Why a Jail or Prison Sentence is increasingly like a death sentence

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Why a jail or prison sentence is increasingly like a death sentence

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Because of current conditions inside American jails and prisons, a sentence to a correctional facility routinely compromises the health, safety, and life of inmates. Four environmental factors can make a jail and prison sentence appear like a death sentence: poor health care, unsanitary living conditions, high levels of violence, and an increased number of people with chronic diseases living in close proximity. Thus, a de facto death penalty, the most controversial sanction of the criminal justice system, is the result for some inmates, and a misapplication of the criminal law is thus achieved. In order to present this argument, the author reviews research which increases the likelihood that a person will die behind bars.

Keywords: sentencing; death sentence; prisons; chronically and terminally ill behind bars

Introduction

The American prison system has four interrelated purposes: to protect society, to punish individuals convicted of crimes, to serve as a deterrent for offenders and those in the wider society, and when possible, to rehabilitate those convicted. The implementation of mandatory minimum sentences, ‘three strikes, you are out’ legislation, life without parole, and ‘truth in sentencing’ methods, combined with the so-called war on drugs has resulted in an increase in the number of individuals being sent to jails and prison. Not only are more people being incarcerated, but because of general increases in life expectancies, we are witnessing a graying of the prison population. Those convicted now spend more time behind bars in state and federal correctional facilities. Although no two prisoners have the same experience, the conditions of confinement present several challenges to those who are incarcerated (e.g. Sykes, 1958). Moreover, although most individuals who are given short sentences leave correctional facilities relatively unscathed by physical violence and medical complications, others are significantly worsened by their experience.

The death penalty, intended to be both the ultimate punishment for law breakers and a deterrent for others contemplating similar kinds of crimes (Katz, Levitt, & Shustorovich, 2003), can easily be the unintended consequence for individuals convicted of noncapital cases. Four environmental factors can make a jail and prison sentence appear like a death sentence: poor health care, high levels of violence,
unsanitary living conditions, and an increased number of people with chronic diseases living in close proximity. Persons do not need to enter a correctional facility in poor health to be susceptible to contracting a life-threatening disease and/or dying because of physical violence while incarcerated. When the criminal justice system allows this kind of practice to occur, the process of justice is subverted. This unacknowledged outcome of incarceration is a de facto death penalty, and thus a violation of constitutional protections (i.e. fifth and eighth amendments), morals/ethics, and human rights accorded to individuals who are incarcerated.

Literature review
The realization that the normal conditions of imprisonment can lead to an inmate’s death is not new. One of the earliest documentations of this happening was provided by British prison reformer John Howard. In *The State of the Prisons* (1784/2010), he recounts (pp. xix–xx) numerous instances of relatively healthy individuals who were incarcerated only to contract various diseases that led to their deaths. Despite the good intentions of prison activists and correctional professionals alike, in many respects, this situation has not changed in the modern era (King & Whitman, 1981). Indeed, over the years, numerous studies have been conducted in jails and prisons examining prisoners health concerns (e.g. Delgado & Humm-Delgado, 2008; Favier, 1998), and a handful of scholarly journals which specialize in this body of knowledge have been published (e.g. *Journal of Correctional Health Care* and *Journal of Jail and Prison Health*). Most of this research is epidemiological (i.e. looking at the presence of particular kinds of diseases and the introduction of methods to address them). Improvements in the provision of health care in correctional facilities have been made because of negative publicity, changing practices in the health care field, and significant court cases. The most important of which is *Estelle v. Gamble* (Wright, 2008).

While other important landmark federal cases bear on *Estelle* (e.g. *Rhodes v. Chapman* 1981; *Farmer v. Brennan* 1994), *Estelle* forms the foundations of most litigation that argues substandard health care in prisons (Wright, 2008). Still, the ethical and moral implications of poor health care and high levels of violence which can lead to death and its connection to the death penalty are rarely acknowledged.

In recent years, there has been some passing attention from legal scholars to the possibility that a prison sentence can lead to death. Vetstein (1997) and Rowe (1998) argue that not only is the problem of Acquired Immunity Deficiency Syndrome (AIDS) a contributor to prisoner death, but that rape in correctional facilities can unnecessarily expose an inmate to AIDS. Vetstein examines how the courts have interpreted the burdens involved in applying deliberate indifference on the part of correctional facilities to convicts who have AIDS or may be exposed to it. Similarly, Hammond (1989) reviews the then current status of AIDS in prison and advocated measures to better test inmates for this disease. Neither author, however, traces the connection between AIDS, and/or rape to the issue of a death sentence.

