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Prisons, Law and Public Health:

The Case for a Coordinated Response to Epidemic Disease Behind Bars

By

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I. Introduction

In many areas of this country, people in prisons constitute communities at heightened risk of HIV, tuberculosis and other communicable diseases. Significant risk factors for imprisonment -- being poor, using IV drugs, and being Brown or Black -- are also correlated with exposure to the leading communicable diseases, particularly HIV. But if the diseases accumulating at the bottom of the class structure in the United States are linked to the causes of incarceration, they do not respect prison walls: the subset of people with HIV (or TB, or HBV) who are in prison is arbitrarily defined, from the public health point of view, except in one crucial respect: we know exactly where they are and 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 in prison communities, and in the free communities to which most prisoners will shortly return. In this Article, I suggest that prisoners' rights advocates and public and voluntary health agencies can unite under a common banner to improve the lives of those of us who are prisoners, and those of us who are not, in a coordinated effort to meet public health needs in prison. Although I will focus on HIV and TB, the thrust of my suggestion that public health work be explicitly added to the role of prisons is fully applicable to other diseases as well.[1]

In 1991, the National Commission on AIDS issued a blueprint for responding to HIV in prisons. The Commission's recommendations included HIV testing and counseling, public health education for inmates and staff, the provision of 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. "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." As long ago as 1989, the federal Centers for Disease Control (CDC) issued comprehensive guidelines for controlling TB in prisons, including improved screening, structural alterations, and timely care.[2]

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 not trained in nor concerned about public health, and see their role 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 in 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 thing on its side: it is a good idea.

Communicable diseases are on the rise within prisons and without, and will not decline again in the near future unless successful preventative measures are taken. Prisons are a cost-effective place to spend public health resources, and better informed, better cared for prisoners may be easier to manage than frightened ones. In this respect it is particularly 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.

In Part II of this article, I review the extent of the communicable disease problem in prison, and outline the sort of programs that can be undertaken to ameliorate it. In Part III, I discuss the role of courts so far and in the future, with particular attention to the barriers to successful litigation. I conclude that litigation on behalf of prisoners is most likely to 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 the structure of a lawsuit that can serve as an organizing device for formal or 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

i. Who Is Ill?

HIV, TB -- and for that matter, syphilis, gonorrhea, chancroid, hepatitis B (HBV) -- are strands in a web of morbidity and

mortality that our society has spun for its poorer, darker members. Prevalence of all these health threats is disproportionate 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, African Americans, who make up less than 12% of the population, suffered 76 percent of the reported syphilis cases and 78 percent of the reported gonorrhea cases. Hispanics, making up only 6.4 percent of the population, accounted for 12 percent of the syphilis cases and 5 percent of the gonorrhea cases.[3] 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 number of cases were falling, to socioeconomic causes.[4] 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 for people with annual incomes of more than $15,000.[5] By any measure, Black and Hispanic families are more likely to suffer poverty and low income than White families in the United States.[6] Over the past thirty years, the number of African Americans and Hispanics below the poverty has been more than twice the number of Whites.[7] Though there are no readily obtainable figures for Hepatitis B because it is often asymptomatic and thus not reported, a U.S. Navy study revealed its incidence to be nearly twice as great among Blacks than Whites.[8] For Herpes (HSV2), one study found the prevalence of the antibody in persons 15 through 74 years to be 13

percent for Whites but 41 percent for African Americans.[9] The recent outbreaks of chancroid in this country have also occurred preponderantly among African Americans and Hispanics.[10]

The incidence of tuberculosis among populations of color is significantly greater than for the White majority. In 1990, almost 70 percent of all TB cases occurred among racial and ethnic minorities.[11] Perhaps more disturbing is the finding that 86 percent of all cases among children occurred in minority groups.[12] By contrast, non-Hispanic Whites accounted for only 30.5 percent of the reported cases in 1990.[13] For Whites, the tuberculosis case rate in 1990 was 4.23 per 100,000 people. 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.[14] Between 1985 and 1990, the percent increase of TB cases reported to the CDC was 54.7 percent for Hispanics and 26.9 percent for Blacks, while the CDC registered a 7.3 percent decrease of TB cases for non-Hispanic Whites during the same period.[15]

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.[16] This new form of TB did not respond to standard drug treatments and proved particularly lethal to those already infected with HIV. Moreover, TB has developed rapidly among HIV-infected persons, who themselves are often intravenous drug abusers or homeless or both.[17] MDR-TB is believed to be particularly dangerous for people with compromised immune systems, and many of its fatalities have been people with HIV disease.[18]

Finally, AIDS, which came to notice in the United States as a

"gay plague," has now become predominantly 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. The statistics on 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. Prevalence per 100,000 was four times higher among Black children and two times higher among Latino children than among White children.[19] In 1988, HIV infection became the 6th leading cause of death for Black males, compared to 10th among White males. [20]

ii. 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.[21] The demographic characteristics that mark an increased risk for having one of the currently resurgent communicable diseases -- particularly race, poverty and drug use -- are also powerful predictors of incarceration. While 1.6 percent of the White population is in custody or under correctional supervision such as parole or probation, the figure is 7.2 percent for the Black population.[22] The National Center on Institutions and Alternatives found that on any given day in Washington, D.C., 42 percent of

young Black males were involved with the criminal justice system and that 70 percent of the Black men in the District are arrested by the time they turn 35.[23] 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 percent of the population behind bars.[24] Indeed, in state prisons, Black prisoners exceed the number of White prisoners.[25] Fourteen percent of state prison inmates were reported to be Hispanic. In California and New York, the percentage of Hispanic prisoners is estimated to be one-third and more than one half in New Mexico. In the federal system alone, the prison population is over one-third Black, and one-fourth Hispanic.[26]

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.[27] Over 13 percent of all those jailed committed their offense to obtain money for drugs.[28] Nearly 80 percent had previously used some illicit drug, such as marijuana, hashish or amphetamines before their jail sentence.[29] Of those inmates who reported drug use, a staggering 93.6 percent stated their parents were also drug abusers.[30] Between one-quarter and one-half of jail inmates were daily users of at least one illicit drug prior to committing their offense,[31] and nearly one-third were under the influence at the time of their arrest.[32] In major urban centers, nearly 70 percent of all arrestees tested positive for one or more drugs. It is estimated that by 1995, fully 70 percent of all federal prisoners will be drug offenders.[33] Moreover, the number

of inmates that have used illicit drugs continues to rise, with the figure reaching 77.7 percent in the last year for which figures are available.[34]

This means that prison populations in many areas represent a distillate of the major public health problems in the communities from which prisoners are drawn.[35] In 1991, Hammett & Daugherty reported a cumulative total of almost seven thousand reported AIDS cases in prisons. Because of poor diagnostic and reporting practices, and social barriers that create disincentives for sick inmates to seek care, this figure is almost certainly a significant undercount.[36] In the hardest hit areas, levels of HIV and TB in prison are substantially higher than in the general population.[37] In 1990, Moini & Hammett estimated an aggregate incidence rate of HIV in state and federal prisons of 181 per 100,000,[38] 10 times higher than the general incidence rate, which makes the risks of acquiring TB in prison is all the greater.[39] In general, seroprevalence in prisons seems to be linked to seroprevalence in the areas from which the prisoners come. Mass screening, carried out for the most part only in low prevalence states, has generally yielded seroprevalence rates less than 1 percent.[40] In states with medium to high prevalence, however, the results of inmate screening range from worrisome to horrifying. One study showed HIV prevalence rates ranged from 2.1 percent to 7.6 percent for male entrants to correctional facilities, and 2.5 percent to 14.7 percent for female entrants. Prevalence overall was nearly twice as high among non-Whites as among Whites.[41] Seventeen percent of male, and over 18 percent of female prisoners in one 1988 New

York prison study were infected.[42] Five percent of prisoners entering Philadelphia's jail system tested positive in a blind study.[43]

Freeman has observed that the diagnosis and care of women with HIV in prison is becoming an ever more pressing problem because women are becoming infected and imprisoned at rates surpassing those for men.[44] It is a safe generalization to assert that facilities and services for imprisoned women are rarely better and are quite often worse than those available for men, a condition that has only been aggravated by the rapid increase in female inmate populations.

