423

Behind the Prison Walls

David Mathis MD

While the COVID-19 crisis has brought prisoners' health issues to the attention of many, these issues are long-standing and critical. Dr. David Mathis, who works for the California Department of Corrections and Rehabilitation, serves as a physician, surgeon, and expert witness. He explains in detail why a sick prisoner is at far greater risk than his or her counterpart on the street and why this difference will be significant to you, should you handle a prisoner's case as an LNC.

- These cases are more often civil rights cases based on deliberate indifference than standard of care issues.
- They rarely go to court but are negotiated.
- They are all federal cases, and they have no cap in terms of damages.
- The extreme time span between initial suspicion of a medical problem and actual treatment contributes to greater medical danger and sometimes death.
- Multiple factors that are unique to a prison setting cause the high incidence of infection.

Patricia: Hi. This is Pat Iyer with Legal Nurse Podcast. I have with me today Dr. David Mathis, who's employed by the California Department of Corrections and Rehabilitation. He is working as a physician and surgeon at the California medical facility. We connected through LinkedIn, and when I looked at his background, I thought he had such good information to be able to bring to you, as a legal nurse consultant, about what goes on behind the prison walls.

David has extensive experience working in the correctional setting in a variety of roles and has to offer you the perspective of a couple of different kinds of cases that arise in corrections. One of them, standard of care, medical care, we're familiar with. Another one in terms of violation of civil rights is another aspect of what he's involved in when he looks at those cases. And as an expert witness, he's reviewed cases and will bring that information to us in this conversation. David, welcome to the show.

David: Thank you.

Patricia: Most of our listeners are probably going to be familiar with the standard of care issues that occur outside of the prison in hospitals, nursing homes, clinics, and doctors' offices. What are the kinds of standard of care issues that arise in a correctional facility?

David: Same thing that arises on the street, except it's an entirely different venue. It may be that someone didn't do what they were supposed to do or didn't act as someone else in a similar situation may have acted, and that the plaintiff suffers as a result of it and they bring a tort claim. Your attorney says, "This is a violation of standard care; let's find an expert who can support that." And then on one hand, there is the standard of care issue, on the other hand there's causation, whether or not that standard of care issue caused the damages. And then they go on from there. But you have to have both the standard of care and the causation.

Patricia: In your experience, what are some of the challenges for inmates in terms of bringing standard of care claims?

David: Well, on the street, you have to have an expert. You have to have someone who is going to sign an affidavit to say that this was a standard care violation, or who may write a report, depending on which state it's in, under any circumstances, be willing to be deposed and say this was a violation in the standard of care. Everyone has to have an expert. Experts are not inexpensive. It's a significant outlay of money, and someone needs to come up with that.

So, a plaintiff's attorney has to be pretty sure that they're going to do well in this case, in order to hire one expert or several experts that are necessary. Usually, like for myself, I'm the standard of care expert, but I'm not a specialist in gastroenterology, or surgery, or pulmonology, or infectious disease to be that causation expert that's also necessary.

Right away, you're looking at two experts, and for the standard of care cases, some of those cases go through fairly rapidly with just the affidavit, review of records, discussions with the attorney, and then a deposition, and sometimes they settle. Rarely, rarely do they go to

court. In the past four years, I haven't been to court once, whether that's the standard of care or the 1983 civil rights cases.

Patricia: Can you explain to me why I got letters all the time, when I was running my legal nurse consulting business, that said, “Dear Nurse Iyer, I need an expert.” How come the attorneys representing those plaintiffs were not contacting me? How come I got letters from the inmates?

David: Inmates have a lot of time on their hands. They have a library, a law library. And when you go by the law library, you might see 30 or 40 inmates there. They have a right to be in the law library. So, they have the intention to look into their own situation. And then there are jail attorneys, there are actual attorneys in jail or prison that help write these cases up. And so a detainee may start the case on their own trying to find an expert. It's not something I'd like to get involved in, because, you know, it's just all over the place. They don't really understand the process as well as they should. And of course, they don't have the capital to take something like this to court.

Patricia: You know, I was just flashing back on the memory of a client who I worked with for many years, who handled medical malpractice cases, and he also had a restaurant at the New Jersey shore. And when times were tight, he decided to stop paying the social security and unemployment taxes out of his employees’ wages, until one of them reported him. So, he ended up in prison himself. I don't know if he is, even this day, helping with writing up those types of complaints.

