The Issue of "Adequate" Care for Incarcerated Diabetics Under Estelle and the ADA

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Abstract

Diabetes is one of the few chronic medical conditions that requires the individual, not a doctor, to make healthcare decisions for themselves numerous times a day. This paper will analyze the consequences of this unique phenomenon in the context of correctional facilities, where inmates are deprived of the ability to make independent treatment decisions, even by legislation that is meant to protect them. While the Eighth Amendment, the Fourteenth Amendment, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act can provide effective avenues to ensure proper treatment for many incarcerated people with disabilities, for diabetics, they currently do not. This paper will begin with a brief overview of the medical complications caused by inadequate diabetes care and what rights to medical care diabetics in prison are guaranteed. It will then explain why the court's understanding of the importance of diabetes care must be refined, as for many diabetic prisoners, their pleas for proper care are heard only after amputation, blindness, or death—all of which would have been preventable, given a more concrete definition of adequate care.

I. Introduction

While a constitutional right to healthcare is not guaranteed, people in correctional facilities are assured a minimum level of medical treatment. Throughout past litigation, prisoners suffering from inadequate medical care have taken two approaches to achieving relief. This paper will examine both of these approaches, their outcomes for prisoners with diabetes, and show where courts have made rulings that impose serious health consequences on diabetic prisoners, contrary to the intentions of protective statutes such as the Eighth Amendment, *Estelle v. Gamble*, the ADA, and Section 504 of the Rehabilitation Act. This paper will argue that the court's current understanding of what constitutes cruel and unusual punishment, as well as noncompliance with ADA and Section 504 guidelines, is inadequate in the context of diabetes management in incarceration facilities. Courts must recognize that long-term health consequences caused by insufficient diabetes care should qualify as "cruel and unusual punishment" under the Eighth Amendment. Prisons and jails must, therefore, reassess the limited treatment options they offer to diabetic inmates and change their guidelines to follow ADA/Section 504-mandated conditions. In many cases, this compliance should take the form of increased ability for self-management of diabetes and access to life-saving diabetes treatment options such as insulin pumps and CGMs. Denial of access to these technologies should be seen as causal for both short- and long-term diabetes-related complications.

II. Background

To begin analyzing the oversights of current laws when it comes to the treatment of prisoners with diabetes, it is important first to understand the disease itself. Diabetes,

as defined by the Centers for Disease Control and Prevention (CDC), is "a chronic (long-lasting) health condition that affects how your body turns food into energy" and comes in three distinct forms: type 1, type 2, and gestational diabetes.[51] Diabetes refers to a condition where the body cannot produce sufficient insulin (in the case of type 2) or any amount of insulin (in the case of type 1). Insulin is a hormone that allows for the processing and usage of glucose—the body's primary source of energy.[52] People with diabetes constantly have to manage their blood glucose levels (also referred to as "blood sugar levels" or "bg") to prevent both hyperglycemia and hypoglycemia—harmful conditions where the body has either too much or too little sugar.

When the quality of diabetes treatment is poor, it permanently damages the body and can lead to severe health consequences. One indicator of this damage is a person's hemoglobin A1C (HbA1c) levels, which show the level of glycated hemoglobin in the bloodstream. Simply put, HbA1c levels can be viewed as a measure of chronic hyperglycemia, and higher HbA1c levels mean the patient has more poorly regulated blood glucose levels.[53] When HbA1c levels are within 5% to 7%, they are considered normal. However, when they go beyond that range, they become indicative of a

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[51] Type 1 diabetes is an autoimmune disorder in which the body is no longer able to produce *any* insulin. This makes it the most severe form of diabetes, as in type 2 diabetes and gestational diabetes the body can usually still produce insulin, just not a sufficient quantity. Type 1 diabetes is not caused by a person's diet and/or lifestyle, and usually develops in children (hence its nickname, "juvenile diabetes"). Type 2 diabetes has a variety of causes, but diet and health choices can increase the risk of a diagnosis. Gestational diabetes develops only during pregnancy, and usually resolves after giving birth—although it can sometimes progress into a form of type 2 diabetes. See: Centers for Disease Control and Prevention, "Diabetes Basics," www.cdc.gov, May 15, 2024, https://www.cdc.gov/diabetes/about/index.html.

