

**A BREEDING GROUND FOR COMMUNICABLE  
DISEASE: WHAT TO DO ABOUT PUBLIC HEALTH  
HAZARDS IN NEW YORK PRISONS**

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## INTRODUCTION

Historically, federal and state governments have had broad power to act in the face of a possible outbreak of disease to protect public health.<sup>1</sup> In the case of jails and prisons, the issue is not solely whether the government's actions are too pervasive as to constitute an infringement on individual rights; but also the failure to act that is threatening the individual's and the public's health. Prison officials have purposely allowed inmates to be exposed to communicable diseases, failed to provide treatment or report known diseases, and are permitted to double-up inmates in cells designed to house only one inmate at a time. Inmates with an infectious disease are also treated with bias and stigma because their rights are not seen to be as important as the rights of free individuals.<sup>2</sup>

In the United States, prisoners have limited health care rights and have the right to be free from cruel and unusual punishment.<sup>3</sup> Allowing communicable diseases to flourish in prisons, and go untreated, will inevitably have a negative impact on the public's health and safety. Leaving diseases untreated may cause the formation of a strand of the disease that is resistant to existing treatments, and because many incarcerated individuals will one day reenter their communities, this may open the door to further spread of disease outside prison walls.<sup>4</sup>

Because prisons are not closed communities, people are constantly detained and released, and prisoners are in close contact

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<sup>1</sup> See *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (upholding compulsory vaccination legislation to prevent the spread of smallpox). The Court emphasized that “[a]ccording to settled principles the police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.” *Id.*

<sup>2</sup> Zulficar Gregory Restum, *Public Health Implications of Substandard Correctional Healthcare*, 95 AM. J. PUB. HEALTH 1689, 1690 (2005).

<sup>3</sup> See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (“[D]eliberate indifference to the serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ proscribed by the Eighth Amendment.”) (citation omitted).

<sup>4</sup> Restum, *supra* note 2, at 1689.

with one another, visitors, and prison staff every day.<sup>5</sup> The spread of communicable diseases in prison will affect anyone who may enter the facility, including fellow prisoners, guards, medical personnel, family and friends, and law enforcement.<sup>6</sup> A member of the community may enter the prison and contract the disease from contaminated persons or objects, and then bring the disease back into the community. From the public health perspective, the risky environment in prisons poses a threat of the mass spread of disease, and therefore, the treatment of contagious diseases in prison must be reformed for the protection of the general public.<sup>7</sup>

There is a historical trend of ineffectual public health mechanisms in prisons nationwide. In New York, there is a question of whether the current laws governing communicable diseases in prison are appropriate given the prevalence of communicable diseases and its ability to spread. The current policies are problematic because they lack uniformity and proper education methods. Also, the current laws allow for double-celling and over-crowding. The laws lack systematic surveillance of prisoners, fail to include proper mandates for prison officials, and do not allow for follow-up health care after release from prison.

In response, all prisons must adopt a preventive plan in which all incoming inmates are screened for diseases and educated on the symptoms and risk factors associated with communicable diseases. Further, there needs to be a monitoring plan to ensure inmates with a communicable disease are properly treated and confined and an action plan in which prison officials act swiftly and uniformly to remove infected individuals and get them the treatment they need.<sup>8</sup> It is also essential to set up a post-release health care plan in order to follow up with inmates who have re-entered society carrying a communicable disease.

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<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> *Id.* at 1691.

<sup>8</sup> *Id.*

Additionally, society as a whole has a need to be healthy, robust, and free from disease. The State must target prisons, where a large class of individuals live and work in extremely close quarters with one another, in order to prevent the mass spread of communicable diseases throughout the entire population at large.<sup>9</sup> In pursuing the State's interest in maximizing the public good and preventing the spread of disease, when issuing new mandates, the State must not improperly infringe on an inmate's liberty interests.

Section I of this Comment outlines the profile of a typical inmate and the history of communicable diseases in prisons, specifically HIV/AIDS, hepatitis C, and tuberculosis. Section II details the federal and New York State laws that are currently applicable to communicable disease control, and hints at the inadequacies of New York law. Section III analyzes the rights of the individual and the State's interests in disease control and prevention within correctional facilities. Section IV restates shortcomings discovered through the analyses in Sections II and III. Finally, Section V suggests some possible reforms to remediate the inadequacies in prison health care administration.

## **I. HISTORY OF THE COMMUNICABLE DISEASE ISSUE IN PRISONS**

The issue of how to deal with communicable diseases in jails and prisons has been a historical problem throughout the United States. There is a difference between jails and prisons; while jails are designed for pretrial detention or sentences of less than one year for low-level felonies, prisons are for convicted felons with sentences longer than one year.<sup>10</sup> Much of the problem stems from the fact that the United States has the highest incarceration rate in the world and there is an extremely high rate of recidivism, impacting the populations of both state and federal prisons.<sup>11</sup> In 1980, the average daily inmate population of prisons

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<sup>9</sup> *Id.* at 1689.

<sup>10</sup> Jordan B. Glaser & Robert B. Greifinger, *Correctional Health Care: A Public Health Opportunity*, 118 *Annals Internal Med.*, 139, 139 (1993).

<sup>11</sup> Restum, *supra* note 2, at 1689.

and jails in the United States was 500,000, which increased to almost 1.2 million in 1990.<sup>12</sup> The ‘public policy of mandatory sentencing for drug offenders’ caused most of the recent increase in jail and prison populations.<sup>13</sup> As of 1993, “the proportion of drug offenders in the Federal Bureau of Prisons [was] expected to increase from 47% in 1991 to 70% by 1995”.<sup>14</sup> There was also a significant increase in the total number of inmates in both state and local systems; for example, New York’s prison population more than doubled from 20,000 in 1979 to 59,000 in 1991.<sup>15</sup> Therefore, almost 10 million inmates are released from jail every year because of the short lengths of their sentences.<sup>16</sup> Many prisoners entering the facilities come from impoverished neighborhoods where cases of HIV/AIDS, tuberculosis, and hepatitis C are prevalent.<sup>17</sup> The overcrowded conditions, inadequate screening and substandard treatment programs contribute to the spread of communicable diseases in prison.<sup>18</sup> The practice of “double-celling” poses a substantial risk of spreading disease, especially through sharing razor blades and both consensual and nonconsensual sex between prison cellmates.<sup>19</sup> As mentioned earlier, even though prisoners are secured from the outside community, these facilities are open communities because of the flow of free individuals between the facility and the outside world.<sup>20</sup> Therefore, untreated inmates pass their communicable diseases to visiting friends and family members, other prisoners, prison administrators, and guards within the prison.<sup>21</sup> Many inmates eventually leave prison and return to

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<sup>12</sup> Glaser & Greifinger, *supra* note 10, at 139.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> Restum, *supra* note 2, at 1689.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

the community, which leads to a continuing risk of infecting family, friends, and even strangers.<sup>22</sup>

It seems obvious that health care in prisons is extremely important to the public health, but reform of the correctional health care system is slow and ineffective. In 1972, an American Medical Association (AMA) survey of jail health services showed only 6% of facilities conducted routine physical examinations on incoming inmates.<sup>23</sup> A 1983 survey of juvenile detention and correctional facilities showed that about 39% of the facilities lacked initial medical screening and almost 20% did not have a regular sick call.<sup>24</sup> In a study about the burden of infectious diseases on inmates and ex-convicts, of the United States population diagnosed with HIV/AIDS, 20-26% of those individuals passed through a correctional facility in 1997; also, 29-43% of the U.S. population infected with hepatitis C, and 40% of the U.S. population with tuberculosis passed through correctional facilities.<sup>25</sup> The authors of this study noted that because of a lack of systematic surveillance of this critical population, “it is impossible to develop precise statistics”.<sup>26</sup> The lack of attention to prison health can be attributed to the attitude of the general public, including prison staff and health care professionals.<sup>27</sup> Prisoners tend to be viewed as “subhuman” and as people who gave up their rights because they were convicted of a crime.<sup>28</sup> According to Restum, “[t]his mental-

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<sup>22</sup> *Id.*

<sup>23</sup> Glaser & Greifinger, *supra* note 11, at 141. The American Medical Association is an organization which provides health information to physicians “by collecting, maintaining, and disseminating primary source physician data” and “report[ing] selected statistics on the population of physicians and the practice of medicine.” *About AMA: Physician Data Resources*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama/pub/about-ama/physician-data-resources.page?> (last visited May 23, 2011).

