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# Prisons, Law and Public Health: The Case for a Coordinated Response to Epidemic Disease Behind Bars

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## Prisons, Law and Public Health: The Case for a Coordinated Response to Epidemic Disease Behind Bars

SCOTT BURRIS\*

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### I. INTRODUCTION

In many areas of this country, prison inmates constitute high-

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\* Assistant Professor of Law, Temple Law School. Work on this Article was supported by a research grant from Temple Law School. This Article is based, in part, on testimony presented to the National Commission on AIDS on August 17, 1990.

risk populations for the contraction and spread of the Human Immunodeficiency Virus (“HIV”), tuberculosis (“TB”), and other communicable diseases. Significant risk factors for imprisonment—poverty, intravenous drug use, and race—correlate with exposure to the leading communicable diseases, particularly HIV. Yet though the communicable diseases accumulating at the bottom of the class structure in the United States are linked to the predictors of incarceration, they do not respect prison walls. The subset of people with HIV or TB who are in prison is arbitrarily defined, from a public health point of view, except in one crucial respect: we know exactly where they are, and so have the ability to reach them there with therapeutic and preventive measures. Seizing this opportunity is a cost-effective, as well as humane, way to address the health problems both in prison communities and in the free communities to which most prisoners will shortly return. In this Article, I suggest that advocates of prisoners’ rights can unite with public and voluntary health agencies in a coordinated effort to meet the public health needs of those of us who are prisoners, and those of us who are not. Although I focus on HIV and TB, my argument—that prisons should become centers of public health work—is equally applicable to other diseases.<sup>1</sup>

In 1991, the National Commission on AIDS issued a blueprint for responding to HIV in prisons.<sup>2</sup> The Commission’s recommendations included HIV testing and counseling, public health education for inmates and staff, community-level medical care to the infected, renewed attention to TB and sexually transmitted diseases, and protection of the infected against discrimination and unjustified disclosure of their status.<sup>3</sup> “We must learn,” the Commissioners wrote, “that we cannot speak of the health of the nation without also addressing the health of individuals in prisons, jails and other institutions.”<sup>4</sup> As long ago as 1989, the federal Centers for Disease Control and Prevention (CDC) issued comprehensive guidelines for controlling TB in prisons, including improved screening, structural altera-

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1. Drug use is, of course, more than merely a causal factor for contracting TB or HIV. As others have persuasively argued, society should see drug use as a significant public health problem in its own right, a problem that treatment can ameliorate, and a problem that can and should be addressed in prisons. See, e.g., Larry Gostin, *The Interconnected Epidemics of Drug Dependency and AIDS*, 26 HARV. C.R.-C.L. L. REV. 114, 131, 169-72 (1991). Although I focus on communicable diseases, much of my argument applies equally to the issue of enhancing the role of prisons in drug abuse prevention and treatment.

2. NATIONAL COMMISSION ON AIDS, REPORT: HIV DISEASE IN CORRECTIONAL FACILITIES (1991).

3. *Id.* at 36-37.

4. *Id.* at 36.

tions, and timely care.<sup>5</sup>

Introducing comprehensive, self-conscious public health programs into prison settings will not be easy. The public has little sympathy for prisoners. Prison managers, as a group, are neither trained in, nor concerned about, public health. They see their role in prisons as custody and control, not disease prevention. The structure of prison health care delivery, particularly the use of contract medical providers, deters investment in major health initiatives. Courts are increasingly reluctant to interfere with prison management, even poor prison management, and the law is an increasingly poor tool for wringing decent treatment from prison systems. Finally, efforts to prevent HIV and TB at the street level, particularly on the streets where people of color live, continue to be insufficiently funded. But the public health approach has at least one point in its favor: it is a good idea. Communicable diseases are on the rise both inside and outside prisons, and these diseases will not decline in the near future unless successful preventative measures are taken. Prisons are a cost-effective place to spend public health resources, and better-informed and better-treated prisoners may be easier to manage than frightened ones. In this respect, it is noteworthy that several major lawsuits seeking to impose a broad public health approach to AIDS upon prisons have ended in amicable settlements proposing to do just that.

Engagement in the cause of better prison conditions will also be therapeutic for government public health workers and advocates in the private sector. Public health began as a social reform movement, its central cause the elimination of the social and environmental conditions that gave rise to disease.<sup>6</sup> For a variety of reasons, the modern understanding of public health is no longer nourished by those reformist roots. Public health has been reduced to a lesser branch of medicine, its practitioners empowered to count cases, promote vaccination, exercise (very occasionally) coercive powers against individuals, and issue hortatory pronouncements on a variety of health threats over which they have no control. Government health workers are forced into the pose of the apolitical technocrat, and confined by the

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5. See CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUM. SERVS., MORBIDITY AND MORTALITY WEEKLY REPORT, PREVENTION AND CONTROL OF TUBERCULOSIS IN CORRECTIONAL INSTITUTIONS: RECOMMENDATIONS OF THE ADVISORY COMMITTEE FOR THE ELIMINATION OF TUBERCULOSIS 313, 314 (May 12, 1989) [hereinafter RECOMMENDATIONS].

6. See generally JOHN DUFFY, THE SANITARIANS (1990); ALLAN M. BRANDT, NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880 (expanded ed. 1987); CHARLES E. ROSENBERG, THE CHOLERA YEARS: THE UNITED STATES IN 1832, 1849 AND 1866 (2d ed. 1987).

limits of their authority to dealing with the expression rather than the causes of disease. Private Health workers, though not formally constrained, are also disempowered by the absence of a strong connection between local, individual action and a broader vision of social change.

In Part II of this Article, I review the extent of the communicable disease problem in prisons and outline programs that can help ameliorate it. In Part III, I discuss both the past and future role of the courts, with particular attention to the barriers to successful litigation. I conclude that litigation on behalf of prisoners will most likely succeed when it links their needs to public health goals, but that even the best court decisions cannot replace leadership and investment by voluntary agencies, public health authorities, and executive and legislative policymakers. In Part IV, I describe a lawsuit that can serve as an organizing device for formal and informal cooperation between legal advocates, health departments, and community health agencies.

## II. PRISONERS AND EPIDEMIC DISEASE

### A. *The Demographics of HIV, TB, Drug Use, and Incarceration*

#### 1. WHO IS ILL?

HIV and TB—as well as syphilis, gonorrhea, chancroid, and hepatitis B (“HBV”)—are strands in a web of morbidity and mortality that our society has spun for its poorer, darker members. The prevalence of each of these diseases is disproportionately large among the disadvantaged, who also make up a large proportion of the nation’s prison population. Sexually transmitted diseases are strikingly more prevalent among minority populations in the United States than among the non-Hispanic white majority. According to the Centers for Disease Control, in 1988, African Americans, who comprise less than 12% of the population, suffered 76% of the reported syphilis cases and 78% of the reported gonorrhea cases.<sup>7</sup> Hispanics, comprising only 6.4% of the population, accounted for 12% of the syphilis cases and 5% of the gonorrhea cases.<sup>8</sup> Leading studies have linked the rise in the number of syphilis and gonorrhea cases among African Americans in the mid-1980s, a time when the total number of cases were falling, to socioeconomic causes.<sup>9</sup> In one study, for example, the prevalence of syphilis was 4.1 per 100,000 for people with annual incomes less than \$6,000, but 1.2 per 100,000 for people with annual

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7. John S. Moran et al., *The Impact of Sexually Transmitted Diseases on Minority Populations*, 104 PUB. HEALTH REP. 560, 560 (1989).

8. *Id.* at 560-62.

9. See, e.g., Sevgi O. Aral & King K. Holmes, *Sexually Transmitted Diseases in the AIDS Era*, 264 SCI. AM. 62 (1991).

incomes of more than \$15,000.<sup>10</sup> By any measure, Black and Hispanic families are more likely to suffer poverty and low income than White families in the United States.<sup>11</sup> Over the past thirty years, the number of African Americans and Hispanics below the poverty level has been more than twice that of Whites.<sup>12</sup>

Although there are no readily obtainable figures for the prevalence of Hepatitis B, because it is often asymptomatic and, thus, not reported, a U.S. Navy study revealed the incidence of HBV to be nearly twice as great among Blacks than Whites.<sup>13</sup> One study found the prevalence of the Herpes ("HSV2") antibody in persons age 15 through 74 to be 13% for Whites but 41% for African Americans.<sup>14</sup> The recent outbreaks of chancroid in this country have also occurred preponderantly among African Americans and Hispanics.<sup>15</sup>

The incidence of tuberculosis among populations of color is also significantly greater than in the White majority. In 1990, almost 70% of TB cases occurred among racial and ethnic minorities.<sup>16</sup> Perhaps more disturbing is the finding that 86% of all cases among children occurred in minority groups.<sup>17</sup> By contrast, non-Hispanic Whites accounted for only 30.5% of the reported cases in 1990.<sup>18</sup> For Whites, the tuberculosis case rate in 1990 was 4.23 per 100,000 people.<sup>19</sup> In the same year the risk of TB was 5.1 times higher for Hispanics, 7.9 times higher for African Americans, and 9.9 times higher for Asians and Pacific Islanders.<sup>20</sup> Between 1985 and 1990, the per-

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10. Robert A. Hahn et al., *Race and the Prevalence of Syphilis Seroreactivity in the United States Population: A National Sero-epidemiologic Study*, 79 AM. J. PUB. HEALTH 467, 468 (1989).

11. BUREAU OF CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1991, at 38, 40. Blacks make up over 30% of the people below the poverty level despite constituting 12% of the population. *Id.* at 12, 38. Blacks and Hispanics also lag behind Whites in percentages of high school graduates, fully employed workers, and homeowners. *Id.* at 38, 40.

12. *Id.* at 426.

13. Mark L. Dembert et al., *Epidemiology of Viral Hepatitis among US Navy and Marine Corps Personnel, 1984-85*, 77 AM. J. PUB. HEALTH 1446, 1446 (1987) (HBV cases per 100,000: Whites=33.8, Blacks=62.6).

14. Robert E. Johnson et al., *A Seroepidemiologic Survey of the Prevalence of Herpes Simplex Virus Type 2 Infection in the United States*, 321 NEW ENG. J. MED. 7, 9 (1989).

15. George P. Schmid et al., *Chancroid in the United States: Reestablishment of an Old Disease*, 258 JAMA 3265, 3267 (1987).

16. CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUM. SERVS., MORBIDITY AND MORTALITY WEEKLY REPORT, PREVENTION AND CONTROL OF TUBERCULOSIS IN U.S. COMMUNITIES WITH AT-RISK MINORITY POPULATIONS 1 (1992) [hereinafter AT-RISK MINORITIES].

17. *Id.* at 2.

18. *Id.*

19. *Id.*

20. *Id.* at 4.

cent increase of TB cases reported to the CDC was 54.7% for Hispanics and 26.9% for Blacks, while the CDC registered a 7.3% decrease of TB cases for non-Hispanic Whites during the same period.<sup>21</sup>

In 1991, the CDC confirmed the presence in a New York prison of a Multidrug-Resistant strain of Tuberculosis ("MDR-TB") from which four inmates died.<sup>22</sup> This new form of TB did not respond to standard drug treatments and proved particularly lethal to those already infected with HIV.<sup>23</sup> Moreover, TB has developed rapidly among HIV-infected persons, who are often intravenous drug abusers, homeless, or both.<sup>24</sup> MDR-TB is believed to be particularly dangerous to people with compromised immune systems, and many of its fatalities have been people with HIV disease.<sup>25</sup>

Finally, AIDS, which entered the American mind as a "gay plague," has now predominantly become a disease of poor people of color. Seventy-four percent of the 18,602 women diagnosed with AIDS as of April 1991 were non-White, primarily African American and Latina. Statistics on the prevalence per 100,000 people show an even more striking imbalance: by 1988, the cumulative number of cases per 100,000 was nearly three and one-half times higher among Black men, two and one-half times higher among Latino men, fourteen times higher among Black women, and seven times higher among Latina women than among their non-Hispanic White counterparts.<sup>26</sup> Prevalence per 100,000 was four times higher among Black children

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21. *Id.*

22. CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUM. SERVS., MORBIDITY AND MORTALITY WEEKLY REPORT, TRANSMISSION OF MULTIDRUG-RESISTANT TUBERCULOSIS AMONG IMMUNOCOMPROMISED PERSONS IN A CORRECTIONAL SYSTEM—NEW YORK 1991, at 507, 507 (July 17, 1992) [hereinafter MULTIDRUG-RESISTANT TUBERCULOSIS].

23. *See id.*

24. *See* Charles Marwick, *Do Worldwide Outbreaks Mean Tuberculosis Again Becomes 'Captain of All These Men of Death'?*, 267 JAMA 1174 (1992) (noting how co-infection poses special difficulties in terms of identification and treatment).

25. MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 22, at 507.

26. Daniel M. Fox, *Chronic Disease and Disadvantage: The New Politics of HIV Infection*, 15 J. HEALTH POL., POL'Y & L. 341, 345 (1990); *see also* CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUM. SERVS., MORBIDITY AND MORTALITY WEEKLY REPORT, FIRST 100,000 CASES OF ACQUIRED IMMUNODEFICIENCY SYNDROME—UNITED STATES 561, 561-62 (August 18, 1989) [hereinafter FIRST 100,000 CASES]; SAIRA MOINI & THEODORE M. HAMMETT, U.S. DEP'T OF JUSTICE, 1990 UPDATE: AIDS IN CORRECTIONAL FACILITIES 1, 10 (1991) ("Blacks and Hispanics continue to be overrepresented among AIDS cases reported in the U.S. Through 1987, 60 percent of total AIDS cases were among Whites, 25 percent among blacks, and 14 percent among Hispanics. By 1990, the percentages have shifted to 55, 28, and 16 percent, respectively. This 5 percent shift in cumulative cases from whites to minorities in three years reflects the more rapid growth of cases among blacks and Hispanics than among Whites in the past several years."); Susan Y. Chu et al., *Impact of the Human Immunodeficiency Virus Epidemic on Mortality in Women of Reproductive Age, United States*,

and two times higher among Latino children than among White children.<sup>27</sup> In 1988, HIV infection became the sixth leading cause of death for Black males, compared to tenth among White males.<sup>28</sup>

## 2. WHO IS ILL IN PRISON?

If poor people and people of color are more likely than paler, wealthier Americans to be ill, they are also more likely to suffer their illness in prison. The links between communicable disease, drug use, poverty, poor living conditions, poor access to medical care, and compliance with medical instructions are inescapable.<sup>29</sup> Demographic characteristics that indicate an increased risk for having one of the currently resurgent communicable diseases, such as race, poverty, and drug use, are also powerful predictors of incarceration.

