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# Cruel and Unusual Punishment: Distinguishing Distributive and Retributive Justice

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The California prison healthcare system is currently in receivership of a size and scope unprecedented nationally. Attorneys representing California prisoners successfully brought two class action lawsuits against the state in 2001 demonstrating that the medical and mental healthcare in California's prisons are so inadequate that they violate the federal Constitution's Eighth Amendment ban on cruel and unusual punishment. *Plata v. Schwarzenegger*[1] addresses medical care and *Coleman v. Schwarzenegger*[2] focuses on mental healthcare. In establishing the receivership, U.S. District Court Judge Thelton E. Henderson wrote, "By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action."[3] At issue are billions of dollars to support the construction of thousands of new beds at existing prisons, re-entry centers, healthcare-related spaces, and local jails, for the 33-prison system.

To date the construction has not been completed — not even initiated. The state settled the suit in 2002 and agreed to a range of remedies that would bring prison medical care in line with constitutional standards. Failure to comply with the court's direction resulted in the establishment of a receivership. Judge Henderson wrote:

> The Court has given defendants (the State) every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's [California Department of Corrections and Rehabilitation's] medical delivery system. It is clear to the Court that this unconscionable degree of suffering and death is sure to continue if the system is not dramatically overhauled.[4]

In August 2008, Federal Receiver J. Clark Kelso moved to seize $8 billion from the California Treasury for medical, mental health, and dental care by the end of the 2011-2012 fiscal year, and requested $2 million per day in fines for failure to fund the needed healthcare beds.

California, so often a leader on social issues, may once again be leading the way — although by court-ordered force — in providing substantive content to the prison healthcare standard established in *Estelle v. Gamble.*[5] The state, mired in a budget crisis with a deficit of $15 billion and extreme prison overcrowding, has not prioritized inmate healthcare. Certainly, this is understandable, if not justifiable, but must be consid-

ered against the larger backdrop. Even in times of budget surplus, prison healthcare has been under funded. This situation, indeed the bleak picture of prison healthcare nationally, suggests at least one fundamental ethical question: How do we define justice in healthcare?

In 1976 the U.S. Supreme Court issued its landmark ruling in *Estelle v. Gamble,* defining the basic constitutional standard of adequate prison healthcare. Justice Marshall wrote for the Court:

> Deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain. . . . proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with treatment once proscribed.[6]

In effect, this decision grants prisoners a right to healthcare. Prisoners, unlike the majority of the American population, are guaranteed both access to healthcare and needed services. Subsequent court rulings and various healthcare organizations have defined inmates' right to healthcare, invoking a community standard or principle of equivalence,[7] that is, prison healthcare ought to mirror that which is available in the community. Such a standard reflects an international consensus on healthcare as a human right. Elger, in this issue of *The Journal of Clinical Ethics,* describes the ethical problems arising out of failure in the U.S. to embrace and operationalize such a standard in American prisons. She notes, "for a country such as the U.S., in which nearly 16 percent of the population does not have access to basic healthcare, applying the principle of equivalence is difficult, and might even be used to justify the absence of healthcare services for poor prisoners."[8] The obvious question: Why should inmates have a right to healthcare when even access to healthcare services has not yet risen to the level of a legal right for law-abiding American citizens? However, the question raised is backward, and its reversal suggests more promising directions for both clinical medicine and public health. Rather than asking why prisoners are guaranteed something the rest of us are not, we should question why all Americans do not have a right to healthcare.

Yet the focus continues to be prisoners' rights. In response to the California receiver's quest for adequate funds for prison healthcare, California Senator Jeff Denham (R-Atwater) said, "the idea of providing $8 billion for state-of-the-art healthcare for murderers like Charles Ng, Richard Allen Davis, and Scott Peterson is sheer lunacy."[9] The implication in these tight budget times is that prisoners do not deserve the healthcare that is constitutionally required, particularly when there are so many other competing needs. On the one hand, to fund prison healthcare when state programs for children, the disabled, the elderly, and other vulnerable populations are being cut or eliminated may be "sheer lunacy." On the other hand, the "lunacy" may be in Denham's response itself. The comment suggests that inmates do not deserve healthcare and appears to rely on a criterion of just desserts to frame a public policy issue. Should our status in society, or our contributions — positive or negative — determine whether we deserve healthcare services? A re-examination of definitions of justice at the societal level and their implications for policy development is needed.

When it comes to the American justice system, it is easy to confuse distributive and retributive justice. Retributive justice involves assessing wrongdoing to determine appropriate punishment. It may seem appropriate to punish the commission of a crime with a denial of healthcare. In committing and being convicted of a crime, one forfeits rights and access to societal goods. Among those goods, some might argue, is healthcare. This may seem especially appropriate for the violent offenders, those who take life or injure their victims. *Lex talionis* or "an eye for eye" thinking can be interpreted to mean that individuals who take life or cause injury deserve whatever ill effects they suffer while incarcerated for their crimes. One who causes harms should suffer harms. However, our criminal justice system has long rejected such a literal interpretation of punishment, preferring to withhold freedom in amounts commensurate with the crime (except for capital cases). Other rights, both legal and human, are preserved. Further, some rights are reserved specifically for those determined to be criminal, such as the right to be free from cruel and unusual punishment. Inmates do have rights, and it is the responsibility of the justice system to assure maintenance of those rights, despite the limited freedom of imprisonment, and despite however heinous their crimes may be.