<sup>24</sup> *Id.*

<sup>25</sup> Theodore M. Hammett et al., *The Burden of Infectious Disease Among Inmates of and Releasees from US Correctional Facilities*, 1997, 92 AM. J. PUB. HEALTH 1789, 1792 (2002).

<sup>26</sup> *Id.*

<sup>27</sup> Restum, *supra* note 2, at 1690.

<sup>28</sup> *Id.*

ity, fueled by political rhetoric, leads to the erection of barriers that affect the delivery of health care to prisoners.”<sup>29</sup> This problem is attributed partly to the federal court’s historical “hands off attitude” towards issues in prison administration.<sup>30</sup> Some reasons for the court’s reluctance to get involved are the general unwillingness to supersede state action and the fear that undertaking the issue of health care in prison would bombard the federal court system.<sup>31</sup> Because of this, prison officials enjoyed privacy in unquestioned policies until a shift in society’s attitudes towards prisoners during the civil rights and antiwar movements of the 1960’s and 1970’s.<sup>32</sup> A group of publicly funded attorneys created strategies forcing prison administrators to justify policies and prove that the “regulation or practice in question furthers an important or substantial government interest.”<sup>33</sup> The AMA was also given a grant in 1975 to survey thirty jails in order to improve health care in varying types of facilities nationwide.<sup>34</sup> The results of this survey showed that the entire setting of prison health care was at fault; for example, 6% of the jails surveyed did not have a first aid kit and less than 33% of the jails had any written policies governing health care delivery to inmates.<sup>35</sup> In light of the efforts of the legal services attorneys, and in response to the shocking results of the AMA survey, the federal courts finally got involved in order to declare a legal standard that would improve prison conditions without overburdening the court system.<sup>36</sup> The Supreme Court confirmed a prisoner’s constitutional right to medical care

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<sup>29</sup> *Id.*

<sup>30</sup> Nancy Neveloff Dubler, *Depriving Prisoners of Medical Care: A ‘Cruel and Unusual’ Punishment*, HASTINGS CTR. REP., Oct. 1979, at 7.

<sup>31</sup> *Id.* at 8.

<sup>32</sup> *Id.* at 7.

<sup>33</sup> *Id.* (quoting *Procunier v. Martinez*, 416 U.S. 396, 413 (1973)).

<sup>34</sup> *Id.* at 8.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

and ruled that an alleged violation of this right should be measured against a standard of “deliberate indifference.”<sup>37</sup>

Though the prisoners’ right to medical care has been recognized, there are still shortcomings that stunt the prison health care systems’ ability to control and treat diseases in such a target community. Currently, there are over two million people incarcerated in the United States.<sup>38</sup> In prisons, rates of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and tuberculosis are constantly higher than the rates of these diseases in the general population.<sup>39</sup> Each year, almost one out of four people with HIV in the United States pass through the correctional system, and one out of three hepatitis C-infected persons are incarcerated.<sup>40</sup> Though some historical development has been made in recognizing problems within the correctional health care system, more preventive steps need to be taken in order to reach the public health goal of averting the passage of communicable diseases between low income communities, jails and prisons, and the general public.

### A. Profile of the Inmate Population

The prison population in the United States consists of both males and females. Many of the two million prisoners in the United States are males between the ages of 18 and 44 and lack the employment and educational opportunities provided to the general public.<sup>41</sup> The male inmates live on “the margins of social existence” and come from chiefly migrant and minority communities where there is a high risk of contracting disease and the least opportunity for proper treatment and timely diagnosis.<sup>42</sup> Of the two million people incarcerated, over 101,000 of them are women,

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<sup>37</sup> *Id.* (quoting *Estelle v. Gamble*, 429 U.S. 97 (1976)).

<sup>38</sup> Timothy P. Flanigan et al., *HIV and Infectious Disease Care in Jails and Prisons: Breaking Down the Walls with the Help of Academic Medicine*, 120 TRANSACTIONS AM. CLINICAL & CLIMATOLOGICAL ASS’N 73, 74 (2009).

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> Restum, *supra* note 2, at 1689.

<sup>42</sup> *Id.*



which amounts to about 7% of the total number of inmates.<sup>43</sup> Inmates in general are often “poor, undereducated, and over-represented by minorities” and many times, their communities have limited access to medical care, especially primary care and disease prevention services.<sup>44</sup>

Prisons are a microcosm of society; they are filled with people who have victimized others, but who are often victims of poverty and racism themselves.<sup>45</sup> Most inmates are not violent criminals, rather are imprisoned for substance related violations; this is attributed to the fact that many inmates come from communities where drug and alcohol abuse is common.<sup>46</sup> Many of the actions of these non-violent criminals can be attributed to the fact that they come from the bottom rung of society and lack the opportunity or ability to become productive citizens.<sup>47</sup> Once he enters prison, the inmate’s living environment stays substantially the same as his community, in one respect: “[t]he impoverished environments of prisons are breeding grounds for hepatitis C, TB, and HIV/AIDS; drug abuse; and violence.”<sup>48</sup> In attempting to provide health care to inmates, health care professionals tend to undertake unnecessary tasks such as shackling hospitalized prisoners to their beds, often because of the myth that all prisoners are violent.<sup>49</sup> In light of this misconception, it is important to look at the profile of inmates to ensure that the correct procedures are being utilized to enhance prisoner health. Next, this Comment will turn to a statistical overview of the most prevalent communicable diseases in prison: HIV/AIDS, hepatitis C and tuberculosis.

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<sup>43</sup> Vivienne Heines, *Speaking Out to Improve the Health of Inmates*, 95 AM. J. PUB. HEALTH 1685, 1685 (2005).

<sup>44</sup> Glaser & Greifinger, *supra* note 11, at 139.

<sup>45</sup> Restum, *supra* note 2, at 1689.

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* at 1691.

<sup>49</sup> *Id.*

### 1. HIV/AIDS

There was an “explosion” of HIV/AIDS cases in United States prisons when the HIV/AIDS epidemic peaked in the 1980’s, and the correctional health care system was slow to react.<sup>50</sup> Since the peak in the 1980’s, the number of inmates with HIV/AIDS has been steadily rising. The cumulative number of correctional inmates in the United States with HIV/AIDS went from 325 cases in 1985 to 4,588 cases in 1994.<sup>51</sup> In state and federal systems in 1994, the aggregate incidence of AIDS was 518 cases per 100,000 people, which increased from 362 cases per 100,000 in 1992.<sup>52</sup>

The incidence rate of AIDS in correctional facilities is much higher than the rates among the total general population because there is a high concentration of people with risk factors for HIV infection.<sup>53</sup> For example, sex, tattooing, and injection drug use, though prohibited in correctional facilities, are high-risk activities that still occur among inmates.<sup>54</sup> Because condoms are not readily available in the correctional system, there are many instances of rape and nonconsensual sex.<sup>55</sup> Further, although studies have shown that injection drug use is less prevalent within prison walls than on the outside, it presents a higher risk because of a shortage of materials, causing inmates to share needles and other drug paraphernalia.<sup>56</sup> Inmates resort to the use of pieces of light bulbs or pens to inject drugs into their bodies<sup>57</sup> and this unsterile use of everyday items to inject drugs poses a high risk of contamination. Due to the shortage of sterile needles, the practice of tattooing in prisons<sup>58</sup> is “often done with guitar strings” or other needle substitutes; the shared use of ink and guitar strings severely

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<sup>50</sup> *Id.* at 1690.

<sup>51</sup> RONALD L. BRAITHWAITE ET AL., PRISONS AND AIDS: A PUBLIC HEALTH CHALLENGE 6 (1996).

<sup>52</sup> *Id.* at 8.

<sup>53</sup> *Id.* at 7.

<sup>54</sup> *Id.* at 11.

<sup>55</sup> *Id.* at 11-12.

<sup>56</sup> *Id.* at 12.