[52] Saidur Rahman, "Role of Insulin in Health and Disease: An Update," *International Journal of Molecular Sciences* 22, no. 12 (2021), https://doi.org/10.3390/ijms22126403.

[53] "The A1C Test & Diabetes," National Institute of Diabetes and Digestive and Kidney Diseases, 2018, https://www.niddk.nih.gov/health-information/diagnostic-tests/a1c-test.

progressive risk factor for cardiovascular disease, neuropathy, kidney damage, blindness, amputations of the extremities, and death.[54]

Importantly, when HbA1c levels are below 7%, diabetes is not significantly associated with these health conditions, but when HbA1c levels go above 7%, the risk is heavily elevated.[55] For example, "each 1% higher A1C is associated with 15–20% greater cardiovascular risk;"[56] HbA1c levels greater than 7% "were associated with a five-fold increased risk" of dementia;[57] and, while diabetics with HbA1c levels lower than 7% were at a very low risk for blindness, "51% of the patients with long-term mean HbA1c above 9.5% developed proliferative retinopathy."[58] While there is limited literature on the empirical HbA1c levels of incarcerated diabetics, one study in California found that diabetic prisoners had a mean A1C of 10.0% during incarceration, putting them at a high risk for many, if not all, of the aforementioned conditions.[59] Moreover, the population of diabetics in prison is significant—an estimated "9% of the incarcerated population has diagnosed diabetes."[60]

Treatment for diabetes is unique, as "diabetics are one of few, if not the only, individuals who must make day-to-day treatment decisions without the explicit

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[54] "Hyperglycemia (High Blood Sugar)," Cleveland Clinic, March 2, 2023, https://my.clevelandclinic.org/health/diseases/9815-hyperglycemia-high-blood-sugar.
[55] Alfredo Ramirez et al., "Elevated HbA1c Is Associated with Increased Risk of Incident Dementia in Primary Care Patients," *Journal of Alzheimer's Disease* 44, no. 4 (February 19, 2015): 1203–12, https://doi.org/10.3233/jad-141521.
[56] Matthew Riddle et al., "Epidemiologic Relationships between A1C and All-Cause Mortality during a Median 3.4-Year Follow-up of Glycemic Treatment in the ACCORD Trial," *Diabetes Care* 33, no. 5 (April 28, 2010): 983–90, https://doi.org/10.2337/dc09-1278.
[57] Ramirez et al., "Elevated HbA1c Is Associated with Increased Risk of Incident Dementia in Primary Care Patients."
[58] Maria Nordwall et al., "Impact of HbA1c, Followed from Onset of Type 1 Diabetes, on the Development of Severe Retinopathy and Nephropathy: The VISS Study (Vascular Diabetic Complications in Southeast Sweden)," *Diabetes Care* 38, no. 2 (December 15, 2014): 308–15, https://doi.org/10.2337/dc14-1203.
[59] Kirnvir K. Dhaliwal et al., "Diabetes in the Context of Incarceration: A Scoping Review," *EClinicalMedicine* 55 (January 2023): 101769, https://doi.org/10.1016/j.eclinm.2022.101769.
[60] Jennifer Sherman, "Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association," *Diabetes Care* 47, no. 4 (March 25, 2024): 544–55, https://doi.org/10.2337/dci24-0015.

direction of their doctor."[61] Type 1 diabetics make an estimated 180 medical decisions per day to address how their body is feeling and reacting to insulin, glucose intake, and other factors.[62] This form of treatment is known as self-management insulin therapy, essentially a regimen where the diabetic tries to emulate the functions of a healthy pancreas by injecting themselves with insulin to precisely manage their blood sugar levels.

