Chapter Four – The Dialectic

John Rohr has reminded us that the moral universe is not tidy (Rohr, 1989, p. 70). Looking at alternative ways of examining a Supreme Court case, a dialectic approach emphasizes the untidiness inherent in that universe and in the administration of human affairs. The dialectic may be a dissenting opinion or a different lens, such as a bioethical perspective or a pragmatic administrative perspective based on budgetary constraints or social expectations. The appropriateness of examining such alternative perspectives was pointed out by Alasdair MacIntyre when he posited that the United States itself was founded on the self-avowed basis of highly debatable moral judgments characterized as “self-evident truths” which he suggested may be “highly debatable moral judgments”—leading to the prospect that the regime may be founded on a moral contradiction (Commission, 1978, Appendix, Vol. I, pp. 10-14 to 10-15).

This chapter, while briefly discussing the contributions of dissenting and concurring opinions, offers an alternative perspective to the majority’s opinion in West v. Atkins (1988) and expands on conflicting opinions, values, and attitudes about medical care for inmates. While it is the intent of this dissertation to use the law as pedagogy to illuminate an administrative question, it is important to recognize that there are competing perspectives vying for the attention of the administrator which may create potentially irreconcilable tensions. Among these competing visions, this chapter will highlight the healthcare perspective and examine the bioethical implications of the West decision, as well as public attitudes about healthcare and punishment. For the public administration practitioner who does not have the luxury of narrowing his or her focus in the execution of day to day responsibilities, the chapter illustrates alternative, complementary, and competing perspectives—perspectives which highlight the complexity of the administrative and dialectical responsibilities faced by the practitioner attempting to unify constitutional perspectives and bioethical issues, while educating the public, helping shape public opinion, and serving the demands of his or her particular area of responsibility. The

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1 MacIntyre suggests that Jefferson, when citing the sources of some of his thoughts in the Declaration of Independence (Aristotle, Cicero, Locke and Algernon Sidney; according to MacIntyre), was more than likely aware of such contradictions.
practitioner attempting to unify these competing demands must exercise informed judgment—
judgment based upon an understanding of the reasoning supporting those competing
responsibilities.

**Dissenting and Concurring Opinions**

The importance of dissenting opinions was illustrated in the previous chapter. The dissent of
Chief Judge Winters of the Fourth Circuit Court of Appeals became a framework for the U.S.
Supreme Court’s *West* decision. For that reason, Winters’ dissent was discussed in some detail
in that chapter (*West, 4th* Cir. 1987).

Justice Scalia, while concurring in part with the majority opinion and concurring with the
Court’s decision, used different reasoning to reach his decision in *West v. Atkins* (1988). He
expressed doubt whether a doctor, lacking both supervisory and penological duties, could inflict
punishment within the meaning of the Eighth Amendment. Scalia’s opinion was that the Court
should have considered whether West had been deprived of liberty without due process as
protected by the Fourteenth Amendment (*West, 1988*, at 58). A brief review of one of the cases
cited by Scalia, *Rochin v. California* (1952), illustrates this perspective and the reasoning that
Justice Scalia preferred.

The Supreme Court granted certiorari to hear *Rochin* (1952) because the case raised questions
about the limitations placed on the conduct of police investigations by the due process clause of
the Fourteenth Amendment. The facts of the case were that “[h]aving ‘some information that
[the petitioner] … was selling narcotics,’” three state officers entered Rochin’s home and forced
their way into the bedroom occupied by Rochin and his wife. After being asked by the officers
about two capsules on a bedside table, Rochin put them in his mouth. Following an unsuccessful
attempt by the officers to extract the capsules by force, Rochin was “handcuffed and taken to a
hospital … [where] an emetic was forced into his stomach against his will.” As a result, he
vomited the capsules which were found to contain morphine. Rochin was sentenced by a
California Superior Court on a charge of possessing morphine and sentenced to 60 days in jail.
The District Court of Appeals affirmed, “despite the finding that the officers were guilty of
unlawfully assaulting and battering defendant while in the room” (Rochin v. California, 1952 at 167). The California Supreme Court declined to review the case. The Supreme Court reversed.

Writing for the Court and finding for the petitioner, Justice Felix Frankfurter found that “[r]egard for the requirements of the Due Process Clause ‘inescapably imposes upon this Court an exercise of judgment upon the whole course of the proceedings …’” in order to determine whether there was an offense to common law decency and fairness “‘even toward those charged with the most heinous offenses’” (Rochin, 1952, at 169, quoting Malinski v. New York, 1945, at 416-417). Justice Frankfurter described the due process of law as a “summarized constitutional guarantee of respect for those personal immunities which,” quoting Justice Cardozo, are “so rooted in the traditions and conscience of our people as to be ranked fundamental,” (Snyder v. Massachusetts, 1934 at 105) and “implicit in the concept of ordered liberty” (Palko v. Connecticut, 1937 at 325). The Court found that due process of law precludes convictions obtained by methods that offend a “sense of justice.” Speaking to the specifics of the case, Justice Frankfurter wrote,

Applying ... general considerations to the circumstances of the present case, we are compelled to conclude that the proceedings by which this conviction was obtained do more than offend some fastidious squeamishness or private sentimentalism about combating crime too energetically. This is conduct that shocks the conscience. ... It would be stultifying of the responsibility which the course of constitutional history has cast upon this Court to hold that in order to convict a man the police cannot extract by force what is in his mind but can extract what is in his stomach (Rochin, 1952 at 172-73).²