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.[45] In recent years, however, the disparity has increased. In the New York prison system, incidence of TB increased fivefold between 1976 and 1986.[46] A 1989 study showed that the incidence of TB in prison (30.9 per 100,000) was nearly ten times the incidence rate among the general population (3.9 per 100,000).[47] A 1992 study reported that 23 percent of inmates and 6 percent of prison employees in New York tested positive for TB.[48] Since 1985 there have been nearly a dozen serious outbreaks among prisoners.[49] King and Whitman's 1981 observation that "prisons and jails play an important role in maintaining the relatively high rates of TB that persist in inner-city, minority, and economically disadvantaged populations" appears to be even truer twelve years later.[50]

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.[51] The 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.[52] Although there is no indication that HIV is being transmitted at high levels within prisons,[53] dangerous sexual and injection activity does occur,[54] and there is no question that overcrowded, poorly ventilated prisons foster TB transmission.[55] 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.[56]

B. The Public Health Responses

The preceding discussion makes clear that prisoners in many areas of this country make up communities at high risk for some of the worst scourges of our time. It should also be clear that prison communities are part of the larger communities from which they draw their members. 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, includes more than 400,000 from state and federal institutions.[57] 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. On this account, prisons present an exceptional opportunity to reach people at high risk with the same

public health interventions being used outside prisons.[58] Indeed, one can go even further: from a legal perspective, there is an extra basis for health action, because, unlike those outside, prisoners are 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

In general, a successful response to HIV in prisons applies public health and medical techniques of proven value to reduce HIV transmission by inmates during and after their imprisonment, and to meet the medical and psychosocial needs of the infected. We have settled into making the best of 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 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 has a trivial positive impact on prevention and public health as a whole.) In particular, organizations as diverse as the ACLU, 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.[59]

<u>Medical care</u>: A prison should have an effective system of early identification of HIV-infected inmates through voluntary,

confidential testing. Such testing most be truly voluntary, and "confidentiality" includes the condition that non-medical prison personnel will not learn the test result, even if it is positive. It is particularly important that testing 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 monitoring by a physician who is trained in infectious diseases in general and HIV in particular. 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 rejected for people outside prison, need to be modified for prisoners.[60] Quality, qualified care must be available for inmates with AIDS. 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 about how to reduce or eliminate their risk of HIV infection. 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 beyond. This kind of education also can reduce the fear of

casual transmission and consequently make discrimination against the infected by the untested less frequent and severe. Correctional staff need the same kind of education, for their own sakes, to prevent discrimination on their part, and to allow them to assist inmates who may be in need of care.

Social conditions: As on the outside, it is important in prison that people affected by HIV are protected against a plague mentality. A program that punished people with HIV will deter cooperation with health efforts, behavioral change, and seeking 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, privacy of HIV-related medical information should be zealously protected.

ii. TB

Tuberculosis control in prisons has suffered from the same apathy that undermined the general TB control effort. Casualness in screening has been combined with an inattention to symptoms of active TB.[61] Three years ago, with outbreaks on the rise, the CDC issued comprehensive recommendations for addressing TB among the incarcerated.[62] Key elements 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 cough, 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 smear and culture examinations. Because latent TB can become active at any time, it is particularly important for prison health care workers to be attentive for possible TB symptoms during the provision of routine care and sick calls. The CDC also recommends swift reporting of cases within the system and to health officials, and contact investigations to identify others at high risk for testing. Experience with TB outbreaks in recent years has shown the importance of timely testing and evaluation of test results, particularly in the case of MDR-TB.[63]

Containment: Preventing 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 patient with TB with a positive chest x-ray, cough and/or 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 (such that air in the isolation area flows from and not to adjacent areas), and four to six air exchanges per hour. New York City's Riker's Island jail recently spent 12 million dollars to purchase 42 modular isolation units.[64] As with identification, it is essential that isolation and treatment be initiated promptly upon diagnosis of active disease to prevent 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 active disease, but who are at an elevated risk to acquire it because of HIV infection or other factors, may have their chances of developing active disease reduced by 6-12 months of medication. Patients in treatment must be monitored for adverse reactions or complications, and expert consultation should be available.

Multidrug-resistent 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 direct observation of medication inside the institution and that the appropriate health department be 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 moral and morale reasons. It is, however, expensive, labor-intensive and reactive. Reducing prevalence significantly will require changes in the environment to make it less conducive to the spread of TB.[65] Reducing overcrowding and improving ventilation are obviously essential. Although its effectiveness is subject to further testing, ultraviolet lighting to kill TB bacteria has been used in hospitals and homeless shelters and may be useful in prisons.[66]

<u>Assessment</u>: Both individual and population outcomes must be

carefully observed and assessed. Because of the importance of completing therapy, special emphasis must be placed 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 medications, and it is not unheard of for guards to make it hard for selected inmates to get their medications on 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 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 subject to developing a dangerous, airborne disease could face ostracism or even violence.[67]

More importantly, controlling TB is every bit as dependent as HIV on cooperation between health workers and patients. The great fear of health authorities is MDR-TB, the result of incomplete treatment. In fact, 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 on defects in the social and health care delivery systems. A proper respect for the dismal history of coercive health measures suggests prisoners 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 they are influenced in their response by the generally accepted public health practices. For example, as the HIV epidemic has progressed, the trend has been away from segregation and toward providing education and community-level medical care.[68] 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 program to ensure continuity of care.[69] Wisconsin has had a voluntary HIV testing and counseling program since the late eighties, which has enjoyed a rate of acceptance as high as 71 percent.[70]

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.[71] Prisons often provide a low standard of health care generally. HIV infection and AIDS are particularly complicated conditions that arise in a setting where

even simple to treat 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 is tending to move towards construction.[72] We can therefore expect that many prisons will fail to implement an effective or even merely adequate response to HIV, TB and other increasing 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, we may turn to what federal courts have prescribed.

III. The Role of Litigation

A. Court Decisions

Although they are certain to rise in the coming months and years, lawsuits aimed at improving TB care have 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, their most significant common element being a low rate of success. In many cases, proponents of an effective response to HIV have been happy 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 about as often. For better and 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 in the three main areas of need identified above.

