A Qualitative Analysis of Section 1983 Filings by Incarcerated Plaintiffs

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A Qualitative Analysis of Section 1983 Filings by Incarcerated Plaintiffs

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Public Policy and Public Administration at Virginia Commonwealth University.

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Abstract

The onset of the COVID-19 pandemic was a “watershed moment” in human history, transcending its role as a mere health crisis to reveal deeper fissures within societies. The present retrospective longitudinal study examined COVID-19 as an “era” of complexity utilizing it as an intermediate construct that delineates “pre-COVID” and “post-COVID.” In order to understand the impact of the COVID-19 era, the design of the study and hypotheses stem from an assumption of the interconnectedness of issues related to health, social justice, racial justice, politics, and information dissemination.

This study utilized both manifest and latent content analysis to explore the most common constitutional violations alleged by incarcerated persons who filed Section 1983 lawsuits between 2018-2023 and whether the nature of the concerns differ pre- and post-COVID-19 onset. This study also examined how inmates frame the alleged violations in their Section 1983 filings and whether this differed pre- and post-COVID-19 onset. Schneider and Ingram’s (1993) Social Construction of Target Populations theory is utilized to help justify the sample and research questions and Goffman’s Framing Theory was utilized as the analytical framework.

I found that the nature of civil rights violations incarcerated persons experience are complex and multifaceted, and mostly related to inadequate access to timely and appropriate medical care which violates the Eighth Amendment Cruel and Unusual Punishment Clause. These violations are often carried out through deliberate indifference to medical needs or disagreement about what is considered a serious medical condition. Further, most Plaintiffs frame their complaints as an individual harm, but we do see some filings that address the institutional and structural issues within the administration of healthcare to inmates. Slight variations in the nature of, and framing of, the violations are discussed.

Ultimately, this study concludes that constitutional rights violations occurred with frequency before and after the onset of the COVID-19 pandemic and the frames used to communicate those harms slightly varied, with more claims framed as institutional and structural rather than purely individual, after the onset of the COVID-19 pandemic. As a nation we need to focus more attention on the state of constitutional healthcare in America with the goal of creating policies that promote the just and equitable treatment of incarcerated people. This paper contributes to many areas of study including corrections, healthcare, public policy, sociology and communications.

Keywords: Corrections, Healthcare, Policy, Civil Rights, Constitutional Rights, Section 1983, Legal Filings, Framing Theory, Social Construction of Target Populations, COVID-19.
DEDICATION

I would like to dedicate this dissertation to all of those who have encouraged and supported me throughout this PhD process, whether in work, school, or life. The past three years were full of learning experiences and major life changes and at points, completing a PhD seemed like a distant dream. I want to specifically thank my dissertation chair, Dr. Hayley Cleary, for providing the structure and guidance necessary to complete a PhD program, but also offering humanity and patience throughout the dissertation process. I'd like to thank the faculty in the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University for sharing their knowledge and teaching me the skills needed to become a competent social scientist and academic. My committee members, Dr. Sarah Raskin, Dr. Lindsey Evans, and Dr. Scott Cook who spent time and energy helping me mold ideas into reality, so that I could produce a valuable piece of research. To my long-time mentor, Virginia Beard, for inspiring me as a student, and as a colleague, and believing in me as an academic over the last 12 years. And, to my dear colleagues at Longwood University for pushing me and believing in me, and regularly answering my research related questions. Finally, to my friends and family, who have helped me so dearly, in professional and personal ways, with a gravity that they don't even know.

I will always treasure the love and support I felt, and feel, from you. Thank you.
POSITIONALITY STATEMENT

In line with the theoretical framework of this study, the positionality of the researcher plays a crucial role in shaping the lens through which they approach and conduct qualitative research (Foote & Bartell, 201). The positionality of a researcher is not a static factor but a dynamic aspect that requires continuous reflection and adaptation throughout the research journey (Holmes, 2020). By being aware of my own weakness, biases, and privileges, I strive for an ethical, culturally sensitive, and equitable research process.

In this case, my positionality as a white woman brings forth various dynamics that can influence the research process and research outcomes. I am aware that this privilege may affect my ability to empathize fully with the lived experiences of less privileged and incarcerated individuals. Thus, I made every attempt to be objective and impartial in my analysis of the documents that have been filed on their behalf. Additionally, I am aware of potential cultural gaps between myself and those who are filing Section 1983 complaints. Being mindful of the cultural context is essential for interpreting and understanding the experiences, perceptions, and frames of the incarcerated individuals (Holmes, 2020). This is why during coding and analysis I took moments for self-reflection to recognize and mitigate potential biases and engaged in a re-coding process to ensure reliability. This involved being aware of personal assumptions, values, and preconceptions that may influence the interpretation of data. Finally, I am cautious about inadvertently becoming a gatekeeper in the representation of the Section 1983 narratives. I believe it is crucial to present a nuanced and authentic portrayal of the Plaintiff’s experiences without reinforcing stereotypes or perpetuating biases.

Positionality of time and place is also important to the context of this research. I am conducting this research in 2024, in a post-pandemic world, with continuing and new social, health, and justice related issues. It is important for me, as the researcher, to reflect and appreciate the environment and context in which this analysis is being conducted, and how that may be similar or different to the environment and context present during the filing of the Section 1983 lawsuits with the Fourth Circuit Court. While the study is retrospective in nature, I aim to utilize my position of time and place to reflect on and learn from the recent past.
Introduction

Overview

A “watershed moment” divides history into distinct periods, before and after the event, symbolizing a profound shift in circumstances or attitudes. Beyond its devastating toll on global health, the COVID-19 pandemic exposed systemic inequities and injustices, catalyzing social and racial justice movements, contributed to pre-existing political instability, igniting protests against criminal justice systems, and fostering economic uncertainty. This study acknowledges the multifaceted nature of the COVID-19 pandemic and recognizes it as an “era” rather than one isolated “matter.” The pandemic exacerbated a nexus of challenges across health, social justice, politics, criminal justice, and economics in the United States.

From its inception, the COVID-19 pandemic posed unprecedented challenges to public health systems worldwide (Harris, 2021). The rapid spread of the virus and its staggering death toll strained healthcare infrastructures and correctional systems, exposing vulnerabilities and inadequacies in preparedness and response mechanisms (De Salvo et al., 2021). The interconnectedness of health became glaringly apparent as the virus transcended national borders, necessitating cooperation and solidarity in the quest for effective treatments, vaccines, and containment strategies between institutions and different levels of governance (Harris, 2021). Simultaneously, the pandemic served as a catalyst for the resurgence of social and racial justice movements, amplifying long standing grievances and demands for systemic change. Marginalized communities, disproportionately impacted by the virus, mobilized against intersecting forms of oppression, including systemic racism, economic inequality, and police brutality (Estrada et al., 2022). The Black Lives Matter movement, reignited by the killing of George Floyd, gained widespread momentum, shining a spotlight on the urgent need to dismantle
political and social structures of racial injustice and inequality, focusing heavily on policing, courts and corrections.

The pandemic also fueled political instability and polarization, testing the resilience of democratic institutions and governance structures. Governments grappled with navigating the delicate balance between public health imperatives, and economic interests, often leading to contentious debates and policy decisions (Harris, 2021). The erosion of trust in leadership, exacerbated by misinformation and disinformation campaigns, sewed discord and division, which fueled harmful rhetoric and social constructions. Further, amidst the backdrop of the pandemic, protests against systemic injustices within criminal justice systems erupted, demanding accountability and reform. Cases of police brutality and racial profiling galvanized public outrage, prompting calls for defunding police departments, reallocating resources to community-based services, and implementing measures to address systemic racism and discrimination within law enforcement agencies and carceral facilities (Braveman et al., 2022).

The pandemic highlighted the interconnectedness of public health and criminal justice, illustrating the disproportionate impact of punitive policies on marginalized communities, particularly during times of crisis. In addition to criminal justice and government related concerns, the pandemic has unleashed economic upheaval on a global scale, triggering recessions, job losses, and disruptions to livelihoods and industries (Harris, 2021). Lockdown measures and social distancing protocols led to widespread closures of businesses, exacerbating income inequality and economic insecurity (Harris, 2021). All of these factors are interconnected with the likelihood of incarceration and the experiences of incarcerated people in the United States.
While incarcerated people have many dynamic experiences in carceral facilities, sometimes they are burdened by constitutional and/or civil rights violations at the hands of facility staff. These rights violations may stem from understaffing, lack of training, or deliberate indifference to the individuals’ needs. When these violations happen, one method of recourse for aggrieved is to file a Section 1983 complaint. Section 1983 filings refer to the process of filing a Section 1983 lawsuit in federal court under the Civil Rights Act of 1871, to seek damages for the violation of an individual's civil rights by a government entity or official acting under the “color of state law” (Civil Rights Act of 1871, 42 U.S.C. § 1983). These lawsuits are an important tool for holding government officials accountable for their actions and protecting the civil rights of vulnerable individuals in the United States. There are many reasons one can file a Section 1983 complaint. For example, an incarcerated person may file a Section 1983 complaint if they have been subjected to excessive force by criminal justice actors or subjected to inhumane living conditions while incarcerated. Additionally, a known recurring allegation in these suits is the violation of the Plaintiff’s Eighth Amendment rights, including the failure to provide timely and appropriate access to healthcare services or being denied adequate medical care (Hanson, 1995). While all allegations of constitutional rights violations are concerning, this study reviewed Section 1983 filings in order to identify the most common types of healthcare-related constitutional violations alleged by prisoners, and the ways in which they are framed, in their lawsuits against correctional facilities and staff.

This study employed content analysis to explore the nature of the healthcare-related Section 1983 filings that arise from incarceration, while under the custody of a local or state correctional facility. Specifically, I sought to understand the types of constitutional violations alleged by incarcerated persons who filed Section 1983 lawsuits between 2018-2023 and whether
the nature of the allegations differ pre-COVID-19 onset (January 1, 2018 - March 1, 2020) and post COVID-19 onset (March 2, 2020 - December 31, 2023). Additionally, I aimed to better understand how inmates frame the alleged violations in their Section 1983 filings and whether framing differs pre- and post-COVID-19 onset. The longitudinal nature of this retrospective study allowed me to examine these potential differences over time. Schneider and Ingram’s (1993) Social Construction of Target Populations theory was utilized to help justify the sample and research questions, and Goffman’s (1974) Framing Theory was utilized as the analytical framework.

**Purpose**

In 1936, Harold Lasswell, who is considered by many to be a principal actor in defining ‘policy science’ as a discipline, asked, “Who gets what, when, and how?” Since then, public policy scholars have engaged in research and theorized about these important questions. As the theorists Schneider and Ingram would say, certain groups are harmed by policies while others are rewarded (deHaven-Smith, 1988; Schneider & Ingram, 1991; 1993; 1995; 2005; 2007a; 2007b; 2019). According to Schneider and Ingram, “social constructions are stereotypes about particular groups of people that have been created by politics, culture, socialization, history, the media, literature, religion, and the like” (1993, p. 335). In the United States, high rates of incarceration and a private healthcare system intertwine to disadvantage certain ‘target’ populations (deHaven-Smith, 1988). According to the Social Construction of Target Populations theory, people who have been accused of, arrested for, and convicted of crimes are often categorized as “deviants” within a diagram of construction and power (see Table 1). This means that they often bear the burdens of policies more than they benefit from them (Schneider & Ingram, 1991; 1993; 1995; 2005; 2007; 2019). There is an abundance of evidence that public policies have
historically burdened certain “target” groups in the United States (Schneider & Ingram, 1991; 1993; 1995; 2005; 2007a; 2007b; 2019). For example, there is a long history of civil rights violations against poor people, immigrants, women, people of color, and incarcerated persons in the United States (Alexander, 2010; Estelle v. Gamble, 1976). Although the Eighth Amendment prohibits cruel and unusual punishment, it was not until 1871 that incarcerated people were awarded constitutional protections under the law that offered some version of redress for harm (U.S. Const. amend. VIII).

Section 1983 of the Civil Rights Act of 1871, now codified as 42 U.S.C., aimed to protect the civil liberties of all citizens, including those who were incarcerated. It was enacted in response to rampant violations of civil rights in the aftermath of the American Civil War. While the 1871 Act was a step in the right direction, it did not specifically address healthcare in correctional settings, leaving inmates vulnerable to inadequate medical care and limited access to care (Civil Rights Act of 1871, 42 U.S.C. § 1983). Section 1983 "lay dormant for nearly 100 years” (Dawson, 2016, p. 532), until the Supreme Court's 1961 decision in *Monroe v. Pape* (Macfarlane, 2023; Nahmod, 1993). In *Monroe v. Pape* (1961) the Supreme Court effectively broadened the interpretation of Section 1983 to police officer conduct (Powell et al., 2017). The Supreme Court held that state police officers who violate the Constitution may nevertheless be acting under color of state law and can be sued under Section 1983 for damages (*Monroe v. Pape*, 1961). It was not until the court decided in *Cooper v. Pate* (1964) that prisoners could use Section 1983 to challenge violations of their constitutional rights, effectively allowing them to bring civil rights claims against state officials and prison authorities. Following the *Cooper v. Pate* (1964) decision, prisoners began filing more Section 1983 claims, seeking relief from
overcrowding, inadequate medical care, unsanitary living conditions, abusive treatment, and other violations of their constitutional rights (Dawson, 2016).

In the context of Section 1983 filings, it is essential to understand the distinction between constitutional rights and civil rights. Constitutional rights refer to the fundamental liberties and protections guaranteed to individuals by the United States Constitution. These rights are typically articulated in the Bill of Rights (the first ten amendments) and subsequent amendments to the Constitution. Constitutional rights include freedoms such as freedom of speech, freedom of religion, the right to due process, the right to equal protection under the law, and protection against unreasonable searches and seizures, among others (American Civil Liberties Union [ACLU], n.d.). Violations of these rights by government officials or entities can form the basis of a Section 1983 claim.

Civil rights, on the other hand, encompass a broader range of rights that are protected by law and pertain to equal treatment and nondiscrimination. While many civil rights are derived from constitutional provisions, civil rights laws also include statutes, regulations, and court decisions that prohibit discrimination on the basis of race, color, national origin, sex, disability, religion, and other protected characteristics. Civil rights laws aim to ensure equal access to opportunities and protections for all individuals within society. In the context of Section 1983, violations of civil rights occur when government actors, acting under the color of law, deprive individuals of their civil rights (American Civil Liberties Union [ACLU], n.d.). Section 1983 of the Civil Rights Act of 1871 provides individuals with a legal remedy for the violation of their constitutional and federally protected civil rights by state or local government officials. It allows individuals to bring lawsuits, seeking damages or injunctive relief, against government officials who, under the color of law, deprive them of their constitutional or civil rights. Therefore,
Section 1983 claims can encompass violations of both constitutional rights and civil rights, as long as the alleged misconduct meets the criteria of acting under the color of law (Legal Information Institute, n.d.).

The Court recognizing prisoners’ rights and providing a pathway to accountability through Section 1983 was a significant victory for civil rights advocates, who had been fighting for the restoration of civil rights protections that had been eroded in the late 1800s and early 1900s. This provision significantly empowered inmates to seek legal recourse and demand improved healthcare standards within correctional settings (Civil Rights Act of 1871, 42 U.S.C. § 1983). The Act also marked a shift in the political climate towards a more proactive approach to protecting civil rights. Section 1983 lawsuits have been used to challenge a variety of actions, including police misconduct, unlawful search and seizure, violations of free speech and assembly, and cruel and unusual punishment (Macfarlane, 2023). As this study is focused on healthcare-related constitutional violations against incarcerated persons, it is important to discuss the healthcare-related implications of Section 1983 of the Civil Rights Act of 1871.

Section 1983 and Healthcare Implications

There are significant healthcare-related implications of Section 1983 of the Civil Rights Act. First, the act prohibits discrimination in healthcare on the basis of race, color, national origin, disability, age, and gender. This means that healthcare providers cannot deny medical care or services based on a patient's race, ethnicity, or gender. Additionally, the Act allows individuals to sue government officials, including those who work in prisons and other correctional facilities, for violating their constitutional rights. The law is often invoked in cases where prisoners allege that their rights to adequate healthcare have been violated. Under the Civil Rights Act of 1871, incarcerated individuals have the right to receive medical care that meets certain constitutional
standards (later solidified in *Estelle v. Gamble*, 1976). This means that prison officials have an obligation to provide prisoners with necessary medical care and treatment, including mental health services, medication, and emergency care. Further, the Civil Rights Act of 1871 allows inmates to sue individual prison officials, such as healthcare providers or administrators, for damages if they believe their constitutional rights have been violated. The Civil Rights Act of 1871 had a significant impact on healthcare in prisons by providing inmates with a legal recourse to challenge inadequate or abusive medical care; however, there are still ongoing challenges and debates around the implementation and enforcement of these rights, particularly in light of the systemic issues that the COVID-19 pandemic illuminated within healthcare and correctional settings.

**Section 1983 Filing Process**

Section 1983 provides individuals with the right to file a civil lawsuit against government officials who violate their civil rights. The Federal Rules of Civil Procedure (FRCP) govern the procedures for Section 1983 litigation in federal courts, including rules related to pleadings, service of process, and other procedural matters. The FRCP were developed by the United States Supreme Court and were enacted by Congress to provide a uniform set of procedures for civil cases across the federal court system. The FRCP were first adopted in 1938 and have since undergone revisions to reflect changes in legal practice, technology, and judicial interpretations. Notable revisions occurred in 1948, 1963, 1966, and most recently in 2007 with further amendments in subsequent years. The rules cover various aspects of civil litigation, including pleadings, motions, discovery, trials, and appeals. The purpose of the FRCP is to promote fairness, efficiency, and uniformity in the federal civil litigation process. Relevant rules to
Section 1983 filings include Rule 4 (Service of Process), Rule 8 (Pleadings), and Rule 12 (Motion to Dismiss).

In order to file a claim for relief under Section 1983, a Plaintiff must prove: (1) the defendant(s) deprived the Plaintiff of a federal constitutional right, and (2) the defendant(s) was acting under the color of state law. To file a Section 1983 lawsuit, the Plaintiff must establish that the defendant acted under the “color of state law.” This means that the defendant must have been acting in their official capacity as a government official or under the authority of a government agency or program. If the defendant was acting under the “color of state law,” the Plaintiff must then show that the defendant's actions deprived them of a constitutional or statutory right. The Section 1983 form (see Appendix B) which is available for Plaintiffs to use, but not necessary for a complaint to be filed, clearly asks the Plaintiff to state what sort of deficiency exists within the correctional institution and what happened to them, by whom and where (“Statement of Claim,”), how the Plaintiff has been harmed by the inadequate policy or specific action (“Injuries”), and what sort of compensation or changes in policy the Plaintiff seeks (“Relief”). If the Plaintiff decides not to use the prescribed form, they must include these sections on their written or typed complaint. Section 1983 lawsuits can be filed by groups and organizations but are mostly filed by individuals.

Section 1983 of Title 42 of the United States Code is a federal statute which means that the United States District Courts have original jurisdiction over all Section 1983 suits, and the Circuit Courts of Appeals have appellate jurisdiction over the Section 1983 cases in their circuit. This includes actions arising under the Constitution, federal laws, or treaties of the United States. The most common types of Section 1983 cases arise out of violations of the various rights guaranteed by the Constitution, such as the First Amendment rights to freedom of speech, press,
assembly, petition, and religion; the Fourth Amendment protections against unreasonable searches and seizures, including the use of excessive force during an arrest and detention; the Fifth Amendment protections against the government taking private property without paying for it; and the Eighth Amendment protections against excessive bail and cruel and unusual punishment and the Fourteenth Amendment substantive and procedural due process, as well as equal protection claims (Civil Rights Act of 1871, 42 U.S.C. §1983).

Section 1983 complaints can arise from a multitude of correctional facilities, spanning local jails and state prisons, hospitals, and treatment programs. Local jails, typically operated by county or municipal authorities, may generate complaints related to issues such as excessive force, inadequate medical care, or unconstitutional conditions of confinement. State prisons, overseen by state departments of corrections, can be sources of complaints regarding denial of access to courts, retaliation by prison staff, or failure to protect inmates from harm. Violations may arise out of a federal penitentiary, managed by the Federal Bureau of Prisons, concerning violations of due process, cruel and unusual punishment, or religious freedoms, but if the actor was acting under federal law, not state law, the claim would likely be considered under the Bivens statute, not Section 1983.

Often, Section 1983 complaints are confused with Bivens claims. In contrast to Section 1983 complaints which arise from the actions of state actors, Bivens claims arise from constitutional violations committed by federal actors. The landmark case Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics (1971) established the right of individuals to seek damages against federal officials for violations of their Fourth Amendment rights. Bivens’ claims typically involve federal law enforcement officers, immigration officials, or other federal agents alleged to have violated constitutional rights.
While *Bivens* claims share similarities with Section 1983 complaints, several distinctions exist between the two. First, *Bivens* claims exclusively involve federal actors, whereas Section 1983 complaints pertain to individuals acting under the color of state law. The relevance of a *Bivens* claim is subject to the doctrine of sovereign immunity, which may limit the types of claims and relief obtainable against federal officials (*Bivens*, 1971). Essentially, sovereign immunity shields the federal government and its agencies from being sued without their consent. This principle is established in cases like *United States v. Sherwood* (1941) and *FDIC v. Meyer* (1994) which emphasized that the United States, as sovereign, is immune from suit save as it consents to be sued. The doctrine of sovereign immunity means that individuals cannot bring a *Bivens* claim against the federal government itself or against federal agencies. This means *Bivens* claims can only be brought against a federal official in the official's personal capacity, who have allegedly violated a Plaintiff's constitutional rights while acting under color of federal authority.

Before filing a federal Section 1983 lawsuit, which allows individuals to sue state or local government officials for violations of their constitutional rights, it is generally required that the Plaintiff has exhausted all available state-level claims. This requirement ensures that the institution or state has the opportunity to address the constitutional violations before federal courts intervene. Before filing a Section 1983 claim, Plaintiffs should identify any potential remedies available under state law that address the alleged constitutional violation (*Civil Rights Act of 1871, 42 U.S.C. §1983*). These claims might include state constitutional provisions, statutes, or common law causes of action. Then, depending on the nature of the claim, state law may require individuals to exhaust administrative remedies (institution level grievance procedures) before pursuing legal action (*Monroe v. Pape*, 1961; *Heck v. Humphrey*, 1994). This may involve participating in administrative hearings, appeals, or other procedures established by
state agencies or departments. If administrative remedies are unsuccessful or unavailable, individuals may seek judicial review of their claims in state court. This often involves filing a lawsuit in state court and litigating the case through the state's judicial system. If a state court issues an adverse decision, individuals may have the right to appeal to higher state courts, such as appellate courts or state supreme courts or if they can not appeal any further, they can file a Section 1983 complaint.

When filing a Section 1983 lawsuit in federal court, Plaintiffs must demonstrate that they have exhausted all available state-level claims (Civil Rights Act of 1871, 42 U.S.C. §1983). This requires providing evidence of prior complaints, administrative actions, or court proceedings related to the same constitutional violation. Exhausting all avenues of appeal is typically necessary before pursuing federal litigation (Monroe v. Pape, 1961; Heck v. Humphrey, 1994) but there are some statutory exceptions to this rule (Ashcroft v. Iqbal, 2009, Monroe v. Pape, 1961; Heck v. Humphrey, 1994). For example, if pursuing state remedies would be futile, inadequate, or if there is a risk of irreparable harm, individuals may be permitted to proceed directly to federal court. Further, it is important for individuals to be mindful of any applicable statutes of limitations when pursuing state-level claims. Failure to file within the specified time frame may result in the loss of the right to pursue legal action claims (Ashcroft v. Iqbal, 2009, Civil Rights Act of 1871, 42 U.S.C. §1983; Heck v. Humphrey, 1994; Monroe v. Pape, 1961).

In order to proceed in federal court, a Plaintiff must state a claim upon which relief can be granted. If a Plaintiff's complaint fails to sufficiently allege facts that establish a violation of a constitutional right by a person acting under color of state law, the court may dismiss the claim for failure to state a claim. Unfortunately for Plaintiffs, government officials, including law enforcement officers and other state actors, may assert qualified immunity as a defense to
Section 1983 claims (Ashcroft v. Iqbal, 2009). Qualified immunity shields government officials from liability unless their actions violated clearly established constitutional rights of which a reasonable person would have known. If the defendant successfully asserts qualified immunity, the court may dismiss the claims (Ashcroft v. Iqbal, 2009). In certain circumstances, federal courts may choose to abstain from hearing a Section 1983 claim in favor of allowing state courts to resolve underlying state law issues first. This discretionary abstention may occur if the federal court determines that there are important state law questions that should be addressed by state courts. Finally, federal courts have limited jurisdiction, generally requiring a federal question or diversity of citizenship between the parties. If a Plaintiff fails to establish federal question jurisdiction or diversity jurisdiction, the federal court may lack the legal authority to hear the case (Civil Rights Act of 1871, 42 U.S.C. §1983; Heck v. Humphrey, 1994; Monroe v. Pape, 1961).

Upon filing, the court assesses the sufficiency of the complaint and may issue summonses to defendants. Subsequently, defendants are afforded an opportunity to respond to the allegations, typically through motions to dismiss, answer, or other pleadings. Courts have recognized a broad array of constitutional rights that may serve as bases for Section 1983 claims, ranging from the First Amendment's protections of Free Speech and Religion, to the Eighth Amendment's prohibition against Cruel and Unusual Punishment, and the 14th Amendment Equal Protection Clause.

While Section 1983 enables a Plaintiff to bring an action for a violation of their federally protected rights, it does not create any right in and of itself (Civil Rights Act of 1871, 42 U.S.C. § 1983). In practice, this means that to have an actionable claim under Section 1983 the Plaintiff must allege more than just a violation of federal law: they must allege the violation of a clearly
established right. Incarcerated persons may file Section 1983 complaints regarding healthcare if they believe that their Eighth Amendment right to receive adequate medical care has been violated. Some common examples of healthcare-related Section 1983 complaints that inmates may file include (a) a deliberate indifference to serious medical needs, (b) failure to provide necessary medication, (c) inadequate mental health treatment, and/or (d) failure to accommodate for disabilities (Civil Rights Act of 1871, 42 U.S.C. § 1983).

“Deliberate Indifference” means that if an inmate has a serious medical condition or injury that requires treatment, and prison officials are aware of the condition but fail to provide adequate medical care, the inmate may file a Section 1983 complaint for deliberate indifference (Farmer v. Brennan, 1994). This may include situations where prison officials delay or deny necessary medical treatment or where medical staff provide inadequate treatment that leads to further harm. “Failure to provide necessary medication” means that an inmate requires medication to manage a medical condition, but prison officials fail to provide the medication in an accurate and timely manner (Brown v. Plata, 2011; Estelle v. Gamble, 1976; Coleman v. Wilson, 1997; West v. Atkins, 1988). “Inadequate mental health treatment” means that if an inmate has a mental health condition that requires treatment, but prison officials fail to provide adequate treatment or fail to take appropriate measures to prevent self-harm, the inmate may file a Section 1983 complaint for deliberate indifference (Brown v. Plata, 2011; Coleman v. Wilson, 1997; Hutto v. Finney, 1978; Madrid v. Gomez, 1995; Rasho v. Baldwin, 2018; Ruiz v. Estelle, 1980). “Failure to accommodate disabilities” refers to when an inmate has a disability that requires accommodations, such as wheelchair accessibility or sign language interpretation, but prison officials fail to provide these accommodations (ADA, 2008). In this case the inmate may file a Section 1983 complaint for disability discrimination (Armstrong v. Davis, 2009; Coleman v.
Brown, 2013; LaFaut v. Smith, 2016; Lane v. Kitzhaber, 2012; Pennsylvania Department of Corrections v. Yeskey, 1998). In this study, filings regarding accommodations for disabilities are considered healthcare-related.

Once a complaint is filed, the district court will hear the case and decide on the merits of the claim. It allows them to seek monetary damages and injunctive relief to address the harm that they have suffered. However, if a party is dissatisfied with the district court's decision, they may appeal to the appropriate Circuit Court of Appeals. United States Circuit Courts have appellate jurisdiction over all final decisions of the district courts, including those involving Section 1983 claims (Civil Rights Act of 1871, 42 U.S.C. § 1983). Filing a Section 1983 lawsuit can bring attention to issues of systemic abuse and mistreatment within the criminal justice system but it cannot result in the release of the inmate or the reduction of their sentence (Civil Rights Act of 1871, 42 U.S.C. § 1983).

Surprisingly, the literature on the nature of Section 1983 filings is limited. Other than a few outdated reports (Turner, 1979; Hanson & Daley, 1995), and many court cases, it seems that we as a society do not have an adequate understanding of the nature of Section 1983 claims. In order to make a novel contribution to the literature, this study utilized two frameworks, one theoretical and one analytical, to examine these filings.

**Theoretical Framework: Social Construction of Target Populations**

I chose to study the Section 1983 filings of incarcerated persons because of these persons’ vulnerable and often powerless status in the American social and political system (Schneider & Ingram, 1993). The theoretical paradigm used to define the scope of this research project is social constructionism. The basic premise of social constructionism is that beliefs and perceptions about the world are socially constructed and then transmitted into the structures and
institutions of government (Berger & Luckman, 1966). The assumptions of social
constructionism can be especially useful when examining government structures and policies and
how specific groups are burdened by governmental decisions or actions (Mannheim, 1936;
Schneider et al., 2007b). Social constructionists note that the constructions held by the powerful
and wealthy tend to gain the most traction when it comes to impacting policy (Schneider &
Ingram, 1997). Thus, powerful people socially construct most aspects of governance; in other
words, they get to decide the “how” and “who” of policy. The paradigm of social
constructionism challenges scholars to examine how this occurs, what the impact is on policy
and public administration, and consequently, the impact on people.

Policy as a product of social construction was first proposed by Schneider and Ingram
theory. Schneider and Ingram’s Social Construction of Target Populations theory helped frame
this study’s purpose, research questions, sample, and study design. The Social Construction of
Target Populations theory refers to the characterizations, stereotypes, and cultural interpretations
of individuals or groups who are affected by public policy (Schneider & Ingram, 1993). These
characterizations set the standard for how groups are viewed by those who are not in the same
group as them. Further, the theory contends that social constructions influence the rationales that
are used to justify policy choices (Schneider & Ingram, 1993) and sometimes those policy
choices are biased, unconstitutional, and/or harmful.

Schneider and Ingram (1993) organized the social construction of target populations
along two dimensions: power and construction. The dimension of power refers to perceptions of
a target population as either politically strong or weak. The dimension of construction refers to
the fact that perceptions often result in categorizing groups into good and bad, or positive and
negative, depending on the narratives or stereotypes that are being portrayed of them (Schneider & Ingram, 1993). Individuals and groups with positive social reputations are constructed as deserving, intelligent, public-spirited, and hardworking but those groups that are portrayed by negative social reputations often are a victim to stereotypical constructions such as: undeserving, selfish, and lazy.

