Looks That Kill: The Punitive and Medical Gazes in Maryland’s Prison Healthcare System

Jack Newhouse
COMMENT

LOOKS THAT KILL: THE PUNITIVE AND MEDICAL GAZES IN MARYLAND’S PRISON HEALTHCARE SYSTEM

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“This is not your fault[;] they should have brought you back.”¹ Maryland prisoner Roger Ervin heard these words from a doctor at the Johns Hopkins Wilmer Eye Institute after being informed that his left eye would need to be removed.² Two years prior, Ervin had a shunt surgically placed in his eye to treat his glaucoma while he was housed at North Branch Correctional Institution in Cumberland, Maryland.³ However, Ervin only attended a post-surgery follow-up appointment five months later when a doctor employed by Corizon Health, the private corporation with which Maryland contracted to manage its prison healthcare, told Ervin that his eyes were infected and “hard as rocks.”⁴ Despite a series of appointments with various prison healthcare providers over the course of several months, Ervin remained in so much pain that he could not lay on his left side, and his eyes were sensitive to direct light.⁵ In May 2021, the doctors at Johns Hopkins informed Ervin that they needed to remove his left eye due to an infection from the shunt being left in

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2. Id. at *9–10.
3. Id. at *7–8.
4. Id. at *7.
5. Id. at *8.
so long after his surgery. The doctors stated that they would not have placed the shunt—which had now damaged Ervin’s optic nerve—in his eye had they known it would take so long for the prisoner to return.

Ervin, representing himself, filed a claim against Corizon and its doctors under 42 U.S.C. § 1983 for violating his Eighth Amendment rights against cruel and unusual punishment by being deliberately indifferent to Ervin’s medical needs. Ultimately, the U.S. District Court for the District of Maryland dismissed Ervin’s claims against Corizon and its doctors. The court found that Ervin, who was bound to a wheelchair while in prison, rather than the prison healthcare professionals, caused the delays in his healthcare. Thus, the district court held that the treatment Ervin received for his glaucoma passed “constitutional muster.”

Roger Ervin’s case epitomizes the crossroads that Maryland is quickly approaching: The state’s five-year, $680 million contract with Corizon, now being managed by YesCare, is set to end in 2024. Maryland can either continue the decades-long failed experiment of privatized prison healthcare, or the state can resume responsibility for the care of its incarcerated population by re-instituting a state-managed system. The choice that the state makes will be the difference between life and death for many of Maryland’s prisoners.

It is well established that the protections of the Eighth Amendment guarantee prisoners the right to adequate healthcare. In Estelle v. Gamble, the Supreme Court declared that pain and suffering serve no penological purpose and that states are required to provide medical services to its incarcerated populations. However, in its adoption of a subjective knowledge standard with regard to deliberate indifference to serious medical needs, the Court failed to establish a solid constitutional floor relative to prison healthcare. Instead, the Court created a constitutional quicksand: The high bar of a subjective knowledge test for claims arising under 42 U.S.C.

6. Id.
7. Id. at *8–9.
8. Id. at *1.
9. Id. at *51.
10. Id. at *44.
11. Id.
13. See infra Section I.C; see also infra Section II.B.
14. See infra Section II.B.
15. See infra Section I.A.
17. See infra Section I.A.
18. See infra Section II.A.
§ 1983 dissolves the ground on which prisoners stand to assert their right to healthcare. Thus, *Estelle’s* promise of adequate healthcare operates not as a right but rather as a privilege for which prisoners like Roger Ervin must fight.

Broadly, the historical context within which prisoners’ rights were born, expanded, and ultimately constricted by judicial construction and legislative constraint demonstrates the limited avenues that prisoners have to assert violations of their constitutional rights. Specifically, the history of the Maryland prison healthcare system from a facility-based model to the modern-day privatized managed-care model demonstrates a concerted effort by the state to shed itself of responsibility for and liability from its provision of substandard healthcare. Prison healthcare operates out of the public’s sight and buttresses the prison industrial machine to perpetuate harm against those deemed enemies of society.

The Maryland government, by contracting out the state’s carceral healthcare to private corporations, essentially leases out a significant portion of the state’s hegemonic power to punish those it labels as “criminal.” As of 2019, Maryland had the highest percentage of Black prisoners of any state, with seventy-one percent of the state prison population being Black, and was among twelve states wherein more than half of the prison population was Black. Consequently, Black people are affected disproportionately not just by the facial consequences of mass incarceration but also by its clandestine effects. Specifically, prison healthcare, like prison diet and prison shelter, is an extension of the state’s ability to punish under the guise of rehabilitation. Furthermore, within the confines of the carceral system, prisoners are caught between the punitive gaze of the state, which objectifies the prisoner by stripping him of his liberties, and the medical gaze of the healthcare provider, who objectifies the prisoner by stripping him of his

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19. *See infra* Section II.A.
20. *See infra* Section II.A.
22. *See infra* Section I.C.2.
23. *See infra* Section I.B.
24. *See infra* Section I.A.
26. *See infra* Section II.B; see also NAZGOL GHANDNOOSH, SENT’G PROJECT, ONE IN FIVE: ENDING RACIAL INEQUITY IN INCARCERATION 6 (2023), https://www.sentencingproject.org/reports/one-in-five-ending-racial-inequity-in-incarceration/ (“In 2021, Black Americans were imprisoned at 5.0 times the rate of whites, while American Indians and Latinx people were imprisoned at 4.2 times and 2.4 times the white rate, respectively.”).
27. *See infra* Section I.B.1.
individuality during diagnosis and treatment. While the medical gaze exists in every doctor-patient relationship, the dehumanizing effect of the medical gaze is compounded by the already dehumanizing and violent prison setting. Therefore, the state, by perpetuating inadequate prison healthcare, is not only violating the constitutional rights of the incarcerated, but also conflicting with judicially recognized penological purpose.

This Comment seeks to accomplish four goals. It will provide the first-known history of Maryland’s prison healthcare system. Second, this Comment will argue that the subjective knowledge test for deliberate indifference dilutes the original intent of the framers of 42 U.S.C. § 1983 during Reconstruction. Thus, an objective standard should be adopted in order to better address the objective harm that prisoners experience through constitutionally inadequate healthcare. Third, Maryland’s decades-long experiment with privatized prison healthcare has been an abject failure. As such, this Comment argues that by publicly managing its prison healthcare system, Maryland can and should take responsibility for those whom the state chooses to criminalize. Fourth, while adopting both an objective standard for deliberate indifference and a publicly-managed prison healthcare system are necessary reforms, neither are sufficient to alleviate the harm perpetrated by prison healthcare because they fail to address the underlying causes of mass incarceration. Therefore, this Comment concludes by advocating for the adoption of abolitionist non-reformist reforms to dismantle the carceral state and obviate the demand for prison healthcare altogether. The only way to ensure that people are not harmed by prison and prison healthcare is to eliminate the supply of prisoners being forced to rely on such institutions.

I. BACKGROUND

Today, prisoners have a qualified right to sue in federal court if their constitutional rights are violated by any person acting under color of law. The statute granting this right, 42 U.S.C. § 1983, was originally adopted

28. See infra Section I.B.1.
29. See infra Section I.B.1.
30. See infra Section I.B.2.
31. See infra Section I.C.
32. See infra Section II.A.
33. See infra Section II.A.
34. See infra Section I.C.
35. See infra Section II.B.
36. See infra Section II.C.
37. See infra Section II.C.
38. See infra Section II.C.
during Reconstruction as a means to combat the two-front war targeting the recently emancipated Black citizens in the South: The physical war being waged by the Ku Klux Klan and the legal war being waged by state legislatures through the Black Codes. The twentieth century proved paradoxical for American prison systems as the Supreme Court’s expansion of prisoner rights regarding medical care was met with unprecedented mass incarceration stemming from the War on Drugs. Consequently, mass incarceration significantly altered prison demographics across the country, increasing the demand for now-constitutionally protected medical care. In response to the increased demand for expensive prison healthcare, many states, including Maryland, turned to cost-saving solutions presented by privatized healthcare corporations. The intersection of prisoner rights, mass incarceration, and healthcare privatization forced the Court to confront questions regarding liability for constitutional violations under § 1983—liability that Corizon seeks to circumvent.

This Background is organized into three sections. Section I.A describes the origins of 42 U.S.C. § 1983 within the historical context of Reconstruction and the development of deliberate indifference doctrine by the Supreme Court. Next, Section I.B surveys the oscillation of legal justifications of punishment in the Court’s discussions, summarizes the objectifying and dehumanizing effects of healthcare in prisons, and explains the abolitionist response to the carceral system as a whole. Finally, Section I.C provides a history of Maryland’s prison healthcare system, Maryland’s adoption of privatized prison healthcare, and the state’s complicated relationship with Corizon.

40. See infra Section I.A.1.
41. See infra Section I.C.
42. See infra Section I.C.
43. LAUREN GALIK & LEONARD GILROY, REASON FOUND., PUBLIC-PRIVATE PARTNERSHIPS IN CORRECTIONAL HEALTH CARE 2 (2014) (“Currently, only 14 state correctional health care systems are completely self-operated by government correctional agencies, while 36 states contract out at least a portion of their correctional health care services to either a private company or their state university health system.”).
46. See infra Section I.A.
47. See infra Section I.B.3.
48. See infra Section I.C.

Understanding the current state of Maryland’s prison healthcare system requires an understanding of Reconstruction.49 That is, the limited avenues for prisoners toward redress for constitutional violations stem from laws designed to protect Black citizens during the failures of Reconstruction.50 Thus, Section I.A.1 provides the historical context within which the third Enforcement Act, commonly referred to as the Ku Klux Klan Act of 1871,51 was passed, providing the foundation for what would eventually be codified as 42 U.S.C. § 1983.52 Then, Section I.A.2 describes how the Supreme Court expanded prisoner rights through its holdings regarding § 1983 litigation and how Congress constricted those rights toward the end of the twentieth century.53


The Civil War Amendments, adopted between 1865 and 1870, redefined the legal relationship between the federal government and the states: The Thirteenth Amendment abolished slavery for non-incarcerated persons;54 the Fourteenth Amendment defined both national and state citizenship and proscribed the states from violating the constitutional rights of all citizens;55 and the Fifteenth Amendment prohibited the denial of the right to vote based on “race, color, or previous condition of servitude.”56 However, the lofty goals of these amendments did not radically change the reality for free Black citizens in the South.57

49. See infra Section I.A.1.
    It is abundantly clear that one reason the [Ku Klux Klan Act] was passed was to afford a federal right in federal courts because, by reason of prejudice, passion, neglect, intolerance or otherwise, state laws might not be enforced and the claims of citizens to the enjoyment of rights, privileges, and immunities guaranteed by the Fourteenth Amendment might be denied by the state agencies.

