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Journal

Harvard Civil Rights-Civil Liberties Law Review, 48, No. 1(Winter 2013)

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Publication Date

2013-01-04

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The Return of the Medical Model: Disease and the Meaning of Imprisonment from John Howard to *Brown v. Plata*

Jonathan Simon¹

INTRODUCTION: MEDICAL MODELS OF THE PRISON

Forty years after “the medical model” — as the rehabilitative-oriented penology that dominated American correctional systems from World War II until the 1970s was widely known — began to be abandoned, *Brown v. Plata*² suggests the imminent return of medicine and the problem of disease to our public imagination of the prison and our constitutional understanding of humane punishment. With its shocking portraits of prisoners afflicted with complex chronic mental and physical illnesses largely abandoned by the modern state to a chaos more reminiscent of medieval jails than modern prisons, *Plata* depicts a correctional system that has drifted far indeed from the old correctional medical model with its aspiration to scientifically tested penal treatments. But in *Plata*’s mandate that California significantly reduce its prison population in order to implement sweeping reforms in its delivery of health care, along with its exposure of the deep hold that chronic illness (both mental and physical) has on prison populations, we can forecast the emergence of a new medical model.

Indeed, the historical analysis offered in this Article suggests that *Plata* signals the rejoining of a constitutional link (in both senses of the term) between corrections and medicine that was forged more than two centuries ago over the problem of “jail disease” — assumed to be what we now know as typhus — that regularly killed prisoners at the end of the eighteenth century. This now-largely-forgotten threat, made hugely famous at the time of the American Revolution by the writings of an Englishman, John Howard,³ highlighted the grave injustice of the state taking forcible control over a person, separating him from the care of his family and friends, and then

¹ Adrian A. Krage Professor of Law, U.C. Berkeley. The author wishes to thank Ian Haney Lopez, Laurel Fletcher, Michael Meranze, Tony Platt, Karen Tani, Franklin Zimring, and all the members of a Berkeley Law faculty retreat workshop for comments on earlier drafts, and my editors at the *Harvard Civil Rights-Civil Liberties Law Review*, including Chrissy Calogero, Josh Freiman, Amanda Frye, William O’Neil, Kimberly Newberry, and Jason Lee, for many extremely helpful suggestions. As always the author affectionately acknowledges ownership of all of his errors.

² 131 S. Ct. 1910 (2011).

³ For the most thorough discussion of Howard’s role in eighteenth-century prison reform, see MICHAEL IGNATIEFF, *A JUST MEASURE OF PAIN: THE PENITENTIARY IN THE INDUSTRIAL REVOLUTION, 1750–1850* 44–117 (1978).

abandoning him to a known and horrific fate unrelated in any way to the magnitude of his crime, or, if not yet convicted, whether he was even guilty of it. Moreover, by linking this humanitarian anxiety about the state's treatment of prisoners to the health of the general public, the publicity surrounding "jail fever" helped upend the prevailing penal system and led directly to the birth of the modern penitentiary-style prison at the turn of the nineteenth century.⁴ From then until the 1980s, the American prison — and the correctional enterprise more broadly — was repeatedly reshaped by moments of heightened concern about disease, prisons, and the general health of the public. During these periodic transformations, contemporaneous medical ideas and procedures have been extended to correctional philosophy and ultimately constitutional understandings of the prison.

This Article identifies three distinct "medical models"⁵ that followed from the irruption of medicine into the penal field with John Howard's account of jail fever (see Table 1).⁶ Model 1 emerged in response to the problem of jail fever. The basic form of the penitentiary-style prison that

⁴ In Howard's day, there was little distinction between jails and prisons. See O. F. LEWIS, *THE DEVELOPMENT OF AMERICAN PRISONS AND PRISON CUSTOMS, 1776–1845* 16 (1922). Influenced in part by Howard and other reformers, both the United States and England created specialized prisons for long-term convicted prisoners. *Id.* at 11–15; HENRY MAYHEW & JOHN BINNY, *THE CRIMINAL PRISONS OF LONDON, AND SCENES OF PRISON LIFE* 80–82 (1862). In the United States, this became institutionalized in most states by the end of the nineteenth century, with jails holding a combination of pretrial inmates and prisoners convicted of offenses and punished by a term in the jail (typically of less than a year). See Seán McConville, *Local Justice: The Jail*, in *THE OXFORD HISTORY OF THE PRISON: THE PRACTICE OF PUNISHMENT IN WESTERN SOCIETY* 297, 298 (Norval Morris & David J. Rothman eds., 1995). Prisons, in contrast, were typically limited to convicted felons serving at least a year. See Seán McConville, *The Victorian Prison: England, 1865–1965*, in *THE OXFORD HISTORY OF THE PRISON*, *supra*, at 131, 132. Ironically, part of the "realignment" plan put in place by California to bring its prisons in compliance with *Plata* lifts the historic cap on jail sentences of a year and permits multiple-year sentences in a jail setting. CAL. PENAL CODE § 1170(h) (West 2012). This may raise Eighth Amendment challenges of its own.

