Do NCCHC Dental Standards Have Any Teeth?

Anne S. Douds, JD, PhD¹, and Eileen M. Ahlin, PhD¹

Abstract

Federal civil rights law establishes legal parameters for correctional dental care, but it does not provide specific standards for implementation. Thus, courts have developed guidelines on a case-by-case basis, often rendering the National Commission on Correctional Health Care (NCCHC) standards on dental care the de facto benchmark for institutions. This systematic review of all court cases that apply NCCHC standards for dentistry in prisons examines how courts use NCCHC standards and provides insights into whether those standards have any “teeth,” or power, in a legal sense. These findings consider the legal relevance of NCCHC standards and speak more broadly to the role of professional organizations in the legal and correctional communities.

Keywords

civil rights, dental care, NCCHC, standards, teeth

Introduction

Legal standards for prison dental care are dominated by overlapping, and often incongruous, sets of constitutional, federal, state, and administrative laws. Stories from the field abound with confusing cases where practices in one facility are deemed legally acceptable, while similar treatment in another facility is considered illegal. For example, some courts require that prisons provide dentures to their inmates, but other courts have found that prisons are not liable if they take dentures away from inmates (cf. Kidwell v. Oklahoma Department of Corrections, 2014, with Johnson v. Simons, 2014). Because these cases are so fact-specific, and because jurisdictions are inconsistent in their findings, it is impossible to define uniform legal standards for prison dentistry. Oftentimes, practitioners want to be told what to do and what not to do, but they cannot find legal precedent to guide them (Douds, 2013). In the absence of judicial guidance, practitioners must rely on their professional organizations to guide their clinical conduct. But is that enough? Is compliance with professional prison dental care standards, such as those promulgated by the National Commission on Correctional Health Care (NCCHC), sufficient to satisfy prison dentists’ legal obligations? This study begins to

¹ Penn State Harrisburg, Criminal Justice Program, School of Public Affairs, Middletown, PA, USA

Corresponding Author:
Anne S. Douds, JD, PhD, Penn State Harrisburg, Criminal Justice Program, School of Public Affairs, 777 West Harrisburg Pike, Middletown, PA 17050, USA.
Email: asdl2@psu.edu
fill that information void, and the inquiry begins with the most fundamental of documents, the Constitution.

The Constitution, on its face, offers almost no insight into what conduct is consistent with the Eighth and Fourteenth Amendments. There is no textual guidance as to what is expected of correctional health care professionals, other than the Eighth Amendment obliquely admonishes that “... nor cruel and unusual punishments [should be] inflicted.” The Fourteenth Amendment is similarly unhelpful on its face, declaring that no person should be deprived of “life, liberty or property without due process of law.” Health care standards are nowhere to be found in the Constitution itself. As with all constitutional provisions, the meaning of “cruel and unusual punishments” and “due process of law” are interpreted through the courts.

Until the Supreme Court decided *Estelle v. Gamble* in 1976, correctional health care lay outside the ambit of the Eighth Amendment. That year, in a sweeping opinion that forever changed the legal understanding of prisoners’ rights, the Court announced that “... deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ as proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care ...” (*Estelle v. Gamble*, 1976). With that language, the Warren Court introduced new legal requirements for prison health care. Those mandates have since been expanded to apply across all correctional institutional settings, including privately run facilities and short-stay centers (*Richardson v. McKnight*, 1997; *West v. Atkins*, 1988).