² Justice Black, while concurring with the Court’s conclusion, disagreed with the majority reasoning which he found too loosely constructed and one that empowered the Court to “nullify any state law if its application ‘shocks the conscience,’ offends ‘a sense of justice’ or runs counter to the ‘decencies of civilized conduct’” (Rochin, 1952, at 175). The justice offered a classic literal interpretation of the Fifth Amendment’s command that “No person ... shall be compelled in any criminal case to be a witness against himself”—

I think a person is compelled to be a witness against himself not only when he is compelled to testify, but also when as here, incriminating evidence is forcibly taken from him by a contrivance of modern science (Justice Black in Rochin, 1952, at 174-175).
Justice Scalia found that the medical treatment that Quincy West received should have been judged on the basis of common law decency and fundamental personal immunities implied by the due process clause of the Fourteenth Amendment. This more philosophical perspective invites other alternative views of Quincy West’s circumstances and different historical emphases.

**Medical Research and Experimentation**

When Dr. Robert Atkins told prison inmate Quincy West that he wanted to undertake an “experiment” to determine if his tendon would knit by itself, the physician was entering an area in which standards, based on a lengthy history of ethical concerns and missteps, had been well established.

U.S. government sponsored clinical research using inmates of prisons and other custodial institutions was instituted during World War II. President Roosevelt created the Office of Scientific Research and Development in the summer of 1941. The responsibilities of that office included oversight of weapons research and the Committee on Medical Research (CMR). The latter was an experiment in coordination of medical research on a large scale. This research was related to dysentery, influenza, malaria, and venereal diseases—looming problems as the nation prepared for war. David Rothman (1995) reported that “researchers with links to custodial institutions had an edge in securing [CMR] grants” (Anderson, 1944; Rothman, 1995, p. 85) and that the public did not question whether the prisoners and other vulnerable populations used for research purposes were able to give voluntary or informed consent. Rather, the public response was to congratulate the inmates and patients for “demonstrating ‘to the fullest extent just how completely this is everybody’s war’” (Rothman, 1995, p. 85; Laurence, 1945). Only one set of CMR experiments, because of its ambiguous social approval, generated a discussion of ethics—research into the prevention and cure of gonorrhea. In general, the use of members of vulnerable populations as research subjects was legitimated by using the analogue of young men drafted and compelled to risk their lives for their country.

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3 Such institutions included children at the Ohio Soldiers and Sailors Orphanage, mentally ill patients at the Mateno Illinois State Hospital, retarded individuals in a Pennsylvania state facility (Penhurst), inmates at a correctional facility for young offenders, etc. (Rothman, 1995).
In the 1950s and earlier, prisoners were induced to participate as research subjects through the use of incentives such as early parole or sentence commutation (Fox, 1960). This practice was discouraged by the American Medical Association House of Delegates in 1952 when they adopted a resolution disapproving of the practice of granting early parole to those convicted of murder and other vicious crimes (Katz, 1972, p. 1025). The types of research that involved prisoners was, most commonly, Phase I drug trials—research which was not expected to provide any health benefits to the subjects. Such research included the testing of “new narcotic derivatives and analogues” and the deliberate infection of prisoners with diseases “ranging in severity from the common cold to malaria.” Other research involved behavior modification techniques and manipulation of the prison environment, for example, “aversion conditioning (employing electric shock or drugs with unpleasant effects) in treating sex offenders or uncontrollably violent prisoners” (West, 1976, p. 25).

The National Research Act, Public Law 93-348, enacted in July 1974, created the National Commission for the Protection of Human Subjects. Section 203 of that act required the Commission to “conduct a ‘special study’ of the ethical, social and legal implications of advances in biomedical and behavioral research and technology.” The results of this special study were to become known as *The Belmont Report* (Commission, 1978).

In discussing its mandate, the Commission report states that “the issues reflected in the special study go back at least to 1945 and have continued to develop in significant ways . . .” (Commission, 1978, p. 1). The justification cited for the study included major scientific and technological advances in the twenty years following World War II—advances that had influenced the character of individual and social life. The side effects, or unintended consequences, of these advances begged ethical, political, and contextual examination. In the Commission’s words, “immediate problems of biomedical and behavioral research and technology must be considered in relation to broader aspects of social change and public policy” (Commission, 1978, p. 1). Unwritten, but undoubtedly telling factors in Commission members’ deliberations, were their memories of the experiments of Nazi physicians exposed at the Nuremberg trials and the widespread public condemnation following media revelations of the
use, within the United States, of vulnerable populations as research subjects. As noted in Chapter Two, the groups who had been the subjects of the latter included, disabled children, cancer patients, and syphilitic black males—none of whom were either capable of, or given an opportunity to, consent to their participation in the research.

While the title of The Belmont Report included the word “research,” it addressed both research and experimentation. At the time it was written, an unclear distinction remained between the two in the understanding of the general public and within many elements of the professional community. However, more recently an important distinction between clinical research and experimentation has been made. The goal of clinical research is neutral: to increase scientific knowledge. While the research subject can be assured that the researcher has no malevolent intent, that subject may not benefit from the research and assumes a risk of potential injury on his or her journey into the unknown.\(^4\) A patient subjected to an experimental procedure during the course of medical care can expect that his physician has a beneficent goal (and duty) associated with the preservation and/or enhancement of his welfare and well being.