Even if retributive and distributive notions of justice are not confused, creating conditions in which prisoners cannot access necessary healthcare services is inappropriate and unfairly distributes healthcare resources. First, it defines distributive justice by merit, which in this situation essentially disguises retributive justice. Second, such a conception of justice is generally soundly rejected as unfair in American political philosophy, in public policy, and certainly in healthcare practice. While we have far from achieved anything close to egalitarianism in healthcare, the distribution of healthcare resources is most often guided by other criteria including need, likelihood of benefit, lottery, and even the ability to pay, rather than merit or societal contribution.[10] Third, any distributive scheme that purposefully leaves out a portion of the population ignores the effect of that population on the whole: "Because prisoners constantly come in contact with other prisoners, staff, guards, healthcare professionals, and the general public through visits, the rampant spread of communicable diseases throughout the nation's prisons affects society as a whole."[11] And inmates are released into the greater community without leaving their illnesses behind. If for no other reason then a utilitarian self-protection, it is imperative that inmates receive adequate healthcare. American prisons have become incubators for infections diseases such as HIV, hepatitis, and tuberculosis. In one survey of prisoners, 44 percent of state inmates and 39 percent of federal inmates reported a current medical problem other than a cold or virus.[12]

Elger suggests that "the actual ethical dilemma" is "the unethical conditions under which many physicians work in correctional institutions."[13] True, but this conceives of the problem narrowly. This is not just an issue for prison physicians. The prison healthcare dilemma represents a larger conflict facing American healthcare in sorting out ethical principles, policy requirements, and reality. Certainly physicians should embrace their ethical obligation to the principle of social justice, "to work actively to eliminate discrimination in healthcare, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category."[14] However, without a clear definition or criteria for justice in healthcare that addresses both public policy requirements and realistic constraints, it is impossible to determine what ethical working conditions are and to what goal(s) healthcare professionals should work.

The World Health Organization has called for a right to health, defined as the right of all to enjoy the highest possible level of health.[15] This right of health suggests that all have access to the services needed to strive for the degree of health experienced by the most privileged group in society.[16] Equity in health or healthcare services may not be an achievable political standard, but the pursuit of equity should not get lost in prejudice and discrimination. The true test of a just society may well lie in how it treats those perceived to be its most undeserving. Imagine a society in which prisoners truly have a right to healthcare. We could then begin to lay claim to such a right for all. California, willingly or unwillingly, may lead efforts to define justice in healthcare for inmates, and ultimately for all Americans.

## NOTES

1. *Plata v. Schwarzenegger***,** 556 F.Supp.2d 1087 (N.D.Cal. 2008).

2. *Coleman v. Schwarzenegger,* Slip Copy, 2008 WL 3843292 (E.D.Cal.).

3. Plata v. Schwarzenegger *accessed online: http://www.prisonlaw.com/pdfs/PlataJudgeOrder.pdf,* accessed 22 August 2008.

4. Ibid.

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

6. Ibid., 104-105.

7. For summary of international standards, see B.S. Elger, "Medical Ethics in Correctional Healthcare: An International Comparison of Guidelines," in this issue of *JCE.* For summary of the U.S. legal standard see, F. Cohn, "The Ethics of End-of-Life Care for Prison Inmates," *Journal of Law, Medicine & Ethics* 27, no. 3 (1999): 252-59.

8. Elger, see note 7 above.

9. M. Rothfeld, "$8 billion is sought for prisoners' care," *Los Angles Times*, 14 August 2008, A13.

10. T. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics,* 5th ed. (New York: Oxford University Press, 2001).

11. Z.G. Restum, "Public Health Implications of Substandard Correctional Health Care," *American Journal of Public Health* 95, no. 10 (October 2005): 1689-91, p. 1690.

12. L.M. Maruschak, Medical Problems of Prisoners, Bureau of Justice Statistics, *www.ojp.usdoj.gov/bjs/pub/html/mpp/mpp.htm,* accessed 22 August 2008.

13. Elger, see note 7 above p. 10.

14. Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, "Medical Professionalism in the New Millennium: A Physician Charter," *Annals of Internal Medicine* 136, no. 3 (5 February 2002): 243-6, p. 245.

15. Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, 45th ed, October 2006, *http://www.who.int/governance/eb/who_constitution_en.pdf,* accessed 28 August 2008.

16. P. Braveman and S. Gruskin, "Defining equity in health," *Journal of Epidemiology and Community Health* 57, no. 4 (April 2003): 254-8.