1. Basic Medical Care For HIV

i. HIV Testing and Counseling[73]

For 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 of 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.[74] At the same time, however, courts were also refusing to stop prisons from testing inmates against their will.[75]

Although the public health issues were essentially the same, the reasoning in these prison cases was often different from that in testing cases outside.[76] In the Glover case,[77] for example, a 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.[78] 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."[79] No evidence was taken about the actual spread of the disease in the prison, or concerning the relationship between the health problem and the measure selected by the prison authorities. 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."[80]

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, AZT and ddI has been approved by the FDA for use in infected people with T-cell counts below 500. So far, however, this change in medical practice has not affected the legal analysis of HIV testing in prisons.[81]

ii. Medical Care After Identification

Throughout most of the epidemic, issues of testing and isolation overshadowed the provision of medical treatment to the infected. Earlier in the epidemic, prisons tended to recognize HIV disease as a medical matter only when AIDS developed, if then, and that view, though harsh, was not grossly out of keeping as a matter of practice with the situation outside. In recent years, treatment of AIDS and asymptomatic HIV disease has improved, and the gulf has widened between the care available to prisoners and to the free. As the difference became great enough, 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, prison medical care is not constitutionally required 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 the factual evidence. On the other hand, a suit for a specific treatment known to be effective, like AZT, may be easier to conduct than a global challenge, but a judge who does not see the systemic failures in care is more likely to indulge what a prison will probably claim is an isolated failure.[82]

The courts have not been strong on making new treatments available to inmates. In Hawley, 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 the International AIDS Conference and the first reliable confirmation of the efficacy of AZT prophylaxis 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.[83]

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.[84]

The case against intervention was stated even more baldly by the district court in Harris v. Thigpen:

> 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. 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.[85]

This attitude may be contrasted with the judicial position in the leading case concerning AZT availability to Medicaid recipients. In Weaver v. Reagan, a suit 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."[86]

In only a few rare instances have courts been willing to look seriously at the possibility that prison HIV care is deficient. As always, one cannot know whether this willingness reflects upon the poor care in the particular prison, the interest of the particular judge, or both. In Roe v. Fauver, 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.[87]

A case that dealt squarely with the fact that prisons are poor places to treat people with HIV was Gomez v. United States.[88] Petitioner Gomez, upon being sentenced to prison, had alleged that he would not be able to receive adequate care for his advanced AIDS anywhere in the federal system. Pending an investigation of the claim, he had been ordered held in a local federal detention center. There, too, he 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, indeed, lack of continuous hospital level care was unacceptable. He was therefore granted bail so he could get hospital care outside.

The court of appeals saw things differently. It did not

question the district court's finding that care was inadequate. Rather, it ruled that even if that were true, the remedy the lower court should have ordered was an improvement in care or placement in a better federal facility, not release. In what amounted to an invocation of Catch-22, the court of appeals ignored the fact that the lower court had still not determined whether the plaintiff could be treated properly anywhere in the federal system, and, although it admitted that "problems of prisons are complex and not readily susceptible to resolution by decree," gave the lower court no option other than to decree and enforce acceptable medical care for a person with AIDS in prison.[89]

2. HIV Prevention Education

Education is as necessary in prisons as it is difficult legally to enforce. There is no recognized legal right to HIV education as such, but the important public health role of education allows it to be hung on a variety of legal hooks. In some cases, it has been argued that a failure to provide preventative education or test-related counseling, is a violation of the Eighth Amendment's right to minimal health care[90] and of the right to privacy.[91] It has also been contended that failure to provide general education to alleviate fear and hostility in the inmate population is a violation of the Rehabilitation Act.[92] So far, however, no court has ordered HIV education in a prison on any of these theories. Squarely raising HIV education in a lawsuit, despite its legal novelty, can be a successful strategy. As we will discuss 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[93]

Housing, privacy and non-discrimination practices all affect the way in which HIV will be played out in a prison. Assuming there is little education, practices that identify the HIV infected to other inmates create a strong likelihood of harassment, isolation and other forms of discrimination. 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 roundly rejected early efforts to either force or end segregation of the HIV infected as such, seeing it as a matter of prison administration rather than medicine or public health.[94] While isolation measures against people with HIV outside have been few, and have been searchingly examined by courts for a solid medical basis,[95] initial attacks on prison isolation practices received little or no serious scrutiny.

For example, in a Pennsylvania case, the court applied the lowest standard of scrutiny to an Equal Protection Clause challenge to segregation at a county jail. 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. Any one of these rationale[s] constitutes a legitimate end: in the conglomerate these goals are certainly legitimate.[96]

To make matters worse, the "AIDS victims" the judge referred to, and of whose complete immunosuppression he 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 seems to have grasped the difference between HIV infection and AIDS.

The evident factual unsupportability of these justifications does not render the court's determination unusual in legal terms: "rational basis" scrutiny under the Equal Protection Clause is designed to be highly deferential to state prerogatives. But the court's disregard for the facts demonstrates the way in which a case that, on the outside, would probably turn on the medical rationality of a particular health action, turns inside prison into one in which the only questions is whether the state can offer a grammatical sentence justifying its practices.[97]

More recently, the right of privacy has proven to be very helpful for bringing some level of rationality and scale into prison AIDS litigation, particularly in the area of housing. In Doe v. Coughlin,[98] a class of HIV positive inmates in the New York state system won an end to a system of involuntarily placement in a special dormitory for the HIV infected. The plaintiffs argued that their placement in the dormitory amounted to an announcement

to the world of their medical condition. The district court found that inmates had two distinct constitutionally protected privacy interests: one in keeping their diagnoses private from others, and the other in deciding when and under what circumstances to have the information revealed. The court avoided a decision on the underlying medical value of the segregated housing scheme, which was justified by the state as the best way to provide care, by finding that the inmates retained a right to reject the benefits of transfer, whatever they might be, if they regarded the cost to privacy as too high.

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. Erie County, a New York federal court rejected a county jail's segregation policy as violative of not only on the right of privacy, but also the inmates's right to due process of law and of New York's state HIV confidentiality law. The court refused to accept the prison's unsupported claims that the segregation was necessary to protect other inmates from sexual transmission. HIV was spread, the court found, not by status but 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." There was, accordingly, no rational basis for the measure.[99]

By contrast, the district judge in Harris v. Thigpen[100] opined that prisoners with AIDS had no privacy right to assert because, in committing crimes and becoming prisoners, and by having

a disease that is expensive to treat, they had given up any such interest. "An inmate's infection with AIDS," the court explained, in a brief declaration unencumbered by any conventional legal reasoning, "is ... not a private matter, but a matter of a controlling State interest."[101] The Court of Appeals corrected the district judge on the law -- recognizing that prisoners do have privacy rights -- but accepted his bottom line that segregation was an acceptable policy choice within the broad discretion of prison managers: "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.'"[102]

Section 504 of the Rehabilitation Act[103] forbids recipients of federal funds to discriminate against the disabled, including people with or perceived as having HIV. It has been one of the most powerful legal tools against discrimination in the era of AIDS, and it is fully applicable to prisons and jails receiving federal funds.[104] The first successful use of the law in prison came on a segregation matter. In a 1989 adjudication of an administrative complaint by several Pennsylvania prisoners with HIV about their isolation, the Office for Civil Rights of the Department of Health and Human Services found that isolation violated the Act. The matter was resolved with the prison's decision to disband the isolation unit and mainstream the prisoners.[105] More recently, in Harris, the Court of Appeals

reversed the district court's decision that segregation did not violate the Act, criticizing 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.[106]

The record with respect to other forms of discrimination against people with HIV has also been mixed, 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, because the time with visiting spouses and children was spent in a trailer, afforded the opportunity for sexual relations. 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 opined that there was a larger public health issue, inasmuch as the visiting spouse might become infected, might pass the infection on to subsequent sex partners, and that, indeed, the virus could well be passed on to succeeding generations of children.[107]

In the 1990 case of Farmer v. Moritsugu[108], a federal court upheld a prison policy prohibiting HIV infected inmates from working in various food and health service positions against attack on constitutional grounds. There was no claim that the inmates posed a significant risk of infection in such positions -- the factor that on the outside 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." Such inmates could "perceive the presence of HIV-positive inmates in food service or the hospital as a threat to their own well-being and might not adequately avail themselves of these services."