While 1.6% of the White population is in custody or under correctional supervision such as parole or probation, the figure is 7.2%

264 JAMA 225, 226 (1990); *The Health Status of the United States*, Fed. News Serv. (Apr. 8, 1991) [hereinafter *Health Status*].

An examination of overall death rates is yet another indicator of the gulf between the White majority population in this country and its minority underclass. For instance, in 1991, the leading cause of death for Black youth between the ages of 15 and 24 was homicide (59 per 100,000), more than seven times the rate for White youth (7 per 100,000). *Health Status*, *supra*, at 13-16. For Hispanic youth, the homicide rate was more than four times the rate of White non-Hispanic youth (29 per 100,000). *Id.* at 14. Black adults between 25 and 44 had the highest overall death rate among all groups (367 per 100,000), 2.5 times the rate for White adults (149 per 100,000). *Id.* Across the board, death rates for black adults were higher than White adults for heart disease, HIV infection, homicide, malignant neoplasms, and cerebrovascular diseases. *Id.* at 13, 16.

Minorities were also more likely to be victims of crime, especially violent crime. Black males were most susceptible, with 53 victimizations per every 1,000 persons, compared with White males at 35.5 per 1,000. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, CRIMINAL VICTIMIZATION IN THE UNITED STATES, 1990 25, tbl. 7 (1991). Hispanic males had a violent crime victimization rate of 49.5 per every 1,000 persons. *Id.* at 27, tbl. 9. Non-Whites were also more likely to be victims of crimes of theft. *Id.* at 24, tbl. 6.

27. See Fox, *supra* note 26, at 345.

28. *Health Status*, *supra* note 26, at 80, tbl. 25.

29. CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUM. SERVS. MORBIDITY AND MORTALITY WEEKLY REPORT, A STRATEGIC PLAN FOR THE ELIMINATION OF TUBERCULOSIS IN THE UNITED STATES 1, 2-3 (April 21, 1989) [hereinafter STRATEGIC PLAN] (two-thirds of TB cases in the U.S. are among Blacks, Hispanics, Asians, and Native Americans, primarily because of "socioeconomic conditions, poor housing and nutrition"). For the link between STD and socioeconomic status, see William W. Darrow, *Social Stratification, Sexual Behavior, and the Sexually Transmitted Diseases*, 6 SEXUALLY TRANSMITTED DISEASES 228 (1979); William E. Morton et al., *Effects of Socioeconomic Status on Incidences of Three Sexually Transmitted Diseases*, 6 SEXUALLY TRANSMITTED DISEASES 206, 206-10 (1979); Mary Haan et al., *Poverty and Health: Prospective Evidence from the Alameda County Study*, 125 AM. J. EPIDEMIOLOGY 989, 989 (1987). For a comprehensive overview of STD and minority, poor, urban populations, see Aral & Holmes, *supra* note 8; Janet Weiner et al., *The Crisis in Correctional Health Care: The Impact of the National Drug Control Strategy on Correctional Health Services*, 117 ANN. INTERNAL MED. 71 (1992).



for the Black population.<sup>30</sup> The National Center on Institutions and Alternatives found that on any given day in Washington, D.C., 42% of young Black males were involved with the criminal justice system, and that 70% of the Black men in the District are arrested by the time they turn 35.<sup>31</sup> The most recent data indicate that less than half of the total federal and state prison population is White non-Hispanic, with Blacks constituting nearly 47% of the population behind bars.<sup>32</sup> In state prisons, Black prisoners actually *exceed* the number of White prisoners.<sup>33</sup> Fourteen percent of state prison inmates are Hispanic.<sup>34</sup> The percentage of Hispanic prisoners is estimated to be one-third in California and New York and more than one half in New Mexico.<sup>35</sup> In the federal system alone, the prison population is over one-third Black and one-fourth Hispanic.<sup>36</sup>

Drug use is strikingly linked to incarceration. The Department of Justice reports that well over half of all jail inmates had used a major illegal drug, such as heroin, cocaine, or LSD, prior to incarceration.<sup>37</sup> Over 13% of all those jailed committed their offense to obtain money for drugs.<sup>38</sup> Nearly 80% had previously used some illicit drug, such as marijuana, hashish, or amphetamines, before their jail sentence.<sup>39</sup> Of those inmates who reported using drugs, a stagger-

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30. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1989, at 6 (1990) [hereinafter CORRECTIONAL POPULATIONS].

31. See also NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES, REPORT: HOBBLING A GENERATION: YOUNG AFRICAN AMERICAN MALES IN D.C.'S CRIMINAL JUSTICE SYSTEM (1992) ("On any given day, 21,800 of the city's 53,377 young African American men were in jail or prison, probation or parole, awaiting trial or sentencing, or being sought on warrants for their arrest"); Jason DeParle, *42% of Young Black Males Go Through Capital's Courts*, N.Y. TIMES, April 18, 1992, at A1.

32. CORRECTIONAL POPULATIONS, *supra* note 30, at 69.

33. *Id.*

34. *Id.*

35. *Id.*

36. G. CAMP & C. CAMP, THE CORRECTIONS YEARBOOK 4-5 (1991); CORRECTIONAL ASSOCIATION OF NEW YORK & NEW YORK STATE COALITION FOR CRIMINAL JUSTICE, IMPRISONED GENERATION (1990); NATIONAL CENTER ON INSTITUTIONS & ALTERNATIVES, YOUNG AFRICAN AMERICAN MEN AND THE CRIMINAL JUSTICE SYSTEM IN CALIFORNIA (1990); Norris, *Study: Black Men Pack State Courts, Prisons*, RENO GAZETTE-JOURNAL, Feb. 2, 1991, at 1A.

The war on drugs has also, it appears, been a war on people of color on drugs. While the National Institute on Drug Abuse estimates that 75% of regular drug users are White, 41% of those arrested on drug-related charges in 1991 were Black. In 1989, almost three quarters of those imprisoned on drug convictions were Black or Hispanic. See David Zucchino, *Racial Imbalance Seen in War on Drugs*, PHILA. INQUIRER, Nov. 1, 1992, at A1, A15.

37. CORRECTIONAL POPULATIONS, *supra* note 30, at 52.

38. *Id.* at 51.

39. *Id.* at 52.

ing 93.6% stated that their parents were also drug abusers.<sup>40</sup> Between one-quarter and one-half of all jail inmates were *daily* users of at least one illicit drug prior to committing their offense, and more than one-quarter were under the influence at the time of their arrest.<sup>41</sup> In major urban centers, nearly 70% of all arrestees tested positive for one or more drugs.<sup>42</sup> It is estimated that by 1995, fully 70% of all federal prisoners will be drug offenders.<sup>43</sup>

Prison populations thus often represent a distillate of the major public health problems in the communities from which prisoners are drawn. Theodore M. Hammett and Andrea L. Daugherty reported that, in 1990, a cumulative total of almost 8,000 AIDS cases were discovered in prisons.<sup>44</sup> Because of poor diagnostic and reporting practices, as well as social barriers that create disincentives for sick inmates to seek care, this figure is almost certainly a significant undercount. In the hardest hit areas, levels of HIV and TB in prison are substantially higher than in the general population.<sup>45</sup> Further studies have estimated an aggregate incidence rate of HIV in state and federal prisons of 181 cases per 100,000 prisoners,<sup>46</sup> ten times higher than the general incidence rate,<sup>47</sup> which makes the risks of acquiring TB in prison all the greater. In general, seroprevalence in prisons appears to be linked to seroprevalence in the areas from which the prisoners come.<sup>48</sup> Screening in low prevalence states has generally

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40. *Id.* at 53.

41. *Id.* at 52.

42. *Id.*

43. NATIONAL COMMISSION ON AIDS, *supra* note 2, at 15.

44. Theodore M. Hammett & Andrea L. Daugherty, 1990 *Update: AIDS in Correctional Facilities* 12, 20 (1991).

45. See, e.g., MOINI & HAMMETT, *supra* note 26, at 25 ("Twenty-seven State and Federal prison systems reported a total of 317 cases of active TB . . . . [T]here were 80 cases in the New York State system at the end of 1990. The county/jail systems that responded to the NIJ survey reported a total of 301 cases. . . . Seventeen State and Federal systems and 4 county/city systems reported over 10% of their inmates tested TB-positive (infected with TB but not with active TB disease.)").

46. *Id.* at 15.

47. Jan Elvin, *TB Comes Back, Poses Special Threat to Jails, Prisons*, NAT'L PRISON PROJECT J., Winter 1992, at 4.

48. See Gina E. Glass et al., *Seroprevalence of HIV Antibody among Individuals Entering the Iowa Prison System*, 78 AM. J. PUB. HEALTH 447, 448 (1988); Neil J. Hoxie et al., *HIV Seroprevalence and the Acceptance of Voluntary HIV Testing among Newly Incarcerated Male Prison Inmates in Wisconsin*, 80 AM. J. PUB. HEALTH 1129, 1130 (1990); Konika K. Patel et al., *Sentinel Surveillance of HIV Infection Among New Inmates and Implications for Policies of Correctional Facilities*, 105 PUB. HEALTH REPS. 510 (1990); David Vlahov et al., *Prevalence of Antibody to HIV-1 Among Entrants to US Correctional Facilities*, 265 JAMA 1129, 1132 (1991).

yielded seroprevalence rates less than 1%.<sup>49</sup> In states with medium to high prevalence, however, the results of inmate screening range from worrisome to horrifying. One study reported that HIV prevalence rates ranged from 2.1% to 7.6% for male entrants to correctional facilities, and 2.5% to 14.7% for female entrants.<sup>50</sup> Overall, prevalence was nearly twice as high among non-Whites as among Whites.<sup>51</sup> Seventeen percent of male prisoners and over 18% of female prisoners in one 1988 New York prison study were infected.<sup>52</sup> Five percent of prisoners entering Philadelphia's jail system tested positive in a blind study.<sup>53</sup>

Alexa Freeman has observed that the diagnosis and care of women with HIV in prison are becoming ever more pressing problems because women are becoming infected and imprisoned at rates surpassing those for men.<sup>54</sup> Facilities and services for imprisoned women are rarely better than those available for men, a condition which the rapid increase in female inmate populations has aggravated.

TB is not a new problem in prison. For many years, reports have indicated a higher rate of TB among prisoners than among the free population, and health officials have warned of the need for action.<sup>55</sup> In recent years, however, the disparity has increased. In the New York prison system, incidence of TB has increased five-fold between 1976 and 1986.<sup>56</sup> A 1989 study reported that the incidence of TB in prison was nearly four times the incidence rate among the general

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49. Alexa Freeman, *HIV in Prison*, in *AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC* 263, 264-65 (Scott Burris et al. eds., 1993).

50. Vlahov et al., *supra* note 48, at 1130.

51. *Id.* at 1131.

52. New York State Commission on Corrections, *Update: Acquired Immune Deficiency Syndrome, A Demographic Profile of New York State Inmate Mortalities* 19 (1987); Hammett & Daugherty, *supra* note 44, at 17, fig. 6 at 18-20.

53. Davidson et al., *Retrovirus Seroprevalence in the Short-Term Incarcerated: The Philadelphia Prison Seroprevalence Study*, Abstract No. M.A.O. 39, Fifth International Conference on AIDS, Montreal (June 5, 1989).

54. BUREAU OF JUSTICE STATISTICS, U.S. DEPARTMENT OF JUSTICE, *WOMEN IN PRISON* 1 (1991) (the rate of growth of female inmate population has exceeded that of males every year since 1981; for 1980-89, the male population grew by 112%, the female by 202.%); Freeman, *supra* note 49; Janet Weiner et al., *supra* note 29, at 73.

55. See, e.g., Hans Abeles et al., *The Large City Prison: a Reservoir of Tuberculosis*, 101 *AM. REV. RESPIRATORY DISEASES* 706, 706-09 (1970); Julius Katz & Robert E. Plunkett, *Prevalence of Clinically Significant Pulmonary Tuberculosis among Inmates of New York State Penal Institutions*, 61 *REV. TUBERCULOSIS* 51 (1950); *TB Warning to Prisons Was Ignored*, *N.Y. TIMES*, Aug. 16, 1992, at 42 [hereinafter *TB Warning*] (health officials warned of TB risk three years before outbreak killed an immunosuppressed guard and 28 inmates).

56. Miles Braun et al., *Increasing Incidence of Tuberculosis in a Prison Inmate Population*, 261 *JAMA* 393, 394; see also Marcel Salive et al., *Coinfection with Tuberculosis and HIV-1 in Male Prison Inmates*, 105 *PUB. HEALTH REP.* 307 (1990).

population.<sup>57</sup> A 1992 study reported that 23% of inmates and 6% of prison employees in New York tested positive for TB.<sup>58</sup> Since 1985 there have been eleven serious outbreaks of TB among prisoners.<sup>59</sup> King and Whitman's 1981 observation that "prisons and jails play an important role in maintaining the relatively high rates of tuberculosis that persist in inner city, minority, and economically disadvantaged populations" appears to be even truer twelve years later.<sup>60</sup>

Prisons have been particularly hard-hit by MDR-TB because of crowded conditions, poor medical care, and the presence of so many people with compromised immune systems.<sup>61</sup> A 1992 study of TB in New York was prompted by the death of more than twenty inmates and one guard in 1991 from the new drug-resistant strain of the disease.<sup>62</sup> Although there is no indication that HIV is being transmitted at high levels within prisons,<sup>63</sup> dangerous sexual and injection activity does occur,<sup>64</sup> and there is no question that overcrowded, poorly ventilated prisons foster TB transmission.<sup>65</sup> Moreover, people with HIV are at a higher risk of acquiring and dying from TB, because the suppressed immune system permits the latent infection to become reactivated. Experts at the CDC regard HIV as the *strongest* risk factor for developing TB.<sup>66</sup>

### B. *The Public Health Responses*

It is clear that prisoners in many areas of this country constitute communities at high risk for some of the worst scourges of our time, and that most prisoners are also members of free communities beyond

57. Dixie E. Snider et. al., *Tuberculosis: an Increasing Problem Among Minorities in the United States*, 104 PUB. HEALTH REPS. 646, 650 (1989).

