NOTES

INDIFFERENCE, INTERRUPTION, AND IMMUNODEFICIENCY: THE IMPACT AND IMPLICATIONS OF INADEQUATE HIV/AIDS CARE IN U.S. PRISONS

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Since its discovery in the 1980s, HIV/AIDS has claimed an estimated half-million lives in the United States alone, and the Centers for Disease Control and Prevention report that over one million citizens are currently HIV/AIDS seropositive. While medical treatments have progressed significantly, HIV/AIDS remains incurable and some one-third of infections still progress from initial HIV infection to AIDS within a single year. Further, rates of infection disproportionately affect particular contingents of society, notably racial minorities, intravenous drug users, and those of lower socioeconomic status. These same risk indicators correlate to another population: prisoners. In fact, the rate of HIV/AIDS among incarcerated populations is 3.5 times that of the general population. This high rate of infection draws attention to the role America's "War on Drugs" plays in racializing our prison population, incarcerating high rates of intravenous drug users, and implementing police procedures that often target low-income communities. It also illustrates the importance of prison as a point of public health intervention for successful HIV/AIDS treatment.

This Note examines the legal implications of HIV/AIDS treatment in prison. Recognizing that seropositive individuals, once incarcerated, are often denied adequate and consistent HIV/AIDS treatment, this Note argues that courts considering claims of inadequate treatment have erred in widely rejecting affected prisoners' Eighth Amendment claims under Estelle v. Gamble*'s "deliberate indifference" standard. Exploring* Estelle*'s progeny, this Note establishes that deliberate indifference to a serious medical need may be shown through disregard of an overwhelming and obvious risk. On this basis, the Note argues that widespread social and cultural recognition of HIV/AIDS, as well as clear cognizance among prison administrators of the disease and its*

health implications (derived from nearly three decades of housing seropositive prisoners) prove the obviousness of risk associated with HIV/AIDS in prison. Moreover, clear treatment guidelines from leading prison healthcare accreditation agencies indicate that the appropriate standard of care is well known to prison administrators. As such, this Note concludes that prisoners' claims of inadequate treatment warrant reconsideration under Estelle.

INTRODUCTION

In the 1970s and 1980s two events began which, in combination, have reshaped the nature of America's prisons. The first event was the outbreak and spread of HIV/AIDS, a biological epidemic and arguably the most destructive disease of the twentieth century.[1] The second event was America's "War on Drugs," a package of legislative policies marketed as the means to combat a very different epidemic, increased drug abuse among American citizens.[2] Since this "war" began, federal prison populations have increased by more

[1] *See Thirty Years of HIV – 1981-2011*, 60 MORBIDITY & MORTALITY WKLY. REP. 689, 689 (2011), *available at* http://www.cdc.gov/mmwr/pdf/wk/mm6021.pdf. AIDS is the common name for Stage-3 HIV infection, indicating substantial progression of the virus. For clarity's sake, this Note generally does not refer to HIV-positive prisoners separately from those with confirmed AIDS, but rather uses the general identifying term "HIV/AIDS" for all persons of seropositive status.

[2] President Richard Nixon, Remarks About an Intensified Program for Drug Abuse Prevention and Control (June 17, 1971) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=3047#ixzz1rPB60Xn7) (using militarized language to describe efforts to curb drug abuse in America, such as staging an "offensive" against perpetrators). Similarly militarized rhetoric continued through subsequent presidencies. *See* President Gerald Ford, Special Message to the Congress on Drug Abuse (Apr. 27, 1976) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=5875&st=war+on+drugs&st1=) ("With the help of State and local governments, community groups, and our international allies in the battle against narcotics, we were able to make impressive progress in combating the drug menace."); President Ronald Reagan, Remarks at a White House Ceremony Honoring Law Enforcement Officers Slain in the War on Drugs (Apr. 19, 1988) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=35698&st=war+on+drugs&st1=) ("America's liberty was purchased with the blood of heroes. Our release from the bondage of illegal drug use is being won at the same dear price. The battle is ultimately over what America is and what America will be."); President George H.W. Bush, Remarks at the National Drug Control Policy Luncheon (Mar. 7, 1990) (transcript available at http://www.presidency.ucsb.edu/ws/index.php?pid=18229&st=war+on+drugs&st1=) ("I think you are America's hometown heroes – unconventional warriors, but this is an unconventional war. You've shown how the communities under siege can be united in a battle for life and how they can be restored to health and safety . . . ."). For an overview of additional rhetorical developments in the "War on Drugs," see Susan Stuart, *War as Metaphor and the Rule of Law in Crisis: The Lessons We Should Have Learned from the War on Drugs*, 36 S. ILL. U. L.J. 1, 8-14 (2011).

than 600%.[3] Beyond sheer numbers, however, the "war" has had another, unforeseen impact: the men and women most commonly incarcerated for drug crimes also have come to exhibit a number of high-risk factors for HIV infection, resulting in prison populations with a significantly increased incidence of HIV/AIDS seropositivity.[4] This Note focuses on the resulting intersection between HIV/AIDS and incarceration, exploring how massive increases in incarcerated populations have strained prison budgets and too often resulted in inadequate health care for prisoners suffering from HIV/AIDS infection.[5] Toward this end, this Note touches on issues of social policy, public health, and constitutional rights. It seeks first to explain what factors cause high rates of HIV/AIDS seropositivity behind bars,[6] then to explore what standard of care is constitutionally guaranteed to seropositive prisoners, and finally to argue that a failure to uphold such standards results in a constitutional violation of the rights of prisoners that is deserving of remedy.

Part I begins with a brief history of HIV/AIDS and then compares the seropositivity rate among prisoners to that of the general population. Drawing on the work of public health specialists and sociologists, this Part then explores the social and cultural factors that help explain the heightened incidence of HIV/AIDS in prison. Part II provides an overview of historical treatment regimens for HIV/AIDS in prison. Moving from the past to modernity, this Part next summarizes today's accepted medical practice for treatment of HIV/AIDS-positive prisoners. Based on the reports and guidelines of leading prison healthcare accreditation agencies[7] and government offices, this inquiry

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[3] Josiah D. Rich et al., *Medicine and the Epidemic of Incarceration in the United States*, 364 NEW ENG. J. MED. 2081, 2081 (2011); *see also* Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health*, 78 J. URB. HEALTH 214, 215 (2001) (stating that, from 1980 to 2001, "the number of inmates in the United States more than tripled; the state prison population increased by 299%, the federal prison population increased by 417%, and the number of local jail inmates increased by 225%").

[4] *See infra* Part I.C. "Seropositivity" refers to having a positive serum reaction to a test for a particular disease antibody. As used in the context of this Note, therefore, seropositive means having tested positive for the HIV/AIDS antibody, while "seroconversion" refers to testing positive for the antibody after having previously tested negative. For instance, a negative test upon entry to prison and a positive one upon exit would imply a prisoner "seroconverted" while incarcerated.

[5] *See, e.g.*, Brown v. Plata, 131 S. Ct. 1910, 1923 (2011) (calling overcrowding the main cause of the "severe and unlawful mistreatment of prisoners through grossly inadequate provision of medical and mental health care" in violation of their constitutional rights).

[6] Rates of infection behind bars are estimated to be three-and-a-half times higher than the general population. *See infra* note 24 and accompanying text.

[7] The leading agency offering voluntary accreditation standards for penological institutions is the National Commission on Correctional Health Care (NCCHC). *See* NAT'L COMMISSION ON CORRECTIONAL HEALTH CARE, http://www.ncchc.org/ (last visited Dec. 15, 2012).

provides a baseline against which treatment may be measured. This Part then concludes with the recognition and description of several obstacles that commonly impede the delivery of this prescribed standard of care. Turning to the question of what legal standards are applicable to questions of prison health care, Part III sets out the evolution of the Eighth Amendment's guarantee of medical care to prisoners. Exploring the legal distinctions between prison, jail, and pre-trial detention, this Part also explains the role of the Fourteenth Amendment in securing a right to medical treatment for incarcerated persons not yet convicted.[8] Finally, Part IV queries whether the disruption or inadequate provision of HIV/AIDS medication to prisoners may amount to a violation of their constitutional rights. A review of precedent shows that courts have failed to find viable constitutional claims in cases arising from inadequate or interrupted treatment, generally due to a perceived lack of subjective intent to harm.[9] Recognizing the seriousness of inadequate medical care for HIV/AIDS infection and the obvious nature of the risks associated with such inadequate care, however, this Note argues that such precedent misapplies the Eighth Amendment's test for deliberate indifference.[10] Because deliberate indifference may be shown through disregard of an obvious risk,[11] this Part urges more careful consideration of the pervasive nature of HIV/AIDS awareness among prison administrators as a means to conclude that systemic inadequacies in treatment amount to a violation of the Eighth Amendment rights of HIV/AIDS-seropositive prisoners. This Note concludes with a brief consideration of the social policies implicated by the provision of HIV/AIDS care in prison and the impact such care may potentially have on communities beyond prison walls.

I. HIV/AIDS IN U.S. PRISONS

Since its discovery in the 1980s, the global epidemic of HIV/AIDS has required the development of social and legal policies surrounding prevention, transmission, and treatment. Because incarcerated persons in the United States present a significantly heightened incidence of HIV/AIDS seropositivity compared to the general population, public health experts view prison as an

[8] *See* Ingraham v. Wright, 430 U.S. 651, 671 n.40 (1977) (citing United States v. Lovett, 328 U.S. 303, 317-18 (1946)) (noting that Eighth Amendment protections are applicable only "after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions").

[9] Wilson v. Seiter, 501 U.S. 294, 296-97 (1991). For a detailed description of the evolution of Eighth Amendment jurisprudence and the requirement of subjective intent, see *infra* Part IV.A.

[10] As described in Part III, *infra*, since 1976 the Supreme Court has developed a doctrinal test for Eighth Amendment violations based on whether claims illustrate "deliberate indifference" on the part of prison administrators. *See* Estelle v. Gamble, 429 U.S. 97, 104-06 (1976).

[11] Farmer v. Brennan, 511 U.S. 825, 842 (1994).

important intervention point in combating the disease.[12] This high incidence of HIV/AIDS in prison has also led to numerous studies exploring the nexus between socioeconomic, cultural, and racial factors common to those populations at high risk for HIV/AIDS and those populations at high risk for incarceration.[13]

A. *The Discovery of HIV/AIDS*

In June of 1981, the Centers for Disease Control and Prevention (CDC) published, in its *Morbidity and Mortality Weekly Report*, a description of five previously healthy young men suffering from what was then identified as *Pneumocystis carinii* pneumonia.[14] In subsequent years, this report has become known as the first scientific publication to discuss what was later identified as the Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS).[15] Today, three decades after the discovery of the disease, estimates place the total death toll from HIV/AIDS in the United States at more than 500,000.[16] Although significant improvements have been made in understanding and treating the disease,[17] no vaccine or cure has been discovered.[18] While modern drug regimens may extend the life

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[12] Amy Nunn et al., *Linking HIV-Positive Jail Inmates to Treatment, Care, and Social Services After Release: Results from a Qualitative Assessment of the COMPASS Program*, 87 J. URB. HEALTH 954, 954 (2010) ("Approximately 17% of individuals living with HIV/AIDS pass through the correctional system each year. Jails provide a unique opportunity to diagnose and treat HIV infection among high-risk, transient populations with limited access to medical services.").

[13] *See, e.g.*, Kim M. Blankenship et al., *Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System*, 16 J. HEALTH CARE FOR POOR & UNDERSERVED 140, 140-44 (2005); James A. Swartz et al., *Correlates of HIV-Risk Behaviors Among Prison Inmates: Implications for Tailored Aids Prevention Programming*, 84 PRISON J. 486, 488-90 (2004).

[14] *Thirty Years of HIV – 1981-2011*, *supra* note 1, at 689.

[15] *Id.*

[16] *Id.*

[17] Ronald O. Valdiserri, *Thirty Years of AIDS in America: A Story of Infinite Hope*, 23 AIDS EDUC. & PREVENTION 479, 480 (2011) (remarking that "the advent of highly active antiretroviral therapy (HAART) in the mid-1990s" resulted in a marked decrease, sixty-three percent, of HIV/AIDS deaths between 1995 and 1998).

[18] Despite not yet discovering a cure or vaccine, researchers have made remarkable progress in the treatment of HIV/AIDS over the past thirty years. *See, e.g.*, David Brown & Alyssa A. Botelho, *AIDS Research Renews Hope for a 'Functional Cure,'* WASH. POST (July 26, 2012), http://www.washingtonpost.com/national/health-science/aids-research-anticipates-a-functional-cure/2012/07/26/gJQA2YGdCX_story.html (relating recent developments in the search for a cure); Richard Knox, *Two More Nearing AIDS 'Cure' After Bone Marrow Transplants, Doctors Say*, NPR (July 26, 2012 7:50 PM), http://www.npr.org/blogs/health/2012/07/26/157444649/two-more-nearing-aids-cure-after-bone-marrow-transplants-doctors-say (describing a study in which two formerly HIV-positive patients showed no incidence of

expectancy of seropositive persons for decades,[19] such treatment programs focus on halting the progressive development of HIV into AIDS rather than eradicating it from the body.[20] The CDC estimates that approximately 1.1 million people in the United States are currently living with HIV/AIDS, with an average of 47,129 new cases of HIV diagnosed and 17,489 deaths caused by the disease each year.[21] Even now, nearly one-quarter of American citizens infected with HIV/AIDS remain unaware of their seropositive status, and, due to gaps in access to adequate care, one-third of all infections still progress from HIV to AIDS within one year.[22]

B. *The Incidence of HIV/AIDS in Prison*

Although HIV/AIDS is a disease that impacts all segments of the U.S. population, incarcerated persons in U.S. prisons exhibit a significantly higher incidence of seropositivity than the general population. The latest statistics on the occurrence of HIV/AIDS in prison indicate that 18,337 men and 1756 women in the U.S. penal system were positive for HIV or had confirmed AIDS in 2010.[23] These 20,093 prisoners make up 1.5% of the U.S. prison population, evidencing a rate of infection nearly 3.5 times that of the general U.S. population.[24] Some state prison systems exhibit even higher rates of incidence among prisoners; in 2010, New York reported that 5.5% of all prisoners tested positive for HIV and three other state systems reported

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infection after receiving bone marrow transplants while on antiretroviral therapy); *SAV001-H: HIV Vaccine Has No Adverse Side Effects in Early Trial*, HUFFINGTON POST (Nov. 13, 2012, 10:22 AM), http://www.huffingtonpost.com/2012/11/09/sav001-hiv-vaccine-side-effects-adverse_n_2102593.html (providing an overview of preliminary test results for an experimental HIV vaccine). Such new treatments, however, also highlight continued discrepancies in access to effective HIV/AIDS care, particularly for those of lower socioeconomic status with limited access to healthcare services.

[19] Valdiserri, *supra* note 17, at 480 (commenting that between 1996 and 2005 the average life expectancy of a seropositive person increased from 10.5 to 22.5 years).

[20] *See Basic Information About HIV and AIDS*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/hiv/topics/basic/index.htm (last visited Dec. 15, 2012).