Since then, things have 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. The court rejected the defendants' "unsubstantiated and unfocussed fears" that other inmates would react violently to HIV-infected food service workers, and held that the Rehabilitation Act would only allow a prisoner to be denied a food service job if there was concrete evidence that that particular prisoner posed a significant risk of transmitting HIV.[109] In reversing the district court's broad rejection of the plaintiffs Rehabilitation Act claims in Harris, the Court of Appeals was particularly encouraging in its suggestion that the prison would have to justify, based on the specific risk of transmission, exclusion from each program from which plaintiffs had been automatically excluded. "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 available to the prison populations at large."[110]

The right of privacy has fared well as a tool to protect inmates from the kind of exposure that sets them up for discrimination. In Woods v. White,[111] the 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,[112] the court came to the same conclusion in a case involving the transfer of an inmate in a "hygiene suit". In the Nolley case, 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 the defendants used the sticker for other contagious conditions as well. Looking beyond their justifications to actual facts, court found that the red sticker policy, even if now supposedly neutral and generally applied, 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 Ms. Nolley's documents either knew or strongly suspected that she was HIV+."[113] Each of these privacy cases is notable for the courts willingness to recognize the importance of confidentiality to a person with HIV. That 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. The most

significant, and revealing, is DiGidio v. Pung.[114] The action lasted over four years, during which time the inmates and their attorneys were able to show an absolutely shocking pattern of indifference and incompetence that allowed a serious TB outbreak to develop involving almost two hundred prisoners. The court's detailed findings of fact leave no doubt that serious derelictions had occurred, and the court ruled that the prisoners' Eighth Amendment rights to be free of cruel and unusual punishment had been violated. 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.[115] Thus the plaintiffs "won" in the sense of having forced a change, but lost in the sense that they were denied the formal relief they sought. Two practical problems flowed from this result. The first was that the plaintiffs had no court order to rely on should the defendants return to their former practices. Second, the failure to obtain an injunction led the court to reduce the plaintiffs' attorneys fees award by 65%, a strong disincentive to future litigation.[116]

With the increasing prevalence of the disease, TB litigation is sure to increase. The future is suggested by an April 1992 decision in which a federal court 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 plaintiff alleged resulted in his being infected with TB while in custody. The court also agreed to appoint counsel for the prisoner.[117] Certainly many current suits

and consent decrees involving prison conditions and medical care will be altered or reopened to address TB.[118]

B. Barriers to Effective Litigation

Even this brief overview shows that, overall, courts have been cautious about 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 public health prevention efforts.

1. The Constitutional Right to Medical Care Is Narrowly Applied

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

Medical care is a prime example. While inmates enjoy an enforceable right to care that free Americans do not, the level of care guaranteed under that right is minimal. The Supreme Court has told us that the Constitution does not guarantee inmates adequate medical care.[119] As one court blunter than the High Court has put it, medical care for prisoners does not have to be "perfect, the best obtainable, or even very good.[120] 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 further weakened by the Supreme Court's new emphasis on subjective intent. In its recent decision of Wilson v. Seiter, 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 with bad conditions but good intentions.[121] Thus in one recent case, a court found that a prison had deprived the plaintiff of a "necessity of life" 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."[122]

Even 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, it 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. [123] 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. Instead, the essence of the claim is a denial of care resulting in pain and suffering that no one sug-

gests serves any valid penological purpose."[124] 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 is due to deliberate indifference is a matter of fact for a judge to determine in an individual case, but, at least, few if any prison officials could plead ignorance of the general need for care. Yet however it is interpreted, the standard is a minimal one, and it tends to create a presumption against intervention, and, where intervention is needed, for 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 in the courts is substantially reduced. Whereas a measure that infringes on a basic constitutional right of a free citizen would be invalid unless it 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."[125]

This test gives "prison officials ... broad discretion in fashioning appropriate responses to legitimate penological objectives consistent with the constitutional rights of inmates."[126] Prison management, says the Supreme Court, is "peculiarly within the province and professional expertise of corrections officials,

and, in the absence of substantial evidence ... to indicate that the officials have exaggerated their response to these considerations, courts should ordinarily defer to their judgment in such matters."[127] Notably, however, at least one court has explicitly found this constitutional analysis inapposite in case brought under statutes like the Rehabilitation Act.[128]

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, several times observed, are complex and intractable, and ... not readily susceptible of resolution by decree."[129] This saw is frequently recited by courts in refusing to act, and even more by courts that wish to convey a sense of reluctance when they do act.[130]

All of these doctrinal strictures raise the institutional cost of intervention, and provide an incentive (and a rationalization) for refusing to act. I am not suggesting that they make action impossible. Federal judges without a doubt remain powerful agents for the preservation or alteration of the status quo. To get a sense of the fairly wide range of discretion the standard allows, one need only compare the responses of the district courts in Gomez -- 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 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 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.[131]

Nevertheless, courts these days 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 patently absurd justifications for practices like isolation will be accepted. It means that medical evidence will weigh far less heavily in prison cases than it does in case outside. Assessment of risk will be weighted with open or covert assumptions about the likelihood of prison sex or drug use, and are likely to be made on a class, rather than individualized, basis. It means, ultimately, that cases involving measures against HIV in prison will not be judged, as perhaps they would be on the outside, in

public health terms, but rather will be evaluated 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. It is going to be hard to win an HIV case without being able to prove, incident by incident, patient by patient, that medical care, housing, education and other policies are leading to unnecessary suffering and premature death; that discrimination and breach of privacy are occurring 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 -- one needs to employ experts in 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 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 strong enough factual case, many HIV suits are lost even before they are filed.

3. Poor Lawyering

Many HIV prison cases show the effects of poor lawyering, by which I mean both lawyering poorly done, and lawyering that represents the best efforts of people poor in legal and other resources. Even assuming the legal system can work in this area, 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 districts and appellate circuits have developed efficient systems of managing this cumbersome case load, there are funds available to appoint attorneys in possibly meritorious cases, and procedural rules have been relaxed 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. It is far easier to dismiss a claim than to try it, and there is virtually no institutional disincentive against doing so.

Most prison AIDS cases have been brought by inmates who are without formal legal training, and who have not had the assistance of an attorney.[132] This means that the complaints often rely on legal 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, and the strong legal advantage resting with the defendant officials. It is nevertheless 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 dismissals of prisoner AIDS cases connote not the inmate's lack of a grievance, but the system's inability or unwillingness to have it effectively aired.

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, federal court is the wrong place to look for support of public health measures, and prison officials are the wrong people to ask to carry them out.

As we have seen, federal courts claim to be reluctant to manage prisons (though, in fact, a substantial number of prison systems across the country are under court order of one kind or another). More specifically, they are often unwilling to resolve disputes of health policy, or disputes between health and correctional goals. Yet to conduct effective programs to prevent

and treat HIV in prisons requires a substantial commitment of expertise, money and human energy in the cause of doing just that. Prisons, being institutions of custody and control rather than of public health, have little experience in public health work, and may be expected normally to have little enthusiasm for it either, especially when, as will be the case in most prisons, effort in that role will mean even 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 role of public health workers.