Although important pieces for their time and place, AIDS/HIV is not the only kind of medical condition that can affect the life chances of inmates. In other words, this argument should not be reserved for individuals who only have AIDS as there are other silent killers in prison, including tuberculosis (TB), and hepatitis. Additionally, given the compromised health of many who enter the prison system,
the poor quality of health care while inside, and high levels of violence behind bars, it would stand to reason that those who are chronically ill either on admittance or during the sentence, stand a higher likelihood of dying in prison (Wallace, Klein-Saffran, Gaes, & Moritsugu, 1991).

Since the early 2000s, because of the passage of the Death in Custody Reporting Act of 2000, the Department of Justice has been collecting data on deaths while in custody. Two Bureau of Justice Statistics (BJS) reports are relevant to the current study. Noonan (2010) reports that between 2000 and 2007, 8097 individuals died in our country’s jails. The principal reasons for these deaths were suicides (29%) and illness (53%). With respect to the illnesses, the majority of individuals who die in jail was because of heart disease or AIDS. Mumola (2007) provides a compilation of medical deaths in state prisons from 2001 to 2004, and reports that during this time frame, 12,129 inmates died and that the leading causes were heart diseases, cancer, and liver diseases. In both cases, no data document whether the deaths are a result of a pre-existing condition or because the condition was contracted when the inmate became incarcerated. Although an important start, no information has been disseminated on medical causes of death in the Federal Bureau of Prisons (FBOP).

Since the creation of the first state (historically associated with the Treaty of Westphalia in 1648), it has been recognized that countries have considerable and in many cases unchecked power. Thinkers, from political philosophers (e.g. Rousseau, 1763/1983) to criminal justice experts (e.g. Goldstein, 1977) argue that we make an unconscious bargain with the state. In order to live in a relatively safe and well-regulated society, citizens give up certain freedoms in order for the state to do its job (e.g. provide national security, domestic security, etc.). In most advanced industrialized countries, the police have the power to take away a person’s life, by engaging in deadly force, if they believe that individual is an imminent threat to their safety or life, or to the safety and life of others (e.g. Tennessee v. Garner). But jails and prisons are different. Although we entrust them to carry out the sentence of death for those so sanctioned, they are otherwise responsible for providing for the safety and security of the individuals who are under their charge. If those who are incarcerated are at risk of dying because of the environmental conditions of the prison, then a contradiction exists. Keep in mind that this is not accidental death per se, nor ‘deliberate indifference’, as it is reasonably well established that the conditions have the possibility of leading to death. We have created conditions that facilitate the possibility of death and thus this is morally, ethically wrong.

Prison conditions in the FBOP and state prison systems

Although copious information (i.e. blogs, personal websites, newspaper articles, documentaries, etc.) exists on the topic of American prisons, scholarly research (i.e. subject to peer review) has the most amount of credibility in courts of law and amongst the academic community. As noted in the studies published to date, four issues mitigate against an inmate’s safety and health, and because of the outcome (i.e. death) can make incarceration appear to be a death sentence: poor health-medical care, high levels of violence (especially proclivity to rape), unsanitary living conditions, and an increased number of people with chronic diseases living in close proximity.
The poor quality of medical care

In general, the level of medical care in the FBOP and state prisons systems is substandard. The scholarly evidence clearly and systematically points to the widely acknowledged perception that the FBOP and Federal Medical Centers (FMCs), where chronically sick or infirm prisoners are housed, engage in symbolic rather than actual health care (Fleisher & Rison, 1997; Murphy, 2003). This perception is not only found in the scholarly literature, but it is also evident from the numerous legal suits regularly filed by inmates against the FBOP and FMCs, from the news media reports regarding the poor quality and neglect of care that the FBOP and FMCs provide to inmates (e.g. Hammel, 2009; Killion Valdez, 2008), and from selected incidents of corruption (e.g. Walsh, 2010). Although almost all FMCs are purportedly accredited by the Joint Commission (a private sector accrediting organization for hospitals and health care organizations in the USA), they are not accredited by the National Commission on Correctional Health Care, an organization specifically charged to accredit jails and prison medical services. Moreover, the Joint Commission had been criticized by numerous individuals for various unethical practices connected to the accrediting process (Fisher, 1998; Gaul, 2005).