While a comprehensive analysis of the techniques of diabetes management and treatment is outside the scope of this article, it is important to define the medical issues diabetics can face. The primary concerns of diabetes management are addressing hyperglycemia ("high blood sugar") and hypoglycemia ("low blood sugar"). Hyperglycemia, in the short term, can lead to diabetic ketoacidosis, a life-threatening situation where the body has far too much sugar and not enough insulin. Prolonged hyperglycemia throughout the duration of a person's life drastically increases the risk of longer-term complications, including, but not limited to, amputation of the extremities due to vascular degeneration, blindness, and a shortened lifespan.[63] Hypoglycemia is also acutely life-threatening, as when the body lacks sufficient amounts of sugar, it can cause fainting and, if untreated, death. Hypoglycemia, in its milder form, can be treated by ingesting fast-acting carbohydrates, essentially pure sugars that will quickly raise blood sugar levels to a normal range.[64] Diabetes treatment requires constant attention to

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[61] Lauren Hubbard, "Inadequate Diabetes Care in Correctional Facilities & the Need For Relief under the ADA and Section 504," North Carolina Civil Rights Law Review 4, no. 2 (April 1, 2024): 429–54, https://scholarship.law.unc.edu/cgi/viewcontent.cgi?article=1032&context=nccvlrts, 439.
[62] Ibid., 439.
[63] "Hyperglycemia (High Blood Sugar)," Cleveland Clinic.
[64] "Hypoglycemia (Low Blood Sugar)," Cleveland Clinic, 2023, https://my.clevelandclinic.org/health/diseases/11647-hypoglycemia-low-blood-sugar.

prevent a potentially disastrous spike or fall in blood glucose levels, leading to severe health consequences.

To prevent hypo- and hyperglycemia, diabetics use a variety of medical tools to raise or lower their blood sugar, depending on their immediate needs. They are only able to do this with the assistance of medical devices such as blood glucose monitors (which allow people with diabetes to check their blood sugar numbers at any given moment), continuous glucose monitors or CGMs (devices implanted on the body that passively measure blood glucose levels on a regular basis), and, perhaps most importantly, insulin pumps or insulin pens/syringes. The insulin pump, widely considered to be the most effective option, is a small device that is connected to a needle inserted into fatty tissue and replaced every few days.[65] These pumps can inject insulin from a reservoir on the device that is connected to the body through a small tube or cannula. Notably, they also allow for passive, regular doses of insulin to be given (a "basal injection" or "basal rate"), which allows for much more effective control over blood glucose numbers.[66] However, in prisons and jails, diabetic inmates often find that access to treatment is heavily restricted, unavailable, or inadequate.

III. The First Approach: The Eighth Amendment and *Estelle v. Gamble*

The first argument for medical care is rooted in the Eighth Amendment's protection against "cruel and unusual punishment."[67] In the landmark case *Estelle v. Gamble* (1976), the Supreme Court held that "failure to provide adequate medical care

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[65] "4 Ways to Take Insulin," Center for Disease Control and Prevention, May 13, 2024, https://www.cdc.gov/diabetes/about/4-ways-to-take-insulin.html.
[66] Guido Freckmann et al., "Accuracy of Bolus and Basal Rate Delivery of Different Insulin Pump Systems," *Diabetes Technology & Therapeutics* 21, no. 4 (April 2019): 201–8, https://doi.org/10.1089/dia.2018.0376.
[67] "U.S. Constitution, Amendment VIII", https://constitution.congress.gov/constitution/amendment-8/.

to incarcerated people as a result of deliberate indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment."[68] Importantly for diabetics who face long-term health consequences due to inadequate care, the Supreme Court's later decision in *Helling v. McKinney* (1993) expanded the *Estelle* decision to protect "against future harm to inmates."[69] Furthermore, under the equal protection clause, the Fourteenth Amendment expands the protection from deliberate indifference to people awaiting trial in jails.[70]

The court's rulings in *Estelle* and *Helling* obligate prisons to provide some level of attention to the medical needs of prisoners, including long-term medical needs. However, the rulings courts have given post *Estelle* and *Helling* are often inadequate from a healthcare perspective and unduly punish diabetic prisoners by considering even medically insufficient treatment as "adequate." Instead of their current understanding, courts must recognize that, in the context of diabetes, inadequate care is a form of punishment. Currently, when "a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second-guess medical judgments."[71] In some medical contexts, contesting "adequacy" may simply refer to comfort or ease of access, but in the context of diabetes treatment, courts must recognize that the level of care is proportionate to the risk of degenerative diseases and death.