[21] The data presented above is from a 2012 report which extrapolated from death and diagnostic statistics gathered in 2009 and 2010. DIV. OF HIV/AIDS PREVENTION, CDC, HIV IN THE UNITED STATES: AT A GLANCE 1 (2012). In addition to the 47,129 new cases of HIV diagnosed in 2010, some 33,015 people were newly diagnosed with AIDS in the same time period. *Id*.

[22] Valdiserri, *supra* note 17, at 484.

[23] LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, BULLETIN NO. NCJ 238877, HIV IN PRISONS, 2001-2010, at 6 tbl.2 (2012), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp10.pdf.

[24] *Id.* at 5 tbl.1; *cf.* ACLU & HUMAN RIGHTS WATCH, SENTENCED TO STIGMA: SEGREGATION OF HIV-POSITIVE PRISONERS IN ALABAMA AND SOUTH CAROLINA 10 n.1 (2010) (reporting that the incidence of HIV/AIDS in the general population was .44% in 2007).

seropositive population rates above 3%.[25] Further, an estimated 17% of all seropositive persons in the U.S. – more than 175,000 individuals[26] – pass through the prison system each year.[27] HIV/AIDS-related deaths accounted for 3.6% of all deaths in prison in 2009.[28]

C. *Beyond Statistics: Causal Factors Impacting the Incidence of Infection*

More critical than statistics and incident rates to an understanding of the significance of HIV/AIDS in the lives of prisoners, however, is a careful evaluation of the factors that create and underlie these rates. The patterns of criminality and incarceration established and exacerbated by America's "War on Drugs" have led to a significant nexus of risk factors for HIV/AIDS in the prison setting.[29] Namely, although the "war" has increased net incarceration rates across the board, communities particularly impacted include African-American men, persons of lower socioeconomic status, and intravenous drug users – all populations at higher risk for HIV/AIDS.[30] It is critical to note, however, that these and other risk factors are inextricably intertwined and occur concurrently, making attribution to any one factor nearly impossible.[31] While no clear, causal linear relationship is evident, commentators suggest that it is the interplay between these and any number of other social, cultural, and economic factors that creates the significantly heightened risk of HIV/AIDS behind bars.[32]

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[25] *See* MARUSCHAK, *supra* note 23, at 5 tbl.1.

[26] This number is calculated based on population estimates provided by the CDC that put the number of persons in the United States with HIV/AIDS at approximately 1,100,000. *See supra* text accompanying note 21.

[27] Nunn et al., *supra* note 12, at 954.

[28] *See* MARUSCHAK, s*upra* note 23, at 4.

[29] For a detailed discussion and ethnographic account of the impacts of racialized incarceration patterns and harsh penalties for drug-related offenses, see BENJAMIN FLEURY-STEINER WITH CARLA CROWDER, DYING INSIDE: THE HIV/AIDS WARD AT LIMESTONE PRISON 43-70 (2008).

[30] *See infra* Part I.C.1-4.

[31] For example, a police drug enforcement policy that disproportionately targets African American men living in a low socioeconomic neighborhood may create higher rates of incarceration among such individuals, which in turn exposes those individuals to a new set of risks common to incarceration, such as tattooing or high-risk sexual activities.

[32] Lawrence D. Bobo & Victor Thompson, *Racialized Mass Incarceration: Poverty, Prejudice, and Punishment*, *in* DOING RACE: 21 ESSAYS FOR THE 21ST CENTURY 322, 330-36 (Hazel Rose Markus & Paula M. L. Moya eds., 2010) (describing the intersecting roles that poverty, punitive drug sentencing, and criminal justice policies play in the racialization of modern prisons).

1. Race

The past three generations have seen a clear and significant racialization of prison populations.[33] Commenting on the results of his empirical study, sociologist Bruce Western noted that "[p]oor and minority men were much less involved in crime in 2000 than twenty years earlier," but "[a]lthough disadvantaged men became much more law-abiding, their chances of going to prison rose to historically high levels."[34] This racialization is so severe that "[b]y middle age, black men in the United States are more likely to have spent time in prison than to have graduated from college or joined the military."[35] According to statistics reported in 1996, ethnic minorities made up 63% of the nation's prison population but comprised only around 20% of the nation's general population.[36] Similar trends of racialization are seen in the HIV/AIDS epidemic. In 2002, while African Americans represented 13% of the U.S. population, they made up 39% of all HIV/AIDS infections and accounted for over half of all new HIV/AIDS cases reported.[37] The infection rate for females and children was even more disproportionate; in 2002 African Americans accounted for approximately two-thirds of both new HIV infections among women and cases of pediatric AIDS.[38] A 2009 CDC study shows this trend has continued, with African American males exhibiting an infection rate more than six times that of white men, while African American women's rate of infection is fifteen times that of white women.[39] Social scientists and public health experts have explored the interrelated nature of these statistical disparities, often concluding that the community destabilization and exposure to high-risk behaviors attendant with incarceration have a significant impact on high rates of HIV/AIDS within disproportionately impacted populations.[40]

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[33] *Id.* at 328.

[34] BRUCE WESTERN, PUNISHMENT AND INEQUALITY IN AMERICA 50 (2006).

[35] Rich et al., *supra* note 3, at 2081.

[36] Freudenberg, *supra* note 3, at 215 ("If current levels of incarceration persist, a black man has a greater than 1 in 4 chance of going to prison in his lifetime, a Hispanic man has a 1 in 6 chance, and a white man has a 1 in 23 chance of serving time. In 1996, people of color constituted 63% of all US jail inmates, almost three times their proportion in the US population as a whole."). This trend has continued. 2009 statistics indicate that 3110 African American males and 1193 men of Hispanic origin are incarcerated for every 487 white males imprisoned. *See* HEATHER C. WEST & WILLIAM J. SABOL, BUREAU OF JUSTICE STATISTICS, BULLETIN NO. NCJ 231675, PRISONERS IN 2009 app., tbl.15 (2010).

[37] Blankenship et al., *supra* note 13, at 140-41.

[38] *Id.*

[39] DIV. OF HIV/AIDS PREVENTION, CDC, HIV AMONG AFRICAN AMERICANS 1 (2011). In the Latino population, the rate of infection for males is more than 2.5 times that of white men, and for females, the rate is four times that of white women. DIV. OF HIV/AIDS PREVENTION, CDC, HIV AMONG LATINOS 1 (2011).

[40] RONALD L. BRAITHWAITE, THEODORE M. HAMMETT & ROBERT M. MAYBERRY, PRISON AND AIDS: A PUBLIC HEALTH CHALLENGE 18-21 (1996); Blankenship et al., *supra* note 13,

2. Socioeconomic Status

Poor and marginalized communities also share a significant risk of HIV/AIDS transmission and incarceration.[41] In describing the impact of income inequality on shaping prison populations, sociologists Bruce Western and Katherine Beckett have suggested that "[h]igh incarceration rates lower conventional unemployment statistics by hiding joblessness but create pressure for rising unemployment once inmates are released."[42] This pressure at the point of reintegration often risks creating a cycle in which individuals unable to reintegrate into a stable community upon release evidence higher rates of recidivism and are commonly re-incarcerated.[43] Comparing wages against the likelihood of incarceration, Western has also revealed a stark picture of income inequality in U.S. prisons: "a $100 increase in weekly pay . . . is associated with a 32-percent decline in the chances of imprisonment."[44] Similarly, the impact of HIV/AIDS on persons of low socioeconomic status is most clearly illustrated by the limited access to health care and medical services faced by many impoverished persons, including those released from prison.[45] This cyclical impact of unemployment, incarceration, lack of community reintegration, and limited access to health care may thus create an ever-burgeoning set of risk factors that put impacted individuals at higher risk for both HIV/AIDS exposure and repeat incarceration.

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at 141; *see also* OFFICE OF NAT'L AIDS POLICY, EXEC. OFFICE OF THE PRESIDENT, HIV/AIDS STRATEGY FOR THE UNITED STATES 12-13 (2010) (stating that the impacts of incarceration may include community destabilization, which leads to an increased rate of HIV/AIDS transmission among the remaining, non-incarcerated, sexually active members of the community).

[41] *See* BRAITHWAITE, HAMMETT & MAYBERRY, *supra* note 40, at 25 (recognizing that prison populations are generally comprised of high rates of impoverished individuals); FLEURY-STEINER, *supra* note 29, at 46-48 (offering a persuasive account of the impact of economic privatization and free market policies on the destabilization of lower socioeconomic communities).

[42] Bruce Western & Katherine Beckett, *How Unregulated Is the U.S. Labor Market? The Penal System As a Labor Market Institution*, 104 AM. J. SOC. 1030, 1053 (1999).

[43] *See* Freudenberg, *supra* note 3, at 216 ("[S]tate cutbacks in prison education, job training, and rehabilitation programs [mean] newly released inmates are far less likely than their counterparts . . . to find jobs, maintain stable family lives, or stay out of the kind of trouble that leads to more prison." (internal quotation marks omitted)).

[44] WESTERN, *supra* note 34, at 77-78 & tbl.3.4.

[45] MELVIN DELGADO & DENISE HUMM-DELGADO, HEALTH AND HEALTH CARE IN THE NATION'S PRISONS: ISSUES, CHALLENGES, AND POLICIES 37 (2009) ("The high rate of poverty of those who go to prison also is reflected in their health status and issues. The typical prison or jail has an inmate population with high disease prevalence that enters the system with a history of inadequate health care utilization."); Rich et al., *supra* note 3, at 2082 (describing how many released prisoners lack medical insurance and how state Medicaid benefits are generally terminated upon incarceration).

3. Intravenous Drug Use

Drug use is perhaps the high-risk activity that most clearly illustrates the nexus between marginalization, incarceration, and HIV/AIDS infection. Intravenous drug use is an inherently high-risk behavior in which co-participants exchange bodily fluids.[46] While governmental attempts to curb such drug use are understandable, the aggressive, prosecution-focused nature of the "War on Drugs" has resulted in harsh penalization of drug crimes that has further increased the attendant risks of intravenous drug use by heightening pressure on marginalized communities and expanding the length of incarceration.[47] The racialized nature of drug policies[48] has been evaluated in empirical studies investigating use behaviors in minority communities: "Intense police surveillance, combined with laws against possession of drug paraphernalia, has made the possession of clean syringes in minority neighborhoods extremely risky. Fear of arrest compels injection drug users to rely on syringes borrowed at the moment of injection."[49] In turn, the rate of incarceration for drug crimes has risen drastically in recent years, increasing by over 1000% between 1980 and 1995.[50] In today's prisons, more than two-thirds of incarcerated individuals report a history of drug or substance abuse.[51] Further, drug use does not halt behind prison walls.[52] Although against prison

[46] In addition to fluids exchanged through the use of shared needles, commentators have noted that "sexual dynamics" are often present in drug networks, with sex commonly used as a form of payment for drugs. *See* Bronwen Lichtenstein, *Drugs, Incarceration, and HIV/AIDS Among African American Men: A Critical Literature Review and Call to Action*, 3 AM. J. MEN'S HEALTH 252, 257 (2009).

[47] Blankenship et al., *supra* note 13, at 142-44.

[48] Bobo & Thompson, *supra* note 32, at 333 (remarking that, although the rate of illicit drug use does not vary significantly between Caucasian and African-American populations, African Americans are more than twice as likely to be convicted for a drug-related crime).

[49] Cathy Lisa Schneider, *Racism, Drug Policy, and AIDS*, 113 POLI. SCI. Q. 427, 433 (1998).

[50] *See* Blankenship et al., *supra* note 13, at 142-43 ("Growth of the incarcerated population, as well as the racially disparate form that is has taken, relates in large part to U.S. drug policy. . . . Between 1980 and 1995, the number of drug offenders in state prison increased by more than 1000% percent, accounting for 1 out of every 16 inmates in 1980 but 1 out of every 4 in 1995.").

[51] *See* DELGADO & HUMM-DELGADO, *supra* note 45, at 71 (2009) ("In 1996, anywhere from 70 to 85% of prison inmates were in need of some type of substance abuse treatment. . . . The relationship between substance abuse and multiple health issues such as HIV . . . is very strong."); Freudenberg, *supra* note 3, at 217.

[52] *See* Block v. Rutherford, 468 U.S. 576, 588-89 (1984) ("We can take judicial notice that the unauthorized use of narcotics is a problem that plagues virtually every penal and detention center in the country."); Jennifer G. Clarke et al., *Active and Former Injection Drug Users Report of HIV Risk Behaviors During Periods of Incarceration*, 22 SUBSTANCE ABUSE 209, 215 (2001).

regulations, high-risk behaviors like needle sharing and tattooing continue among incarcerated populations, creating a continued risk of HIV/AIDS transmission during incarceration.[53]

4. High-Risk Sexual Behavior

Although studies suggest that intra-prison transmission of HIV/AIDS is rare,[54] high-risk sexual activities behind prison walls are another potential contributor to the high incidence of infection among incarcerated populations.[55] Sexual activity in prison may be either consensual or coercive, as in instances of prison rape.[56] The occurrence of rape in prison is well documented.[57] In 2003, responding to the high incidence of sexual assault

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[53] While the majority of studies into drug use behind prison walls have occurred in Europe, there is no significant evidence to suggest similar activities do not occur in U.S. prisons. *See* BRAITHWAITE, HAMMETT & MAYBERRY, *supra* note 40, at 25 (recognizing that prison populations are generally comprised of high rates of impoverished individuals); Chloé Carpenter et al., *Ten Years of Monitoring Illicit Drug Use in Prison Populations in Europe: Issues and Challenges*, 51 HOWARD J. CRIM. JUST. 37, 53 (2012). The occurrence of drug abuse behind prison walls has led some commentators to suggest the advent of clean-needle-exchange programs among prisoners. *See* Kate Abramson, Note, *Unfairly Condemned to Disease: The Argument for Needle-Exchange Programs in United States Prisons*, 16 GEO. J. ON POVERTY L. & POL'Y 695, 696, 718-19 (2009).

[54] *HIV Transmission Among Male Inmates in a State Prison System – Georgia, 1992-2005*, 55 MORBIDITY & MORTALITY WKLY. REP. 421, 422 (2006), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm5515.pdf (identifying, over a thirteen-year study, eighty-eight inmates who tested negative for HIV upon entry into prison and subsequently tested positive during incarceration). The prison population at the time this study concluded was 44,990, indicating a seroconversion rate of approximately 0.2%. *Id.*

[55] APHA TASK FORCE ON CORRECTIONAL HEALTH CARE STANDARDS, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS 86 (2003).

[56] Because prisoners are housed in single-sex facilities, male prisoners that engage in sexual conduct while incarcerated – regardless of how they sexually identify – fall into the category of men who have sex with men (MSM). Recent studies have shown that MSM are at a forty percent higher risk for HIV/AIDS infection than other members of the population. *See CDC Analysis Provides New Look at Disproportionate Impact of HIV and Syphilis Among U.S. Gay and Bisexual Men*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchhstp/Newsroom/msmpressrelease.html (last visited Dec. 15, 2012).