He had a wonderful medical malpractice occupation as an attorney, but the government doesn't forgive things like not paying taxes for employees under those circumstances. So, it was an unfortunate lapse in judgment, and off he went. Thank you for reminding me that attorneys can go in prison, too. I had forgotten all about him. You mentioned the 1983 civil rights cases, can you differentiate, for our listener, what those cases are as opposed to medical malpractice claims?

David: Well, the civil rights cases are almost automatically federal cases, a significant difference in the venue to court. So, it would be in a district court. And they have a significantly higher level of proof that's necessary. They follow Rule 26, which determines how information

comes in during discovery, what the expert can do, how the case is to be managed. And because they're federal cases, it's different as far as the cap is concerned.

In every state that I'm aware of, there's a cap to medical malpractice. There may be punitive damages that are over and above, but there's a cap to the medical malpractice. And in some of the southeastern states that might be $200,000. In the northeastern states, it might be half a million dollars or a million dollars. And then the punitive damages, I don't believe, have any cap.

But the 1983 civil rights cases have no cap, so they can settle for millions of dollars if there are significant issues and damages that are proven in court, and they set the standard for other districts throughout the United States. The Federal cases require a report. It's a complicated report. I've spent a lot of time with these reports so that they pass muster in any of the districts.

But the report has to say essentially what your opinion is, and show your background, your qualifications, must show how much you're being paid, must show your testimonial history for the past four years. And then you have a template that you go through that gives the statement of facts and background, and then finally you give your opinions, which are the most important aspect of the report. And those opinions demonstrate where this case could go, what the attorney is going to try and argue given his supplemental information. And then after the report, there's a deposition where opposing counsel has the opportunity to talk to you about your opinions and your report.

Patricia: So, to burrow down into this a little bit further, if an inmate was transferred from one prison to the other, and there was a delay in treatment, I'm thinking about a case that I was helping the Assistant Attorney General of New Jersey with a case of a man who had—it was either a squamous cell or a melanoma, I think a squamous cell on his scalp. And because he was transferred from one facility to the other, there was a delay in doing the surgery that was necessary to remove the lesion. And it became a more extensive procedure because of the delay. Is that a standard of care issue or is that a deliberate indifference civil rights violation? How would that type of scenario be classified?

David: It can't be clear from the information that you gave me. But this is the type of case that shows up in prisons all the time, because people are so frequently transferred from one location to another. The big difference about having a lesion on your scalp is that you notice it, your wife notices it, you make an appointment with your doctor, possibly dermatologist, even though you might wait two or three months to see the dermatologist.

Then that dermatologist or local physician will biopsy and remove the lesion. So, you'll know what's going on in a timely fashion. What happens in prisons that there are so many obstacles from the time that you notice something and see the physician until you end up in an office where that lesion can be biopsied. Lots of different hurdles.

Patricia: I can think of the medical records that I went through, I saw tons of these requests to be seen slips that the inmate would fill out. And then the requests would languish somewhere in the system, until they would get picked up on. You mentioned the timing issues. And take me through a scenario where that would really make a difference in a person's health and how that plays into the legal system.

David: It might be easier for me to take you through a routine situation for that scalp lesion. The inmate puts in the request to be seen by medical. In California it's called a 7362. Those are picked up every day and triaged by a registered nurse. And it must happen within three days. So, there's a three days' long weekend, could be four days, but three days is about right. And so, then the RN may actually see that patient or have that patient triaged by someone else to be able to look at the scalp lesion. And then have the patient seen by a physician, either immediately or schedule, within a week or two, whatever, depending upon the physician's schedule, provider's schedule, and a number of other factors.

Let's say the provider says, "Oh, that's suspicious. We need to biopsy that." In some locations, that can be done in-house. Where I work, it can be done in-house; we have a procedure clinic. But there's a waiting list for the procedure clinic just like there is on the street for other to see that dermatologist. It might be six or eight weeks.

If the provider recommended initially for that patient to be seen by a dermatologist, for instance, I'm pretty good with skin and I look at

something I say, “Oh, this is not good. This is a superficial spreading squamous cell carcinoma, and it's got to be excised.” So I may say, in my request for service, that needs to be seen by a dermatologist or even a plastic surgeon, depending on its location, because some of the location makes a lot of difference.