State law does not offer much assistance to institutions because it largely defers to the federal “deliberate indifference” standard established by *Estelle v. Gamble* (1976). Thus, it is fair to say that federal law provides a framework for the legal requirements of prison dental care, but the law does not do much to fill in the details to any substantive degree. Instead, practitioners must look within their profession to complete the picture and determine best practices. As an aside, constitutional law has never recognized negligence as a standard for liability against government actors (*Blum & Urbonya*, 1998; *Estelle v. Gamble*, 1976). All government actors, including persons who operate correctional facilities and the dentists who provide services in them, are presumed to have qualified immunity for their actions; they are “immune,” or exempt, from being sued for their actions that might otherwise be considered to be negligence among private practitioners (*Blum & Urbonya*, 1998). That immunity from suit can be overcome only by a showing that the government actor (e.g., the prison dentist) acted willfully, wantonly, deliberately, or otherwise with such improper motive that the courts would find it rose above the level of negligence to a higher standard of culpability. Thus, the relevant inquiry for legal and medical professionals queries whether there has been deliberate indifference to a medical condition in correctional health care settings.
Much like other professional organizations, NCCHC researches, promotes, and accredits institutions using evidence-based dental standards (American Association of Public Health Dentistry, 2014; American Dental Association, 2014; Graskemper, 2004; NCCHC, 2014). For decades, NCCHC has been developing, revising, and promoting standards of care for jails, prisons, and juvenile facilities through its Standards, position statements, and guidelines, and it regularly publishes clinical dental care updates. The data and recommendations proffered by NCCHC are recognized in the field as reliable and sound (Stern, Greifinger, & Mellow, 2010), but it is not clear if NCCHC standards are legally relevant. With a nod to the potential legal significance of NCCHC standards, NCCHC website proclaims that the “nationally recognized Standards lay the foundation for constitutionally acceptable health services systems” (NCCHC, 2014). The phrase “constitutionally acceptable” connotes a legal standard—a legal threshold for testing whether health service systems are adequate. However, while the stamp of approval of a national organization such as NCCHC may have clinical, practical, and political relevance for a correctional facility, it is not clear whether accreditation standards have legal relevance and can serve as mandates for prisons. Seizing on the obvious pun, there is no research investigating whether NCCHC dental standards have any legal teeth. In other words, do NCCHC standards provide prisoners with any legal rights, or are they merely aspirational goals for ideal standards of care?

In the current study, we examine the legal ambit of NCCHC dental standards to govern prison dental policies and procedures. Our study is limited to NCCHC standards because (1) NCCHC is one of the only organizations concerned exclusively with prisoner health care, (2) NCCHC standards are substantially similar to standards promoted by other organizations, and (3) a sample that included American Dental Association standards and American Correctional Association standards was attempted, but the original sample pool size exceeded the search cap of 1,000 hits within LexisNexis due to the inclusion of legal cases irrelevant to the research question.

Methods

To assess the scope of judicial uptake of NCCHC dental standards and the manner in which courts use those standards, the lead author searched the LEXIS database at the end of 2013 and again in October 2014 for all recorded judicial decisions from every U.S. court since the first opinion ever reported that contained the term “NCCHC,” which yielded 102 cases. That set of cases was searched further for one or more of the following terms: “1983,” “tooth,” “teeth,” “oral,” or “dent!” That second search yielded 22 cases, spanning the period from January 1991 to October 2014.1 (Please note that the exclamation point is a method of truncating the search term so that LEXIS would identify all related words, such as dental, dentistry, and dentist.) These 22 cases were analyzed for a range of variables, including demographic data, the circumstances under which NCCHC was referenced, case outcome, and the role NCCHC standards played in that outcome. The cases were synthesized based on thematic content. All cases that had anything to do with dental care and NCCHC in prison were included.

For those unfamiliar with LEXIS, all legal cases that are officially reported are contained in LEXIS. There is only one other such service, Westlaw, and it contains the same cases with slightly different formatting and referencing techniques. The American Bar Association (2014) recognizes these two databases as the ones that are appropriate for legal research and for confirming the current status of the law, and the searches therein are exhaustive. For example, in a search using the keyword phrase “NCCHC,” LEXIS scans every legal case, including the title, names of parties, main body of the opinion, and all footnotes and references.
Results and Discussion

The dental cases in the study represent all judicial decisions in which NCCHC was referenced in relation to some dental or oral health issue. The content of the cases reflect four primary areas of interest for NCCHC and others who promulgate prison dental care standards: (1) on limited occasion, NCCHC standards are applied retrospectively to establish that an inmate’s civil rights have been violated; (2) on other limited occasions, NCCHC standards are applied prospectively to describe what institutions must do in the future to avoid liability and to preserve inmates’ civil rights; (3) frequently, NCCHC standards are used as standards, or goals, to promote better practices among institutions and clinicians; and (4) NCCHC standards are cited as a source of accreditation. These topics are considered in terms of specific cases and generalizability for future application of NCCHC work.