58. Lisa Belkin, *23% of State Prisoners Test Positive for TB*, N.Y. TIMES, March 31, 1992, at B4.

59. CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUM. SERVS., CONTROL OF TUBERCULOSIS IN CORRECTIONAL FACILITIES: A GUIDE FOR HEALTH CARE WORKERS 3 (1992) [hereinafter CONTROL OF TUBERCULOSIS]; see also Howard Goodman, *ACLU Seeks Order on TB in State Jails*, PHILA. INQUIRER, Aug. 7, 1992, at A1 (claiming that treatment must be improved to avoid "disaster" in Pennsylvania's jails).

60. Lambert N. King & Steven Whitman, *Morbidity and Mortality Among Prisoners: An Epidemiologic Review*, 1 J. PRISON HEALTH 7, 20 (1981).

61. See, e.g., Braun et al., *supra* note 56, at 395 (finding that inmates who reported drug use were more likely to develop TB).

62. Elvin, *supra* note 47, at 4.

63. NATIONAL COMMISSION ON AIDS, *supra* note 2, at 11; see generally Brewer et al., *Transmission of HIV-1 within a Statewide Prison System*, 2 AIDS 263 (1988); L. Robert Horsburgh, Jr., et al., *Seroconversion to Human Immunodeficiency Virus in Prison Inmates*, 80 AM. J. PUB. HEALTH 209 (1990).

64. See Freeman, *supra* note 49.

65. See generally MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 22.

66. RECOMMENDATIONS, *supra* note 5, at 313, 314; Elvin, *supra* note 47, at 4.

prison walls. Most prisoners move in and out of the correctional system over relatively short periods of time. More than nine and one-half million people are discharged annually from the nation's prisons and jails, including more than 400,000 from state and federal institutions.<sup>67</sup> On the other hand, prison communities are very stable in the short run: prisoners are easy to find when they are in prison, probably much easier than when they are back on the streets. Prisons, therefore, present an exceptional opportunity to reach these high-risk people with the same public health interventions being used outside prisons.<sup>68</sup> One can go even further: from a legal perspective, there is an additional basis for health action, because, unlike those outside, prisoners cannot be deprived of basic medical care because of their hypothetical freedom of choice. In prison, people have a right to health care.

## 1. A MODEL RESPONSE

### i. HIV

A successful response to HIV in prisons applies public health and medical techniques of proven value to reduce the transmission of HIV by inmates during and after their imprisonment, and meeting the medical and psychosocial needs of the infected. Nationally, we have settled into a three-pronged strategy against HIV: diagnostic and therapeutic medical care, including psychosocial support; education; and protection of the social status of people with, or at risk of, HIV infection, through privacy and antidiscrimination rules. (A persistent strain of compulsion and punishment—as, for example, in criminal prosecution of infected people who engage in risky behavior—is a prominent feature of our response, but it has a trivial impact on prevention and public health as a whole.) In particular, organizations as diverse as the American Civil Liberties Union, the National Commission on AIDS, and the National Commission on Correctional Health Care have generally agreed on most of the following basic elements of an adequate response to HIV in prisons.<sup>69</sup>

*Medical care:* A prison should have an effective system of identifying HIV-infected inmates early through voluntary, confidential test-

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67. Elvin, *supra* note 47, at 4.

68. This, of course, begs the question of whether current interventions work outside the prison.

69. See NATIONAL COMMISSION ON AIDS, *supra* note 2; NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, POLICY STATEMENT REGARDING THE ADMINISTRATIVE MANAGEMENT OF HIV IN CORRECTIONS (Sept. 22, 1991); see also Patel et al., *supra* note 48, at 513-14; Vlahov et al., *supra* note 48, at 1132 (urging targeting of HIV health interventions on prisoners).

ing. Such testing must be truly voluntary, and "confidentiality" should include the condition that non-medical prison personnel will not learn the test result, even if it is positive. Testing must not be perceived by inmates as creating a danger of being isolated or otherwise stigmatized. Testing must also be preceded and followed by meaningful counseling. People who test positive need to be properly examined and regularly monitored by a physician who is trained in treating infectious diseases and, in particular, HIV. The full range of approved medications to prevent or treat symptoms of HIV infection and AIDS must be available. This means that current barriers to use of experimental drugs, now largely eliminated for people outside prison, need to be modified for prisoners.<sup>70</sup> If necessary, early release for treatment or other humanitarian purposes should be available without insurmountable bureaucratic or legal hurdles.

*Prevention Education:* In prison as outside, education is an important and broadly defined measure. Inmates need to be taught how to reduce or eliminate their risk of HIV infection.<sup>71</sup> This serves a primary prevention purpose. Inmates also need to understand how HIV infection is detected, how HIV develops, and how it can be treated. This kind of education is the precondition for inmates' intelligent participation in their own medical care, allowing inmates to make informed choices about the costs and benefits of being identified as HIV-infected in the prison setting and in society. This kind of education can also reduce the fear of casual transmission and, consequently, make discrimination against the infected by the untested both less frequent and less severe. Correctional staff need the same kind of education, for their own sakes, to prevent discrimination by them, and to allow them to assist inmates who may be in need of care.

*Social conditions:* As on the outside, it is important that people in prison affected by HIV are protected against a plague mentality. A program that punishes people who have HIV will deter cooperation with health efforts, behavioral change, and the seeking of medical treatment. Prisons should not routinely isolate inmates with HIV. No medically unnecessary restrictions, such as exclusion from food service jobs, should be placed on the HIV infected. Finally, prisons should zealously protect the privacy of HIV-related medical information.

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70. See Nancy N. Dubler & Victor W. Sidel, *On Research on HIV Infection and AIDS in Correctional Institutions*, 67 MILBANK Q. 171 (1989).

71. See generally Scott Burris, *Education to Reduce the Spread of HIV*, in AIDS LAW TODAY, *supra* note 49, at 82.

## ii. TB

Tuberculosis control in prisons has suffered from the same apathy that undermined the general HIV control effort. Casualness in screening has been combined with an inattention to symptoms of active TB.<sup>72</sup> Three years ago, with TB outbreaks on the rise, the CDC issued comprehensive recommendations for addressing TB among the incarcerated.<sup>73</sup> Key elements of these recommendations are:

*Surveillance:* The CDC recommends a tuberculin skin test for all entering inmates and new employees, to be repeated annually or at other intervals based on prevalence. Those who test positive, or who have symptoms associated with TB, such as coughing, weight loss and fever, should get a chest x-ray. People with HIV should also be x-rayed, even after a negative skin test, because a compromised immune system may not produce antibodies to TB in sufficient quantity to generate a positive skin-test result. (This is known as “anergy.”) Inmates with TB symptoms or abnormal chest x-rays should also undergo sputum smears and culture examinations. Because latent TB can become active at any time, it is particularly important for prison health care workers to be attentive to possible TB symptoms during routine care and sick calls. The CDC also recommends swift reporting to health officials of cases within the system, and contact investigations to identify others at high risk. Experience with TB outbreaks in recent years has demonstrated the importance of *timely* testing and evaluation of test results, particularly in the case of MDR-TB.<sup>74</sup>

*Containment:* Preventing the transmission of TB requires both personal and environmental control measures, with the latter being of far greater value and effectiveness in reducing overall prevalence. The CDC recommends “respiratory isolation” for any confirmed or suspected TB patient who has a positive chest x-ray, cough, or a positive sputum smear, until the diagnosis is confirmed, treatment is begun, and the patient has had at least three daily negative sputum smears. Respiratory isolation requires an area with its own ventilation to the outside, negative air pressure (so that air in the isolation area flows from, and not to, adjacent areas), and four to six air exchanges per

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72. For an illustration of how prison officials can fail to diagnose even obvious TB, see *DeGidio v. Pung*, 704 F. Supp. 922, 936-38 (D. Minn. 1989), *aff'd*, 920 F.2d 525 (8th Cir. 1990) (prison required ten months to diagnose an inmate who had a positive skin test, a persistent productive cough that was ultimately producing one and one-half cups of sputum per day, and back and chest pain); see also Goodman, *supra* note 60 (detailing incidents where major prison systems have disregarded strong warnings from state health officials); *TB Warning*, *supra* note 55.

73. RECOMMENDATIONS, *supra* note 5, at 313.

74. See MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 22, at 509.

hour. In 1992, New York City's Riker's Island jail spent \$12 million to purchase 42 modular isolation units.<sup>75</sup> As with identification, it is essential that isolation and treatment be initiated promptly upon diagnosis of an active disease to prevent its further spread. The delays and snafus that characterize many prisons' health care delivery cannot be further indulged.

Personal measures also include treatment and preventative therapy. Treatment for active TB requires months of daily, and later bi-weekly, medication. Patients who do not have an active disease, but who are at an elevated risk of acquiring one because of HIV infection or other factors, may have their chances of developing an active disease reduced by six to twelve months of medication. Patients in treatment must be monitored for adverse reactions or complications, and expert consultation should be available.

Multidrug-resistant TB results in large measure from incomplete treatment, making the completion of treatment an important public health goal. To ensure continuing compliance, the CDC recommends the direct observation of medication inside the institution, and that the appropriate health department is notified when prisoners in treatment are released.

Preventing transmission from identified active cases through respiratory isolation and personal medical measures is obviously valuable, if only for both moral and morale reasons. It is, however, expensive, labor-intensive and reactive. Reducing prevalence significantly will require changes to make the environment less conducive to the spread of TB.<sup>76</sup> Reducing overcrowding and improving ventilation are obviously essential. Although its effectiveness is subject to further testing, ultra-violet lighting has been used in hospitals and homeless shelters to kill TB bacteria, and it may be useful in prisons.<sup>77</sup>

*Assessment:* Both individual and population outcomes must be carefully observed and assessed. Because of the importance of completing therapy, prison managers must place special emphasis on tracking inmates in treatment as they are moved through the prison system. In poorly managed prisons, inmates may face daily difficulties in actually getting their medication, and it is not unheard of for guards to make it hard for selected inmates to get their medication on

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75. James Barron, *Panel to Recommend Ways to Fight TB in New York Jails*, N.Y. TIMES, June 25, 1992, at B5.

76. This is the lesson of the long-term decline in TB. See, e.g., THOMAS MCKEOWN, *THE ROLE OF MEDICINE* 55-56 (1976); Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 INT'L J. EPIDEMIOLOGY 32 (1985).

77. RECOMMENDATIONS, *supra* note 5, at 317.



a regular basis. The overall impact of the anti-TB program should be reviewed at least every six months.

The CDC recommendations display a general agnosticism towards the social needs and autonomy of prisoners with, or at risk, of TB. In sharp contrast to the agency's HIV guidelines, there is no explicit mention of securing patient consent for diagnostic testing, or the dissemination of medical information within and outside of the prison. The only hint that prisoners might have a say in the matter comes when the CDC suggests that prisoners who refuse preventative therapy should be counseled to seek prompt medical attention if they develop any symptoms suggestive of TB. Of course, TB is not HIV. The medical and social consequences of testing positive are not generally as serious, or as irreversible. Nevertheless, particularly in prison, where prisoners are forced into unhealthy proximity, people who are subject to developing a dangerous, airborne disease could face ostracism or even violence.<sup>78</sup>

More importantly, controlling TB is every bit as dependent on cooperation between health workers and patients as controlling HIV. The great fear of health authorities is the creation of MDR-TB resulting from incomplete treatment. The course of TB policy in this country is likely to be determined by whether incomplete treatment is attributed primarily to "recalcitrant" or "non-compliant" patients, or to defects in the social and health care delivery systems. The dismal history of coercive health measures suggests that prisoners should be given positive incentives to voluntarily accept testing and treatment.

## 2. PRISON PRACTICES

Prisons usually do respond, eventually, to serious health threats, and there is good reason to believe that their responses are influenced by generally accepted public health practices. For example, as the HIV epidemic has progressed, the trend has moved away from segregation and towards providing education and community-level medical care.<sup>79</sup> In a few places, like Philadelphia, the prison has opened its doors to public health workers who provide testing, counseling, and risk-reduction education. In Rhode Island, HIV medical services are provided cooperatively by the state health department, the corrections department, and Brown University, and the program includes efficient discharge planning programs to ensure continuity of care.<sup>80</sup> Wiscon-

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78. Such was the experience of a plaintiff in *DeGidio v. Pung*, 704 F.2d 922, 937 (D. Minn. 1989).

79. MOINI & HAMMETT, *supra* note 26, at 1.

80. Hammett & Daugherty, *supra* note 44, at 60.

sin has had a voluntary HIV testing and counseling program since the late 1980s, which has enjoyed a rate of acceptance as high as 71%.<sup>81</sup>

Nevertheless, there are serious internal obstacles to a comprehensive public health approach, obstacles that few prison systems will overcome on their own. Most of these obstacles have been well canvassed elsewhere.<sup>82</sup> Prisons often provide only a low standard of general health care. HIV infection and AIDS are particularly complicated conditions that arise in a setting where even simply treated problems often fester without adequate medical intervention. Problems in health care sometimes arise from neglect or indifference, but even where there is the will to provide care there may not be the resources. Prisons in America tend to be overcrowded and underfunded, and what new money is available now tends to move towards construction.<sup>83</sup> We can therefore expect that many prisons will fail to implement an effective or even merely adequate response to HIV, TB, or other communicable diseases, or will do so too slowly, when time is measured in unnecessary suffering and death. With some idea of what good public health requires, it is important to now look at what federal courts have prescribed.

### III. THE ROLE OF LITIGATION

#### A. Court Decisions

Although their number is certain to increase in the near future, lawsuits aimed at improving TB care have, so far, been few. Prisoners and their advocates have sought what they believed to be improvements in prisons' response to HIV under a variety of legal theories. Unfortunately, the most significant common element of these lawsuits has been their low rate of success. In many cases, proponents of an effective response to HIV have been satisfied with a losing result, as inmates or staff sought the implementation of punitive measures against the infected. But litigants trying to implement positive measures have lost just as frequently. For better or for worse, courts have given considerable leeway to prisons in the management of HIV, as we will see in the following brief overview of court action under the three main areas of need.