C. Prison Organization, Change, and the Courts

Professor Susan Sturm has provided a compelling account of the "organizational stasis" that limits the ability of prisons to reform themselves. She cites in particular four factors: the lack of a set of values within prisons supporting reform; incentive systems that reinforce the status quo and hamper reformers; inadequate information exchange and poor access to expertise; and the absence of any players who have the actual power to institutionalize reform.[133] 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 intervention can foster the

development of 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.[134]

Professor Sturm considers several alternative judicial approaches to managing prison reform, but in the end 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."[135]

Our discussion thus far should demonstrate that HIV is a problem that prison managers and residents need to engage. Undoubtedly, too, it 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? The preceding discussion has also shown that most judges have not accepted adequate public health care as a norm they are willing to enforce in the prison setting, rendering their potential to bring reform unexpended.

This leads me to two complementary conclusions. The first is that advocates within prisons, within the law, within health agencies, and within communities at risk, must nurture the idea that caring for the public health in prison communities is an

important value. Short of major changes in doctrine, only this will alter judges' thinking about prisons' obligations and enhance their willingness to see public health behind bars as a constitutional issue ripe for judicial management. The second conclusion largely repeats the first: advocates for better public health 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 public health services in prisons. A health secretary is as much a governmental insider as a corrections commissioner. Within an administration they are, to some degree, allies, linked politically to a governor or county leader. Although an outsider easily misses the intensity of bureaucratic jealousy, the fact remains that health authorities have access to prison administrators, and resources of money and personnel, that private parties lack. Public health agencies 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.[136]

Voluntary health agencies, particularly community-based AIDS organizations, can also play an important role as both advocates and service providers. Much of the public health work against HIV has been carried out by publicly funded private agencies, and it is not uncommon for such organizations to provide some educational or case management services to prisoners. Particularly in jails, these organizations, or others like the Red Cross, are the only

reasonably available source of information for administrators and residents alike. Often heavily dependent on public funds, these organizations are often politically connected as well, and can advocate for greater funding for and attention to prison work.

A review of what judges have ordered 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 or money or political capital.[137] Litigation can help, and has helped, to move prison health higher on the political agenda, but it will work best to that end when people in power are getting the message from constituencies unrelated to prisoners.

IV. The Coordinated Public Health Strategy

Legal advocacy can contribute to breaking the "organizational stasis" and enhancing the role of prisons in public health. Success depends, however, on joining with other interested parties in a coordinated, self-conscious manner. I have already suggested that outside advocacy is crucial to developing a norm of public health within prisons. Courts have the power to enforce such a norm, but so, of course, do political officials. And advocates have, at least, the power to articulate it. Moreover, although, again, neither legal nor health advocates can coercively alter the incentive structures within a prison without court intervention, they can try to persuade prison officials, guards and inmates that reform is worth the effort and will be rewarded in 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, as I will suggest below, well-informed lawyers) can help fill the vacuum of expertise in public health matters that obtains in most prisons. 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.[138] 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.[139] These, I suggest, provide a model approach.

The first major settlement came in a pair of class actions in Connecticut.[140] The agreements ended segregation of HIV-infected inmates. They established a comprehensive program of care for HIV-infected prisoners, including voluntary testing and counseling, the provision of infectious disease specialist services for each state prison and detailed treatment plans for intake and assessment. Areas addressed 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 required better discharge planning, staff

education; confidentiality of HIV-related medical information; and a quality assurance program. An "Agreement Monitoring Panel" was set up to oversee implementation. The defendants agreed routinely to 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.

A similar result was reached in Starkey v. Matty, a suit against a Philadelphia area county jail.[141] In addition to voluntary testing, education, confidentiality protection, and an end to segregation and improvements in medical care, the consent agreement was notable in mandating the appointment of an outside community health clinic, funded by the state to reach out to high risk populations, to coordinate medical care and testing and education programs. A notable element of the settlement was the appointment of an outside community health clinic, funded by the state to do outreach in communities at risk, to do education, counseling and testing 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.[142] Suits of the same kind as these are now proceeding in Pennsylvania and New York.[143]

These successful settlements offer several lessons about how to use litigation as part of a larger strategy to introduce public 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 rather less likely than otherwise to be dismissed early, meaning that it will be at least 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, it can rally organizations concerned about HIV generally to assist in improving conditions in prison. 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 what services the defendant prison should be providing. This has, at least initially, nothing necessarily to do with what the prison is legally obligated to provide. The lawsuit is a legal instrument to 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 built supportive ties with local health departments, and voluntary health agencies.

Make the complaint a blueprint for health action. That is, the claims should be organized around the health issues, not the legal ones, and should be written with settlement rather than a final judgment in mind 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. Our legal arguments for 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, 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 done by punitive treatment of those identified as having HIV. The case should not reduce to individual rights versus the public good, but to individual rights serving the public good.

Aim for settlement. Litigation is inevitably adversarial, but successful advocates conducted themselves as sales people. 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, if not 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. 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 can often 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 succeed better without explicit links between legal and political activists. Much of the success of Starkey was due to 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 an internal battle with correctional officials for access.

Ultimately, the prescription for useful public health litigation in prison resonates with E.M. Forster's advice on writing: "Only connect!"[144] 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

A comprehensive disease prevention program in prison would have obvious humanitarian and public health benefits, but the mere fact that it would likely make inmates and their communities better off does not a fortiori mean that it would be against the standard penological needs of prisons. It is a commonplace of discussion about communicable disease in prison that the various interest groups have different definitions of the problem and its solutions. Prisons are interested in custody and control, health authorities are focussed on disease prevention and management, civil libertarians confine themselves to issues of individual rights. This sort of simplification obscures the commonality of interests all parties have in an effective response to health problems in prisons. HIV and TB in prisons will only grow larger as 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. They 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 good order. Good public health practice and adequate medical care in prisons will satisfy civil libertarians, but will also foster prevention of disease within the prison and in the communities from which the prisoners come.

Ultimately, it is necessary to 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: they are essentially the same inside the prison as they are in the communities from which prisoners come and to which most of them will ultimately return. Most inmates with HIV appear to have contracted their infection before prison, in the same manner as others in their community contracted it. 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 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 generally are now and have for the last few hundred years at least been associated with poverty in the form of poor nutrition and sanitary conditions.[145] With the living standards of our

poorest compatriots 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 itself 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.

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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, drug use should be seen as a significant public health problem in its own right, a problem that can be ameliorated by treatment, and a problem that can and should be addressed in prisons. See Larry Gostin, The Interconnected Epidemics of Drug Dependency and AIDS, 26 Harv. C.R.-C.L. 114 (1991). Although this Article focusses on communicable diseases, much of what I say here is equally applicable to the issue of enhancing prisons' role in drug abuse prevention and treatment, and vice versa.

2. National Commission on AIDS, Report: HIV in Correctional Facilities, 1, 36 (1991); see infra note 56 and accompanying text.

3. John S. Moran, et al., The Impact of Sexually Transmitted Diseases on Minority Populations, 104 Pub. Health Rep. 560 (1989)(Syphilis cases per 100,000: Whites=2.5, Hispanics=32.3, blacks=113.7; Gonorrhea cases per 100,000: Whites=53.7, Hispanics=201.1, blacks=1800.7).