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

increases the risk of HIV transmission.<sup>59</sup> In light of the underground activities that frequently go undetected in jails and prisons, voluntary testing does not capture the most reliable estimates of the prevalence of HIV among inmates.<sup>60</sup> Instead, mandatory testing of all inmates (including the incoming, current, and ex-offenders who have been released) and blinded epidemiologic studies have proven to be more effective in capturing the influence of HIV in correctional facilities.<sup>61</sup> For example, during the early nineties in New York it was discovered that blind studies of incoming inmates revealed higher rates of positive HIV tests than testing by request: blind testing showed 15% to be HIV positive instead of 7.5% for males, and 20% instead of 13.4% for females.<sup>62</sup>

Though the prevalence rate of HIV is often higher among female inmates, most inmate deaths attributed to AIDS occur among men.<sup>63</sup> In 1994, 96% of the total number of AIDS deaths and 91% of the total AIDS cases were found among males.<sup>64</sup> Yet, the aggregate rate of AIDS in state and federal correctional facilities is higher for women at 705 cases per 100,000, in contrast to 464 cases per 100,000 for men.<sup>65</sup> This can be attributed to the fact that incarceration rates are steadily rising for women and that women are more likely to use drugs than men.<sup>66</sup> Factors such as crack use, injection drug use, economic dependency, and unsafe sex practices have elevated women's risk of contracting HIV/AIDS.<sup>67</sup>

Furthermore, studies show disproportionate distributions of AIDS among racial and ethnic groups. In 1994, a survey of

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<sup>59</sup> *Id.*

<sup>60</sup> *See id.* at 8.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at 9.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.* at 9-10.

<sup>65</sup> *Id.* at 10.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

correctional facilities revealed the median percentages of AIDS cases as 43% of those diagnosed with AIDS were black, 38% white, and 13% Hispanic.<sup>68</sup> Among the total United States population, the distribution of individuals diagnosed with AIDS was 50% white, 32% black and 17% Hispanic.<sup>69</sup> In New York State, 41% of the inmates with AIDS were black, 12% white, and 47% Hispanic.<sup>70</sup> This overrepresentation of minorities in AIDS cases is attributed to underlying conditions which subject minorities to high-risk behavior such as discrimination, socioeconomic status, lack of opportunity, and other social determinants such as drug addiction.<sup>71</sup> HIV is a serious problem in correctional facilities because of the prevalence of high-risk groups and their fluid movement between prisons and high-risk communities. In 1997, 20-26% of people infected with HIV passed through a correctional facility within that year, which amounts to 150,000-200,000 people.<sup>72</sup>

## 2. Hepatitis C and Tuberculosis

Similar to HIV/AIDS, hepatitis C (HCV) is a disease that is prevalent among inmates in correctional facilities. In 1997, 17-25% of inmates and releasees were infected with HCV.<sup>73</sup> This amounts to 303,000-446,000 inmates infected with HCV and 1.3-1.9 million of those infected with HCV who had recently been released from jail or prison.<sup>74</sup> This estimate suggests that 29-43% of people with HCV passed through the United States correctional system during that year.<sup>75</sup> In 2000, it was reported that about 1.4 million people infected with HCV pass through the correctional system each year.<sup>76</sup> About 20-40% of prison inmates in 2005 were

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<sup>68</sup> *Id.*

<sup>69</sup> *Id.* at 10-11.

<sup>70</sup> *Id.* at 11.

<sup>71</sup> *Id.* at 17-18.

<sup>72</sup> Hammett et al., *supra* note 25, at 1791.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> Restum, *supra* note 2, at 1690.

infected with HCV.<sup>77</sup> Like HIV/AIDS, HCV is spread through blood and the exchange of human fluids; a large number of the infections can be attributed to the common use of injected drugs in prisons.<sup>78</sup> HCV can be spread through “sex, blood transfusions, needle sharing, and” physical altercations both within and beyond the prison setting.<sup>79</sup> According to Phyllis Beck, the cofounder of the Hepatitis C Prison Coalition, the risk factors are significantly multiplied in crowded conditions such as in prisons; therefore, “[o]ur state prisons have become a state-sponsored incubator for HepC, by default.”<sup>80</sup>

Tuberculosis (TB) is another of the most prevalent communicable diseases found in jails and prisons. The increase of TB in correctional facilities can be attributed to the increase in TB within society at large. From 1985 to 1990, “28,000 excess cases” of active tuberculosis occurred in the general population, with the largest increases occurring in cities “with populations over 250,000, such as New York City.”<sup>81</sup> For example, in 1991, New York City reported more than 4,000 active cases of tuberculosis with 30% of these patients resistant to at least one of the drugs used to treat the disease.<sup>82</sup> Among New York State inmates, the incidence of active tuberculosis “increased from 15 per 100,000 in 1976 through 1978 to 139 per 100,000 in 1993.”<sup>83</sup> The tuberculosis infection rate was about 20% in the early nineties, compared to the 13% HIV rate among inmates.<sup>84</sup> There is an association between tuberculosis and HIV; for example, 53% of inmates with tuberculosis in 1985 and 56% of inmates in 1986 also acquired

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<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* (footnote omitted).

<sup>81</sup> Glaser & Greifinger, *supra* note 11, at 140.

<sup>82</sup> *Id.* at 140-41.

<sup>83</sup> Kyle Steenland et al., *Incidence of Tuberculosis Infection among New York State Prison Employees*, 87 AM. J. PUB. HEALTH 2012, 2012 (1997).

<sup>84</sup> *Id.*

HIV/AIDS.<sup>85</sup> Though there is an association between tuberculosis and HIV/AIDS, tuberculosis is an airborne disease<sup>86</sup> and therefore can be transmitted without actual contact, unlike HIV and hepatitis C. Tuberculosis “thrives among people who live in close quarters with poor ventilation”<sup>87</sup>; simply being present in a correctional facility, without taking any overt actions, significantly increases one’s chance of catching tuberculosis through shared breathing air.

Therefore, “[p]risons offer the optimum environment for the growth of TB.”<sup>88</sup> Next, this Comment examines the laws currently applicable to communicable disease control in prisons and to the individual rights that may be implicated.

## II. CURRENT LAWS APPLICABLE TO COMMUNICABLE DISEASE AND RELATED ISSUES IN CORRECTIONAL FACILITIES

New York currently has few laws in place regarding communicable diseases in correctional facilities. According to § 141 of New York State Correction Law, in case of an outbreak of a contagious disease, “the commissioner of correction *may* cause the inmates confined in such a facility, or any of them, to be removed to some suitable place of security”.<sup>89</sup> In other words, the law allows the commissioner to use discretion in deciding whether isolation, confinement, or removal is appropriate during an outbreak within the facility. Further, § 23 of New York’s Correction Law gives the power to transfer inmates between correctional facilities to the commissioner of correction; he must first order the transfer and then the superintendent is in charge of taking “immediate steps to make the transfer.”<sup>90</sup> In order for inmates to receive treatment in outside hospitals, the superintendent must recommend the

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<sup>85</sup> M. Miles Braun, et al., *Increasing Incidence of Tuberculosis in a Prison Inmate Population*, 261 J. AM. MED. ASS’N 393, 395 (1989).

<sup>86</sup> Restum, *supra* note 2, at 1690.

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> N.Y. CORRECT. LAW § 141 (McKinney 2003) (emphasis added).

<sup>90</sup> *Id.* at § 23(1).

treatment, it must be “by reason of inadequate facilities within the institution”, and the commissioner must then use his discretion to grant a written order to allow the inmate to receive diagnosis and treatment.<sup>91</sup> The statute focuses on lack of facilities rather than the need for treatment and containment of disease. Further, Correction Law § 70 sets out rules governing the establishment, use, and designation of correctional facilities in New York.<sup>92</sup> It states the intended use of correctional facilities is to provide confinement and treatment programs: “[s]uch use shall be suited, to the greatest extent practicable, to the objective of assisting sentenced persons to live as law abiding citizens.”<sup>93</sup> The department *may* establish any type of treatment program which is consistent with the law, while keeping in mind “[t]he safety and security of the community”, “[t]he right of every person in the custody of the department to receive humane treatment”, and “[t]he health and safety of every person in the custody of the department.”<sup>94</sup> In order for the commissioner to add to a correctional facility, there must be a need and appropriate funds available for that specific purpose.<sup>95</sup> Each correctional facility should be specified by its name, location, sex of the intended inmates, and the classification of the facility.<sup>96</sup> The classifications include diagnostic and treatment centers, but it does not specify a facility for treatment and confinement of communicable disease.<sup>97</sup>

New York also has general statutory provisions governing the powers and duties of the State in case of risk to the public health. In the case of a possible epidemic, it is the duty of the commissioner to preserve and protect the public’s health “*as he*

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<sup>91</sup> *Id.* at § 23(2).

<sup>92</sup> *Id.* at § 70.

<sup>93</sup> *Id.* at § 70(2).

<sup>94</sup> *Id.*

<sup>95</sup> *Id.* at § 70(3)(a).

<sup>96</sup> *Id.* at § 70(5).