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81. Hoxie et al., *supra* note 48, at 1130.

82. See, e.g., Alexa Freeman, *AIDS and Prisons*, in AIDS PRACTICE MANUAL 14-1 (Paul Albert et al. eds., 1991); Urvashi Vaid, *Prisons*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 235, 248-50 (Harlon L. Dalton et al. eds., 1987).

83. The Justice Department's request of \$2.1 billion to run the federal prison system in 1992 includes \$314 million for new prison construction. The request represents a 24% increase over the previous year. Michael Isikoff, *Number of Imprisoned Drug Offenders Up Sharply*, WASH. POST, April 25, 1991, at A5.

## 1. BASIC MEDICAL CARE FOR HIV

i. HIV Testing and Counseling<sup>84</sup>

During most of the epidemic, testing was seen in prison as it was outside, as substantially unrelated to prevention or the provision of medical care. Litigation focussed on its utility as a tool for case finding. In a number of cases, the courts rejected suits by inmates who sought to have mandatory testing introduced for the purpose of identifying (and then segregating) the infected.<sup>85</sup> At the same time, however, courts were also refusing to stop prisons from testing inmates against their will.<sup>86</sup>

Although the public health issues were essentially the same, the reasoning in these prison cases was often different from that in testing cases outside the prison context.<sup>87</sup> In *Glover v. Eastern Nebraska*

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84. Individualized testing and counseling is the centerpiece of the federal prevention program, particularly for those at highest risk. In 1990, a representative year, the CDC entered into funding agreements for HIV prevention with sixty-five state and local health departments. The contracts included \$23.8 million for risk-reduction education, \$16.8 million for initiatives in minority communities, \$12.3 million for public information, and \$117.6 million for counseling and testing. Overall, 69% of government prevention dollars were spent on counseling and testing. (All prevention activities, in turn, comprised 15% of total HIV-related expenditures.)

The testing program rests on the theory that the offer of HIV testing is an effective way to reach those who believe they are at risk. Even if an individual's test is negative, the program has succeeded in providing intensive education to a particularly likely candidate. Between 1985 and 1990, CDC-funded operations had performed over 3.85 million tests, at an approximate cost of \$66 per person counseled, or \$1,767 per infected person identified.

It seems reasonable to believe that individual testing substantially benefits those who are tested (particularly now that early medical intervention is helpful), and may result in a reduction of risky behavior and an increase in knowledge. But despite massive amounts spent on the program, the CDC has not assessed whether any of these beliefs about testing are not only reasonable but correct. HIV testing probably helps reduce risky behavior to some degree, but is it effective enough, compared to other interventions, to justify the fiscal priority it has received? The research to date raises serious doubts. See Burris, *supra* note 71.

85. See, e.g., Janik v. Celeste, 928 F.2d 1132 (6th Cir. 1991); Holt v. Norris, 871 F.2d 1097 (6th Cir. 1989); Glick v. Henderson, 855 F.2d 536 (8th Cir. 1988); Muhammad v. Bureau of Prisons, 789 F. Supp. 449 (D.D.C. 1992); Deutsch v. Federal Bureau of Prisons, 737 F. Supp. 261 (S.D.N.Y. 1990), *aff'd*, 930 F.2d 909 (2nd Cir. 1991); Portee v. Tollison, 753 F. Supp. 184 (D.S.C. 1990), *aff'd*, 929 F.2d 694 (4th Cir. 1991); Feigley v. Fulcomer, 720 F. Supp. 475 (M.D. Pa. 1989); Alston v. Dep't of Justice, 1989 U.S. Dist. LEXIS 9222 (D.D.C. 1989); Jarrett v. Faulkner, 662 F. Supp. 928 (S.D. Ind. 1987); LaRocca v. Dalsheim, 467 N.Y.S.2d 302 (N.Y. Sup. Ct. 1983).

86. See, e.g., Dunn v. White, 880 F.2d 1188 (10th Cir. 1989) (*per curiam*), *cert. denied*, 493 U.S. 1059 (1990); Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990), *aff'd*, *vacated in part*, 941 F.2d 1495 (11th Cir. 1991); *cf.* Clarkson v. Coughlin, 783 F. Supp. 789 (S.D.N.Y. 1992) (deafness of inmate led to involuntary HIV test).

87. Prisons, because of their unique obligation to provide medical care, can argue that testing is necessary in order to identify inmates who need medical monitoring and, perhaps, prophylactic treatment. This argument has not, however, figured largely in any of the cases to date. In *Dunn v. White*, 880 F.2d 1188, 1196 (10th Cir. 1989), for example, the court observed

*Community Office of Retardation*,<sup>88</sup> for example, the court ruled that testing people who gave institutional care to the developmentally disabled was an unreasonable public health intervention because it was opposed by national health authorities and aimed at alleviating a virtually nonexistent risk of transmission. The court's decision relied entirely on medical evidence and the statements of public health officials, with the institutional prerogatives of the defendants going virtually unmentioned.

In contrast, the court in *Dunn v. White* upheld mandatory testing in prison even though "a review of the record does not reveal whether there is currently a widespread AIDS infection among the prisoners."<sup>89</sup> Indeed, the court found that the prison's interest in assessing prevalence was enough to justify the testing "even assuming that the spread of AIDS in prison is not any greater than its spread in the general population."<sup>90</sup> No evidence was taken concerning the actual spread of the disease in the prison, or concerning the relationship between the health problem and the measures selected by the prison authorities. Furthermore, there was no mention of the fact that mandatory testing is generally disfavored by public health authorities. In reviewing the trial court's determination that testing was legal, the court of appeals found that the lower court had met its factfinding obligation by taking judicial notice "of the seriousness and the potential for transmission of the disease AIDS."<sup>91</sup>

Advances in the treatment of asymptomatic, seropositive people began to be widely reported about the time of the international AIDS conference in June, 1989. Since then, the FDA has approved AZT and ddI for use in infected people with T-cell counts below 500. So far, however, such changes in medical practice have not affected the legal analysis of HIV testing in prisons.<sup>92</sup>

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that "the prison, as caretaker, has an interest in diagnosing and providing adequate health care to those already infected with AIDS," without ever considering whether or not that was the actual purpose of the testing or whether treatment was actually provided. On the contrary, as the dissent pointed out, the procedural posture of the appeal required the court to accept as true the plaintiff's claim that no treatment was provided. *Id.* at 1198-99 (McKay, J., dissenting).

88. 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989), *cert. denied*, 493 U.S. 932 (1990).

89. 880 F.2d at 1195.

90. *Id.*

91. *Id.* at 1195. For further discussion of testing in prisons, see Monica Brion, Comment, *Prisoner AIDS Testing: A Comment on Dunn v. White*, 68 DENVER U. L. REV. 469 (1991); cf. Donna Dennis, *The Federal Government's Response*, in AIDS LAW TODAY, *supra* note 49, at 187 (describing deferential treatment by courts of federal screening programs).

92. See, e.g., Feigley v. Fulcomer, 720 F. Supp. 475, 481 (M.D. Pa. 1989). In some states, the testing of prisoners is a matter of state law rather than individual prison policy. Courts are

## ii. Medical Care After Identification

Throughout most of the epidemic, issues of testing and isolation overshadowed those of medical treatment for the infected. Earlier in the epidemic, prisons tended to recognize HIV as a medical matter only when AIDS developed, if even then, and that view, though harsh, was not unlike the situation outside of prison. In recent years, treatment of AIDS and asymptomatic HIV disease has improved, and the gulf has widened between the care available to the imprisoned and to the free. As the difference became substantial, people began to litigate for improvements.

The prison setting presents peculiar problems for inmates and advocates seeking decent health care. As will be discussed further in the next section, the Constitution does not require prison medical care to be very good, and many prisons live down to that low standard. AIDS patients do not get very good treatment, but neither do heart patients or back patients. When conditions are bad enough, a general attack on the system's medical care, or care of people with HIV, may have a better chance of success than a single inmate's complaint, but such a case requires an enormous investment in collecting and presenting factual evidence. While a suit for a specific treatment known to be effective, like AZT, may be easier to conduct than a global challenge, a judge who does not see the systemic failures in care is more likely to believe the prison's claim that it is an isolated failure.<sup>93</sup>

The courts have been reluctant to compel prisons to provide new treatments to inmates. In *Hawley v. Evans*,<sup>94</sup> for example, the court was unwilling to anticipate the FDA and CDC in ordering care for inmates, even if such care was commonly offered on the outside. On August 4, 1989, two months after both the International AIDS Conference and the first reliable confirmation of the efficacy of AZT pro-

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even less likely to overturn mandatory testing required by state law than testing under prison regulations alone. As of 1989, 14 states had instituted some form of mass screening for HIV in prison. Shawn Marie Boyne, *Women in Prison with AIDS: An Assault on the Constitution?*, 64 S. CAL. L. REV. 741, 751. Some of these testing procedures are compulsory. See, e.g., COLO. REV. STAT. § 25-4-1405(8)(a)(IV) (1989); UTAH CODE ANN. § 64-13-36 (Supp. 1990). Others require written informed consent. See, e.g., MASS. GEN. LAWS ANN. ch. 11, § 70F (West 1990); CONN. GEN. STAT. § 19a-582 (1992). Some states mandate that prisoners be given counseling and an opportunity to be tested. See, e.g., CAL. PENAL CODE § 4018.1 (1992). For a discussion of HIV and mandatory testing schemes, see Steven Eisenstat, *An Analysis of the Rationality of Mandatory Testing for the HIV Antibody: Balancing the Governmental Public Health Interests with the Individual's Privacy Interest*, 52 U. PITT. L. REV. 327, 337-38 (1991); Martha A. Field, *Testing for AIDS: Uses and Abuses*, 16 AM. J.L. & MED. 34 (1990).

93. See, e.g., *Nolley v. County of Erie*, 776 F. Supp. 715, 740 (W.D.N.Y. 1991).

94. 716 F. Supp. 601 (N.D. Ga. 1989).

phylaxis for asymptomatic patients, the court refused to order AZT for such inmates in a prison system that, consistent with FDA approval at that time, was providing the medication only to the symptomatic. The court wrote:

Although [the prison's] policy differs in some ways from the standards of other reputable agencies, the court in this case is not empowered to delve into the particulars and intricacies of modern medicine or to make narrow distinctions on debatable interpretations of what should be acceptable in the medical community. This court's powers are not enlarged by reason of the growing public awareness of the impact of AIDS on the national community. What this court can and must decide is whether the Department of Correction's medical policy is *constitutionally* acceptable.<sup>95</sup>

The court came to the same conclusion with respect to other experimental drugs sought by the inmates, finding inmate access to experimental medications to be a matter within the "exclusive prerogative" of the state.<sup>96</sup>

The case against intervention was stated even more baldly by the district court in *Harris v. Thigpen*.<sup>97</sup>

This Court is aware of the fact that several experimental drugs for the treatment of AIDS are now available and being prescribed by some doctors. Common sense points to the inescapable conclusion that some, if not all, of these drugs are extremely expensive and, accordingly, are well beyond the financial reach of many of those infected with the AIDS virus. The Constitution does not mandate that every possible care or suggested care for serious disease be provided, at the public's expense, to inmates infected with the AIDS virus. The Constitution only requires reasonable medical care. . . . AIDS infected inmates are not constitutionally entitled to the best treatment, rather, they are entitled to what is reasonable. This Court is of the opinion that financial considerations must be considered as one of several factors in determining reasonableness.

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95. *Id.* at 603. This extremely low standard was phrased another way by a court in a similar case:

Since the medical community itself was divided as to the appropriate treatment to be afforded patients suffering from early ARC [in the first half of 1989], the delay in plaintiff's AZT treatment was not an act or omission that was grossly incompetent or shocks the conscience, and does not constitute inadequate medical care. At that time the efficacy of treating early ARC patients with AZT was not known; delay in treatment cannot therefore be judged fundamentally unfair.

*Wilson v. Franceschi*, 735 F. Supp. 395, 398 (M.D. Fla. 1990).

96. *Hawley*, 716 F. Supp. at 604. The court also found an unexplained "legitimate security concern in limiting the exposure of inmates to drugs." *Id.*

97. 727 F. Supp. 1564 (M.D. Ala. 1990), *aff'd in part, vacated in part*, 941 F.2d 1495 (11th Cir. 1991).

Alabama is a poor State, and . . . [t]o hold . . . that inmates are entitled to every drug reasonably thought to be a cure for their illness is not a demand of the Constitution. . . . [A]uthorities must remember that some medicines are extremely rare and, therefore, their cost is prohibitive. To require penal authorities to furnish such drugs without charge to all inmates who need such treatment would inevitably lead to such persons' submitting themselves to imprisonment solely for the purpose of securing such treatment.<sup>98</sup>

This attitude may be contrasted with the judicial position in the leading case concerning AZT availability to Medicaid recipients. In *Weaver v. Reagan*,<sup>99</sup> a suit was brought to force Missouri to pay for AZT treatment for people who did not present the then-current FDA label's indications but for whom the drug had been prescribed by a physician. Neither the trial court nor the court of appeals was deterred by medical disagreement about the utility of AZT. The latter court dismissed Missouri's evidence that AZT was still experimental for the patients who sought it here, writing:

Although Dr. Mills stated that the use of AZT beyond labeled indications was experimental in the sense that scientific studies had not conclusively determined its effectiveness, Dr. Mills agreed that "doctors commonly exercise professional medical judgment and prescribe drugs for uses not within the indications articulated by the FDA."<sup>100</sup>

Only in rare instances have courts been willing to look seriously at the possibility that prison HIV care is deficient. As always, it is impossible to determine whether this willingness reflects upon the poor care in the particular prison, the interest of the particular judge, or both. In *Roe v. Fauver*,<sup>101</sup> Judge Ann Thompson of the federal district court in New Jersey refused to allow the state prison system to avoid a full trial on, among other issues, whether or not it had failed to provide adequate care.<sup>102</sup> The judge's decision paved the way for a

98. *Id.* at 1577-78. The Court of Appeals affirmed the district court's conclusion, but disavowed its reasoning. *Harris v. Thigpen*, 941 F.2d 1495 (11th Cir. 1991). For a similar treatment concerning intervention, see *Lewis v. Prison Health Servs., Inc.*, No. CIV.A.88-1247, 1988 WL 95082 (E.D. Pa. 1988), *appeal dismissed*, 915 F.2d 1561 (3d Cir. 1990).