Schneider and Ingram developed four ideal type groups: advantaged, contenders, dependents, and deviants (Schneider & Ingram, 1993; Kreitzer & Smith, 2018). Advantaged target populations are those characterized as deserving and politically powerful and policy makers are likely to provide beneficial policy treatment to the advantaged type-group (Table 1). Contenders are those who are politically powerful but have poor reputations and policy makers tend to provide hidden or secretive benefits to contenders due to their political power; however, they are willing to provide punitive policy to this group when public interest is high. Dependent target populations are sympathetic, positively constructed groups, but they have little political power. Policy makers have little incentive to produce easily accessible and highly beneficial policies for dependents. Therefore, when benefits are allocated, they tend to be symbolic or hard to access. Finally, and the most relevant group to this study, deviants are target populations associated primarily with negative stereotypes and have little political power (Table 1; Schneider & Ingram, 1993). Policy makers gain political capital for developing punitive policies for groups categorized as deviant, often burdening these already powerless groups (Kreitzer & Smith, 2018; Schneider & Ingram, 1991; 1993; 2007a; 2007b).
Table 1. Depiction of Schneider & Ingram’s Social Construction of Target Populations Theory.

<table>
<thead>
<tr>
<th>MORE DESERVING</th>
<th>LESS DESERVING</th>
</tr>
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<tbody>
<tr>
<td><strong>Advantaged</strong></td>
<td><strong>Contenders</strong></td>
</tr>
<tr>
<td>Expected Policy Designs: Mainly Benefits burdens only when necessary</td>
<td>Expected Policy Designs: Mainly Benefits but hidden, secretive; burdens very risky</td>
</tr>
<tr>
<td>Expected Feedback from Target Group: Mainly positive for benefits, high levels traditional participation such as voting, contacting; burdens are risky and challenged</td>
<td>Expected Feedback from the Target Group: Mainly Positive but suspicious; threatening if don’t make good deals with them and if costs or burdens are imposed unless there are loopholes; high levels participation with money, influence, lobbying</td>
</tr>
<tr>
<td>Expected Feedback from Others: Mainly positive (these people deserve to be treated well). Burdens may be necessary at times but to be avoided</td>
<td>Expected Feedback from Others: Mainly negative for benefits, but they seldom find out; positive support for burdens &amp; costs as these are “greedy” and “untrustworthy” people</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>“Dependents”</th>
<th>“Deviants”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples: Children, women, minorities</td>
<td>Examples: Criminals, “illegal aliens” sex offenders, terrorists</td>
</tr>
<tr>
<td>Expected Policy Designs: Mainly rhetorical &amp; symbolic benefits; some burdens or costs</td>
<td>Expected Policy Designs: Mainly burden &amp; punishment; benefits only when absolutely necessary</td>
</tr>
<tr>
<td>Expected feedback from Target Group: Low participation but mainly supportive of benefits and accepting / submissive about burdens</td>
<td>Expected Feedback from Target Group: Negative but very low traditional participation (demonstrations, strikes); participation sometimes violent</td>
</tr>
<tr>
<td>Expected feedback from Others: Supportive of benefits provided they do not cost much; understanding that burdens are “for their own good.”</td>
<td>Expected Feedback from Others: Positive feedback for inflicting punishment on these “dangerous,” “violent,” “disgusting” people; negative feedback for benefits with accusation “soft on...”</td>
</tr>
</tbody>
</table>

**Note.** Table 1 illustrates Social Constructions and Political Power as defined by Schneider and Ingram’s Social Construction of Target Populations Theory (1993).

Schneider and Ingram's Social Construction of Target Populations theory provides a useful framework for understanding how certain groups, such as incarcerated persons, are
constructed, categorized, and stigmatized in society. This theory emphasizes the role of language, rhetoric, and power in the shaping of our understanding of social problems and the individuals affected by them. This process involves the use of language and discourse to construct a particular image or identity for the group in question. Once this identity is established, it can be used to justify various forms of discrimination, exclusion, and marginalization. In the case of incarcerated people, this process of construction and stigmatization is evident in the way that they are labeled as "criminals" or "convicts." These labels serve to reduce their identity to their past actions and criminal history, rather than acknowledging them as complex individuals with a range of experiences and characteristics. The language used to describe incarcerated persons often reinforces negative stereotypes and assumptions. For example, terms like "felon" or "convict" imply that incarceration is a result of inherent character flaws or a conscious choice, rather than considering the larger structural and societal factors that contribute to crime and incarceration. These labels may lead to unfavorable policies created by wardens, policy makers, government actors, and/or the unconstitutional treatment of incarcerated persons (Schneider & Ingram, 1991; 1993; 1995, 2007a; 2007b).

In addition to language, the Social Construction of Target Populations theory also highlights the role of power in shaping our understanding of these groups. Those with the power to define and label target populations have the ability to shape public opinion, policy, and discourse. In the case of incarcerated persons, this power is often held by law enforcement, the criminal justice system, and politicians, thus their ability to engage in politics to better their treatment is limited. This power dynamic can lead to the perpetuation of harmful stereotypes and policies that further marginalize and discriminate against incarcerated persons. For example, the "tough on crime" rhetoric often used by politicians reinforces the idea that incarceration is the
only solution to crime and fails to address the root causes of crime, such as poverty, inequality, and lack of access to education and employment opportunities. It also leads to negative stigmas that dehumanize incarcerated persons and delegitimizes their needs (Schneider & Ingram, 1991; 1993; 1995).

Incarcerated people are constructed as deviants through a process of socialization. Once deviant behavior is defined, the process of identifying and labeling individuals as criminals begins. Law enforcement agencies are tasked with detecting deviant behavior. Through patrolling, surveillance, and investigations, police identify individuals suspected of criminal activity. Crimes are reported by victims and witnesses, initiating formal procedures. Arrests, prosecutions, and convictions follow, officially labeling individuals as criminals. This official labeling is a critical step in the social construction of deviance, as it transforms a person's identity in the eyes of society (Becker, 1963; Goffman, 1963; Lemert, 1951). Additionally, the media plays a crucial role in shaping public perceptions of crime and criminals, often amplifying societal reactions. Media outlets frequently dramatize crime, portraying criminals in a way that reinforces societal fears and stereotypes. High-profile cases and violent crimes receive disproportionate coverage, skewing public perception of the typical “criminal.” The media can trigger moral panics, where intense public concern and fear over specific crimes lead to heightened societal reactions (Becker, 1963; Lemert, 1951). This phenomenon was evident during the crack cocaine epidemic in the 1980s, where media portrayal fueled widespread panic and led to severe punitive policies (Alexander, 2010).

Once labeled as criminals, individuals face societal stigmatization and institutional responses that further entrench their deviant status. The label of "criminal" carries a stigma that affects all aspects of an individual's life (Becker, 1963; Goffman, 1963; Lemert, 1951).
Stigmatized individuals often struggle with reintegration into society, facing barriers to employment, housing, retaliation, and social acceptance (Rade et al., 2016; Schnittker & John, 2007).

That leads us to the carceral system that manages those labeled as criminals, or as Schneider and Ingram say, “deviants.” The power and social construction of a person as a "deviant" profoundly impacts their treatment while in prison. This status influences their interactions with prison staff, fellow inmates, and the institutional policies governing their daily lives. According to labeling theory, once individuals are labeled as deviant, they are often treated as such by others. This label can lead to stigmatization and marginalization within the prison environment (Becker, 1963; Goffman, 1963; Lemert, 1951). The internalization of the "deviant" label can affect inmates' self-identity and self-esteem, often leading to a sense of hopelessness and resignation (Becker, 1963; Laursen & Faur, 2022; Lemert, 1951). Further, prison staff may harbor biases against inmates, leading to discriminatory treatment. In the administration of healthcare, because of their limited power and negative social construction inmates might receive substandard medical and mental health care. Stigmatization can lead to neglect and inadequate treatment for physical and psychological issues (Akbari et al., 2023).

Using the theoretical framework of Social Construction of Target Populations helped me identify the population that is most impacted by the actions of institutions and government actors, and pushed me to investigate the consequences of social constructions on “deviant” target populations. This study explored the nature of alleged constitutional violations related to correctional healthcare for incarcerated persons (“deviants”) and the ways in which those allegations are framed by the Plaintiff. These findings add to the existing social construction literature by examining the nature of Section 1983 filings through the lens of social
constructionism. Specifically, Schneider and Ingram’s (1991; 1993, 1995; 2019) Social Construction of Target Populations theory was used to help me design a study that examines the nature of the Section 1983 constitutional violation allegations filed by incarcerated people or “deviants.” The theoretical framework allowed me to identify a group of people who experienced a burden resulting from the actions or inactions of government actors, documented those harms through legal filings, allowing for qualitative analysis. The assumptions regarding power and construction illustrated by Schneider and Ingram guided the design of this study.

**Analytical Framework: Framing Theory**

In addition to Schneider and Ingram’s Social Construction of Target Populations theory, framing theory can be utilized to understand how “deviants” communicate their grievances to the courts. The concept of framing can be useful from a critical policy studies perspective (Braun, 2015). Critical policy studies are focused on unveiling the "hidden scripts" through which policy is developed, and framing theory seeks to understand how people use frames or mental structures to help them make sense of the world (Goffman, 1974). Erving Goffman first defined Framing Theory in an essay titled “Frame Analysis" in 1974 to provide a context for understanding and interpreting information that enables people to define and label ideas. Goffman’s concept of frames has its conceptual roots in phenomenology, a philosophical approach that argues that the meaning of the world is perceived by individuals based on their lifeworld beliefs, experiences, and knowledge (Goffman, 1974). Goffman's Framing Theory (1974) enables scholars to gain a deeper understanding of the complexities of human behavior, social structures, and the intricate interplay between individuals and society. By employing this conceptual framework, I can unravel the underlying mechanisms that govern social interactions and contribute to the broader understanding of the human experience with respect to incarcerated persons’ healthcare
experiences. This theory helps communicators define the scope of a situation or argument and transmit meaning (Goffman, 1974). For the framer, the goal is to focus the audience’s attention on a particular part of a message or aspect in order to achieve a specific reaction (Hallahan, 2008). Frames help define problems, identify causes, and make moral judgments in order to suggest ways to solve those problems (Knight, 1999). Framing theory aims to identify schemes in which individuals perceive the world (Goffman, 1974).

At its core, framing theory suggests that individuals use mental frameworks or "frames" to make sense of situations (Goffman, 1974). Framing refers to the process by which people develop a particular conceptualization of an issue or reorient their thinking about an issue (Chong & Druckman, 2007). Framing theory details the ways in which frames serve as conceptual structures that shape how issues or phenomena come to be understood and perceived. Relevant to this study, frames can guide how civil rights issues should be defined, their causes and the proposed solutions (Entman, 1993). People engage in framing strategies to shape how a given problem is conveyed to others. Within this framing, there are implications for which legal responses are acceptable, and the roles and responsibility assigned to different actors (Entman, 1993).

Framing is closely related to Agenda-Setting theory, but while Agenda-Setting deals with telling an audience what to think about, framing theory goes one step further and involves the actual presentation of information to an audience. The theory suggests that the way something is presented to an audience directly affects how people process that information and make decisions based on that information (Hallahan, 2008). The theory suggests that the way information is presented or framed can significantly impact how people interpret it, their attitudes towards it, and their subsequent behavior (Goffman, 1974). The idea to use framing theory to inform the
analysis of the Section 1983 filings was inspired by the construction and framing choices of media outlets, politicians, and general populations regarding incarceration, and more recently, the COVID-19 pandemic. The pandemic not only impacted policies, but global and national rhetoric regarding the deservedness of incarcerated persons, which in turn may have resulted in different types of constitutional violations by prison staff, as well as a difference in the frames utilized by the Plaintiffs in their complaints. Incarcerated people often use Section 1983 lawsuits to communicate the harm against them, challenge conditions of confinement, and assert their rights. However, these lawsuits face hurdles, including legal restrictions, cost, and negative public opinion towards incarcerated individuals (Hanson & Daley, 1995).

The framing of these Section 1983 filings can arguably have a significant impact on their outcome. By framing their lawsuits in a particular way, incarcerated people can influence how their case is perceived, which can, in turn, impact how the courts and the public respond to them. Incarcerated people can use framing to highlight the injustices they face and make their claims more salient to the court. By framing their lawsuits as a matter of basic human rights, they can appeal to broader moral values that resonate with the court. By framing their lawsuits as an issue of systemic injustice, they can show that their experiences are not isolated incidents, but rather reflect broader patterns of mistreatment. For example, if a lawsuit is framed as an individual claim of mistreatment, it may be dismissed as an isolated incident. However, if the lawsuit is framed as a structural or systemic problem, it may receive more attention, and result in broader changes.

Plaintiffs must be careful about how they frame their lawsuits. Negative stereotypes and biases against incarcerated individuals can impact how their claims are perceived, regardless of the merit of their case. For example, if a lawsuit is framed in a way that reinforces stereotypes of
incarcerated individuals as violent and dangerous, it may be dismissed or not taken seriously. Sometimes, framing is done implicitly and other times intentionally but either way, the frame utilization is important and worthy of being examined. Thus, “framing” is an essential tool for incarcerated individuals seeking to assert their rights through Section 1983 lawsuits. By framing their lawsuits strategically, incarcerated individuals can shape how their claims are perceived, appeal to broader moral values, and increase the chances of success (Moore et al., 2013).

The media can also play a significant role in framing Section 1983 filings (Mutua & Ong’ong’a, 2020). Media coverage can influence public opinion and shape how people understand and respond to these lawsuits. For example, media coverage that portrays Section 1983 lawsuits as frivolous or without merit could negatively impact public opinion and make it more difficult for incarcerated individuals to succeed in their claims. During the COVID-19 pandemic, legal and political talking points surrounding correctional policies and COVID-19 may have impacted the nature of the Section 1983 filings by the aggrieved. This study explores whether the pandemic-concurrent rhetoric surrounding criminal justice reform, as well as systemic racial oppression, impacted the ways in which Plaintiffs framed their Section 1983 grievances.

Ultimately, the way Section 1983 filings are framed can be influenced by social constructions and power dynamics. The intentional or unintentional use of frames can significantly impact the outcome of these cases and the broader fight for justice for disenfranchised and/or incarcerated individuals. One goal of this study is to examine the nature of the frames utilized by incarcerated persons prior to and post-COVID-19 onset. This study utilized framing theory as the analytical framework to explore the nature of and frame choices present in Section 1983 complaint filed by incarcerated Plaintiffs. Further, this study examined
whether or not the frames used to communicate alleged constitutional rights violations in Section 1983 lawsuits differed before and after the onset of the COVID-19 pandemic.
Brief Overview of Important Historical Events

Table 2. Important Historical Events Related to Section 1983 Filings

Note. Table 2 illustrates a timeline of important historical events related to the ability of private citizens to file section 1983 complaints against state government actors.

Incarcerated individuals, despite their crimes, maintain fundamental human rights, and, thanks to *Estelle v. Gamble* (1976), access to healthcare has been interpreted as one such right. This belief, though, has not always been upheld. There is a long history of mistreatment of incarcerated persons in the United States, and this section presents a historical overview of key legislation and legal developments in the United States that led to the ability of incarcerated individuals to file Section 1983 claims.

The first protection granted to incarcerated individuals was the Eighth Amendment to the United States Constitution. The Eighth Amendment, ratified in 1791 as part of the Bill of Rights, explicitly prohibits cruel and unusual punishment. This laid the foundation for discussions surrounding the healthcare rights of prisoners. However, during this period, little consideration
was given to providing healthcare for inmates, and prison conditions were often deplorable, and high mortality rates were common among the incarcerated. In an effort to mediate some of the civil rights violations that had occurred in the 1700s and 1800s, the Civil Rights Act of 1871 was passed. The Civil Rights Act of 1871 played a critical role in safeguarding the civil rights of inmates during a time when they were particularly vulnerable to abuse and discrimination. By providing avenues for legal recourse and federal intervention, the Act helped set a precedent for protecting the rights of incarcerated individuals and contributed to the broader struggle for civil rights and racial equality in the United States. The Act is the first of its kind to focus on the enforcement of civil rights. Specifically, Section 1 of this Act, recodified, now as Section 1983 of Title 42 of the U.S. Code, empowered federal authorities to take legal action against state officials who violated individuals' civil rights under the U.S. Constitution. This provision provided a basis to challenge abuses of power and discriminatory treatment of inmates by prison officials and authorities. The Act allowed incarcerated individuals to seek remedies in federal court for violations of their constitutional rights, including access to adequate healthcare, freedom from cruel and unusual punishment, and protection against racial discrimination within the correctional system. Further, the Act criminalized conspiracies to deprive individuals of their civil rights. This provision targeted groups like the Ku Klux Klan, who sought to undermine the rights and freedoms of inmates and other marginalized communities. By attempting to deter these conspiracies, the Act was intended to help to create a safer environment within prisons for those whose rights were threatened.

In a further attempt to restore and expand inmate protections, The Civil Rights Act of 1871 created an actual process for which inmates could file complaints regarding civil rights protections (Civil Rights Act of 1871, § 1983). The 1871 Act was particularly relevant to cases
involving discrimination against minorities, incarcerated people, and women. The Civil Rights Act of 1871 expanded upon the protections of the Eighth Amendment and addressed the issue of inmate health care more directly than prior law. Section 1983 specifically states,

“Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer’s judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this Section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia” (Civil Rights Act of 1871, § 1983).

Although Section 1983 of the 1871 Act outlined some inmates’ rights and created clear laws on the matter, the practical impact of the Act was minimal until Monroe v. Pape (1961) and Cooper v. Pate (1964). In Monroe, the Court articulated three purposes for passage of Section 1983 of the statute: (1) to “override certain kinds of state laws”; (2) to provide “a remedy where state law was inadequate”; and (3) “to provide a federal remedy where the state remedy, though adequate in theory, was not available in practice” (Monroe, 365 U.S, 173–74; Schwartz & Urbonya, 2008). The Monroe Court paved the way for Cooper. In Cooper v. Pate (1964) The Supreme Court decided that the Bill of Rights applied inside prisons, and that, in this particular
case, authorities had erred in denying religious publications and texts to an inmate. Prior to these decisions, and *Cruz v. Beto* (1972), the courts had a “hands off” mentality to corrections (Fox, 1972). The courts previously had considered inmates little more than charges of the state and were reluctant to intervene in the management of prisons, even when egregious constitutional violations of prisoners' rights were alleged (Fox, 1972). But, in 1972, The Court argued that,

“Federal courts sit not to supervise prisons but to enforce the constitutional rights of all ‘persons,’ which include prisoners. We are not unmindful that prison officials must be accorded latitude in the administration of prison affairs, and that prisoners necessarily are subject to appropriate rules and regulations. But persons in prison, like other individuals, have the right to petition the government for redress of grievances” (*Cruz v. Beto*, 405 U.S. 319, 32, 1972). This case granted prisoners clear equal protection under the law, and made clear the right to petition the government for personal civil rights violations.

Further, in 1976, a significant turning point in recognizing the constitutional right to healthcare for inmates came with the landmark case *Estelle v. Gamble* (1976). The Supreme Court ruled that denying necessary medical care to prisoners constituted cruel and unusual punishment, a violation of the Eighth Amendment. *Estelle* set a precedent and established the legal basis for holding prisons accountable for providing adequate medical care (*Estelle v. Gamble*, 1976). 16 years later, *Hudson v. McMillian* (1992) further clarified the standard set in *Estelle v. Gamble* by ruling that deliberate indifference to an inmate's serious medical needs can include the unnecessary and wanton infliction of pain. The Court emphasized that the severity of the inmate's medical condition is not the sole factor in determining whether the Eighth
Amendment has been violated; rather, deliberate indifference to any “serious medical need” can constitute cruel and unusual punishment (Hudson v. Mcmillian, 1992).

The combination of federal legislation and case law has had far-reaching implications for incarcerated persons’ healthcare delivery, access, and outcomes. After each of these aforementioned court decisions, there was immediately an influx of complaints to the federal courts regarding inmate healthcare access and quality. In an effort to mediate the number of cases arriving at the federal courts, the Civil Rights of institutionalized Persons Act of 1980 (CRIPA) was adopted by Congress. This Act authorized the U.S. Attorney General and the federal courts to certify state administrative grievance mechanisms, and to require exhaustion of certified mechanisms, before lawsuits can be filed in federal court. The idea behind this Act was to reduce the caseload of Section 1983 claims in the federal courts by responding to some issues administratively so that the federal courts would be free to resolve the complex Section 1983 cases more quickly (Hanson & Daley, 1995). The issue though, was that many states did not seek certification to resolve these complaints in house, thus, these complaints, many of which were deemed “frivolous” were met with resistance and frustration when they got to the federal court level. A “frivolous” lawsuit is one that is complaining of a non-issue or has already been answered in another ruling. In order to reduce the number of cases reaching the federal courts, the Prison Litigation Reform Act (PLRA) was passed in 1996.

The Prison Litigation Reform Act (PLRA) was passed in response to a perceived increase in frivolous inmate lawsuits. While the PLRA aimed to address this issue, it also imposed restrictions on inmate litigation concerning prison conditions, including healthcare. The Act introduced hurdles for prisoners seeking redress, leading to challenges in enforcing their
constitutional right to healthcare. While the concern of bogging down the courts system is legitimate, these extra hurdles are and were concerning to civil and human rights activists.

More recently, the Affordable Care Act (ACA), signed into law in 2010, had a notable impact on the healthcare rights of inmates. It expanded Medicaid, allowing states to extend coverage to incarcerated individuals during their pre-release period. This step aimed to improve continuity of care and reduce recidivism by ensuring that inmates received essential medical services both pre-trial, during their incarceration, and after release (Patient Protection and Affordable Care Act, 2010). Throughout the 2010s, states took diverse approaches in addressing the healthcare rights of inmates. Some states passed legislation to improve medical services in prisons, acknowledging the constitutional obligation. Conversely, budget constraints in other states led to persistent challenges in meeting the healthcare needs of inmates, leaving some facilities with substandard care.

Further, in 2011, Brown v. Plata (2011) emphasized and re-stated the importance of access to healthcare for inmates. In Brown v. Plata (2011) the Supreme Court addressed overcrowding in California's prison system and its impact on the delivery of healthcare to inmates. The Court held that overcrowding itself is not cruel and unusual but if it contributes to an institutional failure to provide adequate medical and mental health care to prisoners due to overcrowding it does constitute cruel and unusual punishment (Brown v. Plata, 2011). Brown (2011) underscored the importance of ensuring access to healthcare for inmates and highlighted the obligation of prison officials to address systemic issues that impede the delivery of medical services. Systemic issues like underfunding, understaffing, and overcrowding can inadvertently impact the quality of, and access to, healthcare services, especially when coupled with a global pandemic.
COVID-19 and Inmate Healthcare Policies (2020s)

The emergence of the COVID-19 pandemic in March 2020 exposed the vulnerabilities within the prison healthcare system. Congested living conditions and limited access to medical resources increased the risk of outbreaks in correctional facilities. Legislators and the courts were called upon to address the immediate healthcare needs of inmates and ensure that they received proper medical attention during the pandemic. Many policies were adjusted, and new ones created, to help curb the spread of COVID-19 within facilities. Many prisons suspended in-person visitation for families and friends to reduce the risk of the virus being brought into the facility. Some prisons replaced in-person visits with virtual visits or increased phone access to help prisoners stay in touch with loved ones. In response to the pandemic, some prisons implemented early release programs or reduced sentences for some inmates to help reduce overcrowding and prevent the spread of the virus (Montoya-Barthelemy et al., 2020). Some of the key policy changes that could be relevant to the nature of Section 1983 filings during the pandemic include quarantine policies, medical care policies, treatment program related policies, and co-pay policies.

The pandemic highlighted the need for improved healthcare access for prisoners, leading to several policy adaptations. Prisons expanded their healthcare services to accommodate the increased demand for medical attention due to COVID-19. This included setting up dedicated medical units for COVID-19 patients and increasing the availability of mental health services to address the psychological impact of the pandemic (Akiyama, Spaulding, & Rich, 2020). Most correctional facilities implemented stringent infection control measures. These measures include regular testing, quarantine protocols, and the provision of personal protective equipment (PPE) for both inmates and staff. According to Maruschak, Sabol, and Potter (2021), many prisons
adopted mass testing initiatives to identify and isolate infected individuals promptly. Quarantine protocols were established for new admissions and those exposed to confirmed cases. Additionally, the Centers for Disease Control and Prevention (CDC) issued guidelines recommending the use of PPE and the implementation of social distancing practices wherever feasible (CDC, 2021). These guidelines also emphasized the importance of hygiene practices, such as frequent handwashing and the disinfection of high-touch surfaces, which became standard procedures in many correctional settings.

Further, as is common with the delivery of correctional healthcare, some correctional facilities entered into partnerships with external healthcare providers to enhance their capacity to manage the pandemic-related risk. These collaborations facilitated the provision of specialized care and the procurement of essential medical supplies, ensuring that inmates received adequate treatment despite the resource constraints commonly faced in prison settings (Montoya-Barthelemy et al., 2020).

In addition to changes impacting in-person care, the utilization of technology to assist in the management of medical issues increased. Telemedicine emerged as a vital tool, allowing healthcare providers to conduct consultations remotely, thereby reducing the risk of virus transmission. The adoption of telehealth services enabled continuous medical care for inmates, particularly those with chronic conditions who required regular monitoring (Khatri et al., 2021). Further, in response to the urgent need for widespread testing and treatment of COVID-19, many insurers and government health programs implemented policies to waive copayments for COVID-19-related services. This measure aimed to eliminate financial barriers to testing and treatment, ensuring that individuals could access necessary care without facing financial hardship (Antioch, 2023).
Noted above are a few examples of the many policy changes that could have impacted the provision of healthcare services in correctional facilities during the pandemic. One of the goals of this study is to shed light on the impact of these pandemic related policy changes on the nature of the prisoners' complaints and their framing choices in their Section 1983 filings.
Literature Review

The historical timeline of legislation related to the constitutional right to healthcare for inmates reflects the evolving understanding of inmates' rights and their entitlement to adequate medical care. Landmark cases like *Cooper v. Pate* and *Estelle v. Gamble* marked significant milestones in the ability of incarcerated persons to file suits against prison officials and staff and subsequent legislation such as the PLRA and the ACA influenced the ability to file claims and the healthcare quality and access in correctional institutions. However, challenges persist in ensuring that inmates receive the healthcare they deserve, especially during times of crises like the COVID-19 pandemic. This study recognizes that it is crucial to explore the nature of alleged constitutional rights violations and how those filings are framed. This work is important to help understand, and subsequently help address, issues related to inmate care and, most importantly, to uphold the constitutional right to healthcare for all inmates, ensuring their dignity and well-being are protected regardless of their incarcerated status.

The harsh healthcare-related conditions in the American correctional system, coupled with a social and political oppression of “deviants” in American society concerns us with the nature of alleged healthcare-related civil rights violations of incarcerated persons in the United States. Even prior to the onset of the COVID-19 pandemic, the nature of correctional healthcare in the United States is often characterized by underfunding, lack of access to appropriate care, and unaffordable copayments (Sawyer, 2018). According to Kovarsky (2020), “American criminal detention was ground zero for COVID-19 outbreaks” (p. 73). For example, an examination of the healthcare conditions at Rikers Island during the COVID-19 pandemic revealed that participants did not receive needed mental health services from the Department of Corrections, they experienced physical and mental health stressors as a result of the COVID-19
pandemic, they were more likely to get COVID-19 than non incarcerated individuals, and reported that the impact of COVID-19 on the physical and mental health of justice-involved individuals was negative overall (Martin-Howard, 2023). It is well known that correctional facilities house sicker people with complex medical needs (Widra & Wagner, 2020), with poor sanitation, ventilation, close quarters, and an inferior health infrastructure (Neily, 2020).

Incarceration can have significant negative consequences on the health of inmates. For example, many inmates suffer from mental health problems such as depression, anxiety, and post-traumatic stress disorder (PTSD). Incarceration can exacerbate these conditions, as inmates are often isolated from family and support networks, and can experience high levels of stress, trauma, and violence (Wildeman & Wang, 2017). Additionally, inmates are at risk of a range of physical health problems due to the poor living conditions in many prisons. These problems can include infectious diseases, such as tuberculosis and HIV/AIDS, as well as chronic diseases, such as diabetes and hypertension. Inmates are also more likely to have or have had substance abuse problems and to engage in high-risk behaviors that can further compromise their health (Dumont et al., 2012). To compound on the risk of illness, many prisons have inadequate health care facilities and staffing, which can make it difficult for inmates to access necessary medical care. This can lead to delayed diagnoses, inadequate treatment, and a lack of preventative care (Wildeman & Wang, 2017).

Further, incarceration can lead to stigma and discrimination against inmates, which can have negative effects on their mental and physical health. For example, former inmates may have difficulty finding employment and housing due to their criminal records, which can lead to further stress and economic hardship. Incarceration can be a traumatic experience, especially for those who have been victims of violence or abuse. Trauma can have long-lasting effects on an
individual's mental and physical health and can increase the risk of developing mental health problems such as PTSD. The consequences of incarceration on the health of inmates can be significant and long-lasting and can even result in recidivism (Wildeman & Wang, 2017). This study contributes to the literature on correctional health care by exploring the ways in which incarcerated persons believe that their civil and constitutional rights have been violated when it comes to healthcare treatment and access. The literature below reviews what we know about who is most impacted by incarceration, what we know about the historical nature of previously filed Section 1983 claims, and how the pandemic impacted incarcerated people’s healthcare access and quality.

**Mass Incarceration and Social Construction of Target Populations**

Mass incarceration, a phenomenon characterized by the drastic increase in the number of individuals incarcerated in the United States over the past few decades, can be discussed through the lens of Schneider and Ingram’s Social Construction of Target Populations theory (1993, 1997, 2007). The Social Construction of Target Populations theory helps us understand the origins, perpetuation, and consequences of mass incarceration, particularly its disproportionate impact on marginalized communities. The Social Construction of Target Populations theory posits that certain groups within a society are identified, labeled, and treated as "deviant" or problematic by those in power (Schneider & Ingram, 1993, 1997, 2007). These labels and perceptions lead to differential treatment, often resulting in stigmatization, discrimination, and unequal access to resources and opportunities. Societal institutions, media, and policies contribute to the creation and reinforcement of these target populations.

There is a long history of oppressing “deviant” groups in the United States but the conception of mass incarceration in the United States is typically aligned with the War on Drugs,
in the 1980’s. The media, influenced by prevailing biases, perpetuated the idea that criminals were predominantly from poor and/or minority communities. Consequently, policies were enacted that disproportionately targeted and criminalized impoverished people including immigrants and African American and Hispanic individuals, thus, establishing them as a target population for law enforcement and prosecution. Although there are many factors that contribute to the formation of a country’s social and cultural fabric, the one constant factor in the United States has been that the powerful, privileged, usually White class, gets to make and enforce the rules and create (and perpetuate) crime ideologies (Bendix & Lipset, 1966; Marx, 1867; Quinney, 1970). While this is beneficial for the powerful class, we often see that the social construction of policies by the powerful class has historically resulted in negative consequences for the powerless classes (Schneider & Ingram, 1991; 1993; 1995).