<sup>97</sup> *Id.* at § 70(6)(b).

*may deem necessary and proper.*<sup>98</sup> The commissioner and the Board of Estimate and Apportionment must decide by unanimous vote when, and for how long, an imminent risk to the public health exists.<sup>99</sup> Under New York's Public Health law, every local board must protect against the spread of communicable diseases by proper and attentive inspection and control of all those who had been exposed to or infected with the disease.<sup>100</sup> The local health boards and officials *may* "provide for care and isolation" of subjects with the disease in a hospital or elsewhere, and prevent all use of infected premises and objects until they can be purified.<sup>101</sup>

A few provisions of the New York State Constitution are relevant to communicable disease and related rights. Article 17 § 3 of the New York Constitution gives the State power to make provisions to promote and protect the health of its residents.<sup>102</sup> The New York State Bill of Rights, Article 1 § 5 prohibits cruel and unusual punishment and Article 1 § 3 proscribes freedom of religious belief and worship.<sup>103</sup> Section 6 of the Bill of Rights prohibits the deprivation of "life, liberty or property without due process of law"<sup>104</sup> and § 11 allows every person the equal protection of state laws and any of their subdivisions.<sup>105</sup> All of these provisions of the State's Bill of Rights include rights that might be indicated when dealing with communicable diseases in correctional facilities.

Finally, a few federal laws and amendments to the United States Constitution address issues related to communicable disease in prison. The First Amendment freedom of religion pertains, as does the Religious Freedom Restoration Act, which prohibits the federal government from burdening free exercise of religion under

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<sup>98</sup> N.Y. SECOND CLASS CITIES LAW § 153 (McKinney 1994) (emphasis added).

<sup>99</sup> *Id.*

<sup>100</sup> N.Y. PUB. HEALTH LAW § 2100(1) (McKinney 2002).

<sup>101</sup> *Id.* at § 2100(2).

<sup>102</sup> N.Y. CONST. art. XVII, § 3.

<sup>103</sup> *Id.* at art. I, § 5; *Id.* at art. I, § 3.

<sup>104</sup> *Id.* at art. I, § 6.

<sup>105</sup> *Id.* at art. I, § 11.



a generally applicable law, unless the law passes strict scrutiny.<sup>106</sup> Issues concerning treatment of communicable diseases in prison will almost certainly implicate the Fourteenth Amendment of the Constitution, under which all persons are guaranteed equal protection of the laws and may not be denied “life, liberty, or property, without due process of law.”<sup>107</sup> Additionally, “liberty” within the Fourteenth Amendment’s due process clause may protect a prisoner’s privacy interests, though the right to autonomy is not absolute and must be balanced against the state’s interests.<sup>108</sup>

### **III. INDIVIDUAL'S RIGHTS AND THE STATE'S INTERESTS IN CONROLLING COMMUNCABLE DISEASE IN PRISONS**

Many decisions by both federal courts and New York State courts address the way prison officials dealt with communicable diseases and, consequently, allegations that certain acts and procedures violated prisoner’s rights. Courts have taken different approaches to balancing the individual’s rights with the state’s interests, and some decisions have come out contrary to seemingly recognizable rights of prisoners. The decisions of the Supreme Court and the courts of appeals, though not specifically addressing claims arising directly from New York prisons, nevertheless implicate the same rights burdened in prisons across the United States, including New York.

#### **A. 8<sup>th</sup> Amendment Right to be Free from Cruel and Unusual Punishment**

The cases dealing with prisoners’ rights to be free from cruel and unusual punishment argue that the state must provide

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<sup>106</sup> U.S. CONST. amend. I.

<sup>107</sup> U.S. CONST. amend. XIV, § 1.

<sup>108</sup> *See* *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (upholding compulsory vaccination laws under the theory that individuals must give up absolute freedom in exchange for reaping the benefits of society).

medical care to inmates when they are unable to secure their own private medical care.<sup>109</sup> A lack of medical care is not included in the prisoner's sentence, and such failure is considered "an excessive and disproportionate punishment".<sup>110</sup> Since the Supreme Court decided *Estelle v. Gamble*<sup>111</sup> in 1976, prisoners' rights to health care has been recognized by imposing the duty to provide prison healthcare on each jurisdiction.<sup>112</sup> The prisoner in *Estelle* alleged that inadequate treatment for a back injury, which occurred during prison work, violated the Eighth Amendment's prohibition of cruel and unusual punishment.<sup>113</sup> Justice Marshall affirmed the Court of Appeals holding that the respondent's complaint against the prison warden and the Director of the Department of Corrections should be reinstated insofar that it alleged insufficient medical treatment.<sup>114</sup> Justice Marshall disagreed with the Appeals Court's belief that in order to make out an Eighth Amendment violation the prison guard must have acted intentionally in denying or interfering with medical treatment.<sup>115</sup> According to Justice Marshall, the State has a basic obligation to meet minimally adequate health care standards, including "an affirmative duty to provide reasonable access to medical care, to provide competent, diligent medical personnel, and to ensure that prescribed care is in fact delivered."<sup>116</sup> He acknowledged that prisoners, like every person, are at risk of the possibility that a diligent physician may make a mistake,

[b]ut when the State adds to this risk, as by providing a physician who does not meet minimum standards of competence or diligence or who cannot

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<sup>109</sup> Dubler, *supra* note 30, at 7.

<sup>110</sup> *Id.*

<sup>111</sup> *Estelle v. Gamble*, 429 U.S. 97 (1976).

<sup>112</sup> Mary Castle White, *Identifying Infectious Diseases in Prisons: Surveillance, Protection, and Intervention*, 170(3) W. J. MED. 177, 177 (1999).

<sup>113</sup> *Estelle*, 429 U.S. at 98.

<sup>114</sup> *Id.* at 117.

<sup>115</sup> *Id.* at 116 (footnote 13).

<sup>116</sup> *Id.*

give adequate care because of an excessive caseload or inadequate facilities, then the prisoner may suffer from a breach of the State's constitutional duty.<sup>117</sup>

In *DeGidio v. Pung*,<sup>118</sup> the Eighth Circuit heard a class action lawsuit on behalf of inmates who alleged that the tuberculosis screening and control procedures of the correctional facility at Stillwater were so inadequate that they violated the Eighth Amendment protection against cruel and unusual punishment.<sup>119</sup> The District Court had denied injunctive relief because the unconstitutional conditions were remedied before the trial began, notwithstanding the fact that it found the prison's reaction to the outbreak constituted "deliberate indifference."<sup>120</sup> The Court held that the lawsuit and resulting public scrutiny caused the facility to make substantial improvements and therefore DeGidio was declared the prevailing party and awarded attorneys fees and costs of litigation.<sup>121</sup> Pung appealed, asserting that the conditions did not violate the Eighth Amendment and that finding DeGidio to be the prevailing party was error; the Court of Appeals reviewed the Eighth Amendment finding to determine if the award of fees was correct.<sup>122</sup> The Court of Appeals reviewed the District Court's factual findings that from 1981-1986 no one was responsible for providing medical care or control policies for communicable diseases and that there was no written procedure regarding the testing or control of TB.<sup>123</sup> The District Court also found that the TB screening was deficient because not all incoming inmates were tested, no follow up tests were done, and that the failure to consider that one specific inmate may have TB constituted a

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<sup>117</sup> *Id.*

<sup>118</sup> *DeGidio v. Pung*, 920 F.2d 525, 527 (8th Cir. 1990).

<sup>119</sup> *Id.* at 527.

<sup>120</sup> *Id.* at 528.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 528-29.

<sup>123</sup> *Id.* at 529.

deliberate indifference to his health and the serious medical needs of other prisoners.<sup>124</sup> The Court of Appeals denied Pung's contention that intentional deprivation of medical care is necessary to show deliberate indifference and held that the District Court's findings were sufficiently supported by the factual record.<sup>125</sup> In this case, the Court recognized that the prisoner's right to be free from cruel and unusual punishment were violated and, even though the conditions were remedied before trial, awarded the inmates a portion of their fees and costs for revealing the unconstitutional conditions and causing reform.<sup>126</sup>

In another Eighth Amendment case, *Jolly v. Coughlin*,<sup>127</sup> the inmate's right to be free from cruel and unusual punishment was intertwined with his right to free exercise of religion under the Religious Freedom Restoration Act (RFRA).<sup>128</sup> The Rastafarian inmate was held in confinement for three and a half years pursuant to the TB control policy of placing prisoners who refused a TB test in medical keeplock;<sup>129</sup> medical keeplock consists of confinement to one's cell at all times except for one ten-minute shower per week and conferences with legal counsel.<sup>130</sup> According to the defendants, "medical keeplock" had no medical significance because inmates who refused to take a TB test still shared breathing air with other inmates.<sup>131</sup> However, an inmate with latent TB would not be placed in medical keeplock or respiratory isolation, while an inmate with active TB would be placed in respiratory isolation.<sup>132</sup>

In reviewing the appropriateness of the District Court's preliminary injunction to release Jolly from keeplock, the Court of Appeals discussed the likelihood of success of the inmate's RFRA

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<sup>124</sup> *Id.* at 530.