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[68] Marcella Alsan et al., "Health Care in U.S. Correctional Facilities—a Limited and Threatened Constitutional Right," ed. Debra Malina, *New England Journal of Medicine* 388, no. 9 (March 2, 2023): 847–52, https://www.nejm.org/doi/full/10.1056/NEJMms2211252, 847.
[69] Helling v. McKinney (United States Court of Appeals for the Ninth Circuit June 18, 1993)., 33.
[70] Hubbard, "Inadequate Diabetes Care in Correctional Facilities & the Need For Relief under the ADA and Section 504," 434.
[71] Joel Thompson, "Today's Deliberate Indifference: Providing Attention without Providing Treatment to Prisoners with Serious Medical Needs," *Harvard Civil Rights Civil Liberties Law Review* 5, no. 2 (2010): 636–54, https://journals.law.harvard.edu/crcl/wp-content/uploads/sites/80/2009/06/635-6541.pdf, 638.

Eighth and Fourteenth Amendment claims rarely succeed not only because of courts' hesitancy to contest adequacy but also due to the high burden set by *Estelle*, as plaintiffs must prove the facility's "deliberate indifference" through both an "objective" and a "subjective" standard.[72] As explained in *Hunt v. Uphoff* (1999) citing *Farmer v. Brennan* (1994), "the medical need must be sufficiently serious to satisfy the objective component… [and,] in terms of the subjective component, i.e., the requisite deliberate indifference, a plaintiff must establish that defendant(s) knew he faced a substantial risk of harm and disregarded that risk, 'by failing to take reasonable measures to abate it.'"[73] While the consensus judicial opinion is that diabetes is objectively a "serious medical condition,"[74] satisfying the "objective" standard, it is extraordinarily difficult to prove the "subjective" component. "Federal courts have stated that to constitute deliberate indifference, 'treatment must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness'… for example, prison officials deliberately ignoring the express orders of an incarcerated person's physician. Negligent medical treatment and even medical malpractice would not meet the 'deliberate indifference' requirement."[75]

Yet, negligent medical treatment and medical malpractice in diabetes care are so deficient that they directly result in gruesome, torturous, and irreversible health consequences. To suggest otherwise would require proof that either the consequences of current medical treatment for incarcerated diabetics do not result in such health

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[72] Benjamin Eisenberg and Victoria Thomas, "Legal Rights of Prisoners and Detainees with Diabetes: An Introduction and Guide for Attorneys and Advocates" (American Diabetes Association, 2024), http://main.diabetes.org/dorg/living-with-diabetes/correctmats-lawyers/legal-rights-of-prisoners-detainees-with-diabetes-intro-guide.pdf#page=18.40, 10.
[73] Hunt v. Uphoff (United States Court of Appeals, Tenth Circuit 1999), 3.
[74] Eisenberg and Thomas, "Legal Rights of Prisoners and Detainees with Diabetes: An Introduction and Guide for Attorneys and Advocates," 10.
[75] Alsan et al., "Health Care in U.S. Correctional Facilities—A Limited and Threatened Constitutional Right," 848.

consequences or that the consequences themselves are not severe enough to constitute "cruel and unusual punishment." The cause and effect are not separable—if it is the inadequate treatment that results in amputation, blindness, and death, then the inadequate treatment itself should be viewed as "cruel and unusual punishment."

IV. The Second Approach: The ADA and Section 504 of the Rehabilitation Act

The ADA and Section 504 of the Rehabilitation Act offer another avenue to adequate medical care in prisons. Section 12132 of the ADA states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[76] Since *Pennsylvania Dept. of Corrections v. Yeskey* in 1998, courts have held that jails and state prisons are considered "public entities" and therefore must abide by the ADA.[77] Section 504 expands this protection to "federal prisons, jails, and detention centers—as well as in state prisons, private prisons, local jails, and detention centers that receive federal funds."[78]

However, much like the *Estelle* defense, the ADA and Section 504 do not, in practice, protect diabetic prisoners from undue hardships. There is a clear discrepancy between the goals of the ADA and the outcomes of ADA-based pleas for relief and ADA-governed prison policy. The ADA was meant to promise "equal opportunity, full participation, independent living, and economic self-sufficiency" for people with