[57] Christopher D. Man & John P. Cronan, *Forecasting Sexual Abuse in Prison: The Prison Subculture of Masculinity As a Backdrop for "Deliberate Indifference*,*"* 92 J. CRIM. L. & CRIMINOLOGY 127, 128-29 (2001). Man and Cronan emphasize that sexual activity in prison is not a recent phenomenon, citing a 1934 study that found that thirty to forty percent of prisoners were forced to engage in sexual conduct while incarcerated. *Id.* at 128 n.8 (citing JOSEPH FULLING FISHMAN, SEX IN PRISON: REVEALING SEX CONDITIONS IN AMERICAN PRISONS (1934)). Incarcerated women are also commonly subjected to sexual abuse. *See* Angela Y. Davis, *Public Imprisonment and Private Violence: Reflections on the Hidden Punishment of Women*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT, 339, 350 (1998).

among prisoners, Congress passed the Prison Rape Elimination Act.[58] In articulating the need for, and purpose of, the Act, Congress estimated that approximately 200,000 currently incarcerated prisoners will become victims of sexual assault, while the number of prisoners raped in the past twenty years could be as high as 1,000,000.[59] Explicitly linking the high incidence of HIV/AIDS in prison to the risk of transmission of HIV/AIDS and other communicable diseases through sexual assault, the Act refers to sexual assault in prison as "contributing to the spread of these diseases, and often giving a potential death sentence to its victims."[60]

Consensual sex is also prevalent in prisons; while the exact percentage of inmates who engage in consensual sexual activities is unknown, studies have reported an incidence rate as high as sixty-five percent.[61] In 2003 the American Public Health Association (APHA) recognized the discrepancy between stated regulations and actual practice in concluding that, "[r]egardless of institutional regulations, sexual activity occurs . . . [and] may have significant health consequences, which must be recognized and addressed by the health service providers."[62] In at least one instance, a federal court has similarly recognized that "*no* correctional approach can eliminate" high-risk behavior in prisons, including sexual relations between inmates.[63] While certainly not exhaustive, the foregoing summary suggests a number of factors which, when compounded, create a system of incarceration in which prisoners suffer from a significantly heightened risk of HIV/AIDS infection, suggesting the need for a substantial investment in treatment and prevention programs.[64]

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[58] Prison Rape Elimination Act of 2003, Pub. L. No. 108-79, 117 Stat. 972 (codified at 42 U.S.C. §§ 15601-15609 (2006)).

[59] *Id.* § 2.

[60] *Id.* § 2(7).

[61] Kari Larsen, *Deliberately Indifferent: Government Response to HIV in U.S. Prisons*, 24 J. CONTEMP. HEALTH L. & POL'Y 251, 258 (2008).

[62] APHA TASK FORCE ON CORRECTIONAL HEALTH CARE STANDARDS, *supra* note 55, at 86.

[63] Harris v. Thigpen, 941 F.2d 1495, 1520 n.36 (11th Cir. 1991). *Contra* Gibbs v. Martin, No. 01–74480, 2003 WL 21909780, at *4 (E.D. Mich. July 28, 2003) (assuming that inmates abide by rules against sexual activity in rejecting plaintiffs' suggestion that prisons distribute condoms to inmates).

[64] Less than one percent of U.S. prisons provide prisoners access to condoms, a preventative measure used with wide success in other nations. *See* John P. May & Earnest L. Williams, Jr., *Acceptability of Condom Availability in a U.S. Jail*, 14 AIDS EDUC. & PREVENTION 85, 87 (2002). In consequence, prisons exhibit a culture of sexual activity that is generally surreptitious, often violent, and almost always without the benefit of protection. *See* Prison Rape Elimination Act § 2(7); Man & Cronan, *supra* note 57, at 130-32 (discussing the cultural dynamics driving widespread prison rape).

II. TREATING HIV/AIDS IN PRISON

A. *Sweeping Infection Under the Rug: The Historical Treatment of Seropositive Prisoners*

Emerging in the United States in the 1980s, HIV/AIDS was characterized by extreme fear and stigmatization, as misconceptions about the mode of transmission made many fear infection could pass through air or touch.[65] In the early years of the HIV/AIDS epidemic, prisons implemented severe policies like the segregation[66] and public identification of seropositive prisoners – generally through wristbands or stickers on medical records – in lieu of comprehensive treatment plans for prisoners suffering from HIV/AIDS.[67] Narratives emerging from these segregated dorms illustrate instances of inadequate health services and rampant death among the seropositive population.[68] In 1995, some thirty-three percent of deaths in prison were reported as having stemmed from HIV/AIDS-related illnesses.[69] Even as late as 2002, extreme cases showed severe mistreatment and disregard

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[65] ACLU & HUMAN RIGHTS WATCH, *supra* note 24, at 11-12. Early Eighth Amendment litigation related to HIV/AIDS in prison illustrates these fears and misconceptions; these early claims largely focused on issues of casual contact or housing of seropositive alongside negative inmates – both practices which are widely accepted today. *See, e.g.*, Glick v. Henderson, 855 F.2d 536, 538 (8th Cir. 1988); Deutsch v. Fed. Bureau of Prisons, 737 F. Supp. 261, 261 (S.D.N.Y 1990); *cf.* ACLU & HUMAN RIGHTS WATCH, *supra* note 24, at 1 (describing the continued segregation of HIV-positive prisoners in Alabama and South Carolina, the last two states to engage in the now-discredited practice).

[66] Constitutional challenges to segregation were generally brought under the privacy rights implicit in the Fourth Amendment, with prisoners arguing that some inherent aspects of privacy survive beyond incarceration. *See, e.g.*, Lanza v. New York, 370 U.S. 139, 143-44 (1962) ("[E]ven in a jail, or perhaps especially there, the relationships which the law has endowed with particular confidentiality must continue to receive unceasing protection . . . ."). The majority of these cases, however, were either settled or resulted in a finding that such practices are valid to further the penological interests of security and ease of treatment. *See, e.g.*, Onishea v. Hopper, 171 F.3d 1289, 1292 (11th Cir. 1999); *Thigpen*, 941 F.2d at 1498. *But see* Doe v. Coughlin, 697 F. Supp. 1234, 1240-42 (N.D.N.Y. 1988) (enjoining continued segregation as "constitutionally impermissible" because it required revealing private information about the prisoners' medical status and risked "permanently stigmatizing" those impacted).

[67] ACLU & HUMAN RIGHTS WATCH, *supra* note 24, at 13.

[68] FLEURY-STEINER, *supra* note 29, at 2-4. Quoting a report by leading prison healthcare expert Dr. Stephen Tabet, Fleury-Steiner and Crowder described the conditions in an Alabama prison AIDS ward: "'In almost all instances death was preceded by a failure to provide proper medical care or treatment. Consistently, patients died of preventable illnesses. . . . At least one patient had such severe pneumonia that he suffocated in front of the medical staff – despite the patient's requests for treatment, he was not sent to a hospital . . . .'" *Id.* at 19.

[69] ACLU & HUMAN RIGHTS WATCH, *supra* note 24, at 13.

for prisoners segregated into seropositive wards. Describing his first visit to Alabama's Limestone Prison in late 2002, Southern Center for Human Rights Attorney Josh Lipman decried the abhorrent living conditions of HIV/AIDS-positive prisoners:

> The warehouse is literally falling apart around them. The roof has been collapsing, and the rain was leaking in. There are rats and spiders that bite the inmates. They do all of their cooking and living in this warehouse because they are not allowed to associate with the rest of the prison population. The warehouse is located on the other side of the prison from the [medical clinic], so during emergencies, it can take thirty to forty minutes for inmates to be brought there from Dorm 16. . . . [N]umerous inmates had actually died on the route.[70]

B. *Modern Standards of Treatment*

Although extreme examples like that described by Lipman persist, generally there have been significant improvements in HIV/AIDS treatment in prisons. As early as 1988 the U.S. Department of Justice indicated that "AZT [(an early medication for the treatment of HIV)] and other therapeutic drugs that become available should be made available to correctional inmates when medically indicated. Indeed, since AZT has now been approved by the Food and Drug Administration ('FDA'), it *cannot legally be withheld*."[71] In 1995, the Department of Justice published guidelines requiring that medical care for seropositive inmates be in line with "[t]he Centers for Disease Control guidelines, coupled with periodic HIV-guideline updates."[72] In keeping with this directive, the Department of Corrections has since required the treatment of infectious diseases with "a comprehensive approach that includes testing, appropriate treatment, prevention, education, and infection-control measures."[73] The Department of Justice guidelines suggest a widely held understanding among prison administrators that seropositive prisoners must have access to adequate treatment and that denial of such treatment is a constitutional violation.[74] In fact, a clear implication of the Department of

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[70] FLEURY-STEINER, *supra* note 29, at 96.

[71] THEODORE M. HAMMETT, U.S. DEP'T OF JUSTICE, AIDS IN CORRECTIONAL FACILITIES: ISSUES AND OPTIONS 80 (3d ed. 1988).

[72] U.S. DEP'T OF JUSTICE, A JUDICIAL GUIDE TO THE FEDERAL BUREAU OF PRISONS 25 (1995).

[73] 28 C.F.R. § 549.10 (2011) (codifying regulations made effective as of May 20, 2005).

[74] 1 MICHAEL B. MUSHLIN, RIGHTS OF PRISONERS § 4:35 (4th ed. 2009) (citing Gomez v. United States, 899 F.2d 1124, 1126-27 (11th Cir. 1990)). In *Gomez*, the court denied a prisoner's request for release based on the prison system's inability to treat him for HIV/AIDS infection because the appropriate relief would be an injunction "to bring his treatment up to constitutional standards." *Gomez*, 899 F.2d at 1126-27.

Justice's 1988 statements is that such treatment legally must include access to new medications once approved by the FDA.[75]

While there is no federally mandated accreditation procedure for prison healthcare providers, the treatment guidelines articulated by three private organizations – the National Commission on Correctional Health Care (NCCHC), the APHA, and the American Correction Association (ACA) – in combination with those offered by the CDC, generally constitute a medically accepted standard of minimally necessary care.[76] Illustrating an acknowledgment that prison health care should mirror care available to non-incarcerated persons, the NCCHC position statement on the management of HIV/AIDS refers readers directly to the generally applicable community standards promulgated by the U.S. Department of Health and Human Services.[77]

The standards promulgated by the Department of Health and Human Services, in turn, recommend treatment with Antiretroviral Therapy (ART)[78] for all seropositive individuals.[79] Used successfully to halt or significantly slow the progression of HIV since the mid-1990s,[80] ART consists of a combination of several medications that must be taken at least once daily.[81] As

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[75] *See supra* note 71 and accompanying text.

[76] Marc F. Stern et al., *Patient Safety: Moving the Bar in Prison Health Care Standards*, 100 AM. J. PUB. HEALTH 2103, 2103 (2010) (describing the standards set by the NCCHC, the APHA, and the ACA as "set[ting] the bar at an elemental level, trying to ensure the most basic of human rights for prisoners, including access to care," and observing that many prison administrators pursue voluntary accreditation under these standards).

[77] *Position Statements: Administrative Management of HIV in Correctional Institutions*, NCCHC (Oct. 9, 2005), http://www.ncchc.org/resources/statements/admin_hiv2005.html.

[78] ART is also commonly referred to as Highly Active Antiretroviral Therapy, or HAART. While this Note uses ART throughout, quotations from other commentators may refer to HAART. Nearly all modern ART treatments are Highly Active, so the distinction today is insignificant.

[79] PANEL ON ANTIRETROVIRAL GUIDELINES FOR ADULTS AND ADOLESCENTS, DEP'T OF HEALTH & HUMAN SERVS., GUIDELINES FOR THE USE OF ANTIRETROVIRAL AGENTS IN HIV-1-INFECTED ADULTS AND ADOLESCENTS, E1-E2 (2012) [hereinafter PANEL ON ANTIRETROVIRAL GUIDELINES], *available at* http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf (suggesting a regimen of ART therapy for all seropositive patients but stating that the exact drug regimen should be individualized for each patient's needs and dependent upon the progression of HIV exhibited by the individual).

[80] Valdiserri, *supra* note 17, at 480.

[81] *See* PANEL ON ANTIRETROVIRAL GUIDELINES, *supra* note 79, at P1 app. C, tbl.1 (indicating the number of times daily each drug component of common ART therapy regimens must be taken). Of particular importance in ART therapy regimens is strict adherence to dosing schedules as variance from these schedules may result in both disease progression and the development of treatment-resistant strains of viral HIV. *See* Minda Hubbard, *Dealing with the Obstacles in Adhering to Highly Active Antiretroviral Therapy*, 17 J. ASS'N NURSES AIDS CARE 18, 18 (2006).

the aforementioned Department of Justice statement suggests, ART, as an FDA-approved and medically recommended treatment, should be made accessible to all seropositive prisoners.[82]

C. *Standards vs. Practices: Continued Shortages and Inadequate Care*

Despite this articulated standard of care, prisoners often still suffer from inadequate medical treatment and severe shortages of medication caused by the prohibitive costs of providing medication to all eligible patients.[83] The Department of Justice recognized this reality as early as 1988, stating that "serious legal and ethical issues" had arisen because "AZT is extremely expensive, . . . [and] in some [prison] systems, financial constraints have meant that AZT could be offered only to a limited number of qualified inmates."[84] Since the 1980s, the massive increase in the rate of incarceration has exacerbated these cost pressures, often creating severe overcrowding and budget shortages that make adequate provision of ART difficult.[85] Consequently, several studies and reports suggest that medicine shortages and interruptions in care continue unabated in U.S. prisons, with some reports suggesting that only one-third of eligible patients consistently receive treatment.[86] Even where treatment is accessible, there are frequent reports of

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[82] Nick Zaller et al., *Limited Spending: An Analysis of Correctional Expenditures on Antiretrovirals for HIV-Infected Prisoners*, 122 PUB. HEALTH REP. 49, 49 (2007) ("The standard of care in the community and in corrections for the treatment of HIV is highly active antiretroviral therapy (HAART).").

[83] *Id.* at 51 (explaining that in 2004 U.S. correctional facilities spent only twenty-nine percent of the projected $454,877,532 necessary to provide antiretroviral medication to all seropositive prisoners on HIV/AIDS care). For a discussion of the modern costs of incarceration more generally, see Rich et al., *supra* note 3, at 2082 ("State correctional spending has increased by 300% since 1980, to $50 billion annually; it's now the fastest-growing area of government spending after Medicaid. . . . Five states now spend more on corrections than they do on higher education.").

[84] HAMMETT, *supra* note 71, at 80.

[85] *See supra* notes 3-5 and accompanying text for a summary of incarceration rates and resultant overcrowding. For an estimate of the annual per prisoner cost of ART, see Zaller et al., *supra* note 82, at 50 ("The average annual cost of [antiretroviral] treatment in the United States is from $20,000 to $24,000, with an average cost per inmate of $1,863 per month."). Other estimates suggest Zaller's calculations may represent the conservative end of cost estimates. *See* DELGADO & HUMM-DELGADO, *supra* note 45, at 74 ("A 2001 estimate of the costs of providing care to inmates with HIV or AIDS placed the amounts at $80,396 per year for those inmates who were HIV-positive and $105,963 for inmates with AIDS." (citation omitted)).