<sup>125</sup> *Id.* at 533.

<sup>126</sup> *Id.*

<sup>127</sup> *Jolly v. Coughlin*, 76 F.3d 468 (2d Cir. 1996).

<sup>128</sup> *Id.*

<sup>129</sup> *Id.* at 471.

<sup>130</sup> *Id.* at 472.

<sup>131</sup> *Id.* at 471.

<sup>132</sup> *Id.*

and Eighth Amendment claims. The Court found that an inmate's claim under the RFRA is subject to strict scrutiny, but also recognized that the courts should continue to be deferential to prison administrators "in establishing necessary regulations and procedures to maintain good order, security and discipline, consistent with consideration of costs and limited resources."<sup>133</sup> The Court recognized that the State has a compelling interest in protecting staff and inmates from TB, and in fact officials "have an affirmative obligation to protect inmates from infectious disease."<sup>134</sup> In that case, confinement did not further this compelling interest because Jolly was not contagious and even inmates who take the TB test, discover they have latent TB, and refuse to take medication, were not placed in medical keeplock.<sup>135</sup> The Court found that even in light of due deference to officials in regulating the health and safety of its inmates and the recognized compelling interest, there was no evidence that a religious exemption would undermine the discovery of TB.<sup>136</sup> Further, the Court agreed with the District Court that medical keeplock is not the least restrictive means of furthering the State's compelling interest; for example, Jolly could be treated as if he did test positive for latent TB and refused to take medication.<sup>137</sup> The plaintiff also demonstrated a substantial likelihood of success on his Eighth Amendment claim by preliminarily showing he was seriously deprived of any opportunity to exercise, and that "[t]he defendants were aware 'of the undisputed conditions and harm to the plaintiff.'"<sup>138</sup> The Court of Appeals affirmed the District Court's conclusion that irreparable harm would occur without an injunction because: Jolly alleged a violation of his constitutional rights; money would not sufficiently compensate the alleged harm; and the plaintiff suffered headaches,

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<sup>133</sup> *Id.* at 476 (citation omitted).

<sup>134</sup> *Id.* at 477.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* at 479.

<sup>137</sup> *Id.*

<sup>138</sup> *Id.* at 481 (citation omitted).

rashes, inability to stand easily, hair loss, and shortness of breath as a result of confinement to medical keeplock.<sup>139</sup> In that situation, the Court recognized both the individual's rights and the State's interests, but concluded that continued confinement becomes inappropriate when it is not being used to further the State's interest "in administering an effective TB screening program or maintaining prison security."<sup>140</sup> Because "[s]urvival in prison depends on effective medical care . . . [and] may also be supported by the ability to exercise the right to that care[,] . . . the right to medical care in prison is the inmate's single daily exercisable right."<sup>141</sup> Therefore, the inadequacies and prejudices in communicable disease screening and treatment policies implicate an inmate's constitutional right to be free from cruel and unusual punishment.

### B. 14<sup>th</sup> Amendment Right to Due Process

There have been instances of violations of a prisoner's due process rights through inappropriate responses to communicable diseases. In the Erie County Holding Center, a female inmate who tested HIV positive was segregated from the general population, confined to a small area for female inmates who were "mentally disturbed, suicidal, or infected with a contagious disease."<sup>142</sup> After officials discovered Ms. Nolley was HIV positive, they put red-dot stickers on her "inmate records, medical records, clothing bag, and transportation documents."<sup>143</sup> Judge Curtin found that these practices violated her constitutional right to due process and to privacy, and also ruled that banning the inmate from using the library or attending religious services was unconstitutional.<sup>144</sup>

Defending the red sticker policy, Erie County officials

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<sup>139</sup> *Id.* at 482.

<sup>140</sup> *Id.* at 479.

<sup>141</sup> Dubler, *supra* note 30, at 7.

<sup>142</sup> Deborah Pines, *Segregation of Inmate Held Unconstitutional: Damages May be Due HIV-Positive Prisoner*, N.Y. L.J. Nov. 19, 1991, at 1 [hereinafter Pines, *Segregation*]; see *Nolley v. County of Erie*, 802 F.Supp. 898 (W.D.N.Y. 1992).

<sup>143</sup> Pines, *Segregation*, *supra* note 142, at 1.

<sup>144</sup> *Id.*

argued that the red stickers were used for inmates with other infectious diseases as well as HIV and AIDS and therefore the stickers didn't reveal any confidential information strictly relating to HIV.<sup>145</sup> They further argued that even if the stickers did indicate confidential information, it was only communicated to authorized officials for legitimate uses.<sup>146</sup> Judge Curtin recognized that the State has an interest in using "universal precautions" to guard against the spread of disease, but concluded that the red sticker policy was developed in direct response to the panic over HIV and AIDS.<sup>147</sup> Furthermore, the policy was an "exaggerated response" and was not reasonably related to protecting staff from infectious diseases.<sup>148</sup> Ms. Nolley was entitled to constitutional due process because her segregation to the "Female Delta Medical Pod" was "qualitatively different" from those in the general population.<sup>149</sup> Judge Curtin awarded Ms. Nolley a total of \$154,977 in damages, which included punitive damages, presumptive damages, and compensatory damages.<sup>150</sup>

In *Lareau v. Manson*, the Court of Appeals found that overcrowded conditions in a Connecticut prison violated the due process rights of pretrial detainees and sentenced inmates.<sup>151</sup> In addition to overcrowding, the plaintiffs alleged "inadequacies in

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<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *Id.* The superintendent also disregarded state policy by segregating Ms. Nolley to the five cell area. Deborah Pines, *Former Inmate with Aids Wins \$155,000 Bias Award*, N.Y. L.J. Aug. 25, 1992 at 1 [hereinafter Pines, *Former Inmate*].

<sup>150</sup> Pines, *Former Inmate*, *supra* note 149, at 1. Twenty Thousand Dollars in punitive damages was assessed against the jail superintendent, while the rest of the damages were assessed against the superintendent, the sheriff, and a former jail nurse. These included presumptive damages for the unauthorized disclosure of the inmate's HIV test results, compensation for distress resulting from denial of due process and loss of access to facilities, as well as attorney's fees and costs. *Id.*

<sup>151</sup> *Lareau v. Manson*, 651 F.2d 96 (2d Cir. 1981).

health care, sanitation, food, heating, recreation, counseling services and safety.”<sup>152</sup> The District Court found that these conditions, especially the confinement of healthy prisoners in cells with physically ill cellmates and the “failure to screen new incoming inmates for communicable disease,” violated all inmates’ constitutional rights.<sup>153</sup> The Court of Appeals found that the only reason for overcrowding was the economic incentive of the State to house more prisoners without increasing the available space, and this interest was not sufficient to subject pretrial detainees to such serious deprivations.<sup>154</sup> The Court therefore held that keeping healthy detainees in double-bunked cells, medical or isolation units is a violation of their Fourteenth Amendment rights unless it is for fifteen days or less.<sup>155</sup> The Court of Appeals agreed with the District Court’s finding that there is no justification for the failure to have an adequate communicable disease screening procedure and the impending physical threat is so serious that it amounts to a violation of the due process clause.<sup>156</sup>

The due process violation mandated a universal remedy for all inmates, not just pretrial detainees, because it would be impossible for sentenced inmates to contain the spread of disease to inmates of similar status.<sup>157</sup> The remedy addressed the various overcrowding conditions and stated that incoming inmates must have a physical exam within 48 hours and shall only be confined in a one-bunk cell while awaiting the examination.<sup>158</sup> The Court allowed for physician discretion in deciding which tests to administer: “such examination shall include . . . tests as are necessary in the opinion of the physician to identify and isolate

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<sup>152</sup> *Id.* at 98.

<sup>153</sup> *Id.*

<sup>154</sup> *Id.* at 104.

