AIDS and the Federal Bureau of Prisons: A Unique Challenge

Richard S. Wilbur

Follow this and additional works at: https://huskiecommons.lib.niu.edu/niulr

Part of the Law Commons

Suggested Citation

This Article is brought to you for free and open access by the College of Law at Huskie Commons. It has been accepted for inclusion in Northern Illinois University Law Review by an authorized editor of Huskie Commons. For more information, please contact jschumacher@niu.edu.
AIDS and the Federal Bureau of Prisons: A Unique Challenge

INTRODUCTION

The juxtaposition of the epidemic of Acquired Immune Deficiency Syndrome (AIDS) and the Federal Bureau of Prisons (BOP) has produced a unique situation derived from two unique components. The BOP is unique in that it is the only nonmilitary nationwide correctional system in the United States. AIDS is a unique late 20th Century epidemic whose existence has been known for only a decade. The BOP, therefore, has had few guideposts to help it develop its own unique response to this unique dilemma. This article details the problems faced by the BOP and its responses to them.

The article begins with a brief overview of the unique medical nature of this disease and the problems presented by the recentness of its discovery. It is important to understand why the unusual nature of the illness combined with the speed with which our knowledge of it has developed and is developing have made AIDS an elusive and a rapidly changing target, difficult for all of society and especially for the correctional systems to deal with. Next, the article discusses the current, also evolving and rapidly changing, legal climate in the United States regarding the civil rights of privacy and confidentiality and how this evolution complicates the problems of society in general and the prisons in particular in dealing with AIDS in the conventional medical model of epidemic control. The third portion describes the unique nature of the Federal Bureau of Prisons, and the fourth part covers the Bureau’s response to this unique epidemic.

I. THE UNIQUE MEDICAL ASPECTS OF THE AIDS EPIDEMIC

A. HIV-AIDS

1. The Unique Virus

a. Attacks the Immune System

AIDS is caused by the Human Immunodeficiency Virus (HIV). HIV is one of the family of retroviruses, members of which have the

ability to successfully propagate within a human’s own living cell where they take over the genetic properties of the host cell to reproduce themselves.\textsuperscript{2} One unique feature of HIV is that it has a predilection for the particular type of cell, called the T-4 lymphocyte, which mediates the body’s immune mechanism against diseases such as AIDS itself.\textsuperscript{3} The AIDS victim, unlike the sufferer from other fatal virus infections such as smallpox, seldom succumbs directly to the invading virus. Rather, the AIDS patient usually dies of some secondary infection caused by another organism. This infection is often one which is usually not fatal by itself, but which the infected person can no longer resist by the normal immunologic response to disease.\textsuperscript{4}

The AIDS patient’s defense against any infection diminishes as the HIV attacks more of the T-4 lymphocytes. Early in AIDS the victim is more susceptible than the normal person to all of the usual infectious agents. Tuberculosis in this country\textsuperscript{5} and malaria in Africa are two of the serious threats to life which affect the HIV victim more acutely than they do the non-HIV person. As the disease progresses, the victim becomes susceptible even to those common organisms which the normal person’s immune system rejects without any sign of illness. These types of infections are called opportunistic infections. A prime example is pneumocystis carinii pneumonia which rarely bothers the normal person but is fatal to AIDS patients without specific treatment and difficult to eradicate even with appropriate therapy.

b. Constantly Changing and Hard to Treat

Because HIV is also capable of considerable mutation, changing from one genetic form to another\textsuperscript{6} the development of both a treatment which can destroy the virus without harming the host cell and prevention such as by a vaccine has been made extremely difficult.

c. Hard to Infect Others

On the other hand, HIV is a fragile virus in the sense that it can exist for only a short time outside of the host’s living cell.\textsuperscript{7} It can

\begin{itemize}
\item 3. Id. at 112-13. See also Fields & Knipe, Field’s Virology (1990).
\end{itemize}
exist in the blood serum as a free virus, but, at least early in the
disease, it is removed from the blood serum by the body's immune
system. It is within the host human's cells that the virus reproduces
and where it is relatively safe from attack by the human immune
system and/or by medications. It can live only briefly outside of the
human body, except in blood, such as in a transfusion red cell unit
or a blood contaminated syringe, or in a serum component such as
the human Factor VIII globulin which is used to treat hemophilia.\(^8\)
Cleaning of syringes and purifications of the anti-hemophilia factor
by heat treatment during its preparation can eliminate HIV relatively
easily as compared with the greater amount of sterilization needed to
eliminate other viruses or bacteria.