[86] *See, e.g.*, Jacques Baillargeon et al., *Antiretroviral Prescribing Patterns in the Texas Prison System*, 31 CLINICAL INFECTIOUS DISEASES 1476, 1477-78 (2000) (finding that in the year 1998 only 48.8% of HIV-infected inmates in Texas were prescribed HAART and 31.3% of infected inmates received no antiretroviral therapy of any kind); K. Bernard et al., *Provider Perspectives About the Standard of HIV Care in Correctional Settings and*

interruption or inconsistent availability of medications.[87] Because ART medications require close adherence to a daily regimen, these interruptions can have significantly negative impacts on prisoners' health.[88] Despite such clear deviations from accepted standards of care, however, attempts at litigating Eighth Amendment claims of inadequate HIV/AIDS care while incarcerated have often proved unsuccessful, with courts concluding that such claims fall short of proving the requisite intent to harm on the part of administrators.[89] After summarizing the applicable Eighth Amendment standard, this Note argues that these cases have failed to adequately consider the seriousness of harm and the high level of recognition surrounding such harm among prison administrators, which, when properly considered, suggests a clear constitutional violation.[90]

III. THE CONSTITUTIONAL RIGHT TO HEALTH CARE IN PRISON

A. *The History and Scope of the Eighth Amendment*

The Eighth Amendment to the U.S. Constitution provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor *cruel and unusual punishments inflicted*."[91] Although the text of the amendment provides no explicit requirements to be eligible for its protection, courts have interpreted the Eighth Amendment to apply only to duly convicted prisoners, excluding cases of pre-trial and non-criminal detention.[92] Incorporated against the states

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Comparison to the Community Standard of Care: How Do We Measure Up?, INFECTIOUS DISEASES IN CORRECTIONS REP., Mar. 2006, at 1, 2 ("[T]he polled respondents felt that the HIV care available in community-based clinics and hospitals surpassed that which was available to inmates in correctional facilities."); Zaller et al., *supra* note 82, at 51-52. Similar shortages and failures in treatment have been reported in immigration detention facilities. *See* HUMAN RIGHTS WATCH, CHRONIC INDIFFERENCE: HIV/AIDS SERVICES FOR IMMIGRANTS DETAINED BY THE UNITED STATES 1-3 (2007).

[87] Bernard et al., *supra* note 86, at 4 (indicating response rates which suggest some seventy-one percent of prisoners on ART therapy experience at least some interruptions in treatment); Will Small et al., *The Impact of Incarceration upon Adherence to HIV Treatment Among HIV-Positive Injection Drug Users: A Qualitative Study*, 21 AIDS CARE 708, 710 (2009) (reporting incidents of ART disruption lasting several days during incarceration, particularly during intake and short-term detention).

[88] Valerie E. Stone, *Strategies for Optimizing Adherence to Highly Active Antiretroviral Therapy: Lessons from Research and Clinical Practice*, 33 CLINICAL INFECTIOUS DISEASES 865, 865 (2001) (emphasizing the importance of strict adherence to ART therapy, calling such adherence "pivotal" to the treatment's success, and reporting that recent studies suggest a required adherence rate of ninety-five percent or better).

[89] For a discussion of such cases, see *infra* Part IV.A.2.

[90] *See infra* Part IV.B.

[91] U.S. CONST. amend. VIII (emphasis added).

[92] *See, e.g.*, Ingraham v. Wright, 430 U.S. 651, 670-71 (1977) (holding that the Eighth Amendment does not apply in cases of corporal punishment in schools); Fong Yue Ting v.

via the Fourteenth Amendment's Due Process Clause, the Eighth Amendment's proscription on "cruel and unusual punishment" applies equally in both federal and state penal institutions.[93]

Historically the Eighth Amendment finds its direct precedent in the English Declaration of Rights of 1688 and the constitutions of early American States,[94] which recognized the need to curb unfettered legislative power to prescribe punishment.[95] Early Eighth Amendment cases, consequently, focused on the prohibition of a relatively narrow set of retributive measures, those causing "torture or a lingering death."[96] Since that time, however, the protection offered by the Eighth Amendment has expanded.[97] The Supreme Court has

United States, 149 U.S. 698, 730 (1893) (finding that the Eighth Amendment has "no application" to a case of deportation, as such deportation is not punishment). In *Ingraham*, the Court offered a reasoned explanation for limiting Eighth Amendment cases to criminal conviction based on the amendment's historical development and traditional canons of textual interpretation. *See Ingraham*, 430 U.S. at 664 (restricting the application of the Eighth Amendment's punishment clause to criminal convictions in part based on the "parallel limitations [of] the text['s]" other clauses and in part on its historical foundations in English Law and state constitutions of the original American colonies).

[93] U.S. CONST. amend. XIV, § 1. For an early example of the incorporation of the Bill of Rights – specifically the First Amendment's protection of free speech – against states through the Fourteenth Amendment, see Gitlow v. New York, 268 U.S. 652, 664 (1924) ("The precise question presented . . . is, whether the statute, as construed and applied in this case by the state courts, deprived the defendant of his liberty of expression in violation of the due process clause of the Fourteenth Amendment."). The Eighth Amendment's protections against cruel or unusual punishment have similarly been incorporated, providing protection to persons incarcerated in federal and state penal institutions. *See* Robinson v. California, 370 U.S. 660, 666 (1962) (finding that a state statute criminalizing narcotics addiction, considered by the Court to be a "disease" analogous to mental illness or a sexually transmitted infection, constituted "cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments").

[94] *Ingraham*, 430 U.S. at 664.

[95] *See id.* at 666-67 ("When the Eighth Amendment was debated in the First Congress, it was met by the objection that the Cruel and Unusual Punishments clause might have the effect of outlawing what were then the common criminal punishments of hanging, whipping, and earcropping. The objection was not heeded, 'precisely because the legislature would otherwise have had the unfettered power to prescribe punishments for crimes.'" (citation omitted) (quoting Furman v. Georgia, 408 U.S. 238, 263 (1972))).

[96] *In re* Kemmler, 136 U.S. 436, 447 (1890) ("Punishments are cruel when they involve torture or a lingering death, but the punishment of death is not cruel, within the meaning of that word as used in the Constitution. It implies there something inhuman and barbarous, something more than the mere extinguishment of life."); Anthony F. Granucci, *"Nor Cruel and Unusual Punishments Inflicted:" The Original Meaning*, 57 CALIF. L. REV. 839, 842 (1969) (explaining that the Eighth Amendment was originally intended as a proscription of certain types of punishment akin to the "barbarities of Stuart England").

[97] *See, e.g.*, Weems v. United States, 217 U.S. 349, 373 (1909) (justifying the Court's first explicit recognition that the Eighth Amendment proscribes disproportionately severe

explicitly recognized that a determination of what punishments are considered cruel and unusual must take into consideration "evolving standards of decency that mark the progress of a maturing society."[98] To withstand Eighth Amendment scrutiny, therefore, methods of retributive punishment must recognize evolving conceptions of what means and methods of punishment are contemporarily accepted.[99] Eighth Amendment claims based on inadequate medical treatment are an area particularly susceptible to changing standards, as medical knowledge and standards of treatment continually evolve with new technology and scientific advancements.

B. *Eighth Amendment Claims Based on Inadequate Medical Care*

In the 1970s, public attention increasingly focused on grossly inadequate standards of prison sanitation and health care, including instances where fellow prisoners performed medical and dental surgeries on their peers with no medical supervision.[100] With this increased attention came legal challenges under the Eighth Amendment, bringing the issue of substandard prison healthcare systems to the courts, which were tasked with determining the scope of a prisoner's constitutional right to access medical care and treatment.[101] Finally, in 1976, the Supreme Court articulated a constitutional standard for

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punishments, in part because "[t]ime works changes," and for "a principle to be vital," it "must be capable of wider application than the mischief which gave it birth. This is peculiarly true of constitutions. . . . [O]ur contemplation cannot be only of what has been but of what may be.").

[98] Trop v. Dulles, 356 U.S. 86, 101 (1958) (holding that stripping a person of their nationality is a punishment prohibited by the Eighth Amendment).

[99] *Id.* This principle was first applied to medical care in the 1976 case of *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

[100] B. JAYE ANNO, U.S. DEP'T OF JUSTICE, CORRECTIONAL HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM 9 (2001) ("[B]y the 1970s, various studies and court cases had begun to document institutional atrocities that forced society to question seriously whether the necessities of life were being provided to those behind bars."); William J. Rold, *Thirty Years After* Estelle v. Gamble*: A Legal Retrospective*, 14 J. CORRECTIONAL HEALTH CARE 11, 13 (2008) ("[C]ases in the 1970s . . . revealed horrendous medical conditions in which inmates were used without supervision to perform medical care on their fellows, including pulling teeth, suturing, and performing surgery. Dramatic instances were illustrated in which prisoners died, neglected, covered in maggots, and lying in their own filth.").

[101] *See, e.g.*, Battle v. Anderson, 788 F.2d 1421, 1426-27 (10th Cir. 1986); Finney v. Ark. Bd. of Corr., 505 F.2d 194, 202-04 (8th Cir. 1974); Lightfoot v. Walker, 486 F. Supp. 504, 505 (S.D. Ill. 1980); Jones v. Wittenberg, 330 F. Supp. 707, 718 (N.D. Ohio 1971). At the same time that courts began to test the structural limits of Eighth Amendment guarantees with regard to prison health care, Congress began to recognize a need for federally mandated healthcare standards for penal institutions. *See* COMPTROLLER GEN. OF THE U.S., REPORT TO THE CONGRESS: A FEDERAL STRATEGY IS NEEDED TO HELP IMPROVE MEDICAL AND DENTAL CARE IN PRISONS AND JAILS 6 (1978).

prison health care in *Estelle v. Gamble.*[102] *Estelle* involved a prisoner, J. W. Gamble, who had consistently complained of severe back pain and high blood pressure.[103] Although Gamble was prescribed a series of medications by prison doctors, these medications did not alleviate his condition and Gamble was subsequently punished with "solitary confinement" for refusing to perform light labor due to pain.[104] Gamble argued that this punishment, in conjunction with what he alleged was inadequate medical treatment and incomplete diagnostic services, was a violation of his Eighth Amendment rights.[105]

In *Estelle* the Court held that, because prisoners' incarceration prevented them from unilaterally seeking medical care, modern conceptions of decency required that such care be provided by the penal institution, recognizing that it would otherwise not be available at all.[106] In addition to acknowledging that, in extreme cases, such denial of care would result in "torture or a lingering death," the Court found that even "less serious cases" that would result in "pain and suffering" unrelated to any legitimate penological purpose were against modern standards of decency.[107] Therefore, the Court held that:

> *[D]eliberate indifference* to serious medical needs of prisoners . . . [is] proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.[108]

In so holding, the Court explicitly stated that the Eighth Amendment required that the standards, living conditions, and medical treatment of incarcerated persons be judged against "idealistic concepts of dignity, civilized standards, humanity, and decency."[109]

In applying *Estelle*, courts have generally determined the existence of a prisoner's constitutional right to three separate elements of healthcare services.[110] Deliberate indifference may be evidenced by (1) a denial or undue delay in access to health care;[111] (2) an inadequate opportunity to receive a

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[102] 429 U.S. at 104-05.

[103] *Id.* at 99-101.

[104] *Id.*

[105] *Id.* at 101-02.

[106] *Id.* at 103 ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."). The Court in *Estelle* stated that its holding was consistent with "contemporary standards of decency as manifested in modern legislation codifying" state common law. *Id.* at 103-04.

[107] *Id.* at 103.

[108] *Id.* at 104-05 (emphasis added).

[109] *Id.* at 102 (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)).

[110] *See, e.g.*, ANNO, *supra* note 100, at 46.

[111] As the issue in question in *Estelle*, the right to access health care may be the most

professional medical opinion regarding health issues;[112] or (3) a failure to provide treatments once prescribed by a medical professional.[113] Taking care to cabin the scope of this rule, however, the Court in *Estelle* explained that "deliberate indifference" required a showing of "sufficient[] harm[]" beyond mere negligence or inadvertent mistreatment.[114] The Court further concluded that determinations reasonably within the scope of medical judgment, even if against the interests or wishes of a prisoner, were insufficient to sustain an Eighth Amendment violation.[115] Nonetheless, *Estelle*'s citation to *Williams v. Vincent*, which sustained a finding of "deliberate indifference" where a doctor threw away, rather than attempted to reattach, a severed ear,[116] suggests that access to a *professional* medical opinion implies a requirement that such an opinion be in agreement with accepted standards of medical care.[117]

The right to access professional health care without undue delay, as well as the right to receive prescribed treatments, does not extend to all medical needs. The Eighth Amendment's protection, rather, is limited to only serious medical needs that "ha[ve] been diagnosed by a physician as mandating treatment or . . . [are] so obvious that even a lay person would easily recognize the necessity for a doctor's attention."[118] Although such needs do not have to be life-threatening, they must cause "pain, discomfort, or a threat to good health."[119] Despite this seemingly high standard, however, even elective

direct of these three elements. *See Estelle*, 429 U.S. at 99-103. Claims have been brought under the Eighth Amendment relating to mental health and dental health as well as physical medical services. *See, e.g.*, Brown v. Plata, 131 S. Ct. 1910, 1939 (2011) (recognizing severe delays in mental and physical health services caused by prison overcrowding as violations of the Eighth Amendment); Fields v. Gander, 734 F.2d. 1313, 1315 (8th Cir. 1984) (sustaining an allegation that refusal of dental care may amount to an Eighth Amendment violation).

[112] This cause of action does not reach issues where prisoners disagree with their treatment, as long as such treatment is within the bounds of reasonable, professional standards. "In general, the courts will not determine which of two equally efficacious treatments should be chosen. The adjudication of constitutional claims is not the business of 'second guessing' health care professionals." ANNO, *supra* note 100, at 48.

[113] Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977) ("[A] constitutional claim is stated when prison officials intentionally deny access to medical care or interfere with prescribed treatment."). For more on the right to receive treatment for HIV/AIDS, see Sullivan v. Cnty. of Pierce, No. 98-35399, 2000 WL 432368, at *2 (9th Cir. Apr. 21, 2000) (finding a material question as to whether the denial of a patient's prescribed protease inhibitors (drugs that prevent viral replication) amounted to an Eighth Amendment violation).

[114] *Estelle*, 429 U.S. at 105-06.

[115] *Id.* at 107.

[116] Williams v. Vincent, 508 F.2d 541, 544 (2d Cir. 1974).

[117] *Estelle*, 429 U.S. at 106 n.14 (citing *Williams*, 508 F.2d at 544).

[118] Duran v. Anaya, 642 F. Supp. 510, 524 (D.N.M. 1986).

[119] Morales Feliciano v. Calderon Serra, 300 F. Supp. 2d 321, 341 (D.P.R. 2004); *see also* McNally v. Prison Health Servs., Inc., 46 F. Supp. 2d 49, 54-55 (D. Me. 1999)

surgeries are not excluded per se, but must be considered on a case-by-case basis with due regard to factors such as cost, expected benefit, and term of incarceration.[120]

C. *Application of the* Estelle *Standard to Preventative Health Care*

In *Estelle* the Court clearly established a requirement that prisoners have adequate access to a professional diagnosis and treatment of medical conditions after diagnosis.[121] Application of *Estelle* to the area of preventative care, however, remained less clear. After *Estelle*, lingering questions remained: Did prisoners have a right not just to treatment of existing conditions, but to preventative measures taken to decrease the risk of transmission, contagion, or development of such conditions? Were there some conditions in which a refusal of preventative care for early detection or suppression could, alone, amount to deliberate indifference? The answers to these inquiries, however, were left to subsequent cases.