The commissioners were particularly concerned about the use of prison inmates as research subjects and subjects for experimentation. Whether prisoners can exercise a free power of choice, i.e., give informed consent for research or experimentation, was a serious question. The commission members’ concerns were based on the coercive nature of incarceration. In an appendix to the commission report dealing with research involving prisoners, the author, C. West, pointed out that coercion involves a threat that is intended to alter an individual’s behavior, and that prison conditions—by their very nature—restrict the ability of incarcerated individuals to make rational choices (West, 1976). Concurring with the Commission members, Alvin Bronstein, Director of the ACLU National Prison Project (and co-author of the ACLU brief in West) declared, “You cannot create [a prison] institution in which informed consent without coercion is feasible” (Bronstein, 1975; Faden, 1986, p. 344).

\(^4\) It is unethical to conduct randomized clinical trials in circumstances where one therapy (A) is known to be superior to another (B). For this reason, duplication of such research is not permitted once the superiority of one therapy over another has been determined. In circumstances where a third therapy (C) is known to be superior to A and B, Comparisons of A or B to C should not be conducted, unless there is sufficient reason to reject C based on the characteristics of a particular population (Levine, 1986, p. 187).
David J. Rothman, in a 1975 *Hastings Center Report*, reasoned that it is ethically permissible to conduct a study in nature,\(^5\) i.e., an experiment in which the researcher is a passive observer—unless the subject or subjects live in conditions of overwhelming social deprivation. He argued that in the latter instance the researcher is not an objective observer, but becomes an accomplice to the deprivation (Rothman, 1975).

The concerns expressed by the Commission related to the use of prisoners as research subjects were *respect for persons* and *justice* (West, 1976, pp. 6-10). Robert Veatch (2000) points out that the concept of respect for persons “gives a strong commitment to self determination or what is now in ethical theory normally called autonomy” (Veatch, 2000, p. 144).\(^6\) The commission members found the most appropriate expression of the principle of respect for persons—as it was applied to prisoners—consisted of their protection from exploitation.

Recommendations regarding justice, defined as the fair distribution of burdens and benefits and generally referred to as *distributive justice*, were similar to the Commission’s recommendations regarding other vulnerable populations, i.e., that the risks of research participation should be equivalent to risks accepted by non-prisoner volunteers.\(^7\) Robert Levine tells us that the

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\(^5\) In research a “study in nature” is differentiated from controlled research and experimentation. In such a study subjects are observed without application of research protocols or other intervention by the researcher, for example, a researcher observing wildlife or the course of a disease. When the environment is modified by the researcher, or treatment provided in the case of disease, it is no longer a study in nature. The Tuskegee syphilis study was a study in nature. The course of the disease in the infected men was observed and noted without intervention and they were not informed that they were subjects in a study of syphilis. Neither were they informed when an effective treatment became available—even when it had become, not only available, but the community standard of care.

\(^6\) The concept of *autonomy* is closely tied to concepts of independence, freedom and free will. For centuries these concepts have contained conflicting perspectives of man’s exercise of his freedom of choice between options, or his predetermined fate. The word comes from the Greek, *autos*, meaning self; and, *nomos*, meaning law. Autonomy for Kant was the will of man acting from internal principles, as distinguished from herteronymous will: acting from external principles. For Kant, the herteronymous will sacrifices both ethics and its own freedom. (Reese, 1983).

\(^7\) While the language is similar, a different more specific assessment occurs in treatment decisions or when a patient is assessed for participation in a clinical trial. That assessment involves a comparison of potential benefits and potential risks and/or harms. A considerable degree of medical discretion is available in such an assessment. The concept of benefits itself requires subjective value judgment; and, from a liberal Western philosophical perspective, a consideration of the patient’s values. In some circumstances, such as untreatable communicable disease or wartime, community or social benefit may become a dominant consideration. For example, in World War II there
commission members were influenced by John Rawls’ ideas of a non-utilitarian view of justice—theoretically based in the natural rights theory of the contractarian tradition. At the time of the commission report, these ideas were emerging in academic and professional journals and were included in Rawls’ *A Theory of Justice* (Rawls 1971; Levine 1986).

In November 1973, the Department of Health, Education and Welfare (DHEW) published proposed regulations with severe limitations on the use of prisoners in research (DHEW, 1973), and in March 1976, the Federal Bureau of Prisons prohibited the use of federal prisoners for “medical experimentation,” joining eight states that had previously initiated such restrictions (Levine, 1986, p. 292). In 1978, the Department of Health and Human Services (DHHS) published 45 C.F.R. 46, subpart C, constituting final regulations on research involving prisoners. Section 46.306 identifies the types of research allowed. Research not specified in the section was forbidden. The regulations specified the use of Institutional Review Boards (IRBs) for the prior approval of all research involving prisoners and the presence of at least one inmate IRB member. Furthermore, a majority of the IRB members were required to have no other association with the prison.

The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President’s Commission), sworn in on January 14, 1980 by Judge David L. Bazelon, was charged by Congress to produce a sequel to *The Belmont Report*. The commission was chaired by Alexander M. Capron, who, at the conclusion of the new commission’s work, became a professor of law, ethics and public policy at Georgetown was a limited supply of penicillin and decisions had to be made between providing the “miracle drug” to soldiers with septic wounds received in battle or to those with venereal disease.