Serving the interests of the powerful alone creates inequalities because it either directly oppresses powerless groups, or creates gaps in opportunity for less powerful groups. These less powerful people, who are often also negatively constructed, are typically referred to as “deviants” in the social construction literature (Schneider & Ingram, 1991; 1993, 1995). The consequences, whether intentional or unintentional, of the social construction of policy in the interest of the powerful, are perpetuated through our criminal justice systems and society. The theory of social construction of target populations explains the stark racial disparities in mass incarceration rates. African American and Hispanic individuals are disproportionately targeted, arrested, and convicted, leading to a higher likelihood of incarceration (Alexander, 2010; Quinney, 1970). This differential treatment is rooted in historical prejudices and the portrayal of these communities as dangerous or inherently criminal. The stigmatization associated with being
part of a target population further perpetuates cycles of poverty, limited opportunities, and involvement in the criminal justice system (Quinney, 1970).

Over time, the social construction of our systems becomes the status quo. Even though other constructions may be possible, or fairer, we become comfortable and complacent with the construction that we have and have had for centuries. This complacency is illustrated throughout the United States criminal justice system and through the constitutional violations that are alleged within correctional institutions, and it helps explain the U.S. political system’s failure to solve major social crises such as poverty, crime, and racism (Cairney, 2020; Quinney, 1970).

**Nature of Section 1983 Claims**

One in every ten civil lawsuits filed in federal court is a Section 1983 lawsuit (Hanson & Daley, 1995). However, few scholars have examined the nature of Section 1983 civil rights violations claims (Hanson & Daley, 1995; Turner, 1979). In 1979 The Harvard Law Review reported that historically, “the most frequently raised Section 1983 complaints were related to medical care, property loss or damage, and interference with access to the courts” (Turner, 1979, p. 662). Hanson and Daley (1995) authored a report published by the Bureau of Justice statistics and the U.S. Department of Justice that examined Section 1983 claims as they pertained to the conditions of prisons and jails. According to the cases sampled in 1995, most lawsuits were filed by inmates of state prisons (62%), followed by jail inmates (36%) and a few from individuals either paroled or released from a correctional institution (2%). Fewer than one percent were from offenders who are in mental health facilities (Hanson & Daley, 1995, p. 16). The largest number of Section 1983 lawsuits list correctional officers of prisons or jails as defendants (26%). The second largest group named was institutional leadership such as wardens, deputy wardens, building directors, or jail administrators (22%). Medical staff, including both doctors and nurses
(9%), were the third largest group of defendants followed by elected officials, such as governors, mayors, and judges (7%). Sometimes arresting officers are the defendants (6%) and other types of defendants include clerks of court, court reporters, privately retained and court appointed state trial and appellate counsel and others (29%) (Hanson & Daley, 1995, p. 16). The aggregate profile of Section 1983 litigation is that physical security, medical treatment, and due process were the most frequent issues in prisoners' complaints. The most frequently raised issues in the 1995 report concerned the immediate, physical well being of prisoners such as allegations of inadequate medical treatment (17%), a lack of physical security (21%), or transfer to administrative segregation without due process (13%), and living conditions (4%) (Hanson & Daley, 1995, p. 18). Further, according to the 1995 report, suits relevant to medical treatment took, on average, 510 days to be resolved. If the Plaintiff has an attorney, the case takes on average, 743 days to be resolved and if the Plaintiff is pro se, which is the majority of cases, the average time to resolution is 486 days (Hanson & Daley, 1995). Prisoners do win Section 1983 lawsuits, though it is statistically rare. Successful lawsuits demonstrated that some Plaintiffs are not only credible but justified in their allegations of civil rights violations. After filing a claim and going through the stages, the 1995 report notes that the overwhelming majority of the prisoners win nothing as a result of their claim (94%) (Hanson & Daley, 1995).

Turner (1979) reported that prison policies impact the nature and volume of prisoner complaints. The report argues that the effect on civil rights filings becomes most noticeable when there is a change in administration or policies (Turner, 1979), which we saw often after the onset of the COVID-19 pandemic. Turner notes that the legal system imposes many constraints on the number of “input” opportunities and vantage points to influence the process thus the tone of the lawsuits may be a product of restrictive rules, the manner in which prisoner grievances are
responded to within the institution, and the overall concern with prisoner well-being (Turner, 1979). Further, filing a Section 1983 claims is a tedious and specific process that many incarcerated persons do not understand nor have the desire to experience, and the majority of 1983 filings are pro se, which means that the Plaintiff is filing the complaint without the assistance of legal counsel (Hanson & Daley, 1995).

There are a few key elements that must be present for a civil rights violation to be considered a Section 1983 offense. The first is a “state action.” This means that the defendant must be a government official or acting with the authority of the government when the alleged violation occurs. Private individuals or entities generally cannot be sued under Section 1983 unless they are acting in concert with state actors. Second, there must be a deprivation of rights. The Plaintiff must allege that their rights, as protected by the U.S. Constitution or federal law, have been violated. This could include rights guaranteed by the First Amendment (freedom of speech, religion, assembly), Fourth Amendment (protection against unreasonable searches and seizures), Eighth Amendment (prohibition of cruel and unusual punishment), or others. Third, there must be causation. It is required that there is a causal connection between the defendant's actions and the deprivation of the Plaintiff's rights. In other words, the Plaintiff must show that the defendant's conduct directly led to the violation of their constitutional rights. Finally, when the Plaintiff files their complaint they must outline the damages and/or request relief for the violation of their rights. This could include monetary compensation, injunctive relief (an order to stop certain conduct), or declaratory relief (a court declaration of the parties' rights). If these elements are present, a civil rights violation may be pursued as a Section 1983 claim in federal court.
According to the Federal Judicial Caseload Statistics Reports, during the twelve month period between April 2017 and March 31, 2018, there were 18,216 civil rights cases filed by prisoners with the United States District Courts (FJCSR, 2018). In the following twelve month period, from April 2018 to March 31, 2019, petitions related to civil rights with prisoners as the petitioners, increased 5 percent to 19,102 (FJCSR, 2019). In the twelve month period between April 2019 and March 31, 2020, right before the COVID-19 pandemic hit, the amount of petitions related to civil rights with prisoners as the petitioners increased slightly to 19,148 (FJCSR, 2020). Post pandemic onset, the number of civil rights petitions filed by prisoners dropped to 18,660 in 2021 and continued to drop to 17,995 in 2022 (FJCSR, 2021; FJCSR, 2023). This reduction in filings is predictable due to the decrease in the incarceration population between 2019 and 2022 due to COVID-19. In the first year of the pandemic, the U.S. saw significant reductions in prison and jail populations: the number of people in prisons dropped from 2.1 million in 2019 to 1.8 million by midyear 2020. By 2021, however, this decarceration trend appeared to have stalled, as further drops in prison populations were countered by large increases in jail numbers. From mid-2021 to Fall 2023, incarceration rose slightly, up by 4 percent. The amount of people incarcerated hovered at that decreased level, around 1.8 million, until 2023. Between mid-2021 and fall 2023, a total of 34 states increased the number of people in prison, and some saw substantial growth of around 8% and 9% (Colorado, Illinois, Iowa, Kentucky, North Dakota, Mississippi, Montana respectively) (Kang-Brown et al., 2023).

The Present Study

While the Federal Judicial Caseload Statistics reports give us information regarding the type of complaint filed, where it was filed and when it was filed, the reports do not give detail on the specific allegations related to civil rights violations of state or local officials. The last report
that broke down the type of violations present in Section 1983 claims was in 1995 (Hanson & Daley, 1995). Thus, this study is an attempt to fill the gap in knowledge regarding the nature of Section 1983 claims in modern day. After examining the literature on the nature of Section 1983 filings, the impact of the COVID-19 pandemic on the healthcare-related factors of inmates, the research questions that remain unanswered are:

RQ1: What are the most common constitutional violations alleged by incarcerated persons who filed Section 1983 lawsuits between 2018-2023 and do the nature of the concerns differ pre (January 1, 2018 - March 1, 2020) and post COVID-19 onset (March 2, 2020 - December 31, 2023)?

RQ2: How do inmates frame the alleged violations in their Section 1983 filings and does this differ pre (January 1, 2018 - March 1, 2020) and post COVID-19 onset (March 2, 2020 - December 31, 2023)?

The goals of this study are to understand the perceived/experienced constitutional violations that incarcerated people face when attempting to access health care pre- and post-COVID-19 onset and to understand what practices or policies are perceived by incarcerated persons as violating their constitutional or civil rights. Further, I want to explore the differences in the framing of lawsuits pre- and post-COVID-19 onset with the goal of understanding how the COVID-19 era impacted the frames utilization by Plaintiffs.

Research Questions and Hypotheses

Correctional healthcare policies have an impact on millions of Americans each year. These policies have the potential to help offenders and their families get ahead, but often cause further disadvantage. The exacerbation of existing issues and the introduction of novel challenges as a result of the COVID-19 pandemic underscored the need for a scholarly
examination of recent Section 1983 complaints. The research questions and aims of this study are as follows:

RQ1: What are the most common constitutional violations alleged by incarcerated persons who filed Section 1983 lawsuits between 2018-2023, and do the nature of the concerns differ pre (January 1, 2018 - March 1, 2020) and post COVID-19 onset (March 2, 2020 - December 31, 2023)?

Aim 1: Understand the perceived/experienced constitutional violations that incarcerated people face when attempting to access health care during incarceration.

Aim 2: Explore the differences in the nature of complaints prior to the COVID-19 pandemic and post-COVID-19 onset).

H1: The nature of the constitutional violations alleged by incarcerated persons in their Section 1983 complaints will differ pre and post COVID-19 onset.

It is expected that the nature of the constitutional violations will differ pre- and post-COVID-19 onset because of various changes within correctional facilities. For example, understaffing of correctional officers and healthcare providers in jails and prisons due to sickness and resignations (Covid Prison Project, 2023), increased isolation/lockdown of inmates for longer time frames than were previously typical, and less access to “regular” health care procedures due to COVID-19-related health concerns taking precedence within the correctional facilities health care system (Novinksy et al., 2023). The challenges that the COVID-19 era magnified, such as concerns regarding health, social and political concerns, and racial justice uprisings may have impacted the interactions between corrections staff and Plaintiffs causing the nature of the reported violations to differ.
RQ2: How do inmates frame the alleged violations in their Section 1983 filings, and does this differ pre (January 1, 2018 - March 1, 2020) and post COVID-19 onset (March 2, 2020 - December 31, 2023)?

Aim 1: Explore whether inmates frame their complaint primarily as an individual harm, structural harm, or institutional harm.


H2: The Plaintiffs' frame utilization in their Section 1983 claims will differ pre-COVID-19 and post-COVID-19 onset.

It is expected that Section 1983 claims will be framed differently pre- and post-COVID-19 onset. Specifically, it was predicted that the frames would be focused more on the individual harm in the pre-COVID-19 onset group and more focused on structural harm in the post-COVID-19 onset group. The difference in framing choices pre- and post-COVID-19 could potentially stem from a shift in the national rhetoric surrounding health, political, and social issues, a shift in the nature of corrections due to COVID-19 policy, and the co-occurrence of racial and social justice movements in the United States and across the world, part of which enhanced an “us vs. them” rhetoric within American institutions, including the criminal legal system. In addition to these changes, enhanced media coverage of political issues and policy decisions could sway the perspective of Plaintiffs which would impact the perceptions and beliefs they have about the criminal legal system as a whole, the interactions they have with criminal justice staff, and the way they communicate their grievances to the courts.
Methods

Studies examining incarcerated persons' experiences with access to health care typically utilize interviews or focus groups to collect necessary data (Abbott et al., 2018; Harner et al., 2017). Further, many of the existing studies interview participants while they are incarcerated (Abbott et al., 2018). There are many concerns with collecting qualitative data from incarcerated persons such as limited access, privacy, confidentiality, and coercion risks (Hanson et al., 2015). The power dynamic between the study recruiter/interviewer and the participant is well documented (de Viggiani, 2007). Additionally, people who are incarcerated may feel obligated to participate because of the lack of autonomy and status awarded to them during this time in their life (Hanson et al., 2015). The issues are not only relevant for sampling but for interpretation and analysis as well. When working to examine the experiences of vulnerable populations the ethics and feasibility of the research need to be of the utmost concern of the primary investigator (Abbot et al., 2018).

Prior studies interviewed recently released persons through the utilization of community-based non-profit organizations (Vail et al., 2017). They conducted semi-structured, in-person, audio-recorded interviews at the community organization’s transitional living facility (Vail et al., 2017, p. 1448). In prior analyses, researchers utilized independent coding and applied thematic analysis (Vail et al., 2017), common themes (Hanson et al., 2015), and content analysis (Harner et al., 2017). Studies examining incarcerated persons' experiences with healthcare-related policies typically utilize interviews or focus groups to collect necessary data (Abbott et al., 2018; Harner et al., 2017). This study utilized content analysis of Section 1983 filings in which I seek to understand the nature of alleged constitutional violations against incarcerated people.
Content analysis is a research method used to systematically examine and interpret the content of written or verbal communication (Neuendorf, 2017). Content analysis does not require the collection of data from people directly. Content analysis can be used in the examination of recorded communication, such as court filings (Mayring, 1983). The purpose of content analysis is to identify patterns, themes, and meaning within the data (Neuendorf, 2017). There are two main types of content analysis: manifest content analysis (MCA) and latent content analysis (LCA; Kleinheksel et al., 2020). Manifest content analysis focuses on the surface-level features of the communication, such as word frequency, sentence length, or the presence of certain topics or themes (Kleinheksel et al., 2020). Latent content analysis goes beyond the surface-level features to explore the underlying meaning and significance of the communication (Kleinheksel et al., 2020). In this study, I used both manifest content analysis and latent content analysis to identify dominant themes and frames in the filings and to examine the frequency of certain words, topics, and ideas within the data. Specifically, I am interested in exploring the most common types of healthcare-related constitutional and civil rights violations alleged by prisoners in their lawsuits against correctional facilities and staff pre-and post-COVID-19 onset, how those claims were framed by the aggrieved, and whether or not the nature and framing of those claims differs in the claims that were filed before COVID-19 and post-COVID-19 onset.

Evaluating civil rights filings can be considered both a micro- and macro-level analysis. Evaluating civil rights filings can be considered as a macro-level analysis because it involves examining broad patterns and trends across multiple cases or jurisdictions. Macro-level analysis focuses on large-scale phenomena and social structures, rather than on individuals or specific cases. Micro-level analysis focuses on individual or specific cases or interactions. The present study involves both macro-level and micro-level components. While the analytical focus is
centered around the trends and patterns among the filings, I conducted a content analysis of individual filings at the micro level to gain an understanding of the factors that contribute to the macro level patterns. I take a retrospective approach to this analysis by exploring the nature of filings from 2018 through 2023. These years were selected to allow for comparison of pre- and post-COVID-19 onset pandemic filings. The COVID-era, starting with the declaration of pandemic by the United States and WHO, and the nexus of health concerns, policy changes, social justice movements and emergency orders that accompanied the pandemic are treated as the “intervention” in this study. The longitudinal nature of the study allowed us to compare the nature and framing of Section 1983 claims pre and post COVID-19 onset.

**Sampling**

According to the Federal Judicial Caseload Statistics Reports, during the twelve month period between April 2017 and March 31, 2018, there were 18,216 civil rights cases filed by prisoners with the United States District Courts (FJCSR, 2018). In the following twelve month period, from April 1, 2018 to March 31, 2019, prisoners’ petitions related to civil rights increased 5 percent to 19,102 (FJCSR, 2019). In the twelve month period between April 2019 and March 31, 2020, right before the COVID-19 pandemic hit, the amount of petitions related to civil rights with prisoners as the petitioners increased slightly to 19,148 (FJCSR, 2020). Post pandemic onset, the number of civil rights petitions filed by prisoners dropped to 18,660 and in 2023 continued to drop to 17,995 (FJCSR, 2021; FJCSR, 2023).

The appropriate sample size for a qualitative content analysis of legal documents can vary based on several factors. Unlike quantitative research, where sample size is often determined by statistical considerations, qualitative research tends to focus on depth and richness of data rather than generalizability (Lueng, 2015). The specificity of the research questions in
this study requires purposive sampling which, because of the nature of the sampling method, resulted in a smaller sample size (Patton, 2015).

Due to the desire to reach data saturation, as well as considering practical resources and time, the sample was narrowed to Section 1983 filings from the Fourth U.S Circuit Court. The Fourth U.S. Circuit Court of Appeals, often referred to as the Fourth Circuit, is one of the thirteen United States Courts of Appeals. The jurisdiction of the Fourth Circuit includes Maryland, Virginia, West Virginia, North Carolina, and South Carolina. Additionally, the Fourth Circuit has appellate jurisdiction over federal cases originating from various administrative agencies, military courts, and federal courts in the District of Columbia. The 4th U.S. Circuit court was chosen because I am geographically familiar with the jurisdiction and laws present in this jurisdiction prior to, at the time of, and post-COVID-19 onset. The effect of COVID-19 on the zeitgeist of the times in these particular states, the media coverage and my personal knowledge of the jurisdiction, policy and political decisions that were made during the sample years, can help me make sense of the data. Further, due to the homogeneity of the data from a preliminary review of filings, a smaller sample was sufficient. In this exploratory qualitative research study, the emphasis is on the quality of data rather than the quantity. A smaller, more focused sample with an in-depth analysis provided more meaningful insights than a larger, superficial sample, in this case.

I selected a sample of 120 healthcare-related Section 1983 filings from the 4th U.S Circuit Court in the United States between 2018 and 2023. The sample was gathered by using a systematic stratified purposive sampling technique that ensures proportional numerical representation of cases from each filing year. The sample consists of 20 filings from each year, 2018, 2019, 2020, 2021, 2022, and 2023. To be included in the sample, the filings must have
been related to constitutional violations related to healthcare of inmates during confinement, been filed under the Section 1983 statute, and available on the PACER system.

**Data Collection**

In order to examine the nature of Section 1983 filings, I gathered a systematic stratified sample of Section 1983 filings by incarcerated individuals. Data was collected from the Public Access to Court Electronic Records (PACER) system which is a digital database maintained by the Administrative Office of the U.S. Courts that provides public access to federal court records, including case dockets, documents, and filings. The PACER system is used by lawyers, judges, and members of the public to access information about ongoing and past federal cases. The PACER system provides access to court records for all federal district courts, bankruptcy courts, and appellate courts. Users can search for cases by case number, party name, or keyword, and can download or print documents from the system. The system also provides alerts for new filings and updates to cases of interest. Accessing the PACER system requires creating an account with the Administrative Office of the U.S. Courts and paying a fee for each page accessed. The current fee is $0.10 per page, with a maximum charge of $3.00 per document but there is a researcher exception which I applied for and received. The choice to use the PACER system was based on the fact that it allows for efficient and convenient access to federal court records, which can help to promote transparency and accountability in the legal system, and help me understand the constitutional-related concerns of incarcerated persons.

The sample was collected through a process of searching the PACER system. The first step was to open the PACER website: [https://pacer.uscourts.gov/](https://pacer.uscourts.gov/) and log in. During log in, select the “U.S Court of Appeals, Fourth Circuit” in the “Where would you like to go?” drop down menu. Second, I selected the “PACER case search” option. Third, I opened the advanced search
box and in the “Case Type” box select “Prisoner - Civil Rights.” Ensure that in the other boxes, the first empty line is selected. Then I adjust the dates to January 1, 2018 - December 31, 2018, selected “sort by filed date,” selected ascending order, and Hit “search.” The 2018 case search returned 490 cases. With the goal of reviewing 20 cases per filing year, I divided the 490 cases by 20 to determine which filings I would examine for the sample for that year (490/20=24.5). Every 24th case was pulled for examination. I rounded down to ensure that I did not run out of files to examine for the given year. If this 24th case fits the inclusion criteria of a healthcare-related civil rights violation it was accepted into the sample. If not, it was rejected and the prior (23rd) case was examined. If the 23rd case fits the inclusion criteria it was included, if not, the 22nd case was examined, so on and so forth. The same sampling procedure was followed for all years, 2018-2023, for a total sample size of 120.

For 2019, the case search returned 592 filings. 592/20 = 29.6, thus every 29th case was selected for examination following the same procedures outlined above. For 2020, the case search returned 589 filings. 589/20= 29.45 and every 29th case was pulled for examination following the same procedures outlined above. For 2021, the case search returned 487 filings, 487/20 = 24.35 and every 24th case was pulled for examination following the same procedures outlined above. For 2022, the case search returned 459 filings, 459/20 = 22.95 and every 22nd case was pulled for examination following the same procedures outlined above. For 2023, the case search returned 511 filings, 511/20 = 25.55 and every 25th case was pulled for examination following the same procedures outlined above (see Figure 1).
Note. Figure one shows the total frequency of Civil Rights Filings by Prisoners in the Fourth Circuit Court of Appeals available on the PACER system, in each year sampled: 2018-2023. I utilized a purposive stratified sampling approach and sampled 20 filings from each year.

Once a filing was identified as fitting the inclusion criteria it was downloaded and re-named as YEAR Case # in the sample (# of that year). For example the first case from 2018 was titled “2018 Case 1 (1)”, the first case from 2019 was titled, “2019 Case 21 (2)”, the first case from 2020 was titled “2020 Case 61 (1)” and so on and so forth. This allowed me to keep the names of Plaintiffs and defendants confidential while keeping track of each filing in a cataloged manner. Then, based on the detailed notes I took while coding, I numerically coded the data into an excel spreadsheet based on the year, codes, and the frames identified. I used a binary numeric coding scheme of 0 and 1 (0 meaning the code was not present in the filings and 1...
meaning the code was present in the filing) for all variables except for the pre-COVID and post-COVID variable (1 pre-COVID, 2 post-COVID onset), to allow for measurements of frequency and potential future statistical analysis (see Appendix C).

**Data Analysis**

This study employed a qualitative approach to analyze Section 1983 complaints filed by incarcerated individuals. The unit of analysis was the entire Section 1983 filing. It is important to note that one filing could be coded into multiple categories. The research design integrated deductive coding based on predefined categories derived from legal statutes and precedents, supplemented by emergent inductive coding to capture themes and patterns not anticipated in the initial coding framework. Initially, the coding scheme was deductively developed based on prior research and existing literature as well as a preliminary review of a subset of complaints. This coding framework included both manifest content (explicit, surface-level meanings) and latent content (underlying, implicit meanings) categories. I conducted a manifest content analysis of the factual information in the filings to identify patterns and trends in the types of constitutional violations alleged by the prisoners and a latent content analysis of the framing strategies used by incarcerated individuals in their Section 1983 filings.

**Incorporating Framing Theory in the Research Design**

Frame analysis can be utilized in various disciplines and for broad purposes. Due to its broad ranging use, the literature that uses framing theory is often varied and diverse. Framing analysis is still growing and scholars often disagree as to the application of framing as well as a proper methodology (Scheufele, 2004). Scholars often employ different research methods when utilizing framing. Some scholars use quantitative methods and others approach it with qualitative methods, some use a discourse analysis and others utilize an empirical analysis (Braun, 2015;
Although uniform measurement standards do not exist for framing theory and coding, the most convincing studies tend to take the following steps: Initially, an issue or event is identified (Entman, 2004). This is necessary because a “frame” can only be defined only in relation to a specific issue or event. For example, in this study, the “event” is the filing of the Section 1983 complaint by the Plaintiff, in response to a perceived healthcare-related constitutional violation. The ways in which healthcare-related Section 1983 related issues are framed will differ from the frames used to discuss other legal matters, for example, trial related appeals matters. Defining the issue or event created a foundation for reliability in the data analysis portion of the study (Entman, 2004).

Second, since the goal was to understand how frames are utilized in legal filings, I needed to isolate a specific perspective. For example, in this study, because of the nature of the document being analyzed, the perspective is that there has been a perceived constitutional or civil rights violation by someone acting under the color of state law, against the Plaintiff, that they were unable to seek redress for at the institutional or state level. This step allowed me to explore the strategies employed by incarcerated individuals and their attorneys (if applicable) to frame their grievances effectively. This might include emphasizing certain aspects of the incident, presenting themselves as victims of injustice, or drawing on broader social or cultural narratives to support their claims (Chong & Druckmann, 2007).

Third, an initial set of codes for the issue/event were identified deductively to create a coding scheme (Chong & Druckmann, 2007). Prior work in the academic literature and case law guided the deductive codes. These codes represented the underlying assumptions, values, and beliefs shaping their grievances. To answer the first research question, the deductive codes were defined along different types of constitutional violations: Access to Medical Care (AMC), Cruel
and Unusual Punishment in Healthcare (CUH), Right to Privacy in Medical Treatment (RPR), Informed Consent (INCS), Discrimination in Healthcare (DISC-HC). To answer the second research question regarding how filings are framed, the filings were also coded for “frames” that emphasize different aspects of the harm caused by the constitutional or civil rights violation, such as whether the violation was an Individual Harm (INDV), Structural Harm (STRUC) or Institutional Harm (INST). While examining the filings, it became apparent that some filings outlined multiple violations and the ways in which the Plaintiffs explained the violation(s) were multifaceted. In many of the filings, the Plaintiff framed the harm against them as both an individual harm and a broader structural or institutional issue. Thus, the frames were not mutually exclusive and one filing could be coded into multiple framing categories. While coding attention was given to whether the Plaintiff utilized a singular frame and which one if so, employed a dual framing technique and which two if so, and/or employed a triad framing technique.

Finally, once the codes and frames were identified, the next step was to select sources for content analysis. In this study, Section 1983 court filings were selected as the source for content analysis (Chong & Druckmann, 2007). These filings were chosen due to their availability within the PACER system and their relevance to the issue and event chosen. Then, I coded the sample filings using both manifest and latent content analysis techniques, supplemented by emergent inductive coding to capture themes and patterns not anticipated in the initial coding framework.

The documents were coded by hand and detailed notes were taken, then the data were transformed into numerical figures so they could be organized in an excel file to keep track of the most common codes in each year. A comparative analysis was completed post data collection. In addition to deductive coding, emergent inductive coding was employed to identify themes and
patterns that emerged organically from the complaints. Inductive coding allowed for the identification of emerging themes and patterns within the textual data, enabling a nuanced understanding of the issues addressed in these filings (Saldaña, 2016). This approach involved open-ended analysis to capture nuances, subtleties, and novel insights not covered by the predefined coding framework. Emergent codes were iteratively developed through an inductive process of data exploration, pattern recognition, and thematic analysis. The six emergent codes identified in the filings were, Serious Medical Condition (SMC), Deliberate Indifference (DELIB), Lack of Communication (LOC), Lack of Accountability (LOA), COVID-19 Related Complaint (COV), Financial Barrier (FIN).

To address “coding refinement” once all 120 filings had been initially coded, I repeated the coding procedure and cleaned the data to ensure consistency and reliability in the coding process. As the project went on, and I coded more filings, I recognized that the coding was an iterative process evolving as I engaged more deeply with the data. As I continued to analyze the data, I encountered new insights and nuances that required adjustments to my coding scheme and decision making. For example, after being immersed in the filings, I noticed repetitive language clearly highlighting Plaintiffs' concerns around “serious medical conditions,” “deliberate indifference,” and “financial barrier” which pushed me to create additional codes that specifically captured the utilization of these phrases. Once those emergent codes were created, I looked for them in subsequent filings. In the initial coding pass, the emergent codes were only applied to the cases that were examined after the code was developed. To account for this, and to ensure reliability and validity, I chose to engage in a secondary coding process where I blindly reviewed the filings a second time to re-examine the documents for both the deductive and newly identified inductive codes, and then compared the codes from time 1 and time 2. There were a
few additions and adjustments between time 1 and time 2. The biggest discrepancies between
time 1 and time 2 were found in the first 40 filings in the sample. As expected with the nature of
inductive coding, in time 1, the six emergent codes were not captured in the early filings because
they had not been identified or created when the early filings were being analyzed. Once I went
back and examined them for the presence of the new codes in time 2, I did find that many of
them met the criteria for the inductive codes (outlined above) and I incorporated them into the
data sheet. For example, when I initially coded case 10, I found that it met the criteria for Access
to Medical Care (AMC), Cruel and Unusual Punishment in Healthcare (CUH) and
Discrimination in Healthcare (DISC-HC) and when I blindly coded it the second time, I found
that it met the criteria for all of those codes and Deliberate Indifference (DELIB) and Financial
Barriers (FIN) to accessing care.

Coding was done by hand without the use of any software. I chose to code by hand due to
the nature of the research and the desire to deeply immerse myself in the documents. The
analytical plan to utilize inductive coding to gain greater insight into the nature of the violations,
and the need for latent content analysis to answer the second research question, compelled me to
use a manual coding technique so that I could identify subtle nuances and emerging themes that
might be overlooked by qualitative software. Manually coding data necessitated a close, repeated
reading of the filings, fostering a profound understanding of the content. Manually coding
required detailed note taking which was initially done on the downloaded pdf of the filings, blind
re-coding which required a separate note sheet and a clean filing with none of the prior notes,
and then upon comparison of the two coding results, the final notes and codes were imported into
an excel spreadsheet. Further, while examining these filings for the presence of specific content
(as outlined above), I numerically coded the findings into an excel sheet. While translating the
qualitative data into numeric form, I incorporated information on other, potentially relevant, variables such as whether the individual filing the complaint was representing themselves, “pro se”, or if they had an attorney assisting them with their complaint, and whether the case was filed “pre-COVID” or “post-COVID-onset” (1 or 2 respectively). Collecting this additional data and representing it numerically in an excel spreadsheet provided context to the study by allowing me to run frequencies for each code and category, facilitating comparison on the subtle pre-and post-COVID-19 onset differences, and will also open the door for future statistical analysis and assessment.
Results

Nature of Violations

RQ1: What are the most emergent constitutional violations alleged by incarcerated persons who filed Section 1983 filings between 2018-2023 and do the nature of the concerns differ pre (January 1, 2018 - March 1, 2020) and post COVID-19 onset (March 2, 2020 - December 31, 2023)?

The first aim of this research question was to understand the perceived/experienced constitutional violations that incarcerated people face when attempting to access health care during incarceration. Initially, deductive codes were derived from established theoretical frameworks and existing literature regarding Section 1983 claims. These deductive codes were developed based on prior research, literature and legal principles, providing a structured coding framework for the analysis. The deductive coding process involved systematically categorizing the Section 1983 filings according to five predefined categories (codes). Each filing was examined for the presence of these deductive codes, which encompassed various legal claims, civil rights allegations, and health care related elements. Individual filings can encompass multiple codes so there was often overlap in the coding of each filing.
Table 3 Descriptions of Violations in Section 1983 Complaints (Deductive Codes)

<table>
<thead>
<tr>
<th>Violation Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Medical Care (AMC)</td>
<td>When the complaint outlines denial of, or failure to provide, medical care, treatment or medication in a timely manner or, when medical care was provided, the quality of care was not acceptable, effective or appropriate.</td>
</tr>
<tr>
<td>Cruel and Unusual Punishment (CUH)</td>
<td>When the actions or inactions of correctional facility staff violate the Eighth Amendment Cruel and Unusual Punishment clause, when lack of care results in prolonged suffering or the medical care provided causes further harm.</td>
</tr>
<tr>
<td>Discrimination (DISC-HC)</td>
<td>When correctional staff engage in discrimination in any form (age, race, gender, sexual orientation, religion, etc) in the administration of healthcare services to the plaintiff.</td>
</tr>
<tr>
<td>Informed Consent (INSC)</td>
<td>When the complaint raises concerns about the absence of proper informed consent in medical procedures or treatments for prisoners or when individuals are subjected to medical treatments, procedures, or research without their full understanding or voluntary agreement.</td>
</tr>
<tr>
<td>Right to Privacy (RPR)</td>
<td>When the complaint pertains to breaches of privacy concerning medical information or treatment within the prison system or when their confidential medical information was improperly accessed, disclosed, or exploited without their consent.</td>
</tr>
</tbody>
</table>

Note. Table 3 gives descriptions of complaints for each deducitive code that was chosen to help define the nature of each civil or constitutional rights violation.