   Id.
51. The Act’s official title was “An Act to enforce the Provisions of the Fourteenth Amendment to the United States, and for other purposes.” See infra note 62; see also CONG. GLOBE, 42d Cong., 1st Sess. 832 (1871).
52. See infra Section I.A.1.
53. See infra Section I.A.2.
57. CONG. GLOBE, 42d Cong., 1st Sess. 394 (1871). During the debate over the Ku Klux Klan Act of 1871, Joseph H. Rainey, a Black congressman from South Carolina, informed Congress that “as the clemency and magnanimity of the General Government became manifest once again did the monster rebellion lift its hydra head in renewed defiance, cruel and cowardly, fearing the light of day, hiding itself under the shadow of the night as more befitting its bloody and accursed work.” Id.
After the Civil War, the Ku Klux Klan began committing murders, assaults, and arsons against Black people throughout the South to resubjugate formerly enslaved people.\textsuperscript{58} Klansmen killed Black people to maintain white supremacy and justified the sexual assaults of Black women by claiming to protect “white womanhood.”\textsuperscript{59} In response to the Klan’s reign of terror, on March 23, 1871, President Grant called upon Congress to pass a law that would provide the federal government with the legal authority to combat the Klan’s white supremacist terrorism.\textsuperscript{60} After a lengthy debate, the KKK Act was enacted on April 20, 1871, to protect the constitutional rights, as guaranteed by the Civil War Amendments, and lives of emancipated Black citizens.\textsuperscript{61} The Act created civil liability in federal courts for any person who, under color of law or custom, violated another’s constitutional rights.\textsuperscript{62} Additionally, the Act allowed the President to suspend the writ of habeas corpus and use the military to enforce the law.\textsuperscript{63} Finally, the Act declared that a failure to provide protection from violence or deprivation of civil rights constituted “a denial by such State of the equal protection of the laws to which they are entitled under the Constitution of the United States.”\textsuperscript{64}

Empowered by Congress, President Grant proceeded to subdue the Klan by suspending the writ of habeas corpus in southern states like South Carolina and arresting hundreds of domestic terrorists, forcing the Klan’s leaders to flee the state.\textsuperscript{65} Additionally, federal prosecutors brought thousands of criminal cases under the Enforcement Acts, though fewer than half of the cases led to convictions.\textsuperscript{66} Despite the mixed legal results in prosecuting Klansmen in the federal courts, the KKK Act forced the Klan to nominally


\textsuperscript{59} Id.

\textsuperscript{60} Id. at 244 (“I urgently recommend such legislation as in the judgment of Congress shall effectually secure life, liberty, and property, and the enforcement of law in all parts of the United States.”).

\textsuperscript{61} Id. at 832.

\textsuperscript{62} An Act to Enforce the Provisions of the Fourteenth Amendment to the Constitution of the United States, and for Other Purposes (“KKK Act”), ch. 22, § 1, 17 Stat. 13 (1871). The act initially sought to mitigate the violence committed by the Klan by holding civilly liable government officials for their failure to safeguard those Black Americans harmed by the Klan. Id.

\textsuperscript{63} Id. § 3.

\textsuperscript{64} Id.

\textsuperscript{65} FONER, supra note 58, at 121.

\textsuperscript{66} Id.
dissolve by 1871.\(^{67}\) Today, Section 1 of the KKK Act\(^ {68}\) is codified as 42 U.S.C. § 1983.\(^ {69}\) Following its success in quelling domestic terrorism in the Reconstruction South, however, § 1983 would remain in relative obscurity until the mid-twentieth century.\(^ {70}\)

2. The Expansion—and Contraction—of Prisoners’ Rights under § 1983

The Supreme Court’s holding in *Monroe v. Pape*\(^ {71}\) greatly expanded the protection provided by 42 U.S.C. § 1983 by establishing that a state official’s unauthorized abuse of his position qualified as an act under color of law and that the official could be found liable in federal court under § 1983.\(^ {72}\) Next, in 1964, the Supreme Court held that a prisoner may successfully maintain a cause of action under § 1983 for the first time.\(^ {73}\) Twelve years later, the Court held in *Estelle v. Gamble*\(^ {74}\) that a denial of health care to a prisoner amounts to a violation of the Eighth Amendment when the actions, or failure to act, on the part of a Division of Correction official or medical provider rise to deliberate indifference to a serious medical need.\(^ {75}\) The Court found that the Eighth Amendment “proscribes more than physically barbarous punishments.”\(^ {76}\) Additionally, *Estelle* established the government’s obligation to provide medical care for those whom it is incarcerating.\(^ {77}\) The Court found that the government’s failure to treat an inmate could lead to torture or a prolonged death, in severe cases, or pain and suffering, in less

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68. KKK Act, ch. 22, § 1, 17 Stat. 13 (1871). Section 1 provided the following:

That any person who, under color of any law, statute, ordinance, regulation, custom, or usage of any State, shall subject, or cause to be subjected, any person within the jurisdiction of the United States to the deprivation of any rights, privileges, or immunities secured by the Constitution of the United States, shall, any such law, statute, ordinance, regulation, custom, or usage of the State to the contrary notwithstanding, be liable to the party injured in any action at law, suit in equity, or other proper proceeding for redress . . . .


70. Id. at 1169.


72. Id. at 172, 191–92. The Court did not answer the question of whether Congress can hold municipalities liable for civil rights violations committed by their officers. *Id.* at 191.

73. Cooper v. Pate, 378 U.S. 546 (1964) (per curiam).

74. 429 U.S. 97 (1976).

75. *Id.* at 106. Gamble, an inmate in the Texas Department of Corrections, was injured in 1973 while performing a prison work assignment. *Id.* at 98. Gamble, *pro se*, sued Estelle, the Director of the Department of Corrections; the prison’s warden; and the medical director of the Department of Corrections under 42 U.S.C. § 1983 for inadequate medical care. *Id.*

76. *Id.* at 102–03; see also U.S. Const. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”).

severe cases. As stated by the majority, pain and suffering do not “serve any penological purpose.”

The majority concluded that deliberate indifference to the serious medical needs of prisoners violates the Eighth Amendment. Additionally, deliberate indifference can be manifested by prison doctors providing inadequate care or by prison guards preventing or delaying access to medical care. However, accidents or an inadvertent failure to provide adequate healthcare do not constitute “unnecessary and wanton infliction of pain.” Moreover, medical negligence and medical malpractice do not constitute violations of a prisoner’s Eighth Amendment rights. The Court then held that medical malpractice claims should be filed in the state court and that Gamble failed to demonstrate that the medical treatment he received constituted deliberate indifference. In his dissent, Justice Stevens argued that the majority erroneously considered the prison official’s subjective motivations when considering whether his actions constituted cruel and unusual punishment. Furthermore, he contended that “whether the constitutional standard has been violated should turn on the character of the punishment rather than the motivation of the individual who inflicted it.”

The next significant change to the deliberate indifference doctrine came in the Supreme Court’s holding in West v. Atkins. In West, the Court considered whether a physician contracting with a state to provide prison healthcare “acts under color of state law for purposes of § 1983,” even if that physician is employed by a private entity. The Court answered in the affirmative:

We now make explicit what was implicit in our holding in Estelle: Respondent, as a physician employed by North Carolina to provide

78. Id.
79. Id.
80. Id. at 104.
81. Id. at 104–05.
82. Id. at 105–06 (citing Louisiana ex rel. Francis v. Resweber, 329 U.S. 459, 464, 471 (1947)).
83. Id. at 106.
84. Id. at 107.
85. Id. at 116 (Stevens, J., dissenting).
86. Id. Justice Stevens concluded by stating that “[w]hether the conditions in Andersonville were the product of design, negligence, or mere poverty, they were cruel and inhuman.” Id. at 116–17.
87. 487 U.S. 42 (1988). West was an inmate in Jackson, North Carolina, who tore his Achilles tendon while incarcerated. Id. at 43. Atkins, a physician who contracted with one of the state’s prison hospitals, refused to schedule surgery for West, despite acknowledging that surgery was necessary. Id. at 44. West, pro se, sued Atkins under 42 U.S.C. § 1983 for violating his Eighth Amendment rights. Id. at 45. The district court granted summary judgment in favor of Atkins because he was a “contract physician,” and therefore was not acting under color of law. Id. at 45–46. The Fourth Circuit affirmed the district court’s dismissal of West’s complaint. Id. at 46.
88. Id. at 47–48.
medical services to state prison inmates, acted under color of state law for purposes of § 1983 when undertaking his duties in treating petitioner’s injury. Such conduct is fairly attributable to the State. 89

The Court reasoned that, because he was employed by the state to treat prisoners, Atkins was “clothed with the authority of state law.” 90 Furthermore, the fact that state law required West to receive treatment from Atkins without an alternative created a situation wherein any misuse of power by Atkins was in essence a state action, thus constituting deliberate indifference to West’s serious medical needs. 91 The Court concluded that though states may contract out their prison healthcare, states are not relieved of their “constitutional duty” to provide adequate healthcare for their prisoners. 92

The expansion of prisoner rights following the Court’s holdings in Estelle, West, and other cases filed under 42 U.S.C. § 1983 led to a dramatic increase in prison litigation. 93 In fact, Congress found that the volume of prisoner lawsuits grew from “6,600 in 1975 to more than 39,000 in 1994.” 94 By 1995, prisoners brought more than twenty-five percent of the suits filed in federal district courts. 95 To help alleviate this marked increase in litigation, Congress enacted the Prison Litigation Reform Act of 1995 (“PLRA”), 96 which implemented a more stringent requirement for prisoners to exhaust available administrative remedies. 97 The PLRA strengthened the exhaustion requirement of the Civil Rights of Institutionalized Persons Act 98 in several ways, including: (1) removing the discretion of the district courts to require