Because of this fragile nature, HIV-AIDS can only be transmitted
from one person to another by contact close enough to allow the
injection of some of the infected person's body fluid containing the
live virus into the other person's body through a break in the skin or
a mucus membrane.\(^9\) It is more likely to occur if the fluid contains
cells as do blood and semen. This limits the methods of transmission
to intimate contact such as sexual intercourse or a mother to a fetus
or to injection of contaminated body fluid through a needle. Despite
the intimacy of contact of a mother with her fetus, only about 20-
35% of babies born to HIV infected mothers are HIV positive.\(^10\)

d. Slow-acting Virus

Furthermore, HIV is unusual in that it is a slow virus, slow to
reproduce and slow to cause visible disease.\(^11\) A person may carry this
virus for over a decade without showing visible signs of disease.
However, he is infectious and capable of spreading the disease during
this period even while there are no symptoms of the disease. During
this so-called latent period, it requires a blood test to establish that
he carries the virus - a condition which is called being HIV positive.

2. The Unique Disease

a. Prolonged Course

When a person is first infected there is often, but not always, a
"flu-like" disease with a fever, rash, swollen lymph nodes, sore

---

10. Altman, Antibodies Seem to Protect Fetus from AIDS, N.Y. TIMES May 1, 1990, at C2.
throat, general fatigue and variable other signs. At this time the person may have a high level of viremia (virus in the blood) but will not test positively on the commonly used HIV-AIDS blood tests such as Enzyme Linked Immunoabsorbent Assay (ELISA) or the Western Blot which measure the person's antibody level (in effect, they measure the body's resistance to the disease). Since no resistance is detectable early in the disease, the viremia makes the person infectious to others before he/she becomes identifiable as having HIV-AIDS by routine blood testing. The "flu" stage passes, and the viremia lessens but the infectious condition remains. The antibodies produced by the person to fight against HIV are what are tested for in the ordinary screening for HIV-AIDS. These usually develop six weeks to several months after infection. Therefore, during the period before the antibodies can be measured, the person remains infectious but almost undetectable. He has no overt symptoms of disease or detectable antibody level in the blood and, therefore, is called "HIV negative." A relatively difficult and expensive test such as the polymerase chain reaction (PCR) can detect the presence of the virus during this so-called "window" phase which follows the infection and precedes the body's production of detectable amounts of antibodies.

This window phase blends into a latent period which may last more than a decade before the disease of AIDS itself begins. During this latent period, the virus is present within body cells but the disease progresses so slowly as to be inapparent to patient, or doctor or persons who may be exposed by intimate contact. Only a blood test will establish the existence of the person's disease and the fact of his/her infectious state. This condition of a person without signs of disease who can, however, spread the disease makes AIDS an unusually insidious condition and is one of the reasons it is dreaded. This contrasts with diseases such as leprosy which are also slow, but are very obvious.

14. CLOSEN, supra note 2, at 153.
15. CLOSEN, supra note 2, at 154.
17. CLOSEN, supra note 2, at 155.
b. Apparently Incurable

HIV-AIDS is also unique among diseases in that it seems, at least to the present time, to be both incurable and always fatal. Unlike some other incurable diseases, such as insulin-dependent diabetes or hemophilia, AIDS is still without successful longterm treatment. The diabetic requires life-long treatment with insulin, but at least he can look forward to a long life on that treatment. Treatment of HIV-AIDS, and its multiple complications, has prolonged life. However, once the active AIDS disease begins, the prolongation is more by months than by years, and it comes at great expense in money, resources, human time, energy, and emotion. There are, as yet, no known instances of complete cures. It is in the stage that diabetes was before the discovery of insulin.

These dismal facts have had a profound emotional impact on the nation’s attitude towards those who suffer from the disease. An attitude which has made controlling this epidemic both more difficult and less left to medical management.

3. The Medico-legally Unique Epidemic

AIDS is the first serious new epidemic to sweep this country since the Warren Court and the Civil Rights movement. There have been several epidemics in the 1970s and 80s such as the annual influenza epidemics, but these have not produced significant legal problems except for the liability secondary to the development of some vaccines.

a. Comparison With Hepatitis B Epidemic

The hepatitis B epidemic comes the closest to resembling AIDS.\textsuperscript{18} Hepatitis B is spread, as is AIDS, by the transfer of infected body fluid from one person to another. However, it is far more contagious than AIDS since it is a virus which is less fragile and much better able to live outside the body.\textsuperscript{19} Therefore, it can be spread by direct inter-personal contact other than intercourse. Fortunately, there is a good vaccine. Also, although the disease may be chronic or even fatal, it is usually a self-limited disease, meaning that, even without treatment, most people get well by themselves. Their immune systems are not under direct viral attack and can usually control the infection over time.