According to the PACER system, a total of 3,128 prisoner civil rights complaints were filed with the United States Fourth Circuit Court between 2018 and 2023 (see Figure 1). A manifest content analysis grounded in framing theory uncovered that the most common healthcare-related constitutional violation between 2018 and 2023 was “denial of access to medical care” or “AMC”. Out of the 120 cases sampled, 91.7% involved denial of access to medical care ($n = 110$), 58.3% involved cruel and unusual punishment in the administering of healthcare services ($n = 70$), and 12.5% involved discrimination in the provision of healthcare services ($n = 15$). Only 2.5% ($n = 3$) related to informed consent for medical procedures and 1.6% were related to the right to privacy in healthcare ($n = 2$).
Note. Figure 2 illustrates the total number of filings in each deductive coding category for the entire sample. Categories were not mutually exclusive; a complaint could involve multiple alleged violations.

In 2018, all of the sampled filings met the criteria for “AMC”. This means that all filings were related to prisoners' access to timely and adequate medical care \( (n = 20/20) \) and about 70% were also coded as cruel and unusual punishment \( (n = 14/20) \). In 2018, only a few were related to discrimination in healthcare \( (n = 3/20) \). None of the sampled filings from 2018 documented violations related to the privacy of medical information \( (n = 0/20) \) and treatment or violations involving the lack of proper informed consent in medical procedures or treatments \( (n = 0/20) \) (see Figure 3).
In 2019, the most common healthcare-related constitutional violation was denial of access to medical care \( (n = 18/20) \) followed closely by claims of cruel and unusual punishment \( (n = 15/20) \). Out of the 20 cases sampled, none were related to discrimination in healthcare \( (n = 0/20) \), violations related to the privacy of medical information \( (n = 0/20) \) and treatment or violations involving the lack of proper informed consent in medical procedures or treatments \( (n = 0/20) \) (see Figure 3).

In 2020, the most common healthcare-related constitutional violation was denial of access to medical care \( (n = 18/20) \) followed by cruel and unusual punishment \( (n = 6/20) \). Out of the 20 cases sampled from 2020, there was one filing that was related to violations of privacy of medical information and treatment \( (n = 1/20) \). There were also two filings that were related to discrimination in the provision of healthcare services \( (n = 2/20) \). There were no filings in 2020 related to violations involving the lack of proper informed consent in medical procedures or treatments \( (n = 0/20) \) (see Figure 3).

In 2021, the most common healthcare-related constitutional violation was denial of access to medical care \( (n = 19/20) \) followed by cruel and unusual punishment \( (n = 9/20) \). Out of the 20 cases sampled from 2021, there was one filing that was related to violations of privacy of medical information and treatment \( (n = 1/20) \). There were five filings that were related to discrimination in the provision of healthcare services \( (n = 5/20) \). There were no filings related to violations involving the lack of proper informed consent in medical procedures or treatments \( (n = 0/20) \) (see Figure 3).

In 2022, the most common healthcare-related constitutional violation was denial of access to medical care \( (n = 19/20) \) followed by cruel and unusual punishment \( (n = 10/20) \). There were three filings that were related to discrimination in the provision of healthcare services \( (n = 0/20) \) (see Figure 3).
and one filing regarding violations involving the lack of proper informed consent in medical procedures or treatments \((n = 1/20)\). Out of the 20 cases sampled from 2022, there were no filings related to violations of privacy of medical information and treatment \((n = 0/20)\) (see Figure 3).

In 2023, both denial of access to medical care \((n = 16/20)\) and cruel and unusual punishment \((n = 16/20)\) were the most common healthcare-related constitutional rights violations. There were two filings that were related to discrimination in the provision of healthcare services \((n = 2/20)\) and one filing regarding violations involving the lack of proper informed consent in medical procedures or treatments \((n = 2/20)\). Out of the 20 cases sampled from 2022, there were no filings related to violations of privacy of medical information and treatment \((n = 0/20)\) (see Figure 3 and the discussion section for more information on 2018-2023 case filings).

![Figure 3. Nature of Constitutional Rights Violations (Deductive Codes)](image)

*Note.* This chart illustrates the nature of constitutional rights violations in each year 2018-2023.
While examining the filings for the pre-determined deductive codes, a concurrent inductive approach was utilized to uncover unexpected emergent themes and patterns within the dataset. Inductive coding involved a more exploratory and data-driven process, allowing for the identification of new codes and categories that were not anticipated in advance. The inductive coding process began with a thorough review of the Section 1983 filings, focusing on the narrative descriptions of alleged constitutional violations, legal arguments, and frames presented by Plaintiffs. Through iterative readings and reflection, recurring themes and nuanced distinctions in the data were identified. Six inductive codes were developed to capture these novel insights, reflecting the diverse range of issues and grievances addressed in the Section 1983 filings. These inductive codes were refined through constant comparison and validation against the original data, ensuring their relevance and reliability in representing themes and patterns.

The six inductive codes identified were: Serious Medical Condition (SMC), Deliberate Indifference (DELIB), Lack of Communication (LOC), Lack of Accountability (LOA), COVID-19 Related Complaint (COV), Financial Barrier (FIN).
Table 4. Examples of Violations in Section 1983 Complaints (Inductive Codes)

<table>
<thead>
<tr>
<th>Violation Type</th>
<th>Example</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliberate Indifference (DELIB)</td>
<td>When the complaint included the words “deliberate indifference” or the Plaintiff argued clearly that the prison officials or healthcare providers were aware of an inmate's serious medical condition or a substantial risk of harm, but consciously disregarded or failed to respond to it.</td>
<td></td>
</tr>
<tr>
<td>Serious Medical Condition (SMC)</td>
<td>When the complaint illustrated a disagreement between what the Plaintiff believes to be a “serious medical condition” that requires immediate and adequate care, but the defendant(s) did not respond in the manner required per case law, thus suggesting that they did not believe the ailment or condition was “serious”.</td>
<td></td>
</tr>
<tr>
<td>Lack of Communication (LOC)</td>
<td>When the complaint included claims of “lack of communication” or “mis-information” given by facility staff or defendants and the lack of accurate communication resulting in the inmate not receiving the care they needed.</td>
<td></td>
</tr>
<tr>
<td>Lack of Accountability (LOA)</td>
<td>When the complaint included claims of “lack of accountability” by prison medical personnel or prison staff, when the defendant did not attempt to remedy their mistakes, the mistakes of their staff, and/or the defendant passed off the responsibility of their mistake onto the offender or another state actor.</td>
<td></td>
</tr>
<tr>
<td>Financial Barrier (FIN)</td>
<td>When the complaint included claims of financial related barriers to accessing or receiving adequate healthcare services. Types of financial barriers are mandatory medical copayments, directions to seek “outside” care that the inmate would be financially responsible for and cannot afford, or inmate medical debts being applied to their prison account causing other medical or health related issues such as limited access to hygiene products and food.</td>
<td></td>
</tr>
<tr>
<td>COVID-19 Related Complaint (COV)</td>
<td>When the complaint includes claims of healthcare or correctional staff engaging in actions that increased the risk of contracting COVID-19 or spread of COVID-19, or failure to respond appropriately to COVID-19 related medical needs of inmates. This includes the failure to test for, and/or treat, the virus.</td>
<td></td>
</tr>
</tbody>
</table>

Note. Table 4 gives examples of complaints for each inductive code that was iteratively developed to capture more context regarding the civil or constitutional rights violation.

The code SMC was applied when the complaint illustrates confusion regarding what constitutes a “serious medical condition”. I used this code when the complaint illustrated a disagreement between what the Plaintiff believes to be a “serious medical condition” that requires immediate and adequate care, but the defendant(s) did not respond in the manner required per case law, thus suggesting that they did not believe the ailment or condition was “serious”. Out of the 120 filings, 33% fit the criteria for Serious Medical Condition (SMC) (n = 40) (see Figure 4).
The code DELIB was applied when the complaint outlines defendants’ “deliberate indifference” to the Plaintiff's serious healthcare needs. I used this code when the complaint included the words “deliberate indifference” or the Plaintiff argued clearly that the prison officials or healthcare providers were aware of an inmate's serious medical condition or a substantial risk of harm, but consciously disregarded or failed to respond to it. Out of the 120 filings, 53% fit the criteria for Deliberate Indifference (DELIB) \((n = 64)\) (see Figure 4).

The code LOC was applied when the complaint outlines defendants did not communicate to the inmate their responsibilities in obtaining or paying for their own medical care. I used this code when the complaint included claims of “lack of communication” or “mis-information” given by facility staff or defendants and the lack of accurate communication resulted in the inmate not receiving the care they needed. Out of the 120 filings, 6% fit the criteria for Lack of Communication (LOC) \((n = 7)\) (see Figure 4).

The code LOA was applied when the complaint outlines that defendants did not take responsibility for medical mistakes they made when diagnosing, providing care for, or the referral of medical need to proper authority within the facility. I used this code when the complaint included claims of “lack of accountability” by prison medical personnel or prison staff, when the defendant did not attempt to remedy their mistakes, the mistakes of their staff, and/or the defendant passed off the responsibility of their mistake onto the offender or another state actor. Out of the 120 filings, 10% fit the criteria for Lack of Accountability (LOA) \((n = 12)\) (see Figure 4).

The code FIN was applied when the complaint outlined some sort of financial related barrier to receiving healthcare services. I used this code when the complaint included claims of financial related barriers to accessing or receiving adequate healthcare services. Types of
financial barriers are mandatory medical copayments, directions to seek “outside” care that the inmate would be financially responsible for and cannot afford, or inmate medical debts being applied to their prison account causing other medical or health related issues such as limiting access to hygiene products and food. Out of the 120 filings, 4% were related to Financial Barrier (FIN) \((n = 5)\) (see Figure 4).

Finally, the code COV was applied when the filing highlighted violations related to COVID-19 Related Complaint (COV) but since it was only found in the post-COVID-19 onset group, this code will be discussed in detail in coming sections (see Figure 7).

Figure 4. Total Filings in each Inductive Code Category

Note. Figure 4 illustrates the total number of filings in each inductive code category for the entire sample \((N = 120\) filings). We see that Deliberate Indifference was the most common inductive code applied, followed by Serious Medical Condition. Less common
but still present were claims related to Lack of Accountability, Lack of Communication, and Financial Barrier.

In 2018, over half (65%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 13/20)\) and in 25% of the sampled filings Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 5/20)\). Two filings in 2018 fit the criteria for Financial Barrier \((n = 2/20)\), none of the filings from 2018 fit the criteria for lack of communication or lack of accountability (see Figure 5).

In 2019, over half (65%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 13/20)\) and in 55% of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 11/20)\). Further, 25% of filings fit the criteria for Lack of Accountability \((n = 5/20)\). One filing fit the criteria for Lack of Communication \((n = 1/20)\) and one fit the criteria for Financial Barrier \((n = 1/20)\) (see Figure 5).

In 2020, over half (60%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 12/20)\) but in only two of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 2/20)\). Further, 20% of filings fit the criteria for Lack of Accountability \((n = 4/20)\). Two filings fit the criteria for Lack of Communication \((n = 2/20)\) and none fit the criteria for Financial Barrier (see Figure 5).

In 2021, 20 percent of the filings were related to/met the criteria for Deliberate Indifference \((n = 4/20)\). Only three of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 3/20)\). One filing fit the criteria for Lack of Accountability \((n = 1/20)\), one fit the criteria for Lack of
Communication \((n = 1/20)\), and one fit the criteria for Financial Barrier \((n = 1/20)\) (see Figure 5).

In 2022, almost half (45%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 9/20)\). Eight of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 8/20)\). One filing fit the criteria for Lack of Communication \((n = 1/20)\), no filings fit the criteria for Lack of Accountability or Financial Barrier (see Figure 5).

In 2023, over half (65%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 13/20)\) and 55% of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 11/20)\). Further, only a few of the case filings fell into the three other emergent theme categories. Two met the criteria for Lack of Accountability \((n = 2/20)\), two filings fit the criteria for Lack of Communication \((n = 2/20)\) and one fit the criteria for Financial Barrier \((n = 1/20)\) (see Figure 5).
Figure 5.
Nature of Constitutional Rights Violations (Inductive Codes)

<table>
<thead>
<tr>
<th>Year</th>
<th>Deliberate Indifference</th>
<th>Serious Medical Condition</th>
<th>Lack of Communication</th>
<th>Lack of Accountability</th>
<th>Financial Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>13</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2019</td>
<td>13</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>2020</td>
<td>12</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2021</td>
<td>9</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2022</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2023</td>
<td>13</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Figure 5 shows the number of Section 1983 filings that met the criteria for each inductive coding category related to the nature of constitutional rights violations in each year: Serious Medical Condition (SMC), Deliberate Indifference (DELIB), Lack of Communication (LOC), Lack of Accountability (LOA), Financial Barrier (FIN).

The deductive and inductive coding processes were complementary, enabling a comprehensive analysis of the Section 1983 filings. Deductive codes provided a structured framework for organizing the data according to predefined concepts, while inductive codes facilitated the discovery of new insights and contextual nuances within the dataset. More details on the nature of the Section 1983 complaints, with examples are provided in the next section.
Nature of Violations

This section will discuss the codes that were utilized in the data analysis process, discuss why they are important to the research questions, and provide examples of how the codes were present in the filings. These deductive codes were developed based on prior research, literature, and legal principles, providing a structured framework for the analysis. Each filing was examined for the presence of these deductive codes, which encompassed various legal claims, constitutional rights allegations, and health care related elements. In this section, the term “medical” will be used within the case examples. "Medical" in this context is specific to the healthcare system within the prison environment and may have its own set of procedures, terminology, and challenges compared to medical services outside of incarceration settings. This could include medical examinations, treatments, medications, or any other healthcare-related activities offered to inmates. Often, inmates use the term “medical” instead of doctor or nurse, or the medical facility at the institution. Further the Plaintiffs' and defendants’ names, specific institutional details, and specific company information (for companies that contract with the correctional facility to provide care) have been redacted for confidentiality purposes. The term Plaintiff(s) will refer to the incarcerated person(s) who filed the Section 1983 complaint and defendant(s) will refer to the person(s) or institution(s) being accused of the violation(s).

Access to Medical Care

The first deductive code is Access to Medical Care (AMC). This code was applied when the Section 1983 complaint outlined violations related to prisoners' access to timely and adequate medical care. I assigned this code when the complaint specifically involves issues related to prisoners being denied timely and adequate medical care, medical prescriptions, or medical evaluations. In this study, a majority of cases outlined violations related to access to medical
care. Below are six cases, one from each year, that exemplified this code, and illustrate the broad scope of experiences that incarcerated people face at the hands of varying correctional actors.

In case 2, filed in 2018, the Plaintiff alleges they sent off a sick slip requesting to be seen for a hernia that was increasing in size and causing severe pain. At this point, medical staff refused to see them (no reason was given). Four days later, they filed another complaint because of extreme pain, in which they were seen, but medical misdiagnosed them and failed to provide a treatment plan. Over the next 5 months they requested medical care to address the increased pain and only Tylenol was administered. After 5 months, a CT scan was eventually conducted where they found two hernias and potentially a cancerous mass on their pancreas. At this point, doctors told them that because there was a potential cancerous mass, the hernias were not a priority anymore and treatment was again withheld. For another two months, the Plaintiff requested sick calls and medical treatment but did not receive it until an emergency surgery was conducted to repair the hernias and remove part of their colon. The Plaintiff had to wait 6 months for their medical issue to be addressed, undoubtedly allowing the issue to worsen. Once the surgery was completed, the Plaintiff did not receive appropriate medical care to address the incisions despite multiple requests to be seen post-operation, and had to take care of their own wounds for a year, which resulted in extensive healing time, complications, and prolonged suffering. The extensive wait time for receiving medical care, deliberate indifference to medical need, and failure to provide appropriate and adequate post operative care are the basis for the civil and constitutional rights violations outlined in this filing (Case 2).
In case 39, filed in 2019, the Plaintiff argued that they started to experience blurry vision and submitted a sick slip requesting medical services to examine the ailment. For over one month, they did not get allowed a visit to medical, nor was any response provided. The Plaintiff's vision continuously got worse every day and after not receiving care after a month they filed a grievance with the institution arguing they needed medical care and it was not being provided. They did not hear back on that grievance. This denial of medical attention resulted in almost complete blindness in the Plaintiff's right eye. In this case, timely and appropriate medical care was withheld, resulting in long-term health-related consequences (Case 39).

In case 42, filed in 2020, the Plaintiff argues that the defendant did not provide adequate and appropriate medical care in a timely manner. The Plaintiff put in a sick call request to medical when they started experiencing severe pain and swelling in their abdominal region, as well as other painful symptoms. At the first request for care, they were granted a telehealth appointment where they were prescribed medications and told that if the symptoms were not resolved in 14 days to come back. After 14 days, the symptoms had not been managed and the prescriptions had run out, and the Plaintiff communicated to the doctor on staff that their condition had not improved and they would like to get a consult at the hospital to address the cause of the symptoms. The defendant (staff doctor) refused to put in the consult. Over the next two months, the Plaintiff continuously asked for medical support and a consult, which was continuously denied despite the doctor agreeing the symptoms were worsening. Eventually, the condition worsened to a medical
emergency where the Plaintiff was rushed to the hospital where the doctor engaged in a medical procedure to reduce the swelling and pain. Between the initial complaint, and procedure to reduce the swelling and pain, two months had passed. The Plaintiff argues that by the original doctor delaying the appropriate care for two months, they experienced unnecessary pain and suffering (Case 42).

In case 67, filed in 2021, the Plaintiff alleges inadequate access to medical care and gross negligence because medical staff refused to administer prescribed breathing treatments in a timely manner. They were prescribed breathing treatments every four hours and/or as needed. In prison, this meant they had to visit medical every four hours to receive those treatments. Over a period of two months, their request for a trip to medical to receive the breathing treatments were ignored multiple times. The Plaintiff reports frustration in accessing the care they need and prolonged suffering resulting in the hospitalization of the Plaintiff. In this case, timely and appropriate administration of prescribed medications was not met, resulting in the exacerbation of a chronic illness (Case 67).

In case 83, filed in 2022, the Plaintiff argued they experienced inadequate access to medical care and prolonged and unnecessary suffering because of a nurse refusing to properly treat them. The Plaintiff made a medical request for treatment because they were struggling to breathe and were in severe pain, the calls for help were ignored for ten hours. Once another nurse was contacted, the nurse ordered an x-ray and they found the patient was suffering from a collapsed lung. Treatment was then provided. Four months later, the patient again was suffering from pain and struggling to breathe, they requested
to be sent to the hospital or an outside medical provider for care and the nurse on staff argued that “there was nothing wrong with them” (p. 6) and denied their claims regarding their history of a collapsed lung. Again, the patient was made to wait for two days until they received medical care, where it was again found that they were suffering from a collapsed lung. This case exemplifies failure to provide medical care in a timely manner resulting in prolonged pain and suffering (Case 83).

In case 117, filed in 2023, the Plaintiff alleges their serious medical needs were violated with reckless disregard for their health when they were refused appropriate treatment for a mental health issue. When the Plaintiff was transferred into a new institution, the medical staff failed to follow previously established psychiatric protocols for the Plaintiff. Specifically, the Plaintiff was prescribed Zoloft with a “no crush order” because it results in adverse side effects when it is crushed. Prison staff failed to provide the pill in the prescribed “no crush” form on multiple occasions. For context, sometimes prison medical staff crush medication in pill form prior to dispersal at pill call, for various reasons. Crushing medications can prevent inmates from hoarding or diverting the medication for illicit purposes. It also ensures that the medication is consumed as intended and reduces the risk of misuse or abuse. Further, some medications, like extended-release formulations, are designed to release the drug gradually over time. Crushing these medications disrupts the controlled-release mechanism, ensuring that the inmate receives the entire dose at once. By crushing medications, correctional healthcare staff can monitor and verify that inmates have taken their prescribed medications as directed. This helps to ensure medication compliance and adherence to treatment
regimens. After the Plaintiff addressed this lack of compliance with the “no crush order” with medical staff and it was not resolved, he filed a grievance against the staff. Then, rather than complying with the no crush order, medical staff abruptly halted the dispersal of medication to the Plaintiff. For a medication like Zoloft, which is prescribed for mental health related ailments, to be halted abruptly with no step down period, can result in withdrawals and relapses. This case exemplifies inadequate access to medical care by not administering medications as prescribed and eventually, withholding them (Case 117).

From an institutional perspective, inadequate medical care in correctional facilities can contribute to the spread of communicable diseases among inmates, staff, and the broader community. Prisons may lack sufficient healthcare resources, including medical personnel, facilities, medications, and equipment. As a result, inmates may face long wait times to receive medical attention, limited access to specialists or diagnostic tests, or inadequate follow-up care. Sometimes, the actions or inactions of staff result in multiple inmates being harmed.

In one filing, a "Class Action" lawsuit filed by multiple Plaintiffs arguing medical malpractice, Eighth Amendment violations, and discrimination against multiple inmates with disabilities. In this case, the allegations outline that some of the Plaintiffs are “sick, almost dead, blind, bedridden” (p. 13) and the facility medical staff will not prescribe adequate pain medication preventing effective pain management, prolonged suffering and increased medical risk to inmates. The filing outlines that “we are not requesting any money, we are just requesting pain management and correct pain medications” (p. 14) as many inmates are “scream and cry all night” (p. 14) in pain and “have to take 1,000 mg of ibuprofen multiples time a day which doesn’t even touch the pain” (p. 14). One
Plaintiff was hospitalized due to vomiting blood (p. 14), due to the adverse effects of taking too much ibuprofen. The filings allege deliberate indifference to pain and medical needs, as well as inadequate access to medical treatment (Case 92).

In case 118, the Plaintiff alleges that they did not receive timely and adequate mental health care and medical staff engaged in deliberate indifference to medical needs. The Plaintiff, due to ongoing and serious mental health needs, is prescribed mental health medication and blood pressure medication, 3 times per day. The Plaintiff counted at least 40 days where they were only administered their medication 2 times a day and although the medical staff are supposed to visit their housing unit three times a day. In response to this non-compliance with prescribed dosage, over 7 months, the Plaintiff submitted hundreds of complaints with prison staff. The Plaintiff claims many others are also experiencing delay in care because of medical staff not following procedure, resulting in inmates going without their appropriate dosage of medications. This type of inaction by medical staff is impacting many inmates, resulting in inconsistent dosage, ineffective treatments, and increased medical risk (Case 118).

Regardless of their circumstances, individuals retain their fundamental human rights, including the right to healthcare. Providing medical care to prisoners upholds their dignity and recognizes their inherent worth as human beings. Further, timely access to medical care ensures that prisoners receive treatment for illnesses, injuries, or chronic conditions promptly, alleviating their suffering and preventing unnecessary pain or complications. Many of the Plaintiffs who argued their access to adequate medical care was impeded, also claimed that this was a violation of the cruel and unusual punishment clause of the Eighth Amendment.
Cruel and Unusual Punishment in Healthcare

The second deductive code was Cruel and Unusual Punishment in Healthcare (CUH). This code encompasses instances where healthcare practices or lack thereof were considered excessively punitive or inhumane. I applied this code when the complaint alleged that healthcare practices within a prison context, or the failure to provide care, were excessively punitive or inhumane, potentially violating constitutional rights. If the Plaintiff wrote the words cruel and unusual punishment or referred to the defendant’s action or inaction as an Eighth Amendment violation it fit the inclusion criteria. Cruel and unusual punishment in healthcare within the context of prisons refers to situations where incarcerated individuals are subjected to inadequate, substandard, or deliberately withheld medical care, resulting in unnecessary suffering, harm, or even death.

For example, in case 3, the Plaintiff argues that they were denied medical treatment after “falling and hitting their head and then having two seizures” (p. 6). After the incident, they were never evaluated and were left to experience “strong and extreme head and chest pains” (p. 7) and prolonged medical issues. This case exemplified cruel and unusual punishment through the denial of access to medical care and was coded into both categories (Case 3).

In case 30, the Plaintiff argues the “Eighth Amendment of the United States Constitution” (p. 5) was violated when the hospital and doctor failed to protect them from cruel and unusual punishment by “unnecessarily performing a hernia operation and also being deliberately indifferent by unnecessary and wanton infliction of pain” (Case 30, p. 8).
Another way this was present in this sample was through the neglect of chronic conditions. Prisoners with chronic health conditions, such as diabetes, hypertension, or HIV/AIDS, may not receive the ongoing monitoring, medication, or lifestyle management needed to manage their conditions effectively. Without proper care, these conditions can worsen over time, leading to complications and diminished quality of life. Some plaintiffs argued that their treatment for chronic conditions was stopped or interrupted upon their intake to the prison facility or at random points during their incarceration.

In case 33, the Plaintiff argues they were denied access to treatment for a pre-existing hepatitis C diagnosis upon incarceration. They alleged that they were undergoing care for a chronic disease prior to incarceration and the care was refused upon transfer into the new facility. This caused symptoms to worsen and unnecessary pain and suffering (Case 33).

Additionally, this code was represented in this study through the neglect of mental health disorders. Inmates with mental health disorders may be particularly vulnerable to mistreatment or neglect, as their conditions may be stigmatized or misunderstood. Failure to provide appropriate mental health treatment, including counseling, therapy, and psychiatric medications, can exacerbate symptoms, increase the risk of self-harm or suicide, and contribute to a cycle of deteriorating mental health.

For example, one Plaintiff argued that their right to adequate mental health care was infringed upon when they were not provided mental health treatment and/or medication. Within their complaint they note “systemic problems” in the delivery of mental health care and deliberate indifference to mental health concerns in their facility (Case 50, p. 2).
In another case, the Plaintiff argues that they were not able to access adequate care or treatment for their mental health issues. The defendant had been previously prescribed Prozac but upon incarceration, they were prescribed another similar but different drug. The prescribed drug did not work for them and they were experiencing adverse side effects. On a medical visit they requested a specific prescription that works for them but was told that Prozac “costs too much money and that their company (redacted for privacy purposes) wouldn't pay for the Prozac, even if it worked better” (p. 4). As a result, medical continued to dispense the medication that caused adverse health effects (Case 63).

Often, prisoners may receive substandard or inferior healthcare compared to the general population, characterized by delayed appointments, inadequate diagnostic testing, limited treatment options, or inadequate follow-up care. This disparity in care quality can contribute to poorer health outcomes and diminished well-being among incarcerated individuals. Sometimes, the quality of care may be impacted by social constructions of incarcerated persons.

In case 46, the Plaintiff outlines that a medical mistake was made by prison staff, with no accountability or follow up care. The Plaintiff started having seizures, which they had a history of and is noted in their medical chart. The medical staff responded, assumed they were having a drug overdose and treated them for a drug overdose with narcan. The administration of Narcan, which created additional symptoms and adverse side effects, then was given benadryl to counteract the Narcan. The assumption that they were using
drugs affected their medical care and potentially their security status, good time credits and release date. The Plaintiff argues this is cruel and unusual punishment (Case 46).

*Right to Privacy in Medical Treatment*

Another deductive code utilized in this study was Right to Privacy in Medical Treatment (RPR). In the United States, inmates have limited rights to privacy regarding their healthcare information compared to individuals outside of correctional facilities. However, they still have some protections under the Health Insurance Portability and Accountability Act (HIPAA) and other regulations. When it comes to inmates, HIPAA allows for the disclosure of certain medical information to correctional facilities' healthcare staff for the purpose of providing healthcare to the inmate. This includes diagnosis, treatment plans, medications, and other relevant medical information necessary for the inmate's care (Health Insurance Portability and Accountability Act of 1996). HIPAA also requires covered entities to implement safeguards to protect the privacy of individuals' healthcare information. This means that while information can be shared within the correctional facility's healthcare system, it should be limited to those directly involved in the inmate's care.

To prevent the disclosure of private medical information to other inmates, correctional facilities typically have their own policies and procedures in place. Despite these safeguards, there are instances where inmates' medical information may need to be disclosed for legal or safety reasons, such as in cases of infectious diseases or emergencies. In such cases, the disclosure is typically limited to the minimum necessary information required to address the situation (Health Insurance Portability and Accountability Act of 1996).
The right to privacy is implicitly protected by the Fourth Amendment to the United States Constitution, which safeguards individuals from unreasonable searches and seizures. Violating prisoners' privacy rights in healthcare undermines their constitutional protections and erodes trust in the justice system. This code was applied when the Section 1983 filing outlined violations related to the privacy of medical information and treatment. I used this code when the complaint pertained to breaches of privacy concerning medical information or treatment within the prison system or when their confidential medical information was improperly accessed, disclosed, or exploited without their consent. For example, I apply this code when correctional staff or other individuals access prisoners' medical records without a legitimate medical or administrative reason. This breaches the confidentiality of patients' health information and violates their right to privacy. In this study there were two examples of the inappropriate disclosure of medical information.

In case 44 the Plaintiff's allegation notes that medical information regarding their chronic condition and the accommodations for it were improperly disclosed to third parties not involved in patient care. In this study specifically, the medical information was shared with non-medical jail staff and inmates which caused the patient's medical information to be spread around the jail facility. Plaintiff argues that the actions were a violation of right to privacy and H.I.P.A.A resulting in other inmates being informed of private medical details (Case 44).

Prisoners with certain medical conditions, such as HIV/AIDS, mental illness, or substance use disorders, may face stigma, discrimination, or mistreatment based on their health status. This can result in denial of medical care, isolation from other inmates, or punitive
measures, exacerbating their health outcomes and perpetuating cycles of marginalization. Further, prisoners may be coerced or pressured into disclosing sensitive medical information, such as their HIV status, mental health history, or substance abuse treatment, against their will. This violates their right to autonomy and confidentiality in healthcare decision-making.

In case 61, the Plaintiff argues they were forced to share their STD status to obtain necessary medical treatment when the status was irrelevant to the request for care. The Plaintiff alleged that they did not receive adequate and appropriate medical care and they were prescribed medication without being informed it was supposed to be taken in conjunction with another medication. This failure to treat the correct medical issue and provide appropriate medical instruction for medication led to prolonged hospitalization. They note they felt they were forced to tell people, other than the medical team, about their medical history so that he could get the appropriate medical care (Case 61).

While there were only two obvious examples of violations related to the right to privacy in medical treatment, it is concerning because it can lead to stigma, discrimination, or retaliation against the individual, by inmates, and poses risks to their safety and well-being in the jail. Breaching prisoners' privacy in healthcare can have broader public health implications by discouraging individuals from seeking medical care, disclosing sensitive and pertinent health information, or participating in health-related programs within correctional facilities. Protecting the privacy rights of incarcerated persons promotes trust, transparency, and collaboration in healthcare delivery, ultimately benefiting the health and well-being of incarcerated individuals and society at large.