99. 886 F.2d 194 (8th Cir. 1989).

100. *Id.* at 199.

101. No. CIV.A.88-1225 (AET), 1988 WL 106316 (D.N.J. 1988).

102. "Plaintiffs allege that they were not always given correct dosages of AZT, sometimes did not get it at the correct time and sometimes did not receive it [at] all. . . . AZT is the only medication that has proved successful in treating AIDS now distributed in the U.S. Plaintiffs' affidavits allege a number of occasions on which they have not been treated for ailments or occasions when treatment did not occur until they had complained of symptoms for a number of months." *Id.* at \* 4.

successful settlement.<sup>103</sup>

*Gomez v. United States*<sup>104</sup> dealt squarely with the fact that prisons are poor places to treat people with HIV. Petitioner Gomez, upon being sentenced to prison, alleged that he would be unable to receive adequate care for his advanced AIDS anywhere in the federal prison system. Pending an investigation of the claim, the court ordered Gomez held in a local federal detention center. There, too, Gomez claimed he was receiving insufficient care and brought suit for his release via a writ of habeas corpus. The judge found that Gomez could not get certain necessary drugs, such as ddI and pentamidine; that he was seeing his treating physician only once a week, and a specialist only once a month; that necessary psychological counseling was unavailable; and that lack of continuous hospital-level care was unacceptable. Gomez was granted bail so he could obtain hospital care outside.

The court of appeals viewed things differently.<sup>105</sup> It did not question the district court's finding that care was inadequate. Rather, it ruled that even if the findings were true, the lower court should have ordered an improvement in care, or placement in a better federal facility, but not release. In what amounted to an invocation of Catch-22, the court of appeals ignored the fact that the lower court had not yet determined whether the plaintiff could receive proper treatment anywhere in the federal system. Although the court of appeals admitted that "problems of prisons are complex and not readily susceptible to resolution by decree," it gave the lower court no option other than to decree and enforce acceptable medical care for a person with AIDS in prison.<sup>106</sup>

## 2. HIV PREVENTION EDUCATION

Education is as necessary in prison as it is difficult to legally enforce. Although there is no recognized legal right to HIV education, the important public health role of education allows plaintiffs to hang HIV education on a variety of legal hooks. In some cases, plain-

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103. *Roe v. Fauver*, No. CIV.A.88-1225 (AET) AIDS L. & Litig. Rep. 366 (D.N.J. Mar. 4, 1992).

104. 725 F. Supp. 526 (S.D. Fla. 1989), *rev'd*, 899 F.2d 1124 (11th Cir. 1990).

105. *Gomez v. United States*, 899 F.2d 1124 (11th Cir. 1990), *rev'g*, 725 F. Supp. 526 (S.D. Fla. 1989).

106. *Id.* at 1126-27. Malpractice lawsuits against prison medical personnel are an option in individual cases, and may have a system-wide impact. *See, e.g., McIlwain v. Prince William Hosp.*, 774 F. Supp. 986 (E.D. Va. 1991) (private physician employed by prison is a "state actor" and can be held liable for failure to properly inform inmate of HIV status); *Maynard v. New Jersey*, 719 F. Supp. 292 (D.N.J. 1989) (family of deceased inmate brought action for failure of medical personnel to properly treat HIV infection).



tiffs have argued that refusing to provide preventative education or test-related counseling is a violation of the Eighth Amendment's right to minimal health care,<sup>107</sup> and a violation of the right to privacy.<sup>108</sup> Prisoners have contended that failure to provide general education to alleviate fear and hostility in the inmate population is a violation of the Rehabilitation Act.<sup>109</sup> So far, unfortunately, no court has ordered HIV education in a prison on any of these theories, but squarely raising HIV education in a lawsuit, despite its legal novelty, can be a successful strategy. As will be discussed below, several comprehensive settlements have included HIV education in consent decrees that probably would not have been ordered by a judge.

### 3. SOCIAL CONDITIONS FOR PEOPLE WITH HIV<sup>110</sup>

Housing, privacy, and non-discrimination practices all affect HIV-infected inmates. Assuming there is little education, practices that identify the HIV infected create a strong likelihood of harassment, isolation, and other forms of discrimination against the infected inmate. The fear of this sort of maltreatment deters people at risk from seeking testing or treatment.

Segregation of prisoners with HIV usually deprives them of access to prison programs and activities, and identifies them to staff, guards, and, ultimately, the outside world, as HIV-infected. Courts routinely rejected early efforts to either force or forbid segregation of the HIV-infected, believing that the treatment of HIV-infected inmates was a matter of prison administration rather than of medicine or public health.<sup>111</sup> While isolation measures against people with

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107. See, e.g., *Starkey v. Matty*, No. 89-9011 (E.D. Pa. amended complaint filed June 4, 1990).

108. *Inmates of New York State with Human Immune Deficiency Virus v. Cuomo*, 16 Fed. R. Serv. 3d (Callaghan) 1397 (N.D.N.Y. 1990).

109. See, e.g., *Starkey v. Matty*, No. 89-9011 (E.D. Pa.).

110. One of the more novel aspects of the national response to HIV has been the attention to the social status of the infected. Armed with a broader concept of disease, as well as the hard won recognition that cooperation is more effective than compulsion on the broad social scale, health authorities have allied with civil libertarians to promote the legal protection of privacy as well as social prerogatives. There is no evidence that this actually reduces disease, but there is plenty of evidence that discrimination exists and that it reduces the quality of life for the infected. Of all the assumptions made about HIV and how to prevent it, the assumption that privacy and social safety will promote cooperation with health advice strikes me as one of the most reasonable.

111. See, e.g., *Holt v. Norris*, 871 F.2d 1087 (6th Cir. 1989) (text in WESTLAW); *Glick v. Henderson*, 855 F.2d 536 (8th Cir. 1988); *Muhammad v. Carlson*, 845 F.2d 175 (8th Cir. 1988); *Muhammad v. United States Bureau of Prisons*, 789 F. Supp. 449 (D.D.C. 1992); *Alston v. United States Dep't of Justice*, No. CIV.A.89-1883 SSH, 1989 WL 308033 (D.D.C. 1989); *Lewis v. Prison Health Servs.*, No. CIV.A.88-1247, 1988 WL 95082 (E.D. Pa. 1988); *Judd v. Packard*, 669 F. Supp. 741 (D. Md. 1987); *Jarrett v. Faulkner*, 662 F. Supp. 928 (S.D.

HIV outside of prison have been rare and have been searchingly examined by courts for a solid medical basis,<sup>112</sup> courts gave little or no serious scrutiny to initial attacks on prison isolation practices.

For example, in 1988, a Pennsylvania district court applied the lowest standard of scrutiny to an Equal Protection Clause challenge to segregation at a county jail.<sup>113</sup> The jail officials stated (without supporting evidence) that segregation was instituted to:

- (1) protect non-AIDS inmates from exposure to the disease; (2) to protect AIDS victims from physical abuse from the general population; (3) to limit the exposure of AIDS victims to various diseases which arise in the general population (such as the common cold or chicken pox) which can be deadly to any AIDS victim; and (4) to control prison staff exposure to the disease.<sup>114</sup>

As the court stated, "Any one of these rationale [sic] constitutes a legitimate end: in the conglomerate these goals are certainly legitimate."<sup>115</sup> To make matters worse, the "AIDS victims" the judge referred to, and of whose complete immunosuppression the judge was instinctively convinced, were virtually all in the early, asymptomatic stages of infection. Indeed, throughout the case, which stretched on for almost a year, the judge never seemed to grasp the difference between HIV infection and AIDS.

Despite the lack of factual support for these justifications, the court's determination is not unusual in legal terms. "Rational basis" scrutiny under the Equal Protection Clause is designed to be highly deferential to state prerogatives. Nevertheless, the court's disregard for the facts demonstrates the way in which a case that, outside of the prison context, would probably depend on the medical rationality of a particular health action, inside prison depends on whether the state can offer a grammatical sentence justifying its practices.<sup>116</sup>

More recently, the right of privacy has proven to be very helpful in bringing some level of rationality and scale into prison AIDS litigation, particularly in the area of housing. In *Doe v. Coughlin*,<sup>117</sup> a class of HIV-positive inmates in the New York state system were successful in ending a system that involuntarily placed HIV-infected inmates in

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Ind. 1987); *Powell v. Dep't of Corrections*, 647 F. Supp. 968 (N.D. Okla. 1986); *Cordero v. Coughlin*, 607 F. Supp. 9 (S.D.N.Y. 1984).

112. See, e.g., *Martinez v. School Bd. of Hillsborough County*, 861 F.2d 1502 (11th Cir. 1988) (the notorious "glass booth" case).

113. *Lewis v. Prison Health Servs.*, No. CIV.A.88-1247, 1988 WL 95082 (E.D. Pa. 1988).

114. *Id.* at \* 2.

115. *Id.*

116. For a discussion of the varieties of scrutiny in health cases, see generally Scott Burris, *Rationality Review and the Politics of Public Health*, 34 VILL. L. REV. 933 (1989).

117. 697 F. Supp. 1234 (N.D.N.Y. 1988).

a special dormitory. The plaintiffs argued that their placement in the dormitory amounted to an announcement to the world of their medical condition.<sup>118</sup> The district court found that the inmates had two distinct, constitutionally protected privacy interests: keeping their diagnoses private from others, and deciding when and under what circumstances to have that information revealed.<sup>119</sup> The court avoided deciding the underlying medical value of the segregated housing scheme, which the state justified by claiming it was the best way to provide care, by finding that the inmates retained the right to reject the benefits of transfer to the dormitory, whatever they might be, if they regarded the cost to privacy as too high.<sup>120</sup>

The continuing attitudinal and doctrinal barriers to judicial protection of the social status of inmates with HIV can be illustrated by comparing two recent cases. In *Nolley v. County of Erie*,<sup>121</sup> a New York federal court rejected a county jail's segregation policy as violative of not only the right of privacy, but also the inmates' right to due process of law and of the state of New York's HIV confidentiality law. The court refused to accept the prison's unsupported claims that segregation was necessary to protect other inmates from sexual transmission. HIV was spread, the court found, not by status but by behavior. Segregation "only on the basis of an inmate's HIV status, while it may slightly reduce the possibility of accidental HIV transmission, does not seriously further that goal."<sup>122</sup> There was, therefore, no rational basis for the measure.

By contrast, the district judge in *Harris v. Thigpen*<sup>123</sup> ruled that prisoners with AIDS could not assert a right of privacy because, in committing crimes and becoming prisoners, and by having a disease that is expensive to treat, the prisoners had given up any such privacy interests. In a brief declaration unencumbered by any conventional legal reasoning, the court explained that "[a]n inmate's infection with AIDS is therefore not a private matter, but a matter of a controlling State interest."<sup>124</sup> Subsequently, the court of appeals corrected the district judge on the law—recognizing that prisoners do have privacy rights—but accepted the ultimate conclusion that segregation was an acceptable policy choice within the broad discretion of prison

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118. *Id.* at 1236.

119. *Id.* at 1237.

120. *Id.* at 1240, 1243.

121. 776 F. Supp. 715 (W.D.N.Y. 1991).

122. *Id.* at 736.

123. 727 F. Supp. 1564 (M.D. Ala. 1990).

124. *Id.* at 1572.

managers:<sup>125</sup>

Even if Alabama's approach . . . is now a minority position among state correctional systems, we simply are unable to say . . . that the DOC's use of combined mass screening and segregation is so remotely connected to the legitimate goals of reducing HIV transmission and violence within the state's penal system "as to render the policy arbitrary or irrational."<sup>126</sup>

Section 504 of the Rehabilitation Act<sup>127</sup> forbids recipients of federal funds to discriminate against the disabled, including people with or perceived as having HIV. This statute has been one of the most powerful legal tools against AIDS discrimination, and courts have held that the statute is fully applicable to prisons and jails receiving federal funds.<sup>128</sup> The law was first successfully applied in the prison setting in a segregation matter. In a 1989 adjudication of an administrative complaint filed by several Pennsylvania prisoners with HIV, the Office for Civil Rights of the Department of Health and Human Services found that the isolation of these prisoners violated the Act. The matter was resolved when the prison decided to disband the isolation unit and mainstream the prisoners.<sup>129</sup> More recently, in the *Harris* case, the court of appeals, in reversing the district court decision holding that segregation did not violate the Act, criticized the lower court's decision as "devoid of the kind of individualized inquiry and findings of fact necessary to determine" the merits of the plaintiffs' claims.<sup>130</sup>

Attempts at eradicating other forms of discrimination against inmates with HIV have had mixed results, with a slight trend towards greater protection. One of the earliest cases was certainly one of the worst. In a 1987 decision, the highest court in New York upheld a state prison regulation barring inmates with HIV from participating in the private family visit program, a program which permitted the inmate to visit a spouse in a trailer, affording the opportunity for sexual relations.<sup>131</sup> The plurality opinion not only assumed that a fully-informed spouse would nevertheless engage in unsafe sexual behavior with the infected inmate—thus implicating the prison's interest in health issues inside its walls—but also stated that a larger public

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125. *Harris v. Thigpen*, 941 F.2d 1495 (11th Cir. 1991).

126. *Id.* at 1517 (quoting *Turner v. Safley*, 482 U.S. 78, 89-90 (1986)).

127. 29 U.S.C.A. § 794 (West 1985 & Supp. 1992).

128. *See, e.g.*, *Bonner v. Lewis*, 857 F.2d 559 (9th Cir. 1988).

129. David S. Owens, Jr., Pennsylvania Department of Corrections, Ref. Nos. 03892002, 03892003, 03892006, 03892013 (Dep't of Health and Human Services opinion letter, Sept. 19, 1989).

