

Bioethics and Corrections:

An Experiment in Bioethics In the Florida Department of Corrections

By David L. Thomas

Before the late 1960s, many state correctional systems operated relatively independently. The people working in corrections ranged from extremely professional on one end of the spectrum to abusive on the other. In the early 1970s, Florida, as most other states, found itself embroiled in many legal challenges. The publicly expressed philosophies of personal independence and freedom in the late 1960s and 1970s were reflected in the U.S. Supreme Court decisions. Within correctional systems, models based on rehabilitation rather than incarceration were the penitentiary approaches of the time. However, like all cyclic historical movements, this lasted several decades and then waned.

The late 1980s and 1990s saw a return to a public desire for more and tougher incarceration in its various wars on crime. Advocates of “hard time” were every bit as zealous as reform model supporters of a decade and a half earlier. These huge changes in public philosophy over a very short span of time created tremendous pressure on correctional systems to appropriately care for inmates. While pendulum swings between reform and retribution are common in the history of penology, such a great swing in such a short period of time was very unusual. The pressure facing corrections seemed greater than ever.

One approach to dealing with such pressure was the establishment of a forum based on the rational approach to the humane treatment of people, irrespective of their class in society. The Florida Department of Corrections elected to establish such a bioethics forum in 1995.

Community Background

Beginning in the early 1970s, the Supreme Court was presented with and settled a variety of cases involving the substantive rights of inmates in correctional systems. These include access to courts, with the affirmative duty of prison officials to assist inmates in preparing and filing legal papers (*Bounds v. Smith*); freedom of speech, association and religion, unless the “interference is related to a legitimate penal interest” (*Thornburgh v. Abbott*); and some rights concerning personal property, searches and seizures (*Hudson v. Palmer*). Other decisions involving the Eighth Amendment sought to distinguish cruel and unusual punishment from the obvious realities of prison life. *Rhodes v. Chapman* assured due process and equal treatment, but

went on to clearly state that “the Constitution does not mandate comfortable prisons.”

In the fundamental case concerning health care (*Estelle v. Gamble*), the court found that deliberate indifference to the serious medical needs of inmates constitutes the “unnecessary and wanton infliction of pain” and, therefore, violates the Eighth Amendment. From this case, a series of decisions has evolved to ensure inmates three basic rights: access to medical care, receipt of care that is ordered and a professional medical judgment.

At the same time that these Supreme Court decisions were being made, many states were faced with federal District Court challenges, including (in Florida) *Cellestino and Costello et al. v. Wainright*, later *Dugger* and then *Singletary*; (in Texas) *Ruiz v. Estelle*, later *Scott*; and (in Georgia) *Cason v. Seckinger*. Most states increased their expenditures on health services for inmates and responded to court decisions. During the 1980s, many of the large prison systems operated under consent decrees with federal courts and monitoring teams.

Bioethics Committees In Community Hospitals

During the same two decades of these court actions came an explosive revolution in the health care industry. Many varieties of difficult and technical procedures became commonplace, medical miracles in diagnostics and therapies were regular occurrences, and costs were addressed seriously for the first time since 1965. Federally mandated concepts, such as “diagnostic related groups” (Instituted by Medicare as a cost-control measure, they were assigned patients who had been hospitalized and dictated the amount of reimbursement predicated on the simplest treatment of the diagnosis irrespective of the complexity of the individual case.) and the threat of a totally government-controlled universal health care system, pushed providers and reimbursers into the concept of managed care.

Simply stated, managed care is managing the determination of who gets what care. Nowhere in the health care industry is the opportunity for abuse of managed care higher than in the correctional system. Appropriated public funds pay for health care in an environment where citizens

and legislators are currently posturing a “get tough on crime” philosophy. The legislators and the public they represent resent the care that is provided to inmates, have no desire to fund the care given, and view with suspicion the providers of that health care.

This milieu is where health care providers have to advocate for inmates. Most health care providers understand that inmates are a protected class of people. In spite of that, the pressure to ignore those protections because of the inmates’ status as convicted felons are rampant. In fact, there is extensive documentation of the abuse of inmates as subjects in clinical trials, as cited in *Acres of Skin*, the seminal work by Allen Hornblum. Also, recent newspaper accounts appearing in *The Baltimore Sun*, *The Washington Post* and *The New York Times* indicate that, despite federal protections, human subjects are being abused in clinical trials, both inside and outside the correctional setting.

Because of the speed with which medical devices and medications were entering the market, the lag time between final Food and Drug Administration approval, and consumer demand, many physicians found themselves obliged to be clinical investigators for industry in order to bring cutting-edge treatment to their patients. Clinical investigators must register as researchers to use certain medical devices, and they must follow a researcher protocol involving informed consent and an experimental design. Both physician and patient had to agree to participate in a research project, rather than the physician simply doing what he or she felt best for the patient. Nowhere was this more apparent than in the fields of ophthalmology (intraocular lens implants after cataract surgery) and orthopedics (joint replacement hardware and newer cements). Ordinary community hospitals, previously with no thought of being involved in patient research, found themselves embroiled in federal laws concerning the protection of human subjects. As a result, they had to establish institutional review boards to assure protection of patients who were now human subjects. Hospitals were mandated to add to their boards people fitting the role of ethicists.