**Informed Consent**
The fourth deductive code utilized in this coding process was Informed Consent (INCS). This code was used when the Section 1983 complaint outlined violations involving the lack of proper informed consent in medical procedures or treatments. This code was applied when the complaint raises concerns about the absence of proper informed consent in medical procedures or treatments for prisoners. Informed consent violations related to healthcare for prisoners occur when individuals are subjected to medical treatments, procedures, or research without their full understanding or voluntary agreement. In some cases, prisoners may be coerced or forced to undergo medical treatments, procedures, or research studies against their will or without fully understanding the potential risks, benefits, and alternatives.

In one case, the Plaintiff alleges they did not consent to medical procedures used against them. Specifically, the Plaintiff was unwillingly injected with anti-psychotic medications after stating “he did not consent to medical treatment numerous times, to both medical staff and officers” (p. 2, Case 114).

Healthcare providers may fail to provide prisoners with sufficient information about the nature of proposed treatments, procedures, or research studies, including potential risks, benefits, side effects, and alternatives. Without adequate disclosure, prisoners cannot make informed decisions about their healthcare, leading to uninformed consent or consent obtained under duress.

For example, in case 112, the Plaintiff argues that they were not told about the side effects of a drug before they were prescribed it and while they were taking it. The filing notes, “the doctors who prescribed lisinopril (prinivil-zestril) to me fully knew the side effects but prescribed it to me without telling me the side effects verbally and/or in stated & signed print as required by law” (p. 2). Therefore, the Plaintiff could not make an
informed decision about whether or not to take the specified drug or a “less consequential drug.” (Case 112).

Additionally, prisoners may be misled or deceived about the nature, purpose, or consequences of medical treatments, procedures, or research studies. This can involve withholding information, providing false information, or misrepresenting the potential outcomes to obtain consent.

For example, in one filing, the Plaintiff alleges that although they do have a history of serious mental illness (SMI), they are being forced into a “Secure Diversionary Treatment Program” for seriously mentally ill offenders. In this extremely restrictive program, offenders are kept in isolation. The Plaintiff reports being kept in isolation for 18 months although the state Department of Corrections policy outlines that someone who has an SMI cannot be kept in isolation for more than 28 days at a time. They claim they were not allowed to consent to or deny participation in the mental health treatment they were forced into. The Plaintiff claims a violation of informed consent for medical treatments and argues this was a violation of the Plaintiff's 8th and 14th Amendment rights, as well as deliberate indifference to inmates' medical needs (Case 96).

Although there were only three cases where the allegation involved violations of informed consent in medical treatment, it is important to acknowledge that deceptive practices undermine trust in the correctional system as a whole and harm the individuals who experience them. Prisoners are inherently vulnerable due to their confinement and dependence on correctional authorities for essential services, including healthcare and prisoners may have
limited access to independent advocacy or legal representation to help them understand their rights, navigate complex healthcare decisions, and challenge informed consent violations. This lack of support further undermines prisoners' ability to make informed choices about their healthcare and advocate for their best interests. This vulnerability can make them susceptible to coercion, manipulation, or undue influence when consenting to medical interventions or research participation, particularly if they fear retaliation or adverse consequences for refusing.

**Discrimination in Healthcare**

The fifth deductive code utilized in this study was Discrimination in Healthcare. Discrimination-related civil rights violations in healthcare against prisoners occur when individuals are treated unfairly or unequally based on their status as incarcerated persons, leading to disparities in access to healthcare services, quality of care, or treatment outcomes. This code was applied when the Section 1983 filing outlined a violation or violations based on discriminatory practices in the provision of healthcare services to an incarcerated person. I used this code when the complaint alleges discrimination in the provision of healthcare services within the prison context. Not only are there domestic rules and laws regarding discrimination in the administration of healthcare services to incarcerated persons, various international human rights instruments, such as the Universal Declaration of Human Rights and the Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), affirm the right of prisoners to receive healthcare without discrimination.

Discrimination in healthcare can take many forms, such as denial of care or treatment. Prisoners may be denied access to necessary healthcare services, including medical evaluations, treatments, medications, or surgical procedures, based on their incarcerated status. This denial of care can result in the worsening of health conditions, increased suffering, or preventable harm.
For example, in case 19, the Plaintiff argues they were denied medical care and medication by a nurse, and were prohibited from seeing a licensed doctor for their illness. Further, Plaintiff argues the health center was engaging in discrimination based on age because the doctor stated “it’s about age, if you're 50 or under, you're more than likely to receive it, if you’re 50 or older you're more than likely not going to receive it” (p. 14). In the filing, the Plaintiff claims other inmates have been harmed by the medical staff disregarding sick call requests and not administering medicine and argues some of them have died due to lack of medical attention (Case 19).

Further, prisoners may face barriers to accessing specialized healthcare services, such as care for disabilities, mental health treatment, substance abuse counseling, reproductive healthcare, or gender-affirming care. This unequal access can exacerbate existing health disparities and perpetuate systemic injustices within correctional healthcare systems. This study uncovered situations where prisoners with certain medical conditions, such as HIV/AIDS, mental illness, substance use disorders, or disabilities were segregated, isolated, or stigmatized within correctional facilities based on their health status. This segregation can result in social isolation, reduced access to supportive services, and discrimination in healthcare delivery.

Specifically with mental health related issues, case 14 showed that an inmate was put in segregation because of a mental health crisis and phobia resulting from a police dog attack. The segregation inevitably made the mental health crisis worse and the conditions were poor leading to respiratory problems. Initially they were prescribed mental health medication to help address their condition but “it was waay [sic] too strong” to the point that “the Plaintiff could not even function” (p. 6). The Plaintiff then asked for a “less
strong” medication, and it was not provided because medical staff alleged they were “just trying to manipulate to get a single cell” (p. 6). The Plaintiff argues deliberate indifference was taken by psychiatric staff regarding the need for medication for a mental health related issue and the lack of medication resulted in adverse behavioral actions of the Plaintiff that led to them being locked down in segregation, rather than being able to participate in a re-entry program. The filing requests some sort of accommodation that could allow them to manage their mental health condition, that would allow them to move out of segregation. The complaint alleges discrimination as a result of a mental health issue and failure to address a mental health issue (Case 14).

This study found that prisoners with disabilities may encounter barriers to accessing healthcare services, including physical, communication, or structural barriers that prevent them from fully participating in medical appointments, understanding treatment instructions, or receiving necessary accommodations. This lack of accessibility constitutes discrimination under the Americans with Disabilities Act (ADA) and compromises prisoners' rights to equitable healthcare access.

For example, in case 41, the Plaintiff was assaulted by other inmates and suffered a serious head injury. As a result, they were diagnosed with bilateral sensorineural hearing loss and were “fitted for a hearing aid and afforded access to auxiliary equipment to assist with communication” (p. 8). After this diagnosis, the inmate requested they be transferred to the Deaf, Hearing Impaired or Visually Impaired POD (housing unit) and requested approval to order (and pay for themselves) the hearing accommodation equipment. They were denied the ability to purchase accommodation equipment. The Plaintiff argues that
they were discriminated against because of their hearing disability and that they “were not provided the same disability accommodations as other similarly situated hard of hearing inmates” (p. 17). Further, there was lack of clear communication and proper instructions given to the inmate regarding how to file a request for a property adjustment due to their disability and the Plaintiff's internal grievances regarding the discrimination were never addressed (Case 41, 2020).

In case 77, the Plaintiff alleges that they were denied proper medical care and medical equipment which had been prescribed to them for 15 years prior to incarceration. In this case, the Plaintiff claims that the prison staff “violated the Plaintiff’s civil rights established under the Americans with Disabilities Act by having denied them proper medical treatment and supplies” (p. 8). The inmate was never provided the appropriate prosthetic shoes, a medical accommodation “which he had been prescribed for 15 years” (p. 7). The Plaintiff states they made medical requests with the proper paperwork for four years, and were forced to live in pain from not having the appropriate medical equipment (Case 77).

In case 110, (2023), the Plaintiff alleges staff did not abide by medical orders, forcing the Plaintiff to climb up and down stairs, when they were specifically not supposed to, due to a disability. While climbing the stairs to their bunk they fell as a result of “fatigue due to their disability and the exhaustion of the climb” (p. 9) staff not accommodating them for their disability and endangering their health and safety. As a result of this negligence, the Plaintiff “is experiencing pain and suffering (....) mental anguish, emotional distress, ptsd
and loss/difficulty sleeping” (p. 9). The complaint also mentions deliberate indifference and cruel and unusual punishment (Case 110).

Further, healthcare providers may hold biases or prejudices against prisoners, leading to differential treatment based on stereotypes, assumptions, or discriminatory attitudes. These biases can influence treatment decisions, patient-provider interactions, and healthcare outcomes, contributing to disparities in care delivery and patient experiences. In this study, there were complaints of racism, homophobia, and religious discrimination, as well as discrimination related to disability and physical ability.

In case 82, the Plaintiff was denied various medical visits and medical treatments, and released from medical treatment with untreated broken face bones, in the complaint he asks, ”I don’t know if it's because (1) I’m black, (2) a prisoner or (3) a black prisoner?? [sic]” (p. 9) (Case 82).

In case 95, Plaintiff argues discrimination against themselves as well as "many black Americans" by way of policy and procedure, in addition to multiple violent acts that caused injuries which were not immediately treated. Claims of Eighth Amendment Violations (Case 95).

**Serious Medical Condition**

While coding, one recurring emergent theme was the debate on what constitutes a “serious medical condition.” In the realm of prison healthcare, the determination of what constitutes a "serious medical condition" holds critical implications for the rights and well-being of inmates. The legislation requiring prison officials to determine whether an ailment from an
incarcerated person constitutes a "serious medical condition" typically falls within broader laws governing inmate healthcare rights. In *Estelle v. Gamble* (1976), the Court defined a serious medical need as one that has been diagnosed by a physician as requiring treatment or one that is so obvious that even a layperson would easily recognize the necessity for medical attention. While Estelle outlines the serious medical need standard, many courts have interpreted this differently. For example, one court held that a two-day delay in treatment of appendicitis caused pain sufficient to pose serious risk of harm (*Blackmore v. Kalamazoo County*, 2004), another ruled that a back condition that resulted in pain so serious it caused the incarcerated person to fall down sufficiently created a serious need (*Spruill v. Gillis*, 2004). In *Farrow v. West* (2003) pain, bleeding, and swollen gums of an incarcerated person who needed dentures were interpreted as a serious medical need. In *Boretti v. Wiscomb* (1991) held that even needless pain, that does not result in long term injury, should be considered serious and *Johnson-El v. Schoemehl*, (1989) ruled that a delay in medical care for a condition that is “painful in nature” is actionable. *Koehl v. Dalsheim*, (1996) found that loss of vision may not be “pain” but it is “suffering” and should be considered serious. *Monmouth Cnty. Corr. Inst. Inmates v. Lanzaro*, (1987) found that a medical need is serious if it imposes a life-long handicap or permanent loss. Inconsistencies in defining serious medical conditions can result in confusion for medical staff and improper or inadequate treatment for inmates. Without a standardized understanding of what constitutes a serious medical condition, healthcare providers may fail to prioritize certain health concerns or may misdiagnose conditions that require urgent attention. This can lead to delays in treatment, inappropriate medication regimens, or failure to provide necessary medical interventions, all of which violate the rights of inmates to receive adequate healthcare while incarcerated (Rich et al., 2015).
Moreover, inconsistency in defining serious medical conditions can exacerbate issues of inequity in carceral facilities. Inmates with similar medical issues may receive disparate levels of care based on the subjective interpretations of healthcare providers. This can disproportionately affect vulnerable populations within prisons, such as those with mental health disorders or chronic illnesses, leading to disparities in access to medical services and exacerbating health inequalities among inmates (Nowotny & Graves, 2017). These cases below illustrate discrepancies in what is considered a “serious medical condition” and how the discrepancies in the definition of “serious” result in individual harm. While these filings are reflective of the actions or inactions of prison staff, the confusion over what should be considered “serious” stems from a long history of case law.

In case 34, the Plaintiff argues deliberate indifference to medical needs after they fell, while incarcerated and obtained a shoulder injury. While working in the kitchen at the facility, the Plaintiff fell and their “collarbone and rotory cuff [sic]” were injured (p. 3). The Plaintiff argued this was a serious medical need that needed surgery, but it was not provided for 19 months. The delay in care brings up the concern regarding the discrepancy in what type of injuries are a "serious medical condition". The Plaintiff argued that their injury was serious but he did not receive appropriate or timely care, other than pain management (Case 34).

In case 64, the Plaintiff claims deliberate indifference to serious medical needs because medical care was refused to the inmate after they were sprayed with chemicals in their cell. In this case, the Plaintiff's water was also turned off in their cell, to prevent the
Plaintiff from rinsing their own eyes. According to the Plaintiff, after they made multiple requests for sick call, asked to be escorted to take a shower, they were told by staff that they would relay the message to request care for the Plaintiff but never did. This incident compounded on the pre-existing eye problems, migraines that the Plaintiff was experiencing and not receiving appropriate care for. The Plaintiff alleges they should have been prescribed protective eyewear due to their sensitivity to light and other optometric ailments, but was not. The Plaintiff requested multiple medical visits regarding their eye injuries and eye diseases, and they were not addressed. The Plaintiff also outlines they repeatedly requested care for a hand injury that was never adequately addressed. The Plaintiff goes further to claim that the staff maliciously did not respond to the serious medical need (Case 64).

Further, in case 82, the Plaintiff alleges “deliberate indifference to my very serious medical needs” (p. 2) and “deliberate indifference to my serious dental needs” (p. 2), by refusing to prescribe pain medication on several occasions, “intercepting and trashing their grievance receipts, therefore hindering their attempts to resolve their medical complaints” (p. 7) and by “refusing to send the Plaintiff out for necessary outside treatment” (p. 8). In addition, “denied their yearly flu shot” (p. 7) (Case 82).

In case 99, the Plaintiff alleges their constitutional rights were violated when they did not receive medical care and were discriminated against because of their disability. The Plaintiff is partially paralyzed, has a brain injury and was already malnourished at the time of their filing. They report that in an emergency grievance they wrote, “I'm in pain.
My head is banging and my stomach is turning. I can’t stop defecating. I’m weak and dizzy all the time. I’m sneezing blood. I’m hungry but the food on the trays causes me to defecate through the night” (p. 4). The staff nurse responded to the grievance “deeming it not to be an emergency” (p. 4). The Plaintiff also outlines other similar instances where they ask for dietary adjustments due to illness and they were denied. Further, because of the Plaintiff’s paralysis, they were ordered to receive physical therapy. Access to these sessions was inconsistent for ten months, and then abruptly terminated because their “condition would not improve any further” (p.3). Treatment and care was limited after this termination, despite ongoing pain and physical struggles (Case 99).

While *Estelle* contributed to shaping the legal understanding of what constitutes a "serious medical condition," there have been many court rulings that convolute the definition. In the context of incarceration, the burden of determining what is and is not a “serious medical condition” in any given circumstance is placed on correctional facility staff. This seems to be creating uncertainty and inconsistencies in who gets care or how swiftly that care is administered. When there is a lack of consistency among nurses and medical staff regarding this definition, it can result in severe civil rights violations as seen above. This inconsistency can manifest in several ways, including denial of medical care, improper treatment, and neglect, ultimately undermining the constitutional rights of incarcerated individuals.

*Deliberate Indifference*

Another emergent theme was the constitutional concept of “deliberate indifference”. The deliberate indifference code was applied when the complaint outlines defendants’ “deliberate indifference” to Plaintiff’s serious healthcare needs. I used this code when the complaint includes
claims of “deliberate indifference” or the Plaintiff argues that the prison officials or healthcare providers were aware of an inmate's serious medical condition or substantial risk of harm but consciously disregarded or failed to respond to it. Deliberate indifference, as defined by legal precedents and healthcare ethics, refers to a situation where healthcare providers are aware of a serious medical need but consciously disregard or fail to address it (Estelle v. Gamble, 1976).

Correctional staff or healthcare providers may demonstrate deliberate indifference to prisoners' medical needs, ignoring or downplaying their complaints or symptoms, delaying or denying necessary treatment, or providing care that falls below accepted medical standards. In the context of prison healthcare, deliberate indifference by nurses and medical staff can have profound implications for the civil rights of incarcerated individuals.

In one case, the Plaintiff argues that prison staff engaged in deliberate indifference by not prescribing a medical sleep aid to assist with insomnia. The Plaintiff alleges that the defendant lied to them about their scope of practice when they told them “they don’t treat sleep” (p. 5). The failure to treat lack of sleep, coupled with claims of malnutrition, resulted in physical, emotional and mental distress (Case 45).

In case 60, the Plaintiff alleges that defendants engaged in deliberate indifference and their right to adequate medical care was violated after the medical staff caused injury to the plaintiff, while placing an intravenous needle that caused the Plaintiff's arm to swell up and change colors. The doctor noted that they could be treated for the arm injury back at the correctional facility, but when they arrived they were denied care. Further, once the CT scan was completed, the specialist referred the Plaintiff to an oral surgeon but staff claimed that “they were only eligible for extractions” (p. 7) which could be done within
the correctional institution. Referrals for follow up specialty care were denied by prison doctors. Eventually two teeth were extracted, leaving the Plaintiff with pain, trouble eating and headaches. Comprehensive and effective care was denied to the Plaintiff (Case 60).

In case 98, the Plaintiff argues their Eighth Amendment rights were violated by being repetitively exposed to secondhand smoke, even after they had requested to be removed from the environment that caused it because of a pre-existing medical issue. Plaintiff’s medical concerns were not addressed, and they were continuously exposed to the smoke, contributing to pain and suffering of the victim, including labored breathing and rapid increase in heart rate, showing “deliberate indifference” (p. 4) to medical need.

In case 109, the Plaintiff alleges deliberate indifference via inadequate and untimely medical care. The Plaintiff complained to medical about a rash on their abdomen and thighs and was not seen or treated for 6 months. The complaint outlines “deliberate indifference to Plaintiff’s and other inmates' rights to medical care” (p. 6).

When healthcare providers disregard medical protocols, neglect follow-up care, or administer medication inappropriately despite being aware of an inmate's medical condition, they violate the inmate's right to receive medically necessary treatment. When nurses and medical staff exhibit deliberate indifference by ignoring or downplaying inmates' medical complaints or failing to provide timely and adequate treatment, they foster an environment where neglect and maltreatment thrive. This can include delayed responses to medical emergencies, failure to
provide essential medications, or neglecting to monitor chronic health conditions, all of which violate the rights of inmates to receive humane and adequate medical care (Venters & Mellow, 2019).

**Lack of Communication**

Another emergent theme uncovered in the filings was “Lack of Communication”. In this study, "Lack of Communication" was present when the complaint outlined that the defendants did not communicate to the inmate their responsibilities in obtaining or paying for their own medical care. I used this code when the complaint included claims of “lack of communication” or “mis-information” given by facility staff or defendants and the lack of accurate communication resulted in the inmate not receiving the care they needed. The presence of this theme in the complaints is concerning because incarcerated individuals rely heavily on medical staff and nurses within prison facilities for their healthcare needs. When nurses and medical staff fail to communicate effectively with inmates regarding their health concerns or dismiss their complaints without proper assessment, it can lead to the denial of necessary medical care, improper treatment, and neglect, all of which infringe upon the constitutional rights of incarcerated individuals (Cruz v. Beto, 1972; Venters & Mellow, 2019).

In case 23, the Plaintiff alleges cruel and unusual punishment at the hands of medical staff for delay in medical treatment for a serious medical disorder that resulted in blindness. The Plaintiff filed a sick call regarding pain and blurriness in their eyes, and declining vision in their left eye. The nurse told them, they would see what they could do. Ten days later, they still had not been examined and had not received any care. When the Plaintiff filed another sick call, they were told that this was not an emergency and they needed to refer to the instructions they were given. The Plaintiff argues they were never
given any instructions. Eventually, once the condition worsened, the doctor told the Plaintiff that they would have to be referred to an outside doctor and they would have to pay for it themselves. The delay in medical treatment was the result of lack of communication from medical staff to the Plaintiff about how to obtain treatment for non-emergency care (Case 23).

In case 35, the Plaintiff argues medication was withheld for 60 days while they suffered physically from migraines. The Plaintiff wrote “there is no information available to inmates concerning the parties responsible, the forms to fill out” (p. 3). This filing notes a lack of communication from the facility regarding medical liability. They also note that the institutional handbook outline of policy is inadequate regarding who is liable for misconduct related to the dispersal of medication (Case 35).

In another case, the Plaintiff argues that the policies and procedures that the institution is abiding by are continually harming inmates. Further, there was lack of clear communication and no proper instructions given to the inmate regarding how to file a request for a property adjustment due to disability (Case 41).

One of the most significant repercussions of poor communication in prison healthcare is the denial of timely and adequate medical care to inmates. When nurses and medical staff fail to communicate effectively with inmates regarding their health concerns or dismiss their complaints without proper assessment, it can lead to the denial of necessary medical care (Cruz v. Beto, 1972). Without clear and thorough communication between healthcare providers and inmates,
there is a higher likelihood of misdiagnosis, incorrect administration of medication, or failure to provide necessary follow-up care. This not only compromises the health and well-being of the inmate but also violates their rights to receive appropriate medical treatment while incarcerated (Rich et al., 2015). It is imperative for prison healthcare systems to prioritize effective communication between healthcare providers and inmates to uphold the constitutional rights of incarcerated individuals and ensure their access to adequate medical care.

**Lack of Accountability**

Another emergent theme in the filings was “Lack of Accountability.” In this study, “Lack of Accountability” was present when the complaint outlines that defendants did not take responsibility for medical mistakes they made when diagnosing, providing care for, or the referral of medical need to proper authority within the facility. This code was applied when the complaint includes claims of “lack of accountability” by prison medical personnel or prison staff, when the defendant did not attempt to remedy their mistakes, the mistakes of their staff, and/or the defendant passed off the responsibility of their mistake onto the offender or another state actor. The presence of this theme is concerning because when healthcare providers fail to admit errors or take corrective action, inmates may receive inadequate or ineffective medical interventions, exacerbating their health conditions and compromising their well-being.

In case 27, the Plaintiff argues harm caused by a botched dental procedure and deprivation of medical needs of which the harm was compounded by lack of accountability on behalf of staff, blaming other staff for administering wrong medication. The Plaintiff alleges that the defendant stated, “I didn't pack it, I don't know anything, I just pass out medicine” (Case 27, p. 7).
In case 37, the Plaintiff argues that the defendant failed to adequately respond to their serious medical needs and did not take accountability for their medical mistakes. The Plaintiff reported that they were suffering from a severe rash outbreak from the uniform and linens. The doctor administered Benadryl and said they would order them a new uniform, linens and a medical blue blanket. After two days, the Plaintiff never received the new items and the Plaintiff discovered that the order was never placed for the new uniform, linens or blanket. The rash outbreak continued to worsen over the next two days resulting in another trip to medical. The doctor on duty did not check the patient's vitals, but ordered the Plaintiff to be put in isolation in a cell in which the “living conditions was [sic] for below human standard” (p. 13) (even though the outbreak was not contagious if it was indeed an allergic reaction). Early the next day, the Plaintiff awoke to their “entire body inflamed like I was in a hot oven about to cook, with chemical burns on various parts of my body. I was fighting hard to live” (p. 7). When the correctional officer arrived at their cell in the morning, they noticed the “horrific” medical state of the Plaintiff and said “he would contact medical as an emergency” (p. 8). The Plaintiff did not receive medical care for four more days. On a third trip to medical, the Plaintiff was given “worm care”. The worsening of the rash and prolonged suffering, as well as mandated isolation, was due to the infection not being treated correctly initially. The complaint notes that the defendant would not take accountability for their medical mistakes, “she will do anything to cover-up their medical negligence as far as to hurt someone else” (Case 37, p. 9).

In case 38, the Plaintiff argues that living conditions were below human standard, mental health services are not being provided adequately, and emergency medical needs were not
responded to in a timely manner. The Plaintiff argues they “turn [sic] in 22 sick calls and was not seen to renew medication” (p. 9), and that the “Disability Rights of Md and the ACLU came into this institution and warned you about this and again you assured them you would change your behavior and work on these issues and you didn't and haven't. The lack of accountability is right here in front of you” (Case 38, p. 10).

In case 106, the Plaintiff alleges that their psychiatrist failed to provide adequate and appropriate medical care for deficient iron levels, despite being aware of the dangers of low iron. Further, when other medical staff were informed about the dangerous iron levels, the complaint notes they “want the prescribing psychiatrist to fix it because he started it” (p. 3) did not make the effort to remedy the issue. Instead of providing an alternative prescription that would be safer for the Plaintiff, the defendant told the Plaintiff to “stop all pain meds that go through my liver, and as a result, I’ve had to suffer through major pain from my other injuries” (p. 3).

Improper treatment due to lack of accountability not only violates the rights of inmates to receive medically necessary care but also undermines the integrity of the prison healthcare system. When nurses and medical staff evade responsibility for medical errors, it perpetuates a culture of impunity where substandard care and negligence become normalized. Inmates may suffer avoidable harm, including exacerbation of medical conditions, preventable complications, or even death. Further, when wardens or supervisors fail to hold their staff accountable for grievances, mistakes, or malpractice allegations, they foster a culture that perpetuates harm against inmates.
Financial Barriers

Another emergent theme in the filings was “Financial Barriers.” In this study, “Financial Barriers” was present when the complaint outlines some sort of financial related barrier to receiving healthcare services. I used this code when the complaint included claims of financial related barriers to accessing or receiving adequate healthcare services. All of the filings where this code was present also fell into the Access to Medical Care (AMC) coding category. Types of financial barriers are mandatory medical copayments, directions to seek “outside” care that the inmate cannot afford, or inmate medical debts being applied to their prison account causing other medical or health related issues. It was important to include this as an emergent theme, because financial barriers such as copayments, medical debts, and the obligation to pay for medical care outside the prison system often impede access to healthcare for incarcerated people. These barriers not only exacerbate existing disparities in healthcare access but also constitute a violation of inmates' constitutional rights.

Financial barriers to healthcare access effectively erect obstacles between inmates and necessary medical treatment, leading to delays or denials of care, potentially violating a person’s civil rights. Copayments, for instance, require inmates to pay a fee for each medical visit, medication, or service received. While seemingly innocuous, these fees can quickly accumulate, especially for individuals with limited or no income. For inmates already struggling with poverty, paying copayments may force them to forgo necessary medical care or prioritize other basic needs, thus endangering their health and well-being.

For example, in case 10, the Plaintiff argues medical co-pays have prevented them from receiving medical care over a span of 11 years. The Plaintiff notes that “I had a medical condition that required medical attention, when I went to see the nurse in the medical
department of the prison the nurse informed me that I had to fill out a sick call request and to also pay 5.00 dollars to be seen (...) if I wanted any treatment then I needed to sign a consent to the assessment of a 5.00 dollar co-pay to my prison trust-fund account or I would not be seen. I was also informed that if I didn't have the 5.00 dollars to pay “at the time of treatment” then a fee of 5.00 would be lodged against my account until it was available” (p. 5). A medical fee of 5.00 was charged if the inmate filed a sick slip and a medical fee of 7.00 was charged if the inmate filed for an emergency call. The Plaintiff has multiple chronic medical conditions that have caused them to accrue $402.00 in medical fees levied against their account. He cannot pay them because he makes only $2.80 a week and only gets to keep $2.00 of that. This medical debt has prevented them from being able to buy hygiene products, canteen products and utilize their financial account. In order to survive, the Plaintiff has been forced to barter and trade for the supplies they need, which has resulted in them being charged with rule violations and fined for those as well (Case 10).

In another case, the Plaintiff argues that they were not able to access adequate care or treatment for their mental health issues. On a medical visit they requested a specific prescription that works for them but was told that Prozac “costs too much money and that their company (redacted for privacy purposes) wouldn't pay for the Prozac, even if it worked better” (p. 4). As a result, medical continued to dispense an alternate medication that caused the Plaintiff adverse side effects (Case 63).
In case 23, the Plaintiff alleges cruel and unusual punishment at the hands of medical staff for delay in medical treatment for a serious medical disorder that resulted in blindness. The Plaintiff filed a sick call regarding pain and blurriness in their eyes, and declining vision in their left eye. The nurse told them, they would see what they could do. Ten days later, they still had not been examined and had not received any care.

Eventually, once the condition worsened, the doctor told the Plaintiff that they would have to be referred to an outside doctor and they would have to pay for it themselves. When they stated they did not have the money to pay for care, they were told they would have to get a family member to pay for the cost of outside care. Thus, the Plaintiff claims that necessary medical care was withheld due to funds (Case 23).

In case 108, the Plaintiff argues they were not given the appropriate instructions regarding how to get shoes with the medically prescribed arch supports and had to pay additional copays to get approved for the shoe profile, even though their prior medical shoe profile was supposed to be “permanent.” Then, when they were finally approved to order new shoes, the defendant(s) “denied to sign off on a Plaintiff’s inmate withdraw [sic] account form to verify did Plaintiff have enough funds to order their shoes that was [sic] authorized by defendant” (p. 7) for their medically prescribed shoes. Although this was a necessary medical accommodation, the Plaintiff was willing to pay for these shoes on their own, but they were not allowed to by the defendant(s). The complaint outlines that in addition to many medical complaints being ignored by medical staff, allowing staff to impose financial decisions on behalf of the defendant, preventing the inmate from ordering specialty medical shoes that were deemed necessary to prevent continued and
increasing pain and injury, the defendant(s) engaged in deliberate indifference to serious medical needs (Case 108).

Similarly, the burden of medical debts incurred during incarceration can persist long after release, creating financial hardships and limiting access to healthcare in the community. Inmates may be saddled with substantial debts for medical services received while incarcerated, further entrenching cycles of poverty and exacerbating existing healthcare disparities. Moreover, the requirement for inmates or their families to cover the costs of seeking medical care outside the prison system places an undue financial burden on already marginalized individuals. This obligation effectively denies access to specialized or emergency medical treatment that may be unavailable within the prison healthcare system, perpetuating inequalities in healthcare access and outcomes.

Financial barriers to healthcare access in prisons not only violate inmates' constitutional rights but also perpetuate systemic injustices. By disproportionately affecting economically disadvantaged individuals, these barriers exacerbate existing disparities in health outcomes along socioeconomic lines. Furthermore, they undermine the rehabilitative goals of the criminal legal system by hindering inmates' access to necessary medical treatment, which is essential for their physical and mental well-being.

Differences in Nature of Complaints pre- and post-COVID-19 onset

The second aim of the first research question was to explore the differences in the nature of complaints prior to the COVID-19 pandemic, during the pandemic and after the height of the pandemic (“post”-COVID-19 onset). To do this, I examined 47 Section 1983 complaints that were filed with the Fourth Circuit Court before the onset of COVID-19 and compared those with
73 Section 1983 complaints that were filed with the Fourth Circuit Court after the onset of COVID-19 (after March 2, 2020). The pre-COVID-19 numbers include filings that were populated in the case search on PACER as being filed between January 1, 2018 and March 1, 2020. The post COVID-19 numbers include filings which were populated in the case search on PACER as being filed after March 2, 2020 through December 31, 2023. The PACER system filing date was the recorded filing date with the United States Fourth Circuit Court, not the date that the original complaint was sent to the district court.