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[76] "Americans with Disabilities Act of 1990, as Amended," ADA.gov (US Department of Justice Civil Rights Division, 1990), https://www.ada.gov/law-and-regs/ada/#subchapter-ii---public-services-title-ii.
[77] Pennsylvania Dept. of Corrections v. Yeskey (United States Court of Appeals, Third Circuit 1998).
[78] Hubbard, "Inadequate Diabetes Care in Correctional Facilities & the Need For Relief under the ADA and Section 504," 443.

disabilities.[79] However, when a judge sentences someone with diabetes, there is no reasonable expectation that their punishment also includes blindness, dementia, amputations of the extremities, or an early death. Even in comparison to other prisoners, inmates with diabetes are forced to suffer unique punishments as a direct result not of their sentence but of their disability.

Furthermore, even if such medical punishment could be considered acceptable during a person's sentence, the effects of that punishment are not limited to just the time served in prison. An estimated "95% of the prison population will at some point reenter society,"[80] but for diabetic prisoners, the medical harms they suffer because of inadequate care will carry over into their life after prison. As Lauren Hubbard writes in the North Carolina Civil Rights Law Review, "Irreversible diabetic complications, such as nerve damage, amputation, and bone and joint problems, can lead to the inability of individuals to work and an increased reliance on the social safety net once released. And individuals who are able to work but also face diabetes-related complications often have decreased productivity due to more severe symptoms and consistent medical appointments. Therefore, correctional institutions' failure to provide adequate medical care to incarcerated diabetics hinders both their ability to fully participate in society and their economic self-sufficiency upon release,"[81] explicitly contrary to the promise of the ADA to protect against those exact issues.

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[79] Joseph Biden, "Proclamation 10426—Anniversary of the Americans with Disabilities Act, 2022," Authenticated US Government Information, July 25, 2022, https://www.govinfo.gov/content/pkg/DCPD-202200657/pdf/DCPD-202200657.pdf.

[80] "Reentry Trends in the United States," Bureau of Justice Statistics (US Department of Justice, 2018), http://www.bjs.gov/content/reentry/reentry.cfm.

[81] Hubbard, "Inadequate Diabetes Care in Correctional Facilities & the Need For Relief under the ADA and Section 504," 449.

To fulfill the promises made by the ADA, there must be clarity as to what qualifies as adequate care and a commitment to uphold that standard. Even within the American Diabetes Association's article on "The Legal Right to Medical Care in Detention Facilities," adequate care is defined by a list of things it "may" include.[82] Amorphous definitions of adequate care allow prisons to overlook the plight of diabetic prisoners that goes far beyond any semblance of fairness or reasonable restrictions. While the Federal Bureau of Prisons Clinical Guidance does suggest that intensive insulin therapy should be provided to prisoners with diabetes, along with access to blood glucose meters,[83] the specifics of what that care looks like are unclear, allowing prisons to neglect the medical needs of prisoners without breaking any rules. Furthermore, cost-cutting measures and the use of private contractors undermine even the limited protection that the Federal Bureau of Prison's guidelines guarantee.[84] For example, in 2019, "there were 12 diabetic ketoacidosis (DKA) related deaths in Georgia jails and prisons, most likely a result of inadequate diabetes care."[85] Numerous lawsuits have been filed against CoreCivic—the company that runs one of Tennessee's largest and newest correctional facilities—on the basis of inadequate diabetes care, and there are a litany of cases where prisoners have individually been denied diabetes care, died, and had their diabetes-related deaths covered up.

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[82] "The Legal Right to Medical Care in Detention Facilities" (The American Diabetes Association, 2025), https://diabetes.org/sites/default/files/2025-01/The-Legal-Right-to-Medical-Care-in-Detention-Facilities-Fact-Sheet-2023.pdf.