As people involved in ethics became more involved with their community hospitals, it was a natural outgrowth that these boards looked at other areas of hospital operations. There was no mechanism in federal law to permit that, so many health care establishments founded bioethics committees to assist providers in the many ethical dilemmas that regularly face physicians and nursing staff.

In today’s typical hospital setting, the bioethics committee meets regularly (and can meet for an emergency consultation) but provides its advice only upon request. A physician or nurse facing a perceived ethical situation contacts the committee and explains the situation. The committee then researches the issue and renders an advisory opinion. Some common issues taken up by the committees include terminating life support, conflicting approaches to patient care between provider levels and providing end-stage dialysis for the mentally ill who are refusing it.

Bioethics Committees in Corrections

In 1993, Florida settled a 21-year-old lawsuit dealing with confinement conditions. Three areas were addressed in

Costello v. Wainright/Singletary: food, living quarters and medical care. The first two were corrected and dismissed early in the process. The health care portion went on for two decades. The complaints, which the court found legitimate, were poor access; access controlled by nonmedical personnel, especially wardens; poor quality of care; limited formulary of medications; no real health care protocols; and that the director of health care held a low-level position within the organization. The court ordered a monitor in the early 1980s that continued until 1991 for physical health care and 1993 for mental health care. In closing this case, District Court Judge Susan Black said she felt comfortable removing court monitoring primarily because outside bodies would review and evaluate the DOC’s health services operations. (The state Legislature had created an independent review body, the Correctional Medical Authority, to evaluate the department’s health care services and report its findings to the governor and Legislature.)

With that in mind, in late 1994, the Florida DOC physician in charge of clinical operations attended a meeting of the Florida Bioethics Network, which is an organization comprised of representatives from bioethics committees, interested persons and others primarily concerned with ethics as it pertains to patient care settings. Discussions ensued within Florida’s Office of Health Services concerning the need for such a committee for the Florida DOC’s health service operations. The Office of Health Services at that time was headed by an assistant secretary for health services who by statute reported directly to the secretary of corrections — a direct appointee and the agency head. In 1995, the Office of Health Services established a bioethics committee to discuss potential ethical dilemmas facing the inmate population within the Florida DOC.

Correctional systems by their very nature function out of public view. Appropriately, access to the inside of a correctional institution is limited. And in many cases, as is true with Florida, it is strictly limited by state law. Openly sharing information about and then freely discussing the inner workings of a correctional facility, the inmates within that institution, the health care of those inmates and the problems associated with that care with a group of noncorrectional people was a foreign and, to some extent, revolutionary concept.

By design, the committee comprises state leaders in the ethics field and includes more people on the committee who are not affiliated with corrections than people working in corrections. The Florida Bioethics Network seemed like the right group from which to recruit committee members, so its leadership was tapped. Because a correctional bioethics committee was a novel idea throughout the country, many people professionally involved in ethics wanted to be a part of it. (Only one other state, Hawaii, has a correctional ethics committee, but it is not like Florida’s.)

Members of the bioethics committee include two people from Florida medical schools, a practicing physician, a hospital chaplain, a nurse consultant from the Florida DOC and the two top physicians of the Florida DOC. The committee serves exclusively in an advisory capacity to the Office of Health Services, represented by the three corrections professionals on the committee. This is the same model used for community hospital bioethics committees, except in

the community, there is greater representation by people affiliated with the hospital.

Although the committee had regularly scheduled quarterly meetings, it most frequently meets about three times per year. Some of the issues that have been presented to the committee are typical of those faced by its community counterpart; other problems differ significantly.

Initially, the noncorrectional committee members had to be educated on correctional operations and the correctional environment, and the meetings were held in a hotel conference room. Since, the meetings have all been held behind the fence of one of the state correctional facilities in either the day room or the visiting area. For many of the discussions, a case presentation format is used, while for others, a policy proposal or procedure change is presented by DOC physicians for committee discussion.

Topics of Discussion

Surprisingly, the advice provided by the committee frequently differed from what the DOC representatives had expected. One such case, which involved a man who had attempted suicide by firing a shotgun under his chin, illustrates this vividly. After the man had attempted to kill himself and failed, he was incarcerated for previous crimes. His medical condition was quite serious. Because of the trauma from the shotgun blast, his entire lower jaw had to be rebuilt in order to provide a portal for nourishment. Good dental hygiene was essential for this inmate to keep his oral cavity patent. However, the patient refused to take care of himself, and the portal closed regularly, which required it be reopened surgically. Mental health consultations were obtained and other modalities were used in an effort to get the inmate to care for his oropharynx, but it was all to no avail.