130. *Harris v. Thigpen*, 941 F.2d 1495, 1526 (11th Cir. 1991).

131. *Doe v. Coughlin*, 518 N.E.2d 536 (1987), *cert. denied*, 488 U.S. 879 (1988).

health issue was implicated, because the visiting spouse might become infected and might pass the infection on to subsequent sex partners and that, indeed, the virus could well be passed on to succeeding generations of children.<sup>132</sup>

In the 1990 case of *Farmer v. Moritsugu*,<sup>133</sup> a Wisconsin federal court upheld the constitutionality of a prison policy prohibiting HIV-infected inmates from working in various food and health service positions. Prison officials made no claim that the inmates posed a significant risk of infection in these positions—a factor that, outside of prison, would be decisive—but the court nevertheless approved the practice for security reasons. “If it became known that an inmate working in food services or the hospital had the HIV virus, the potential for disruption among uninformed or unconvinced inmates would be great.”<sup>134</sup> Such inmates could “perceive the presence of HIV positive inmates in food service or the hospital as a threat to their own health and well-being and might not adequately avail themselves of these services.”<sup>135</sup>

Since then, the situation has improved slightly. In 1991, a federal district court in Arizona found that a policy in the Arizona state prisons similar to the one upheld in *Farmer* violated the Rehabilitation Act.<sup>136</sup> The court rejected the defendants’ “unsubstantiated and unfocused fears” that other inmates would react violently to HIV-infected food service workers, and held that the Rehabilitation Act would allow a prisoner to be denied a food service job only if there was concrete evidence that that particular prisoner posed a significant risk of transmitting HIV.<sup>137</sup> In *Harris*, the court of appeals remanded the plaintiffs’ Rehabilitation Act claims, instructing the district court that the prison would have to justify, based on the specific risk of transmission, its decision to exclude a particular inmate from a particular program.

We . . . do not believe . . . that the prison’s choice of blanket segregation should alone insulate the DOC from its affirmative obligation under the Act to pursue and implement such alternative, reasonable accommodations as are possible for HIV-positive prisoners with respect to various programs and activities that are avail-

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132. In 1988, a new suit was filed against the policy, resulting in the corrections department reversing itself and voluntarily rescinding the rule. *Kozlowski v. Coughlin*, 771 F. Supp. 83 (S.D.N.Y. 1988), *aff’d*, 871 F.2d 241 (2d Cir. 1989); *see also* Sam H. Verhovek, *Spouse Visits for Inmates with HIV*, N.Y. TIMES, Aug. 5, 1991, at B1.

133. 742 F. Supp. 525 (W.D. Wis. 1990).

134. *Id.* at 527.

135. *Id.*

136. *Casey v. Lewis*, 773 F. Supp. 1365 (D. Ariz. 1991).

137. *Id.* at 1372-73.

able to the prison populations at large.<sup>138</sup>

The right of privacy has been useful as a tool to protect inmates from the kind of treatment that exposes them to discrimination. In *Woods v. White*,<sup>139</sup> a Wisconsin district court held that an allegation that prison officials disclosed HIV test results to non-medical personnel and inmates stated a claim for violation of the constitutional right to privacy. In *Rodriguez v. Coughlin*,<sup>140</sup> the court reached the same conclusion in a case involving the transfer of an inmate in a "hygiene suit." In *Nolley v. County of Erie*,<sup>141</sup> the court found that the practice of placing red stickers on all documents pertaining to an HIV-infected prisoner was a violation of the state HIV confidentiality law, even though prison officials used the sticker for other contagious conditions as well. The court found that the red sticker policy was developed "in response to the hysteria [at the prison] over HIV and AIDS," and that it was "also clear . . . that staff people and others who saw the red dot on [plaintiff's] documents either knew or strongly suspected that she was HIV+."<sup>142</sup> Each of these privacy cases is notable for the courts' willingness to recognize the importance of confidentiality for a person with HIV. This individual interest resonates as well with a larger social interest in reducing the stigmatization of people with HIV. Most significantly, the courts did not allow the issue to be obscured by prison assertions of "penological interests" in retaining discretion to breach confidentiality.

#### 4. TB PREVENTION AND TREATMENT

Cases involving TB control have been few. Two are of significant interest, one as an instance of strong judicial intervention, the other of a more deferential approach. *Austin v. Pennsylvania Department of Corrections* is the first major case since the revival of concern about TB.<sup>143</sup> In 1992, an outbreak of TB in the Pennsylvania state prison system revealed years of indifferent efforts to control the disease. Although the correctional authorities, in cooperation with the state health department, had already begun the development of a revised TB policy, the American Civil Liberties Union, representing a class of inmates in a comprehensive suit challenging prison conditions, filed a motion for a preliminary injunction. Interestingly, the proposed

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138. *Harris v. Thigpen*, 941 F.2d 1495, 1527 (11th Cir. 1991) (footnote omitted).

139. 689 F. Supp. 874 (W.D. Wis. 1988), *aff'd*, 899 F.2d 17 (7th Cir. 1990).

140. No. CIV-87-1577E, 1989 WL 59607 (W.D.N.Y. June 5, 1989).

141. 776 F. Supp. 715 (W.D.N.Y. 1991).

142. *Id.* at 726.

143. Civ. No. A 90-7497, 1992 WL 277511 (E.D. Pa. Sept. 29, 1992). The author is co-counsel in this case.

injunction accepted the proposed new policy as adequate—on paper. An injunction was necessary, plaintiffs argued, because of the state's poor record of actually putting its policies into practice. Finding that the inmates were faced with irreparable harm until the policy was actually in place, the court held hearings and granted the injunction in a matter of weeks.

By contrast, *DeGidio v. Pung*<sup>144</sup> dragged on for more than four years, during which the inmates and their attorneys were able to show a shocking pattern of indifference and incompetence that allowed a serious TB outbreak to develop and infect almost 200 prisoners. The court's detailed findings of fact left no doubt that prison officials were guilty of serious derelictions of duty. In fact, the court ruled that the actions of the officials violated the prisoners' Eighth Amendment right to be free from cruel and unusual punishment. Nevertheless, at the end of the case, the court refused to issue an injunction on the ground that the litigation had sparked so many improvements that the health care system was no longer constitutionally deficient.<sup>145</sup> Thus, the plaintiffs "won" in the sense that they forced a change, but they "lost" in the sense that they were denied the formal relief they sought.

Two practical problems flowed from the result in *DeGidio* that are avoided by the order in *Austin*. First the plaintiffs had no court order on which to rely should the defendants return to their former practices. Second, the failure to obtain an injunction led the court to reduce the plaintiffs' attorney's fees award by 65%, a strong disincentive to future litigation.<sup>146</sup>

With the increasing prevalence of TB, litigation regarding the disease is sure to increase. The future is suggested by a 1992 decision in which a federal court in Illinois refused to dismiss a prisoner's civil rights complaint against the Cook County Department of Corrections based on its failure to separate TB-positive from TB-negative inmates, a policy that the plaintiff alleged resulted in his being infected with TB while in custody.<sup>147</sup> The court also agreed to appoint counsel for the prisoner.<sup>148</sup> Certainly many current suits and consent decrees

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144. 704 F. Supp. 922 (D. Minn. 1989), *aff'd*, 920 F.2d 525 (8th Cir. 1990); *see also* Hochman v. Rafferty, No. CIV.A.89-2398, 1989 WL 200955 (D.N.J. Oct. 19, 1989) (another early case where the court rejected inmate demands for HIV and TB testing and segregation).

145. *DeGidio*, 704 F. Supp. at 960.

146. *DeGidio v. Pung*, 723 F. Supp. 135 (D. Minn. 1989), *aff'd*, 920 F.2d 525 (8th Cir. 1990). *DeGidio* is also noteworthy in the court's finding that a plaintiff was "subjected to cruel and unusual punishment when he was ostracized and threatened by inmates due to symptoms resulting from his undiagnosed tuberculosis." *DeGidio*, 704 F. Supp. at 957.

147. *See* Wilder v. Leak, No. 90 C 5044, 1992 WL 97678 (N.D. Ill. May 4, 1992).

148. *Id.* at \* 4.

involving prison conditions and medical care will be altered or reopened to address TB.<sup>149</sup>

### B. *Barriers to Effective Litigation*

Even this brief overview demonstrates that courts generally have been cautious in prescribing measures to deal with communicable diseases in prisons. There are a number of reasons for this, ranging from the mundane—inmates often prosecute their cases with no legal assistance—to the insurmountable—many prisons are simply not equipped to carry out effective disease prevention efforts.

#### 1. THE CONSTITUTIONAL RIGHT TO MEDICAL CARE IS NARROWLY APPLIED

Although I have focussed more on the results of suits than on the legal theories used, and, despite my view that, in practice, courts retain sufficient discretion to define and enforce minimal standards of care and prevention in prisons, the response of the courts must be seen in light of the severe doctrinal limitations on the rights of prisoners.

Medical care is a prime example. While inmates enjoy an enforceable right to medical care that free Americans do not, the level of care guaranteed under that right is minimal. The United States Supreme Court has held that the Constitution does not guarantee inmates adequate medical care.<sup>150</sup> As one court bluntly stated, medical care for prisoners does not have to be “perfect, the best obtainable, or even very good.”<sup>151</sup> Rather, the Eighth Amendment’s prohibition of “cruel and unusual punishment” protects prisoners only from “deliberate indifference” to serious medical needs, a standard that has been weakened further by the Supreme Court’s new emphasis on subjective intent. In *Wilson v. Seiter*,<sup>152</sup> the Supreme Court ruled that the “deliberate indifference” standard of the Eighth Amendment incorporates a subjective intent analysis, which may be used to exculpate prison officials whose prisons’ conditions are bad but whose intentions are good.<sup>153</sup> Following this decision, a district court in New York found that a prison had deprived the plaintiff of a “necessity of life”

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149. See Goodman, *supra* note 59, at A1.

150. *Estelle v. Gamble*, 429 U.S. 97, 105 (1976).

151. *Brown v. Beck*, 481 F. Supp. 723, 726 (S.D. Ga. 1980), *quoted with approval in* *Hawley v. Evans*, 716 F. Supp. 601, 603 (N.D. Ga. 1989) (resting decision not to order AZT for asymptomatic inmates on distinction between general medical practices and “constitutionally acceptable” care).

152. 111 S. Ct. 2321 (1991).

153. *Id.* at 2328.



by repeatedly failing to provide her with prescribed AZT, but that “[a]lthough this was deplorable conduct in the care of an HIV+ inmate, there is not enough evidence that defendants possessed the culpable state of mind necessary to be found guilty of an Eighth Amendment violation.”<sup>154</sup>

Leaving aside the possible development of a strong intent element, there is always the question of exactly what sort of objective behavior constitutes “deliberate indifference.” According to one court, “deliberate indifference” includes: the denial of reasonable requests for medical treatment, where such denial exposes an inmate to undue suffering or the threat of tangible residual harm; the intentional refusal to provide needed care; delaying or denying necessary medical care for non-medical reasons; the erection of burdensome, arbitrary procedures that result in substantial delays or outright denial of medical care; or the choice of an easier, but less efficacious, treatment.<sup>155</sup> As for “serious medical need,” the Supreme Court has offered the reassurance that an inmate does not have to suffer “physical ‘torture or a lingering death’ ” for a medical need to be serious.<sup>156</sup> Instead, the essence of the claim is a denial of care resulting “in pain and suffering which no one suggests would serve any valid penological purpose.”<sup>157</sup> We are left to speculate as to what penological interests could ever be served by inmate pain and suffering.

One must believe that adequate care for HIV and AIDS qualifies as a serious medical need. Whether failure to provide such care results from deliberate indifference is an issue of fact for a judge to determine in an individual case, but few, if any, prison officials could plead ignorance of the general need for care. Unfortunately, no matter how the “deliberate indifference” standard is interpreted, it is a minimal one that tends to create a presumption against intervention, and, where intervention is needed, a presumption for only minimal intervention.

This same presumption in favor of upholding prison policies is explicitly part of the general analysis of prisoners’ constitutional rights. Prisoners do not lose all their constitutional rights by virtue of their imprisonment, but the protection to which these rights are entitled is substantially reduced. Whereas a measure that infringes on a basic constitutional right of a free citizen would be invalid unless it

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154. *Nolley v. County of Erie*, 776 F. Supp. 715, 740 (W.D.N.Y. 1991).

155. *Monmouth County Correctional Inst. v. Lanzara*, 834 F.2d 326, 346-47 (3d Cir.) (citations omitted), *cert. denied*, 486 U.S. 1006 (1988).

156. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (citation omitted).

157. *Id.*

was the least intrusive way of achieving a compelling state interest, prison actions violating prisoners' rights are valid as long as the measure "is reasonably related to legitimate penological interests."<sup>158</sup> This test gives "[p]rison officials . . . broad discretion in fashioning appropriate responses to legitimate penological objectives consistent with the constitutional rights of inmates."<sup>159</sup> Prison management, according to the Supreme Court, is "peculiarly within the province and professional expertise of corrections officials, and, in the absence of substantial evidence . . . indicat[ing] that the officials have exaggerated their response to these considerations, courts should ordinarily defer to their expert judgment in such matters."<sup>160</sup> Notably, however, at least one court has explicitly found this constitutional analysis inapposite in a case brought under statutes like the Rehabilitation Act.<sup>161</sup>

The respect accorded to prison officials' judgment also reflects a judicial belief that courts are not institutionally equipped to manage prisons. "The problems of prisons in America," the Supreme Court has observed, "are complex and intractable, and . . . not readily susceptible of resolution by decree."<sup>162</sup> This belief is frequently recited by courts which refuse to act, and even more by courts that wish to convey a sense of reluctance when they do act.<sup>163</sup>

These doctrinal strictures raise the issue of the institutional cost of intervention, and provide an incentive (and a rationalization) for refusing to act. This is not to suggest that they make action impossible. Without a doubt, federal judges remain powerful agents for the preservation or alteration of the status quo. To get a sense of the fairly wide range of discretion the law allows, one need only compare the responses of the district courts in *Gomez v. United States* (releasing the sick prisoner to allow adequate care immediately) and *Roe v. Fauver* (refusing to accept official bromides about the adequacy of care and insisting upon proof at trial) with the attitude of judicial powerlessness with which the trial judge in *Harris* decorated his indifference:

[I]t is well established that prisoners lose some of their freedoms because of the nature of themselves and their incarceration. The

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158. *Turner v. Safley*, 482 U.S. 78, 89 (1987).