When examining the data for the most common healthcare-related constitutional violation in the pre-COVID-19 filings I found that denial of access to medical care was the most common \( (n = 43/47) \) violation, with 92 percent of the pre-COVID-19 sample fitting the conditions for AMC. 79 percent of the pre-COVID-19 sample fit the conditions for cruel and unusual punishment \( (n = 31/47) \) and just 9% fit the parameters discrimination in healthcare \( (n = 4/47) \). Interestingly, when comparing the pre and post-COVID-19 onset data for the most common healthcare-related constitutional violation I found that the prevalence of denial of access to medical care in the post-COVID-19 complaints was exactly the same as the pre-COVID-19 rate (92%) and again, was the most common violation alleged in the filings \( (n = 67/73) \). Regarding the filings in the post-COVID-19 onset sample, just over half of the filings (53%) fit the parameters for cruel and unusual punishment \( (n = 39/73) \) which is much lower than the pre-COVID-19 rate. There were smaller numbers for both the right to privacy in healthcare and informed consent. There was only one case filing relevant to right to privacy in the pre-COVID-19 sample \( (n = 1/37) \) and only two in the post-COVID-19 sample \( (n = 2/73) \). Further in the pre-COVID-19 sample, there were no filings related to informed consent but in the post-COVID-19 sample there were 3 \( (n = 3/73) \). Interestingly, the frequency of filings related to
discrimination in healthcare were different. Pre-COVID-19 there were only 4 cases in the sample related to discrimination in the provision of healthcare services \( (n = 4/47) \) but post-COVID-19 there were eleven \( (n = 11/73) \). The nature of the complaints pre and post-COVID-19 were not drastically different but there were some interesting nuances which will be examined in detail in the discussion section (see figure 6).

![Figure 6](image)

**Figure 6.**
Nature of Constitutional Rights Violations Pre and Post Covid-Onset (Deductive)

<table>
<thead>
<tr>
<th>Type of Constitutional Violation Alleged in Filing</th>
<th>Pre-COVID</th>
<th>Post-COVID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Medical Care</td>
<td>43</td>
<td>67</td>
</tr>
<tr>
<td>Cruel and Unusual Punishment</td>
<td>31</td>
<td>39</td>
</tr>
<tr>
<td>Right to Privacy</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Discrimination in Healthcare</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

*Note.* Figure 6 compares the nature of the Section 1983 filings pre- and post COVID-19 onset for each deductive coding category: Access to Medical Care (AMC), Cruel and Unusual Punishment in Healthcare (CUH), Right to Privacy in Medical Treatment (RPR), Informed Consent (INCS), Discrimination in Healthcare (DISC-HC). Pre-COVID-19 numbers include filings that were populated in the case search on PACER as being filed between January 1, 2018 and March 1, 2020. Post COVID-19 numbers include filings
that were populated in the case search on PACER as being filed after March 2, 2020 through December 31, 2023.

During the inductive coding phase, I found a few differences in the nature of the Section 1983 complaints. This prompted me to create more nuanced inductive codes, in an effort to capture more context from the written documents. Out of the 47 filings collected pre-COVID, over half (60%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 28/47)\) and 34 percent of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 16/47)\). Only a few of the case filings fell into the three other emergent theme categories. Seven met the criteria for Lack of Accountability \((n = 7/47)\), two filings fit the criteria for Lack of Communication \((n = 2/47)\) and three fit the criteria for Financial Barrier \((n = 3/47)\).

When examining the 73 filings that were collected in the post-COVID-19 onset category, almost half (49%) of the filings were related to/met the criteria for Deliberate Indifference \((n = 36/73)\) and 32% of the sampled filings the Plaintiff argued there was some sort of confusion or disagreement regarding what constitutes a Serious Medical Condition \((n = 24/73)\). Only a few of the case filings fell into the three other emergent theme categories. Five met the criteria for Lack of Accountability \((n = 5/73)\), five filings fit the criteria for Lack of Communication \((n = 5/73)\) and two fit the criteria for Financial Barrier \((n = 2/73)\). Further, while coding the 2020-2023 data, I started noticing a few Section 1983 complaints regarding COVID-19. Thus, the code COV was applied when the complaint outlines some sort of healthcare-related grievance related to the spread of COVID-19 or COVID-19 related protocols. I use this code when the complaint includes claims of healthcare or correctional staff engaging in actions that increased the risk of
contracting COVID-19 or spread of COVID-19, or failure to respond appropriately to COVID-19 related medical needs of inmates. Out of the 73 post-COVID-19 onset filings, only 5% were related to COVID-19 ($n = 4$) (see Figure 7).

![Figure 7](image-url)

**Figure 7.**
Nature of Constitutional Rights Violations Pre and Post Covid-Onset (Inductive Codes)

*Note.* Figure 7 illustrates the differences in the nature of the Section 1983 complaints pre and post-COVID-19 onset: Serious Medical Condition (SMC), Deliberate Indifference (DELIB), Lack of Communication (LOC), Lack of Accountability (LOA), Financial Barrier (FIN), COVID-19 Related Complaint (COV). Pre-COVID-19 numbers include filings that were populated in the case search on PACER as being filed between January 1, 2018 and February 29, 2020. Post COVID-19 numbers include filings that were populated in the case search on PACER as being filed after March 1, 2020 through December 31, 2023.
**COVID-19 Related Complaints**

One emergent theme in the sample of post-COVID onset filings was “COVID-19 Related Complaint (COV)”. In this study, “COVID-19 Related Complaint” was present when the complaint outlines some sort of healthcare-related grievance related to the spread of COVID-19 or COVID-19 related protocols. I used this code when the complaint includes claims of healthcare or correctional staff engaging in actions that increased the risk of contracting COVID-19 or spread of COVID-19, or failure to respond appropriately to COVID-19 related medical needs of inmates.

The COVID-19 pandemic brought into sharp focus the challenges faced by incarcerated individuals in accessing healthcare within correctional facilities. One significant factor affecting inmates' healthcare access is the adherence of correctional staff to COVID-19 policies and procedures. Correctional facilities have a legal obligation to provide inmates with access to adequate healthcare, including measures to prevent and mitigate the spread of infectious diseases like COVID-19. When correctional staff fail to comply with these policies or when the policies themselves are inadequately implemented, the health and well-being of inmates are jeopardized, potentially violating their constitutional right to healthcare.

Incarcerated individuals are particularly vulnerable to the spread of infectious diseases like COVID-19 due to the congregate nature of correctional facilities and the inability to practice social distancing effectively. Thus, strict adherence to COVID-19 policies, including mask-wearing, regular testing, and isolation protocols, is crucial for mitigating the spread of the virus among inmates. This can result in untreated illnesses, exacerbation of existing medical conditions, and increased mortality rates among incarcerated populations.
When correctional staff fail to abide by these policies, they not only increase the risk of COVID-19 transmission within the facility but also undermine inmates' access to healthcare. For example, if staff members do not consistently wear masks or adhere to hygiene protocols, they may inadvertently introduce the virus into the facility, putting inmates and healthcare staff at risk. Moreover, lax enforcement of testing and isolation protocols can lead to delays in identifying and containing outbreaks, further compromising inmates' health and safety.

In one case, the Plaintiff argues prolonged suffering due to COVID-19. The main medical-related allegation is that the facility medical staff “did not adhere to the Centers of Disease Control (CDC) protocol (...) which plainly states for anyone administering tests to people to change gloves and sanitize hands before and after each person” (p. 10) causing the spread of the COVID-19 infection. In addition to the COVID-19 related concerns, the complaint outlines that multiple inmates were impacted by the staff’s failure to adhere to protocol. Further, the filings outline that “this facility has no medical ward for any kind of illness, they use a punitive segregation cell or cells, for observation” (p. 12) which meant that prisoners who were positive were transferred into punitive segregation cells. In this case, the Plaintiff feels that they would not have had to suffer prolonged medical problems if it weren't for the staff’s deliberate indifference to COVID-19 policies and the prolonged suffering from a medical and isolation standpoint was cruel and unusual punishment (Case 73).

In case 76, the Plaintiff argues multiple constitutional rights violations by prison staff for not providing care for COVID-19 symptoms. In this case, the Plaintiff notes, “I
contracted COVID-19 Coronavirus, I required testing, to see a doctor and receive
treatment for the symptoms and did not receive any treatment upon “extreme” amounts of
request” (Case 76, p. 6).

In case 113, the Plaintiff made multiple claims of cruel and unusual punishment and
deliberate indifference at the individual and institutional level. The main
healthcare-related complaint was that the staff are infecting inmates with COVID-19 via
“their saliva-spit sealed envelopes and papers” (p. 7) and other infectious diseases and
then refusing to provide medical treatment despite multiple requests for treatment (Case
113)

Furthermore, the implementation of COVID-19 policies within correctional facilities is
often fraught with challenges, including inadequate resources, overcrowding, and systemic issues
such as understaffing. When policies are inconsistently enforced or poorly implemented, inmates
may face barriers to accessing timely medical care for COVID-19 symptoms or other health
conditions. This can result in untreated illnesses, exacerbation of existing medical conditions,
and increased mortality rates among incarcerated populations.

In case 116, the Plaintiff argues they were denied timely access to medical care for a
knee injury (that was caused by unsafe conditions within the prison) and were told
“medical was not seeing anyone because of the COVID-19 virus” (p. 3). They were
provided tylenol for pain, but they were forced to go without a proper examination (MRI)
of the knee injury for 9 months resulting in long term pain and suffering (Case 116).
Although there were only four COVID-19 related filings in the sample, the filings in which this code was present were particularly interesting because of the novel and unknown nature of the virus (Asmundson & Taylor, 2020). Even prior to the onset of a worldwide pandemic, many prisoners face stress, anxiety and uncertainty regarding their legal status, safety, access to healthcare and resources, and relationships inside and outside of the correctional facility (Haney, 2018; Metzner & Fellner, 2010; Wright et al., 2012). Compared to the non-COVID related filings, there was a sense of uncertainty and urgency in the filings. All of the filings coded in this category noted or alluded to some sort of mental or emotional suffering by the Plaintiff or concern about the unknown consequences of the disease. In case 73, the Plaintiff addresses their concern with not only the short term consequences of contracting COVID-19 from correctional staff, but the long term and unknown consequences of the disease (which we now call long COVID). In case 76, the Plaintiff argued they required COVID-19 testing a treatment but were denied. In the injuries section of the filing, they wrote “extreme emotional distress and pain and suffering” (p. 6). This suffering was likely exacerbated by the pre-existing prison conditions and uncertainties of prison life, the consequences of quarantine policies on mental health of inmates and on staffing, widespread health concerns that arose from COVID-19, and the coincidence of COVID-19 with the already disadvantaged health of incarcerated people (compared to the general population). COVID-19 might have impacted staff’s actions and/or the willingness of incarcerated people to file complaints and may have impacted health services on a broad scale, even if the Plaintiff did not identify COVID-19 as being a factor in their complaint. For example, lack of staffing due to illness and staff burnout could have contributed to the constitutional rights violations that were uncovered in this analysis. By not adequately or appropriately addressing inmate concerns, addressing the staffing need, and not following newly
implemented health and safety protocols regarding the coronavirus, the health and safety of inmates was threatened.

Due to the time it takes to exhaust all institutional and state level grievances and the administrative and procedural hurdles that prolong the filing of a Section 1983 complaint, as well as the continuing spread and evolution of the COVID-19 virus, the small number (4) of COVID-related claims in the post-COVID-onset sample may be a function of time. In the 2024 filings, it is likely that we will see more COVID-19 related cases than in the first three post-COVID-onset years.

Frame Utilization

**RQ2: How do inmates frame the alleged violations in their Section 1983 filings and does this differ pre- and post-COVID-19 onset?**

The first aim of this research question was to explore whether inmates frame their complaint as an individual harm, structural, or an institutional harm. To do this, a latent content analysis grounded in framing theory was utilized to explore whether inmates framed their complaint as an individual harm, structural harm, or an institutional harm. I considered this aspect of analysis to be latent in nature because the Plaintiff’s did not specifically argue a harm “type.” I had to analyze the tone of the complaint, examine the information provided, and make a judgment call on their position or “frame.” I explain the specifics of what characteristics I looked for for each frame category in the section below.

This study uncovered that every single Section 1983 complaint between 2018 and 2023 was framed as an individual harm ($n = 120/120$). In addition to the emphasis on an individual harm, some of the Plaintiffs utilized what I am calling “dual frames” and “triad frames.” In these cases, the Plaintiff emphasized the institutional or structural harms as well as the individual
harm, employing two or three frames within one complaint. Out of the 120 filings, 21 were dually coded as individual harm and institutional harm and 7 utilized “tripad frames” where the Plaintiff framed their complaint as an individual harm, structural harm and institutional harm. None of the filings were dually coded as individual harm and structural harm. All 7 of the filings that were coded as employing a structural frame mentioned institutional practices and actors that were responsible for perpetuating the structural harms. This does not negate the importance of the framing as a structural harm, but awards insight into the manner in which structural and systemic issues can permeate institutions to impact incarcerated individuals’ healthcare access and quality.

In 2018, all of the filings were framed as an individual harm, thus that was the most commonly utilized frame to describe the nature of the constitutional violation, followed by institutional harm (50%), then structural harm (5%). There were 9 “dual frames” employed, where the Plaintiff argued the constitutional rights violation was both an individual harm and an institutional harm. There was one “tripad frame” where the Plaintiff framed their argument as an individual harm, institutional harm, and structural harm. There were a total of 10 filings that utilized multiple frames, the most of any year sampled (see Figure 8 and Figure 9).

In 2019, the most commonly utilized frame to describe the nature of the constitutional violation was individual harm, followed by institutional harm (10%). There were 2 “dual frames” employed, where the Plaintiff argued the constitutional rights violation was both an individual harm and an institutional harm. No Plaintiffs framed their complaints as a structural harm in 2019 thus there were no “tripad frames” utilized in 2019 (see Figure 8 and Figure 9).

In 2020, the most commonly utilized frame to describe the nature of the constitutional violation was individual harm, followed by institutional harm (25%) and structural harm (5%).
There were 4 “dual frames” employed, where the Plaintiff argued the constitutional rights violation was both an individual harm and an institutional harm. There was 1 “triad frame” where the Plaintiff framed their argument as an individual harm, institutional harm, and structural harm (see Figure 8 and Figure 9).

In 2021, the most commonly utilized frame to describe the nature of the constitutional violation was individual harm, followed by institutional harm (10%). There were 2 “dual frames” employed, where the Plaintiff argued the constitutional rights violation was both an individual harm and an institutional harm. No filings in 2021 framed their complaint as a structural harm therefore there were no “triad frames” (see Figure 8 and Figure 9).

In 2022, the most commonly utilized frame to describe the nature of the constitutional violation was individual harm, followed by institutional harm (10%), then structural harm (5%). There was one “dual frame” employed, where the Plaintiff argued the constitutional rights violation was both an individual harm and an institutional harm and there was one “triad frame” where the Plaintiff framed their argument as an individual harm, institutional harm, and structural harm (see Figure 8 and Figure 9).

The filings from 2023 had more filings with triad frames, than any other year. The most commonly utilized frame to describe the nature of the constitutional violation was still individual harm, but 7 were also framed as an institutional harm (35%) and 4 were framed as a structural harm (20%). There were 3 “dual frames” employed, where the Plaintiff argued the constitutional rights violation was both an individual harm and an institutional harm. There were 4 “triad frames” where the Plaintiff framed their argument as an individual harm, institutional harm, and structural harm (see Figure 8 and Figure 9).
Note. Figure 8 shows the number of Section 1983 filings that met the criteria for each deductive frame category related to the ways in which Plaintiffs characterized the nature of constitutional rights violations in their Section 1983 complaints, by year. Categories were: Individual Harm, Structural Harm, Institutional Harm.
Note. Figure 9 shows the number of filings that employed multiple frames to characterize the nature of harm against them. Categories were: Individual Harm, Structural Harm, Institutional Harm. “Dual Frames” employed both strategies that emphasized individual harm as well as institutional harm, “Triad Frames” employed strategies that emphasized all types of harm.

In order to explore how inmates frame their Section 1983 complaints and whether or not there was a difference in their framing, pre and post-COVID-19 onset, deductive codes were formed. With these codes, I aimed to examine whether inmates frame their complaint as an individual harm, structural harm, or an institutional harm.

**Individual Harm**

In framing a healthcare-related Section 1983 complaint as an individual harm rather than a structural or institutional one, an inmate would focus on their personal experience and the specific ways in which they've been affected by inadequate healthcare treatment. In this study, the code for Individual Harm was applied when the Section 1983 complaint was framed as individual harm/targeted harm. I applied this code when the complaint specifically highlights individual or targeted harm suffered by a person (likely themselves) within the prison system.

For example, the inmate could provide a detailed account of their interactions with healthcare staff, treatments received (or lack thereof), and the consequences for their health. By emphasizing their own suffering, they highlight the individual harm caused by state actors’ failures. The Plaintiff may describe the emotional and psychological toll of being denied adequate healthcare can further emphasize the individual harm. This could include feelings of fear, anxiety, or hopelessness resulting from untreated medical conditions. For example:
In case 1, the Plaintiff experienced a seizure, “fell to the floor and hit their head. Blood started coming out from the Plaintiff’s right ear” (p. 4). The Plaintiff was seen by the defendant, but “did not properly evaluate the Plaintiff’s condition, and did not examine or treat the injury” (p. 4). Then they were placed “in a medical holding cell for monitoring without a doctor’s examination” (p. 4). The defendant “observed that the Plaintiff’s nose was bleeding and did not examine or treat the injury” (p. 4). “While in the medical cell, the Plaintiff suffered another seizure (...), Plaintiff's head hit the floor, fracturing their skull” (p. 4). As a result the patient was taken to the hospital where the Plaintiff's condition “worsened to the point that he underwent intubation and trauma surgery was consulted for admission. Thereafter, the Plaintiff was taken to the operating room for a craniotomy” (p. 5). “Plaintiff has suffered from loss of brain function, hearing, memory loss, and continues to endure additional physical and mental effects including loss of taste, erectile dysfunction, extreme migraines, irritability, fatigue, anxiety, depression and further seizures. Plaintiff also suffers from post-traumatic stress disorder and is unable to work. Defendants acted in individual and official capacities in denying the Plaintiff medical care (...) failed to train its officers, and failed to enact policies and procedures to ensure Plaintiffs constitutional rights would not be violated” (Case 1, p. 5).

The Plaintiff may contrast the healthcare received in prison with the standard of care expected in the broader community as to highlight the disparity and underscore the individual harm suffered by the inmate. There were many filings where the Plaintiff asked to see an “outside” physician, under the expectation that they would receive better and more
comprehensive care. Many of those requests were denied, causing prolonged suffering. For example:

In case 21, the Plaintiff outlines they were prevented from accessing adequate medical care resulting in a “second and more detrimental injury”. The Plaintiff argues that access to proper medical care was impeded by administration refusing to refer them to MRI’s despite doctor’s orders. “Because the first injury to the knee was not properly diagnosed due to an MRI being refused (...) allowed for the second injury to occur so easily, and has left (the Plaintiff) with a constant limp, and severe pain with every step” (Case 21, p. 3).

In case 22, the Plaintiff alleges medical malpractice after years of not receiving effective medical care. The filing notes, “medical staff (....) ordered many different antibiotics + steroids multiple times that proved to not work” (p. 2). Despite medical staff not being able to treat the issue successfully, “they have failed to send me to an outside physician nor do a biopsy” (p. 2). The Plaintiff notes they want to see an outside physician but it has been denied resulting in medical neglect (Case 22).

In case 58, the Plaintiff alleges that defendants “failed to provide adequate medical care or refer Plaintiff to qualified wound care” (p. 2) “creating an imminent threat of amputation to the Plaintiff's left leg and/or Plaintiff's life” (p. 3). Further, the medical staff did not take appropriate measures to “dry wrap Plaintiffs' damaged and highly sensitive wound area for the purpose of preventing the wounds reopening” (p. 3-4). The complaint notes that while the institution failed to make appropriate outside referrals for specialty care, they also did not manage the condition appropriately internally (Case 58).
Another way to emphasize individual harm could be including medical records and reports that document instances of neglect or mistreatment against them. These documents can serve as concrete evidence of the inmate's specific health issues and how they've been affected by inadequate care. Many of the filings had accompanying attachments that included medical histories, records, and sick call slips as well as grievances and the responses to those grievances.

In case 55, the Plaintiff argues that on three occasions, the defendants “refused outright to treat me because I filed a grievance” (p. 5). They note that “medical records will show that not even vitals were taken. All 3 visits are documented and no proof of any treatment will be recorded no even [sic] vitals that is protocol” (Case 55, p. 6).

In case 102, the Plaintiff argues they are being denied medical care for a multitude of acute and chronic conditions, some of which were caused by “baton beating by officers” (p. 2) and refers to exhibits, the attached documents, that prove denied medical care and assaulted by staff (Case 102).

While outlining the individual harm they experienced, there were multiple cases where the Plaintiff discussed how their experience was shaped by intersecting identities such as race, gender, or disability, highlighting a personal bias or stereotype that were causing harm.

In case 20, the Plaintiff claims that institutional actors engaged in discriminatory and unconstitutional practices by being prevented from receiving services when requested. In the filing, the Plaintiff notes they “requested to see psychology. Psychology has not/refused to respond as of today (13 days)” (p. 3). Further, they note “inmates
(including me) are denied medical tmt [sic]” and they were kept in isolation for 128 days with no sick call access, noting “they have only had SHU “sick call” on two occasions in those 128 days (...) violating FBOP policy. The warden knows and refused to enforce the policy” (p. 4). Further, they note they were called homophobic names by staff, denied food with meals, and transferred out of their housing unit because they are “a gay white male who was friends with a large group of black males” (p. 6) and the staff did not like that. The Plaintiff also argues retaliation, in the form of denying food, for filing grievances that claims discrimination based on race and sexuality (Case 20).

Individual Harm was by far the most common frame in the entire sample, and when examining the framing choices pre- and post-COVID-19 onset. All of the filings in the sample outlined some form of individual harm. This is likely due to the requirement that a Section 1983 complaint outline the damages resulting from the state actors actions. By framing their complaint in this way, the Plaintiff focuses on the specific ways in which they've been personally impacted and the damages against them. This approach not only strengthens their legal case but also highlights the ways in which social constructions, stigmas, and stereotypes contribute to individual harms within the prison system.

Structural Harm

In framing a healthcare-related Section 1983 complaint as a structural harm rather than an individual or institutional one, an inmate would focus on the systemic failures and patterns of neglect within the prison healthcare system. In this study, Structural Harm was applied when the violation outlined in Section 1983 complaint was framed as a structural harm or a broad constitutional issue. I assigned this code when the complaint emphasizes a broader, systemic
issue or a violation of constitutional rights affecting multiple individuals within the prison system.

For example, instead of focusing solely on their own experience, the inmate could gather evidence to demonstrate a pattern of neglect or mistreatment affecting a broader group of inmates. This could include testimonies from multiple individuals, documentation of similar incidents, or statistical data showing disparities in healthcare outcomes among incarcerated populations. It could also include arguments that multiple people are impacted by a specific practice. For example:

In case 10, the Plaintiff highlighted systemic issues of charging copayments for medical care. The Plaintiff has multiple chronic medical conditions that have caused them to accrue $402.00 in medical fees levied against their account. He cannot pay them because he makes only $2.80 a week and only gets to keep $2.00 of that. This medical debt has prevented them from being able to buy hygiene products, canteen products and utilize their financial account. In order to survive, the Plaintiff has been forced to barter and trade for the supplies they need, which has resulted in them being charged with rule violations and fined for those as well. The Plaintiff argues that medical co-pay policies are unconstitutional resulting in violations against not only them, but all inmates at the facility. In addition, the Plaintiff argues that requiring medical copays is a form of discrimination based on economic status, unfairly harming a specific group of people (Case 10).

In the same case, the Plaintiff argues “I, myself and other prisoners similarly situated [sic] have for years written grievances concerning this issue (...) to which the grievance
examiners have all and repeatedly ignored our grievances by providing ineffective and inadequate responses” (p. 9). The Plaintiff provides statistics to further their argument noting, “it is a statistical state-wide fact that 98.2% of all prisoner grievances (...) are shot down and the grievance examiner differs [sic] to the judgment of the prison guards or their supervisors and provides no remedy what-soever” (p. 10). This means that even if the incarcerated person wants to raise concerns about treatment, or handle the violations internally within the institution, they are not heard (Case 10).

In case 56, the Plaintiff argues that while being held in a local jail, he suffered a hernia and sought medical care, was examined but denied care because it “wasn’t life threatening at the time” (p. 2). A few weeks later, the pain was increasing and ultimately, the Plaintiff passed out from the pain and was rushed to the hospital. While at the hospital, procedures were done to confirm he “had a severe hernia which isn’t strangulated yet shows discomfort and will eventually need repairing through the surgical process not authorized to perform at the time because of non-strangulation” (p. 4) due to the contracted jail healthcare provider’s policy. After prolonged pain and many grievances, the staff noted that he “needed surgery and I’d be placed on the fast-track for transfer to the department of corrections because the [sic] jail nor contracted medical provider wanted to pay for the procedure” (p. 4). Claims neglect and deliberate indifference in the care provided by the contracted medical staff at the jail. This filing highlights systemic issues resulting from discrepancies in healthcare policies by contracted companies who provided care to incarcerated persons being held in local jails versus state prisons (Case 56).
In addition, some Plaintiffs may discuss the historical context of healthcare in prisons. In this way, they can try to shed light on how social constructions, stigmas, and stereotypes have shaped the current system. For example, the legacy of punitive approaches to incarceration and the devaluation of incarcerated lives have perpetuated systemic injustices in healthcare provision. One way to do this is to reference past legal cases or rulings that have addressed similar structural issues in prison healthcare. By building on established legal precedents, the inmate can demonstrate that their complaint is part of a larger pattern of constitutional violations. Multiple cases in this study cited legal cases such as, but not limited to, *Estelle v. Gamble* (1976), and referenced other Supreme Court decisions as well as the First, Fourth, Fifth, Eighth, and Fourteenth Amendments to the United States Constitution.

By framing their complaint as a structural harm, the inmate shifts the focus from individual incidents to the underlying systemic issues that perpetuate injustices within the prison healthcare system. This approach not only addresses the immediate grievances of the Plaintiff but also seeks to bring about broader concern about incarcerated persons’ well-being and ideally, systemic change to improve healthcare outcomes for all incarcerated individuals.

**Institutional Harm**

In framing a healthcare-related Section 1983 complaint as an institutional harm rather than an individual or structural one, an inmate would focus on the policies, practices, and culture within the specific institution that contribute to inadequate healthcare. In this study, Institutional Harm was applied when the violation outlined in the Section 1983 complaint was framed as an institutional harm. I used this code when the complaint focuses on issues within the institutional framework itself, such as policies, procedures, or systemic practices affecting the entire
institution. In some cases, the complaint attempted to outline the root causes of inadequate healthcare within the institution. These complaints included claims such as underfunding, understaffing, lack of accountability training. For example:

In case 38, the Plaintiff argues that the health provider contracted with the prison is “understaff [sic] not properly monitoring the quality of medical care provided by the company (...) placing profit over patient safety leaving the facility undermanaged with insufficiently trained medical personnel” (Case 38, p. 3).

In case 49, the complaint outlines deliberate indifference to medical care due to “systemic deficiencies in staffing facilities”” (p. 11). The Plaintiff argues that they were denied access to medical care, post-surgical follow ups, and medication refills. Within the filing, the Plaintiff notes,“the factors could also include staffing on inadequate [sic] that the medical staff lacked essential training that are necessary to make a professional judgment from proper diagnosis and treatment and/or rules or policies restricting medical care based on costs” (p. 10-11). Further, to strengthen their case, the Plaintiff attaches exhibits of medical procedures and refers to their medical history to show severity of their injury and long-term harm (Case 49).

When framing a complaint as an institutional harm, the Plaintiff could highlight specific policies or protocols within the institution that hinder access to adequate healthcare. This could include restrictions on medical appointments, delays in treatment, or barriers to accessing necessary medications. By demonstrating how institutional policies contribute to substandard healthcare, the inmate can establish the institutional nature of the harm.
In case 18, the Plaintiff outlines multiple complaints related to cruel and unusual punishment and access to medical care. They note that there was one policy in particular causing harm. The Plaintiff writes, although the Plaintiff “is a registered nurse, they are not authorized to medically treat the Plaintiff's allergic reaction from prescription medication without a doctor's approval. (3) Therefore, the Plaintiff's request form, requesting immediate medical assistance should've have [sic] forwarded to (the doctors on staff - names redacted for confidentiality purposes) in accordance with (stateDOC), medical procedure” (p. 8). In this case and according to policy, RN's were not allowed to treat allergic reactions and needed the oversight of a doctor but they failed to seek assistance of the doctor in a timely manner and did not attempt to provide relief until the allergic reaction was over. “The Plaintiff suffered for over a period of sixty days and had to endure the effects of their allergic reaction from prescription medication” (Case 18, p. 13).

Sometimes institutional harms stem from prison and staff culture. If the Plaintiff discussed the attitudes and beliefs among staff members or administrators regarding incarcerated individuals and their healthcare needs, they are highlighting the institutionalized nature of the harm. This could include stereotypes about inmates feigning illness, deserving lesser care, or not deserving empathy and compassion. For example:

In case 14, the Plaintiff was put in segregation because of a mental health crisis and phobia resulting from a police dog attack. The segregation inevitably made the mental health crisis worse and the conditions were poor leading to respiratory problems. Initially they were prescribed mental health medication to help address their condition but “it was
waay [sic] too strong” to the point that “the Plaintiff could not even function” (p. 6). The Plaintiff then asked for a “less strong” medication, and it was not provided because medical staff alleged “just trying to manipulate to get a single cell” (Case 14, p. 6).

In case 71, the Plaintiff was scheduled to meet with the psychiatrist (defendant) on duty. The defendant arrived at their cell and “I refused to be seen where other inmates could overhear my discussion with the Dr. (...) Dr. (name redacted for privacy reasons) took this as a refusal to see them, but I wanted to see them without my HIPPA [sic] rights being violated again. Dr. (name redacted for privacy reasons) used this so-called [sic] refusal as the reason to stop my medications” (p. 2). Due to the discontinuation of the meds the Plaintiff, “had a seizure, increased depression and attempted suicide” (p. 2). Then upon further inquiries seeking medical help, the Plaintiff was refused medical treatment. He notes the Dr’s., “case load is so large and overburdened that I’m unable to receive proper mental health treatment” (p. 2). They also note that institutional grievance procedures are never answered or responded to, the “only ones returned are ones in which I can not sue the prisons or its employees” (Case 71, p. 5).

Another way inmates framed their harm as institutional was by emphasizing the collective impact of inadequate healthcare on the well-being of all inmates within the institution. By demonstrating how deficiencies in institutions’ policies or procedures have harmed multiple people or the entire incarcerated population at that institution, the Plaintiff makes the case that the institution itself is liable for the harm.

