institutions that have the dubious hiring practices. Although beyond the scope of this Article, mandatory accreditation of prison health care facilities should be considered.

Despite our nation's shameful earlier history of treatment of its prisoners, we have made substantial progress in treating incarcerated people more humanely. With *Estelle*,<sup>244</sup> the groundbreaking case in 1976, the Supreme Court recognized that denial of medical attention could be cruel and unusual punishment.<sup>245</sup> Pain management for terminally ill prison patients has substantially improved in the last decade, mostly through adoption of hospice programs, but also due to some general advancement in pain management protocols, particularly with cancer patients.<sup>246</sup> Within the prison hospice population there are still complaints of overly conservative treatment with

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tuberculosis, hepatitis B virus infection, and gonorrhea. See also Jordan B. Glaser & Robert B. Greifinger, *Correctional Health Care: A Public Health Opportunity*, 118 ANNALS INTERNAL MED. 139, 139 (1993).

240. James E. Lessenger, *Health Care in Jails: A Unique Challenge in Medical Practice*, 72 POSTGRADUATE MEDICINE 131, 131-32 (1982).

241. See generally Andrew A. Skolnick, *Prison Deaths Spotlight How Boards Handle Impaired, Disciplined Physicians*, 280 JAMA 1387, 1387-90 (1998). This article details cases of physicians who have committed serious professional misconduct, resulting in lost or restricted licensing, yet manage to secure positions as prison doctors, where some continue to endanger the lives of their patients. *Id.*

242. See, e.g., ASSEMBLY SELECT COMM. ON PRISON REFORM & REHAB., AN EXAMINATION OF CALIFORNIA'S PRISON HOSPITALS 60-61 (1972), cited in *Estelle*, 429 U.S. at 111 n.3 (Stevens, J., dissenting).

243. AM. COLLEGE OF PHYSICIANS, ET AL., *The Crisis in Correctional Health Care: The Impact of the National Drug Control Strategy on Correctional Health Services*, 117 ANNALS INT. MED. 71, 71 (1992) [hereinafter AM. COLLEGE OF PHYSICIANS, ET AL.]. By 1991, the "NCCHC accredited 73 prisons (11%) and 230 Jails (7%)." *Id.* In 2000, fewer than 25% of facilities had been certified. CORRECTIONAL NEWS, Vol. 7, No. 5, Sept./Oct. 2001, at 22.

244. 429 U.S. at 97.

245. *Id.* at 104-05.

246. Fleet W. Maull, *Issues in Prison Hospice: Toward a Model for the Delivery of Hospice Care in a Correctional Setting*, 13 THE HOSPICE J. 57, 68 (1998).



opioid drugs for terminally ill patients, but some improvement has been documented.<sup>247</sup>

In addition to the tradition of under-treating pain in general, pain relief may be cautiously meted out to suffering prisoners because of the potential for abuse of these drugs. Indeed, some prisoners routinely abuse sick call and medical service procedures in prisons for social reasons.<sup>248</sup> Some experts recommend erring on the side of caution in dealing with manipulative patients, diagnosing patients who are "malingering, faking or hysteri[cal]" carefully by "exclusion," so as not to potentially endanger a prisoners' life.<sup>249</sup>

Strict controls can be administered to ensure that prescribed medication is used to treat a prisoner's pain.<sup>250</sup> In a California state prison hospice program, pain medication is monitored closely by staff and "[e]very pill, injection, etc. is accounted for," as well as the patient's "intake and response[s]."<sup>251</sup> Personnel who administer medications to prisoners must also protect against attempts to stockpile medications for potential suicide attempts, or for trade with other inmates.<sup>252</sup> One expert suggests administering liquid medications whenever possible to guard against "pouching," that is, holding a pill in the mouth and retrieving it once the prisoner is alone.<sup>253</sup> Although hoarding prescribed medications is not an insubstantial problem, it pales in comparison to the problem of prisoner access to a variety of illegal substances. In spite of extraordinary precautions to prevent their import into the prison community, illegal drug and alcohol use among prisoners is endemic in prisons.<sup>254</sup> The market for these contraband drugs is well established, as it is estimated that seventy-five percent of prisoners entering state facilities, and two-thirds of all federal prisoners have substance abuse problems requiring treatment.<sup>255</sup>

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247. *Id.*

248. *Id.* Sometimes referred to as "skaters," these prisoners may just seek an outlet for social interaction with others, or may be drug seeking.