Five years after *Estelle*, the Court of Appeals for the Second Circuit explicitly considered the scope of the Eighth Amendment's requirement for disease screening upon entry into prison in *Lareau v. Manson*,[122] ultimately finding that a failure to screen incoming inmates could amount to deliberate indifference.[123] In this case, the court reasoned that such "inadequate medical practice" was "sufficiently harmful" to sustain an Eighth Amendment claim despite its focus on prevention rather than treatment of contagious disease outbreaks.[124] Critically, the court's holding also included an explicit statement that a claim alleging inadequate preventative care could be sustained even absent proof that the disease had previously, or was currently, being transmitted within the prison.[125] Subsequent courts that have considered similar issues have also found a requirement to prevent contagion, rather than just treat it after transmission.[126] This requirement of preventative care has

(sustaining against a motion for summary judgment a plaintiff's allegation that denial of HIV medication for several nights showed "deliberate indifference"). With regard to the application of the Eighth Amendment to preventative care, this element of a "threat to good health" will be paramount.

[120] Delker v. Maass, 843 F. Supp. 1390, 1400 (D. Or. 1994) ("[T]he words 'elective surgery' are not a talisman insulating prison officials from the reach of the Eighth Amendment. Each case must be evaluated on its own merits.").

[121] Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977).

[122] 651 F.2d 96, 109 (2d Cir. 1981).

[123] *Id.*

[124] *Id.*

[125] *Id.* ("[I]t is unnecessary to require evidence that an infectious disease has actually spread in an overcrowded jail before issuing a remedy.").

[126] *See* DeGidio v. Pung, 920 F.2d 525, 533 (8th Cir. 1990) (affirming the district court's finding that a prison's failure to stop a tuberculosis outbreak amounted to a violation of the Eighth Amendment).

since formed the basis of arguments that prisoners must be given cancer screenings within a reasonable time period, even if asymptomatic.[127] This application to preventative health care has specific relevance to progressive diseases such as HIV/AIDS, where initial prevention efforts must be coupled with daily preventative treatment to arrest the development of HIV into AIDS even after initial infection. The fact that no post-infection cure exists makes preventative and suppressive measures of this type even more critical, as the sole means for stabilizing the progress of infections and maximizing chances of continued health.

D. *The Meaning of "Deliberate Indifference"*

As established in the 1991 case of *Wilson v. Seiter*, to sustain an Eighth Amendment claim, prisoners must also prove adequate mens rea on the part of the prison administrator allegedly in violation.[128] In *Wilson* the Court sought to explain an apparent disparity between *Estelle*'s "deliberate indifference" standard and the subsequent ruling in *Whitley v. Albers*, which held that only "obduracy and wantonness, not inadvertence or error in good faith," could amount to an Eighth Amendment violation.[129] The respondents in *Wilson* alleged that *Whitley* had overruled *Estelle*'s earlier holding and created a more stringent requirement of intent, whereby only actual knowledge on the part of administrators, not "deliberate indifference," could sustain a constitutional violation.[130] Importantly, however, *Whitley* had involved a claim alleging inadequate access to necessary medical treatment during a prison riot and resulting security lockdown.[131] The Court in *Wilson* distinguished the cases on this ground, reasoning that *Whitley*'s use of a heightened standard was based on the specifics of that case and could not be applied uniformly.[132]

Despite this distinction, an important element of *Whitley*'s central holding survived *Wilson*; to sustain an Eighth Amendment violation prisoners still had

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[127] Kendra D. Arnold, Note, *The Right to Live: A Constitutional Argument for Mandatory Preventative Health Care for Female Prisoners*, 10 WM. & MARY J. WOMEN & L. 343, 343-44 (2004) (arguing that "routine access to preventative measures" to detect breast cancer and cervical cancer in female prisoners is constitutionally required by the Eighth Amendment"). For an extreme case of inadequate care, see *Brown v. Plata*, 131 S. Ct. 1910, 1925 (2011), where the prison failed to screen for cancer even after a prisoner presented with symptoms for over a year.

[128] Wilson v. Seiter, 501 U.S. 294, 298-99 (1991) (requiring "inquiry into a prison official's state of mind" to sustain a claim of cruel and unusual punishment).

[129] Whitley v. Albers, 475 U.S. 312, 319 (1986).

[130] *Wilson*, 501 U.S. at 303.

[131] *Whitley*, 475 U.S. at 314.

[132] *Wilson*, 501 U.S. at 302. In attempting to reconcile "deliberate indifference" with *Whitley*'s standard of wantonness, the *Wilson* Court also reasoned that with respect to denial of medical treatment, "deliberate indifference" was, in itself, wanton. *Id*.

to prove subjective intent on the part of prison administrators.[133] The *Wilson* Court thereby made clear that, for a condition of confinement to amount to cruel and unusual punishment, two elements had to be met.[134] First, courts had to consider the objective element of whether a "deprivation [was] sufficiently serious."[135] Second, courts had to consider whether the actor's state of mind was "sufficiently culpable."[136] The Court held that this second, subjective element was required by the Eighth Amendment's limited proscription of punishment; because the ordinary understanding of punishment is an act taken with the intent to deter or seek retribution, the Court reasoned that it required a "mental element" of deliberate action.[137] Nonetheless, *Wilson* failed to clarify exactly what mental state established deliberate indifference, leaving untouched *Estelle*'s relatively vague holding that acts by prison administrators amounted to deliberate indifference when they were done with less than actual knowledge but were more than an "inadvertent failure" or "mere" medical malpractice.[138]

The 1994 case of *Farmer v. Brennan*[139] provided the Court an opportunity to further articulate the boundaries of deliberate indifference, answering questions about the test's scope previously left open by *Wilson.*[140] The petitioner in *Farmer* was a pre-operative transsexual who claimed that the prison's failure to protect him from repeated violence and rape at the hands of other prisoners in the general population, despite clear knowledge that a small prisoner displaying feminine characteristics would be at increased risk, amounted to an Eighth Amendment violation.[141] While remanding the case for additional factual determinations, the Court articulated a stringent test for "deliberate indifference" which required proof that prison administrators had knowingly disregarded "an excessive risk to inmate health or safety" despite having understood the risks.[142] Claims alleging liability based on a failure to prevent harm must therefore prove that the conditions of incarceration "pos[e] a substantial risk of serious harm."[143] *Farmer*, however, also made clear that

[133] *Id.* at 299.

[134] *Id.* at 303-05.

[135] *Id.* at 298, 303 ("[T]he medical care a prisoner receives is just as much a 'condition' of his confinement as the food he is fed, the clothes he is issued, the temperature he is subjected to in his cell, and the protection he is afforded against other inmates.").

[136] *Id*. at 298.

[137] *Id.* at 300.

[138] Estelle v. Gamble, 429 U.S. 97, 105-06 (1976).

[139] 511 U.S. 825 (1994).

[140] *Id.* at 845.

[141] *Id.* at 830-31.

[142] *Id.* at 837.

[143] *Id.* at 834. *Farmer* applies both to cases of prison health – as part of a line of interpretation stemming from *Estelle* – and to cases concerning prison-to-prisoner violence, in which prisoners allege that prison administrators failed to protect them from a known

such knowledge need not be actual; where a risk is longstanding[144] or obvious,[145] knowledge may be inferred from the surrounding facts. In the case of health care, such a risk may be sufficiently obvious where the harm stemming from a denial of care or refusal of a professional medical opinion is serious or debilitating.[146]

E. *Substantive Due Process Claims When the Eighth Amendment Does Not Apply*

Because the Eighth Amendment only applies to punishment, its protections cannot be invoked by incarcerated persons not yet convicted.[147] Therefore, because individuals in short-term detention facilities awaiting trial are not considered punitively detained, they cannot allege an Eighth Amendment violation.[148] The Supreme Court, in *Bell v. Wolfish*,[149] took up consideration of what protections must be afforded to pre-trial detainees.[150] The Court held that under the Fourteenth Amendment,[151] individuals detained prior to conviction "retain at least those constitutional rights that . . . are enjoyed by convicted prisoners."[152] Consequently, although the constitutional rights of detainees may be restricted to protect the legitimate aims of penological institutions, restrictive measures lacking a legitimate basis amount to an unconstitutional punishment.[153] While this holding set a mandatory floor for

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risk. *See* MUSHLIN, *supra* note 74, § 3:9.

[144] *Farmer*, 511 U.S. at 842.

[145] *Id.* ("[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.").

[146] ANNO, *supra* note 100, at 47 ("In health care, failure to provide access to care, denial of the care that is ordered, or the absence of professional medical judgment in the delivery of medical services will usually satisfy the subjective test of *Farmer* when the unaddressed medical needs are serious.").

[147] *See* City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983) (holding that the "Eighth Amendment has no application" where an individual was injured by police officers during an arrest and required immediate medical care prior to conviction); Ingraham v. Wright, 430 U.S. 651, 671 n.40 (1977) (citing United States v. Lovett, 328 U.S. 303, 317-18 (1946)).

[148] *Ingraham*, 430 U.S. at 671 n.40.

[149] 441 U.S. 520 (1979).

[150] *Id.* at 523.

[151] *Id.* at 535 n.16 ("Due process requires that a pretrial detainee not be punished. A sentenced inmate, on the other hand, may be punished, although that punishment may not be 'cruel and unusual' under the Eighth Amendment.").

[152] *Id.* at 545.

[153] *Id.* at 539 ("[I]f a restriction or condition is not reasonably related to a legitimate goal – if it is arbitrary or purposeless – a court permissibly may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees *qua* detainees.").

the consideration of constitutional claims by pre-trial detainees, it did little to clarify what standard should be applied to claims of inadequate medical treatment prior to conviction, consequently muddying the decision's application in lower courts.[154]

In practice most courts have considered the claims of pre-trial detainees in a manner indistinguishable from claims brought by convicted prisoners.[155] Therefore, whether actionable under the Eighth Amendment or Fourteenth Amendment, an individual must generally prove the same level of indifference to substantiate a claim for inadequate medical care.[156] Despite this lack of substantive distinction, the rights of persons in pre-trial detention deserve particular attention in the context of HIV/AIDS care, specifically because lapses in medical treatment and access to antiretroviral medications occur most frequently during short-term incarceration.[157]

IV. DOES INTERRUPTED OR INADEQUATE TREATMENT CONSTITUTE A VIOLATION?

Having set out the applicable constitutional standard, this Note now turns to whether claims brought by prisoners for inadequate or interrupted antiretroviral treatment amount to a violation of the Eighth Amendment. First, this Part summarizes relevant judicial precedent, seeking to understand why past claims have failed and how future claims can succeed. Considering these precedents

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[154] *See* Leslie B. Elkins, Note, *Analyzing a Pretrial Detainee's § 1983 Claims Under the Deliberate Indifference Standard Amounts to Punishment of the Detainee*, 4 SEVENTH CIRCUIT REV. 91, 100 n.69 (2008) (providing a summary of cases that illustrate the lack of uniformity among lower courts in analyzing claims under *Wolfish*).

[155] *See, e.g.*, Cook v. Sheriff of Monroe Cnty., 402 F.3d 1092, 1115 (11th Cir. 2005) (adopting the same standard for considering claims of pre-trial detainees and convicted prisoners); Board v. Farnham, 394 F.3d 469, 478 (7th Cir. 2005) (finding it both "convenient and entirely appropriate" to apply the same standard to pre-trial detainees' Fourteenth Amendment claims and convicted prisoners' Eighth Amendment claims); Johnson v. Phelan, 69 F.3d 144, 145 (7th Cir. 1995) (stating that in light of *Wolfish*, a plaintiff "does not argue that detainees have rights exceeding those of prisoners following conviction").

[156] For an argument against this conflation of standards, see Elkins, *supra* note 154, at 114-15. An analogy in support of Elkins's argument may be drawn from non-punitive immigration detention; in this context some courts have supported a higher standard of protection than that offered to convicted prisoners. *See, e.g.*, Jones v. Blanas, 393 F.3d 918, 932 (9th Cir. 2004). *But see* Lancaster v. Monroe Cnty., 116 F.3d 1419, 1425 (11th Cir. 1997) (applying an Eighth Amendment standard to a claim stemming from immigration detention).

[157] Freudenberg, *supra* note 3, at 216 (highlighting the shortage of medical services available at jails, which generally house pre-trial detainees and persons sentenced to less than one year of incarceration); Small et al., *supra* note 87, at 710 (describing entry into prison, as well as transfers between facilities during trial, as common instances in which treatment disruption occurs).

against Eighth Amendment standards more generally,[158] this Part then suggests that courts should reappraise claims brought by prisoners for inadequate care, ultimately recognizing a broader conception of "deliberate indifference" based on prison administrators' constructive knowledge[159] of the unique harms stemming from inadequate treatment of HIV/AIDS.

A. *Courts' Consideration of Claims Arising from HIV/AIDS Treatment in Prison*

While the Supreme Court's Eighth Amendment jurisprudence is clear, the Court has generally avoided consideration of cases specifically dealing with the rights of seropositive persons.[160] Moreover, decisions by lower courts evidence a divided record in dealing with claims of inadequate treatment. Although some courts have held disrupted or delayed treatment *may* sustain a constitutional claim, others have denied such claims due to lack of subjective intent to harm on the part of prison administrators.

1. Potential Indifference: Violations Which May Sustain a Claim

In 2000 the Ninth Circuit held that a material question existed as to whether the denial of duly prescribed protease inhibitors, a critical element of ART, amounted to deliberate indifference.[161] In this instance, it was undisputed that the plaintiff was, "for at least 48 to 72 hours, . . . deprived of his medication, although . . . medical officials knew that [he] was in the final stage of AIDS and that he was in dire need of that medication."[162] Further, prison medical officials testified it was "common medical knowledge" that strict adherence to ART is necessary.[163] This case, *Sullivan v. County of Pierce*,[164] recognizes that denial of HIV treatment violates an obvious, "common knowledge" medical need and suggests that deliberateness may be inferred from similar actions in analogous cases.[165]

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[158] *See supra* Part III.

[159] *See* Farmer v. Brennan, 511 U.S. 825, 840 (1994) (recognizing that the "obviousness" of a risk may amount to knowledge on the part of prison administrators).

[160] The first Supreme Court case involving a substantive claim based on HIV-positive status, in which the Court held that respondent's HIV seropositivity was a disability under the Americans with Disabilities Act, was decided in 1998, more than ten years after the discovery of HIV/AIDS. *See* Bragdon v. Abbott, 524 U.S. 624, 641-42 (1998); Michael L. Closen, *The Decade of Supreme Court Avoidance of AIDS: Denial of Certiorari in HIV-AIDS Cases and Its Adverse Effects on Human Rights*, 61 ALB. L. REV. 897, 900-02 (1998).