In one filing a "Class Action" lawsuit filed by multiple Plaintiff's arguing medical malpractice, Eighth Amendment violations, and discrimination against multiple inmates
with disabilities. In this case, the allegations outline that some of the Plaintiffs are “sick, almost dead, blind, bedridden” (p. 13) and the facility medical staff will not prescribe adequate pain medication preventing effective pain management, prolonged suffering and increased medical risk to inmates. The filing outlines that “we are not requesting any money, we are just requesting pain management and correct pain medications” (p. 14) as many inmates are “scream and cry all night” (p. 14) in pain and “have to take 1,000 mg of ibuprofen multiples time a day which doesn’t even though the pain” (p. 14). One Plaintiff “was hospitalized due to vomiting blood” (p. 14), due to the adverse effects of taking too much ibuprofen. The filing alleges deliberate indifference to pain and medical needs, as well as inadequate access to medical treatment (Case 92).

Institutional culture, characterized by a lack of transparency and accountability, fosters an environment where abuse can flourish (Goffman, 2014). By Framing their complaint as an institutional harm, the Plaintiff shifts the focus from individual incidents or systemic issues to the specific policies, practices, and culture within the institution. This approach not only holds the institution accountable for its role in perpetuating inadequate healthcare but also challenges broader social constructions, stigmas, and stereotypes that inform decision-making within the prison system.

**Dual Frames and Triad Frames**

"Dual frames" and “Triad Frames” in the context of this qualitative research study refers to the simultaneous utilization of multiple analytical frames within a single Section 1983 filing. In this study, I found that inmates are sometimes employing multiple frames at once, to include complaints alleging not only individual harm but institutional harm and structural harm as well.
“Dual Frames” were used in 22 cases (1, 4, 6, 7, 8, 9, 18, 19, 20, 32, 35, 41, 49, 50, 60, 71, 73, 92, 111, 112, and 115) to convey a harm that was both individual and institutional in nature and “Triad Frames” were utilized in 7 cases (10, 56, 95, 109, 113, 118, 119) where the Plaintiff framed their complaint as an individual harm, structural harm and institutional harm.

I believe that inmates may employ multiple frames within a single complaint for several reasons. The harm experienced by inmates is often multifaceted and often cannot be adequately captured by a single framework. For the Plaintiff, the use of multiple frames within a single complaint allows inmates to convey the complexity and severity of the harm they have experienced, enhancing the comprehensiveness and effectiveness of their legal grievance. By presenting their grievance through multiple lenses, inmates can underscore the seriousness and depth of the harm they have endured. This can be particularly important in cases where the harm is systemic or pervasive, affecting not only them but a wider population of vulnerable or incarcerated people.

From a legal perspective, each frame may serve a different legal purpose or help support different aspects of their case. For example, individual harm may establish the direct impact on the inmate, while institutional and structural harm may demonstrate broader patterns of negligence or misconduct that resulted in individual harm to the inmate but the root cause is broader than just that one instance. Legal systems often require specific criteria to be met for a complaint to be addressed. By framing their grievance in multiple ways, inmates may increase the likelihood of their complaint being heard and acted upon, as it addresses various angles of the issue.

\textit{Framing Choices Pre- and Post-COVID-onset}
The second aim of this research question was to explore the framing choices of incarcerated people who file Section 1983 complaints, pre, and post-COVID-19 onset. When I examined the most common frame utilized to describe the nature of the constitutional violation pre and post-COVID-19 I found that frame utilization was similar. In both the pre and post-COVID-19 onset samples, individual harm was far the most common frame, followed by institutional harm and then structural harm. While I did not see an overwhelming difference in frame utilization, there were variations in the raw numbers, but when looking at the rate, prevalence of individual harm frames were equal with individual harm being used in 100% of cases in both samples (pre-COVID and post-COVID onset) and institutional frames being used in 25.5% of cases pre-COVID and 21% of cases post-COVID onset.

The biggest difference in the frame utilization in the filings was the increase in filings that addressed the structural harm associated with their complaint. Pre covid, there was only one filing that outlined the structural nature of the civil rights violation against them (2%), but post-COVID onset there were 6 Plaintiffs who utilized the structural frame (8%) (see Figure 10). The increase in the use of structural harm frames post-COVID-19 could be due to the rhetoric and narrative around recent co-occurring social justice movements, framing choices of the media and politicians, public attention and discussion around racial and economic oppression by government actors, and other healthcare or criminal justice related reform movements.
Note. Figure 10 illustrates Plaintiff’s frame utilization pre and post-COVID-19 onset. The number of filings in each category were compared by group whether the filings were filed before or after the onset of COVID-19 (March 2).

![Figure 10. Frame Utilization pre-and post-COVID onset](image)

<table>
<thead>
<tr>
<th>Frame Category</th>
<th>PRE COVID</th>
<th>POST COVID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>47</td>
<td>73</td>
</tr>
<tr>
<td>Structural</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Institutional</td>
<td>13</td>
<td>15</td>
</tr>
</tbody>
</table>

Interestingly there were more triad frames utilized post-COVID than pre-COVID. “Triad frames” are filings where the Plaintiff framed their complaint as an individual harm, structural harm and institutional harm. Before COVID-19 many Plaintiffs used dual frames (11) but only one (1) Plaintiff utilized a triad frame. After the onset of COVID-19, Plaintiffs still utilized “Dual Frames” (10) but used “Triad Frames” more frequently (6). It is important to note that the utilization of a “Triad Frame” means that the Plaintiff incorporated arguments of structural harm into their Section 1983 complaint as well as individual and institutional harm (see Figure 11).
Note. Figure 11 illustrates Plaintiff's frame utilization pre and post-COVID onset.

Specifically, whether the Plaintiff utilized two “Dual Frame” or three frames “Triad Frame” in one filing. The strategy of framing in each filings in each category were compared by group: whether the filings were filed before or after the onset of COVID-19 (March 1, 2020).

Beyond the Healthcare Related Observations

Out of curiosity and in order to gain substance, while examining the documents I coded for whether or not the initial complaint was drafted with the assistance of an attorney. To do this, I examined the initial complaint for the words “pro se” and the defendants signature. "Pro se" is a Latin term meaning "for oneself" or "on one's own behalf." In legal terms, it refers to the act of representing oneself in a court of law rather than being represented by a lawyer. When a person chooses to proceed pro se, they take on the responsibilities and roles that an attorney would typically handle, in this case, drafting and filing the Section 1983 complaint. There is a section
on the Section 1983 form where the Plaintiff has to denote whether they are representing themselves “pro se” or if someone is filing the claim on their behalf, or if they have an attorney working with them to draft the complaint. In the vast majority of cases, the Plaintiff was filing their Section 1983 complaint “pro se”. In only 8 of the 120 filings the inmate had acquired counsel to assist them. Often, the reason for this is that a Plaintiff who brings a Section 1983 claim does not have a right to have counsel appointed to them for the drafting of the complaint. The court is only required to appoint counsel to help an indigent defendant to file a Section 1983 complaint if there are exceptional circumstances. In the United States, the legal framework governing the right to counsel for inmates filing Section 1983 complaints stems primarily from the decision in Lewis v. Casey, (1996). In this case, the Supreme Court held that there is no automatic constitutional right to counsel for prisoners in civil rights actions, including those brought under Section 1983 of the Civil Rights Act. The rationale behind this decision lies in the principle that while access to courts is a fundamental right, the assistance of counsel is not always necessary to ensure meaningful access (Lewis v. Casey, 1996). However, there are exceptional circumstances where the court may appoint counsel for indigent prisoners. These circumstances typically revolve around complexities in the case, such as when the legal issues involved are particularly dynamic, making it difficult for the inmate to present their case effectively without legal assistance. Additionally, if the inmate suffers from physical or mental impairments that significantly impede their ability to articulate their claims or navigate the legal process, or any other extraordinary circumstances that would make it unjust or inequitable for the inmate to proceed without counsel, then counsel should be provided (Lewis v. Casey, 1996).

Further, while I did not code specifically for abuse or mistreatment that was not related to the administration of healthcare services, many of the complaints alleged physical abuse or
mistreatment of the inmate by staff. Incarceration, ostensibly designed for punishment and rehabilitation, too often becomes a breeding ground for abuse, with inmates vulnerable to various forms of mistreatment. Inmate abuse within correctional facilities is a pervasive issue that manifests in various forms (Smith & Fogel, 2019). In this study, I found multiple cases where Plaintiffs were, in addition to the healthcare-related complaint, alleging abuse at the hands of guards and staff. In extreme cases, prisoners allege they were subjected to physical abuse or mistreatment by correctional staff or healthcare providers, resulting in injuries and trauma. For example:

In case 18, in addition to outlining issues with medical policies that were cruel and unusual, the Plaintiff notes they were spontaneously assaulted by correctional officers. The complaint outlines the details of the assault to include “placing them into a chokehold” “baled their hands into a fist, and proceeded to strike the Plaintiff in their mouth busting their bottom lip open (...) knee the Plaintiff in the ribs also kicking them in their forehead” (p. 10). When the Plaintiff requested medical assistance for the pain and injuries resulting from the assault, the “nurse then left the cell without treating the Plaintiff's injuries. (...) the Plaintiff was left in said location to heal on their own without medical treatment for a period over 24 hours” (p. 10). Eventually, pain management medication was administered but wasn’t able to see the doctor until two weeks later. “As a result, the Plaintiff is now living with life-time permanent injuries that cannot be cured” (Case 18, p. 5).

In this study, I explored the nuanced nature of constitutional rights violations against incarcerated individuals, with a particular focus on healthcare-related violations and the
distinctions observed pre- and post-COVID-19 onset. The findings illuminated the detailed nature and frequencies of different types of healthcare-related constitutional rights violations before and after the onset of the COVID-19 pandemic. The findings also provided insight into the ways Plaintiffs frame the constitutional rights complaints in their Section 1983 filings. The next section will summarize the main findings of this study, discuss the findings through the lens of the theoretical and analytical frameworks used to design the study, and discuss the policy and practice implications of the findings.

**Discussion**

**Summarized Findings**

The most common violations outlined in the filings were related to access to medical care, followed by cruel and unusual punishment, deliberate indifference, and serious medical condition, respectively. Less common but still present in the filings, were violations related to discrimination in healthcare, lack of accountability, lack of communication, financial barriers, COVID-19 related complaints, informed consent and right to privacy in medical treatment, respectively. In addition to exploring the nature of violations outlined in the filings, one goal in this study was to explore the mechanism responsible for the shift in the nature of the alleged civil rights violations pre- and post-COVID-19 onset. Contrary to the hypothesis, there were not drastic differences in the nature of the civil rights violations pre and post-COVID-19 onset. The proportion of filings in each coding category was similar pre and post COVID-onset but there were interesting minute differences in some types of claims. In the post-COVID-19 onset group there were more claims of discrimination in healthcare, an increase in filings related to COVID-19, and less filings related to financial barriers.
All filings sampled in this study utilized individual frames to communicate the extent of the harm against them, with institutional frames being the second most common, and structural frames being used the least. The biggest difference in the frame utilization in the filings was the increase in filings that addressed the structural harm in their complaint, post-COVID-onset. Pre COVID, there was only one filing that outlined the structural nature of the civil rights violation against them (2%), but post-COVID onset there were 6 Plaintiffs that utilized the structural frame (8%).

Further, Plaintiff’s often utilized “Dual” and “Triad” frames to communicate the extent of the harm against them. “Dual Frames” were used by Plaintiffs to communicate both the individual and institutional nature of the harm against them, whereas “Triad Frames” were used to communicate the individual, institutional, and structural nature of the harm against them. “Dual Frames” were used more commonly than “Triad Frames” but the prevalence of “Triad Frames” was much higher in the post-COVID-19 onset group.

In addition to the healthcare-related concerns, many Plaintiffs also reported being assaulted and abused by staff, retaliation for filing grievances, and frustration with the internal institutional grievance process constantly favoring the guards over the inmates.

**Theoretical and Analytical Connections**

Integrating established theoretical frameworks with contemporary issues and problems in qualitative research is essential for crafting a robust and insightful analysis. To successfully and reliably answer the research questions posed in this study, I needed to ground the research design and hypothesis in some sort of theoretical framework. In this study, the incorporation of Schneider and Ingram’s Social Construction of Target Populations Theory (1991; 1993; 1997)
and Goffman’s Framing Theory (1974) serve as a foundation for comprehensively addressing the research questions through content analysis.

By grounding the hypothesis within the framework of Schneider and Ingram, I leveraged their theory's capacity to illuminate the intricate dynamics of how societal perceptions shape the construction and portrayal of specific target populations. As I examined the contemporary issue of constitutional rights violations this theoretical lens provided a nuanced understanding of how deviant populations are burdened by the correctional healthcare environment.

Moreover, the adoption of Goffman’s framing analysis offered a structured approach to analyzing the data, ensuring consistency and coherence in my interpretation. Building upon Goffman’s seminal work, I explored how different frames are utilized within the written healthcare-related constitutional rights violations allegations filed by incarcerated Plaintiffs between 2018 and 2023. This conceptual framework facilitates the identification of underlying patterns and themes, enriching the qualitative analysis.

By merging these established theories with the contemporary research questions I bridged the gap between historical insights and contemporary phenomena. This synthesis not only enhanced the theoretical rigor of the study but also enabled me to uncover insights into the complexities of social systems that do not consistently uphold incarcerated individual’s rights within the delivery of constitutionally protected healthcare access. In essence, the integration of old theories with modern social issues, not only acknowledges the enduring relevance of foundational frameworks but also demonstrates their adaptability in elucidating contemporary socio-cultural phenomena. This approach not only enriches the scholarly discourse but also offers practical implications for addressing real-world challenges and advancing equity in criminal justice services.
Social Construction of Target Populations & Findings

Schneider and Ingram's Social Construction of Target Populations Theory provided a lens through which to analyze the disparities in health outcomes experienced by incarcerated populations during the COVID-19 pandemic. By examining how societal dynamics shape the perception and treatment of different social groups, this theory offers insights into the disproportionate impact of COVID-19 on inmates. This section explores the relationship between Schneider and Ingram's theory and the results of the first research question, what are the most emergent constitutional violations alleged by incarcerated persons who filed Section 1983 filings between 2018-2023, and do the nature of the concerns differ pre and post COVID-19 onset?

Schneider and Ingram's theory posits that societal institutions and cultural narratives construct certain social groups as "target populations," subjecting them to specific forms of treatment, both positive and negative. This process of social labeling is influenced by power dynamics, cultural beliefs, and institutional practices, which shape how individuals within these groups are perceived and treated. Applying Schneider and Ingram's theory, we can understand how incarcerated populations have been constructed as "target populations", specifically a “deviant” group that is negatively constructed and lacks the power to change that.

In this study, the most common violations outlined in the filings were related to access to medical care, followed by cruel and unusual punishment, deliberate indifference, and serious medical condition, respectively. Less common but still present in the filings were discrimination in healthcare, lack of accountability, lack of communication, financial barrier, COVID-19 related complaints, informed consent and right to privacy in medical treatment, respectively. One factor that can contribute to the sheer number of constitutional rights violations is that incarcerated individuals are often stigmatized and marginalized within society, leading to their construction as
"undesirable" or "disposable" populations (Schneider and Ingram, 1991; 1993; 1995). This stigmatization influences how correctional institutions and policymakers perceive and respond to the health needs of inmates during the pandemic. Further, in this study, all of the filings where the Financial Barrier code was present, also fell into the Access to Medical Care (AMC) coding category. This finding demonstrates a link between people who are less fortunate economically, and the burdens they face when attempting to access healthcare services. The findings of this study align with Schneider and Ingram’s Social Construction of Target Populations theory regarding how institutional practices and policies perpetuate burdens on incarcerated populations.

One of the ways that carceral institutions perpetuate the marginalization of incarcerated persons is by creating an environment where civil rights violations can flourish. In this study I found that many inmates experience civil rights violations. While all of the complaints sampled were related to health care in some way, the details and nature of the violations highlight other abuses that co-occurred with the healthcare related violations. I found that some of the complaints regarding healthcare related violations mentioned other types of abuse at the hands of correctional staff. While this is an important additional detail to include when discussing the results of this study, this knowledge is not novel. Smith and Fogel (2019) conducted a comprehensive study examining the prevalence of physical and sexual abuse in prisons, revealing alarming rates of victimization among inmates. Similarly, a national survey conducted by James et al. (2018) found high incidences of verbal harassment, physical violence, and sexual assault experienced by inmates, highlighting the systemic nature of abuse within carceral settings. The cause of these civil rights violation allegations could be attributed to structural inequities, such as inadequate staffing, training and healthcare funding, overcrowded living
conditions and stigmas and stereotypes about the “worthiness” of incarcerated persons. These structural factors intersect with systemic issues such as racial disparities in incarceration rates and socioeconomic inequalities to impact governmental decision making, potentially further exacerbating health disparities among inmates. Schneider and Ingram's theory helps us understand how these structural inequities shape the social construction of incarcerated populations as "at-risk" and "vulnerable" within the context of healthcare.

This study found that many of the civil rights complaints were coupled with concerns regarding the institutional grievance processes. Incarcerated populations often lack access to advocacy and resources to protect their health and well-being during the pandemic. Schneider and Ingram's theory elucidates how the absence of robust advocacy efforts and limited resources allocated to correctional facilities contribute to the neglect of inmates' health needs (1991; 1993; 1997; 2003; 2019). Without adequate support, communication, and accountability within the institution, incarcerated individuals are left vulnerable to the actions of prison staff, with limited avenues for recourse.

Another main goal in this study was to explore the mechanism that is responsible for the shift in the nature of the alleged civil rights violations pre- and post-COVID-19 onset. Contrary to the hypothesis, there weren’t drastic differences in the nature of the civil rights violations pre and post-COVID-19 onset. Ratio wise, the amount of filings in each coding category were similar pre and post COVID-19 onset but there were interesting minute differences in some types of claims. In the post-COVID-19 onset group there were more claims of discrimination in healthcare, an increase in filings related to COVID-19, and less filings related to financial barriers.
The co-occurrence of COVID-19 with the racial justice uprising in 2020, which brought carceral injustices to the forefront, suggest the need to think carefully about whether it is possible to separate the effects of COVID-19 from the historical oppression, stigmatization and negative social constructions of criminals as “deviants” as well as the effects of other events. For example, the resurgence of the Black Lives Matter movement following the murders of George Floyd, Breonna Taylor, and other Black individuals at the hands of law enforcement brought renewed attention to systemic racism and inequality in various facets of society, including the criminal justice system (Cobbina & Elicock, 2021). Within correctional facilities, racial disparities in healthcare provision became a focal point of advocacy efforts, with inmates and activists alleging discriminatory practices that disproportionately affected marginalized communities, particularly Black and Hispanic inmates (Sawyer & Wagner, 2020). The intersectionality of race and incarceration magnified existing disparities, amplifying the voices of inmates who claimed to have experienced discriminatory treatment based on their race or ethnicity and their incarcerated status (Wakefield et al., 2019). Further, the amplification of systemic injustices through media coverage and public discourse further empowered inmates to speak out against perceived discrimination in healthcare provision, causing an increase in discrimination based complaints related to the administration of healthcare in correctional facilities (Mutua & Ong'ong'a, 2020).

The COVID-19 pandemic underscored the vulnerability of incarcerated individuals to infectious diseases due to the confined and often overcrowded conditions within correctional institutions (Williams et al., 2020). In this study, there were four cases related to COVID-19. They outlined various complaints regarding inadequate access to healthcare services, including testing, treatment, and preventive measures which exacerbated the risks they and other inmates faced. There were claims of staff spreading disease and not following protocol, leading to
outbreaks within prisons and jails. Additionally, the psychological toll of the pandemic and social unrest stemming from racial injustice heightened awareness and advocacy efforts within carceral settings. Filings that included complaints related to COVID-19 often included “injuries” such as emotional and mental distress along with the physical harms from the healthcare violation itself. I believe this is the case because inmates, already coping with the stressors of incarceration, grappled with heightened fears of contracting COVID-19 and heightened concerns about their vulnerability to mistreatment and neglect within the criminal justice system (Elger et al., 2021).

I did expect that the data would reflect a higher number of COVID-19-related filings, and the low number (4) in this sample might be partially dependent on two things. The first is that, as noted above, Section 1983 filings often take a year or more to be resolved in the court therefore, while more violations related to COVID-19 might have happened, the aggrieved had not been able to file the section 1983 complaint before 2023 year end, thus it was not able to be included in the sample. Further, we know that COVID-19 disproportionately impacted incarcerated people. As of July 3, 2023, 647,349 incarcerated people and 246,858 staff working in prisons had tested positive for COVID, while 2,933 prisoners and 292 staff have died due to the disease (COVID Prison Project, 2023; Noviksy et al., 2023). If an incarcerated person experienced a constitutional rights violation at the hands of a state actor, but passed away shortly thereafter, then a Section 1983 filings would not have been filed.

When discussing filings related to Financial Barriers, it is important to note that many people who are incarcerated make little to no money, and often rely on their non-incarcerated family members to pay for their care. The economic struggles in the “free world” during the pandemic directly impacted those who are incarcerated and receiving financial support from their
families. Regarding financial barriers to care, there were fewer filings in the post-COVID-19 onset group. This may seem surprising since the onset of the pandemic brought about unprecedented levels of economic uncertainty, leading to financial instability for many households (Adams-Prassl et al., 2020). Staffing cutbacks and risk of disease transmission translated into diminished incomes for workers already grappling with job insecurity (Goolsbee & Syverson, 2020). Moreover, the reliance on government assistance programs, such as expanded unemployment benefits, underscored the severity of the economic fallout from the pandemic (Daly & Hobijn, 2020). Many households faced challenges in meeting basic financial obligations, including rent or mortgage payments, further exacerbating economic distress. The COVID-19 pandemic also resulted in increased healthcare costs and medical expenses for many and the economic downturn triggered by the pandemic led to widespread loss of employer-sponsored health insurance coverage, leaving many individuals without adequate access to healthcare services (Shambaugh et al., 2020). The combination of health-related expenses and diminished access to healthcare further strained household budgets, exacerbating financial hardship on families and those who were relying on them for deposits into their institutional account.

While incarcerated persons typically face financial hardships and struggle to pay for copays, medical visits, and other healthcare-related services, during the pandemic, corrections departments could not legally deny care because of financial reasons. As noted earlier, incarcerated individuals are the only population in the United States that have a constitutionally protected right to health care thanks to *Estelle v. Gamble* (1976). Further, during the pandemic, many jails and prisons that fall under the jurisdiction of the Fourth Circuit Court removed mandatory copayments for inmates, allowing them easier access to necessary care. In response to
the urgent need for widespread testing and treatment of COVID-19, many insurers and
government health programs implemented policies to waive copayments for COVID-19-related
services. This measure aimed to eliminate financial barriers to testing and treatment, ensuring
that individuals could access necessary care without facing short or long term financial hardship
(Antioch, 2023). Further, because of social distancing measures, which were enforced to curb the
spread of infectious diseases, telehealth emerged as a critical tool for delivering healthcare
remotely. To facilitate access to telehealth services, insurers and government programs expanded
coverage and waived copayments for telehealth visits. This policy change aimed to promote safer
access to care while reducing the need for in-person visits to healthcare facilities (Hollander &
Carr, 2020). Because of these changes in policies, inmates faced less financial barriers to
health-care post-COVID-19 onset thus we saw less complaints related to financial barriers
preventing access to healthcare.

Frame Analysis

Erving Goffman's Frame Analysis provides a valuable lens through which to understand
the perspectives and decisions of individuals within various social contexts. Applying this
framework to examine the legal filings of incarcerated persons, both before and after the
COVID-19 pandemic, offered insights into how ones’ perspectives, strategies, and experiences
are shaped by their social, political and physical environment. This section will discuss how the
Plaintiffs framed the alleged violations in their Section 1983 filings and whether this differed
pre-and post-COVID-19 onset through the lens of frame analysis.

As mentioned earlier, Goffman's Frame Analysis revolves around the concept of "frames"
which are cognitive structures that shape individuals' interpretations of events, interactions, and
situations (Goffman, 19740). Frames provide a framework through which individuals make
sense of their experiences and navigate social reality. These frames are influenced by societal norms, cultural values, and personal experiences, shaping individuals' perceptions and actions within social contexts. In this study, I utilized the naturally occurring “COVID-19 era” as a mechanism that splits the sample into two unique categories. In qualitative research a “mechanism” can be considered the equivalent concept to a mediating variable in qualitative research (Charmaz, 2014; Maxwell, 2013).

Mechanisms or processes in qualitative research refer to the underlying dynamics, interactions, or causal pathways that connect different aspects of the phenomenon being studied. They represent the ways in which certain factors or conditions influence or shape other factors or outcomes within the context of the research. Identifying and understanding these mechanisms or processes is essential for developing a comprehensive understanding of the phenomenon under study in qualitative research, as they help explain the underlying dynamics and interactions that contribute to the emergence of specific patterns or themes within the data. I chose to use the COVID-19 era as the mechanism because of its overwhelming impact on every aspect of American society and the well documented disproportionate impact on disadvantaged or “deviant” groups (Saloner et al., 2020).

**Applying Frame Analysis to Incarcerated Persons’ Legal Filings**

Even before the COVID-19 pandemic, incarcerated individuals faced numerous challenges in accessing legal resources and navigating the legal system. Goffman's framework helps to understand how these individuals framed their legal challenges within the context of their incarceration experience in order to advance their opportunities for legal redress. For many, the specificity and strictness of court procedure when filing a section 1983 claim likely served as the main variable influencing their frames, by influencing their understanding of legal processes
and helping shape their strategies for filing Section 1983 complaints. It is important to consider that most Plaintiffs did not have formal legal representation when filing their initial complaint (observed through the vast majority of pro-se filings in the sample), that there are many institutional barriers such as mandatory institutional grievance procedures that must be completed prior to filing a Section 1983 complaint, and power dynamics within correctional facilities impact their frame utilization in their Section 1983 filing.

The onset of the COVID-19 pandemic introduced new dynamics to the legal landscape for incarcerated persons. Lockdowns, restricted visitation, and even more limited access to legal resources further exacerbated existing challenges. Goffman's Frame Analysis helped to elucidate how incarcerated individuals reframed their legal experiences in response to the pandemic with concerns about health and safety taking precedence. Legal filings increasingly incorporated arguments related to COVID-19 risks within correctional facilities, such as inadequate healthcare, understaffing, unsanitary conditions and lack of adherence of COVID-19 policy. Prison life post-COVID-19 onset changed drastically, for inmates and staff, convoluting the already strained prison healthcare system. In this study, I explored whether or not the frames utilized by inmates in their Section 1983 complaints differed pre- and post-COVID-19 onset. Interestingly, I found that the framing of the complaints was not drastically different. With individual harm being the most commonly utilized frame both before and after the onset of COVID-19, institutional frames being the second most common, and structural frames being used the least overall, but more frequently post-COVID-19 onset.

Goffman's framework provided a lens to understand how inmate grievances are handled by the institution staff and law actors. In many of the cases, Plaintiffs argued that they were not able to access adequate medical care due to the actions and inactions of the staff. Individual harm
was outlined in every case in the sample. This means that the Plaintiff felt that the actions or inactions of prison staff individually targeted them, violating their constitutional and civil rights. Institutional harm was the second most utilized frame. From the Plaintiff’s perspective, institutional harm refers to the negative and often enduring impact of policies, practices, and conditions within the correctional facility that adversely affect their physical, mental, and emotional well-being. This concept encompasses a wide range of harmful experiences that stem from institutional policy and practice issues often leading to a constitutional or civil rights violation against an individual.

The biggest difference in the frame utilization in the filings was the increase in filings that addressed the structural harm associated with their complaint post-COVID-onset. Pre-COVID-19 onset there was only one filing that outlined the structural nature of the civil rights violation against them (2%), but post-COVID onset there were 6 Plaintiffs who utilized the structural harm frame (8%). Structural harm, from a prisoner's perspective, refers to the pervasive and systemic disadvantages and injustices embedded within the correctional system and society at large that negatively impact their lives. Unlike individual or isolated incidents of mistreatment, structural harm is rooted in system wide practices, policies, and constructions that perpetuate inequality and hinder prisoners' well-being and rehabilitation.

One explanation for the increased frame utilization of “structural harm” could be social and political narratives. During the COVID-era, the criminal legal system faced amplified criticism and social justice movements frequently highlighted racial disparities in the treatment of prisoners, linking these issues to broader societal injustices such as systemic and structural oppression. Rhetoric and social justice movements highlighted the deep-rooted inequities within the criminal justice system and the pandemic acted as a catalyst, amplifying existing calls for
reform and bringing issues of systemic oppression to the forefront. In this study, I found that post-COVID-19 onset, Plaintiffs more often framed their grievances within the context of structural and systemic oppression, focusing on the structural deficiencies that caused healthcare-related constitutional rights violations. The post-COVID-19 onset complaints increasingly framed grievances within this broader structural context, addressing not only individual and institutional harms but also systemic issues such as inadequate access to healthcare, detailing inadequate protective measures by staff, delayed medical care, lack of compliance with public health policies, understaffing, and procedural discrepancies.

Further, Plaintiffs often utilized “Dual” and “Triad” frames to communicate the extent of the harm against them. “Dual Frames” were used by Plaintiffs to communicate both the individual and institutional nature of the harm against them, whereas “Triad Frames” were used to communicate the individual, institutional, and structural nature of the harm against them. “Dual Frames” were used more commonly than “Triad Frames” but the prevalence of “Triad Frames” was much higher in the post-COVID-19 onset group. The increased use of “Triad Frames” could also be due to the above mentioned social, political, and racial justice related concerns that gained traction during the COVID-era.

While this study sheds light on frames and perspectives that Plaintiffs employ when reporting the actions of institutional actors through Section 1983 filings, we also have to consider the frames that the defendants are operating from in their day to day actions and interactions with the Plaintiffs. The complaints outlined in the filings illustrate an interaction between two or more individuals. We are only able to review the initial complaint from the Plaintiff’s perspective. This means that we are lacking some context and perspective about each incident and the nature of the harm. This does not degrade the legitimacy of the Plaintiff’s initial complaint but it is important
to acknowledge that the defendant's actions and responses to inmate requests and complaints are shaped by their own frames, including concerns about security, stereotypes, resource allocation, and public perception. Pre-existing biases and power dynamics within the criminal justice and legal system, as well as society, may influence how healthcare-related requests and the associated legal filings from incarcerated individuals are perceived and processed. The pandemic introduced additional considerations, as institutions grappled with balancing public health imperatives with legal and ethical obligations towards incarcerated populations. Understanding the interplay of social construction and power dynamics, in the thinking and behavior of incarcerated individuals, as well as institutional actors that are responsible for their care, is crucial when examining the administration of health care services to incarcerated persons.

**Policy and Practice Implications**

*Consequences of Violating Inmates’ Rights*

Healthcare-related civil and constitutional rights violations within carceral institutions have profound consequences for individuals, institutions, and society at large. Such violations engender adverse effects on the health and well-being of inmates, exacerbating their vulnerabilities and diminishing their prospects for rehabilitation and reintegration into society (Williams et al., 2019). Additionally, these violations undermine the foundational principles of justice and human dignity enshrined in constitutional frameworks, eroding trust in the legal system and perpetuating cycles of recidivism (Cloud et al., 2015).