[83] "Federal Bureau of Prisons Clinical Guidance on the Management of Diabetes" (Federal Bureau of Prisons, 2017), https://www.bop.gov/resources/pdfs/diabetes_guidance_march_2017.pdf#page=20.42, 17, 21

[84] "Diabetes behind Bars: Challenging Inadequate Care in Prisons," *The Lancet Diabetes & Endocrinology* 6, no. 5 (May 2018): 347, https://doi.org/10.1016/s2213-8587(18)30103-7.

[85] Mike Hoskins, "For People with Diabetes, Arrest and Incarceration Could Be Lethal," Healthline, August 20, 2020, https://www.healthline.com/healthy/diabetes-endangered-arrest-and-incarceration?utm_source=ReadNext#Diabetes-care-behind-bars.

The ADA was extended to people in prisons to ensure they do not face an undue burden simply because they happen to have a disability and their fellow prisoners do not. As it stands today, there is no parity between the sentence of a person with diabetes and a person without it. Even if both inmates are housed in the same prison for the same sentence, the prisoner with diabetes is discriminated against by virtue of being disabled. The persistence of ambiguity in the definition of adequate care and the unwillingness of courts to uphold ADA standards in prisons violate the rights of disabled prisoners and inflict avoidable harm on diabetic prisoners.

V. Rethinking "Adequate Care"

Adequate care must be rethought in the context of diabetes to include the long-term health effects of poor diabetes management. It is well known that insulin pumps and CGMs, which allow for independent, adaptable treatment, significantly reduce HbA1c levels, rates of diabetic ketoacidosis, and hospitalizations due to diabetes,[86] and allowing for those forms of treatment would be a massive step towards reducing the unnecessary deaths and injuries of diabetic prisoners. However, at minimum, it is crucial that prisons be required to provide insulin multiple times a day, regular blood sugar checks, and access to fast-acting sugar in the event of hypoglycemia.

Courts have begun to recognize this need in certain circumstances. In *Montez v. Owens*, a court found a violation of the ADA and Section 504 when the correctional institution did not keep a diabetic medication in stock, and the plaintiff once had to wait three weeks for it. Most notably, the court in *Montez* stated that "a diabetic in prison has

[86] Kajal Gandhi et al., "Insulin Pump Utilization in 2017–2021 for More than 22,000 Children and Adults with Type 1 Diabetes: A Multicenter Observational Study," *Clinical Diabetes* 42, no. 1 (October 12, 2023): 56–64, https://doi.org/10.2337/cd23-0055.

no option to seek appropriate medication on his own or through non-prison sources. To deny a diabetic needed medication is to treat that individual differently, as the non-diabetic does not need [diabetes medication] or insulin to keep on living."[87] The court's interpretation of "adequate care" in *Montez* was based on comparing the conditions of diabetics and non-diabetics in prison. When courts recognize that insulin is necessary not three weeks in the future but on a daily basis, they are coming to terms with the real medical needs of diabetics.

VI. Conclusion

Inadequate care is not simply a matter of opinion—it's a matter of medical fact. Existing protections for prisoners with disabilities, such as the *Estelle* protection from deliberate indifference and the ADA/Section 504, must be expanded to cover not just the bare-minimum level of treatment to ensure someone remains alive but also holistic treatment that takes into account the unique nature of chronic disabilities like diabetes. Courts must critically examine the actual medical needs of prisoners and come to terms with the harms of ignoring that reality. Diabetes is unique in how drastically its side effects depend on the quality of treatment, but it is not the only chronic illness that is exacerbated by poor treatment. Courts must, more generally, adopt a critical lens when analyzing the standard of care in prisons. When the quality of care for illnesses is poor, the risks of horrific medical consequences skyrocket. It is for this reason that courts must rethink their implied separation of treatment and consequences. While courts have given relief to plaintiffs after a serious injury is sustained,[88] they must recognize

[87] Hubbard, "Inadequate Diabetes Care in Correctional Facilities & the Need For Relief under the ADA and Section 504," 446.
[88] "Georgia to Pay $550,000 to Convicted Felon for Amputation," AP News, September 23, 2017, https://apnews.com/general-news-1a49ef1f1bfb4cd0b603fdcb41817287.

that if they find the consequences of inadequate care in violation of the Eighth Amendment or the ADA, then they should also view the conditions that directly result in those consequences as illegal.

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