159. *Monmouth County*, 834 F.2d at 343.

160. *Bell v. Wolfish*, 441 U.S. 520, 540 n.23 (1979) (quoting *Pell v. Procunier*, 417 U.S. 817, 827 (1974)).

161. See *Casey v. Lewis*, 773 F. Supp. 1365 (D. Ariz. 1991).

162. *Rhodes v. Chapman*, 452 U.S. 337, 351 n.16 (1981) (quoting *Procunier v. Martinez*, 416 U.S. 396, 404-05 (1974)).

163. See, e.g., *Tillery v. Owens*, 907 F.2d 418, 429 (3d Cir. 1990).

case necessarily involves a balance of rights of and duties to affected inmates with those of unaffected inmates and with the State's rights and duties to effect reasonable penological administration. Certain things are simply and naturally not available for unfortunate and perhaps unfair reasons. This Court cannot exempt anyone from the natural results of burdens he must bear.<sup>164</sup>

Nevertheless today courts are probably far more likely to make the kind of passive policy decisions that the *Harris* court did—that society cannot afford, and inmates do not deserve, a decent response to HIV in prisons—than to decide that millions of dollars should, under court order, be directed into a policy of intervention.

Whether because of the law or the perceived practical difficulties of successfully intervening, the general rule or posture of deference has a strong influence on the conduct and outcome of HIV litigation in prisons. It means that courts will accept patently absurd justifications for practices like isolation, and will give medical evidence far less weight in prison cases than in cases outside the prison context. Courts will assess risk under the weight of open or covert assumptions about the likelihood of prison sex or drug use, and are likely to make decisions on a class, rather than an individualized, basis. Ultimately, this means that courts will judge cases involving measures against HIV in prison not in public health terms, but rather, almost entirely in terms of security and institutional authority.

## 2. POOR FACTS

The legal bias against intervention makes the factual development of cases a matter of great practical importance. HIV cases will be hard to win without proving, incident by incident, patient by patient, that medical care, housing, education, and other policies lead to unnecessary suffering and premature death; that discrimination and breach of privacy occur on a regular basis; and that discrete, identifiable changes in prison programs could significantly improve matters.

This kind of case is expensive to bring. A statewide suit could easily consume hundreds of thousands of dollars in direct costs alone, not including lawyers' salaries. In addition to the collection of evidence from inmates—a great challenge in and of itself—the plaintiff needs to employ experts in both prison management and HIV treatment and prevention who can convincingly testify that the defendant prison's policies are so ineffective, dangerous, or unnecessary that no

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164. *Harris v. Thigpen*, 727 F. Supp. 1564, 1567 (M.D. Ala. 1990).

penological interest could possibly justify them. And even then, the case will not necessarily be won, because merely showing that some authorities disagree with a prison's decisions is not enough. In prison litigation, a tie goes to the defendant. Even well-equipped, well-funded civil liberties lawyers with experience in litigating AIDS cases have difficulty developing successful cases, and there are not enough of these lawyers to represent all the HIV-affected inmates with legal claims. Given the challenges of pulling together a sufficiently strong factual case, many HIV suits are lost even before they are filed.

### 3. POOR LAWYERING

Numerous HIV prison cases demonstrate the effects of poor lawyering—by which I mean both lawyering that is poorly done, and lawyering that represents the best efforts of people poor in legal and other resources. Any credible analysis of the legal system must recognize that poor, stigmatized litigants do not do as well as litigants with wealth or power, and, indeed, the research on AIDS litigation bears this out. Even assuming that the legal system can escape the gravity of the status quo, the lack of resources brought to bear in HIV cases means that the factual record and legal analysis are very likely to be impoverished.

Federal courts deal with thousands of prisoner suits annually. Most district and appellate courts have developed efficient systems of managing this cumbersome case load. Funds are available to appoint attorneys in possibly meritorious cases, and the courts have relaxed procedural rules to prevent untrained prisoners from being deprived of their day in court for purely technical reasons. In practice, however, much of this effort goes to moving cases through the system to an early conclusion as efficiently, rather than as justly, as possible. Dismissing a claim is far easier than trying one, and there is virtually no institutional disincentive against doing so.

Most prison AIDS cases have been brought by inmates who are both without formal legal training and who have not had the assistance of an attorney.<sup>165</sup> Their complaints, therefore, often rely on legal

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165. See, e.g., *Janik v. Celeste*, 928 F.2d 1132 (6th Cir. 1991) (text in WESTLAW); *Dunn v. White*, 880 F.2d 1188 (10th Cir. 1989), cert. denied, 493 U.S. 1059 (1990); *Muhammad v. United States Bureau of Prisons*, 789 F. Supp. 449 (D.D.C. 1992); *Farmer v. Moritsugu*, 742 F. Supp. 525 (W.D. Wis. 1990); *Wilson v. Franceschi*, 735 F. Supp. 395 (M.D. Fla. 1990); *Deutsch v. Federal Bureau of Prisons*, 737 F. Supp. 261 (S.D.N.Y. 1990), aff'd, 930 F.2d 909 (2d Cir. 1991); *Portee v. Tollison*, 753 F. Supp. 184 (D.S.C. 1990), aff'd, 929 F.2d 694 (4th Cir. 1991); *Hawley v. Evans*, 716 F. Supp. 601 (N.D. Ga. 1989); *Alston v. United States Dep't of Justice*, No. CIV.A.89-188355H, 1989 WL 308033 (D.D.C. Aug. 3, 1989); *Feigley v. Fulcomer*, 720 F. Supp. 475 (M.D. Pa. 1989); *Hochman v. Rafferty*, No. CIV.A.89-2398 1989 WL 200955 (D.N.J. Oct. 19, 1989); see also Jim Thomas, *Prisoner Cases as Narrative*, in

theories that have a low likelihood of success. Advocates may be appointed, but that appointment may be based on qualifications other than knowledge of AIDS or AIDS law.

A substantial percentage of these cases are dismissed at the earliest stage of litigation, before any facts have been presented to the court. This reflects the deficiencies of prisoner pleading, as well as the strong legal advantage that rests with the defendant officials. The lack of opportunity to present facts is particularly disturbing given the importance of strong facts in prevailing upon a judge to intervene. By dismissing cases before discovery or trial, the system virtually guarantees that it will not receive the information it needs to make a truly informed adjudication of claims that prison officials have abused their considerable discretion to handle HIV. Seen in that light, the early dismissal of prisoner AIDS cases connotes not the inmate's lack of a grievance, but the system's inability or unwillingness to air the grievance effectively.<sup>166</sup>

The impact of class, race and AIDS stigma on litigation outcomes is now being documented, and is reflected particularly in inmate cases. In an important study of HIV-related opinions published between 1983 and 1987, Musheno, Gregware and Drass found that courts tended to support the positions of institutional forces over those of individuals with HIV and "showed a great reluctance to give equal standing to stigmatized parties."<sup>167</sup> Not surprisingly, prisoners and arrestees with HIV were among the most likely losers. While state agencies won 62% of their cases as plaintiffs, and 69% as defendants, "parties associated with the institutional interests of criminal justice won 73% . . . of the time."<sup>168</sup> Thus the defence with which courts treat prison decisions is more than a matter of legal doctrine, reflection as well a larger tendency of courts to legitimate the regulatory decisions of "dominant institutional players' operations" within their claimed spheres of autonomy.<sup>169</sup> Prisoners, it could well be said, are supposed to lose suits against their jailers.

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NARRATIVE AND THE LEGAL DISCOURSE: A READER IN STORYTELLING AND THE LAW (David R. Papke ed., 1991). Path-breaking social science suggests that the influence of legal representation is "pervasive and dynamic . . . on jail litigation process and outcomes." Wayne N. Welsh, *The Dynamics of Jail Reform Litigation: A Comparative Analysis of Litigation in California Counties*, 26 L. & SOC'Y REV. 591, 616 (1992).

166. For a rare instance of an appellate court reversing a hasty dismissal of a prisoner's HIV claim, see *Moore v. Mabus*, 976 F.2d 268 (5th Cir. 1992).

167. Michael C. Musheno, Peter R. Gregware, Kriss A. Drass, *Court Management of AIDS Disputes: A Sociolegal Analysis*, 16 L. & SOC. INQUIRY 737, 770 (1991).

168. *Id.* at 760.

169. *Id.* at 742.

#### 4. WRONG PARTIES, WRONG PLACE

The most important reason we cannot expect the courts to offer effective assistance in the handling of HIV in prisons is in some ways the least blameworthy. The HIV epidemic in prison, like the HIV epidemic in the rest of the world, is a public health problem. In terms of traditional roles, the federal courts are the wrong places to look for the initiation of public health measures, and prison officials are the wrong people to ask to carry these measures out.

As previously discussed, federal courts claim to be reluctant to manage prisons (though, in fact, a substantial number of prison systems across the country are under some form of court order). More specifically, the federal courts often are unwilling to resolve disputes regarding health policy, or disputes between health and correctional goals. Yet effective programs to prevent and treat HIV in prisons require a substantial commitment of expertise, money, and human energy. Prisons, as institutions of custody and control rather than of public health, have little experience in public health work, and little enthusiasm for it, especially when, as will be the case in most prisons, efforts in that role will mean fewer resources going to the institution's "basic" functions. The success of any litigation depends, in part, on making judges and prison administrators comfortable with taking on the roles of public health workers.

#### C. *Prison Organization, Change, and the Courts*

Professor Susan Sturm provides a compelling account of the "organizational stasis" that limits the ability of prisons to reform themselves.<sup>170</sup> She cites four causal factors: (1) the lack of a set of values within prisons supporting reform; (2) incentive systems that reinforce the status quo and hamper reformers; (3) inadequate information exchange and poor access to expertise; and (4) the absence of any players who have the actual power to institutionalize reform.<sup>171</sup> She argues that courts generally have the remedial power to remove each of these barriers:

The court is an external source of normative authority that is insulated from the direct political pressures that pervade the prison dynamic. The court has the power to affect conduct by distributing both formal and informal rewards and sanctions to the prison system's participants . . . [, altering] the prison's incentive structure and . . . [encouraging] change. Active judicial oversight and inter-

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170. Susan Sturm, *Resolving the Remedial Dilemma: Strategies of Judicial Intervention in Prisons*, 138 U. PA. L. REV. 805 (1990).

171. *Id.* at 811-46.

vention can foster the development of both new channels of information and expertise within the prison system. . . . Because judicial pronouncements are public and highly visible, they expose prison conditions to public scrutiny. Finally, by using its formal and informal power to promote change, the court can shift the power balance within the prison system to enable responsible participants to bring about change.<sup>172</sup>

Professor Sturm considers several alternative judicial approaches to managing prison reform, but ultimately recommends what she calls the "catalyst approach." In essence, the catalytic jurist uses her power "to engage the necessary parties in effective confrontation of the prison problems and foster the internal development of a new normative framework."<sup>173</sup>

The discussion thus far should demonstrate that HIV is a problem that prison managers and residents need to engage. Undoubtedly, too, HIV is the archetype of the problem whose solution depends on managers and residents changing their hearts as well as their habits. "Safer thinking" can no more be imposed from above than safer sex. But who are to be the catalysts? Most judges have not accepted the need to enforce adequate health care in the prison setting.

This leads to two complementary conclusions. First, advocates within prisons, within the law, within health agencies, and within communities at risk, must nurture the idea that caring for the health of inmates in prison communities is an important value. Improvements in public health must be explicitly linked to prison reform. Short of major changes in doctrine, there is no other way to alter judges' beliefs about prisons' obligations, nor enhance their willingness to see health care behind bars as a constitutional issue ripe for judicial management. The second conclusion largely repeats the first: advocates for better health care in prisons must look beyond the courts to other players who can influence prison policies.

Public health authorities should play a leading role in advocating, and then providing, better health services in prisons. A state health secretary is as much a governmental insider as a corrections commissioner. Within an administration, health secretaries and corrections commissioners are, to some degree, allies, linked politically to a governor or county leader. Although an outsider could easily miss the intensity of bureaucratic jealousy, the fact remains that health authorities have access to prison administrators, as well as resources of money and personnel, that private parties lack. Public health agen-

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172. *Id.* at 846-47 (footnotes omitted).

173. *Id.* at 811.

cies already conduct or fund testing and prevention work. Increasingly they have a role in training health workers employed by correctional agencies, and current CDC recommendations envision at least that role.<sup>174</sup> Paradoxically, health authorities must also act like outsiders, embracing reform as a cause and joining with private citizens to articulate and promote a health reform agenda. As a rule of thumb, no health bureaucrat should ever feel fully comfortable with the insider role, no matter how skillfully she may play it.

Voluntary health agencies, particularly community-based AIDS organizations, can also play important roles as both advocates and service providers. Publicly funded private agencies have carried out much of the public health work against HIV, and it is not uncommon for such organizations to provide some educational or case management services to prisoners. In jails, these organizations and others, like the Red Cross, are often the only reasonably available local source of information for administrators and residents. Often heavily dependent on public funds, these organizations have had to practice politics to survive, and can advocate for greater funding for, and attention to, prison work.

A review of judges' orders simply points to the importance of governors, health commissioners, legislators, county commissioners, and mayors. Prisons will not initiate, or succeed, in public health work without reinforcement, whether negative or positive, from those who have expertise, money, or political capital.<sup>175</sup> Litigation can help to move prison health higher on the political agenda, but it will work best to that end when people in power receive the message from constituencies unrelated to prisoners.

#### IV. THE COORDINATED PUBLIC HEALTH STRATEGY

Legal advocacy can contribute to break the "organizational stasis" and enhance the role of prisons in health care. Success depends, however, on joining with other interested parties in a coordinated, self-conscious manner. I have already suggested that advocacy is crucial to developing a standard for health care within prisons. Courts have the power to *enforce* such a standard, as do political officials. Advocates have, at least, the power to articulate the standard. More-

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174. See, e.g., RECOMMENDATIONS, *supra* note 5, at 318-19.