89. Id. at 54.
90. Id. at 55 (quoting United States v. Classic, 313 U.S. 299, 326 (1941)).
91. Id.
92. Id. at 56.
93. E.g., Alexander v. Hawk, 159 F.3d 1321, 1324 (11th Cir. 1998).
95. Id.
97. 42 U.S.C. § 1997e(a) requires the following:
   No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.
In Maryland, prisoners must exhaust the Administrative Remedy Procedure (“ARP”) to sustain any § 1983 claim. Chase v. Peay, 286 F. Supp. 2d 523, 529–31 (D. Md. 2003). The ARP process has very strict timelines that prisoners must adhere to in order to sustain their claim. See Md. CODE REGS. 12.02.28.09 (2023) (stating that prisoners must file an ARP request within thirty days from the date on which the incident occurred). If the prisoner fails to follow any of the prescribed steps, his § 1983 claim may be dismissed for failure to exhaust administrative remedies. Woodford, 548 U.S. at 102–03.
exhaustion; (2) requiring prisoners to exhaust all available remedies, not just those which adhered to federal standards; and (3) requiring exhaustion for all suits related to prison conditions, even those not brought under § 1983.\textsuperscript{99} The PLRA was extremely effective, reducing the number of federal prisoner lawsuits from “41,679 in 1995 to 25,504 in 2000.”\textsuperscript{100} Justice Stevens argued that the strict procedural requirements of the PLRA resulted in a “[d]raconian punishment” for prisoners making a good-faith effort to comply with the requirements but who had made a “procedural misstep along the way.”\textsuperscript{101}

The expansion and contraction of prisoner rights in the twentieth century did not occur in a vacuum.\textsuperscript{102} Rather, the waxing and waning of prisoner rights paralleled the Supreme Court’s fluctuating stances on penological purpose.\textsuperscript{103} In turn, the evolving nature of prisons and punishment is documented in the writings of philosophers and sociologists who have sought to define the realities of carceral punishment and abolitionists seeking to dismantle those realities.\textsuperscript{104}

\textbf{B. Penological Purpose and Reality: Philosophy, the Court, and Abolitionist Theory}

The Supreme Court’s declaration in \textit{Estelle} that denying prisoners medical care, specifically, and inflicting pain and suffering, in general, serve no “penological purpose”\textsuperscript{105} highlights an age-old fundamental question: What is the purpose of incarceration? Moreover, the evolution of prison healthcare in Maryland and elsewhere further complicates this question by juxtaposing the doctor’s duty to heal with the state’s power to punish.\textsuperscript{106} First, philosophical and sociological perspectives reveal how the seemingly disparate concepts of carceral punishment and healthcare combine to dehumanize prisoners.\textsuperscript{107} Second, a survey of the Supreme Court’s decisions demonstrates how its broad discussions of legitimate penological purpose through criminal sentencing has reflected that of the contemporary penological zeitgeist at a given time.\textsuperscript{108} Finally, against the backdrop of philosophical reality and legal justification, abolitionist theorists advocate

\begin{enumerate}
\item[99] \textit{Woodford}, 548 U.S. at 85.
\item[100] \textit{Id.} at 115 (Stevens, J., dissenting).
\item[101] \textit{Id.} at 119.
\item[102] \textit{See infra} Section I.B.2.
\item[103] \textit{See infra} Section I.B.2.
\item[104] \textit{See infra} Section I.B.3.
\item[106] \textit{See infra} Section I.C.
\item[107] \textit{See infra} Section I.B.1.
\item[108] \textit{See infra} Section I.B.2.
\end{enumerate}
not just for prison reform but for abolition of the carceral system altogether.\(^{109}\)

I. The State’s Power to Punish: The Punitive Gaze and the Medical Gaze

In the eighteenth century, Jean-Jacques Rousseau argued that “every wrongdoer, by attacking society’s laws, becomes, through his transgressions, a rebel and a traitor to his country; by violating its laws, he ceases to be one of its members, and he even makes war against it.”\(^{110}\) Later, Michel Foucault found that, by violating the law, criminals are viewed as having become “detached from society.”\(^{111}\) Therefore, by punishing the criminal, society believes that it is carrying out “legitimate vengeance.”\(^{112}\) In describing the gradual transition from the generous application of capital punishment prior to the eighteenth century to the modern day institution of incarceration, Foucault argued that the prison became an apparatus of justice wherein the state’s power to punish now manifested silently and clandestinely rather than in the public eye.\(^{113}\) Thus, punishment evolved into the objectifying conception and treatment of the imprisoned.\(^{114}\) Reforms to both the prison and the methods of discipline transformed the state’s manifestation of punishment from “an art of unbearable sensations” to “an economy of suspended rights.”\(^{115}\) As a result of the prolonged incarceration of the criminal, prisons became permanent observatories of the incarcerated.\(^{116}\) This evolution led to prisons serving the double function of depriving the individual criminal of his liberties while also transforming him.\(^{117}\) Ultimately, the modern formulation of the punitive gaze emerged: Prisons became observatories of prisoners, and thus, functioned as apparatuses of knowledge.\(^{118}\)

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109. See infra Section I.B.3.
112. Id. at 94.
113. Id. at 256.
114. Id.
115. Id. at 11.
116. Id. at 126.
117. Id. at 233.
118. Id. at 126. The Walnut Street Penitentiary in Philadelphia exemplifies how the punitive gaze became concentrated in American prisons: First, Walnut Street did not publicize penalties, but rather carried out sentences in secret. Id. at 124. This marked a stark contrast from the system of public executions and “therefore the decline of the spectacle.” Id. at 10. Second, punishment became a process that was kept between the prisoner and the correctional officials. Id. at 127. These
Foucault observed that as the objectives and methods of state punishment evolved over time, so too did the makeup of the prison administration staff in order for the new system to legitimize itself:

As a result of this new restraint, a whole army of technicians took over from the executioner, the immediate anatomist of pain: warders, doctors, chaplains, psychiatrists, psychologists, educationalists; by their very presence near the prisoner, they sing the praises that the law needs: they reassure it that the body and pain are not the ultimate objects of its punitive action.119

Foucault’s comments regarding the relationship between prison doctors and prisoners was foreshadowed a decade earlier by his analysis of the relationship between all doctors and all patients.120 In The Birth of the Clinic, Foucault argued that, in general, medical patients are placed in a paradoxical position: “If one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities.”121 Furthermore, since the eighteenth century, professional medicine has stripped the patient’s individuality from the interaction between the doctor and the ailment.122

As a result, the doctor-patient relationship has changed: Because doctors and patients have been brought into closer proximity to one another, doctors have, over time, adopted a more penetrating gaze toward the patient.123 Thus, the doctor employs what Foucault refers to as “the medical gaze”. By fixating on the dehumanized body concealing the disease from the doctor, the doctor perceives the patient in an objectifying manner, cleaving the patient’s self from their body.124 Notably, the medical gaze has neither been a permanent fixture in the medical canon nor was it necessarily inevitable:

The access of the medical gaze into the sick body was not the continuation of a movement of approach that had been developing in a more or less regular fashion since the day when the first doctor cast his somewhat unskilled gaze from afar on the body of the first patient; it was the result of a recasting at the level of epistemic

correctional officials were charged with transformation of the prisoner’s soul, and thus, the prison became both an “administrative apparatus” and “a machine for altering minds.” Id. at 125. Prisoners were observed daily in order to evaluate their progress and to gather knowledge that could further enhance the efficacy of the prison itself. Id. at 126.

119. Id. at 11.
121. Id.
122. Id. at 97–98.
123. Id. at 15–16.
124. Id.
knowledge . . . itself, and not at the level of accumulated, refined, deepened, adjusted knowledge . . . . 125

Joe Sim elaborated on the medical gaze and the role of prison healthcare in relation to carceral punishment in Medical Power in Prisons. 126 Sim, like Foucault, argued that “[d]omination through observation objectified the prisoner.” 127 Additionally, Sim averred that, since the eighteenth century, the conditions of carceral punishment have profoundly impacted the quality of medical care that prisoners have received and that prison medicine has played a role in maintaining order in prisons. 128 Sim argued that as prison healthcare workers entrenched themselves within both prisons and the criminal justice process, prison healthcare became an extension of the state’s power to punish. 129

2. The Court, Penological Purpose, and Evolving Standards of Decency

As evidenced by discussions within the Supreme Court’s case history, the Court does not direct, but rather reflects, the popular penological theory at any given time. 130 In the eighteenth century, England and other western European countries began reforming how criminals were punished by relying less on capital punishment for minor offenses. 131 Instead, criminal justice and prison reformers advocated for sentences based on the proportionality of the crime. 132 As these reforms made their way to the United States, what emerged over time were the four dominant and acceptable penological theories used to justify criminal sentencing and punishment today: rehabilitation, retribution, incapacitation, and deterrence. 133

These penological justifications are neither mutually exclusive nor dominant of the penological zeitgeist in a linear or chronological manner. 134 Rather, the Supreme Court’s decisions show that society, and the Court itself,

125. Id. at 137.
126. JOE SIM, MEDICAL POWER IN PRISONS: THE PRISON MEDICAL SERVICE IN ENGLAND 1774–1989, at 9 (1990) (“The prison became a laboratory in which the advice and expertise of the medical profession, both physicians and psychiatrists, was geared to reintegrating the confined back to normality.”).
127. Id. Sim also described the historical intersection of the medical gaze with the additional sexist motivations behind reforming female prisoners. Id. at 130.
128. Id. at x.
129. Id. at 128.
130. See infra note 146 and accompanying text.
132. Id. at 820.
134. See FREDERICK HOWARD WIVES, PUNISHMENT AND REFORMATION: AN HISTORICAL SKETCH OF THE RISE OF THE PENITENTIARY SYSTEM 25 (1895) (describing the nineteenth-century understanding of the different penological purposes).
have oscillated over time between which theory should be given most weight in determining how it should punish criminals.\textsuperscript{135} For example, in the late eighteenth century, the Walnut Street Penitentiary in Philadelphia, the first penitentiary in the United States, served as the ultimate form of state retribution short of capital punishment.\textsuperscript{136} In an ostensible attempt to rehabilitate, the Walnut Street Penitentiary was designed to ensure the permanent and “complete isolation of the prisoner from all human society and his confinement in a cell of considerable size, so arranged that he had no direct intercourse with or sight of any human being, and no employment or instruction.”\textsuperscript{137} These conditions resulted in prisoners falling into “semi-fatuous” conditions, becoming “violently insane,” or committing suicide.\textsuperscript{138} Ultimately, the results of this experiment epitomized the retributive logic of punishment for punishment’s sake: “[Prisoners] pay the penalty because [they] owe it, and for no other reason.”\textsuperscript{139} Those prisoners who survived Walnut Street were generally neither reformed nor mentally fit to return to the community.\textsuperscript{140}

The failures of the Walnut Street Penitentiary model led to a social, and in turn legal, shift away from retribution, and by the mid-twentieth century, rehabilitation had been accepted as a more significant penological purpose.\textsuperscript{141} In 1949, the Court summarized this transition: “Retribution is no longer the dominant objective of the criminal law. Reformation and rehabilitation of offenders have become important goals of criminal jurisprudence.”\textsuperscript{142} With regard to sentencing, the Court reflected the public sentiment, which accepted that individualized, indeterminate sentences and non-judicially implemented practices such as parole and probation were “wise” policies.\textsuperscript{143} The Court found that the penological changes were strongly motivated by the belief that careful, individualized study of a prisoner required less severe punishments, engendering a quicker return to free society.\textsuperscript{144}