After analyzing data from the ‘1997 Survey of Inmates in State and Federal Correctional Facilities’, Maruschak and Beck (2001), researchers with the US Department of Justice, BJS, reported that ‘21% of State inmates and 22% of Federal inmates said they had a medical problem (excluding injury) after admission; … and 10% … said they had a medical problem that required surgery’ (p. 1). Although this information conflates both men and women, the researchers also acknowledged that ‘a fifth of male inmates reported a medical problem since administration’ (p. 1).

Further in-depth analysis by Maruschak and Beck revealed that ‘28% of State inmates and 26% of Federal inmates’ reported injuries since admission to a correctional facility and ‘20% of State inmates and 23% of Federal inmates said they had been injured in an accident; … and 10% and 3%, respectively, said they had been injured in a fight’ (p. 4). Maruschak and Beck also determined that injuries were more prevalent among certain groups of inmates:

State and Federal inmates with a physical impairment more commonly than those without a physical impairment reported being injured in an accident since admission. Among inmates with a physical impairment, 22% of those in State prisons and 25% of those in Federal prisons reported being injured in an accident compared to 19% and 22%, respectively, of those without a physical condition. (p. 6)

Finally, the authors note that the need for medical care became greater with the passage of time:

… the percentage of inmates who reported requiring surgery or a specific medical problem since admission increased with the time served in prison. […] [After 72 months or more] state prisoners were about 5 times as likely to have had a medical problem that required surgery … than those who has served less than 12months. […] Among Federal inmates who had served 72 or more months at the time of the interview, 18% had required surgery, and 19% had other medical problems, compared to 4% and 14% of those who had served less than 12months. (p. 7)

Although these statistics were reported almost a decade ago, there is reason to believe that the patterns continue to exist and may even be worse today. In addition,
the increased occurrence of illness in the prisons indicates that inmates’ stress levels have become greater over the years (Rabkin & Struening, 1976; Suls, Gaes, & Philo, 1991).

The poor quality of medical care in most American jails and prisons has been well researched and documented (e.g. Berkmann, 1995; National Commission on Correctional Health Care, 1992; Novick & Al-Ibrahim, 1977; Vaughn & Carroll, 1998; Willmott & Olphen, 2005). Sources include not only respected nongovernmental commissions (e.g. Gibbons & Katzenbach, 2006), but also scholarly studies (e.g. Marquart, Merianos, Hebert, & Carroll, 1997; Murphy, 2003; Wilper et al. 2009a, 2009b). Over the past 15 years, the possibility of individuals in American correctional facilities actually dying has increased (Dugger, 1995; Zimmermann, Wald, & Thompson, 2002). Besides medical care being open for criticism, the quality of physician care in correctional facilities also has been critiqued (Dabney & Vaughn, 2000). Furthermore, the risk of contracting other physical and life-threatening diseases is exacerbated while behind bars. Copious recent literature supports this claim (e.g. Delgado & Humm-Delgado, 2008).

Over the past two decades, negative publicity, changing practices in the health care field, and significant court cases (e.g. Estelle v. Gamble 1976; Rhodes v. Chapman 1981; Farmer v. Brennan 1994) have inspired slight improvements in the conditions of many state systems and federal correctional facilities, although much progress still needs to be made. One example of improved conditions is evident in the medical services of the California Department of Corrections. This department is now under a federal consent decree, which means that at least theoretically, with the federal government supervision, the medical care in these prisons will improve.

Over the past decade, because of prison crowding and overcrowding, and declining budgets, the provision of health care in most American prisons has been in a general decline. One of the most helpful pieces of research bearing on this issue was conducted by Wilper et al. (2009b). Their study included interviews with 3686 federal inmates, which, according to the authors, constituted 84.6% of their contact group, and ‘among inmates with a persistent medical problem, 13.9% of federal inmates [and] 20.1% of state inmates … had received no medical examination since incarceration’ (p. 669). The study also found that 20.9% of federal inmates and 24.3% of state prisoners who were required to take ‘a prescription medication for an active medical problem routinely requiring medication’ stopped taking the medication following incarceration (p. 669).

According to Wilper et al. (2009a), after ‘a serious injury or assault, … 7.7% of federal, [and] 12.5% … of state inmates … did not receive a medical examination’ (p. 106). Moreover, ‘a large number of inmates with serious chronic physical and mental illness fail to receive basic care while incarcerated’ (p. 107). Although scholarly research methods have their limitations, particularly when it comes to issues of official deviance and state crimes (e.g. Marx, 1988; Ross, 2000a; 1995/2000b; Rothe, 2009), such studies provide a window into the less sanguine activities of the US prison system.