175. This is not to say that public health work in prison depends on new money. In many states, prisons are among the biggest recipients of public funds. See, e.g., Janet Weiner et al., *supra* note 29, at 75; Michael Hinds, *Feeling Prisons' Costs, Governors Weigh Alternatives*, N.Y. TIMES, Aug. 7, 1992, at A17 (reporting that state and local prison expenditures rose from 12 to 23 billion dollars in the last five years).



over, although neither legal nor health care advocates can coercively alter the incentive structures within a prison without court intervention, advocates can try to *persuade* prison officials, guards, and inmates that reform is worth the effort and that it will be rewarded through enhanced public prestige and improved prison management. Fear of disease, in particular, is uncomfortable, and can be altered by education. Similarly, health agencies (and even well-informed lawyers) can help to fill the vacuum of expertise in health matters that exist in most prisons, as well as validate the reform agenda. There is, for example, a trend away from routine segregation of HIV-infected inmates; advocates can inform prison managers of the trend and its bases, and even assist managers in networking with better-informed colleagues.<sup>176</sup> Finally, advocates can help receptive prison managers or political officials simply by working as organized political allies. Willingness to reform is bitter without the ability to do so, and that is a function of politics both within and outside the prison.

The previous discussion of litigation left out perhaps the most significant class of cases, those in which a well-funded and managed class action lawsuit has resulted in a consent decree implementing new public health programs against HIV in prisons.<sup>177</sup> These, I suggest, provide a model approach for obtaining what one may call "the persuasive injunction."

The first major settlement came in a pair of class actions in Connecticut.<sup>178</sup> The settlements ended segregation of HIV-infected inmates. They established a comprehensive program of care for HIV-infected prisoners, including voluntary testing and counseling, infectious disease services for each state prison, and detailed treatment plans for intake and assessment. Areas addressed by the settlement included routine and acute care, drug therapies (including experimental drugs under investigation), diet, mental health, dental and eye care, and special care for women with HIV. The agreements also

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176. Professor Sturm notes that prison managers often lack accurate information about practices within their own institutions, a lack of information "exacerbated by the absence of a professional network of resources and expertise to facilitate the development of creative, pragmatic approaches to corrections." Sturm, *supra* note 170, at 837.

177. There have also been well-organized lawsuits that catalyzed change, even if they did not end in a consent decree or favorable judgment. In both Colorado and Maryland, the states essentially adopted the measures advocated by the plaintiffs while the litigation progressed. See Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980), *cert. denied*, 450 U.S. 1041 (1981); Wiggins v. State, 544 A.2d 8 (Md. Ct. App. 1988), *rev'd*, 554 A.2d 356 (Md. 1989).

178. Doe v. Meachum, Nos. H-80-506 (JAC), CIV.H.-88-562 (PCD), 1990 WL 261348 (D. Conn. Dec. 6, 1990) (order entering consent judgment); Smith v. Meachum, No. 87-221 (D. Conn. Mar. 14, 1990) (order entering consent judgment). For an inside look at the Meachum case, see Deborah S. Chang, *Out of the Dark Ages and Into the Nineties: Prisons' Responses to Inmates with AIDS*, 23 CONN. L. REV. 1001 (1991).

required better discharge planning, staff education, confidentiality of HIV-related medical information, and a quality assurance program. The settlement established an "Agreement Monitoring Panel" to oversee implementation. The defendants agreed to routinely provide prisoners, upon admission, with HIV education consisting of written materials, a video, and a live question and answer period, and to regularly hold follow-up sessions. Upon discharge, prisoners are to be given a packet containing referral numbers for AIDS programs, more written information, and condoms.

The litigation in *Starkey v. Matty*,<sup>179</sup> a suit against a Philadelphia-area county jail, reached a similar result. In addition to voluntary testing, education, confidentiality protection, an end to segregation, and improvements in medical care, the consent agreement mandated the appointment of an outside community health clinic, already funded by the state, to provide services to communities at risk and to coordinate medical care, testing, and education programs at the prison. Most recently, in *Roe v. Fauver*, a similarly comprehensive consent decree bound the New Jersey Department of Corrections to major improvements in its response to HIV.<sup>180</sup> Similar suits are now proceeding in Pennsylvania and New York.<sup>181</sup>

These successful settlements offer several lessons about how to

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179. *Starkey v. Matty*, No. CIV.A.89-9011 (E.D. Pa. May 24, 1991) (order entering consent decree); see also *Crutchfield v. Wright*, No. 88-2308 (D. Md. filed Aug. 3, 1988) (settlement on July 18, 1990 required AIDS counseling and education programs at the Montgomery County Detention facility). With Lynanne Wescott of the law firm Saul, Ewing, Remick & Saul, the AIDS and Civil Liberties Project of the American Civil Liberties Foundation of Pennsylvania, of which I am counsel, represented the plaintiff class in *Starkey*.

180. *Roe v. Fauver*, No. CIV.A.88-1225 (AET), AIDS L. & Litig. Rep. 366 (D.N.J. Mar. 4, 1992); see also *Gates v. Deukmejian*, No. CIV.S.87-1636 (E.D. Cal. Mar. 8, 1990) (order entering consent decree increasing access of segregated HIV-positive prisoners to Vacaville prison programs, and setting up experimental program to introduce infected prisoners back into population); *Ramos v. Lamm*, No. 77-K-1093 (D. Colo. Mar. 7, 1990) (bench order rejecting desegregation settlement).

The history of HIV care at California's Vacaville prison indicates how difficult it can be for any one actor to improve conditions. The prison has settled two different HIV-related class action suits since the epidemic began, both of which settled on terms short of total success but which seemed to lead to real improvements. For several years the prison's HIV treatment program, directed by Dr. German Maisonet, was seen as a model of commitment, effectiveness and internal advocacy. In 1992, however, Dr. Maisonet and another top specialist resigned, charging that resources were inadequate for proper HIV care and that prison officials were apathetic about HIV care. There followed a hunger strike by some HIV-infected inmates, demonstrations by Act-Up, and a highly critical legislative report. Most recently, the Department of Corrections has adopted most of the report's recommendations and hired a new outside specialist to run the AIDS programs. Jane Gross, *California Inmates Win Better Prison AIDS Care*, N.Y. TIMES, Jan. 25, 1993, at A 12.

181. *Austin v. Pennsylvania Dep't of Corrections*, No. CIV.A.90-7497, 1992 WL 277511 (E.D. Pa. Sept. 29, 1992); *Inmates of New York State with Human Immune Deficiency Virus v. Cuomo*, 16 Fed. R. Serv. 3d (Callaghan) 1397 (N.D.N.Y. 1990).

use litigation as part of a larger strategy to introduce health measures to prisons. The strength of litigation, even in the face of hostile judges, is its capacity to focus official and public attention on a problem and its solutions, and to move the issue higher on the agenda. A well-funded, well-conceived lawsuit is less likely to be dismissed early, which means that it will at least be a nuisance, and potentially a serious threat, to prison officials and their political superiors. Such a lawsuit can give courage and tools to government insiders, like health commissioners, who are advocating for expanded health programs in prisons. Finally, this kind of lawsuit can rally organizations concerned about HIV to assist in improving conditions in prisons. Drawing upon my own experience in *Starkey*, as well as the experience of litigators in other major settlements, I suggest the following basic steps:

*Design a prison health program.* The litigation should be based on a clear vision of the specific services the defendant prison should be providing. This has, at least initially, nothing to do with what the prison is legally obligated to provide. The lawsuit is a legal instrument to achieve a policy end. It should make the case for the model response described above. The process of identifying health problems and solutions also serves as an occasion to build supportive ties with local health departments and voluntary health agencies.

*Make the complaint a blueprint for health action.* The claims should be organized around the health issues, not the legal ones, and should be written with settlement in mind, rather than a final judgment, as the primary goal. Some claims are easy to ground in both law and public health, the best example being the need for adequate medical care. Even here, however, the narrative of the complaint should emphasize the public health role of the particular improvement sought. For example, the best Eighth Amendment claim for HIV testing is that it is a therapeutic, personal medical measure that allows early identification and prophylactic treatment of infected inmates. The complaints in cases like *Meachum* and *Starkey* stress testing and counseling as a preventative public health strategy for a population at risk. Similarly, it is more important to explain why and how education serves public health than to explain why it is legally required in prison. In *Starkey*, our legal arguments for health education—that it was a medical need, that it was essential to autonomous medical decision-making by infected prisoners, and that it was required to eliminate a discriminatory atmosphere against the infected—were legitimate claims of law, but secondary in the narrative to the public health value of the measure. Even our strongest

legal claims, such as the argument that segregation of the infected violated the Rehabilitation Act and the right of privacy, were cast in terms of the harm to public health efforts caused by punitive treatment of those identified as having HIV. The case should not reduce to a conflict between individual rights and the public good, but to the protection of individual rights and serving the public good.

*Aim for settlement.* Litigation is inevitably adversarial, but successful advocates often conduct themselves as sales people. In *Starkey*, we believed, and sought to convince prison officials, that their management of the prison's health problems would be easier if they accepted our proposed approaches, and that they might also get credit for service to the community outside the prison. Prison officials, particularly in smaller systems or institutions, often need a fair amount of education about what is being done in other prisons, as well as in the basics of HIV and other diseases. Selling the virtues of change is also important if there is to be any real hope that what is agreed to will be implemented with efficiency and dedication. An agreement signed by a judge and enforceable through contempt proceedings is essential, but ideally the defendants will have been persuaded of the virtues of the terms and will accept the inclusion of an enforcement mechanism as a legal technicality. In *Starkey*, we saw the fruits of our work when, after one year, we found that the terms of the agreement had been, for the most part, successfully integrated into the prison routine.

*Coordinate with other advocates and interest groups.* State and local health departments frequently provide services in prisons, or would like to. They often can be excellent sources of information and insight into the politics of the problem, and may often be advocating for the very changes the lawsuit seeks. Similarly, voluntary health agencies, particularly community-based AIDS service organizations, can and often do provide services in prisons, and are well-positioned to advocate for greater services in prisons.

In some instances, there may be a formal coalition, organized around the goal of advocating public health measures in the press, legislative lobbies, executive offices, and courts, but the cooperation need not be formalized. In fact, in many instances the cooperation may be more successful without explicit links between legal and political activists. Much of the success in *Starkey* resulted from the work done by a local voluntary health agency to win support from the county's political leadership, work that was deliberately carried on independently of a lawsuit brought by liberal "outsiders." Similarly, public criticism directed against a health department for "failing" to reach prison populations may actually help the health authorities in

their internal battle with correctional officials for access. Ideally, state and local health authorities are openly advocating health work—and funding for health work—in prisons.<sup>182</sup>

Ultimately, the prescription for useful public health litigation in prison resonates with E.M. Forster's advice on writing: "Only connect!"<sup>183</sup> The links between the civil rights of individual prisoners and the welfare of the community must be forged, as must those between people who advocate for prisoners and people who advocate for public health. Litigation itself must confess its limitations and tie real hope for change in prison health to stronger leadership and support from health departments and politicians.

## V. CONCLUSION

It is a commonplace of discussion about communicable disease in prison that various interest groups have different definitions of the problem of prison health care and its solutions. Prisons are interested in custody and control, health authorities are focussed on disease prevention and management, and civil libertarians confine themselves to issues of individual rights. This sort of simplification obscures the commonality of interests that all parties share in responding effectively to health problems in prisons. HIV and TB in prisons will only become larger medical and management problems unless they are addressed in a positive and effective way. Systems with a large amount of HIV infection are finding it impossible to segregate everyone who tests positive. These prisons will be under steady pressure to provide care for those with HIV and TB. Staff and inmates will have to be educated to avoid serious breakdowns in morale and order. Good public health practice and adequate medical care in prisons will satisfy civil libertarians, but it will also foster prevention of disease within the prison and in the communities from which the prisoners come.

Ultimately, we must recognize that communicable disease among the incarcerated is, in most significant respects, not a prison issue at all. The epidemics of TB and HIV are not changed by prison walls. The epidemics are essentially the same inside the prison as they are in the communities from which the prisoners come and to which most of

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182. E.M. FORSTER, *HOWARD'S END* 227 (1910).

183. Philadelphia's health commissioner, for example, took the lead in a public confrontation with the local Board of Prisons over the distributions of condoms to inmates, eventually winning the decisive support of the mayor. Thomas Ferrick, Jr. & Michael B. Coakley, *City Says No to Condoms for Inmates*, PHILA. INQUIRER, Aug. 23, 1988, at A1; Edward Culimore, *Condoms in Prison Ordered*, PHILA. INQUIRER, Aug. 25, 1988, at A1.

them will ultimately return. Most inmates with HIV appear to have contracted their infection before prison, and in the same manner as others in their community contracted the disease. Those who are at risk because of dangerous behavior in prison were already practicing dangerous acts before prison. Both those at risk, and those infected, are part of the web of transmission in their communities, even if they are sometimes temporarily absent. With TB, the case is even stronger, given the evidence that prisons have helped keep the disease prevalent in the outside community.

I cannot conclude this positive portrayal of effective strategies for addressing critical public health problems without, to some degree, abjuring it. HIV, TB, syphilis, and communicable diseases in general are now, and have been for at least the last few hundred years, associated with poverty in the form of poor nutrition and sanitary conditions.<sup>184</sup> With the living standards of our poorest citizens falling, it is no surprise that public health is on the decline as well. It is depressing that prison, itself, is one of our major housing programs for the poor. It is not likely that we can control the resurgent communicable diseases without improving the social context in which they have thrived. This is something that is often well understood in communities at risk, and that understanding makes incremental, ameliorative public health measures, like health interventions in prison, difficult to sell. As we advocate palliative and preventive measures, we should not forget that public health in this day and age must operate as a critique of the way resources are deployed, and human beings valued, in our society.<sup>185</sup>

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184. See McKeown, *supra* note 74, at 56; John B. McKinlay & Sonja M. McKinlay, *The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century*, 55 MILBANK MEMORIAL FUND Q. 405 (1977).

185. See generally Dan E. Beauchamp, *THE HEALTH OF THE REPUBLIC: EPIDEMICS, MEDICINE, AND MORALISM AS CHALLENGES TO DEMOCRACY* (1988).