However, by the 1980s the penological pendulum swung back toward retribution, incapacitation, and deterrence.\textsuperscript{145} Under President Ronald

\textsuperscript{135} Payne, 501 U.S at 819.
\textsuperscript{136} See In re Medley, 134 U.S. 160, 168 (1890) (describing the history of the Walnut Street Penitentiary).
\textsuperscript{137} Id.
\textsuperscript{138} Id.
\textsuperscript{139} F.H.Bradley, Ethical Studies 26 (2d ed. 1927).
\textsuperscript{140} Id.
\textsuperscript{141} See Williams v. New York, 337 U.S. 241, 247–48 (1949) (finding that “[t]he belief no longer prevails” that every criminal offense requires identical punishment “without regard to the past life and habits of a particular offender”).
\textsuperscript{142} Id. at 248.
\textsuperscript{143} Id.
\textsuperscript{144} Id. at 249.
Reagan, the Comprehensive Crime Control Act of 1984 sought to require that federal criminal offenders serve virtually all of their imposed prison sentence by abolishing parole and substantially restructuring good behavior term of confinement adjustments. Additionally, the Federal Sentencing Guidelines published in 1987 further limited the discretion of federal judges in making sentencing decisions. The legislative and judicial heel turn from the rehabilitative model in the 1980s reflected a broader societal dissatisfaction with this model, leading to harsher and longer sentences aimed at retribution, incapacitation, and deterrence.

Today, the Court still references the basic penological purposes in its discussions of the Eighth Amendment, but it also considers “the evolving standards of decency that mark the progress of a maturing society.” The Court continues to reflect society’s ever-changing views on penological purpose as evinced by the Court’s conflicting interpretations of what constitutes a decent and mature society.

3. The Abolitionist Perspective: Incarceration as Spatial-Temporal Social Control

One such societal view that has emerged in the past several decades is that of prison abolition. Recently, academics and activists have rejected both the inevitability and the necessity of the carceral superstructure and have proposed alternative systems that would obviate the caging of human beings. Angela Davis, prominent abolitionist academic and activist, argued that prisons function ideologically and spatially “as an abstract site into which undesirables are deposited,” thus relieving society of the responsibility of seriously engaging with its problems. Specifically, within the United States, prisons absolve society from engaging with problems originating from and sustained by racism. Davis traces the evolution in penological praxis

151. Miller, 567 U.S. at 469, 478, 489. In Miller, the majority considered “evolving standards of decency” in relation to rehabilitation when finding that Alabama and Arkansas statutes requiring that all children convicted of homicide receive life sentences without the possibility of parole unconstitutional under the Eighth Amendment. Id. However, in his dissent, Chief Justice Roberts argued with retribution and incapacitation language in his interpretation of that standard. Id. at 495 (Roberts, C.J., dissenting).
153. Id.
in concert with the rise of capitalism—transitioning from corporal harm to temporal control through imprisonment as the primary “mode of state-inflicted punishment.” Specifically, the fact that modern prison sentences are communicated in terms of time reflects this transition: The “computability of state punishment in terms of time—days, months, years—resonates with the role of labor-time as the basis for computing the value of capitalist commodities.” Ruth Wilson Gilmore frames the temporal control of prisoners as a form of extraction. Through incarceration, time is extracted from the “territories of selves,” creating a process which “opens a hole in a life.”

To address the harm caused by incarceration, abolitionists call for society to challenge the prevailing notion that punishment follows in a logical sequence from crime. In an alternative viewpoint, punishment in the form of imprisonment follows from its various associations:

Imprisonment is associated with the racialization of those most likely to be punished. It is associated with their class[,] and . . . gender structures the punishment system as well. If we insist that abolitionist alternatives trouble these relationships, that they strive to disarticulate crime and punishment, race and punishment, class and punishment, and gender and punishment, then our focus must not rest only on the prison system as an isolated institution but must also be directed at all the social relations that support the permanence of the prison.

Through the critical lens employed by Davis, the carceral system has existed historically and exists presently to exact punishment on the basis of race, class, and gender. And thus, the facial justification of “crime” is used to rationalize this prejudiced and oppressive system. That is, Davis contends that the coupling of crime and punishment in the current carceral imagination functions as a pretense for the caging of historically marginalized peoples. After laying bare the iniquity endemic to incarceration, Davis observes the insufficiency of prison reforms, as they perpetuate “the stultifying idea that nothing lies beyond the prison.”

154. Id. at 43.
155. Id. at 44.
156. RUTH WILSON GILMORE, Abolition Geography and the Problem of Innocence, in ABOLITION GEOGRAPHY: ESSAYS TOWARDS LIBERATION 471, 474 (Brenna Bhandar & Alberto Toscano eds., 2022).
157. Id.
158. DAVIS, supra note 152, at 112.
159. Id.
160. Id.
161. Id.
162. Id.
163. Id. at 20.
example, reforms like those advocated for and implemented in the Walnut Street Penitentiary were once considered progressive. Consequently, abolitionists seek alternatives to the prison industrial complex altogether in part through what are called “non-reformist reforms”—reforms intended not to improve the carceral system but rather to render it obsolete. Thus, abolitionists propose a fundamental question separate from penological purpose: What would it mean to imagine a system “in which punishment itself is no longer the central concern in the making of justice?”

To answer that question, Davis suggests systemic changes to our societal institutions and strategies, with the ultimate goal of “removing the prison from the social and ideological landscapes of our society.” For example, abolitionists propose demilitarization of schools, investment in education, free physical and mental healthcare, and a justice system “based on reparation and reconciliation rather than retribution and vengeance.” The history of Maryland’s prison healthcare system provides an acute example of why abolitionists seek to eliminate both the institution of and demand for prisons and prison healthcare.

C. A Brief History of Maryland’s Prison Healthcare System

Because there is no existing comprehensive history of Maryland’s prison healthcare system, this Comment seeks to provide a brief overview of the subject to fill that lacuna. Subsection I.C.1 will demonstrate that the importance of prison healthcare was known long before Estelle was decided and examine the context within which Maryland corrections officials decided to move from the facility-based model to privatization. Subsection I.C.2 will explore Maryland’s adoption of contract-based private prison healthcare

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164. Id. at 47–50.
165. Id. at 106; see also ANDRÉ GORZ, STRATEGY FOR LABOR 7–8 (Martin A. Nicolaus & Victoria Ortiz trans., Beacon Press 1967) (1964). Gorz explains:

A non-reformist reform is determined not in terms of what can be, but what should be. And finally, it bases the possibility of attaining its objective on the implementation of fundamental political and economic changes. These changes can be sudden, just as they can be gradual. But in any case they assume a modification of the relations of power . . . . They assume structural reforms.

GORZ, supra, at 7–8.
166. DAVIS, supra note 152, at 107.
167. Id.
168. Id.; see also MARIAME KABA, SO YOU’RE THINKING ABOUT BECOMING AN ABOLITIONIST, in WE DO THIS ’TIL WE FREE US 6, 13 (Tamara K. Nopper ed., 2021) (providing specific intermediate steps to reduce police power, with the ultimate goal of police abolition, such as abolishing police unions, disarming the police, and reducing police budgets).
169. See infra Section I.C.
170. See infra Section I.C.1.
leading up to the state contracting with Corizon.\textsuperscript{171} Finally, Subsection I.C.3 will demonstrate Maryland’s shortcomings in overseeing Corizon’s performance throughout contract until the corporation ultimately filed for bankruptcy.\textsuperscript{172}

1. Prison Healthcare Prior to Privatization

The importance of adequate prison healthcare was not a twentieth century discovery. For example, in 1777, an English justice of the peace named John Howard published a widely influential book detailing the deplorable conditions in English and Welsh prisons and jails.\textsuperscript{173} Howard’s findings led him to propose that every jail have an experienced and competent surgeon responsible for providing sick prisoners with a healthy diet, medicine, clean linens, and fresh air.\textsuperscript{174} Additionally, he argued that sick prisoners should be inculcated from the “danger of crowding prisoners together.”\textsuperscript{175} In the early twentieth century, studies of prison systems in the United States reiterated the necessity of providing prisoners with adequate healthcare, hygiene, and diets.\textsuperscript{176} These studies also attempted to rid broader society of the notion that the general public is immune from the diseases found within prisons.\textsuperscript{177} In Maryland, an exhaustive 1877 report to Maryland Governor John Lee Carroll by the Secretary of the State Board of Health detailed the inspections of every state prison and reformatory and found that many of the state institutions were in “shocking condition.”\textsuperscript{178} Despite over a century of studies and reports reiterating the importance of adequate prison healthcare, states like Maryland continued to maintain inadequate—and after Estelle, unconstitutional—healthcare for the incarcerated.\textsuperscript{179}

\textsuperscript{171} See infra Section I.C.2.

\textsuperscript{172} See infra Section I.C.3.

\textsuperscript{173} JOHNS H E W A R D, THE STATE OF THE PRISONS IN ENGLAND AND WALES (1777).

\textsuperscript{174} Id. at 56.

\textsuperscript{175} Id.


\textsuperscript{177} Id. at 273 (“Society is inclined to be selfish in this matter, and to consider that so long as a prison population is isolated, the extinction of the disease in the penal institutions has little to do with the general problem of its extinction in the community at large.”).

\textsuperscript{178} C.W. CHANCELLOR, REPORT ON THE PUBLIC CHARITIES, REFORMATORIES, PRISONS AND ALMSHOUSES, OF THE STATE OF MARYLAND 2 (1877), https://tile.loc.gov/storage-services/public/gdcmassbookdig/reportonpublicch00mary_0/reportonpublicch00mary_0.pdf (“It is painful to report the shocking condition in which many of the public institutions were found, and it is difficult to conceive that anything worse ever existed in a civilized country.”).