NCCHC Standards as Retrospective Tests for Legality of Conduct

By definition, NCCHC dental care standards are intended to establish standards of care for prison dental practitioners (NCCHC, 2014). In four cases, NCCHC standards were, in fact, used to establish one or more standards of care for a variety of dental practices (Andrews v. Camden County, 2000; Feliciano v. Calderon, 2004; Gaddis v. Campbell, 2004; Laube v. Campbell, 2004). NCCHC standards were used generally by the judge who wrote the opinion in relation to the need for better teamwork among medical and correctional components (Laube v. Campbell, 2004) and specifically to find deficiencies in quadrant scaling performed with certain hand tools (Gaddis v. Campbell, 2004). In the Andrews case, the Court relied heavily on NCCHC standards to find that the prison violated an inmate’s constitutional rights after it denied the inmate treatment for his infected tooth, which ultimately resulted in sepsis, organ failure, and a 4-month hospital stay. The court further found that, by ignoring obvious evidence of swelling and loss of appetite, the prison violated the inmate’s constitutional right to adequate care (Andrews v. Camden County, 2000). 3

In these cases, NCCHC standards were used to prove culpability. The standards were part of the plaintiffs’ litigation tool kit to demonstrate that certain institutional and clinical practices violated civil rights laws. The logical syllogism under this line of cases flows as follows: The defendant institution did not follow one or more NCCHC standards; the institution knew or should have known that it needed to follow that standard(s); the failure to follow was so blatant that it amounted to “deliberate indifference”; failure to follow the standard(s) may have contributed to an inmate’s injury, for which the institution may be liable. Notably, none of the cases in this category involved a final verdict. Each case terminated prior to final judgment, which suggests that the cases settled or were otherwise resolved before a final reported decision could be issued by the courts.

NCCHC Standards as Prospective Requirements for Proving Compliance With Consent Decrees

Four additional courts found that NCCHC standards are the appropriate lens through which to examine prison practices prospectively and are “widely accepted as a model for best practices” (Riker v. Gibbons, 2010; see also Cody v. Hillard, 2000; Graves v. Arpaio, 2008; Ruiz v. Johnson, 2001). For example, several cases involved consent decrees in which the courts established prospective protocols for future prison operations and a “system of ready access to adequate dental care” (see, e.g., Graves v. Arpaio, 2008). Those courts drafted comprehensive plans, with specific directives for determining what, where, and when dental care had to be provided, by whom and for whom. These comprehensive plans became part of the courts’ consent decrees, which were
essentially operating manuals for prison dental care. For those consent decrees, the courts incorporated NCCHC dental standards. Essentially, NCCHC standards became part of the consent decrees. For context, consider a series of cases in Texas where the court made specific findings in the 1980s and 1990s concerning the inadequacy of dental care in Texas prisons. The investigator applied NCCHC standards to find “a number of deficiencies” in Texas prison health care (*Ruiz v. Johnson*, 1999). As a result of those findings, the federal courts assumed oversight of prison health care operations. The resulting settlement agreement and consent decree incorporated NCCHC standards to describe what would be required of Texas in order to be released from federal oversight.

A similar situation arose in South Dakota when inmates sued over the conditions of their confinement. After the inmates won, the South Dakota Bureau of Prisons (SDBP) and the inmates reached a settlement agreement and submitted that agreement to the court for consideration. The federal court approved the agreement and noted “that the SDBP had been accredited by the NCCHC, which gave [the investigator] some assurance that improvements he saw in 1996 have been institutionalized” (*Cody v. Hillard*, 2000). In other words, compliance with NCCHC standards was used as evidence by the court that the prison system had improved its health care and brought it within legally acceptable parameters.\(^4\)

Accreditation also has been used prospectively as a prerequisite for both future care and government contracts (*Roberts v. Mahoning County*, 2007). In a few cases, the courts have required prison systems to become accredited by NCCHC as part of a larger consent decree. Stopping short of using NCCHC standards as the lens through which to examine constitutionally sufficient care, these courts nonetheless announced that evidence of accreditation would be sufficient to establish that the systems had brought their programs within constitutionally required minimums (*Ruiz v. Johnson*, 2001).

In a case from Ohio, all entities bidding on health services contracts for state prisons had to be accredited by NCCHC, and the medical director had to demonstrate compliance with NCCHC standards. In that same case, other contractors had to become accredited within 12 months or face a $50,000 fine (*Roberts v. Mahoning County*, 2007).