4. Sevgi Aral & King Holmes, Sexually Transmitted Diseases in the Aids Era, 264 Sci. Amer. 62 (1991).

5. R.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 (1989).

6. U.S. Bureau of Census, Statistical Abstract of the United States: 1991, 38, 38-40 (Blacks make up over 30 percent of the people below the poverty level despite constituting 12 percent of the population. Blacks and Hispanics also lag behind Whites in the percentage of high school graduates, fully employed workers, and homeowners.).

7. Id. at Fig. 14.2.

8. M.L. Dembert, et al., Epidemiology of Viral Hepatitis among U.S. Navy and Marine-Corps Personnel, 1984-85, 77 Am. J. Pub. Health 1446 (November 1987)(HBV cases per 100,000: Whites=34, Blacks=63).

9. R.E. Johnson, et al., A Seroepidemiology of the Prevalence of Herpes Simplex Virus Type 2 Infection in the United States, 321 New Eng. J. Med. 7 (1989).

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

11. CDC, Prevention and Control of Tuberculosis in U.S. Communities With At-Risk Minority Populations, 41 MMWR 1 (1992).

12. Id. at 2.

13. Id. at 2.

14. Id. at 4.

15. Id.

16. CDC, Transmission of MultiDrug Resistant Tuberculosis Among Immunocompromised Persons in a Correctional System- New York 1991, 41 MMWR 507 (1992).

17. Charles Marwick, Do Worldwide Outbreaks Mean Tuberculosis Again Becomes "Captain of All These Men of Death?", 267 JAMA 1174 (1992) (noting how coinfection poses special difficulties in terms identification and treatment).

18. CDC, supra, note 16, at 507.

19. See, e.g., Fox, Chronic Disease and Disadvantage: The New Politics of HIV Infection, 15 J. Health Pol'y, Pol. & Law 341, 345 (1990); The Health Status of the United States, Federal News Service, Apr. 8, 1991 [hereinafter Health, United States]; Chu, et al., Impact of the Human Immunodeficiency Virus Epidemic on Mortality in Women of Reproductive Age, United States, 264 J.A.M.A. 225 (1990); 38 MMWR 561, 563 (1989); see also Saira Moini & Theodore M. Hammett, Nat'l Inst Just., 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.").

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, for Black youth between the ages of 15 and 24, the leading cause of death was homicide (59 per 100,000), more than seven times the rate among White youth (7 per 100,000). Health, United States, 13-16. (1991). 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 25-44 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. Nat'l Inst. Just., Criminal Victimization in the United States: 1990, at 25, table 7 (1991). Hispanic males had a violent crime victimization rate of 49.5 per every 1,000 persons. Id. at 27, table 9. Non-Whites were also more likely to be victims of crimes of theft. Id. at 24, table 6.

20. Health, United States, supra, note 19 at 80, table 25.

21. CDC, A Strategic Plan for the Elimination of Tuberculosis in the United States, 38 MMWR 1, 2 (1989) (citing two-thirds of TB cases in the U.S. are among blacks, Hispanics, Asians and Native Americans, due "primarily [to] socioeconomic conditions, poor housing and nutrition."). For the link between STD and socioeconomic status, see W. Darrow, Social Stratification, Sexual Behavior, and the Sexually Transmitted Diseases, 6 Sex. Transm. Dis. 228-30 (19779); W.E. Morton, et al., Effects of Socioeconomic Status on Incidences of Three Sexually Transmitted Diseases, 6 Sex. Transm. Dis. 206-10 (1979); M. Haan, et al., Poverty and Health: Prospective Evidence from the Alameda County Study, 125 Am. J. Epidemiol. 989-98 (1987). For a comprehensive overview of STD and minority, poor, urban populations, see Aral & Holmes, supra, note 4; see also Janet Weiner, et al., The Crisis in Correctional Health Care: The Impact of the National Drug Control Strategy on Correctional Health Services, 117 Ann. Int. Med. 71 (1992).

22. Bureau of Just. Stat., Correctional Populations in the United States: 1989, at 6 (1990).

23. Jason DeParle, 42% of Young Black Males Go Through Capital's Courts, N.Y. Times, April 18, 1992, at A1; 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.").

24. Bureau of Just. Stat., supra note 22, at table 5.6.

25. Id.

26. G. Camp & C. Camp, The Corrections Yearbook 1991 at 4-5; Correctional Association of New York & New York 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.

27. Bureau of Just. Stat., supra note 22, at table 4.11.

28. Id. at table 4.10.

29. Id. at table 4.12.

30. Id. at table 4.14.

31. Id. at table 4.10.

32. Id. at 4.10.

33. National Commission on AIDS, supra note 2, at 15.

34. Bureau of Just. Stat., supra note 22, at table 4.12.

35. National Commission on AIDS, supra note 2, at 9. Selwyn finds detention itself may be a predictor of persistent needle-sharing. Put another way, incarceration is a good marker for HIV risk. See, e.g., Selwyn, et al., AIDS and High-Risk Behavior Among Intravenous Drug Users in New York City, in AIDS and IV Drug Users 215, 226; Janet Weiner, et al., The Crisis in Correctional Health Care: The Impact of the National Drug Control Strategy on Correctional Health Services, 117 Ann. Int. Med. 71, 73-4 (1992).

36. Hammett & Daugherty, 1991 Update: AIDS in Correctional Facilities 12, 20 (1992).

37. See, e.g., Moini & Hammett, supra note 19, at 25 ("Twenty-seven State and Federal prison systems reported a total of 317 cases of active TB...there 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.").

38. Id. at 15.

39. Jan Elvin, TB Comes Back, Poses Special Threat to Jails, Prisons, Nat'l Prison Project J., Winter 1992, at 4.

40. Alexa Freeman, HIV in Prison, in AIDS and the Law: A Guide for the Nineties (S. Burris, H. Dalton & J. Miller eds forthcoming 1993); Vlahov, et al., Prevalence of Antibody to HIV-1 Among

Entrants to U.S. Correctional Facilities, 265 J.A.M.A. 1129, 1132 (1991); see, e.g., Konika Patel, et al., Sentinel Surveillance of HIV Infection Among New Inmates and Implications for Policies of Correctional Facilities, 105 Pub. Health Rep. 510 (1990); Gina Glass, et al., Seroprevalence of HIV Antibody among Individuals Entering the Iowa Prison System, 78 Am. J. Pub. Health 447 (1988); Neil Hoxie, et al., Seroprevalence and the Acceptance of Voluntary HIV Testing among Newly Incarcerated Male Prison Inmates in Wisconsin, 80 Am. J. Pub. Health 1129 (1990).

41. Vlahov, et al., supra note 40, at 1131.

42. 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 36, at 17, fig. 6 at 18-20.

43. 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).

44. Alexa Freeman, supra note 40; U.S. Department of Justice, Bureau of Just. Stat., Women in Prison 1 (1991) (rate of growth of female inmate population has exceeded that of males every year since 1981; for 1980-89, male population grew by 112%, female by 202.%); Janet Weiner, et al., supra note 35, at 73.

45. See, e.g., Katz, et al., Prevalence of Clinically Significant Pulmonary Tuberculosis among Inmates of New York State Penal Institutions, 61 Amer. Rev. Tuberculosis 51-6 (1950); H. Abeles, et al., The Large City Prison: a Reservoir of Tuberculosis, 101 Amer. Rev. Respir. Diseases 706-09 (1970); see also State Prisons Ignored Alert to TB Threat, N.Y. Times, Aug. 16, 1992, at 42 (health officials warned of TB risk three years before outbreak killed 28 inmates with AIDS and immunosupressed guard).