\textsuperscript{179} Robert P. Wade, State Prison Medical Care Seriously Ailing but Can Recover, BALT. SUN, Dec. 20, 1973, at A17 (“A five-page report prepared by the Medical and Chirurgical Faculty, the state medical society, called inmate health care ‘barely adequate on a day-to-day basis’. . . .”).
Prior to contracting with private corporations and for most of the twentieth century, Maryland employed part-time physicians to provide medical care for the state’s prisoners. Under a facility-based model, state corrections officials were directly responsible for prison healthcare. Into the 1970s, however, Maryland only employed seven full-time prison doctors and dentists for the state’s five thousand prisoners. Apart from the lack of medical staff, the employees that the state did employ failed to work their required hours. Due to Maryland’s increasingly publicized failures regarding prison healthcare, state corrections officials conducted studies to explore options “for contracting out-patient health care in prisons to a private bidder.” Specifically, investigations revealed that only two out of ten prisoners who went to sick call were seen by a doctor and that “poor medical care” was one of the leading complaints in the Maryland prison uprisings and strikes in the early 1970s. By 1981, the state planned to dismantle the medical services staff within the Division of Corrections and hired a consultant to oversee contracts between Maryland and private healthcare agencies to provide care for prisoners. However, the hopes for private

180. Prisons Director to Assist Faculty, BALT. SUN, Jul. 19, 1937, at 16.
182. Jim Flanery, New Prison Care Setup Studied, BALT. SUN, Nov. 29, 1972, at C13. The state also employed another thirty part-time prison doctors. Id. However, state auditors found that the full-time doctors and dentists were not working enough hours to justify their salaries. Id. This finding helped spur the movement within the state government to begin investigating “prepaid group health programs.” Id.
183. Doctors and Dentists at Prisons Criticized, WASH. POST, Nov. 18, 1972, at B1 (“The seven full-time doctors and dentists in the state prison system are working only a third to half as much as they are supposed to, according to the personnel chief of the state Department of Public Safety and Correctional Services.”).
184. Jackie Jones, State’s Prisons Lack Medical Care, BALT. SUN, Apr. 5, 1981, at K3. In 1979, a court ordered Maryland “to upgrade medical services at the Maryland Correctional Institution in Hagerstown by May, 1980.” Id. However, the state never complied with the order. Id. The Division of Corrections developed a plan but failed to submit it to the court because “there was no money to pay for it and no one had been contracted to provide the medical services.” Id. Neither the Division of Corrections nor the governor communicated to the legislature that the court ordered the medical plan. Id. The judge responded by extending the deadline. Id.
185. Knudson, supra note 181.
186. Victor Cohn, Medical Care in Md. Prisons Hit, WASH. POST, Dec. 20, 1973, at C14. The Maryland Medical and Chirurgical Faculty urged the state to shift the prison healthcare system to “an autonomous prison medical system, not one reporting to individual wardens.” Id. Confronting these conditions, the chairman of the Maryland state medical committee commented that “[p]aradoxically, the average poor, black prisoner, even though he gets ‘barely adequate’ care, gets better care than he got when he was free.” Id.
healthcare to serve as a panacea for the state’s prison conditions would ultimately clash with the realities of mass incarceration.\textsuperscript{188}

2. Maryland’s Adoption of Privatized Prison Healthcare

In general, there are many reasons why privatized prison healthcare would present as tempting for states, such as higher quality care, expertise in recruiting healthcare professionals, and the ability to shed prison administrators of the burden of managing healthcare and instead focus on correctional services.\textsuperscript{189} However, contracting with private corporations for prison healthcare is not without risk.\textsuperscript{190} Therefore, states seek to implement “deceptively simple” quality control measures such as: (1) clear, measurable contract requirements; (2) incentivized payment provisions; and (3) monitoring procedures to identify and resolve problems.\textsuperscript{191} In sum, states that choose to contract with private corporations to provide comprehensive medical services are embracing “perhaps the most dramatic reform that can be undertaken” with regard to managing prison healthcare.\textsuperscript{192}

In the 1980s, the nascent stages of Maryland’s privatized prison healthcare experiment were characterized by a patchwork of contracts between prison facilities and healthcare providers.\textsuperscript{193} Consequently, the quality of care varied from facility to facility, as did the amount spent for medical services per prisoner.\textsuperscript{194} While the shift to privatized healthcare increased the spending per prisoner, this increased spending was not met with a substantial increase in the quality of medical care for Maryland’s

\textsuperscript{188} Neal R. Peirce, \textit{The Cost of Cheaping Public Health}, BALT. SUN, Oct. 5, 1992, at 9.A (“In a decade, we have doubled our prison and jail population, often tolerating conditions of gross overcrowding.”).

\textsuperscript{189} DOUGLAS C. MCDONALD, NAT’L INST. OF JUST., MANAGING PRISON HEALTH CARE AND COSTS 64 (1995).

\textsuperscript{190} \textit{Id.} at 65. One such risk that the National Institute of Justice (“NIJ”) highlighted in this report was the risk that the contracting company, “by their insensitivity or, in the worst case, by going bankrupt, may burn bridges between the department and the community of outside health care providers.” \textit{Id.} Moreover, the NIJ found that “the more an agency relies on contracting for health care services, the greater the threat of disruptions in service by strikes and bankruptcies.” \textit{Id.}

\textsuperscript{191} \textit{Id.} However, “a health care ‘system’ that is fragmented, weakly controlled, and essentially ‘unmanaged,’ both cost control and quality of service may suffer.” \textit{Id.} at 91 (emphasis omitted).

\textsuperscript{192} \textit{Id.} at 92.

\textsuperscript{193} For example, the Baltimore City Jail contracted with Prison Health Services, Inc. (“PHS”) to provide medical services for its incarcerated population from 1985 to 1990, after which the contract was awarded to Pickens Comprehensive Health Services. Ann LoLordo, \textit{Baltimore City Jail Health Services Are Found Lacking}, BALT. SUN, Nov. 22, 1989, at 1B. The contract with PHS proved problematic as a U.S. District Court judge ordered a review of the jail’s medical operations following complaints regarding the quality of care. \textit{Id.}

\textsuperscript{194} Karen Hosler, \textit{Hagerstown Medical Pact: Md. OKs Costlier Inmate Care}, BALT. SUN, Apr. 29, 1982, at D14 (“Currently, the state spends about $433 an inmate annually at Hagerstown, compared to an average of $728 an inmate throughout the state prison system for medical services that one state official acknowledged are ‘spotty.’”).
prisoners. In fact, an independent consultant hired to evaluate the quality of the state’s prison healthcare system warned state officials that the current state of the system created a “liability time bomb” for the government. Moreover, the consultant’s report explained that “a large part of the problem dates to 1981, when prison officials began contracting prison medical services to private firms” and that state officials “failed to properly monitor the services after they hired private contractors.”

By 1989, Maryland had contractors providing all health services in all of the state’s prisons. However, shifting prison demographics, disease, and overcrowding combined to stress Maryland’s new system. Though overcrowding in Maryland’s prisons was not a new phenomenon, older populations, chronic illnesses, AIDS, and tuberculosis exacerbated problems within the prison healthcare system unlike ever before. For example, in 1992, four-hundred prisoners at Roxbury Correctional Institution in Hagerstown, Maryland, were diagnosed with tuberculosis after a prisoner diagnosed with the disease was returned to the general population. While the state struggled to combat in its prisons the consequences of mass incarceration, it also faced battles with its healthcare providers in the

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195. Consultant Warns Md. of Shortcomings in Prison Health Care, BALT. SUN, Nov. 27, 1986, at 24C. A consultant for the state reported that Maryland’s prison healthcare was below the “‘minimal nationally accepted standards’ for prisons.” Id.

196. Id.

197. Id.

198. MCDONALD, supra note 189, at 62.

199. Avram Goldstein, Md. Prison Infection Rate High, WASH. POST, May 7, 2003, at DMB1 (“Nearly one in three inmates entering the Maryland prison system is infected with HIV, syphilis, hepatitis B virus or hepatitis C virus—many of them with more than one infection—according to a blood survey released yesterday by state health officials.”); see also Richard Tapscott, Md. Prison, Welfare Costs Keep Ahead of Budgeters, WASH. POST, Feb. 17, 1990, at B2. By 1990, Maryland’s prison system incarcerated 6,000 prisoners over its design capacity due primarily to convictions related to the War on Drugs. Tapscott, supra. Maryland was housing nearly 17,000 prisoners, “a total planners had not expected until 1998.” Id. When seeking a $15 million budget increase, the secretary of Maryland’s Department of Public Safety and Correctional Services stated that he “can’t predict prison growth anymore.” Id.

200. See COMM. ON MD. PRISON ADMIN., REPORT OF THE LEGISLATIVE COUNCIL COMMITTEE ON MARYLAND PRISON ADMINISTRATION 7 (1962) (finding that three facilities were operating at 30.2%, 53.7%, and 74.3% in excess of their respective capacities).

201. Sandra G. Boondman, Prison Medical Crisis: Overcrowding Created by the War on Drugs Poses a Public Health Emergency, WASH. POST, July 7, 1992, at 5. This was the largest tuberculosis outbreak in Maryland in decades. Id.

courtroom, with some of these cases between Maryland and its prison healthcare contractors costing the state millions of dollars.

By as early as 1992, Maryland prison healthcare was being provided solely by St. Louis-based corporation Correctional Medical Services (“CMS”), the largest prison healthcare provider in the country at the time. Despite the advantages of having one healthcare provider, state audits revealed that CMS was overcharging Maryland for their services. The experience with the CMS contract led state officials to create a plan to subdivide the contract again. However, the contract was then given solely to Prison Health Services, Inc., a Tennessee-based firm, for several years. In 2005, Maryland split the contract, worth a total of $223 million, between five different companies, with the largest module of the contract being awarded again to CMS. In 2012, the contract was given to the Pittsburgh-based Wexford Health Sources, Inc., which alone held the contract until 2018. Finally, Maryland awarded a five-year contract to Corizon in 2018. In October 2022, Maryland acknowledged that CHS TX, Inc., doing business as YesCare, had assumed Corizon’s interest in the state’s prison healthcare contract and is currently performing the contract today.


204. PHP Healthcare Corp., Nos. MSBCA 2130, 2173, at 1 (Md. State Bd. Cont. Appeals Sept. 24, 2004). In 1996, PHP Healthcare Corp. had a contract with the Department of Public Safety and Correctional Services to provide prison healthcare in the Baltimore region. Id. The then-named Court of Special Appeals ordered the state to pay PHP over $3 million of withheld compensation. Id. at 2. Then, Maryland was forced to pay PHP an additional $1.5 million in interest, accumulating from 1998 to 2004, based on the withheld amount. Id. at 8.

205. Thomas W. Waldron, Audit Contends Md. Was Overbilled for Inmate Care, BALTIMORE SUN, Feb. 1, 1992, at 1B.

206. Id. Maryland’s Department of Fiscal Services claimed that Correctional Medical Services “overcharged the state at least $1 million, and perhaps as much as $5 million over the last three years.” Id. CMS’s contract with Maryland was worth approximately $74 million. Id.