249. Lessenger, *supra* note 240, at 143. Dr. Lessenger recommends taking each prisoner's claim seriously, giving each prisoner a thorough examination, ordering tests, double checking the patient's history, even admitting the patient to the hospital for observation. Dr. Lessenger realizes that this may be playing into the prisoner's manipulative wishes; it may also be lifesaving. *Id.* at 143-44.

250. Maull, *supra* note 246, at 69.

251. *Id.*

252. Maury J. Greenberg, *Prison Medicine*, 38 AM. FAM. PHYSICIAN 167, 170 (1988).

253. *Id.*

254. *See, e.g.*, Lessenger, *supra* note 240, at 133.

255. AM. COLLEGE OF PHYSICIANS, ET AL., *supra* note 243, at 74.

VII. APPLICATION OF THE EXISTING LEGAL STANDARD WITH THE  
REALITY OF THE CAPABILITIES OF EFFECTIVE PAIN MANAGEMENT

Deliberate denial of requests for medical assistance has long been held to be a form of cruel and unusual punishment, "provided that the illness or injury . . . is sufficiently serious or painful to make the refusal of assistance uncivilized."<sup>256</sup> The Supreme Court has found that the definition of cruel and unusual punishment, prohibited by the Eighth Amendment, is not fixed in stone, but expands and "may acquire meaning as public opinion becomes enlightened by a humane justice."<sup>257</sup> The Court has recognized "that the words of the Amendment are not precise, and that their scope is not static."<sup>258</sup> In his fascinating history of the concept of cruel and unusual punishment, Justice Marshall commented on its ability to keep pace with social mores, noting "a penalty that was permissible at one time in our Nation's history is not necessarily permissible today."<sup>259</sup>

Certainly our nation no longer permits deliberate infliction of physical punishment on our prisoners.<sup>260</sup> The notion of whipping a prisoner created quite a stir in 1994 when an eighteen-year-old U.S. citizen, Michael Fay, was sentenced to be "caned" in punishment for his acts of vandalism and graffiti in Singapore.<sup>261</sup> President Clinton and thirty-four U.S. senators appealed to the Singapore government for clemency on Mr. Fay's behalf.<sup>262</sup> Many U.S. citizens were also outraged by what they called "draconian" and "barbarous" punishment.<sup>263</sup>

Whipping was certainly not considered cruel and unusual punishment when the framers of our Constitution wrote the original Bill of Rights.<sup>264</sup> Even as late as 1963, the Supreme Court of Delaware ruled that whipping prisoners for certain crimes, as required by a

256. *Cooper v. Casey*, 97 F.3d 914, 916 (7th Cir. 1996).

257. *Weems v. United States*, 217 U.S. 349, 378 (1910). For a fascinating history of cruel and unusual punishment and its prohibition from common law to modern times, see Justice Marshall's exposition in *Furman v. Georgia*, 408 U.S. 238, 314-33 (1972) (Marshall, J., concurring).

258. *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958).

259. *Furman*, 408 U.S. at 329 (Marshall, J., concurring).

260. See *Jackson v. Bishop*, 404 F.2d 571 (8th Cir. 1968) (rejecting the use of the strap on prisoners as a violation of the Eighth Amendment).

261. See, e.g., *Not Sparing the Rod; How Cruel, How Unusual?*, BOSTON GLOBE, Apr. 10, 1994, at 69.

262. *Id.*

263. *Flogging in Singapore*, L.A. TIMES, May 13, 1994, at B6. Note also that many U.S. citizens also applauded Singapore's punishment of Mr. Fay. *Id.*

264. In deliberation over the language of the Amendments, Mr. Livermore of New Hampshire stated "villains often deserve whipping, and perhaps having their ears cut off; but are we to be prevented from inflicting these punishments because they are cruel?" 1 ANNALS OF CONG. 782-83 (Joseph Gales ed., 1789).

Delaware statute, did not violate either the Delaware Constitution, nor the Eighth or Fourteenth Amendments of the U.S. Constitution.<sup>265</sup> But the Eighth Amendment prohibits punishments that are incompatible with "evolving standards of decency that mark the progress of a maturing society."<sup>266</sup> So today, both whipping and denial of medical care are now unconstitutional.