Hepatitis B, although it is a serious problem, is not new. It has led to a number of civil rights concerns and legal actions by inmates within prisons, institutions for the mentally ill and the mentally retarded, and preschool nurseries which have served as a legal guide to the BOP. Blood test measurements of the Hepatitis B seroconversion rate of individuals from the negative or disease-free state to the blood test positive, or infected condition, show less than 1% per year catch the disease while in prison. This low rate of spread of Hepatitis B, despite its relatively easier means of transmission than HIV, has been helpful as a medical guide to the rate of HIV-AIDS spread within prisons.

By contrast with Hepatitis B, AIDS is a lethal plague which is now spread almost exclusively by activities which are socially disfavored; i.e., promiscuous sexual intercourse and intravenous drug usage. In fact, in many states it is a felony if one is HIV positive. The more socially acceptable methods of HIV-AIDS transmission to "innocent" victims, through contaminated anti-hemophilic globulin and HIV infected transfusions have been drastically reduced in recent years by appropriate precautions in preparing the blood derivative products and in testing blood for HIV.

b. Civil Rights

The conjunction of a menacing deadly plague with "socially impermissible" methods of transmission has produced a unique result - the country's first serious epidemic in which the civil rights, particularly confidentiality and privacy, of the infected person have been considered as important, or sometimes more so, as the need for an aggressive public health response to defend the health of the uninfected portion of the population. Both the traditional public health response to an epidemic and the legal ramifications of this AIDS epidemic deserve examination.

B. THE EFFECT OF THE HIV-AIDS EPIDEMIC ON THE TRADITIONAL PUBLIC HEALTH RESPONSE TO AN INFECTIOUS EPIDEMIC

1. Identification of the Cause

The traditional public health response to a large-scale threat to the health of the American population, such as a viral epidemic,

begins with the attempt to identify the cause. This is often difficult in diseases such as AIDS when the course of the disease is long and the cause is obscure and/or multiple. Sometimes the process of locating and confirming the identity of the cause is controversial in itself. This was true in the case of cigarettes as a cause of lung cancer. The tobacco industry has consistently denied the link and the resulting controversy delayed proof of causation and, therefore, the scientific response to the epidemic of lung cancer. This delay in the establishment of the cause, therefore, further put off the onset of an effective public response. In the case of AIDS, it took three years to identify HIV and even the facts of that identification are still a matter of contention. Whether HIV was first discovered in France or at the National Institutes of Health in this country, is now mainly a matter of patent dispute, scientific history and scientist pride, but at the time (1983-5) the dispute slowed progress toward control of the epidemic.

2. **Identification of Methods of Transmission**

The methods by which a disease spreads from one person to another must also be identified and proven in order to prevent the spread. AIDS was first identified in male homosexuals, and the spread of early cases were reported as being aggravated as the result of homosexual practices. For instance, there was a belief that the use of "poppers" (amyl or butyl nitrite) was the cause of the immunosuppression in this disease which was only found in homosexual men.

Then it began to be reported that illicit drug users of either sex who injected drugs intravenously (I.V.) and who shared needles developed AIDS. It was also found that some persons who had received transfusions and many hemophiliacs were also victims of AIDS. These last observations focused attention upon the role of blood in the spread of the infection and away from the view that AIDS can be spread by casual contact. Recently, AIDS has become increasingly a heterosexually transmitted disease of the venereal type.


with infection of non-drug using women. Children of women with AIDS are also at risk of contracting the disease. About 25-30% of infants born to HIV infected mothers will develop AIDS. There is some evidence that this comes from breast milk as well as by transplacental spread.27

The methods by which the disease does NOT spread are also vital to learn. The initial public concern over the dissemination of AIDS by shaking hands or other casual contact, mosquito bites, food, drinking water, swimming pools, etc.28 distracted concentration away from the truly dangerous actual transmission methods of sexual intercourse and needle sharing and led to some irrational responses both in and out of prisons. The subsequent discovery that many of these initial responses were inappropriate led to the unfortunate result of a rejection of some of the more rational responses as well.