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8 In general terms, the “contractarian tradition” is based on the concept of a social contract which postulates an implicit agreement by which human beings abandoned the “state of nature” in favor of the formation of society. Different versions of the concept were developed by Hobbes and Locke. However, they agreed that such a contract would have entailed the surrender of certain freedoms, powers, and control by the individual in exchange for society’s protection. This exchange highlights the essential element of any contract: consideration, i.e., the exchange of something of value by each of the parties. An agreement without consideration does not constitute a legally binding contract. The concept of the social contract and society’s (and government’s) responsibility to its citizens was used as justification for the French and American revolutions.

9 Title III of Public Law 95-622 enacted on November 9, 1978, codified at 42 U.S.C. Ch. 6A, was the enabling legislation for the President’s Commission. The original legislation contained a “sunset” date of December 31, 1982. The later was amended on December 20, 1982 extending the date to March 31, 1983.
University. The new commission was asked to examine eleven areas which The Belmont Report had suggested for further research and ultimately produced five reports related to the provision of health care. The three principal interests of the President’s Commission were: “(1) the patient’s right of self-determination and (2) the patient’s well-being, as reflected in (3) the health professional’s expert judgment.” (Capron, 1986, p. 17). One of those reports was Making Health Care Decisions (President’s Commission, 1982). That report placed the primary responsibility on the health care professional (physician), but also concluded that hospitals and similar institutions held a major responsibility to facilitate the physician-patient decision making process.

Informed Consent

As implied above, the concept of informed consent is a fairly recent phenomenon, the source of which is embedded in the history of medical research and experimentation, in the law, and in ethical principles. As noted in Chapter Two, based on the case law premise that “self-determination is a basic right of free men,” Angela Roddey Holder defined the doctrine of informed consent as “the duty to warn a patient of the hazards of new and experimental or unusual therapy as well as the possible complications or expected results of more standard treatment” (Holder, 1970a, p. 1181). The Belmont Commission report built on the concept of respect for persons to develop a consent doctrine for research and experimentation.

Informed consent was also one of the focus areas of the President’s Commission. Among that commission’s findings and conclusions were: (1) a determination that “[a]lthough the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative; (2) [e]thically valid consent is a process of shared decision-making …; (3) … patient choice is not absolute [but is subject to the following three caveats]…. Caveats associated with patient choice included: (a) patients may not insist on health care services which “breach the bounds of accepted practice or violate a professional’s own deeply held moral beliefs or would draw on a limited resource to which the patient has no binding claim;” (b) alternate arrangements must be made for patients lacking the capacity to make their own decisions; and, (c) patients “lacking
decisional capacity should be consulted about their own preferences … out of respect for them as individuals” (President’s Commission, 1983, p. 20).

Other findings and conclusions in the area of informed consent included: (4) the principle that unpleasant information should not be withheld from patients by providers; (5) and, various recommendations regarding protections for patients lacking decision-making capacity. Those recommendations were: (a) surrogate decisions should be in the patient’s best interests and, when possible, replicate the decision that the patient would have made had he been able; (b) ethics committees should, ideally, be used as mechanisms for review and consultation regarding decision-making for those lacking capacity; and (c) “[s]tate courts and legislatures should consider making provisions for advanced directives through which people may designate others to make health care decisions on their behalf and/or give instructions about their care should they become incapacitated” (President’s Commission, 1983, p. 21).

The living will and durable power of attorney for health care documents are documents currently used by individuals desiring to provide instructions for future instances when they may no longer be able to make their own decisions or articulate their preferences. In the absence of prior consent or such documents, a court order may be required for treatment unless the condition is life threatening and requires immediate medical intervention.10

The Hippocratic Oath includes the admonition to do no harm (nonmaleficience). However, the Hippocratic Oath is a paternalistic approach to the doctor-patient relationship in contrast to modern concerns that persons have the right to consent to or refuse medical treatment. The most dramatic challenge to the Hippocratic tradition was the adoption of the Nuremberg Code in 1946. Nazi physicians had not been working for the benefit of their individual patients, but were conducting research in support of the agenda of the Nazi regime. However, a return to the Hippocratic tradition would not allow physicians, ethically bound to the principles of beneficence and nonmaleficence, to conduct research for the general good because of the

10 Consent law is complex and varies from state to state. Generally, the consent of a parent is required for a minor, except in the instance where that minor is considered to be emancipated. Disabled individuals may be represented by a guardian or other individual with custodial responsibilities.
element of uncertainty and potential for injury to the subject in research.\textsuperscript{11} Pointing out that medical research benefits humankind, Robert Veatch (2000) tells us that the 1946 Nuremberg Code was

“The first medical ethical document in the 2500 years after Hippocrates that mentioned the concept of informed consent: that is, the notion that the patient or subject has the right to be informed of the relevant facts of what is being proposed and to approve or disapprove before the physician proceeds” (Veatch, 2000, pp. 9-10).