As medical researchers have nearly obviated the need for physical suffering from medical conditions, will not all refusals to treat the pain of prisoners eventually be considered an "unnecessary and wanton infliction of pain?" The Eighth Amendment's protections have expanded to mirror our nation's sense of decency and concern for suffering. The elasticity of the Eighth Amendment need not be tested further, as the current medical standard dovetails neatly with the current law to adequately protect prisoners. Applying the evolving medical standard of care to the existing legal standard should lead courts to characterize every failure to ameliorate a prisoner's pain due to a serious medical condition, as "deliberate indifference" to suffering, which is prohibited by the Eighth Amendment.

It is clear from a review of the medical literature that pain can be aggressively treated and successfully ameliorated with the arsenal of medicines and treatments available. As the views of Professors Rich and Furrow, as well as other legal scholars, are adopted and pursued in the courts to make the undertreatment of pain not only medically unethical, but legally actionable, the public will no longer tolerate unnecessary suffering based on outdated social mores and cultural assumptions. This lowered tolerance for pain among the general population will also demand a new "civilized minimum" for our nation's prisoners.

After the *Estelle* ruling, many legal commentators were concerned that the standard of "deliberate indifference" was largely unworkable, making it impossible to secure adequate protection for prisoners against cruel and unusual punishment. Other critics of the *Estelle* decision claimed that the Supreme Court reached beyond the scope of the Eighth Amendment, and that a failure to provide medical treatment to prisoners should never be considered punishment at all. They believed that failure to treat pain was not the same as inflicting pain, and could therefore not be considered punishment. *Estelle* held that the fact that a prison official did not directly inflict a prisoner's pain does not make that official any less culpable for fail-

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265. *Delaware v. Cannon*, 55 Del. 587, 597 (1963). The court noted that in Great Britain, whipping was in use until 1948, and in Canada until 1957. *Id.* at 596. The court also noted that Delaware had abolished the punishment of pillory only in 1905. *Id.* at 593. Pillory is "[a] wooden framework with holes through which an offender's head and hands are placed." BLACK'S LAW DICTIONARY 1168 (7th ed. 1999).

266. *Trop*, 356 U.S. at 101.

ure to properly treat that pain.<sup>267</sup> The *Estelle* standard placed the bar of proving an Eighth Amendment violation rather high, requiring a prisoner to prove an element of intent.<sup>268</sup> *Farmer* clarified the deliberate indifference standard,<sup>269</sup> and again spurred legal commentary concerning what constituted a breach of the Eighth Amendment's prohibition against cruel and unusual punishment, but kept the bar rather high, permitting claims only in fairly egregious circumstances. Recent advances in medicine have lowered the standard for acceptable pain, and with it, the amount of suffering that should trigger a finding of deliberate indifference.

The Seventh Circuit's approach to weighing the costs of treatment against the potential harm of failure to treat<sup>270</sup> should be revised to incorporate the costs of potential legal action and the diminished healing abilities of a suffering prisoner. Courts and prison officials alike may then conclude that withholding adequate pain medication is not only cruel and unusual punishment, but may also be economically short sighted.

Lawyers who help prisoners with securing humane medical treatment for their suffering must embrace the modern medical standards of effective pain management in fashioning their claims for relief or for damages against state actors who deny effective pain amelioration. Especially in claims of drug substitution, or failure to provide adequate amounts or timely delivery of pain medication, it is essential that practitioners and pro se litigants feature the reality of medicine's ability to ameliorate suffering in their pleas to the courts.

In future claims of cruel and unusual punishment for failure to adequately treat pain, a prisoner or his lawyer should incorporate the mounting evidence available in the medical literature revealing medicine's true capacity for alleviation of suffering. Recognition of the fact that almost all pain is treatable, makes substituting inferior drugs or the denial of prescribed medication for a prisoner's pain tantamount to a choice to deliberately inflict suffering. When the reality of the principles of modern pain management are considered, the existing legal standard for litigating Eighth Amendment claims is ade-

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267. *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976). The line of reasoning that argues that a jailer is not inflicting punishment on prisoners by denying them medical treatment reminds me of a child wildly thrashing his fists in a windmill fashion, advancing upon his victim, saying "I am just walking towards you, swinging my fists, if you happen to be in the way it is your own fault." The prisoner obviously has no other recourse to end his suffering.

268. *Id.* at 105-06 (stating that not every claim of inadequate treatment is a violation of the Eight Amendment; for example, where this is an accident or inadvertent failure, or malpractice).

269. *Farmer v. Brennan*, 511 U.S. 825, 835-45 (1994) (holding that deliberate indifference requires recklessness, as measured under a subjective test).

270. *Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999).

quate to provide a valid claim for relief to prisoners who are denied appropriate pain amelioration for serious medical conditions.