3. Statistical Data Gathering

The Federal Center For Disease Control (CDC) in Atlanta ordinarily relies upon physician and hospital reporting of cases of a disease for its statistics about the prevalence of that disease. It can then track the epidemic's progress and plan effective public health strategies to limit the further spread. Unfortunately, the social unacceptability of the major methods of transmission of AIDS has resulted in a tendency for patients and doctors to conceal the existence of the disease, which has led, in turn, to unreliable statistics. For instance, many death certificates have been deliberately falsified in an effort to “protect” the patient or his family from the presumed social disgrace of factual disclosure of the diagnosis of AIDS. This has frustrated the efforts of the health community to establish the scientific and epidemiologic facts about AIDS and, thereby, to combat this “new plague” successfully.

4. Testing to Determine Disease Prevalence

a. Rationale for Screening

The CDC also traditionally depends upon various forms of routine screening in order to obtain statistical evidence of the size and location of an epidemic. This is done by individual testing, random screening of the general population, and testing certain populations,

especially those at risk. Again, the unique nature of HIV-AIDS, especially of its means of transmission, has led these approaches to conflict with the perceived civil rights of infected persons. The concept of testing has been less of a civil rights concern than has been the possibility of the subsequent revelation that a given person is infected with AIDS. For contrast, as an example, the routine testing of students, health care workers, food handlers, and prisoners for tuberculosis has been carried out for decades but has caused civil rights concerns among only a few small religious groups. Much less extensive efforts to test for AIDS have caused public uproars. The fact that a person is known or suspected to have AIDS has led to social ostracism or even quarantine and isolation. This is remarkable when one considers how much easier it is to catch tuberculosis which can be spread to strangers by a cough or by casual contact than it is to contact AIDS which requires intimate contact.

b. Accuracy of Test Results

This threat of ostracism or worse is further complicated by the unfortunate circumstance that, by definition, all screening tests including those for AIDS, are deliberately made so sensitive that there are false positive results. These screening tests are made oversensitive so as to be sure that no infected person is missed by the screen (a false negative). That is, that no one is mistakenly told that he is well, when he is actually infected. However, in order to be sure that 100% of infected persons are identified, this caution means inevitably that some persons will be falsely labeled as positive. That is, persons who are not truly HIV positive may be mistakenly told that they tested positive. This inescapable flaw in screening test methodology is not so much of a problem with most disease conditions.

c. Consequences of An Inaccurate Test Result of AIDS

Before a physician makes a treatment plan, the same test or another more selective and specific test is performed. However, with AIDS the false positive first test can have tragic consequences. In a prison this false positive report could lead to inappropriate work and housing assignments and severe ostracism. The BOP, therefore, requires confirmatory testing of the screening test (ELISA) result with Western Immunoblot test before making a definitive diagnosis.

5. Prevention of Disease Spread

Public Health officials are expected not only to learn about the extent of the spread of the disease, but also to make active efforts to
prevent an epidemic from spreading. This can be controversial as, for instance, was the Surgeon General's anti-tobacco campaign to prevent lung cancer. So, too, have ideas such as the distribution of condoms, new sterile intravenous needles to drug users, or bleach to clean the needles to prevent AIDS have met with social resistance. Therefore, only a few prisons, such as those in New York, have attempted this type of prophylaxis. The BOP has chosen to emphasize education as to the methods of transmission, counseling, and the limitation of the sharing of personal items which might carry body fluids such as razors and toothbrushes. As will be cited, no significant spread of HIV has been found within Federal prisons.

6. Diagnosis and Identification of the Diseased Individual

Part of the public health response is to define and describe each new disease syndrome so that it can be recognized and diagnosed by physicians when they see an individual patient. This, too, was slow with AIDS.29 It was not until 1987, that the CDC came out with definitive guidelines which both standardized and altered the previous parameters for the diagnosis of HIV-AIDS.30

These CDC guidelines, plus the development of blood tests have sped the ability to locate and treat individual cases. However, this disease is still difficult to diagnose. It is insidious. It only becomes clinically apparent long after the time of infection. It appears in many different forms. Sometimes as an unusual tumor (Kaposi's Sarcoma), sometimes as a difficult to treat pneumonia caused by a common or uncommon pathogen or, sometimes, as a neurologic disorder affecting nerves and/or the brain.