⁵ Our periodization includes three medical models: of miasma (mid-eighteenth through mid-nineteenth centuries), infectious or "germ" models of disease (late nineteenth and twentieth centuries), and chronic illness (twentieth and twenty-first centuries), which draw on a similar analysis of the relevant field of epidemiology. See Mervyn Susser & Ezra Susser, *Choosing a Future for Epidemiology: I. Eras and Paradigms*, 68 AM. J. PUB. HEALTH 668, 668–73 (1996). For penology, we break the germ model into two distinct models: one centered on notions of degeneracy and associated with eugenics, and the other centered on notions of deviance. We also add a model based on pure penal incapacitation, which we call "anti-medicine," although it could be compared to the isolation imposed for quarantine purposes on those afflicted with incurable and infectious diseases, most infamously leprosy. See MICHEL FOUCAULT, *DISCIPLINE AND PUNISH* 198–99 (Alan Sheridan trans., Vintage Books 2d ed. 1995) (1977).

⁶ We should be clear that because the United States is a federal system composed of independent, state-operated prison systems, as well as a variety of federal ones and another distinct set of detention systems (civilian, immigration, military, war on terror), there is no "American prison" other than a rather blurry, ideal concept. Some states, like Arizona, were just adopting the third medical model at a time when advanced states, like California, were beginning the expulsion of medicine. See MONA LYNCH, *SUNBELT JUSTICE: ARIZONA AND THE TRANSFORMATION OF AMERICAN PUNISHMENT* 4 (2010) (providing information on Arizona and California).

Medical Models	Historical Moment	Exemplary Disease	Medical Paradigm	Penal Expression	Penology	Constitutional Expression
Model 1 Plague City	Lt. 18th c	Jail Fever	Miasma	Penitentiary	Punitive Discipline	<i>Ex Parte Wilson</i> (1885); <i>In re Medley</i> (1890)
Model 2 Eugenic Asylum	Lt. 19th c	Degeneracy	Germ/Darwinism	Big House Prisons		<i>Buck v. Bell</i> (1927)
Model 3 Penal Therapy	20th c	Deviance	Psychotherapy	Correctional Institution	Penal Welfarism	<i>Williams v. New York</i> (1949)
Model 4 Quarantine	Lt. 20th c	Monsters	Anti-Medicine or “Zombie Medicine”	Supermax	Total Incapacitation	<i>Ewing v. California</i> ; <i>Lockyer v. Andrade</i> (2003)
Model 5 Hospice	21st c	Chronically Ill Consumers	Correctional Geriatrics	Correctional Health Maintenance Center		<i>Brown v. Plata</i> (2011)

remains at the core of how we imagine the prison — a stack of cells surrounded by a well-ventilated fortress — emerged in the late eighteenth century as an extension of the dominant school of miasma medicine. This hugely influential invention placed its stamp on virtually every modern prison since, not only in the United States and England, but globally. It was followed, and extended in many respects, by two less momentous, but nonetheless influential, models that reflected the revolutions in nineteenth-century medicine associated with the confirmation of the causal role of microorganisms in disease etiology (germ theory) and the theory of evolution (Darwinism). Model 2, far less visible historically, arose over concerns with biological “degeneracy” in the urban population, which were directly connected to the racialized anxieties of white native Protestants over mass immigration. While this response took many legal and extralegal forms, an important component was the revitalization of the prison, now read through the lens of Social Darwinism⁷ and medical “germ theory”⁸ as a tool of eugenics. Model 3, which developed alongside Model 2 in the Progressive era, emerged as dominant after World War II based in part on the discredit-

⁷ ANTHONY M. PLATT, *THE CHILD SAVERS: THE INVENTION OF DELINQUENCY* 27–28 (3d ed. 2009).