Research indicates that infringements upon inmates' healthcare rights exacerbate existing health disparities and contribute to adverse health outcomes (Cloud et al., 2015). Denied access to timely and adequate medical care, individuals experience heightened risks of morbidity and mortality (Ahalt et al., 2013). For instance, untreated chronic conditions, infectious diseases, and
mental health disorders prevail among incarcerated populations, leading to increased suffering and diminished quality of life (Williams et al., 2019). Furthermore, the neglect of inmates' healthcare needs perpetuates cycles of illness and suffering (Reiter & Gustafson, 2017).

In addition to the individual, who bears the majority of the harm, carceral institutions can face significant repercussions stemming from healthcare-related rights violations. Inadequate medical care not only violates legal mandates but also exposes institutions to costly litigation and settlements (Nowotny et al., 2016). Financial resources allocated for legal defense could otherwise be directed towards improving healthcare infrastructure and services within these facilities. Moreover, the erosion of trust between inmates and correctional staff undermines institutional order and safety, potentially exacerbating tensions and conflicts within carceral settings and impacting the culture of the facility (Cloud et al., 2015).

There are also broader societal ramifications of healthcare-related rights violations. Persistent disparities in access to healthcare and the perpetuation of injustices within the criminal legal system contribute to social inequities and undermine public trust in governmental institutions (Reiter & Gustafson, 2017). Furthermore, the failure to address the healthcare needs of incarcerated individuals impedes their successful reintegration into society upon release, perpetuating cycles of recidivism and exacerbating community health concerns (Ahalt et al., 2013).

**Social Advantages of Quality Correctional Healthcare in Correctional Institutions**

Many individuals caught up in the criminal legal system come from marginalized communities with limited access to healthcare. Providing prisoners with medical care helps mitigate health disparities and ensures that all individuals, regardless of their socioeconomic status or legal status, have access to essential services. Access to healthcare can contribute to the
rehabilitation and reintegration of prisoners into society by addressing underlying health issues that may hinder their ability to lead productive lives upon release. There is also evidence to suggest that addressing prisoners' healthcare needs, including mental health and substance abuse treatment, can reduce the likelihood of recidivism (Landenberger & Lipsey, 2005; Wang et al., 2012). The literature suggests that inmates who received adequate healthcare during their period of incarceration were better able to manage chronic conditions, which improved their overall well-being and reduced their likelihood of reoffending (Wang et al., 2012). There are various health-related mechanisms that contribute to a reduction in recidivism. Healthier people are more likely to obtain and keep a full time job resulting in a stable income from conventional means which enhances one's ability to find housing and transportation, all of which are crucial to the successful reintegration of offenders (Wang et al., 2020). Further, the adequate treatment of mental illness and/or drug dependency can address the main cause of some offenders’ criminality, and remove the stressor that led to crime in the first place (Baillargeon et al., 2009; Chandler et al., 2009). By providing comprehensive care, correctional facilities can support crime prevention goals by addressing some of the root causes of their involvement in the criminal justice system (Landenberger & Lipsey, 2005).

Relevance of these Findings to Policy and Practice

According to Cairney (2020), policy is created through the process of social construction. Ideas about policy and people are transmitted through relationships and ideas that have been passed on from generation to generation, person to person, group to group, and institution to institution (Cairney, 2020). Much of the public policy and public administration literature outlines that powerful people make policy and enforce policy that furthers their own interests (Quinney, 1970). Then, when their policies and the unfair enforcement of said policies create
unfavorable life conditions for the less powerful, or “target” populations, those groups are forced to turn to unconventional means of survival (Merton, 1964; Quinney, 1970). Then, after observing these unconventional means (which are often criminal in nature), negative labels are applied to the “criminal”, constructions are formed, and crime ideology is perpetuated by the powerful classes, justifying more policies and practices that target these “deviant” groups (Merton, 1964; Quinney 1970). This cycle of burdens on “deviant” groups impacts the social constructions and power dynamics that infiltrate governance structures and institutions. While these constructions are often beneficial for the powerful class, the social construction of policies by the powerful class has historically resulted in negative consequences for the powerless classes (Alexander, 2010; Schneider and Ingram, 1991; 1993; 1995). In line with the literature, it is no surprise that the interests of the powerless class are disregarded in the creation of and implementation of correctional health care policies and correctional health care practices. Broadly, serving the interests of the powerful alone creates inequalities by either directly oppressing powerless groups or unintentionally harming target populations such as “deviants”. The consequences, whether intentional or unintentional, of the social construction of policy in the interest of the powerful, are perpetuated through our criminal justice systems and society as a whole.

The occurrence of civil and constitutional rights violations against incarcerated people by state actors is a prime example of conflict between the powerful and the powerless in American society. This study illustrates that, unfortunately, social constructions and power dynamics are embedded in the fabric of American correctional institutions. While we know that the process of designing, passing, implementing and assessing public policy is intricate and complex, we also know that policymakers use their value judgements to make fundamental choices about which
social groups should be treated positively or negatively by the government (Cairney, 2020; Schneider and Ingram, 1991; 1993; 1995). When addressing highly politicized issues, policy makers seek to reward positively constructed groups with government support and punish negatively constructed groups with sanctions (Cairney, 2020; Schneider et al., 2019). While, in the United States, corrections officers are not supposed to be arbiters of physical punishment, just the managers and supervisors of detention and treatment, this study found that negative sanctions resulting from policies and practices are often unconstitutionally meted out by state actors in jails and prisons. Conflict over policy and government practice has persisted in the U.S. for centuries but the only way to prevent continued harm caused by unfair correctional policies and practices happening at the local and state levels, is to rewrite social constructions and our understanding of “who deserves what”, expand access to voting to allow more equal representation in state legislatures, increase accountability for violations by state actors, and promote democracy by allowing the voices of all Americans to be heard in the policy making and policy implementation processes.

**Limitations**

While content analysis is a valuable research method for examining existing written/recorded data, there are several limitations to be aware of. First, the reliance on publicly available data from court records introduces the possibility of selection bias, as not all cases may be represented in these records. Additionally, the scope of this study is limited to a specific time frame, 2018-2023, and jurisdiction, Fourth Circuit, potentially limiting the generalizability of findings to other contexts (Smith, 2015). Furthermore, the qualitative nature of content analysis may subject the interpretation of data to researcher bias, despite efforts to minimize subjectivity through established coding and re-coding procedures (Krippendorff, 2018). The subjective nature
of qualitative analysis also means that findings may not be easily replicable, as interpretations of
the data may vary between researchers (Miles et al., 2020). I have to be concerned with the
limited reliability and validity of content analysis. I was and am cautious about inadvertently
becoming a gatekeeper in the representation of the Plaintiff's Section 1983 narratives. I believe it
is crucial to present a nuanced and authentic portrayal of the inmate’s experiences without
reinforcing stereotypes or perpetuating biases. Thus, I made every attempt to be objective and
impartial in my analysis of the documents that have been filed on their behalf, and quoted
directly from the documents when possible to give context and validity to my interpretations.

Another limitation pertains to the potential for incomplete or inaccurate information
within court records, which may affect the validity of the findings. In this study, I only examined
the complaints, written from the Plaintiff’s perspective. This means that the narrative and frames
are subjective to the perspective of the aggrieved and should not be taken as an objective report
of the elements of the violation.

Further, the omission of certain identifying variables, such as demographic information,
socio-economic status or prior legal history, from the analysis limits the depth of understanding
regarding the factors influencing Section 1983 filings (Creswell & Creswell, 2017). Additionally,
the findings from content analysis are limited to the specific sample of written/recorded data
analyzed and may not be generalizable to other populations or contexts (Neuendorf, 2016).
Further, in this study, content analysis is descriptive in nature and does not allow for causal
inference or statistical testing of hypotheses.

One of the biggest limitations in this study is the lack of member checking. According to
the American Psychological Association (2020), member checking is a qualitative research
technique used to enhance the credibility and trustworthiness of research findings. Member
checking would serve as a form of validation for my interpretations of their complaints. In this study, that would have involved sharing my interpretations and findings with the Plaintiffs who filed the Section 1983 complaints, to validate or confirm their accuracy (Birt et al., 2016; Creswell, 2007). I was unable to do this, for various reasons, one of which being the confidential nature of the analysis, as well as the author's protected status within human subjects research. Further, when determining whether or not to make this study “human subjects research” I carefully weighed the risks and benefits of research participation for inmates. Given the unique histories and vulnerabilities of the prison population, including higher rates of mental illness and exposure to traumatic experiences, I did not feel that the potential benefits of member checking justified any potential risks to the Plaintiff's well-being. Instead, I clearly defined the codes by utilizing a conceptual and analytical framework derived from framing theory to ensure I was taking a strategic and reliable approach to coding, engaged in inductive coding, and I coded and recoded the filings to ensure reliability and account for coding refinement. I also checked the filings for discrepancies and duplicates.

**Ethical Considerations**

Content analysis raises ethical concerns about privacy, consent, and anonymity, particularly when analyzing sensitive or personal information, such as in the Section 1983 filings. To protect the privacy and confidentiality of the individuals involved in the Section 1983 filings, I removed all personally identifiable information from the data during data collection and data analysis. This study involved the analysis of publicly available court documents, and no human subjects were involved although the study did adhere to ethical guidelines for research involving human subjects including the protection of privacy and confidentiality. I was mindful of the potential impact of negative stereotypes and biases against incarcerated individuals in my
analysis and reporting of findings. I did obtain an exception from the VCU Institutional Review Board prior to conducting the study to ensure that it meets ethical standards for research since these filings are snapshots of lived human experiences.

**Contributions to the Literature**

The findings of this study contribute to many disciplines and areas of interest. First, the study contributes to the literature on the social construction of target populations. Specifically, the analysis provides an informed evaluation of the nature of constitutional violations certain “deviant” groups allege. The findings illustrate that the healthcare-related treatment of incarcerated persons is often inadequate and harmful, and not as effective or timely as the treatment of “free” persons. The burdens incarcerated people face as a result of correctional healthcare policy and practice are magnified by constitutional and civil rights violations despite having the same, and in some cases more, constitutional protections that non-“deviants”. Within these findings the compounding impact of power, hierarchy, status, systemic prejudice, stereotypes, and social constructions are accounted for. Second, this study’s findings contribute to the literature on correctional health care policy. The nature of the Section 1983 filings can paint a picture of the impact of prison healthcare policies and practices. The findings reveal that despite having policies and procedures in place that are intended to improve the administration of healthcare services, and allow for institutional redress if care is not adequate, constitutional and civil rights violations are occurring with frequency. Further, inadequate healthcare of the incarcerated population negatively impacts their likelihood at successful reintegration post-release. The content of the section 1983 filings illustrates the realities of correctional healthcare in the United States. Third, the findings contribute to a better understanding of the role of framing in formal prisoner complaints and court documents and inform strategies for
communicating violations through Section 1983 filings. This study found that while most violations in the section 1983 complaints were communicated as an individual harm, there was also emphasis on the institutional and structural components that contributed to the harm. Finally, the exploration of impact of the COVID-19 pandemic and policies related to the pandemic, on the nature and framing of prisoner complaints, is an important and valuable insight. This knowledge is relevant to the fields of law, corrections, healthcare, public policy, sociology, and communications.

**Future Research**

Future research should expand the scope of this investigation by doing a more comprehensive and nationally inclusive examination of Section 1983 filings. This study only examined filings from the Fourth Circuit Court, which is only one of the thirteen federal appeals courts in the United States and only examined healthcare-related complaints. Many of the Section 1983 complaints filed each year are in other circuit courts, and are not related to healthcare violations, thus examining the types of complaints across multiple or all jurisdictions, as well as violation type, would give a more holistic understanding of the state of constitutional rights violations against incarcerated people in the United States. Future studies should also examine *Bivens* claims, which allows insight into the civil and constitutional rights violations of individuals acting under the color of federal law, such as federal prison employees. Further, a mixed method technique utilizing more in depth quantitative analysis should be conducted to examine the frequencies and statistical differences between multiple years of filings and to uncover minute differences in the nature of filings and frames used pre- and post-COVID-19.
onset. A logistic regression could be used to examine the relationship between the two groups, pre- and post-COVID-19 onset in the “outcome variables”.

**Conclusion**

A society is judged by how it treats its most vulnerable members. As Dostoyevsky and Edwards (1962) noted, “the degree of civilization in a society can be judged by entering its prisons.” Healthcare-related civil and constitutional rights violations among inmates have far-reaching consequences that extend from the individual level to carceral institutions and more broadly, to society as a whole. Addressing these violations necessitates a comprehensive approach that upholds the rights and dignity of incarcerated individuals, promotes institutional accountability, and advances broader societal goals of justice and equity. Ensuring that prisoners have access to quality healthcare reflects a commitment to fairness, compassion, and justice.

The emergence of the pandemic triggered a multitude of changes within correctional facilities, such as lockdowns, restricted visitations, and altered healthcare protocols, but there was not much of an impact on the nature of Section 1983 complaints. Many of the same issues were present before and after the pandemic, illustrating that the culture of the criminal legal system is producing inequities regardless of “watershed” moments in history. Furthermore, this study shed light on the role of public discourse and policy changes in influencing the nature of constitutional rights violations. The heightened awareness brought about by the pandemic prompted discussions around reforming correctional policies, advocating for the rights of incarcerated individuals, and addressing systemic issues that were laid bare during this unprecedented period.

The policy problem inherent in cruel and unusual punishment in healthcare for prisoners lies in its violation of civil rights, constitutional rights, ethical principles, and public health
imperatives. From a legal standpoint, the Eighth Amendment to the United States Constitution prohibits cruel and unusual punishment, including deliberate indifference to prisoners' serious medical needs. Failing to provide adequate healthcare to inmates constitutes a violation of this constitutional right and can expose correctional facilities to legal liability. Moreover, from an ethical perspective, denying prisoners access to basic healthcare services contradicts principles of human dignity, compassion, and justice. Incarceration should not strip individuals of their fundamental right to healthcare, regardless of their legal status. Failing to provide proper medical care to prisoners not only perpetuates their suffering but also undermines the legitimacy and moral authority of the criminal justice system.

The Civil Rights Act of 1983 helped to ensure that all individuals have equal protection of civil rights laws when they are under the supervision of local, state or federal governments. Allowing inmates to file Section 1983 complaints regarding the constitutionality of their treatment while incarcerated is not only ethical but imperative to the legitimacy of American democracy and the American criminal justice system. The power dynamic outlined by Shneider and Ingram (1991; 1993; 1997; 2005; 2007, 2019) of the advantaged, dependent, contenders and deviants is apparent in the distribution of benefits and harms resulting from carceral healthcare policies and the administration of healthcare in prisons and jails. “Deviants” are continuously burdened by said policies and once incarcerated, hindered even further by state actors engaging in unconstitutional conduct and hampering their access to adequate and timely healthcare.

This study not only explored the nature of civil and constitutional rights violations against incarcerated persons pre and post-COVID-19, and the frames utilized to convey those complaints, but also highlighted the dynamic interplay of social constructionism, power, racial justice initiatives, carceral justice awareness, governance and policy related factors on the nature
and framing of constitutional rights violations outlined in Section 1983 filings. Providing timely and adequate medical care serves to protect public health, promote rehabilitation, uphold legal obligations, and advance principles of equity and justice in society.

In sum, the goal was to utilize the Social Construction of Target Populations Theory (Schneider and Ingram, 1991; 1993; 1995) and Framing Theory (Goffman, 1974) to explore the potential impact the COVID-era on the nature of healthcare-related constitutional rights violations within the confines of correctional facilities filed by incarcerated persons through Section 42 U.S.C. 1983. The results of the content analysis were integrated to provide a comprehensive understanding of the Section 1983 complaints. Manifest and latent content analyses utilizing pre-defined deductive codes offered a structured framework for assessing the legal complaints, while emergent inductive codes enriched the analysis by capturing nuanced experiences and contextual factors embedded within the complaints. The integrated findings facilitated a discussion of the nature of Plaintiff’s grievances, the ways in which they were framed, and informed the recommendations for policy and practice improvements within correctional systems. Addressing healthcare-related civil and constitutional rights violations among inmates is imperative for fostering individual well-being, safeguarding institutional integrity, and promoting societal cohesion (Cloud et al., 2015). Efforts to uphold these rights not only serve to enhance the quality of life for incarcerated individuals but also contribute to the cultivation of a fair and just society for all.
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Appendix A: Qualitative Codebook

Codebook

Introduction

- **Research Objective**
  - This study employed content analysis to review Section 1983 filings in order to identify the most common types of constitutional violations alleged by prisoners and the ways in which they are framed, in their lawsuits against correctional facilities and staff. Section 1983 filings refer to the process of filing a Section 1983 lawsuit in federal court to seek damages for the violation of an individual's civil rights by a government entity or official. These lawsuits are an important tool for holding government officials accountable for their actions and protecting the civil rights of vulnerable individuals in the United States. Incarcerated persons may file Section 1983 lawsuits if they believe that their rights have been violated while in prison or jail (Civil Rights Act of 1871, 42 U.S.C. § 1983). A well-known recurring allegation in these suits is the violation of the Plaintiff's Eighth Amendment rights, including the failure to provide timely and appropriate access to healthcare services.

- **Scope**
  - I selected a sample of 120 healthcare-related Section 1983 filings from the 4th U.S Circuit Court in the United States between 2018 and 2023. The sample was gathered by using a stratified systematic sampling technique that ensured proportional numerical representation of cases from each filing year. The sample consists of 20 filings from each year, 2018, 2019, 2020, 2021, 2023. The sample was narrowed to healthcare-related Section 1983 filings from the 4th U.S Circuit Court. The Fourth U.S. Circuit Court of Appeals, often referred to as the Fourth Circuit, is one of the thirteen United States courts of appeals. The jurisdiction of the Fourth Circuit includes 9 courts that span various states: Maryland, Virginia, West Virginia, North Carolina and South Carolina. Additionally, the Fourth Circuit has appellate jurisdiction over federal cases originating from various administrative agencies, military courts, and federal courts in the District of Columbia.
  - To be included in the sample, the filings must be related to constitutional violations related to healthcare during confinement.

**Deductive Codes & Instructions for Coders**

**Nature of Violations**

1. **Access to Medical Care**
   - Code: AMC
   - Description: Violations related to prisoners' access to timely and adequate medical care.
   - Instructions: Assign this code when the complaint specifically involves issues related to prisoners being denied timely and adequate medical care.

2. **Cruel and Unusual Punishment in Healthcare**
   - Code: CUH
• Description: Instances where healthcare practices or lack thereof are considered excessively punitive or inhumane.
• Instructions: Apply this code when the complaint alleges that healthcare practices within a prison context, or lack thereof are excessively punitive or inhumane, potentially violating constitutional rights.

3. Right to Privacy in Medical Treatment
• Code: RPR
• Description: Violations related to the privacy of medical information and treatment.
• Instructions: Use this code when the complaint pertains to breaches of privacy concerning medical information or treatment within the prison system.

4. Informed Consent
• Code: INCS
• Description: Violations involving the lack of proper informed consent in medical procedures or treatments.
• Instructions: Apply this code when the complaint raises concerns about the absence of proper informed consent in medical procedures or treatments for prisoners.

5. Discrimination in Healthcare
• Code: DISC-HC
• Description: Violations based on discriminatory practices in the provision of healthcare services.
• Instructions: Use this code when the complaint alleges discrimination in the provision of healthcare services within the prison context.

Frames of Violations
1. Individual Harm
• Code: INDV
• Description: Complaint is framed as individual harm/targeted harm
• Instructions: Apply this code when the complaint specifically highlights individual or targeted harm suffered by a person (likely themselves) within the prison system.

2. Structural Harm
• Code: STRUC
• Description: Complaint is framed as a structural harm/broader constitutional issue.
• Instructions: Assign this code when the complaint emphasizes a broader, systemic issue or a violation of constitutional rights affecting multiple individuals within the prison system.

3. Institutional Harm
• Code: INST
• Description: Complaint is framed as an institutional issue.
• Instructions: Use this code when the complaint focuses on issues within the institutional framework itself, such as policies, procedures, or practices affecting the entire institution.

Inductive Codes & Instructions for Coders

Nature of Violations
1. **Serious Medical Condition**
   - **Code:** SMC
   - **Description:** The complaint illustrates confusion regarding what constitutes a “serious medical condition”.
   - **Instructions:** Use this code when the complaint illustrates a disagreement between what the Plaintiff believes to be a “serious medical condition” that requires immediate and adequate care, but the defendant(s) did not respond in the manner required per case law, thus suggesting that they did not believe the ailment or condition was “serious”.

2. **Deliberate Indifference**
   - **Code:** DELIB
   - **Description:** The complaint outlines defendants “deliberate indifference” to Plaintiff's serious healthcare needs.
   - **Instructions:** Use this code when the complaint includes claims of “deliberate indifference” or the Plaintiff argues that the prison officials or healthcare providers were aware of an inmate's serious medical condition or substantial risk of harm but consciously disregarded or failed to respond to it.

3. **Lack of Communication**
   - **Code:** LOC
   - **Description:** The complaint outlines defendants did not communicate to the inmate their responsibilities in obtaining or paying for their own medical care.
   - **Instructions:** Use this code when the complaint includes claims of “lack of communication” or “mis-information” given by facility staff or defendants and the lack of accurate communication resulted in the inmate not receiving the care they needed.

4. **Lack of Accountability**
   - **Code:** LOA
   - **Description:** The complaint outlines that defendants did not take responsibility for medical mistakes they made when diagnosing, providing care for, or the referral of medical need to proper authority within the facility.
   - **Instructions:** Use this code when the complaint includes claims of “lack of accountability” by prison medical personnel or prison staff, when the defendant did not attempt to remedy their mistakes, the mistakes of their staff, and/or the defendant passed off the responsibility of their mistake onto the offender or another state actor.

5. **Financial Barrier**
   - **Code:** FIN
   - **Description:** The complaint outlines some sort of financial related barrier to receiving healthcare services.
   - **Instructions:** Use this code when the complaint includes claims of financial related barriers to accessing or receiving adequate healthcare services. Types of financial barriers are mandatory medical copayments, directions to seek “outside” care that the inmate cannot afford, or inmate medical debts being applied to their prison account causing other medical or health related issues.

6. **COVID-19 Related Complaint**
- Code: COV
- Description: The complaint outlines some sort of healthcare-related grievance related to the spread of COVID-19 or COVID-19 related protocols.
- Instructions: Use this code when the complaint includes claims of healthcare or correctional staff engaging in actions that increased the risk of contracting COVID-19 or spread of COVID-19, or failure to respond appropriately to COVID-19 related medical needs of inmates.
Appendix B: Example Complaint for Violation of Civil Rights (Prisoner)

**UNITED STATES DISTRICT COURT**
for the

_________ District of _________

_________ Division

Case No. (to be filled in by the Clerk's Office)

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**Plaintiff(s)**
(Write the full name of each plaintiff who is filing this complaint. If the names of all the plaintiffs cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)

---

**Defendant(s)**
(Write the full name of each defendant who is being sued. If the names of all the defendants cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names. Do not include addresses here.)

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**COMPLAINT FOR VIOLATION OF CIVIL RIGHTS**
(Prisoner Complaint)

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**NOTICE**

Federal Rules of Civil Procedure 5.2 addresses the privacy and security concerns resulting from public access to electronic court files. Under this rule, papers filed with the court should not contain: an individual’s full social security number or full birth date; the full name of a person known to be a minor; or a complete financial account number. A filing may include only: the last four digits of a social security number; the year of an individual’s birth; a minor’s initials; and the last four digits of a financial account number.

Except as noted in this form, plaintiff need not send exhibits, affidavits, grievance or witness statements, or any other materials to the Clerk’s Office with this complaint.

In order for your complaint to be filed, it must be accompanied by the filing fee or an application to proceed in forma pauperis.
I. The Parties to This Complaint

A. The Plaintiff(s)

Provide the information below for each plaintiff named in the complaint. Attach additional pages if needed.

Name
All other names by which you have been known:
ID Number
Current Institution
Address

City  State  Zip Code

B. The Defendant(s)

Provide the information below for each defendant named in the complaint, whether the defendant is an individual, a government agency, an organization, or a corporation. Make sure that the defendant(s) listed below are identical to those contained in the above caption. For an individual defendant, include the person’s job or title (if known) and check whether you are bringing this complaint against them in their individual capacity or official capacity, or both. Attach additional pages if needed.

Defendant No. 1

Name
Job or Title (if known)
Shield Number
Employer
Address

City  State  Zip Code

☐ Individual capacity  ☐ Official capacity

Defendant No. 2

Name
Job or Title (if known)
Shield Number
Employer
Address

City  State  Zip Code

☐ Individual capacity  ☐ Official capacity
II. Basis for Jurisdiction


A. Are you bringing suit against (check all that apply):
   - Federal officials (a Bivens claim)
   - State or local officials (a § 1983 claim)

B. Section 1983 allows claims alleging the “deprivation of any rights, privileges, or immunities secured by the Constitution and [federal laws].” 42 U.S.C. § 1983. If you are suing under section 1983, what federal constitutional or statutory right(s) do you claim is/are being violated by state or local officials?

C. Plaintiffs suing under Bivens may only recover for the violation of certain constitutional rights. If you are suing under Bivens, what constitutional right(s) do you claim is/are being violated by federal officials?
D. Section 1983 allows defendants to be found liable only when they have acted “under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia.” 42 U.S.C. § 1983. If you are suing under section 1983, explain how each defendant acted under color of state or local law. If you are suing under Bivens, explain how each defendant acted under color of federal law. Attach additional pages if needed.

III. Prisoner Status

Indicate whether you are a prisoner or other confined person as follows (check all that apply):

- [ ] Pretrial detainee
- [ ] Civilly committed detainee
- [ ] Immigration detainee
- [ ] Convicted and sentenced state prisoner
- [ ] Convicted and sentenced federal prisoner
- [ ] Other (explain)

IV. Statement of Claim

State as briefly as possible the facts of your case. Describe how each defendant was personally involved in the alleged wrongful action, along with the dates and locations of all relevant events. You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If more than one claim is asserted, number each claim and write a short and plain statement of each claim in a separate paragraph. Attach additional pages if needed.

A. If the events giving rise to your claim arose outside an institution, describe where and when they arose.

B. If the events giving rise to your claim arose in an institution, describe where and when they arose.
C. What date and approximate time did the events giving rise to your claim(s) occur?

D. What are the facts underlying your claim(s)? (For example: What happened to you? Who did what? Was anyone else involved? Who else saw what happened?)

V. Injuries

If you sustained injuries related to the events alleged above, describe your injuries and state what medical treatment, if any, you required and did or did not receive.

VI. Relief

State briefly what you want the court to do for you. Make no legal arguments. Do not cite any cases or statutes. If requesting money damages, include the amounts of any actual damages and/or punitive damages claimed for the acts alleged. Explain the basis for these claims.
VII. Exhaustion of Administrative Remedies Administrative Procedures

The Prison Litigation Reform Act ("PLRA"), 42 U.S.C. § 1997e(a), requires that "[n]o 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."

Administrative remedies are also known as grievance procedures. Your case may be dismissed if you have not exhausted your administrative remedies.

A. Did your claim(s) arise while you were confined in a jail, prison, or other correctional facility?
   - [ ] Yes
   - [ ] No

   If yes, name the jail, prison, or other correctional facility where you were confined at the time of the events giving rise to your claim(s).

B. Does the jail, prison, or other correctional facility where your claim(s) arose have a grievance procedure?
   - [ ] Yes
   - [ ] No
   - [ ] Do not know

C. Does the grievance procedure at the jail, prison, or other correctional facility where your claim(s) arose cover some or all of your claims?
   - [ ] Yes
   - [ ] No
   - [ ] Do not know

   If yes, which claim(s)?
D. Did you file a grievance in the jail, prison, or other correctional facility where your claim(s) arose concerning the facts relating to this complaint?

☐ Yes
☐ No

If no, did you file a grievance about the events described in this complaint at any other jail, prison, or other correctional facility?

☐ Yes
☐ No

E. If you did file a grievance:

1. Where did you file the grievance?

2. What did you claim in your grievance?

3. What was the result, if any?

4. What steps, if any, did you take to appeal that decision? Is the grievance process completed? If not, explain why not. *(Describe all efforts to appeal to the highest level of the grievance process.)*
F. If you did not file a grievance:
   1. If there are any reasons why you did not file a grievance, state them here:
   
   2. If you did not file a grievance but you did inform officials of your claim, state who you informed, when and how, and their response, if any:
   
G. Please set forth any additional information that is relevant to the exhaustion of your administrative remedies.

(Note: You may attach as exhibits to this complaint any documents related to the exhaustion of your administrative remedies.)

VIII. Previous Lawsuits

The “three strikes rule” bars a prisoner from bringing a civil action or an appeal in federal court without paying the filing fee if that prisoner has “on three or more prior occasions, while incarcerated or detained in any facility, brought an action or appeal in a court of the United States that was dismissed on the grounds that it is frivolous, malicious, or fails to state a claim upon which relief may be granted, unless the prisoner is under imminent danger of serious physical injury.” 28 U.S.C. § 1915(g).

To the best of your knowledge, have you had a case dismissed based on this “three strikes rule”?

☐ Yes
☐ No

If yes, state which court dismissed your case, when this occurred, and attach a copy of the order if possible.
A. Have you filed other lawsuits in state or federal court dealing with the same facts involved in this action?
   ☐ Yes
   ☐ No

B. If your answer to A is yes, describe each lawsuit by answering questions 1 through 7 below. (If there is more than one lawsuit, describe the additional lawsuits on another page, using the same format.)

   1. Parties to the previous lawsuit
      Plaintiff(s) ____________________________________________
      Defendant(s) ____________________________________________

   2. Court (If federal court, name the district; if state court, name the county and State)

   3. Docket or index number

   4. Name of Judge assigned to your case

   5. Approximate date of filing lawsuit

   6. Is the case still pending?
      ☐ Yes
      ☐ No
      If no, give the approximate date of disposition.

   7. What was the result of the case? (For example: Was the case dismissed? Was judgment entered in your favor? Was the case appealed?)

C. Have you filed other lawsuits in state or federal court otherwise relating to the conditions of your imprisonment?
D. If your answer to C is yes, describe each lawsuit by answering questions 1 through 7 below. *(If there is more than one lawsuit, describe the additional lawsuits on another page, using the same format.)*

1. Parties to the previous lawsuit
   - Plaintiff(s)  
   - Defendant(s)  

2. Court *(if federal court, name the district; if state court, name the county and State)*  

3. Docket or index number  

4. Name of Judge assigned to your case  

5. Approximate date of filing lawsuit  

6. Is the case still pending?  
   - Yes  
   - No  
   If no, give the approximate date of disposition  

7. What was the result of the case? *(For example: Was the case dismissed? Was judgment entered in your favor? Was the case appealed?)*
IX. Certification and Closing

Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

A. For Parties Without an Attorney

I agree to provide the Clerk’s Office with any changes to my address where case-related papers may be served. I understand that my failure to keep a current address on file with the Clerk’s Office may result in the dismissal of my case.

Date of signing: 

Signature of Plaintiff 
Printed Name of Plaintiff 
Prison Identification # 
Prison Address  

City State Zip Code

B. For Attorneys

Date of signing: 

Signature of Attorney 
Printed Name of Attorney 
Bar Number 
Name of Law Firm 
Address  

City State Zip Code

Telephone Number  
E-mail Address
Appendix C: Numerical Representation of Codes - Example Excel Sheet