With so many different possible means of presentation combined with a reluctance to label a person as an AIDS patient, it is not surprising that AIDS has been misdiagnosed. This is especially true among physicians in areas where the disease is uncommon such as the upper Plains States. AIDS requires special training of health care personnel to ensure prompt and accurate diagnosis. Delay in diagnosis can lead to delay in treatment and increased likelihood of spread.

7. Treatment

For most new diseases the FDA and other government agencies slowly sift through scientific documentation as to the efficacy and safety of drugs for treatment - a process that often takes many years.31 The social pressures of the AIDS epidemic have distorted this process dramatically and many medicines have been tried on humans without the usual long, careful process of testing. Nevertheless, to-date the most successful safe therapy for HIV has been Zidovudine (AZT), which has some beneficial effect in delaying the onset of the clinical symptoms. This is the primary AIDS medication now in general use by the Bureau.32 Other medications are used to prevent and to treat the secondary opportunistic infections such as pentamidine against Pneumocystis carinii. In addition, the BOP has approved several carefully supervised trials of promising new drugs such as ddI.

II. The Unique Legal Aspects of the AIDS Epidemic

As the first really new post-civil rights movement epidemic, HIV-AIDS is also the first in which the requirements of law have often over-whelmed those of medicine. The most crucial issues are those dealing with confidentiality and the right to privacy.33 The 1960's and 70's saw a considerable change in American sexual morals towards more openness, particularly in the matter of declaring one's homosexuality. In some communities such as San Francisco, the fact of one's homosexual preferences did not just "come out of the closet," but was openly flaunted in parades and by other public displays.34 This was also a period in which the use of mind altering drugs was more condoned than it had been previously. There has been serious advocacy of the legalizaton of addictive drugs.

Nevertheless, when the AIDS epidemic began in the early 80's, the initial reaction, particularly within the homosexual community, was an attempt to protect the infected person from any public knowledge of his diagnosis. While some of this desire for protection was moti-vated by concern over the same possible loss of health insurance or of employment which may result from any chronic disease, most of it was an attempt to protect the patient from public knowledge of the diagnosis of AIDS. This concealment was intended less to hide from

the public the knowledge that the victim suffered from a virus infection than to conceal his involvement in those activities which were his probable method of having contracted the disease.\textsuperscript{35}

The protection of an individual's confidentiality and privacy were felt to be so important that some lawyers were even advising the afflicted person not to confirm his diagnosis of HIV-AIDS for himself so that he could not be forced to reveal this potentially negative information on preemployment or other official questionnaires. He would not have to lie when denying his knowledge of having HIV-AIDS. When there was no treatment for the disease the diagnosis did not matter and would only prove to be a depressing confirmation of ones fears.\textsuperscript{36}

Since the advent of prophylactic therapy such as AZT for HIV-AIDS itself and other medications for the prevention of the more common concurrent opportunistic infections, the desirability of keeping the knowledge of the disease diagnosis even from oneself has waned. Nevertheless, state laws on notification of test results cover a wide gamut and often, as in California, severely restrict the classes and the number of persons who may be notified. Most of the laws have been designed to protect the person with AIDS against disclosure of his/her diagnosis rather than to protect the public against the potential for transmission of an incurable, fatal disease to an uninfected person. Public Health Departments' need-to-know so as to be able to protect citizens from disease has been sharply circumscribed during this unique post-1960's epidemic. Similarly, the Civil Rights aspect of this epidemic has complicated the response of the correctional institutions to its presence within prisons.

III. THE UNIQUE CORRECTIONAL SYSTEM: THE FEDERAL BUREAU OF PRISONS

A. OVERVIEW

The BOP is unique in its nationwide aspects. Unfortunately, it is not unique among prison systems in having problems caused by being the growth industry of the 1990's. It expects a 50% increase in the number of inmates (55,000 in 1990) within the decade. It has also


been subject to the general American legal doctrine that the Eighth Amendment protects against cruel and unusual punishment, which includes a prohibition against the Government's deliberate indifference to a prisoner's serious medical need. A prison system such as BOP, therefore, stands in a special health care relationship to those who are involuntarily confined within it.

The BOP is not only unusual because of its wide-flung (nation-wide) and large (60) number of prisons and its rapid growth but also because in recent years its population, 1) has become older, 2) has stayed in prison longer because of the Federal Court sentencing changes leading to longer prison terms, and 3) has acquired a large non-U.S. component, incarcerated because of their roles in the importation of drugs from outside the United States. Many come from nations such as Haiti which have a high incidence of HIV-AIDS.