But there are different immediacies of consultations. Emergency is lights and siren, life-threatening, heart attack, unable to breathe, that sort of thing. Urgencies vary from state to state and contract to contract. In California, it's two weeks. In Michigan, by contract, it's one week. But the urgent consultations have to go through a little different process because they are urgent and because it takes the much more effort and attention.

Whenever the request is made, it has to be signed off by a provider or maybe the nurse manager, someone who understands the utilization management process. Utilization management is also governed, in most of the prisons and jails, by a software called InterCall, which is a peer-reviewed software program used by correctional facilities, hospitals, insurance companies, and other networks in United States. And you must satisfy InterCall criteria to be able to see the consultant, or to have a CT scan, or an MRI, or whatever. So if that request for service initially passes InterCall, the utilization management nurse demonstrates that, or the physician supervising utilization management finds that it satisfies InterCall, then it can be approved.

Now, then we come up to what is the routine time period during which an appointment is reasonable. That can vary from state to state. It's generally 60 days, sometimes 90 days, and can depend on the location, who is available to do that consultation, or who hasn't been jaded by working with prisoners and is still taking prisoners in their office. The reimbursement’s generally pretty good, higher than what they would get otherwise. But nevertheless, having inmates come into your office in shackles and chains and sitting with a young mother can put off office managers.

So, within 60 to 90 days on a routine, this scalp lesion is seen in the dermatologist’s office, and they do a biopsy. That's what dermatologists do, they biopsy everything. So, they biopsy it and they find out it's melanoma. And then that comes back within one to two weeks. And then it's seen by someone who can remove it. Now, some

of the dermatologists will do that, sometimes it's a plastic surgeon. But trying to get a lesion like that on the schedule to be removed may take another six or eight weeks.

As you can see, now we've already gotten to approximately five months since that melanoma was first discovered, and now we have the excision occurring. And if it has spread, or even if it hasn't spread and the plastic surgeon's saying, "Well, we need to have a further evaluation, we need an MRI or a PET scan to see whether there any metastases," well, that can take another two weeks before it's done, before it's read, and before the excision occurs. So, it could be six months.

Defense will argue that this is within the contractual relationship with the government entity that was set up in the beginning. Plaintiff will argue that it was inappropriate to wait so long. And most of us would think, "Oh yeah, that's way too long. I've got a melanoma. I thought so from the beginning, but now it's six months later they're taking it out. And it's a level four and I'm likely to succumb to this in the next months or years, no matter what anybody does, immunotherapy or whatever."

So, I did mention immunotherapy, it may be that that person needs chemotherapy. And the first thing you know, it's been eight or nine months since the lesion was suspected and it's being treated. That's a long time. Now, providers can make these referrals urgent. And in many circumstances, I would make that referral urgent because I think it looks like a melanoma and I know it needs to be taken care of, but sometimes they don't.

And defense will argue that no one knew at the time, plaintiff will argue that they should have known at the time. And that's the process of this lawsuit. Now, in the 1983 cases, in deliberate indifference cases, the plaintiff will try and establish that this was a serious medical illness from the beginning and that should have been taken care of, and was ignored or unreasonably delayed for the plaintiff. Defense will argue that no one knew for sure, at that time, it was suspicious, that it wasn't documented. And then that's the court case. Hopefully, the plaintiff is still surviving at the end of it, but not necessarily so. It may be a family member that's the plaintiff.

Patricia: You mentioned that you haven't been to court to testify for four years. Is that because these cases are settling?

David: Yes, these cases always settle. It's on the strength of the report, the strength of the deposition, the cost of trial. And all these factors come into play. And within the last couple of weeks is really crunch time. And the attorneys will get together. The judge may say, “Settle this,” or, “come to a settlement conference and work with them.” So, these cases almost always settle.

Patricia: And I wish I had a nickel for every case that I was involved in that settled at five o'clock on Friday, when the trial is supposed to start on Monday.

David: If your contract was good, you'd have that nickel, because we’d be paid at least one week before that trial was to come off. Attorneys don't necessarily like that, but they’re also sometimes helpful because it pushes them to get that negotiation done. Because, otherwise, they're on the hook to pay you for your time, because that's really all experts have. If an expert is busy in a practice, and they set aside time for a trial, let's say it's on the opposite coast, that's three days, and they need to be compensated for that as they're taking time off their own work.

Patricia: Well, I wanted to bring our talk today to a close by focusing on one aspect of prison care that a lot of people are concerned with, and that is the spread of COVID within the population of people who are incarcerated. What have you seen, from your perspective, in terms of the implications of this?