[161] Sullivan v. Cnty. of Pierce, No. 98-35399, 2000 WL 432368, at *2 (9th Cir. Apr. 21, 2000).

[162] *Id.*

[163] *Id.*

[164] This case is unpublished, limiting its precedential value. *See id.* at *1.

[165] *Id.* at *1-2; *see also* Farmer v. Brennan, 511 U.S. 825, 840 (1994).

Also in 2000, the U.S. District Court for the Eastern District of Virginia evaluated the constitutional implications of a prison's choice to alter a prisoner's drug regimen based on cost considerations rather than medical need.[166] The pro se plaintiff in *Taylor v. Barnett* argued that this switch was done without his knowledge and caused serious side effects, potentially shortening his life expectancy.[167] The court made clear that, while HIV/AIDS was a serious medical need, plaintiffs must do more than establish "mere negligence or malpractice" to meet the subjective-intent requirement of deliberate indifference.[168] Nonetheless, the court reasoned that *if* the change in medication truly occurred only on the basis of cost considerations, then this would form the basis of an actionable claim of deliberate indifference.[169]

In the 1999 decision *McNally v. Prison Health Services*,[170] the U.S. District Court for the District of Maine considered whether a three-day deprivation of a prisoner's prescribed medication amounted to deliberate indifference of a serious medical need.[171] In this instance, the prison admitted it had knowledge of the plaintiff's condition for at least two days, but refused treatment based on administrators' understanding that restarting treatment after disruption might be harmful.[172] The court, reasoning that a jury might find deliberateness in these acts and holding that a delay of treatment was undoubtedly a serious medical need due to its potential cumulative effects, denied summary judgment and concluded that "a genuine dispute exist[ed] as to whether [the prison] was deliberately indifferent to Plaintiff's need for his HIV medication."[173] The court later denied the prison's motion for reconsideration.[174]

2. Invalid Claims Due to a Lack of Deliberateness

Despite these limited instances of support for constitutional claims based on inadequate provision of treatment for HIV/AIDS, most courts have continued to hold such claims non-actionable, arguing that interruptions may amount to

[166] Taylor v. Barnett, 105 F. Supp. 2d 483, 489 (E.D. Va. 2000).

[167] *Id.* at 485.

[168] *Id.* at 487.

[169] *Id.* at 489.

[170] 46 F. Supp. 2d 49 (D. Me. 1999).

[171] *See id.* at 51-52.

[172] *Id.*

[173] *Id.* at 56-57. A number of unpublished decisions have reached similar conclusions, allowing claims to survive summary judgment based on their potential to support an Eighth Amendment violation. *See, e.g.*, Rivera v. Sheahan, No. 97 C 2735, 1998 WL 531875, at *6 (N.D. Ill. Aug. 14, 1998) (allowing a claim where a prisoner became comatose due to missed medications); Roe v. Fauver, No. 88-1225, 1988 WL 106316, at *4 (D.N.J. Oct. 11, 1988) (denying summary judgment based on claims that treatment with AZT was delayed, disrupted, or incorrectly dosed because AZT was the only successful means of treating HIV/AIDS available in 1988).

[174] McNally v. Prison Health Servs., 52 F. Supp. 2d 147, 149 (D. Me. 1999).

malpractice, but not deliberate indifference.[175] For example, in *Perkins v. Kansas Department of Corrections*, the Tenth Circuit considered a claim for deliberate indifference where a plaintiff was given two medications as part of a drug regimen but was denied the third, a protease inhibitor.[176] Because patients may become immune to the impact of other drugs unless accompanied by a protease inhibitor, the plaintiff alleged that he was forced to stop all treatment until such an inhibitor was provided, lest this treatment later become ineffective.[177] The court found this claim unpersuasive, holding that "prison officials have recognized his serious medical condition and are treating it. Plaintiff simply disagrees with medical staff about the course of his treatment."[178] As mere disagreements with the nature of medical treatment cannot sustain an Eighth Amendment claim,[179] the court affirmed dismissal, concluding that the alleged facts amounted to "malpractice" at most.[180] An earlier case from the Western District of New York, *Nolley v. County of Erie*, reached a similar conclusion.[181] Notably, however, the court in *Nolley* did not question the seriousness of the prisoner's need, holding that denial of AZT would always constitute a serious medical need because it was the only medication, at the time, that effectively suppressed the effects of HIV.[182] Therefore, unlike *Perkins*, where the court suggested a simple choice between medications did not amount to a serious medical need, *Nolley*'s holding rested only on a lack of deliberate indifference, not a denial of the significant harm caused by treatment interruptions.[183]

As these cases make clear, courts remain hesitant to question the medical care provided by prisons.[184] Because the standard of deliberate indifference to

[175] *See, e.g.*, Perkins v. Kan. Dep't of Corr., 165 F.3d 803, 811 (10th Cir. 1999).

[176] *Id.* at 807.

[177] *Id.* at 811.

[178] *Id.*

[179] MUSHLIN, *supra* note 74, § 4:10 ("[A]n inmate has no constitutional right to have the treatment he or she prefers."). An unpublished decision from 1998 similarly denied claims based on the court's belief that plaintiffs only alleged a disagreement about the nature or adequacy of a chosen treatment plan. *See* Owens v. O'Dea, No. 97-5517, 1998 WL 344063, at *4 (6th Cir. 1998) ("[The plaintiff's] complaints go to the adequacy of the medical care; they do not fairly suggest that the defendants acted, or failed to act, with deliberate indifference.").

[180] *Perkins*, 165 F.3d at 811.

[181] Nolley v. Cnty. of Erie, 776 F. Supp. 715, 740 (W.D.N.Y 1991) (calling the denial of AZT a serious medical need, but finding no subjective intent to harm).

[182] *Id.*

[183] *Id.*; *cf. Perkins*, 165 F.3d at 811.

[184] In evaluating the claims of prisoners, a governing rule for courts is to "respect hard choices made by prison administrators." Johnson v. Phelan, 69 F.3d 144, 145 (7th Cir. 1995). In the medical context, this idea was clear from *Estelle*'s holding. *See* Estelle v. Gamble, 429 U.S. 97, 107 (1976) (holding that reasonable medical decisions cannot sustain

a serious medical need falls somewhere between negligence and purposeful disregard – it has been described by the Supreme Court as "the equivalent of recklessly disregarding that risk"[185] – claims are most often dismissed for lack of deliberateness on the part of prison administrators.[186] Nonetheless, the recent cases finding a possible Eighth Amendment violation where medical decisions are made purely for cost considerations or with disregard of obvious risks suggest potential room for reevaluating the application of deliberate indifference to cases involving HIV/AIDS treatment.[187] The following Section builds upon this potential, suggesting a framework for re-conceptualizing deliberate indifference to more adequately protect the medical needs of seropositive prisoners.

B. *An Argument for Protection from Inadequate and Disrupted Treatment*

While the cases above evidence limited instances of litigation aimed at ensuring adequate care, they do not answer the concerns expressed by public health officials about widespread medical shortages, with as little as one-third of all eligible prisoners receiving adequate HIV/AIDS treatment while incarcerated.[188] As mass incarceration, high medical costs, and shrinking budgets continue to place pressure on even the most well-intentioned prison administrators,[189] these reports of systemic violations of the medical rights of prisoners require attention. As such, more thorough consideration of the constitutionally mandated standard of treatment for seropositive prisoners is necessary to ensure that constitutional violations do not go unanswered based on flimsy defenses of unawareness or lack of intent.[190]

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a constitutional claim no matter how strongly the patient disagrees with such decisions).

[185] Farmer v. Brennan, 511 U.S. 825, 836 (1994).

[186] *See, e.g.*, *id.* at 847.

[187] Sullivan v. Cnty. of Pierce, No. 98-35399, 2000 WL 432368, at *2 (9th Cir. Apr. 21, 2000); Taylor v. Barnett, 105 F. Supp. 2d 483, 489 (E.D. Va. 2000).

[188] *See* Zaller et al., *supra* note 82, at 52.

[189] *See* FLEURY-STEINER, *supra* note 29, at 63.

[190] Given its far-reaching impact on prison litigation, a short note on the impact of the 1996 Prison Litigation Reform Act (PLRA) is warranted here. Responding to what was seen as a proliferation of non-meritorious cases brought by prisoners, PLRA narrowed inmates' ability to seek judicial relief for prison conditions. *See generally* Prison Litigation Reform Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321 (codified as amended in scattered titles and sections of the U.S.C.) (introducing and modifying statutory requirements for prisoners seeking legal recourse). In addition to requiring that prisoners exhaust administrative remedies, PLRA banned grants of punitive damages in cases alleging only mental or emotional harm. *Id.* § 803(d) (codified at 42 U.S.C. § 1997e (2006)). Prospective relief nonetheless remains available so long as such relief is "narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." *Id.* § 802(a) (codified at 18 U.S.C. § 3626 (2006)). While the impact of PLRA has been a substantial narrowing of

1. Proving the Serious Medical Need

Indifference to a serious medical need is the objective prong of the Court's established test for Eighth Amendment claims of inadequate medical care.[191] As described above, indifference to a serious medical need is generally evidenced in one of three ways: (1) undue delay in providing medical services; (2) denial of access to medical opinions or appointments; or (3) inadequate access to treatment, once prescribed.[192] Because of the nature of HIV, which is a progressive retrovirus that presents as AIDS after reaching late-stage development, medical care for an HIV infection may either be viewed as treatment for an active medical need, or preventative care to arrest the progression to AIDS.[193] A disruption of HIV/AIDS treatment for a patient with a known infection most clearly accords with the third type of claim available under *Estelle*, failure to provide treatments once prescribed by a medical professional.[194] Nevertheless, denial of treatment may alternately qualify as the second type of violation, an undue delay in access to treatment.[195]

In the case of HIV/AIDS, the issue of seriousness may appear obvious; HIV is incurable. Without treatment its effects can be devastating, including AIDS wasting syndrome, opportunistic infections, and increased incidences of deadly co-infections such as pneumonia and Hepatitis C.[196] In fact, some courts have

permissible prisoner litigation, *see* FLEURY-STEINER, *supra* note 29, at 66-67, this Note proceeds on the assumption that this Act would not bar the Eighth Amendment claims described herein for two reasons. First, the majority of claims regarding inadequate treatment are likely to seek injunctive relief in the form of medical treatment, a type of relief still actionable under PLRA. Second, in instances where a prisoner seeks monetary damages, because HIV/AIDS is an incurable disease which invariably results in death if not treated, a claim of physical injury resulting from inadequate treatment should not face significant obstacles.

[191] Connie M. Mayer, *Unique Mental Health Needs of HIV-Infected Women Inmates: What Services Are Required Under the Constitution and the Americans with Disabilities Act?*, 6 WM. & MARY J. WOMEN & L. 215, 233 (1999) ("To prevail on an Eighth Amendment claim, an inmate must prove . . . an objective element, that the deprivation was sufficiently serious . . . .").

[192] *See supra* notes 111-113 and accompanying text.

[193] For a detailed description of treatment aimed at halting the progression of HIV, see *supra* Part.III.C.

[194] Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977) ("[A] constitutional claim is stated when prison officials intentionally deny access to medical care or interfere with prescribed treatment.").

[195] This was the type of claim brought in *Estelle*. *See* Estelle v. Gamble, 429 U.S. 97, 99-103 (1976).

[196] *See* SUSAN SONTAG, AIDS AND ITS METAPHORS 21 (1989) ("AIDS is progressive, a disease of time. . . . Besides the commonest 'presenting' illnesses (some hitherto unusual, at least in fatal form, such as a rare skin cancer and a rare form of pneumonia), a plethora of disabling, disfiguring, and humiliating symptoms make the AIDS patient steadily more

presumed the existence of a serious need and decided inadequate treatment claims only on the basis of subjective intent.[197] Further, given that the Department of Justice has publicly acknowledged the need for all eligible prisoners to have access to modern treatment methods[198] – namely ART[199] – it would seem that cases alleging a failure to provide treatment would easily sustain a finding of serious harm. Nonetheless, such a conclusion cannot be assumed; at least one court, in *Perkins*, suggested that the denial of a single medication forming part of a combination drug regimen is not a violation of care amounting to serious harm.[200] Similarly, where disruptions are short they could potentially be defended as having little or no immediate physical impact. Therefore, the next Section begins by setting out a clear argument for finding a serious medical need, the objective element of the test for deliberate indifference.[201]

Initially, it is important to note that the court in *Perkins* appears to have failed to properly consider the underlying basis mandating strict adherence to a treatment regimen. Namely, even limited deviation from an ART regimen can lead to significant decreases in the regimen's effectiveness due to acquired drug immunity and viral resistance.[202] Minor deviations in dosing threaten to create drug-resistant strands of the HIV/AIDS virus, mitigating the effectiveness of all future treatments.[203] Because of this serious impact, even a short deviation in administering ART cannot be considered part of a reasonable "course of [] treatment,"[204] and it is unclear how administering only a subset of prescribed drugs, made ineffective without a complementary protease

infirm, helpless, and unable to control or take care of basic functions and needs."); Mark S. Dworkin et al., *AIDS Wasting Syndrome: Trends, Influence on Opportunistic Infections, and Survival*, 33 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 267, 267-68 (2003); Vincent Soriano et al., *Care of Patients with Chronic Hepatitis C and HIV Co-Infection: Recommendations from the HIV-HCV International Panel*, 16 AIDS 813, 814 (2002) (estimating a thirty-percent rate of HIV-HCV co-infection in the United States).

[197] *See, e.g.*, Taylor v. Barnett, 105 F. Supp. 2d 483, 487 (E.D. Va. 2000); McNally v. Prison Health Servs., 46 F. Supp. 2d 49, 51-52 (D. Me. 1999).

[198] *See supra* Part II.B.

[199] Zaller et al., *supra* note 82, at 49 (describing ART as the modern standard of care for HIV/AIDS seropositivity).

[200] Perkins v. Kan. Dep't of Corr., 165 F.3d 803, 811 (10th Cir. 1999).

[201] Wilson v. Seiter, 501 U.S. 294, 303 (1991).

[202] *See* Stone, *supra* note 88, at 865; Anne-Marie Cusac, *"The Judge Gave Me Ten Years. He Didn't Sentence Me to Death,"* PROGRESSIVE (July 2000), http://www.progressive.org/mag_cusac10years ("The basic government recommendations for HIV and AIDS medications, as outlined by the National Institutes of Health at the Department of Health and Human Services, urge three-drug combination therapy for all patients with symptoms ascribed to HIV infection. Using a combination of two drugs, or one drug alone, is strongly discouraged." (internal quotation marks omitted)).

[203] Hubbard, *supra* note 81, at 18.

[204] *Perkins*, 165 F.3d at 811.

inhibitor, would ever be an appropriate medical choice. Further, while short-term disruptions[205] may not immediately evidence negative physical symptoms,[206] the progressive nature of HIV means that such disruptions may have a significant and serious cumulative impact both on the patient's health and the effectiveness of future treatments.[207] Even absent outward manifestations of illness, therefore, patients will be more susceptible to secondary infections and less likely to respond positively to future treatments when they experience slight disruptions in their drug regimen.[208]

Given the significant cumulative impact of even small disruptions or deviations in treatment, seropositive prisoners experiencing such erratic and inadequate treatment should clearly be able to meet the objective element of the test for deliberate indifference. Having established the objective seriousness of harm, however, prisoners still must show adequate proof of deliberateness before an Eighth Amendment claim can be sustained.[209] Because the majority of cases to consider the constitutional mandates of treatment for seropositive prisoners have been dismissed for lack of indifference,[210] this Part now turns to three potential arguments intended to illustrate deliberate disregard of an obvious risk.