In general, this research lends support to the inmates’ arguments about poor health care. Unfortunately, Wilper et al. did not include a breakdown of the different types of FBOP settings included in their study, thus it is unclear if their data reflect the conditions at all types of FBOP facilities or only a few. In other words, no research to date provides detailed results (particularly based on the federal data) tied to the various types of institutions in the USA (e.g. security level; FMC versus
nonFMC facility). Wilper et al.’s study was based on the 2004 Survey of Inmates in State and Federal Correctional Facilities database. Since the database is publicly available, a skilled researcher could analyze these data further in order to make these kinds of useful distinctions.

Those who are chronically and terminally ill, especially those suffering from life-threatening diseases like HIV/AIDS, are at a greater risk for additional diseases and premature death. Once convicted of a felony, a defendant’s lawyer or a judge may recommend that the defendant (who is now a convicted felon) be sentenced to a medical center. However, not all states have medical centers, although the FBOP operates a variety of FMCs. In general, FMCs are supposed to provide FBOP inmates with better health care than that which is typical (also known as mainline) in minimum, medium, and maximum security prisons. The FBOP runs six FMCs [i.e. FMC Carswell (TX), FMC Lexington (KY), FMC Devens (MA), FMC Butner (NC), FMC Rochester (MN), and MCFP Springfield (MO)].

If convicted of a federal crime and sentenced to the FBOP, the prisoner is remanded to a medical center, and placed in the custody of the FBOP, which has the ultimate legal responsibility for his care and security. The FBOP then makes the final decision as to which correctional institution is best suited to a particular inmate’s needs and management requirements. These decisions are usually made in conjunction with the drafting of a Presentence Investigation Report (PSI). PSIs are written by probation officers employed by the FBOP and are conducted during the time between conviction and sentencing. The PSI is then given to the judge at the time of sentencing.

Although a defendant and/or his/her lawyer may present medical evidence testifying to his/her current state of health, a judge may order an independent or ‘unbiased’ medical evaluation by FBOP doctors or their subcontractors (i.e. a medical services company that employs its own doctors, such as the Physicians Network Association) to determine if a defendant is malingering or if s/he is indeed suffering from a unique medical condition.

The judge may also be presented with a report by a ‘sentence mitigation expert’ hired by the defendant or his/her lawyer. The defendant, his/her lawyer, or his/her sentencing mitigation expert must carefully read the PSI. If any unfair or untrue characterizations of his alleged role in the crime or other statements of fact (i.e. his/her education, work history, health status, etc.) are included in the PSI, then the defendant or his lawyer has the legal right (and obligation) to object to the falsehoods as they have important implications for the sentencing and incarceration particulars.

After the judge makes his/her recommendation, the defendant will be either taken into custody or asked to appear at a FBOP facility for initial intake at some reasonable point in the future. Upon intake into most jails and prisons, inmates are given a brief medical examination, the findings of which typically become part of their official file. Once in custody, the defendant will likely be transported to Oklahoma to the Federal Transfer Center where s/he will be further evaluated and classified.

One other legal issue bears upon the conditions of chronically ill inmates; once behind bars, prisoners with disabilities face greater abuse and discrimination than they encounter on the outside. For example, throughout the USA, correctional officers have been known to confiscate from disabled inmates those items that would be most acutely missed: wheelchairs, walkers, crutches, braces, and medications.
Prisoners who require personal care or assistance – for example, quadriplegic inmates who need help with eating, dressing, bathing, and other daily tasks – are often ignored (Russell & Stewart, 2001, p. 62).

This state of affairs has led to numerous prisoners with disabilities filing lawsuits against various states. The Supreme Court cases of Yeskey v. Pennsylvania 1990 and Goodman v. Georgia 2006 have confirmed the claim that the Americans with Disabilities Act 1998 applies equally to the prison system as it does to the free world. Unfortunately, both state and federal prisons are lagging behind in upholding this law.