<sup>155</sup> *Id.* at 105.

<sup>156</sup> *Id.* at 109.

<sup>157</sup> *Id.* Even if the current medical practice was not a violation of the due process clause, the court noted that it absolutely violated the Eighth Amendment as a “deliberate indifference to serious medical needs.” *Id.* (quoting *Estelle v. Gamble*, 429 U.S. 97, 106 (1976)).

<sup>158</sup> *Id.* at 111.



those who have communicable disease.”<sup>159</sup> The testing requirement did not apply to new inmates who had a recorded medical exam during the three months prior to admission.<sup>160</sup> Here, the Court attempted to remedy the violation of the inmates’ due process rights. Though the ruling cured some of the temporary problems in the facility, it did not completely achieve the goal of long-term communicable disease prevention.

### C. Privacy Interests

In some situations, the privacy rights of inmates have been implicated in practices and procedures relating to communicable disease. As previously mentioned, practices such as branding inmate’s records and belongings with red-dot stickers constitute a violation of the right to privacy.<sup>161</sup>

In *Doe v. Coughlin*,<sup>162</sup> another privacy right was questioned when an inmate was denied participation in the conjugal visit program because he had AIDS.<sup>163</sup> Through the Family Reunion Program, selected inmates are able to spend a couple days with a spouse or other relatives in a trailer that is outside the main prison buildings in order to “‘preserve, enhance, and strengthen family ties that have been disrupted as a result of incarceration.’”<sup>164</sup> John Doe was allowed to participate in the Family Reunion Program initially, but was denied further visits after he was diagnosed with AIDS.<sup>165</sup> Doe brought suit based on three alleged constitutional violations: denial of due process, equal protection, and the fundamental right to privacy in marriage.<sup>166</sup> The Court of Appeals recognized that inmates have some privacy rights, including the

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<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> Pines, *Segregation*, *supra* note 139, at 1.

<sup>162</sup> *Doe v. Coughlin*, 518 N.E.2d 536 (N.Y. 1987).

<sup>163</sup> *Id.*

<sup>164</sup> *Id.* at 538 (citation omitted).

<sup>165</sup> *Id.*

<sup>166</sup> *Id.* at 539.

right to marry if the inmate is not serving a life sentence, but also recognized that an inmate only retains rights that are consistent with his prisoner status and the goals of the prison system.<sup>167</sup> The government has important interests in maintaining “security, deterrence, and rehabilitation” through confinement, and has no obligation to create a conjugal visit program as intimate marital relations are contrary to these interests.<sup>168</sup> Therefore, the Court rejected Doe’s privacy claim to conjugal visits and also rejected his claim that the implementation of the program created a legitimate expectation that he would be able to participate.<sup>169</sup>

Regarding the petitioner’s equal protection claim, the Court applied rational basis review because there is no constitutional right to conjugal visits, and classifying prisoners by infected status is not a suspect classification.<sup>170</sup> The State has a legitimate interest in preventing the spread of communicable diseases and because prison officials cannot control the transmission of AIDS to a non-prisoner during private visits, there was a rational basis for denying Doe conjugal visits because he was diagnosed with AIDS.<sup>171</sup> The rationality of the decision was unaffected by petitioner’s argument that they would use safe sex practices or possibly not engage in sex during a trailer visit.<sup>172</sup> When an inmate has a communicable disease, he or she forfeits the right to marital intimacy, and the voluntary institution of conjugal visit programs at some facilities does not revive this right.<sup>173</sup> In instituting a conjugal visit program, the State has a duty to regulate the protection of health and safety of those within the prison facility and the community outside prison walls; this duty is conferred upon the Department of Correctional Services in Correction Law § 70(2)(a), which states

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<sup>167</sup> *Id.*

<sup>168</sup> *Id.* at 540.

<sup>169</sup> *Id.*

<sup>170</sup> *Id.* at 542. There may be occasions when equal protection does apply to issues of prisoners’ rights, but only if a suspect classification is involved, for example, if a prisoner was treated differently in communicable disease screening procedures because of his or her race. *See Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Id.* at 541-42.

<sup>173</sup> *Id.* at 543

that “due regard [must be given] to . . . the safety and security of the community” when creating rehabilitation programs.<sup>174</sup> The majority found no constitutional violations as the prison officials’ decision had a rational relationship to the operation of the program and preventing the spread of disease to visitors.<sup>175</sup>

The concurring and dissenting views on the importance of the prisoner’s constitutional rights are noteworthy in this case. Chief Judge Wachtler concurred that the majority’s conclusion was correct, but he believed a constitutional right was implicated and the analysis should be more rigorous than rational basis review.<sup>176</sup> Because the Commissioner’s decision to deny conjugal visits was “based upon a calculated risk that, if left alone, the inmate and his wife as a married couple would engage in sexual relations,” the concurrence discussed how the decision raises constitutional questions as to whether the fundamental right to marriage has been impinged.<sup>177</sup> Though Chief Judge Wachtler believed, even under higher scrutiny, that the Commissioner had a sufficient basis for his decision, he recognized the prisoner’s fundamental right to marriage and suggested possible safe alternatives instead of complete denial of participation in the conjugal visits program.<sup>178</sup> He noted that the petitioners in this case did not argue for easy alternatives to accommodate the inmate’s right to privacy in the marriage relationship without risking exposure to the visitor, but hinted that in future cases an analysis of fundamental privacy rights in this context may require implementation of more structured visits with a prisoner’s family.<sup>179</sup>

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<sup>174</sup> *Id.* (citation omitted).

<sup>175</sup> *Id.* at 544.

<sup>176</sup> *Id.* at 545 (Wachtler, C.J., concurring).

<sup>177</sup> *Id.*

<sup>178</sup> *Id.* Significantly, Chief Judge Wachtler notes that the emotional support provided through the marriage relationship may be the only comfort for an inmate with a terminal illness. *Id.*

<sup>179</sup> *Id.*

In the dissent, Judge Alexander took a strong stance that the Commissioner's decision to deny access to the conjugal visit program is a burden on the petitioner's fundamental right—an unjustified interference.<sup>180</sup> He recognized that “if petitioner husband was not an inmate, he and his wife could not be denied the right to be together as a married couple, and to engage in sexual relations—despite his affliction with AIDS—absent a compelling government purpose, and the most narrowly tailored means to achieve that purpose.”<sup>181</sup> Although inmates lose some privileges when they are incarcerated, they still retain the right to marry. This Court recognized the importance of maintaining family bonds when it found that the Due Process Clause in the New York State Constitution gives pretrial detainees the right to visit with loved ones.<sup>182</sup> Through the institution of the Family Reunion Program, respondents recognized that the preservation of family ties is consistent with the goals of the facility.<sup>183</sup> While participation in the program is not a right, once admitted to the program the decision to engage in sexual conduct is an aspect of the fundamental right to marriage; therefore, denying access to the program based on the way petitioners may exercise their right to marriage is an invasion of their marital privacy.<sup>184</sup> In balancing the interests of the state's promotion of institutional objectives and the inmate's fundamental right, the dissent concluded that,

respondent's asserted objective does not justify the intrusion on [petitioner's] marital prerogative to engage in or abstain from sexual relations, nor does it warrant treating petitioner husband differently from other eligible inmates in such a way as to effect a total deprivation of the benefits of the Family Reunion Program.<sup>185</sup>

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<sup>180</sup> *Id.* at 546 (Alexander, J. dissenting).

<sup>181</sup> *Id.* (citation omitted).

<sup>182</sup> *Id.* at 548.

<sup>183</sup> *Id.*

<sup>184</sup> *Id.* at 548-49.

<sup>185</sup> *Id.* at 554.

There are extremely conflicting views of the importance of an inmate's fundamental right to privacy in the marital relationship, though the dissent's reasoning seems to be the most compelling in finding that a privacy right has in fact been encroached.