B. HEALTH CARE IN THE BUREAU

The BOP has a carefully organized system of health care under Dr. Kenneth Moritsugu, the Medical Director. Each person has a specified number of physicians, physicians’ assistants, nurses, pharmacists, and auxiliary personnel reporting to a Health Services Administrator (HSA). Mental Health has a separate reporting system within each prison. In addition, there are six specialized medical facilities. The three principal ones are hospitals for men in Springfield, Missouri and Rochester, Minnesota and for women in Lexington, Kentucky.

It's worthy of note, that in the BOP, the health care providers in each institution have a direct line reporting responsibility to the senior correctional officer within that institution rather than to other senior health care officials within the BOP regionally and/or nationally. The Medical Director at the BOP in Washington has more of a staff responsibility than a direct operational line responsibility for health care within each prison. This has the effect of occasionally subordinating some health concerns to security concerns. This is peculiarly important in AIDS where the attitudes of other prisoners and of correctional officers toward the infected inmate present unusual disciplinary and security problems outside of the control by the health care team.

IV. BUREAU OF PRISON'S RESPONSE TO THE UNIQUE EPIDEMIC

A. INFORMATION GATHERING AND DISSEMINATION METHOD OF STATISTICAL DATA GATHERING

The BOP has gathered statistics on the number of inmates with AIDS by a number of methods, particularly by blood testing.\(^9\) During 1990, all new arrivals were tested for the presence of HIV at the time of intake. There is also, as part of the intake health examination, an interview screening of all new inmates to identify those whose behavior might make them a risk for AIDS.\(^40\) In 1991, those identified through this screening as at risk are blood tested,\(^41\) but only random testing will be done from among the other new arrivals.\(^42\) In both years, retesting of the same individuals at six months is mandatory for all HIV negative members of that test group.\(^43\) This follow-up locates those persons who were in the latent period of HIV negativity even though already infected with the virus at the time of admission.

There is also a mandatory random testing from among all inmates once a year without, however, mandatory retesting of the same HIV negative persons as a follow up.\(^44\) This is for statistical purposes rather than to detect individuals. There is voluntary testing upon the request by an inmate if the person is found to be at risk and there is both a clinical indication for testing and pre and post test counselling.\(^45\) This voluntary testing is allowed no more than twice a year, even if the inmate desires it more often, unless there is some other reason, in addition to inmate request, for testing more often.\(^46\) Testing is also done for patients with illness resembling AIDS, with pregnancy, or those who are admitted to community hospitals.\(^47\) It is also done for inmates with promiscuous, assaultive, or predatory sexual behavior.\(^48\) However, this last is said to be uncommon in Federal Prisons. Nacci and Kane reported in 1982 that fewer than 1% of Federal inmates were victims of sexual aggression each year.

---

\(^{41}\) Id.
\(^{43}\) Id.
\(^{44}\) Id. at § 549.16(a)(2).
\(^{46}\) Id.
\(^{47}\) Id. at § 549.16(b)(2).
The BOP approach attempts to avoid the opposite hazards involved in mass screening where on the one hand there are state laws opposing blood testing for HIV-AIDS without informed consent by the testee and on the other hand there have been prisoners’ suits demanding more testing. These prisoners’ suits have been motivated by desire for self-protection on the part of those not infected. Since drawing blood is legally a form of search, this search (blood test for AIDS) must be “reasonable.” 49 In Schmerber v. California, 50 Justice Brennan wrote that the proper function of the Fourth Amendment was to constrain against intrusions into the human body which were not justified in the circumstances. However, the Constitution does not forbid minor intrusions into an individual’s body (in Schmerber it was drawing blood for an alcohol test) understringently limited conditions. The drawing of blood was a search which must, and in Schmerber did, meet Fourth Amendment standards of reasonableness.

The next year Justice White in Camara v. Municipal Court, 51 wrote that administrative searches are significant intrusions upon Fourth Amendment interests but that warrantless municipal inspections of buildings according to a housing code section were justified by a reasonable governmental interest.