Levels of violence

Although much anecdotal research exists about the levels of violence that may exist in the prison context (i.e. inmates versus inmate, inmate versus correctional staff, correctional staff versus inmates (Bowker, 1986) and self-inflicted violence), no scholarship has been conducted which specifically tests the level of violence that emerges at different federal correctional facilities. Over the past 16 years, research has been conducted into general level factors (e.g. Wolff et al., 2008; Wolff, Shi, Siegel, & Bachman, 2007) and into the inter-relationship of various inmates’ level factors, such as age (Kerbs & Jolley, 2007), education level, ethnicity, gender (Wolff et al., 2006), mental health status (Basking, Summers, & Steadman, 1991), the specific types of crimes supposedly committed by individuals, individual lifestyles behind bars (Wooldredge, 1998), and race (Steiner, 2009; Wolff & Shi, 2009; Wolff, Shi, & Siegel, 2009). Other studies have explored facility-related variables including violence, crowding (Gaes, 1994), occurrences of misconduct in correctional facilities, inmate capacity, design capacity, and other selected components of correctional facilities (e.g. Wooldredge & Steiner, 2009).

Most research, regardless of the facility, indicates that violence is endemic to American correctional facilities (e.g. Amnesty International, 1998; Fleisher, 1989; Johnson, 2001). Unfortunately, the majority of scholarly research with respect to levels of violence and health care concerns reflects the state of affairs in local lock-ups and state correctional facilities, while almost completely ignoring the federal system. Anecdotal evidence suggests the reason for this state of affairs is the difficulty researchers experience in gaining access to the federal system. In an oft-cited chapter, Bottoms (1999) has suggested that the social organization of prisons (i.e. differences among staff and inmates, degrees of crowding, etc.) has an effect on violence behind bars. Bottoms, however, does not suggest that the security level or type of facility in question impacts violence.

Rape as a method of violence

Most of those who are sent to prison fear being raped (Human Rights Watch, 2001, Chap. 6; Lockwood, 1980; Rideau, 1992; Ross & Richards, 2002). Undoubtedly, both consensual and coerced sex exist in prison. These practices are further complicated by male prostitution. However, sexual assault is rarely about physical attraction or gratification; it involves violence, politics, power, and business. ‘In some extreme cases, rape can become a “management tool” to punish prisoners who step out of line, break a potentially strong inmate leader, coerce prisoners or crime suspects, create snitches, silence dissidents, and divide inmates’ (Leighton &
Roy, 2005, p. 822). Some convicts routinely and habitually exploit others sexually. When in prison, convicts or groups of convicts may try to coerce ‘fish’ (a new arrival), using fear and/or violence to force the newcomers into sexual submission. Surrendering to the harassment places a fish at the mercy of the violent thugs. If new convicts resist, their stance becomes a challenge to rapists and they risk serious injury since they might be raped regardless of their efforts, and even death (Ross, 2008). In some correctional facilities, both correctional officers and administrators have been known to ignore inmates’ complaints about rape, thus contributing to the problem. According to Hensley (2001, p. 58), 46% of correctional officers in the Texas prison system suggested that the prisoners were culpable for their rapes.

Needless to say, statistics on male sexual assault in American prisons are difficult to obtain (Wolff, Shi, Blitz, & Siegel, 2007). Most victims never report being raped because of their fear of retribution and/or their embarrassment that they let themselves fall prey to this kind of victimization. Nevertheless, since the passage of the Prison Rape Elimination Act 2003 the federal government has collected data on the frequency and type of sexual violence that occurs behind bars. In the most recent victimization survey (the second of its kind), conducted by the BJS between 1 January and 30 June 2007, 242 allegations of sexual violence were made; this translated into a rate of 2.91/1000 inmates located in federal correctional facilities (Beck, Harrison, & Adams, 2007, p. 3). The report, however, does not contrast the number of males versus females that were sexually assaulted in federal facilities. Moreover, the writers caution that:

... the 2006 survey results should not be used to rank systems or facilities. Given the absence of uniform reporting, caution is necessary for accurate interpretation of the survey results. Higher or lower counts among facilities may reflect variations in definitions, reporting capabilities, and procedures for recording allegations as opposed to differences in the underlying incidence of sexual violence. (p. 1)

Since the BJS data should be interpreted with caution and regarded as simply the ‘tip’ of the research iceberg, other published research estimates on the frequency of male rape guess that approximately 196,000 men are raped in prisons each year (Donaldson, 1995). According to Leighton and Roy

[other research concludes the number of men raped behind bars is 20% to 30%, with a high number of repeat victimizations (at the extreme involving 50–100 incidents per victim) and a significant number (up to 80%) of incidents involving multiple perpetrators. (p. 819)