207. Id.


209. Id.

210. Meredith Cohn, City Jail Faulted Over Health: Rights Advocates Return to Court Over ‘Inhumane’ Conditions, BALTIMORE SUN, June 3, 2015, at A.1.


3. Maryland’s Prison Healthcare Contract with Corizon

Corizon was formed in 2011 following the merger of two of the largest prison healthcare providers in the country. By 2019, Corizon provided healthcare services to approximately 149 prisons around the United States. However, Corizon quickly faced scrutiny around the country for its management of prison healthcare. For example, a 2015 investigation by the City of New York Department of Investigation revealed that Corizon, which was contracted to provide medical services on Rikers Island, failed to conduct background checks for mental health employees and employed personnel that smuggled contraband and weapons into the facility. Furthermore, Corizon staff “provided inadequate care—sometimes seriously so—and have engaged in other illegal activity.” As a result of this investigation, New York ended its relationship with Corizon.

In 2018, Maryland awarded its prison healthcare contract to Corizon following a legal dispute from the prior contractor, Wexford Health Services, Inc. Wexford, which held the contract since 2012, disputed multiple aspects of the contract bidding process, including the fact that Corizon underbid Wexford by nearly $50 million. The Maryland State Board of Contract Appeals found no issue with Corizon being awarded the contract despite the Procurement Officer not being able to review “the type of information she would have liked to have” from Corizon. The Procurement Officer relied on Corizon being the largest correctional healthcare provider in the country.

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215. See N.Y. CITY DEP’T OF INVESTIGATION, INVESTIGATION FINDS SIGNIFICANT BREAKDOWNS BY CORIZON HEALTH INC., THE CITY-CONTRACTED HEALTH CARE PROVIDER IN THE CITY’S JAILS, AND A LACK OF OVERSIGHT BY THE CITY CORRECTION AND HEALTH DEPARTMENTS (2015) [hereinafter NYC INVESTIGATION]; see also MICHAEL PENNE, PRIVATE EQUITY STAKEHOLDER PROJECT, PRIVATE EQUITY FIRMS REBRAND PRISON HEALTHCARE COMPANIES, BUT CARE ISSUES CONTINUE 7 (2022) (“By late 2021, YesCare/Corizon had faced more than 1,000 lawsuits across the country alleging substandard care in jails and prisons and paid out millions of dollars to settle wrongful death lawsuits.”).
216. NYC INVESTIGATION, supra note 215, at 1.
217. Id. at 27.
220. Id. at 9, 18.
221. Id. at 29.
and reference checks when making her decision. After Corizon was awarded the contract, Maryland auditors found issues with how the contract was being managed by Corizon and the Department of Public Safety and Correctional Services (“DPSCS”). Specifically, auditors determined that, during the COVID-19 pandemic, Corizon overcharged or failed to justify $944,686.42 of the over $15.7 million paid to the company by Maryland for COVID costs. Notably, this was not the first time that DPSCS failed to effectively monitor the state’s prison healthcare contract.

Maryland’s original contract with Corizon in 2018 was worth approximately $680 million over five years. However, Corizon—now rebranded as Tehum Care Services—has filed for bankruptcy, with a reported $176 million in unsecured debt. Meanwhile, dozens of Maryland prisoners who filed suits against Corizon for inadequate healthcare are having their lawsuits stayed due to Corizon’s bankruptcy proceedings.

II. ANALYSIS

Maryland’s wanting record of inadequate prison healthcare evinces the acute need for fundamental, non-reformist reforms at many levels of the carceral punishment apparatus. First, this Comment argues that the current subjective knowledge test within the deliberate indifference doctrine violates the original intent of the framers of the Ku Klux Klan Act and that an objective test should be implemented instead. However, an objective test in § 1983 analyses should not be construed as an end in and of itself, but as

222. Id. at 29–30.
224. Id. at 14.
229. Campbell & Einbinder, Corizon, supra note 227.
230. See supra Sections I.B–C.
231. See infra Section II.A.
one of many steps toward dismantling the structural impediments to protecting the constitutional rights of the incarcerated. Second, this Comment advocates for Maryland to eliminate the practice of privatizing its prison healthcare and for the state to take direct responsibility for the health of its incarcerated population. Yet, the evidence demonstrates that a publicly-managed system will not sufficiently alleviate all of the harm caused by prison healthcare. The adoption of an abolitionist framework demonstrates how society should seek not the mere improvement of prison healthcare, but, rather, its obsolescence. Thus, this Comment concludes by arguing that structural reforms with the goal of eliminating the demand for prison healthcare as an institution should be Maryland’s primary objective. Alone, each of these reforms, though necessary, will fail to sufficiently dismantle the de facto system of double punishment caused by privatized prison healthcare.


The scope and interpretation of 42 U.S.C. § 1983 has evolved since its enactment as part of the Ku Klux Klan Act of 1871. Despite these changes, § 1983 is still being used to perform its original purpose: to vindicate the constitutional rights of Black Americans. During Reconstruction, the threat to Black people in postbellum America stemmed primarily from those operating outside of and against the state via white supremacist terrorist organizations like the Klan. Today, prison healthcare providers violate the constitutional rights of a disproportionately Black incarcerated population. Congress enacted the KKK Act, and § 1983 therewithin, in light of the objective harm being perpetuated throughout the South. However, the Supreme Court abandoned the original intent of § 1983 through its development of the subjective knowledge test within the deliberate indifference doctrine. The Court’s subjective knowledge standard has transformed the firm ground of constitutional vindication provided by § 1983 into the modern day constitutional quicksand on which the nation’s prisoners

232. See infra Section II.A.
233. See infra Section II.B.
234. See infra Section II.B
235. See infra Section II.B
236. See infra Section II.C.
237. See infra Section II.C.
238. See supra Section I.A.1.
239. See supra Section I.A.1.
240. See supra Section I.A.1.
241. See supra Section I.A.2; see also supra note 25 and accompanying text.
242. See infra Section II.A.1.
243. See infra Section II.A.2.
must stand. Thus, the original intent of the statute can only be realized by applying an objective test to § 1983 analysis.

1. The KKK Act as a Means to End Objective Harm

In the late 1860s and early 1870s, the Ku Klux Klan perpetrated a “cascade of violence” against free Black people and the governments attempting to protect them. For example, in 1968, an Alabama legislative commission detailed the unfettered terrorist attacks committed by the KKK across the state. The commission’s investigation revealed that the Klan had burned Black schoolhouses, threatened teachers, forced innocent people from their homes under threat of violence, and murdered “[n]ot a few” people through shootings, stabbings, and lynchings. The Klan even targeted members of the General Assembly by threatening assassination, shooting at legislators, and even abducting one member from his home in the middle of the night and whipping him sixty times. Due to this marked inability of the state to protect its people or enforce the law, the committee recommended that several counties be placed under martial law.

In light of the violent reality that recently freed Black Americans faced in Alabama and other southern states, the framers of § 1983 understood that a legal pathway in the federal courts was necessary to help guarantee the promises of the Fourteenth Amendment to all Americans. Congressman Robert Elliot, a Black representative from South Carolina, summarized this violent reality: “In one section of the Union crime is stronger than law. Murder, unabashed, stalks abroad in many of the southern States.” In response to the overwhelming evidence of atrocities being committed against Black communities across the South, Congress did not focus its construction of the KKK Act on the subjective intent or recklessness of the individual Klansman but, rather, focused it on the objective harm caused by the terrorist organization’s actions. Essentially, just as the KKK’s intent was immaterial while committing shootings, stabbings, and lynchings during

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244. See infra Section II.A.2.
245. See infra Section II.A.3.
246. Foner, supra note 58, at 116.
248. Id. at 5.
249. Id. at 4.
250. Id. at 6.
251. See supra Section I.A.1.
253. E.g., id. at 391 (citing evidence of KKK threats forcing public officials to resign).
Reconstruction, so too is the intent of a negligent prison healthcare provider immaterial to a prisoner deprived of his eyesight, or even his life.254

2. The Harmful Effects of Deliberate Indifference

In Estelle v. Gamble,255 the Supreme Court created the constitutional right to healthcare for prisoners while simultaneously distorting the original intent of § 1983 by creating a subjective knowledge test for deliberate indifference to a serious medical need.256 Justice Stevens’s dissent in Estelle criticized the majority’s adoption of the subjective knowledge test and instead argued for a focus on the objective harm caused by the punishment, not the subjective motivations of the individual instituting it.257 However, in Farmer v. Brennan,258 the Court reaffirmed its commitment to the subjective knowledge test by analogizing deliberate indifference to criminal recklessness.259

Echoing Justice Stevens’s call for an objective standard for deliberate indifference, Justice Blackmun argued in his Farmer concurrence that “inhumane prison conditions violate the Eighth Amendment even if no prison official has an improper, subjective state of mind.”260 Furthermore, Justice Blackmun averred that an unintended harm is no less a cruel or unusual punishment.261 He also argued that there was no evidence to suggest that the framers of the Eighth Amendment only intended to prohibit intentionally inflicted cruel and unusual punishment.262 For Justice Blackmun, punishment “does not necessarily imply a culpable state of mind on the part of an identifiable punisher.”263 He believed that the majority, by narrowly interpreting what constituted punishment, turned a blind eye to the realities of incarceration.264

The subjective standard to deliberate indifference is problematic due to its disregard of the objective harm experienced by the prisoner and even more so for its creation of such a high bar for the prisoner to meet; by requiring prisoners to prove the subjective knowledge and motivation of prison healthcare providers, the providers are insulated from liability for inadequate

254. See supra note 248 and accompanying text.
256. See supra Section I.A.1.
257. See supra notes 85–86 and accompanying text.
259. Id. at 842 (“[I]t is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm.”).
260. Id. at 851 (Blackmun, J., concurring).
261. Id. at 856.
262. Id.
263. Id. at 854.
264. Id.
treatment. Additionally, courts have used subjective knowledge standards to shield public officials from the repercussions of harm to prisoners long before *Estelle* and *Farmer* were decided.

For example, in 1896, a mob of twenty-five men in Charles County, Maryland compelled a jail janitor to open the cell of a man named Joseph Cocking and took Cocking from the jailhouse in the middle of the night. Then, the mob, emboldened by a crowd of approximately two-hundred spectators, hanged Cocking from a bridge about two-hundred yards from the jail. Available sources indicate that, because the evidence against Cocking was "purely circumstantial," the mob acted before he could be acquitted at his trial. At the civil trial against the sheriff who was responsible for Cocking’s safety and present when the mob abducted Cocking, the then-named Court of Appeals of Maryland held that the sheriff was not liable for the prisoner’s death. The court reasoned that as the sheriff’s “passivity” lacked “malicious intent,” he was not liable despite the fact that he stood idly by while the mob hanged Cocking. Though this case was not brought under § 1983, it demonstrates the high bar created by subjective knowledge tests for prisoners with limited resources, especially when the harm is perpetrated not in front of hundreds of witnesses but hidden behind prison walls.