David: I'm involved right now in a case in Washington, DC, in the federal court for a sentencing hearing. It's a 73-year-old man with multiple medical illnesses, who's at high risk for COVID. And William Barr has given a memo to the Federal Bureau of Prisons to try and get people out of prison. And retaining counsel is trying to keep this fellow out of prison and to enter home detention.

In my more immediate circumstances, I've been working from home for six months because, well, I'm of a certain age, and at risk, and can work by video. Today's actually the first day I'm going back to work because my boss tells me that it's safer to be in her prison than it is to

be in the grocery store. But nevertheless, I'll be wearing a P100 and face shield.

Patricia: Can you give our listeners any perspective of why COVID is so difficult to control in the prisons?

David: San Quentin was in the news recently, the governor and headquarters wanted to transfer people from down south, near the border in California, to another location because there was so much COVID in that particular prison. And they made the determination they were going to send a couple of hundred inmates up to San Quentin.

And they tested them, some of them a month before they came. So, then they came, they transferred in a big Greyhound bus without social distancing. They're moved into detention cells with maybe a dozen other people. That was before everyone had to be wearing masks. And then they're moved into the detention cells at San Quentin. They're moved into a tier, like a level in your house. In this particular housing unit, there were five tiers, so five floors. They put these new guys on the top floor, and it's open on the side. So, they're coughing and sneezing. And what we know now is that the aerosol and droplet, and droplets and aerosol were coming out of the fifth tier and coming down, all the way down to the first tier.

The air isn't mixing very well, San Quentin has been around for 150 years. And so then they get, out of 2,500 inmates, they had over 1,500 positives, they had 25 inmates that died, they had multiple staff members, some staff members died as a result of that exposure. The ventilation systems in a prison, they're commonly old facilities. They have single cells, and dormitories, where there may be a dozen, or maybe even 50 or 60 inmates in the same dormitory.

Inmates may not have the same sort of hygiene that some of us have, after we read about it every day and watch it on the news. And they may not have personal protective equipment. They may not have the soap in the dispenser, because somebody didn't replace it. Or the shower may not be cleaned every time they go in. And they've got some guy who's coughing but who also has the potential to be violent. And it's not the type of person you go up and tap on the shoulder and tell him to cover his cough. So, these are some of the things that come up.

Patricia: I hadn't even thought about the open environment where those aerosol particles can travel that far. Yeah, that certainly is a risk factor in the environment. Any last thoughts or tips that you'd like to share with our audience before you tell our listener how they can get in touch with you to find out more about your services.

David: There are a lot of these correctional cases around the United States. Some attorneys have to take them on a pro bono basis, because the judge tells them to take them. They sometimes work their way up to the point where the judge will make that recommendation. There are companies, major medical vendors that work throughout the United States and in some, some governmental organizations. For instance, in California, we run our own prison system.

But like myself, there are people who have worked in this system for a long time who understand how it works, what comes to play with the contract, that the governmental entity makes. What comes to play with certain standards, essential and required, from national organizations like the American Correctional Association, and the National Commission on Correctional Healthcare. One of the big differences about these types of cases versus the standard of care cases is we have organizations and contracts that come into play about how the behavior should occur, and helps to set the standard in essentially is authoritative when the contract says to do this, or where the contract says to follow the NCCHC standards, the defendant is hard pressed to say why they wouldn't follow those standards in this particular circumstance. So, to some degree, it makes these cases easier to put together a report about.

Patricia: Thank you for those points, those are great. How can our listeners connect with you and find out more about your services?

David: Well, email's David@PrisonMDExpert.com. So, the website is PrisonMDExpert.com.

Patricia: All right, perfect. Thank you so much, David, for sharing your insights and experiences. You've given some great examples that help our listener understand the environment and the challenges associated with providing care to people within the population that you serve. And I appreciate your service and the time that you've given us today in explaining the way that things look behind the walls.

David: Thank you for the opportunity.

Patricia: And for you who is listening to this, thank you for spending your 30 minutes of time with us. I appreciate you coming back week after week. Legal Nurse Podcast is now in its fifth year of production. That's number five. We have been interviewing and doing podcasts with guests since Labor Day in September of 2016. And as we record right now, it's just past our fifth-year anniversary. So, I'm pleased to bring the show to you, and please come back and listen to future shows. Thanks so much.

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