After the inmate had received nine surgical procedures to recreate the mouth area, all of which eventually closed because he would not care for the opening, the case was presented to the bioethics committee for consultation. The committee's recommendation was that the DOC had done more than it should have for this inmate. The committee members said that with just a small amount of care on his part, the opening would have remained patent, and that they would have stopped before the fifth procedure. Extensive discussions were held concerning the inmate's right to refuse care, which he never did, and the agency's requirement to provide necessary care. Without the surgically created aperture, there was no way the inmate could eat, other than with a feeding tube or hyperalimentation. The inmate had regularly and repeatedly refused a feeding tube.

Although some of the discussions were agonizing, the committee members deliberated thoughtfully and provocatively and made the recommendation that the department do nothing further for this inmate. The Office of Health Services never had the opportunity to accept or reject the advice of the committee because prior to the aperture closing, the inmate was released from custody due to the results of a class action lawsuit.

On many occasions, the committee adopted positions that contradicted the DOC's position and the legislative

direction given the executive agencies. Most commonly, this concerned capital punishment. In Florida, the DOC is charged with carrying out the death penalty. Although well established by law, the administration of capital punishment for inmates was repeatedly advised against. The members had a great deal of trouble acknowledging that health care personnel had to, by state law, make the pronouncement of death.

When Florida was in the process of changing the death penalty from electrocution to lethal injection, the public members of the bioethics committee felt it was a very appropriate topic for the committee to tackle. At that time, inmates on death row could select which method of execution they desired. Much vigorous debate occurred concerning the "but for" scenario, which occurred when a condemned inmate received either the first shock or the first bolus of drug combinations but could not be declared dead by the physician. Therefore, another shock or bolus of drugs would have to be administered to achieve death. That being the case, the inmate would not have died but for the actions of the physician. Consequently, a health care provider had an active role in causing an inmate's death. It made no difference to many committee members that the health care provider may have been a volunteer or someone not affiliated with the DOC, or that state law mandates the presence of a physician in the execution chamber. They were adamant that this was not an ethical use of a physician. Indeed, one of the more articulate members stated, "This is not an ethical dilemma. There is no dilemma here. It is simply, morally wrong." This advisory opinion of the committee was not followed.

One particularly interesting case involved an end-stage renal dialysis patient who was experiencing a psychotic episode and refusing care. Typically, an emergency court hearing would have taken too long and put the inmate in danger of uremia poisoning. The patient would have required one hearing for determination of competence, and if the court determined he was incompetent, a second court hearing would have to be held to rule on treatment against his will. At that time, Florida statute was rather strict in protecting inmates in DOC custody.

An emergency meeting of the bioethics committee was held by telephone. The committee unanimously supported the department's position that the inmate should be dialyzed immediately, if necessary, against his will and then treated for his psychoses, again if necessary, against his will. Once his medical and mental health conditions were stabilized then appropriate consents retrospectively could be obtained. If he would not retrospectively consent, the committee was willing to support the department's decision in any court or administrative proceeding.

During many of the meetings, there was no case for presentation, so the committee would evaluate Office of Health Services policies and procedures. Frequently, the committee would point out omissions or commissions to the procedures that improved the quality of the work product.

One downside to the committee was the lack of consultations on the institutional level. Almost all the cases presented to the bioethics committee were initiated by the DOC's central office physicians. Institutional physicians and nursing personnel did not avail themselves of the com-

mittee's deliberative process. Great efforts were made to educate institutional staff on the workings of the committee, and they were encouraged to seek it out, but there was never any real attempt by institutional or regional staff to access this resource. Certainly, an institutional health services operation sees the same kind of problems that a community hospital faces. Where a community hospital would seek bioethics consultation regularly, individual correctional institutions seemed to want central office administrators to handle this aspect of care.

This reluctance on the part of institutional and even regional personnel was the topic of many discussions of the bioethics committee, but no real resolution was ever made. The discussions centered primarily on three possibilities: institutional providers did not perceive the ethical impact of their actions, institutional functions were so routine that any ethical consideration had long since been cast aside due to repetition of behaviors, or institutional staff were too busy or too intimidated to seek out ethical opinions.

The Office of Health Services engaged in several surveys to attempt to elicit why bioethics committee deliberations were not sought after. Some of these inquiries were formal; they were during working hours and within the institutions. And some efforts were informal, taking place outside the correctional setting. No satisfactory reason was ever elicited for the lack of institutional staff accessing bioethics consults.

Conclusion

The creation and use of a bioethics committee for deliberation of inmate medical care was a cutting-edge decision made by the Florida DOC's Office of Health Services. The committee's deliberations were sophisticated and provocative, frequently seeing results of actions that many corrections professionals would not have predicted. If anything, the creation of the committee certainly helped to demystify what happens behind the walls of correctional facilities and served to break down barriers between the community and the DOC.

It is unfortunate, however, that the people who could have benefitted the most from the committee, the institutional health care providers, were so reluctant to engage in its services. It has certainly served a valuable function as an advisory board to the decision-makers in the Office of Health Services. Hopefully, the committee will continue to function in the Florida DOC, and other state prison agencies will adopt the concept.

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