Although accreditation by NCCHC is not mandatory, and failure to achieve accreditation is not actionable or sanctionable, it appears that it has some independent value in the judicial world. One federal judge summarized it best when announcing that, even without additional evidence of compliance with a consent decree, the fact that the defendant facility had obtained NCCHC accreditation provided “assurance of institutionalization” of the practices that were required under the consent decree. In this sense, accreditation serves as a sword, or a tool, for proving compliance with judicial monitoring schemes and conformity with standards of care for prison dentistry. On the other side of that same coin, NCCHC accreditation operates as a shield, protecting facilities and practitioners from liability. In many cases, facilities were required to obtain NCCHC accreditation as a condition of a monitoring scheme. If they did not obtain accreditation, then they would be deemed to have failed to satisfy the settlement agreement, and they would be exposed to liability. Conversely, if they had obtained accreditation, then they could be shielded from liability regardless of whether injuries occurred. The facilities with accreditation were presumed to have satisfied the standard of care requirement. That presumption was rebuttable, but it provided a strong defense to those that were facing lawsuits for prison dental practices.

Accreditation often was used as a precondition for conducting business or engaging in contracts with prisons and the governments that run them. In several cases, contractors were required to prove that they had NCCHC accreditation before they could bid on any prison service contracts. In other cases, a penalty scheme was integrated into the contracts, whereby contractors had to obtain accreditation within a set amount of time after receiving a contract or they would face penalties and potential contract termination.
NCCHC Standards as Goals, Not Minimums

In the majority of cases, NCCHC-based standards of care were described by most courts as targets for ideal care, not as minimums. So while NCCHC standards represented the appropriate quality of care that prison dental practitioners aspire to achieve, only a handful of courts used the standards to describe conduct for which the institutions could be held liable. Most of the courts found that NCCHC standards exceeded what is legally required for prison dental care. A given dental practice might be demanded by NCCHC standards, and failure to meet that standard might constitute negligence in the private sector. However, negligence is not actionable in the prison health care context. Only intentional, willful, wanton, or deliberate indifference to a known dental need gives rise to liability (Estelle v. Gamble, 1976).

For example, in a recent case occurring in Arizona, the court cited NCCHC standards 16 times to find that factual issues remained as to whether the facilities had come into compliance with constitutional standards of care. However, despite its reliance on NCCHC standards to examine compliance, the court nevertheless announced that failure to comply with NCCHC standards does not equate to a per se constitutional violation. Citing Farmer v. Brennan and its progeny, this court found that NCCHC may prescribe conduct that is constitutionally acceptable, but it declined to use NCCHC standards to tag conduct as unconstitutional (Farmer v. Brennan, 1994; Hart v. Maricopa County, 2005).

Another court used NCCHC standards to create a comprehensive consent decree but redacted references to NCCHC in a subsequent version of the decree in order to avoid the appearance of giving NCCHC standards constitutional weight (Graves v. Arpaio, 2008). These opinions beg the question, are the courts de facto constitutionalizing NCCHC standards for dental care? From a more practical perspective, what does this mean for practitioners? If the law uses NCCHC standards to assess whether there is, in its own words, “a substantial risk of serious harm,” yet simultaneously announces that those standards exceed what is constitutionally required, then how are facilities supposed to understand their duty? (Hart v. Maricopa County, 2005). The court relied on NCCHC standards, but then hedged by deeming the standards “inconclusive” (Hart v. Maricopa County, 2005). If the standards only inconclusively describe constitutionally prohibited conduct, then what “conclusively” describes constitutionally deficient health care? This question remains unanswered.

As one judge tried to explain, the courts are not “constitutionalizing NCCHC . . . standards, but using them as evidence that treatment is inadequate” (Patten v. Pearce, 1991). For the courts, NCCHC standards provide a filter through which to examine prison dental care, but those standards are not the litmus test for compliance with the Eighth or Fourteenth Amendment (Graves v. Arpaio, 2008). However, the courts use that same filter to assess constitutionality, thereby undercutting their own claims that they are not constitutionalizing standards (Graves v. Arpaio, 2008; Hart v. Maricopa County, 2005; Motto v. Correctional Medical Services, 2010; Patten v. Pearce, 1991). This legal hair-splitting is tedious for dental practitioners and attorneys alike. But it is perhaps not surprising in the politically charged environment in which courts operate; they do not wish to establish constitutional policy, and they are seeking only to rule on a specific case.