#### **D. Right to Diagnosis and Treatment of Disease**

Though inmates have brought suits against prison administrators for failure to diagnose and treat a communicable disease, the courts have varying responses to their claims. One Binghamton judge awarded a former inmate \$256,000 against the state for failure to detect and treat his tuberculosis.<sup>186</sup> Judge Jerome Hanifin “found state physicians committed malpractice by ignoring Mr. Ogle’s positive TB skin test results in their diagnoses, assuming his complaints were psychosomatic without conducting tests to rule out a physical cause, and violating written Corrections Department policy and guidelines on TB treatment.”<sup>187</sup> While Mr. Ogle was at Riker’s Correctional Facility, he tested positive for TB during a routine skin test and began treatment which ended when he was released shortly after.<sup>188</sup> After a subsequent conviction, Ogle returned to Riker’s where medical personnel were going to resume the treatment, but his medical records were mixed up during multiple transfers to other prisons.<sup>189</sup> When he was retested at a prison in Elmira, doctors assumed the positive result was caused by a prior vaccination; at another prison in Coxsackie, New York, he went to the prison hospital twelve times in one month with complaints of stomach, back, and chest pains and was continuously written up for abusive behavior.<sup>190</sup> The inmate was again transferred to Ogdensburg where a nurse wrote on his record

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<sup>186</sup> Gary Spencer, *Award to Inmate for Failure to Detect TB*, N.Y. L.J., Dec. 26, 1991, at 1.

<sup>187</sup> *Id.*

<sup>188</sup> *Id.*

<sup>189</sup> *Id.*

<sup>190</sup> *Id.*

that his TB at Elmira was negative since no result was recorded.<sup>191</sup> He was sent to an outside prison mental health clinic after he collapsed, and was then returned to the infirmary at Ogdensburg with complaints of paralysis and numbness of his legs.<sup>192</sup> Mr. Ogle was finally taken to a hospital and diagnosed with TB of the spine, also known as Pott's disease. "Physicians there said he had a humpback, a fever of 103 degrees and no reflexes in either leg. They fused four vertebrae, employing a bone graft from his hip, to correct spinal deformities."<sup>193</sup> Because of prison doctors' gross negligence in ignoring the inmate's symptoms for almost four months, Mr. Ogle was awarded damages for pain and suffering.<sup>194</sup>

The judge found the inmate 20% liable for failure to give prison officials adequate notification about his medical treatment at Riker's and his initial refusal to be admitted to the infirmary; his medical expenses were paid by the State in addition to the damages he received.<sup>195</sup> Certainly, 80% of the inmate's permanent spinal injury can be attributed to the gross miscommunication between prisons in different localities and the indifference and inattentiveness of prison medical staff.

In a subsequent case, *Kaminsky v. New York*,<sup>196</sup> a survivor of a prison inmate brought suit against the State for failure to diagnose the inmate with AIDS.<sup>197</sup> The claimant argued an earlier diagnosis would have allowed for medication to prevent pneumonia, which was the cause of the decedent's death.<sup>198</sup> The State's experts rebutted this contention by stating that the abrupt onset of pneumonia was not treatable because it would have taken time for the medication to start working.<sup>199</sup> The decedent was also suffering from hepatitis, heart disease, diabetes, and cirrhosis of the liver.<sup>200</sup>

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<sup>191</sup> *Id.*

<sup>192</sup> *Id.*

<sup>193</sup> *Id.*

<sup>194</sup> *Id.*

<sup>195</sup> *Id.*

<sup>196</sup> *Kaminsky v. State*, 265 A.D.2d 306 (N.Y. App. Div. 1999).

<sup>197</sup> *Id.*

<sup>198</sup> *Id.* at 307.

<sup>199</sup> *Id.*

<sup>200</sup> *Id.*

On appeal from a judgment for the State, the Court found that the failure to detect the prisoner's AIDS was not the proximate cause of his death.<sup>201</sup> In this case, it seems that the existence of other medical conditions provided the Court with other causes of death besides the failure of prison personnel to diagnose a communicable disease.

As the foregoing examples demonstrate, inadequacies in the prison health care system have led to the infringement of the rights of many inmates and their loved ones. Though a conviction necessarily leads to the forfeiture of many rights that the outside community is able to enjoy, becoming a prisoner does not change the basic human need for adequate medical treatment. Many inmates are subjected to stigmatization and denial of their fundamental right to due process before deprivation of their life, liberty, or property. Even the fundamental right to marriage and the implicit right to procreate are infringed upon by the decisions of prison administrators which seem unjustified.

#### **IV. SHORTCOMINGS OF COMMUNICABLE DISEASE CONTROL IN THE PRISON SYSTEM**

Many of the deprivations of prisoners' rights can be attributed to various deficiencies in the prisons' administration of testing and control procedures for communicable diseases. The prison health care system reacted slowly in developing treatment programs for inmates infected with HIV, and there is still an "inconsistency in administering these programs and in helping prisoners overcome the stigma attached to HIV."<sup>202</sup> Because of the stigma that attaches to incarceration, the state has historically provided inadequate physicians and medical facilities in

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<sup>201</sup> *Id.* at 306.

<sup>202</sup> Restum, *supra* note 2, at 1690. This problem of effective administration is true for all communicable disease treatment programs, not just HIV.

correctional facilities.<sup>203</sup> Health care professionals in prisons often have a negative view of prisoners and consequently provide them with “shoddy treatment.”<sup>204</sup> In one instance, an inmate complaining of chest pains “was told to get on a gurney and wait. He waited for an hour, until he died, completely unattended.”<sup>205</sup> There have been numerous occasions of less-than-diligent prison medical personnel who failed to recognize the symptoms of communicable diseases.<sup>206</sup>

Also, the current procedures required to see a physician in prison become obstacles to adequate health care and communicable disease detection. For example, prisoners must be approved before they can see a doctor and some states require co-payments be made by the individual.<sup>207</sup> Most correctional facilities lack a policy that mandates all incoming inmates be tested for communicable diseases and typically once an infected inmate is identified there is no follow up testing protocol in place.<sup>208</sup> There are also no surveillance measures in place for inmates who re-enter society; for example, Mr. Ogle tested positive for TB and his treatment ended when he was released into the community.<sup>209</sup> Further, many prisons lack the proper facilities to house inmates with infectious diseases.<sup>210</sup> One New York judge ordered the construction of an isolation unit for inmates at Riker’s Island with infectious diseases, but when a spreading drug-resistant strain of TB was encountered, there was “no true ‘isolation’ of infected prisoners” and inadequate ventilation could not be remedied until the construction was complete.<sup>211</sup> The current New York statutes governing the

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<sup>203</sup> *Id.*

<sup>204</sup> *Id.* at 1691.

<sup>205</sup> *Id.*

<sup>206</sup> *DeGidio v. Pung*, 920 F.2d 525, 530 (8th Cir. 1990).

<sup>207</sup> *Restum*, *supra* note 2, at 1691.

<sup>208</sup> *DeGidio*, 920 F.2d at 530.

<sup>209</sup> *Spencer*, *supra* note 186, at 1.

<sup>210</sup> *See e.g.*, Pines, *Segregation*, *supra* note 142, at 1 (describing a situation at the Erie County Holding Center where women with infectious diseases were kept in a five cell area along with inmates who were mentally disturbed or suicidal).

<sup>211</sup> Deborah Pines, *TB Facility for Inmates Due by May 1: Judge Gives City Deadline to Build Isolation Cells*, N.Y. L.J. Jan. 27, 1992, at 1. New York State



procedure for communicable disease control are vague and give too much discretion to prison officials in administering policies. The procedure to get an inmate treatment at an outside facility involves a recommendation from the superintendent as well as a written order from the commissioner.<sup>212</sup> There is no universal state procedure to be followed in case of a disease outbreak within a correctional facility.

#### **V. SUGGESTIONS TO IMPROVE THE DEFICIENCIES OF DISEASE CONTROL AND PREVENTION IN CORRECTIONAL FACILITIES**

In order to address the widespread problem of communicable diseases in prison, there must be collaboration between public health and correctional health officials.<sup>213</sup> According to Mary Castle White, “[i]n the case of chronic conditions that require long-term or even lifelong therapy, . . . the correctional facility represents a starting point for care that must be continued after release.”<sup>214</sup> Because the number of infectious diseases in prison is much higher than in the general community, the prison setting is a good place to properly treat diseases before anyone else is infected.<sup>215</sup> There must be cooperation between the prison health system and the public health system in order to provide continuous follow-up care after an inmate’s release.<sup>216</sup> The prevalence of disease in the prison population calls for a universal screening procedure and action plan across the State. New York’s correctional

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also was criticized for allowing prisoners to be “doubled-up in cells that are about the size of a standard-sized bathroom and which were built to house only one prisoner.” *Agency Urges Ending Prison Double-Celling*, N.Y. L.J. Feb. 17, 1998.

<sup>212</sup> N.Y. CORRECT. LAW § 23(2) (McKinney 2000).

<sup>213</sup> White, *supra* note 112, at 177.