3. The Need for an Objective Standard for Deliberate Indifference

The objective reality of incarceration is that the state confines prisoners in a dangerous environment wherein they lack the ability to provide for their own healthcare and bodily protection. Thus, the state has an “affirmative obligation” to protect its prisoners from harm and to provide for their basic needs. Professor Sharon Dolovich, founding director of UCLA’s Prison

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265. See Clark v. Md. Dep’t Pub. Safety & Corr. Servs., 316 F. App’x 279, 283 (4th Cir. 2009) (holding that the Correctional Medical Services prison nurse leaving an injured prisoner “sitting in his own waste, though offensive, [did] not amount to deliberate indifference to a serious medical need”); Loya v. Wexford Health Sources, Inc., No. GJH-19-1646, 2020 U.S. Dist. LEXIS 40767, at *3, *8 (D. Md. Mar. 9, 2020) (dismissing the prisoner’s § 1983 claim because he could not prove that Wexford healthcare professionals had actual knowledge that his abdominal pain, which became a burst appendix, was anything more “severe than [] constipation”).

266. See State v. Wade, 87 Md. 529, 40 A. 104 (1898) (discussing the lynching of a legally innocent prisoner).


268. *Id.*

269. *Id.*

270. Wade, 87 Md. at 544, 40 A. at 107.

271. *Id.* at 542, 40 A. at 106. The court also held that even had the plaintiff claimed that the sheriff had acted maliciously, he would not be held liable. *Id.* at 544, 40 A. at 107.

272. *See supra* Section I.B.1.


274. *Id.*
Law and Policy Program, frames the relationship between the state and its obligation to care for prisoners as an exchange of a benefit for a burden: If the state wants “the benefits of incarceration,” then it must “bear the burden” of providing for the needs of those whom it incarcerates. The state bears this burden even if it fails to provide for the needs of those living in free society. However, the relationship between the prisoner, the state, and the state’s obligation to care for the health of the prisoner is further complicated by “[t]he prisoner’s movement through the geographical space of the prison.” Specifically, prisoners seeking healthcare are subject to the prison’s custodial policies, routines, and regulations, which may delay or even prevent prisoners from receiving care.

In Maryland, a prisoner’s ability to traverse the geographical space of the prison in order to receive medical care is further obstructed by a financial barrier to entry. Prisoners may be subject to paying fees of up to four dollars for each visit “to a medical unit, physician, dentist, or optometrist for health care services.” While this may seem like a nominal fee to most, it can serve as an impediment to treatment for prisoners who are typically impoverished upon arriving to prison—their poverty only being exacerbated during imprisonment. In 2020, prisoners in Maryland who were able to obtain work for the Division of Correction earned wages that varied “from $0.90 to $2.75 per day.” Prisoners working for Maryland Correctional Enterprises (MCE) earned “between 17 cents and $1.16 an hour.” Meanwhile, MCE earned $52 million in 2019 from the sale of products made by prisoners such as furniture, flags, and license plates.

The state has structured its “burden” to care for its prisoners in such a way that prisoners must navigate the physical space of the prison under the

275. Id. at 892.
276. Id.
278. Id.
280. Id.
281. See Bernadette Rabuy & Daniel Kopf, Prisons of Poverty: Uncovering the Pre-incarceration Incomes of the Imprisoned, PRISON POL’Y INITIATIVE (July 9, 2015) https://www.prisonpolicy.org/reports/income.html (finding that “incarcerated people had a median annual income of $19,185 prior to their incarceration, which is 41% less than non-incarcerated people of similar ages”).
283. Id.
284. Id.
objectifying punitive gaze of the state simply to seek medical treatment. If the prisoner can afford to pay the fees, he must pay for the opportunity to be seen by a medical professional who further objectifies the prisoner through the imposition of the medical gaze. If the prisoner is denied access to constitutionally required healthcare, or if the prisoner receives constitutionally inadequate healthcare, he must then navigate an expensive legal system in order to vindicate his rights. However, under the Supreme Court’s holdings in *Estelle* and *Farmer*, the prisoner must then prove either that the correctional officer who denied the prisoner access to healthcare knew that the prisoner had a serious need of medical attention, or that the healthcare professional who provided inadequate care knew that they provided reckless care. The prisoner’s claim will still fail even if he can prove that the officer was negligent or that the medical professional committed malpractice. In general, the subjective knowledge test creates a perverse incentive for prison correctional and healthcare officials to maintain ignorance toward a prisoner’s health risks. In Maryland, prisoners must overcome both the subjective knowledge standard and the acute reality that private healthcare companies can hide behind bankruptcy proceedings to escape liability.

The current deliberate indifference doctrine rewards prison officials for being ignorant of their prison’s reality. Additionally, the subjective knowledge test creates a high bar for prisoners to meet, inflicting pain and suffering which, according to the Supreme Court, serves no penological purpose. An objective standard—one that compares the actions of the defendant prison healthcare professional to those of a reasonable healthcare professional—is necessary to both acknowledging the harmful realities faced by prisoners and holding the state accountable for its burden to care for those prisoners.

However, the framers of § 1983 also understood that the statute alone was an insufficient remedy in the face of the violent reign of terror raging

285. See supra Section I.B.1.
286. See supra Section I.B.1.
287. See supra Section I.A.2.
288. See supra Section I.A.2.
289. See supra Section I.A.2.
290. Dolovich, supra note 273, at 892.
291. See supra Section I.C.3.
293. See supra Section I.B.2.
294. Dolovich, supra note 273, at 892.
across the reborn Union. Thus, Congress empowered the president with the authority to effectively address the root cause of the threat endangering the lives and liberty of Black Americans. Ultimately, the legislative history of the KKK Act demonstrates that, although 42 U.S.C. § 1983 was a necessary step toward vindicating the rights of historically marginalized communities, it was never intended to be a wholly sufficient solution to prevent the objective harm caused by constitutional violations.

B. The Effects of Privatized Prison Healthcare

Prison healthcare, both publicly- and privately-managed, is an extension of the state’s power to punish. While incarcerated, prisoners live under the constant and objectifying punitive gaze of the state and the intermittent, but equally objectifying, medical gaze of the prison healthcare provider. When a state contracts with private corporations to fulfill the state’s constitutional obligation to provide for the basic needs of its prisoners, the state is, in effect, leasing its hegemonic power to punish to that corporation. Empirically, privatized prison healthcare has proven less effective and more deadly than publicly-managed healthcare. In Maryland, the state’s decades-long experiment of contracting out its prison healthcare consistently illustrates the state’s incompetence in overseeing the corporations providing healthcare services for the state’s prisoners. Thus, Maryland must end its practice of contracting with private corporations and publicly manage its prison healthcare system instead.

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295. CONG. GLOBE, 42nd Cong., 1st Sess. 821–22 (1871) (“[G]iving to these parties injured... nothing but an expensive legal right to sue in the courts of the United States, is an inadequate result of a great debate.”).
296. See supra Section I.A.1.
297. CONG. GLOBE, 42nd Cong., 1st Sess. 392 (1871). Congressman Horace B. Smith from New York highlighted the significance of the Congress’ responsibility:
Sir, what are the fruits of this war? For all the money expended, for all the suffering endured, what have we got to show? The only fruits of this terrific struggle, sir, are embodied in the three late amendments to the Constitution. Sir, if it was the duty of the Union soldier on the battle-field to win those fruits, is it not doubly our duty religiously to save them?
Id.
298. See supra Section I.B.1.
299. See supra Section I.A.2.
300. See supra Section II.A.3.
301. See infra Section I.B.1.
302. See supra Section I.B.2.
303. See supra Section I.B.2.
1. Privatized Prison Healthcare in General

In general, states like Maryland sought out privatized prison healthcare in an attempt to provide cost-effective constitutionally adequate healthcare. However, the War on Drugs and the resultant mass incarceration substantially altered the demographics of jails and prisons across the country, with prison populations becoming older and sicker. These overcrowded, aging, and sick populations clash with private prison healthcare corporations’ “cost containment” methods used to further their primary motivation of generating profit. As a result of this tension, privatized prison healthcare generally leads to fatal results for the prisoners—who lack both autonomy and alternatives and are thus forced to rely on the state.

A 2020 study by Reuters found that between 2016 and 2018, carceral facilities contracting with one of the five leading private healthcare corporations had higher prisoner death rates than facilities with publicly-managed healthcare. At the time of this study, Corizon was one of those five corrections healthcare providers. Reuters discovered that, depending upon the company, the death rates in jails with healthcare managed by private corporations were eighteen to fifty-eight percent higher than those with publicly-managed medical services. The study determined that between 2010 and 2015, death rates in jails using these healthcare contractors were comparable with those of jails with publicly-managed care. However, the death rates began to diverge from 2016 to 2018, with higher death rates seen in privately-managed healthcare systems.

In 2016, one of the biggest jail systems in the country, Alameda County, California, terminated its contract with Corizon, and seven months later, Corizon lost its contract with the Indiana state prison system. Thus, by the time Maryland awarded its state prison healthcare contract to Corizon in

304. See supra Section I.C.
305. See supra Section I.C.3.
308. Id.
309. Id.
310. Id.
311. Id.
312. Id. ("Jails using the major companies had 691 fatalities among an average total population of 138,000 inmates in that three-year span. By contrast, jails using publicly managed care had 587 fatalities while caring for more than 152,000 inmates.").
313. Id.
2018, the company had recorded significant death rates for prisoners and had been so problematic that states around the country were terminating their respective relationships with Corizon.\textsuperscript{314}

2. Ending Privatized Prison Healthcare in Maryland

Maryland has a long history of failure regarding its prison healthcare system.\textsuperscript{315} In the mid-twentieth century, Maryland’s poor prison healthcare management led it to pursue private healthcare contracts in an attempt to shield the state from the “liability time bomb” that it had created through poor management.\textsuperscript{316} Decades of privatized prison healthcare and a revolving door of corporations have not solved Maryland’s unconstitutional care for its prison population, and yet, the state continues to insulate itself from liability by contracting out its healthcare.\textsuperscript{317} These private healthcare providers are further protected by the courts’ application of the subjective knowledge test for deliberate indifference.\textsuperscript{318}

Maryland has had ample experience, investigations, litigation, and press coverage to realize that privatized prison healthcare is not a panacea to the state’s failings in its constitutional obligation to care for its prisoners.\textsuperscript{319} However, rather than assume responsibility for its systemic failings and the harmful impacts on its prisoners, the Maryland government chooses to fight and delay improvements to its prison healthcare system.\textsuperscript{320} In fact, Maryland has demonstrated its staunch opposition to prison healthcare reform, having recently hired outside counsel, including a former member of the YesCare board of advisors, to defend the state from liability for unconstitutional healthcare.\textsuperscript{321}

The long and winding history of Maryland’s healthcare system supports several significant conclusions. First, prisoners in Maryland cannot rely on

\textsuperscript{314} Id.; see also supra notes 216–218 and accompanying text.