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[205] *See, e.g.*, Sullivan v. Cnty. of Pierce, No. 98-35399, 2000 WL 432368, at *2 (9th Cir. Apr. 21, 2000) (considering a delay of seventy-two hours); Small et al., *supra* note 87, at 710 (describing common disruptions of several days during initial incarceration or transfer between facilities).

[206] The medical providers in *McNally v. Prison Health Services* evaluated potential physical harms by conducting a blood test to count "viral load." *See* McNally v. Prison Health Servs., 46 F. Supp. 2d 49, 51-52 (D. Me. 1999). Absent such a test, however, the impact of treatment lapses in the plaintiff's early stages of infection may not have been immediately manifested in physical symptoms. *Id.*

[207] Stone, *supra* note 88, at 865 (explaining that effectiveness requires adherence rates of ninety-five percent or better for all dosages).

[208] *See* Hubbard, *supra* note 81, at 19 (explaining the impact of disrupted treatment and resulting increases in viral load). While recognizing that deliberate indifference requires a higher subjective intent than negligence, an analogy to tort law may help illustrate the negative cumulative effect of delayed or disrupted treatment. In tort law, "[i]f the . . . actor is liable for another's injury which so lowers the other's vitality as to render him peculiarly susceptible to a disease, the actor is also liable for the disease which is contracted because of the lowered vitality." RESTATEMENT (SECOND) OF TORTS § 458 (1965). Similarly in the case of a failure to treat a prisoner with HIV/AIDS, even disrupted treatment which has no immediate or observable impact may increase the prisoner's susceptibility to other, future harms or cause a quicker progression from HIV to AIDS.

[209] Wilson v. Seiter, 501 U.S. 294, 298 (1991) (finding that the objective component of an Eighth Amendment claim turns on whether the deprivation was sufficiently serious).

[210] *See, e.g.*, Perkins v. Kan. Dep't. of Corr., 165 F.3d 803, 811 (10th Cir. 1999) (finding that disagreement concerning a prisoner's course of treatment does not "give rise to a claim for deliberate indifference to serious medical needs").

2. Illustrating the Obviousness of Risk

Because the subjective element of the *Estelle* standard requires proof that prison administrators knowingly disregarded a significant risk, this test potentially eliminates otherwise actionable claims based on a defense of mere negligence or misunderstanding.[211] Nonetheless, *Farmer* made clear that an inference of knowledge based on the obviousness of a risk may satisfy the requisite intent requirement necessary to sustain a constitutional violation.[212] Therefore, "prison officials [cannot] . . . insulate themselves from liability . . . by intentionally turning a blind eye or a deaf ear to harmful prison conditions."[213] Consequently, where the danger of inadequate or interrupted treatment for HIV/AIDS is obvious to prison administrators, their constructive knowledge of such a risk alone may prove deliberate indifference if adequate measures are not taken.[214] This Note proceeds to offer three arguments that support a finding of such knowledge in the case of HIV/AIDS treatment. First, knowledge may be constructed out of the widely cited and circulated standards of prison accreditation organizations, such as the NCCHC.[215] Second, knowledge may be based upon other institutional policies related to HIV/AIDS management in prison.[216] Third, the unique nature of HIV/AIDS as a modern health epidemic and the attendant high level of public consciousness suggest constructive knowledge on the part of healthcare administrators.[217]

The first argument for establishing deliberate indifference is based upon the common practice, employed by over 500 prisons, of seeking voluntary medical accreditation.[218] The widespread nature of such accreditation, although not

[211] *See* Estelle v. Gamble, 429 U.S. 97, 105-06 (1976) ("[A] complaint that a physician has been negligent in diagnosing or treating a medical claim does not state a valid claim of medical mistreatment under the Eighth Amendment.").

[212] Farmer v. Brennan, 511 U.S. 825, 840, 842 (1994).

[213] Larsen, *supra* note 61, at 296.

[214] *Id.* ("'[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.'" (quoting *Farmer*, 511 U.S. at 842)).

[215] *Position Statements: Administrative Management of HIV in Correctional Institutions*, *supra* note 77.

[216] As described in detail below, such policies include segregation of seropositive prisoners, HIV testing upon incarceration, and education programs designed to ensure prisoners are aware of the risk associated with HIV/AIDS transmission in prison. *See infra* notes 226-229 and accompanying text.

[217] Valdiserri, *supra* note 17, at 481-82 (describing how the public's understanding of HIV/AIDS and its treatment has changed over time and explaining that there is "greater awareness today that to effectively reduce HIV incidence at a population level, prevention approaches must be multi-modal, complementary, and mutually reinforcing").

[218] *Accreditation*, NCCHC, http://www.ncchc.org/accred/index.html (last visited Dec. 15, 2012) ("NCCHC's voluntary health services accreditation program is well-known and well-respected among the nation's prisons, jails and juvenile detention facilities. Nearly 500 institutions . . . participate in the program, including most of the largest and most innovative

mandated, invariably suggests that prison administrators are aware of the standards and requirements set forth by accreditation organizations.[219] These standards commonly include statements that HIV/AIDS treatment in prison should match the standard of care available to the general population.[220] The relevant portion of the NCCHC position statement reads as follows:

> All medications approved for HIV antiviral therapy and prophylaxis should be on the formulary of the facility. All intake facilities should have a system to assure continuity of HIV medications.
>
> Successful HIV therapy requires that there be no interruption in antiviral medications. Correctional medical programs can assure this necessary continuity by establishing mechanisms to enhance the continuous availability of HIV treatment to infected patients.[221]

Because of the number of institutions seeking guidance and accreditation from the NCCHC and similar organizations,[222] policy statements such as this one suggest recognition on the part of prison administrators of the importance of adequate HIV/AIDS treatment. The APHA's guidelines also articulate specific requirements for treatment of HIV/AIDS, emphasizing that "[p]risons and jail clinicians must keep current with the U.S. Department of Health and Human Services . . . guidelines for the treatment of HIV" and recognizing that "[a]s national treatment standards change, so must the policies and practices in jail and prison health programs."[223]

In the case of HIV/AIDS, however, knowledge comes not just from voluntary accreditation standards and treatment guidelines but from the Department of Justice's own position statements. As early as 1988, the Department of Justice noted that any denial of FDA-approved medication to

in the country.").

[219] Each leading accreditation agency publishes a manual detailing the minimum standard of care required for all incarcerated persons. *See generally* APHA TASK FORCE ON CORRECTIONAL HEALTH CARE STANDARDS, *supra* note 55; NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS (2008); NCCHC, STANDARDS FOR HEALTH SERVICES IN PRISONS (2008).

[220] *See Position Statements: Administrative Management of HIV in Correctional Institutions*, *supra* note 77.

[221] *Id.*

[222] *Accreditation*, *supra* note 218.

[223] APHA TASK FORCE ON CORRECTIONAL HEALTH CARE STANDARDS, supra note 55, at 67. The APHA lists specific requirements for compliance with this standard of care, which include: offering current Department of Health and Human Services recommended treatments (namely, ART), providing for "expert clinical consultation," and developing individualized treatment plans with due attention paid to "previous antiretroviral intervention" and "adherence instruction and assistance." *Id.* at 68. This focus on a prisoner's previous ART therapy and the importance of strict adherence reveals a clear understanding of the negative impact that treatment interruption may have on ART-responsiveness and future treatment outcomes.

eligible prisoners would create "serious legal and ethical issues."[224] There is no indication that the intervening twenty years have altered or alleviated the inherent legal issues caused by denying an adequate standard of care or disrupting duly prescribed treatment. As such, any claim that prison administrators are unaware of the need to provide treatment identical to that available beyond prison walls directly conflicts with over two decades of clear statements to the contrary. This long history, in turn, arguably amounts to constructive knowledge sufficient to satisfy the subjective element of deliberate indifference.

The second argument for a finding of constructive knowledge is based on the vast number of other regulations concerning HIV/AIDS management in the prison system. Prisons commonly engage in HIV testing of incoming prisoners.[225] In addition, prisons have historically undertaken severe measures to segregate seropositive populations for fear of spreading infection.[226] Beyond physical segregation for purposes of housing, such policies commonly denied seropositive prisoners access to education, professional skills, parole, and work-release programs.[227] Severe punishments and additional security measures have also been taken against seropositive prisoners perceived to be a health risk. For instance, after one instance in which he spit at a guard, the plaintiff in *Perkins* was forced to wear a mask whenever he left his cell.[228] These measures, many of which have bordered on hysteria,[229] indicate a wide and implicit acknowledgement of the serious and unique nature of HIV/AIDS infection. In light of these restrictive administrative regulations – which clearly evidence knowledge and fear of HIV/AIDS – a claim by prison administrators that they were unaware of the seriousness of infection and the need for proper treatment rings hollow. The obviousness of the risk, in this

[224] HAMMETT, *supra* note 71, at 80.

[225] John D. Kraemer, *Screening of Prisoners for HIV: Public Health, Legal and Ethical Implications*, 13 MICH. ST. U. J. MED. & L. 187, 199 (2009) (referencing 2004 Department of Justice statistics which show that twenty state prison systems conduct mandatory HIV tests on incoming prisoners while nearly all other state and federal facilities offer voluntary screening); Kim Marie Thorburn, *Health Care in Correctional Facilities*, 163 W. J. MED. 560, 562 (1995) (remarking that as early as 1992, sixteen states and all federal prisons engaged in mandatory HIV testing).

[226] *See* ACLU & HUMAN RIGHTS WATCH, *supra* note 24, at 13-15 (describing historical practices of segregation and public identification of seropositive prisoners).

[227] *See* Onishea v. Hopper, 171 F.3d 1289, 1292 (11th Cir. 1999).

[228] Perkins v. Kan. Dep't of Corr., 165 F.3d 803, 806 (10th Cir. 1999) ("[P]laintiff became angry with two prison guards and then spat on them when he went outside into the prison yard. Since then, plaintiff has been required to wear a face mask that covers his entire head whenever he leaves his cell and he has been denied all exercise outside his cell.").

[229] FLEURY-STEINER, *supra* note 29, at 3 (describing the case of a seropositive prisoner who was forced to scrub his shower stall with pure bleach and then mop the floor back to his cell while nearby prison administrators donned surgical masks).

instance, may arise simply from the daily exposure by prison administrators to the magnitude of prison policies aimed specifically at combating the transmission of HIV/AIDS.

A third constructive-knowledge argument may be developed from the high level of awareness of the effects of HIV/AIDS among the general public. Globally, HIV/AIDS is known as a "generalized epidemic,"[230] and in the United States alone it has lead to over half a million deaths since the 1980s.[231] Even today, almost four percent of deaths in state prisons are caused by HIV/AIDS each year.[232] This is a significant decrease from the thirty-five percent of HIV/AIDS-related deaths witnessed annually by prison administrators in the 1990s.[233] Still, these statistics evidence an unavoidable recognition on the part of prison administrators of HIV/AIDS' effects when not adequately treated. Ongoing exposure to such deaths may necessarily form the basis of constructive knowledge in future cases; prison administrators cannot escape personal exposure to prisoners struggling with HIV infection. Where prison administrators are exposed to such deaths, as well as to the positive impact of proper treatment, their ability to claim unawareness is negated, particularly in light of *Farmer*'s specific acknowledgement that the long-standing nature of a risk may indicate constructive knowledge.[234] Litigation in 2000 referred to the importance of strict ART regimen adherence as "common medical knowledge,"[235] and certainly the previous twelve years have only seen an increase in awareness of HIV/AIDS and its impact.[236] Indeed, nearly all leading health organizations currently offer policy statements regarding the

[230] Valdiserri, *supra* note 17, at 482.

[231] *Thirty Years of HIV – 1981-2011*, *supra* note 1, at 689.

[232] *See* MARUSCHAK, *supra* note 23, at 4.

[233] PETER M. BRIEN & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, BULLETIN NO. NCJ-158020, HIV IN PRISONS 1994, at 1 (1996), *available at* http://bjs.ojp.usdoj.gov/content /pub/pdf/Hivip94.pdf.

[234] Farmer v. Brennan, 511 U.S. 825, 842 (1994).

[235] Sullivan v. Cnty. of Pierce, No. 98-35399, 2000 WL 432368, at *2 (9th Cir. Apr. 21, 2000).

[236] A comprehensive national strategy for the prevention and treatment of HIV/AIDS was first promulgated in 2010. *See* OFFICE OF NAT'L AIDS POLICY, *supra* note 40, at 16. Prior to this date, commentators noted the lack of a coordinated national response, particularly with regard to HIV/AIDS in prison. *See* Larsen, *supra* note 61, at 261 (calling the lack of a comprehensive, national strategy for management of HIV in prison "appalling"); Susan Okie, *Sex, Drugs, Prison, and HIV*, 356 NEW ENG. J. MED. 105, 106 (2007) (discussing shortcomings and lack of coherency in the United States' approach to HIV/AIDS prevention in prison as compared to other developed countries). Even after its announcement, some commentators have questioned whether the national strategy is under-resourced and inadequate to combat domestic rates of HIV/AIDS transmission. *See* Mark Harrington, *A Global Plan to End AIDS Everywhere but at Home*, ATLANTIC (Dec. 1, 2012 10:40 AM), http://www.theatlantic.com/politics/archive/2012/12/a-global-plan-to-end-aids-everywhere-but-at-home/265799/.

treatment and prevention of HIV/AIDS.[237] This evidence of constructive knowledge increasingly suggests that failures to treat HIV/AIDS stem not from ignorance, but from indifference. The three arguments offered above, either individually or in tandem, illustrate an unavoidable acknowledgement on the part of prison administrators as to the risk of HIV/AIDS and the paramount importance of adequate treatment.[238] In light of such knowledge, Eighth Amendment claims seeking to challenge and eradicate the systemic shortages in HIV/AIDS care within prisons[239] must be upheld.

3. Evolving Standards of Decency vs. Legitimate Budget Constraints

The foregoing argument does not take for granted the legitimate hardships that prison administrators may face in balancing the increasing tension between budgetary restraints and necessary treatment programs.[240] Nationwide, financial pressures caused by shrinking state budgets have played havoc on prison administrators' ability to manage the costs of incarceration.[241] This may reasonably lead to an argument that the provision of inadequate medical services to HIV/AIDS-seropositive prisoners does not stem from indifference, but instead from the harsh realities of modern prison systems. Indeed, in *Wilson* the Court recognized that a "'clash with other equally important governmental responsibilities'" may require a heightened standard of deliberateness.[242] Arguably, the financial stewardship of penological institutions could be cast as one such important responsibility, supporting the application of a more stringent standard in light of financial constraints on prison administrators. Critically, however, the competing responsibility referred to in *Wilson* was prison security, not financial concerns.[243] While

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[237] *See, e.g.*, NAT'L INST. OF HEALTH, HIV AND ITS TREATMENT: FACT SHEET 6-8 (2012), *available at* http://AIDSinfo.nih.gov/contentfiles/HIVandItsTreatment_cbrochure_en.pdf; PANEL ON ANTIRETROVIRAL GUIDELINES, *supra* note 79, at E1-E2; WORLD HEALTH ORG., PREVENTION AND TREATMENT OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS AMONGST MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE: RECOMMENDATIONS FOR A PUBLIC HEALTH APPROACH 57-59 (2011), *available at* http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf.