<sup>214</sup> *Id.*

<sup>215</sup> *Id.*

<sup>216</sup> Restum, *supra* note 2, at 1689.

law gives discretion to the commissioner of corrections to decide what to do if faced with an outbreak<sup>217</sup>; the statute should be changed to mandate every incoming inmate be screened for communicable diseases and in the case of a positive test, the inmate should be isolated to a medically appropriate area and promptly begin a treatment plan. There should be more efficient communication between facilities when an inmate is transferred, and the inmate should be retested regardless of how recently he was tested at the previous facility. If the correctional facility does not have a medical isolation center, there should be properly ventilated vehicles to transfer the inmate to the nearest facility equipped to house infected prisoners. All correctional facilities should be required to make a good faith effort to create a medical isolation area.<sup>218</sup>

Regardless of whether there are isolation facilities on site, the barriers to accessing a physician must be removed.<sup>219</sup> Further, New York should officially outlaw the use of double-celling in order to reduce the problem of overcrowded conditions.<sup>220</sup> Mandating all incoming inmates be tested, unifying the communication between state prisons, and implementing appropriate medical isolation cells will fulfill the state's interest of protecting the population from disease while also protecting the individual's right to medical care and to be free from cruel and unusual punishment.<sup>221</sup>

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<sup>217</sup> N.Y. CORRECT. LAW § 141 (McKinney 2000).

<sup>218</sup> There should be a facility designated for treatment and confinement of communicable disease in New York State. N.Y. CORRECT. LAW § 70(6)(b).

<sup>219</sup> Restum, *supra* note 2, at 1691.

<sup>220</sup> This would protect inmates as well as prison staff. For example, in 1995 when a Supreme Court judge lifted the ban on double-celling, "[t]he prison guards' union warned in court papers that double-celling would create a dangerous work environment for correction officers, leading to more violence and encouraging the spread of disease". Gary Spencer, *Judge Permits State to Double up Inmates: 1981 Ban Vacated as 'Stale and Outdated'*, N.Y. L.J. May 17, 1995, at 1.

<sup>221</sup> See generally *Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996) (finding that medical keeplock did not further the compelling interest of protecting others from TB and therefore the inmate was likely to succeed on his 8th amendment

Additionally, widespread education of prison health personnel, inmates, and the community at large is essential in gaining control of communicable diseases in prison. It is important to address the stigma associated with being incarcerated in order to break down negative attitudes toward inmates. Prison staff should be informed about their duties to administer proper procedure and should be held accountable if they stray from the protocol. Prison health officials should be educated about the close correlation between communicable diseases contracted in prison and the spread of disease outside prison walls. Perhaps the physician's willingness to treat disease in prison will be enhanced when they recognize that health interventions in the correctional facilities will "benefit not only inmates themselves and their families and partners, but also the public health of the communities to which the vast majority of inmates return."<sup>222</sup>

The attitude of the community may change if society realizes that it ultimately "pays the price, in the high cost of both private health care providers—who often fail to deliver adequate care—and of public health care for released inmates receiving treatment and for their families and friends who become infected and cannot afford private care."<sup>223</sup> It may also be beneficial to the public to place nonviolent offenders in treatment programs or facilities other than prison because it would reduce the number of people exposed to disease.<sup>224</sup>

The inmates should also be properly educated on the risk factors, symptoms, treatment, and consequences of communicable diseases. One program, implemented in Oklahoma, trained inmates to become peer educators to help other inmates with communic-

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claim); *DeGidio v. Pung*, 920 F.2d 525, 528 (8th Cir. 1990) (holding that deliberate indifference to the inmates' medical needs had occurred but injunctive relief was not necessary because the eighth amendment violations were remediated as a result of the lawsuit).

<sup>222</sup> Hammett, *supra* note 25, at 1793.

<sup>223</sup> Restum, *supra* note 2, at 1691.

<sup>224</sup> *See Id.* at 1690.

able diseases.<sup>225</sup> According to Heines, “[t]he program’s main appeal is that the inmates learn how to teach themselves and others about issues such as HIV/AIDS prevention” and inmates can earn college credit while helping their peers.<sup>226</sup> It was recognized that inmates were more receptive to counseling from those who are in similar situations.<sup>227</sup> Further, inmates must be educated on safe sex practices and be given access to condoms and sterile needles.<sup>228</sup> Though providing these objects may seem to be encouraging illicit conduct, it is only encouraging safe practice of conduct that will inevitably occur. Prisoners should also be provided with their own toiletries, such as razors; this will also help reduce the chance of transmission through shared personal products.

Implementation of these suggested reforms will not only remediate the problems that infringe on inmates’ rights, but also further the State’s compelling interest in protecting the public from disease, and promote deterrence, security, and rehabilitation.<sup>229</sup> Many of the policies that infringe upon individual rights are not currently furthering any of the State’s interests.<sup>230</sup> For example, the

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<sup>225</sup> Heines, *supra* note 42, at 1686.

<sup>226</sup> *Id.* In response to this program, there was a low rate of recidivism for peer educators and the rate of HIV/AIDS in prisons that utilized the program had dropped by two-thirds. *Id.*

<sup>227</sup> *Id.* Even if a prisoner peer education program is not utilized, “[t]he prison environment and culture should be responsive to the needs of both staff and inmates. Any efforts at education should emphasize a positive, consistent relationship between the educator and the inmate.” BRAITHWAITE, *supra* note 51, at 181.

<sup>228</sup> BRAITHWAITE, *supra* note 51, at 186-87. “[F]or injection drug users who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most-effective approach for limiting HIV transmission.” *Id.* at 187.

<sup>229</sup> *Doe v. Coughlin*, 518 N.E.2d 536, 543 (N.Y. 1987).

<sup>230</sup> The confinement of an inmate who refused to take a TB test was not furthering the state’s interest in protecting staff and inmates from disease because inmates who test positive for latent TB but refuse treatment are not isolated. *Jolly v. Coughlin*, 76 F.3d 468, 476 (2d Cir. 1996). Also, the state’s policy of labeling HIV inmates with red stickers violated individual rights and was not fulfilling the goal of preventing the spread of disease. Pines, *Segregation*, *supra* note 142, at 1.

majority in *Doe* stated that inmates forfeit the right to marital intimacy regardless of whether they have a disease.<sup>231</sup> The decision to deny Doe conjugal visits with his wife does not further the State's goal because other inmates who do not have a disease are still able to be intimate with loved ones. In order to remediate these inadequacies, the State should implement a family group visit program where the opportunity to have sexual relations is eliminated. This way, the State may further its goals of incarceration and all inmates, especially the terminally ill, may still receive support from loved ones and exercise their fundamental rights to marriage and family bonds.

Finally, there must be a more systematic approach to communicable disease prevention and control in prison. In order to move towards a successful prison healthcare system, New York must implement preventive services such as mandated testing and an information-sharing network between prisons, a monitoring plan to ensure all inmates are receiving the proper treatment within a medically acceptable isolation area, and a surveillance plan in which inmates who've been released are still checked periodically. New regulations must include procedural safeguards to ensure the inmate's right to privacy, protection, and medical treatments are not improperly infringed. The State should provide for advanced training of prison personnel to emphasize the importance of administering adequate medical care and remaining unbiased in performing mandated duties. New York should institute uniform rules in handling inmates with communicable diseases and provide funds for state facilities to install proper counseling and health care programs. The enhancement of prison health care will provide dual benefits to society; it will further the State's interests in protecting the public from disease, maintaining security, and furthering the goals of incarceration, while also respecting the inmates' privacy interests under the Fourteenth Amendment, their right to adequate

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<sup>231</sup> *Doe*, 518 N.E.2d at 543.

health care, and their right to be free from cruel and unusual punishment.

### **CONCLUSION**

In the past, both federal and state governments have struggled to control the outbreak and spread of communicable diseases. It has recently become apparent that much of the problem with containing communicable diseases stems from the government's ineffective response to the health care of those individuals in jails and prisons. Every human being has the right to adequate health care and to be free from cruel and unusual punishment under the United States Constitution, regardless of the stigma attached to those individuals who break the law. By improving health care in jails and prisons, the government can help prevent cross-contamination between the correctional facilities and society in general, thus improving the public health of its citizens. Going forward, there must be an interaction between the public health care system and the prison health care system. Though this Comment focused only on the current statutes in New York State and the rights vested in each citizen by the United States Constitution, there is room for improvement in every state correctional health care system in order to protect the health, safety, and welfare of the public at large.