Gangs as contributors to violence in FBOP and state prisons
Some jails, prisons, and other correctional facilities are literally run by gangs (Camp & Camp, 1985; Stastny & Tyrnauer, 1982). Even if convicts want to ‘do their own time’ and be left alone, there are strong pressures to join a gang for self and mutual protection. In situations like these, unaffiliated individuals are subject to routine victimization and may not be able to defend themselves. Gang members may coerce, extort, or steal material possessions or services from convicts. Sometimes this is done when inmates conduct a cell invasion, by running on mass into the victims’ cell and grabbing anything of value (Hassine, 2004). According to Sheldon, ‘The
guards can be of little help in protecting him, since in many institutions administrators may “look the other way” as rival gangs tend to maintain a certain level of social control and order’ (2005, p. 361). It is generally understood that because of competition over space, drug markets, and rivalries on the streets, gangs are responsible for the lion’s share of violence in prisons (Camp & Camp, 1985; Fleisher & Decker, 2001; Ingraham & Wellford, 1987). Camp and Camp (1985), though dated, indicate that gangs make up only about 3% of the inmate population but are responsible for the 50% of the violence.

**Unsanitary living conditions**

When individuals are sent to jail or prison, they must worry about catching serious and possibly life-threatening diseases. Correctional facilities are typically dirty, lack proper sanitary conditions, are overcrowded, and have poor ventilation (McDonald, 1999; Murphy, 2003; Speed Weed, 2001). In the USA, prisoners are at constant risk of being infected with TB, hepatitis, and HIV/AIDS. There are also a number of health concerns caused by unsanitary living conditions, beyond infectious diseases including: noise/hearing loss, lung cancer, and asbestos poisoning. In situations like this, communicable diseases can quickly spread through the entire inmate population. In November 2009, it came to public attention that the New Jersey State Commission on Corrections discovered numerous unsanitary practices at the Nassau County jail including a lack of appropriate cleaning supplies for floors and kitchen implements, leaky roofs, and moldy ceilings.

**Individuals suffering from diseases living in close proximity**

Because of the economic status of most individuals who are sentenced to jail and prison it often means that they have either neglected their health care and/or they received substandard health care when they were in the free world. If they were homeless, this means even higher proclivity to contract health-related problems. One might argue that the susceptibility of getting a disease while in prison would be less than in public and/or private hospital. True, but hospitals are oriented towards curing individuals, and are often better funded. Moreover, in a hospital there are greater precautions taken to avoid the spread of disease. With respect to jails and prisons, there is also a problem of crowding and overcrowding that will exacerbate these problems. America’s jails and prisons are severely overcrowded (McKinnon, 2004). In some facilities, four prisoners are sleeping in cells originally designed for one person. Other correctional institutions have converted their halls, recreational areas, and classrooms into dormitories with double and triple bunking.

By 1980, two-thirds of all inmates in this country lived in cells or dormitories that provide less than sixty square feet of living space per person – the minimum standard deemed acceptable by the American Public Health Association, the Justice Department, and other authorities. Many lived in cells measuring half that. (Hallinan, 2003, p. 97)

California, for example, has one the most severe overcrowding problems of the country. In 2008, the Berkeley-based Prison Law Office filed suit in federal court against the overcrowded prison conditions in California prisons. In January 2010,
the court mandated that the California DOC reduce the number of inmates by 137.5% of their design capacity.

Conclusion
Regardless of the type of correctional facility to which s/he is sentenced, it is almost impossible for prisoners to escape violence, and that violence can have a serious, negative impact on his/her health if not on his/her life. Moreover, the medical services available to the average convict, not to mention the chronically and terminally ill inmates, are inadequate to their health needs. If the chronically and terminally ill are sentenced to either a state-run or a FBOP prison, whether mainline or FMC, their health conditions will likely worsen, since their health care needs will not be adequately met. In the likely event that such individuals will be assaulted, they will suffer trauma to their body and perhaps their psychological state of mind. All in all, a sentence to a state prison or FBOP functions as a de facto death sentence for such prisoners. Increasing awareness concerning prison conditions in the USA that fall below generally accepted standards of ethical care may provide a valuable loophole for lawyers and their clients who are seeking to block incarceration in state and federal facilities. They may also force our correctional institutions to better insure the health and safety of those whom they supervise.

Notes
1. A similar argument can be made for the disabled behind bars, however this is not discussed in this paper. For a discussion of the disabled in correctional facilities see, for example, Russell and Stewart (2001).
2. The term his is meant to indicate that males are most at risk for this kind of transmission. Thus, the construction his/her is avoided.

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