46. Miles Braun, et al., Increasing Incidence of Tuberculosis in a Prison Inmate Population, 261 JAMA 393; see also Marcel Salive, et al., Coinfection with Tuberculosis and HIV-1 in Male Prison Inmates, 105 Pub. Health Rep. 307 (1990).

47. Dixie E. Snider, et.al., Tuberculosis: an Increasing Problem Among Minorities in the United States, 646 Pub. Health Rep. 646 (1989).

48. Lisa Belkin, 23% of State Prisoners Test Positive for TB, New York Times, March 31, 1992, at B2.

49. CDC, Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers, Public Health Service Report (1992); Howard Goodman, ACLU Seeks Order on TB in State Jails, Phil. Inq., Aug. 7, 1992 at A1 (claiming that treatment must be improved to

avoid "disaster" in Pennsylvania's jails).

50. L.N. King, S. Whitman, Morbidity and Mortality Among Prisoners: AN Epidemiologic Review, 1 J. Prison Health 7 (1981).

51. See, e.g., Miles Braun, et al., supra note 46, at 395 (finding that inmates who reported drug use were more likely to develop TB).

52. Jan Elvin, supra note 39, at 4.

53. National Commission on Aids, supra note 2, at 11; Brewer et al., Transmission of HIV-1 within a Statewide Prison System, 2 AIDS 263 (1988); Horsburgh et al., Seroconversion to Human Immunodeficiency Virus in Prison Inmates, 80 Am. J. Pub. Health 209 (1990).

54. See Alexa Freeman, supra note 40, at --.

55. CDC, supra note 49 ("TB has become a major problem in correctional facilities... Since 1985, there have been 11 major outbreaks in prisons in eight states. ...Both TB and HIV strike hardest among the poor and minority groups, especially those who are injecting drug users.")

56. CDC, Prevention and Control of Tuberculosis in Correctional Institutions: Recommendations of the Advisory Committee for the Elimination of Tuberculosis, 38 MMWR 313, 314; Jan Elvin, supra note 39, at 4.

57. Jan Elvin, supra note 39, at 4.

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

59. 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 Vlahov, et al., supra note 41, at 1132 (urging targeting of HIV health interventions on prisoners); Konika Patel, et al., supra note 40, at 513-14.

60. Nancy N. Dubler & Victor W. Sidel, On Research on HIV Infection and AIDS in Correctional Institutions, 67 Millbank Q. 171-207 (1989).

61. For an illustration of how even obvious TB can fail to be diagnosed, the reader is directed to DiGidio v. Pung, 704 F. Supp. 922, 936-38 (D. Minn. 1989), wherein the judge recounts how the prison required six 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. Major prison systems have disregarded strong warnings

from state health officials. See, e.g., State Prisons Ignored TB Threat, supra note 45; Howard Goodman, supra note 49.

62. CDC, supra note 56, at 313.

63. See CDC, supra note 16, at 509.

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

65. This is the lesson of the long-term decline in TB. See, e.g., Thomas McKeown, The Role of Medicine (976); Geoffrey Rose, Sick Individuals and Sick Populations, 14 Int'l J. Epidemiology 32 (1985).

66. CDC, supra, note 56, at 317.

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

68. Saira Moini & Theodore Hammett, supra note 19 at 1.

69. Hammett & Daugherty, supra note 36, at 60.

70. Hoxie, et al., supra note 40, at 1130.

71. See, e.g., Vaid, Prisons, in AIDS and the Law: A Guide for The Public 248-50 (Dalton & Burris eds. 1987); Alexa Freeman, AIDS and Prisons, in Aids Practice Manual (1991).

72. 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 percent increase over last year. Michael Isikoff, Number of Imprisoned Drug Offenders Up Sharply, Washington Post, April 25, 1992, at A05.

73. 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 percent of government prevention dollars were spent on counseling and testing. (All prevention activities, in turn, comprised 15 percent 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 themselves to be 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 has substantial benefits to those who are tested (particularly now that early medical intervention is helpful), and that it may result in a reduction of risky behavior and an increase in knowledge. But despite the massive amounts spent on the program, the CDC has not assessed whether any of these beliefs about testing are true as well as reasonable. 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 so far raises serious doubts. See Scott Burris, Education to Reduce the Spread of HIV, in AIDS and the Law: A Guide for the Nineties (S. Burris, H. Dalton & J. Miller eds. forthcoming 1993).

74. See, e.g., 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); 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); 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, 120 Misc. 2d 697, 467 N.Y.S.2d 302 (Sup. Ct. 1983).

75. 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, 941 F.2d 1495 (11th Cir. 1991); cf. Clarkson v. Coughlin, No. 91 Civ. 1792-RWS (S.D.N.Y. 1992) (deafness of inmate led to involuntary HIV test).

76. Prisons, because of their unique obligation to provide medical care, could 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, for example, the court observed 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. 880 F.2d 1188, 1196 (10th Cir. 1989). 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).

77. Glover v. Eastern Nebraska Community Office of Retardation, 686 F. Supp. 243 (D. Neb. 1988), aff'd, 867 F.2d 461 (8th Cir. 1989), cert. denied, 110 S. Ct. 321 (1990).

78. 880 F.2d at 1195.

79. Id.

80. Id. at 1195; see Monica Brion, Note, 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 and the Law: A Guide for the Nineties (S. Burris, H. Dalton & J. Miller eds., forthcoming 1993) (describing deferential treatment by courts of federal screening programs).

81. Feigley v. Fulcomer, 720 F. Supp. at 481. In some states, the testing of prisoners is a matter of state law rather than individual prison policy. Mandatory testing required by state law is even less likely to be overturned that 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.R. 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. Pen. 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 Pitt. L. Rev. 327, 337-38 (1991); Martha A. Field, Testing for AIDS: Uses and Abuses, 16 Am. J.L. & Med. 34 (1990).

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

83. 716 F. Supp. 601, 603 (N.D. Ga. 1989). The extremely low standard was phrased this way by another 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, 730 F. Supp. 420, 422 (M.D. Fla. 1990).

84. Id. at 604. The court also found an unexplained "legitimate security concern in limiting the exposure of inmates to drugs."

85. 727 F. Supp. at 1577-78. The Court of Appeals affirmed the district court's conclusion, but disavowed its reasoning. 941 F. 2d at 1509; see also Lewis v. Prison Health Services, Civ. A. No. 88-1247, 1988 WL 95082 (E.D. Pa. 1988), appeal dismissed, 915 F.2d 1561 (3rd Cir. 1990).

86. Weaver v. Reagan, No. 88-2560, slip op. at 9 (8th Cir. Sept. 25, 1989), affirming No. 87-4314-CV-C-5 (W.D. Mo. Sept. 29, 1988).

87. "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." Roe v. Fauver, Civ. A. No. 88-1225 (AET), 1988 WL 106316 (D. N.J. 1988).

88. 725 F. Supp. 526 (S.D. Fla. 1989), rev'd, 899 F. 2d 1124 (11th Cir. 1990).

89. 899 F.2d at 1126-27. It should be noted that lawsuits against prison medical personnel for malpractice are an option in individual cases, and may have a system-wide impact. See, e.g., Maynard v. New Jersey, 719 F. Supp. 292 (D.N.J. 1989) (family of deceased inmate stated cause of action for failure of medical personnel to properly treat HIV infection); McIlwain v. Prince William Hospital, 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).