Presumably, this above described BOP arrangement for blood testing for AIDS meets the test of a reasonable governmental interest to meet the problems presented by this deadly pestilence within the confines of a prison. Certainly, there is a compelling state interest in obtaining access to facts about the extent and the progress of the epidemic within the prison system. 52

1. Statistical Results of Testing

A study of consecutive admissions to ten non-BOP correctional systems between June, 1988 and March, 1989 showed HIV-1 antibody (positives) percentages ranging from 2.1% to 7.6% for men and 2.5% to 14.7% for women, depending upon the part of the county the system was in. 53 By comparison, a 10% random sample testing in BOP from 1988 to August, 1989 has shown 2.8% of BOP entrants

---

to be HIV positive.\textsuperscript{54} A survey of incoming admissions to BOP had showed 2.5% positive in 1987, and a similar one in 1987 of those released showed 2.6% HIV positive.\textsuperscript{55} This indicates that there has been as much of a spread of this epidemic outside of the prisons as there has been inside among that class of people who are, or will be, convicted of Federal crimes. Other surveys also confirm the relatively small amount of in-prison transmission of AIDS.\textsuperscript{56} This is cross-confirmed by the less than 1% annual Hepatitis B seroconversion rate, since Hepatitis B is more easily transmitted than is HIV-AIDS and is transmitted among other ways by the same methods of intercourse and contaminated needles.

2. Regulation of Notification of Test Results

Because of the particular sensitivity about the dissemination of information about an inmate’s HIV status, the BOP has set up specific regulations, most recently in the December 21, 1990 Federal Register, about which persons must or may be notified that an inmate is HIV positive.\textsuperscript{57}

In balancing the inmates right to privacy against the correctional officer’s right to know, the BOP has said that knowledge of HIV results shall be “limited to those Bureau staff with the need to know (ordinarily, this includes members of the medical staff and the institution psychologist),” and ordinarily the Warden, inmate’s unit manager and case manager.\textsuperscript{58} In addition, for inmates being released for parole or placement in the community-based program, the warden shall send a letter to the Chief United States Probation Officer (USPO) of the district where the inmate is being released advising the USPO of the inmate’s positive HIV status.

If the inmate is to participate in a community activity, such as when going on a furlough, a notification of HIV positivity is made by the prison Warden to the USPO in the district to be visited and by the Prison’s HSA to the State Health Department of the state to be visited if that state requires such notification and if it is not an escorted trip.\textsuperscript{59}

\textsuperscript{55} Id.
\textsuperscript{57} 28 C.F.R. § 549.16(d) (1991).
\textsuperscript{58} Id. at § 549.17.
\textsuperscript{59} Id. at § 549.16(d)(1).
Prior to release or furlough, an HIV positive inmate "shall be strongly encouraged to notify his/her spouse (legal or common law) or any identified significant others with whom it could be assumed the inmate might have contact resulting in possible transmission of the virus." There is, however, a reluctance to force notification and there is no penalty for an inmate's failure to notify his future partner. The BOP does not notify potential contacts directly. One reason for this is the difficulty in ascertaining who or how many persons should be notified that they are at risk. Another is the confidentiality imposed because the inmate is confined involuntarily and, therefore, BOP has an increased responsibility for the inmate.

The HSA within each prison is responsible for notifying the State Health Department in whatever state the institution is located, and also the one in the state in which the inmate is expected to be released at the time of confirmation of seropositivity.

B. CONTROL OF THE EPIDEMIC WITHIN THE BOP


a. Identified HIV Positive Inmates

The BOP attempts to locate and to treat inmates who are sick with any disease. In the case of AIDS, identification is accomplished by interviewing during intake, at the time of presentation to a health care unit and by the random testing. Those identified are educated as to their need for special hygienic precautions, and are followed medically each month even while free of symptoms.

b. Universal Precautions for All Inmates

As was noted in Section 1, the disease is spread from one person's body fluid to another's blood by direct contact. Since this is most commonly accomplished through sexual intercourse and the use of unsterile needles, both of these activities are controlled as well as is possible in a prison population. In addition, "toothbrushes, razors or other personal implements that could become contaminated with blood may not be used by more than one inmate." Multiple use

---

60. Id. § 549.16(d)(3).
62. Id. § 549.16(d)(2)(ii).
63. See 28 C.F.R. § 549.16 (1991); Id. § 549.19(a).
items, such as bandage scissors, barber equipment, etc. are to be washed in warm soap water and agitated in disinfectant for not less than 15 seconds and then dried with a clean cloth following each use.65

c. Autologous Transfusion

All inmates are to be informed that they may store their own blood for use in scheduled elective surgery, although not for later use in case of an unexpected emergency.66