\textsuperscript{315} See supra Section I.C.1.

\textsuperscript{316} See supra note 196 and accompanying text.

\textsuperscript{317} See supra Section I.C.2.

\textsuperscript{318} See supra Section II.A.2.

\textsuperscript{319} See supra Sections I.C.1–2.

\textsuperscript{320} See Ben Conarck, State Officials Tell Judge They’re Still Years Away from Fixing Health Care in Baltimore Jails, BALT. BANNER (Aug. 2, 2023, 5:30 AM), https://www.thebaltimorebanner.com/community/criminal-justice/healthcare-city-jails-monitor-2BWGG2GX5AU7B6U2U6ET3BJ7A/ (“State attorneys told a federal judge this week that Maryland’s corrections department won’t meet the court’s December 2024 deadline to fix health care and mental health in Baltimore jails.”).

corporations to provide adequate healthcare. Second, prisoners cannot rely on the state to properly oversee the corporations with which the state chooses to contract. Third, prisoners cannot rely on the courts to consistently affirm their right to healthcare either through individual litigation or class action lawsuits. Thus, in order to address the state’s constitutional failings, Maryland should cease its practice of contracting out its prison healthcare and instead adopt a publicly-managed system, which may in turn reduce the risk of harm to its prisoners.

C. Reducing Spatial-Temporal Control and the Demand for Prison Healthcare

The solutions proposed in Sections II.A and II.B are tangible stopgap measures, but they are insufficient to prevent the double punishment perpetuated by prison healthcare systems. Prison healthcare in and of itself does not advance any of the penological purposes recognized by the Supreme Court; rather, it is designed to preserve the prisoner’s body so that the state may continue to inflict punishment on it. In this sense, prison healthcare serves as an extension of the state’s power to punish those it chooses to criminalize, which in Maryland are primarily the state’s Black residents. In relation to the spatial-temporal control implemented through incarceration, prison healthcare exists as a cruel and unusual irony: At best, prison healthcare prolongs the extraction of time from the prisoner; at worst, it shortens that extraction. Given this reality, Maryland’s goal when addressing the issues surrounding prison healthcare should not end at adequacy—toward which applying an objective standard to § 1983 and municipalizing prison healthcare would aspire—but rather should strive for obsolescence. To this end, non-reformist reforms must be adopted to shrink the carceral state and reduce the demand on prison healthcare. “We need to get ourselves out of the habit of looking for a one-to-one replacement for any carceral institution, whether it be a prison or a prison alternative.”

322. See supra Sections I.C.2–3.
323. See supra Sections I.C.2–3.
324. See supra Subsection I.C.2; see also supra note 320.
325. See supra Section II.B.1.
326. See supra Section I.B.3.
327. See supra note 241.
328. See supra Section I.B.3.
329. See supra Section I.B.3.
330. See supra note 165 and accompanying text.
331. Maya Schenwar & Victoria Law, Prison By Any Other Name: The Harmful Consequences of Popular Reforms 213 (2020).
1. Decarceration Initiatives

Given the trajectory of demand for prison healthcare, it stands that mitigating the root cause and combating mass incarceration would alleviate the demand for prison healthcare in the first place. 332 Although the state has struggled to provide adequate healthcare for its prisoners, as of 2021, Maryland has successfully reduced its prison population by nearly thirty-four percent since its peak in 2007. 333 Therefore, while Maryland should end its current practice of contracting out its prison healthcare, the state should continue its efforts to decarcerate its current prison population by expanding programs such as the Juvenile Restoration Act (JRA). 334 The JRA allows juvenile offenders who have served at least twenty years of their sentence to file a motion for a reduction of their sentence. 335 The Act recognizes that “adolescents are less culpable for their criminal acts,” and that as a result, the traditional penological purposes “apply with less force to juvenile offenders.” 336 In 2022, the Maryland Office of the Public Defender (“OPD”) determined that there were more than two-hundred prisoners eligible for consideration under the JRA. 337 Furthermore, the OPD argues that the Maryland legislature should expand the JRA and oppose reliance on incarceration altogether:

The General Assembly should expand on the success of the JRA by expanding eligibility for sentence reduction consideration to people who were emerging adults (18 to 25 year olds) at the time of the crime and older prisoners who have similarly served long prison terms. Funds should also be invested in implementing these recommendations and encouraging reliance on community based services where incarceration is no longer necessary for public safety. 338

The OPD’s support for expanding the JRA and for implementing community-based solutions rather than continuing to cage is a call for non-reformist reforms that seek to decrease the total prison population, and thus, reduce the demand for prison healthcare. 339

332. See supra Section I.A.1.
333. NAZGOL GHANDNOOSH, SENT’G PROJECT, ENDING 50 YEARS OF MASS INCARCERATION: URGENT REFORM NEEDED TO PROTECT FUTURE GENERATIONS 6 (2023) [hereinafter SENTENCING PROJECT, URGENT REFORM].
335. Id.
336. Id. at 4.
337. Id. at 2.
338. Id.
339. See id.
2. Sentencing Reform

According to a recent report by The Sentencing Project, one in seven incarcerated people are serving life sentences.\textsuperscript{340} In 2020, the population serving life sentences nationally exceeded the total prison population of the country in 1970.\textsuperscript{341} While reforms targeting drug offenses have been successful in reducing prison populations in the past, such reforms for violent crimes remain unexplored.\textsuperscript{342} This is significant because fifty-six percent of the total incarcerated population is sentenced for a violent crime.\textsuperscript{343} In 2016, Maryland passed the Justice Reinvestment Act, which was designed to prioritize the imprisonment of violent offenders.\textsuperscript{344} The state recognized that “prison is often not the best or most cost-effective method for keeping the public safe and that for certain offenders, longer prison sentences can actually increase recidivism.”\textsuperscript{345}

However, the Justice Reinvestment Act also enhanced penalties for “serious and violent crimes” by increasing maximum penalties for child abuse and second-degree murder, amplifying gang statutes in a pastiche of the Racketeer Influenced and Corrupt Organizations Act, and increasing the term of confinement that offenders with multiple drug convictions must serve before becoming parole-eligible.\textsuperscript{346} Thus, Maryland’s give and take in the Justice Reinvestment Act serves as a problematic compromise that reflects a broader unwillingness to eliminate extreme sentences contrary to the empirical evidence that incarcerating older populations provides limited penological advantages while detracting from more efficacious public safety strategies.\textsuperscript{347}

3. Policing and Rejecting Reformist-Reforms

Policing in Baltimore, specifically, has a significant impact on the Maryland prison system as a whole because, “while 9% of Maryland residents call Baltimore home, 40% of Maryland residents in state prison are

\textsuperscript{340} ASHLEY NELLIS, SENT’G PROJECT, MASS INCARCERATION TRENDS 8 (2023).
\textsuperscript{341} SENT’G PROJECT, URGENT REFORM, supra note 333, at 4.
\textsuperscript{342} Id.
\textsuperscript{343} Id.
\textsuperscript{344} S.B. 1005, 2016 Leg., 436th Sess. (Md. 2016).
\textsuperscript{345} PEW CHARITABLE TR., MARYLAND’S 2016 CRIMINAL JUSTICE REFORM 6 (2017).
\textsuperscript{346} Id. at 10.
\textsuperscript{347} SENT’G PROJECT, URGENT REFORM, supra note 333, at 4.
from the city.”³⁴⁸ Despite its history of racist and unconstitutional policing,³⁴⁹ the Baltimore City Police Department (BPD) has an annual budget that continues to grow.³⁵⁰ In effect, BPD’s unconstitutional police practices disproportionately expose Baltimore’s Black communities to the unconstitutional prison healthcare provided by the state.³⁵¹ Moreover, the BPD works in concert with the criminal legal system, the carceral system, and the prison healthcare system to objectify and dehumanize those that the state, at the discretion of law enforcement officers, chooses to criminalize.³⁵² Thus, any significant step in reducing the demand on and for prison healthcare begins with reducing the power and material resources of the police.³⁵³

To implement non-reformist reforms, like those advocated for by Angela Davis and Ruth Wilson Gilmore, we must reject spending programs and legislative policies that reinforce the carceral state.³⁵⁴ For example, the construction of a $330 million police training facility has been proposed at the HBCU Coppin State University campus in West Baltimore.³⁵⁵ This proposed “Cop City” is several times more expensive than the highly-controversial $90 million Atlanta police training facility.³⁵⁶ The abolitionist framework requires opposition to any further maldistribution that diverts resources away from community-oriented solutions designed to replace the carceral system.³⁵⁷


³⁵⁰ See supra Section I.B.1.

³⁵¹ See supra Section I.B.1.

³⁵² MARIAME KABA & ANDREA J. RITCHIE, NO MORE POLICE.: A CASE FOR ABOLITION 108 (2022) (“We want something new, which requires us to abolish institutions and practices of policing, not simply reshape them.”).

³⁵³ See supra Section I.B.3.

³⁵⁴ See supra notes 167–168 and accompanying text.
Baltimore, we can reduce the number of prisoners subjected to the dehumanizing punitive and medical gazes of the state and its agents.358

CONCLUSION

This year, Maryland approaches a crossroads for its prison healthcare.359 The state can persist in maintaining its decades-old revolving door of private corporations whose financial goals directly conflict with both the state’s constitutional obligations and the well-being of the state’s prisoners.360 Or, Maryland can resume control of its prison healthcare system and endeavor to minimize the harm inherent to such an institution.361 In the meantime, prisoners, like Roger Ervin, continue to navigate the dehumanizing space between the punitive gaze and the medical gaze just to assert their right to healthcare.362

358. See supra Section I.B.1.
359. See supra note 12 and accompanying text.
360. See supra Section II.B.
361. See supra Section II.B.
362. See supra notes 1–7 and accompanying text and Section I.B.1.