The 1973 American Hospital Association’s (AHA) Patient Bill of Rights continued the liberal tradition of the Nuremberg Code in its break with the Hippocratic tradition. The AHA document affirmed patient rights and included informed consent and the patient’s right to information. Finally in 1980, the American Medical Association changed its code to include the rights of patients.\textsuperscript{12}

The principle of respect for autonomy is rooted in the traditions of Kant and liberal Western philosophy. Veatch tells us that “the term liberalism has within it a respect for liberty” and that liberal political philosophy “has dominated medical ethics in the United States and much of the rest of the Western world since radical rethinking of medical ethics began about 1970.” This philosophy is frequently represented by “rights” language. Veatch points out that there is a reciprocal relationship between rights and duties: that is, if an appeal is made to a right, normally others have duties associated with the assurance of that right. In addition, a rights claim is often seen as having special standing “such that mere appeals to consequences cannot be used to

\textsuperscript{11} Robert Veatch (2000) expressed this thought in a different way:

The Hippocratic ethic would have prohibited the Nazi experiments, but it would also have foreclosed even the most benign and defensible research. ... Instead of returning to a Hippocratic model, spokespersons for Western society [at the Nuremberg trials] acknowledged that research was necessary for the individual patient....[P]rotection came in the form of requiring informed consent from subjects so they could look out for their own interests (Veatch, 2000, p. 9).

\textsuperscript{12} While adopted in 1980, the AMA “Principles of Medical Ethics (1980) of the American Medical Association” were published in 1981.
override the right.” Appeals expressed in rights language are based on the principle of respect for autonomy (Veatch, 2000, pp. 65-66).

The term “autonomy” is associated with concepts such as the freedom to choose, privacy, self-mastery, and so forth (Faden, 1986, p. 7). Ruth Faden and Tom Beauchamp (1986) define the “principle of respect for autonomy” as “[p]ersons should be free to choose and act without controlling constraints imposed by others” (Faden, 1986, p. 8). Faden and Beauchamp also differentiate between the autonomous person and the autonomous act and reason that a non-autonomous person, such as Quincy West, may make an autonomous decision under circumstances requiring informed consent or refusal. Bronstein (1975) and others concur that there are serious problems in obtaining informed consent from prison inmates because of their coercive circumstances.

There is an additional concept within the ethics of clinical research and experimentation worthy of consideration: the concept of clinical “equipoise,” i.e., a genuine uncertainty about the comparative therapeutic merits of the proposed treatment in relationship to the currently accepted treatment. The researcher is ethically restrained from offering a treatment known to be inferior (Freedman, 1995).

From the perspective of ethical philosophy as articulated in the 20th Century, liberal codes of medical ethics and in the Hippocratic tradition, Quincy West was denied the opportunity to choose his physician and treatment; and, his physician withheld needed treatment, causing West harm. This position is supported by the legal perspective.

Where the term “autonomy,” founded in deontology, is used in medical ethics, the term “liberty” is more frequently applied by the courts. Veatch (2000) differentiates between liberty rights (negative rights) and entitlement rights (positive rights). He posits that while a liberty right is a right to be free from state interference or to be left alone, an entitlement right is a more extensive claim implying an obligation on the part of the state or another, not only to refrain from

13 I refer to Quincy West as “non-autonomous” because of the coercive nature of his incarceration.
interfering with a liberty, but also to provide some sort of resources. According to Veatch, an entitlement right will be grounded in a principle imposing an affirmative duty to act, such as beneficence or justice (Veatch, 2000, p. 67).

In Chapter Two, a sketch of the legal history of informed consent was offered with reference to early cases including: (1) *Schoendorff v. Society of New York Hospital* (1914), in which the court emphasized the right of an individual to determine what shall or shall not be done to his or her body; (2) *Salgado v. Leland Stanford Jr. University Board of Trustees* (1957), in which the court established a new standard of consent that acknowledged the patient’s autonomy and right to information; and, (3) *Natanson v. Kline* (1960), which prohibited the physician from substituting his own judgment for that of the patient. Reference was also made to later cases included in that chapter in which the courts refined their concept of informed consent: *Canterbury v. Spence* (D.C. Cir. 1972), in which the court focused on the patient’s right to self-determination and the patient’s need for adequate information to make an informed decision; *Cobbs v. Grant* (1972); and *Wilkinson v. Vesey* (R.I. 1972).

Both *Cobbs* and *Wilkinson* followed the *Canterbury* reasoning, but held that the determinations regarding whether to proceed with a therapy were not solely medical, but also required consideration of the values of the patient. The significance of these 1972 cases is their balance between (1) the *Natanson* version of negligence and concern for the self-determination of patients and (2) the “exigencies and demands of the physician-patient relationship and the complexities of the legal setting” (Faden, 1986, p. 138). Faden and Beauchamp point out that the *Canterbury* court relied on legal scholarship, including student writings, for its “groundbreaking ideas” (Faden, 1986, p. 148, note 80).

Court records indicate that the Atkins-West physician-patient relationship was far from stellar, that Atkins substituted his own judgment for the consent of his patient, and that West’s continued efforts to obtain treatment from Atkins or access to other physicians’ care documented neglect by Atkins of his duty to his patient.
As a footnote to this discussion of informed consent, it should be noted that in a potentially controversial 1995 *Hastings Center Report* Robert Veatch postulated a move beyond informed consent. His thesis was that “[c]linicians cannot obtain valid consent to treatment because they cannot guess which treatment options will serve a particular patient’s best interests” and that such guesses “could be made more accurately if patients were paired with providers who share their deep values” (Veatch, 1995, p. 5). Veatch held that values such as religious affiliations are likely to be insufficient and that “[t]he difficulty in establishing a convergence of deep values cannot be underestimated.” It was his suggestion that pairing based on such “deep values” might be accomplished by providing an institutional framework for such pairing based on deep value convergence (Veatch, 1995, p. 11). He suggested that the concept of consent be replaced by “a more radical, robust notion of active patient participation in the choice among plausible alternatives—either by getting much greater information to the patient or by actively selecting the professional on the basis of convergence of ‘deep’ value systems” (Veatch, 1995, p. 112). Veatch suggests that such convergence might be available in organizations that announce their value orientation, for example, feminist health centers, holistic health centers, and so forth.¹⁴ Veatch proposed that patients seek the opportunity to obtain better rapport with their physicians and allied health care providers and include value orientations in their lists of provider criteria.