[238] *Farmer*, 511 U.S. at 842.

[239] Baillargeon et al., *supra* note 86, at 1477-78; Zaller et al., *supra* note 82, at 51-52.

[240] Zaller et al., *supra* note 82, at 50 (calculating the average cost of ART treatment, per prisoner, to be over $1800 a month).

[241] Adam Skolnick, *Runaway Prison Costs Trash State Budgets*, FISCAL TIMES (Feb. 9, 2011), http://www.thefiscaltimes.com/Articles/2011/02/09/Runaway-Prison-Costs-Thrash-State-Budgets.aspx#page1.

[242] Wilson v. Seiter, 501 U.S. 294, 302 (1991) (quoting Whitley v. Albers, 475 U.S. 312, 320 (1986)) (distinguishing the standard of indifference applied in *Whitley* from that generally applicable under *Estelle*).

[243] *See id.* (acknowledging that where prison administrators respond to emergency situations, like the prison riot in *Whitley*, a heightened standard of deliberateness is

appropriate budgeting is critically important in prison management, financial concerns cannot be considered as intrinsic to prison administration as security issues, security being the primary purpose of incarceration.[244]

In relation to security concerns, paramount as they are to the overall purpose of incarceration, deference to the decisions of prison administrators may well be warranted. In contrast, however, deference is unfounded where it is used to excuse or explain inadequate treatment due to financial strain. Other means may more effectively combat financial hardship without threatening prisoners' health and well-being. Indeed, the Supreme Court has recently required the state of California to increase early release programs and decrease punitive sentencing for non-violent crimes to remedy overcrowding and budget shortages.[245] This opinion illustrates a careful balance between valid budgetary concerns and the health of prisoners. Ultimately, such financial strain may call into question the United States' larger policies of mass incarceration.[246] It cannot, however, trump the constitutional guarantee that punishment will not violate society's "evolving standards of decency."[247] Given the debilitating nature of HIV/AIDS when left untreated, as well as the recognition that incarcerated persons lack any means by which to seek independent care,[248] modern standards of decency certainly require uniform and adequate access to effective treatment. Therefore, where governmental policies have led to exorbitant increases in prison populations and spiraling healthcare expenses,[249] the costs of such incarceration must, constitutionally, be borne by the state, not the prisoner's body.

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appropriate).

[244] Courts generally accord great deference to the decisions of prison administrators where issues of prison security are implicated. *See, e.g.*, Bell v. Wolfish, 441 U.S. 520, 547-48 (1979).

[245] In 2011, the Supreme Court mandated a reduction in overall prison population to combat constitutional violations in California's prison system. Brown v. Plata, 131 S. Ct. 1910, 1947 (2011). Compare this position, however, with Justice Alito's dissent, which groups security and financial interests together as legitimate interests to be balanced against the need to reduce prison populations. *Id.* at 1959 (Alito, J., dissenting).

[246] Critics argue that mass incarceration stemming from America's "War on Drugs" has not only failed to curb drug abuse but has also had a wide variety of negative impacts on communities and public health. *See, e.g.*, Rich et al., *supra* note 3, at 2083 ("Locking up millions of people for drug-related crimes has failed as a public-safety strategy and has harmed public health in the communities to which these men and women return."). To offer perspective on the scope of mass incarceration, Rich and his co-authors note that the United States has five percent of the world's population but twenty-five percent of the world's prisoners. *Id.* at 2081.

[247] Trop v. Dulles, 356 U.S. 86, 101 (1958).

[248] Fitzke v. Shappell, 468 F.2d 1072, 1076 (6th Cir. 1972) ("[*R*]*estrained by the authority of the state*, the individual cannot himself seek medical aid . . . .").

[249] FLEURY-STEINER, *supra* note 29, at 62-64 (describing how increases in prison populations and inadequate budgetary resources have led many prison administrators to

4. A Final Note on Policy and Prevention

While not the primary focus of this Note, it bears mentioning that other commentators have suggested a corollary argument that focuses on stemming the transmission of HIV/AIDS in prison through the provision of prophylactic devices to prisoners.[250] This argument proceeds on the presumption that a right to preventative care for HIV/AIDS[251] is largely indistinguishable from the established right to preventative treatment for other communicable diseases in prison;[252] while modes of transmission may differ, the duty of penological institutions necessarily remains the same.[253] The prevention of HIV/AIDS diverges only in the method of prevention; because no vaccination or treatment exists, prophylactic devices become the paramount means of reducing transmission.[254]

Although courts have had little opportunity to consider this argument for preventative care, parallels can arguably be drawn from the right to access

privatize health care in an attempt to "do[] prison health care on the cheap").

[250] *See, e.g.*, Larsen, *supra* note 61, at 310; Mark Parts, *The Eighth Amendment and the Requirement of Active Measures to Prevent the Spread of AIDS in Prisons*, 22 COLUM. HUM. RTS. L. REV. 217, 238-39 (1991); Mary Sylla et al., *The First Condom Machine in a US Jail: The Challenge of Harm Reduction in a Law and Order Environment*, 100 AM. J. PUB. HEALTH 982, 983-84 (2010).

[251] It is important to note that HIV/AIDS prevention is not limited to the provision of prophylactics or other medical devices. However, because of this Note's focus on the Eighth Amendment's requirements regarding medical care, discussion has been narrowed here to medical prevention, namely through prophylactics. This decision is not intended to overlook or minimize the importance of broader HIV/AIDS-prevention techniques, such as sexual health education and trainings in prison. Successfully combating the current epidemic of HIV/AIDS in prison requires a holistic approach that combines both medical care and education. The limited scope of this Note, however, suggests that a thorough exploration of the impact and importance of educational or other non-medical treatment plans is best left to others.

[252] *See* Lareau v. Manson, 651 F.2d 96, 109 (2d Cir. 1981) ("[I]t is unnecessary to require evidence that an infectious disease has actually spread in an overcrowded jail before issuing a remedy.").

[253] *Estelle* has been interpreted to encompass all medical needs that "threat[en] . . . good health." *See* Morales Feliciano v. Calderon Serra, 300 F. Supp. 2d 321, 341 (D.P.R. 2004); *see also* DeGidio v. Pung, 920 F.2d 525, 533 (8th Cir. 1990) (finding a potential Eighth Amendment violation for inadequate response to a tuberculosis outbreak).

[254] CDC, CONDOMS & STDS: FACT SHEET FOR PUBLIC HEALTH PERSONNEL 1 (2011), *available at* http://www.cdc.gov/condomeffectiveness/docs/Condoms_and_STDS.pdf; WORLD HEALTH ORG., *supra* note 237, at 32; *Condoms and HIV Prevention: Position Statement by UNAIDS, UNFPA, and WHO*, UNAIDS, http://www.unAIDS.org/en/Resources/PressCentre/Featurestories/2009/March/20090319preventionposition/ (last updated Mar. 19, 2009) ("The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections.").

ART more generally.[255] Antiretroviral treatments are not wholly preventative in nature, but instead are aimed at arresting the progression of HIV before it becomes AIDS.[256] Therefore, such treatments – when conceived as *prevention* of AIDS in persons with weakened immune systems due to HIV seropositivity – can arguably be analogized to a right to adequate medical care for prevention of HIV seroconversion in persons with currently healthy immune systems. A main objection to this argument for preventative care is that prophylactic devices would only stop transmission through sexual activity, which is banned by prison regulations.[257] There is nothing intrinsically contradictory, however, about banning sexual activity in prison and still providing protection for when (not if) these regulations are disregarded.[258] Further, studies conducted in other countries that provide condoms to prisoners show no increased security or safety problems for prison administrators,[259] which suggests that deference for security reasons may be unnecessary here.

Putting constitutional arguments aside, there are also significant policy grounds that support improvements in prevention and treatment of HIV/AIDS among incarcerated populations. Primarily, prison populations are not static, and the impacts of incarceration on a prisoner's health affect not only that individual but also the community to which the prisoner will eventually return.[260] The success of programs aimed at prevention and treatment of HIV/AIDS in prison, therefore, potentially impacts not only the fundamental rights of prisoners but also the health of entire at-risk populations. Commentators have noted the potential for prison systems to serve as a critical intervention point, improving the health of seropositive prisoners by ensuring access to adequate treatment both within and beyond prison walls.[261] Where

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[255] *See supra* Parts IV.B.1-3.

[256] NAT'L INST. FOR HEALTH, *supra* note 237, at 2 ("ART can't cure HIV, but anti-HIV medications help people infected with HIV live longer, healthier lives.").

[257] *See, e.g.*, Gibbs v. Martin, No. 01-74480, 2003 WL 21909780, at *4 (E.D. Mich. 2003) ("Why should the prison provide condoms so prisoners can perform what is prohibited?").

[258] Nearly all federal prisons in Canada distribute condoms, despite maintaining regulations which make sexual activity an administrative violation. Rebecca Nerenberg, *Spotlight: Condoms in Correctional Settings*, 6 HIV & HEPATITIS EDUC. PRISON PROJECT NEWS (Brown Med. Sch. Office of Continuing Med. Educ., Providence, R.I.), Jan. 2002, at 6, *available at* http://img.thebody.com/legacyAssets/30/17/jan02.pdf.

[259] Larsen, *supra* note 61, at 266.

[260] *Id.* at 310 (stating that because ninety-six percent of prisoners are eventually released, health outcomes for incarcerated persons may have a significant effect on public health more broadly).

[261] Josiah D. Rich et al., *Successful Linkage of Medical Care and Community Services for HIV-Positive Offenders Being Released from Prison*, 78 J. URB. HEALTH 279, 280 (2001) ("For many HIV-positive substance abusers, incarceration may be the first opportunity to diagnose HIV infection and to have their health needs addressed . . . . [Such i]nterventions . . . promise to benefit not only the inmates, but also the broader public health.").

prison systems have made concerted efforts to ensure adequate follow-up and access to treatment after release, studies have shown a marked increase in the mental and physical health of recently released seropositive prisoners.[262] In contrast, where intervention in prison is not combined with adequate follow-up upon release, studies have illustrated the likelihood of disrupted treatment[263] and negative health outcomes, such as increased drug resistance.[264] Therefore, in addition to constitutional guarantees, there is a strong policy ground for ensuring adequate HIV/AIDS treatment in prison as a predicate for achieving better public health outcomes more generally.[265]

CONCLUSION

American courts have long struggled to define the nature and scope of constitutional rights afforded to prisoners.[266] Where some rights continue unabridged, others are necessarily bounded by the nature of punishment.[267]

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[262] *Id.* at 279 (summarizing the results of a study evaluating Rhode Island's Project BRIDGE – a leading post-release healthcare access program – and indicating that all study participants were able to access specialty medical services after release).

[263] Rich et al., *supra* note 3, at 2082 (finding that prisoners are often released with only two weeks of medication and no access to primary care outside prison walls); Small et al., *supra* note 87, at 708 (reporting that recent incarceration correlates with a "five-fold increase" in the likelihood of treatment disruption).

[264] Freudenberg, *supra* note 3, at 224 ("Initiating [] treatment for . . . HIV, or other sexually transmitted diseases without adequate follow-up to ensure completion of treatment can lead to the development of drug resistance, a peril to the community as a whole.").

[265] *Id.* at 223 (arguing that mass incarceration since the 1980s has had profound physical and mental-health impacts in marginalized communities); *see also* OFFICE OF NAT'L AIDS POLICY, *supra* note 40, at 9 (describing the destabilizing effects of HIV and incarceration on communities).

[266] Justice Brennan articulated this ongoing struggle eloquently:

> It is thus easy to think of prisoners as members of a separate netherworld, driven by its own demands, ordered by its own customs, ruled by those whose claim to power rests on raw necessity. Nothing can change the fact, however, that the society that these prisoners inhabit is our own. Prisons may exist on the margins of that society, but no act of will can sever them from the body politic. When prisoners emerge from the shadows to press a constitutional claim, they invoke no alien set of principles drawn from a distant culture. Rather, they speak the language of the charter upon which all of us rely to hold official power accountable.

O'Lone v. Estate of Shabazz, 482 U.S. 342, 355 (1987) (Brennan, J., dissenting).

[267] *See generally* JOHN W. PALMER, CONSTITUTIONAL RIGHTS OF PRISONERS (8th ed. 2008). Generally, courts evaluate the scope of constitutional rights retained by prisoners under two guiding principles. The first is that constitutional rights which are not necessarily limited by incarceration survive beyond prison walls. *See* Pell v. Procunier, 417 U.S. 817, 822 (1974). The second, however, recognizes the need for significant deference to prison administrators in their role of ensuring the legitimate ends of mass incarceration. *See* Turner v. Safley, 482 U.S. 78, 85 (1987). For a discussion of these competing principles, with specific focus on the First Amendment, see Peter R. Shults, Note, *Calling the Supreme*

The Eighth Amendment, in contrast, is rare in its recognition that, because incarceration limits an individual's ability to independently access care, the state bears a positive obligation to ensure such care is provided.[268] This right, however, has come under severe strain in the context of HIV/AIDS. Overwhelming increases in prison populations at high risk for infection have combined with shrinking institutional budgets to create significant gaps in the provision of adequate and consistent treatment for HIV/AIDS.[269] Where a prisoner's treatment is irregular or inadequate, serious and irreparable harm may occur. Even single days of lost treatment may compound to create long-term health issues.[270] Nonetheless, establishing a constitutional violation is not without obstacles; under the intent standard a prisoner must show that administrators understood the risk of harm and still refused treatment.[271] Difficulty, however, does not belie a lack of importance, and despite these obstacles this Note has suggested a viable claim may be sustained through reliance on constructive knowledge. Given modern standards of treatment, such as those articulated by prison healthcare accreditation services, this knowledge may be rightly expected of prison administrators. Further, where inadequate care is predicated on administrative decisions regarding the costs of incarceration, particularly in light of massive increases in prison populations, the legitimacy of such policies must be stringently reviewed to ensure that prison budgets are not met at the cost of prisoner health. As this Note has argued, a correct evaluation of deliberate indifference, fully considering the implicit obviousness of the risk arising from inadequate treatment regimens for seropositive prisoners, makes clear that the current level of treatment awarded to many incarcerated individuals amounts to a violation of their Eighth Amendment rights.

Court: Prisoners' Constitutional Right to Telephone Use, 92 B.U. L. REV. 369, 372-79 (2012).

[268] Estelle v. Gamble, 429 U.S. 97, 103 (1976) ("[A]n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.").

[269] Bernard et al., *supra* note 86, at 2; Zaller et al., *supra* note 82, at 51-52.

[270] *See* Stone, *supra* note 88, at 865.

[271] Wilson v. Seiter, 501 U.S. 294, 298-99 (1991).