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

91. Inmates of New York State with Human Immune Deficiency Virus v. Cuomo, No. 90-CV-252 (N.D.N.Y. filed Mar. 6, 1990).

92. Starkey v. Matty, supra, note 90.

93. One of the more novel aspects of the national response to HIV has been the attention to the social status of infection. 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 and social prerogatives. There is no evidence that this actually reduces disease, but plenty of evidence that discrimination exists and reduces 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.

94. See, e.g., Holt v. Norris, 871 F.2d 1087, 1989 U.S.App. LEXIS 2147 (6th Cir. 1989); Glick v. Henderson, 855 F.2d 536 (8th Cir. 1988); Muhammad v. Carlson, 845 F.2d 175 (8th Cir. 1988); Alston v. United States Department of Justice, No. 89-1883 SSH, 1989 U.S. Dist. LEXIS 9222 (D. D.C. 1989); Lewis v. Prison Health Services, Civ. A. No. 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, 929 (S.D. Ind. 1987); Powell v. Department of Corrections, 647 F. Supp. 968, 970-71 (N.D. Okl. 1986); Cordero v. Coughlin, 607 F. Supp. 9 (S.D.N.Y. 1984).

95. See, for example, Martinez v. School Brd., 861 F.2d 1502 (11th Cir. 1988), the notorious "glass booth" case.

96. Lewis v. Prison Health Services, Civ. A. No. 88-1247, 1988 WL 95082 (E.D. Pa. 1988).

97. For a discussion of the varieties of scrutiny in health cases, see generally Burris, Rationality Review and the Politics of Public Health, 34 Villanova L. Rev. 933 (1989).

98. 697 F. Supp. 1234 (N.D.N.Y. 1988).

99. Nolley v. Erie County, 776 F. Supp. at 735-36.

100. Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990).

101. 727 F. Supp. at 1568.

102. 941 F.2d at 1513-21 (citations omitted).

103. 29 U.S.C.S. § 794 (1992).

104. See, e.g., Bonner v. Lewis, 857 F.2d 559, 562 (9th Cir. 1988).

133. Susan Sturm, Resolving the Remedial Dilemma: Strategies of Judicial Intervention in Prisons, 138 U. Pa. L. Rev. 805, 811-46 (1990).

134. Id. at 856-47 (footnotes omitted).

135. Id. at 811.

136. See, e.g., CDC, supra, note 56, at 318-19.

137. 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. 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 in last five years); Janet Weiner, et al., supra note 21 at 75.

138. 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." Susan Sturm, supra note 133, at 837.

139. 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 state essentially adopted the measures advocated by the plaintiffs while the litigation progressed. Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980), cert. denied, 450 US 1041 (1981); Wiggins v. State, 76 Md. App. 188, 544 A.2d 8 (1988).

140. Doe v. Meachum, No. 88-562, 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).

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142. Roe v. Fauver, No. 88-1225 (D.N.J. Oct. 7, 1988); 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-

105. 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).

106. 941 F.2d at 1526-27.

107. Doe v. Coughlin, 518 N.E.2d 536 (1987), cert. denied, 488 U.S. 879 (1988). In 1988, a new suit was filed against the policy and the corrections department reversed itself and voluntarily rescinded the rule. Kozlowski v. Coughlin, 771 F. Supp. 83 (S.D.N.Y. 1988); see also Sam Verhovek, Spouse Visits for inmates with HIV, N.Y. Times, Aug 5, 1991 at B1.

108. Farmer v. Moritsugu, 742 F. Supp. 525 (W.D. Wis. 1990).

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

110. 941 F.2d at 1526-27 (footnote omitted).

111. 689 F. Supp. 874 (W.D. Wis. 1988).

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

113. 776 F. Supp. at 726.

114. 704 F. Supp. 922 (D. Minn. 1989), aff'd, 920 F. 2d 525 (8th Cir. 1990). Another early case is Hochman v. Rafferty, 1989 U.S. Dist. LEXIS 16577 (D. N.J. Oct. 19, 1989) (rejecting inmate demands for HIV and TB testing and segregation).

115. Id. at 960.

116. DiGidio v. Pung, 723 F. Supp. 135 (D. Minn. 1989), aff'd, 920 F. 2d 525 (8th Cir. 1990). DiGidio 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." 704 F. Supp. at 957.

117. Wilder v. Leak, 1992 U.S. Dist. LEXIS 6132 (N.D. Ill. Apr. 29, 1992).

118. Howard Goodman, supra note 49.

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

120. Brown v. Beck, 481 F. Supp. 723, 726 (S.D. Ga. 1980), quoted with approval in Hawley v. Evans, 716 F. Supp. 601 (N.D. Ga. 1989) (resting decision not to order AZT for asymptomatic inmates on

distinction between general medical practices and "constitutionally acceptable care").

121. See Wilson v. Seiter, 111 S.Ct. 2321 (1991) (holding that plaintiff must prove "culpable state of mind" as well as objective deprivation to show cruel and unusual punishment).

122. 776 F. Supp. at 740.

123. Monmouth County Correctional Institution v. Lanzara, 834 F.2d 326, 346-47 (3d Cir.), cert. denied, 108 S. Ct. 1731 (1987).

124. Estelle, 429 U.S. at 103 (citations omitted). See generally Monmouth County, 834 F.2d at 347 (citing cases).

125. Turner v. Safeley, 482 U.S. 78 (1987).

126. Monmouth County, 834 F.2d at 343.

127. Bell v. Wolfish, 441 U.S. 520, 540 (1979).

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

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

130. See, e.g., Tillery v. Owens, 907 F. 2d 418 (3rd Cir. 1990).

131. Harris, 727 F. Supp. at 1567.

132. See, e.g., Janik v. Celeste, 928 F.2d 1132 (6th Cir. 1991); Dunn v. White, 880 F.2d 1188 (10th Cir. 1989), cert. denied 493 U.S. 1059, (1990); Muhammed v. 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); Hawley v. Evans, 716 F. Supp. 601 (N.D. Ga. 1989); 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); Alston v. Dep't of Justice, 1989 U.S. Dist. LEXIS 9222 (D.D.C. 1989); Feigley v. Fulcomer, 720 F. Supp. 475 (M.D. Pa. 1989); Hochman v. Rafferty, 1989 U.S. Dist. LEXIS 16577 (Oct. 19, 1989); see also, Jim Thomas, Prisoner Cases as Narrative, in Narrative and the Legal Discourse: A Reader in Storytelling and the Law (David R.Papke, ed., 1991).

133. Susan Sturm, Resolving the Remedial Dilemma: Strategies of Judicial Intervention in Prisons, 138 U. Pa. L. Rev. 805, 811-46 (1990).

134. Id. at 856-47 (footnotes omitted).

135. Id. at 811.

136. See, e.g., CDC, supra, note 56, at 318-19.

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positive prisoners to 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).

143. Austin v. Pennsylvania Department of Corrections, No. 90-7497 (E.D. Pa. filed July 26, 1991); Inmates of New York State with Human Immune Deficiency Virus v. Cuomo, No. 90-CV-252 (N.D. N.Y. filed Mar. 6, 1990).

144. E.M. Forster, Howard's End, at 186 (1921).

145. Thomas McKeown, supra note 65; 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 Millbank Q., 405 (1977).