a. Prisoners

There is no segregation in housing within BOP simply because an inmate is found to be HIV positive.67 However, such inmates are not ordinarily assigned to work in food handling or health service units.68 This is done more for the presence of mind of the other prisoners rather than for any serious concern on the part of the BOP about the potential for transmissibility of AIDS in such sites.69 Otherwise, HIV positive inmates work at any job to which they are properly adapted.70 This concern by the non-infected prisoners has led to frequent - at least quarterly - educational programs available to all inmates regarding what they should know about AIDS.71

b. Correctional Officers

The BOP has instituted educational programs regarding the real and fancied dangers of the spread of disease; in particular, the potential consequences (or lack thereof) from a human bite from an HIV positive inmate.72 Fortunately, at least up through 1989, there were no known cases of transmission of HIV-AIDS to a BOP correctional officer from an inmate by any means.73

65. Id. § 549.13.
66. Id. § 549.20.
67. Id. § 549.12.
68. Id. § 549.14.
69. See generally Glick v. Henderson, 855 F.2d 536 (8th Cir. 1988).
71. Id. § 549.16.
72. Id. § 549.16.
C. TREATMENT

1. HIV Positive

Each HIV positive inmate is clinically evaluated at least once a month in the prison health care facility.\(^7\) When the T4 (helper cell) lymphocyte cell count falls to 500 or below, the inmate is offered the opportunity to receive AZT on a prophylactic basis. This is in line with current CDC recommendations for all HIV positive persons. AZT therapy is expensive and before 1990 had been available in the Federal prisons only in more seriously ill cases. At that time, routine therapy did not begin until the cell count was below 200, unless there were signs or symptoms of actual overt disease. Therapy at a T4 cell count of 500 is more to maintain good health than it is to treat any illness resulting from HIV. Unfortunately, the medication's unwanted side effects, such as anemia, requires careful medical monitoring.

2. AIDS

Patients who have progressed to the active disease stage of AIDS are transferred to and treated in the BOP hospitals in Springfield, Missouri and Rochester, Minnesota, especially the former. In some instances of acute illness, enough treatment to stabilize the patient is given initially within a community hospital adjacent to the correctional institution. The BOP's treatment of AIDS is that which is routinely expected in any other good hospital setting. It is of sufficiently high caliber that within the year 1989 six patients with AIDS who were offered early release from prison opted to stay within the BOP hospital where they felt they could receive definitive care more readily than they could outside the institution. These infected inmates believed that they would live longer and in better health inside the BOP hospital than they would outside.

3. Refusal of Treatment

It has been firmly established, at least since *Estelle v. Gamble*,\(^7\) that all patients with AIDS within the BOP are entitled to appropriate health care. It is less firmly established, however, whether they are entitled to refuse care. There is an established common law right to refuse health care, as the Supreme Court recently affirmed in *Cruzan v. Director, Missouri Dep't of Health*.\(^7\) However, security and order

\(^7\) 429 U.S. 97, 103-06 (1976).
\(^7\) ___ U.S. ___, 110 S. Ct. 2841 (1990).
within a prison may lead to a compelling state interest in testing patients for HIV.77 This could also be interpreted as establishing a state interest in treating AIDS patients similar to that in treating psychiatric patients against their personal desire to avoid treatment.78 This may be especially so if it seems that the refusal of treatment is an effort to obtain early release from the prison setting.

4. Education and Counseling

a. Inmates

All inmates are offered HIV education at the time of admission and are given an opportunity at least once each quarter to receive further education if they desire.79

b. Correctional Officers

Correctional officers all receive educational courses regarding HIV as a part of their original orientation and during required re-education programs.80

c. Significant Others

Counseling of significant others is encouraged but is not mandatory. It is the inmate who is expected to communicate with them before his release as to his HIV-AIDS status and, therefore, the need for this counseling.81

V. CONCLUSION

AIDS is a unique, rapidly changing disease which is difficult to prevent, diagnose and treat. It is insidious, incurable, deadly and terrifying. Its medical control throughout the country has been hampered by an active legal effort to protect AIDS patients from public knowledge of their disease. This protection is centered around concern about discrimination against the patient because of the sexual promiscuity and/or illicit drug use connotations of AIDS. This legal emphasis on patient confidentiality has severely hampered the medical

78. Id.
and public health efforts to control the epidemic and to protect the uninfected public.

The unique BOP, responsible for the nation's largest prison system, has a difficult balancing of prisoners' civil rights with the need for security and protection of inmates' health. The BOP's response is moderate and, so far, is successful and a model for other systems to follow.

RICHARD S. WILBUR
M.D., J.D.