Additional issues related to informed consent and public policy continue to emerge—along with questions such as “can any system of secular bioethics (indeed, moral philosophy in general) avoid the expression of an ideology … ?” (Spicker, 1996). Among such issues are: the medicalization and secularization related to the religious practice of male circumcision and issues related to female circumcision/genital mutilation (Szasz, 1996); the use of adults admitted to emergency rooms as human subjects for research (Brody, 1995, pp. 131-144); regulations related to the use and potential misuse of children of short stature in placebo research protocols

¹⁴ I was involved in such a value convergence problem as a health care administrator. An elderly gentleman was brought into the emergency room following his collapse while on his way to a Christian Science hospital for treatment. The two grandchildren who were accompanying him called paramedics who followed their protocols. Surgeons determined that he had a ruptured artery and would have somewhat less than a 25 percent chance of survival if they operated immediately. His grandchildren believed that he would not have wanted the surgery because of his life-long devout Christian Science beliefs—but the surgeons were pressing them for their consent.
to determine the efficacy and effects of recombinant human growth hormone (Williams, 1996); and so forth.

The foregoing issues raise broader questions related to the level and nature of the state’s role and responsibilities in bioethical and similar matters. These questions are part of a historic dialogue exploring the tension between the state and its citizens.

Medical Malpractice

The physician engaged in medical practice has a duty to his or her patient and, failing the fulfillment of that duty, risks liability. Black defines malpractice as “[p]rofessional misconduct or unreasonable lack of skill” and “[f]ailure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage …” (Black, 1990, p. 959). In contrast to the constitutional standard of deliberate indifference to a prisoner’s medical needs established in Estelle v. Gamble (1976), the standard for medical malpractice litigation is negligence. In order to establish negligence, the following elements must be established:

(1) the existence of the physician’s duty to the plaintiff, usually based upon the existence of the physician-patient relationship; (2) the applicable standard of care and its violation; (3) a compensable injury; and, (4) a causal connection between the violation of the standard of care and the harm complained of. (Kosberg v. Washington Hospital Center, Inc., 129 U.S. App. D.C. 322, 394 F 2d 947, 949) (Black, 1990, p. 959).

In my experience, the term community standard of care is used to reference the above “applicable standard of care.” The community standard of care is the type and level of treatment provided in similar circumstances by other physicians and/or hospitals. For example, if a hospital does not have the same level of diagnostic equipment available in similar institutions in the same community or area, it is not meeting a community standard of care. Similarly, if a
physician is not providing treatment or services comparable to those provided by his or her colleagues, that health care provider is not providing a community standard of care.

It should be noted that the absence of full disclosure, including disclosure of treatment options, even in instances where treatment may have been performed skillfully, may constitute malpractice.

Quincy West stated in his complaint of November 29, 1984 that Dr. Atkins explained to him that he should schedule West for surgery, but wanted to experiment … (West, 1987, p. 5). This alleged statement on the part of the physician suggests an acknowledgment that the community standard of care differed from the course of treatment selected. West also alleged injury and claimed a causal connection between his injury and the course of treatment—or non-treatment—selected by Atkins. It was clear from West’s repeated attempts to be seen by Atkins or another physician and complaints to prison administrators that he had not consented to non-treatment.

A number of members of the Court asked why West chose to file a constitutional claim rather than seek redress for medical malpractice in state courts. The answer to that question remains unclear. However, it was suggested during argument that he may have believed that a suit against the state filed in state courts may not have been viewed as objectively as one filed in federal courts.

**Contract and the Duty of Care**

Writing in 1981, shortly after the release of the *Belmont Report*, Robert Veatch, offered a “triple contract theory.” This theory included the thesis that there is an implied contract between the professions and society; and, that the values incorporated in that agreement are, more or less, the values included in an implicit social contract (Veatch, 1981). Inherent within this theory is the implication that changing power relationships, seen as tensions existing in the social contract, in particular those between the individual and the state/society, are also reflected in a professional contract between the professions and the state; and, within the value frameworks of both.
The third contract within Veatch’s triple contract is the relationship between the medical practitioner (professional) and the patient (individual). This contract is often quite explicit in terms of the responsibilities of the patient to pay for services provided; and, it may explain what services will be provided by the medical practitioner. Implicit within this contract are, in the case of the physician, the professional duties of nonmaleficence (to do no harm) and beneficence (to do good) that are also a part of the physicians’ contract with society. Also included in that contract are requirements of adherence to professional standards and state licensure. However, there was an imbalance of power in the relationship between the physician and the patient. The imbalance was found in the physician’s role as educated expert and in his or her paternalistic authority to serve as a representative of a self-regulating sovereign profession. This imbalance was extensively documented in Paul Starr’s Pulitzer Prize winning history of American medicine (Starr, 1982). The patient side of the physician-patient contract had, until the 1970s and 1980s, been substantially weaker, relying on the terms of the physician’s contract with society and his or her duties of beneficence and nonmaleficence. The subsequent shift from Hippocratic paternalism to a liberal Western philosophy of patient self-determination has greatly strengthened the patient’s position and the import of the contract between the physician and patient.