NCCHC Affiliation as a Professional Credential

NCCHC, its standards, and accreditation frequently were used to buttress the creditability of expert witnesses. As most practitioners who have been involved in litigation know, an expert witness must satisfy the Daubert standard for qualifications before an expert can testify. The proffered expert must be shown to have sufficient education, training, and experience to qualify as an expert in the discipline (Daubert v. Merrell Dow Pharmaceuticals, Inc., 1993). NCCHC standards were used twofold in this regard. In some instances, proposed experts were deemed qualified by virtue of their
affiliation with NCCHC. In other instances, being affiliated with an NCCHC-accredited institution enhanced their credibility as experts.

Broader Implications and Conclusion

Courts, prisons, and practitioners working in the corrections system have adapted to the above-described legal obscurity on prison dental care by looking to NCCHC standards. This piecemeal approach provides a substandard safety net for inmates and dental practitioners alike. The current investigation demonstrates that NCCHC dental standards do, in fact, have a bite hold on the legality of correctional dental practice. However, the ad hoc judicial adoption of portions of NCCHC standards presents several potential problems.

First, NCCHC standards are written collectively, to be read and interpreted holistically, not in a vacuum. By taking one or more standards and applying them outside of their intended context, courts may jeopardize inmates' dental health and provide incomplete guidance to institutions and practitioners. We encourage NCCHC and other professional organizations to work with the judiciary to develop more comprehensive guidelines for judicial adoption. For example, judges often rely upon "bench briefs" for scientific or obscure topics (Klarfeld, 2011; see, e.g., State of Oklahoma v. Tyson Food, Inc., 2005). These bench briefs provide objective analysis of specific issues. In the case of prison dentistry, a bench brief would concisely explain the clinical considerations in the social, administrative, and cultural context of a prison. Consideration also should be given to inclusion of other professional organizations (e.g., American Dental Association, American Dental Hygienists Association) in development of any such publication.

Additionally, NCCHC and other accrediting institutions should consider their own potential exposure if their standards and/or accreditation were to gain the force of law. If accreditation is a legal prerequisite to proper functioning of a facility, and an injury occurs at an accredited facility, then NCCHC may be exposed to liability. If the standards have the force of law, then the authors of the standards may be held accountable.

In sum, this review found that courts look to NCCHC to support prison standards of dental care when retrospectively finding liability for civil rights violations, when prescribing future conduct within dental units, when approving criteria for selecting dental providers, and when assessing experts' credentials. At this point, NCCHC standards are not "law," they are merely evidence of compliance with law. But as courts continue to debate whether they are, in effect, constitutionalizing NCCHC and other professional standards, those professional organizations need to consider the second- and third-order effects of any such adoption.

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Notes

1. Alabama (1), Arizona (4), Massachusetts (1), Nevada (1), New Jersey (2), Ohio (1), Oregon (1), Pennsylvania (1), Puerto Rico (2), South Dakota (1), Texas (4), West Virginia (1), and Wisconsin (1).

2. References to NCCHC also arose in relation to expert witnesses’ credentials. In all cases, NCCHC affiliation was cited favorably as an evidence of credibility (see, e.g., Graves, 2008; Jama v. Esmor Correctional Services, 2007).
3. This case arose in 2000, and it is an anomaly among other cases arising in this decade. As discussed, courts have been reluctant to apply professional associations’ standards to establish constitutional levels of care. The tension between courts adopting NCCHC standards yet declining to define constitutional minimums with those standards continues to develop in the courts through the present day.

4. A court in Puerto Rico similarly cited NCCHC accreditation as evidence that a prison system had brought their care within acceptable standards, but the court retracted approval of the consent decree after discovering that the prison system had falsified documents in its application for NCCHC accreditation (Feliciano v. Gonzalez, 1998).

5. This court noted potential problems with inconsistency between NCCHC and APPA standards, with the former requiring one doctor per 750 to 1,000 inmates and APPA requiring one doctor per 200 to 750 inmates.

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