For centuries the law has recognized a contract between the physician and the patient and its attendant obligations. One of those obligations is a duty of care. Once the physician-patient relationship (an express or implied contract) is established, a duty of care, attendant upon the physician, is a component of that relationship. A contract is offered by a patient who goes to a physician’s office for care, and an implied contract is accepted when the physician examines the patient. The physician in private practice is free to decline to enter a physician-patient relationship, even in emergency conditions, and must normally consent before such a relationship is established (St. John v. Pope, S.W.2d, 1995 at 423). However, in contrast to the traditional physician-patient relationship binding him or her to a particular individual, an express

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15 It should be noted that the 1981 publication of Veatch’s triple contract theory was during a time of change in medical services delivery and the shift between the utilitarian and paternalistic Hippocratic philosophy and an emerging liberal Western philosophy of medicine.
contract exists when a physician is employed by an institution to provide care to a defined patient population (Furrow, Greaney, Johnson, Jost, & Schwartz, 2000, pp. 261-262).

A contract to provide care existed between Dr. Atkins and the State of North Carolina Department of Correction. His contract, although sketchy, establishes Atkins’ responsibilities for orthopædic care for all inmates assigned to Central Prison Hospital. That responsibility carried with it a duty of care. The existence of such a duty of care generally must be established as a basis for a medical malpractice claim.

The existence of an implied or express contract may also serve as the basis for a breach of contract claim. While the individual physician in private practice has no legal or ethical responsibilities to provide care to a particular patient, once a physician-patient relationship has been established, that physician has an obligation not to abandon the patient. Furrow, et al. tell us that “This duty not to abandon patients has been an important doctrine in litigation challenging decisionmaking within the strictures of cost-containment programs” (Furrow, Greaney, Johnson, Jost, & Schwartz, 2000, p. 510). Patient abandonment and contract claims are not constitutional issues and were not explored in *West* (1988).

**Community Attitudes**

Along with other forces, public opinion and community attitudes are both reflected in and shaped by the media. Attitudes and concerns expressed in the press range—from critiques that prisoners may be able to obtain a level of healthcare exceeding the care available to the average citizen and related implications that the prisoners are not worthy of receiving the care—to exposés of inmate neglect. As an example of the former, a 1996 article in the Walnut Creek, California *Contra Costa Times* about new co-payments for jail medical services describes how a Contra Costa County Jail inmate, after putting off dental care for 15 years, had his dental work done while in

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10 Appendix C.

17 The statute of limitations for contract claims is generally longer than for tort claims and it may not be necessary to establish a standard of care or provide expert testimony for a breach of contract claim (Furrow, Greaney, Johnson, Jost, & Schwartz, 2000, p. 262).
jail at a cost of five dollars. The journalist also quotes Captain Dave Albrecht of San Luis Obispo County jail where clinic visits dropped 15 percent following the imposition of a three dollar charge: “We would have people that would constantly go to medical. They would go every day on anything—‘My finger hurts,’ ‘my toe hurts’—anything to get out of the cell” (Hytha, 1996).

The perceived unworthiness of inmates to receive expensive care is implied by the author of a 2002 article, appearing in Corrections Professional. The author reported that a 31-year-old “convicted felon serving 14 years in a California prison has been given a heart transplant – an operation that could cost taxpayers as much as 1 million [sic] and spur debate over prison health care costs.” The article concludes with a statement of the expected cost of state prison health care for the year and the notation that the amount exceeds the prior year by 11 percent (Calif. Inmate Gets Million-Dollar Heart, 2002). The same topic was discussed in the February 26, 1996 issue of American Medical News. The author of the article reported that legislation then pending in Washington State sought to deny death row inmates organ transplants. The lead sentence in the article was: “Should the state pay for organ transplants for prisoners on death row?” An earlier failed Washington State bill would have withheld funding for “‘extraordinary, life-saving medical procedures’ for death row inmates.” The concept of perceived unworthiness was emphasized by a comment by Dr. Clarence H. Braddock III, a professor of medicine and medical ethics at the University of Washington. Dr. Braddock is reported to have conceded that “the ‘man in the street’ [sic] gut reaction inspires ‘outrage at the idea that a convicted killer would get an organ … that would be otherwise available to some presumably innocent person’” (Gianelli, 1996).

Examples of inmate medical neglect were included in a 2003 report in The Birmingham News. In that article the results of an audit of health care services in Alabama prisons were summarized and reported to be found “dangerous and extremely poor quality health care.” The authors of the audit report raised the issue of a community standard of care and noted that inmates with chronic illnesses “go as long as seven or eight months without seeing a doctor, and diabetes patients get only monthly rather than daily blood sugar tests” (Bailey, 2003).
Similar reports have emerged from other sections of the country. The author of an article in *The Seattle Post-Intelligencer* reported in 2002 that the state had paid “more than $1.26 million in judgments, settlements and claims of poor prison health care” in the past five years. The claims included: the death of a mentally ill inmate who had complained to officers of trouble breathing who was found dead in his cell hours later; the loss of vision in one eye by a prison inmate who suffered a detached retina and allegedly received inadequate treatment; and, the death of a mentally ill inmate who allegedly received inadequate care when he refused medication and did not properly care for his own dietary and hygiene needs. The reporter suggested that the claims paid did not properly reflect the total amount of medical malpractice and neglect claims made because lawyers are reluctant to take such cases. The reasons given were that medical malpractice defendants are provided special protections by the state and “[c]riminals usually make poor victims when trying to win the sympathy of a jury” (Galloway, 2002).

In California, in a May 8, 2002 edition, the author of a *San Francisco Chronicle* article reported that the state Department of Corrections had agreed to comply with a court order “to bring prison health-care facilities up to licensing standards that were supposed to have been met six years ago.” The law requiring compliance with licensing standards was passed in 1987 and the Department of Corrections had been given until 1996 to comply. The reason given for noncompliance was that the state legislature and the Governor had rejected the department’s budgetary requests for funding to meet licensure requirements (Egelko, 2002). In the Midwest in 2001, it was reported that a Wisconsin legislative audit found that the state Department of Corrections met less than half of the national prison health standards (Zahn & McBride, 2001). In Texas, the *Austin American-Statesman* ran an award winning series on the inadequacies of health care in that state’s prisons. Of particular interest in the Texas exposés were the operation of a prison hospital and clinics by the University of Texas Medical Branch (UTMB) and that school’s involvement in clinical trials of various drugs—an involvement that included the use of their inmate patients as research subjects. A December 16, 2001 segment in the series reported that, “UTMB’s Office of Clinical Trials boasts that one of the ‘special features’ available at UTMB that ‘support clinical research’ is the prison hospital, and the tens of thousands of Texas inmates who look to that hospital for medical care.” Reporter interviews with inmates revealed that the prisoners believed that “[t]he only way to receive … decent medical care was to join a
biomedical trial in Galveston,”—the location of the prison hospital operated by UTMB (Ward & Bishop, 2001).

A May 8, 2003 report on PBS (Public Broadcasting System) cited an ACLU report critical of Virginia prison conditions and a response from the state Department of Corrections that many inmates are receiving better health care in prison than they received before they were incarcerated.

A 2001 Omaha, Nebraska editorial, entitled “Better Prison Care Is Only Right,” appears to summarize the many reports of inadequate care from other sections of the nation:

A poorly performing medical system in a “downward spiral”—that was the troubling description a task force offered last year of the medical services provided at Nebraska prisons. The task force … found much to criticize.

Prison medical providers … had often failed to use standardized treatments and procedures. Non-medical employees had overruled the medical staff on insufficient grounds in regard to treatment decisions. Prison staff had displayed insensitivity to inmates’ reports of pain, and medical equipment was often inadequate (Editorial, 2001).

In Chapter One, I wrote of the Virginia physician providing services in a state prison whom I interviewed and I briefly described the experience of a physician treating a dying inmate who was convicted of a heinous crime (Manian, 1999). In both instances the physicians found themselves pressured by hospital staff or administrators to withhold care—in the first instance for fiscal reasons and in the second because the patient was considered “undeserving” of care.

The above reports of bioethical issues and community attitudes have been provided to illustrate competing perspectives to one which uses constitutional law to illuminate an administrative question. While the latter is the focus of this dissertation, the public administration practitioner
does not have the luxury of narrowing his or her focus when meeting the responsibility of overseeing medical care for those who are charges of the state.

**Challenges of Prison Medical Services**

The prison medical administrator operates in a complex politically charged environment with competing pressures from mandates of the courts, statutory responsibilities, political priorities, public opinion, budgetary limitations, institutional risk management considerations, bioethical expectations, licensure and accreditation standards, and community standards of care. This environment dictates the balancing and synthesis of these competing and contradicting demands by the administrator. The complexity of this administrative role characterizes the roles of many public administrators—a role in which the administrator may not neglect any one demand or concern in their day to day operational synthesis and exercise of administrative discretion.

Not only must the administrator be responsive to the mandates of the courts, he or she must note the subtle nuances offered in concurring and dissenting opinions. It is not unusual for a concurring or dissenting opinion, as it becomes a part of the ongoing jurisprudential dialogue, to lead the Court to the refinement of a distinction or reconsideration of an earlier decision. Such was the case in *West* where the dissenting opinion of Chief Judge Winters in the Fourth Circuit’s opinion appears to have influenced the Supreme Court majority.

How does an administrator function in an ever changing environment of shifting political winds and evolving jurisprudence? I believe that the answer to that question is: with careful attention and sensitivity to these political and legal streams of thought and undercurrents; with reflection on ethical considerations and normative responsibilities; and, with an understanding that administrative foresight, like so many other human endeavors, is often less than perfect—but can be improved upon with effort, experience, and knowledge.

There are varied perspectives for viewing the message of *West v. Atkins* (1988) beyond the use of the law as pedagogy. This chapter has offered alternative, complementary, and competing perspectives to the majority’s opinion in *West* and expanded on conflicting opinions, values and
attitudes about medical care for inmates. It has highlighted the healthcare perspective on the topic and examined the bioethical implications of the West case and public attitudes about healthcare and punishment. For the public administration practitioner, the chapter has emphasized the complexity of administrative dialectical responsibilities wherein the practitioner must attempt to synthesize and unify constitutional perspectives and bioethical issues, while educating the public, helping shape public opinion, and serving the demands of his or her particular area of responsibility. It is not an easy task. However, this summary of competing forces has emphasized the administrator’s need for skill, wisdom, and attention to the evolution of constitutional interpretations.

The following chapter, The Pertinent, will speak to the relevance of the Court’s actions in West for the public administration and healthcare communities and issues that fall at the nexus of the law, public administration and healthcare—such as privatization decisions and contracting processes.