⁸ Germ theory, or “pathogenic theory,” holds that many infectious diseases are caused by microorganisms, or germs (or “viruses” later), that move from a host animal to another animal. Although germ theory had been proposed as early as 1700, it remained highly contested until the mid- to late nineteenth century when the emerging science of microbiology largely validated it. The leading alternative explanation for disease propagation was “miasma theory,” which held that diseases arise from pollution resulting from corrupting organic matter and develop through repeated exposures of an animal to this pollution. Susser & Susser, *supra* note 5, at 669.

ing of eugenics, which had become associated with the use of genetics in Nazi genocidal practices. The paradigm shift was further precipitated by increasing anxiety over social deviance (especially among youth), made possible by the affluence and tight labor markets of America in the 1950s and 1960s. The new correctional institution drew heavily on the widespread acceptance of psychotherapy as a solution to both acute mental illness and more moderate “adjustment” problems. For contemporary historians, this rehabilitative penology is what is generally meant by the expression “the medical model.”⁹

The 1970s, a period of escalating crime (until the end of the decade) and growing discomfort with the civil liberties implications of a medical model of punishment, began a long-term decline in the prestige and influence of the medical model. When America began a massive prison boom in the 1980s, it was with the goal of delivering extended punishment and incapacitation, not treatment. The new penal regime, which has been described as “mass incarceration,”¹⁰ not only lacked a medical vision of how to treat crime, but at its extreme, as in the California record before the Supreme Court in *Plata*, it lacked a vision of its prisoners as requiring or deserving medical care at all. Jail fever and its lessons had finally been forgotten. Mass incarceration is the first penal regime in American history that follows what might fairly be called an “anti-medical” model.¹¹ Anchored in the extraordinary cultural ferment around violent crime in the 1970s, and highlighted by the apparently relentless criminal aggression of a long string of serial killers and often-distorted and sometimes completely false reports of violent assaults and murders of correctional officers, this new penology es-

⁹ See generally DAVID J. ROTHMAN, *CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA* (1st ed. 1980) (discussing U.S. developments); DAVID GARLAND, *PUNISHMENT AND WELFARE: A HISTORY OF PENAL STRATEGIES* (1985) (discussing British cases).

¹⁰ “Mass incarceration” is the term generally recognized by scholars of punishment and society to describe the enormous increase in United States prison populations that took place between the end of the 1970s and the first decade of this century. See generally Jonathan Simon, *Mass Incarceration: From Social Policy to Social Problem*, in *THE OXFORD HANDBOOK OF SENTENCING AND CORRECTIONS* 23 (Kevin Reitz & Joan Petersilia eds., 2012); FRANKLIN E. ZIMRING & GORDON HAWKINS, *THE SCALE OF IMPRISONMENT* (1991); David Garland, *Introduction* to *MASS IMPRISONMENT: SOCIAL CAUSES AND CONSEQUENCES* 1, 1–3 (David Garland ed., 2001). Scholars of mass incarceration in the United States have identified two key features that distinguish it from other variations of carceral punishment since the eighteenth century: (1) a quantum shift upward in the long-running level of incarceration in a particular society, and (2) a transformation in the logic of prison sentencing toward incarcerating whole groups or categories of offenders without much individualized consideration. We would add a third: the abandonment of all reform goals of imprisonment in favor of punitive segregation mostly for the purpose of incapacitation. See Simon, *supra* at 28.

¹¹ We are tempted, however, by the term “rabies medicine” for this monstrous approach. Rabid animals have for centuries defined a kind of aggressive threat that cannot be deterred or cured (in the attacker), but only neutralized. See generally BILL WASIK & MONICA MURPHY, *RABID: A CULTURAL HISTORY OF THE WORLD’S MOST DIABOLICAL VIRUS* (2012). On the role of monsters in the development of the anti-medical model, see Jonathan Simon, *Managing the Monstrous: Sex Offenders and the New Penology*, 4 *PSYCHOL. PUB. POL’Y & L.* 452 (1998).

chewed individualizing knowledge, including medicine, in favor of a general presumption of dangerousness. The new goal — to place as many criminal offenders in prison for as long as possible to bring down the overall level of crime — could be achieved without politically and economically costly individualization. Everywhere, prison populations soared.¹² And while prison building enjoyed an unprecedented boom, almost everywhere it fell short of the increase in prisoners, leading to chronic overcrowding in the nation's prisons for much of the last quarter century (and chronic hyper-overcrowding in the California record before the Court in *Plata*).

As a result of mass incarceration policies, prisons have accumulated and retain a population peculiarly vulnerable to the health problems of aging and chronic illness. Estimates suggest that as many as 40% of state prison inmates have chronic illnesses,¹³ and given that prison populations are rapidly aging,¹⁴ it is likely that this ratio will rise steeply in coming decades. Today, as a result of growing alarm at the humanitarian consequences of mass incarceration, we are in the midst of another moment comparable to the upheaval at the end of the eighteenth century that led to the birth of the modern prison and established a humanitarian concern about the fate of prisoners as part of our constitutional culture. Just as then, the problem of disease has emerged not just as a metaphor for crime, but as the revelation of a fundamental failure to fulfill the duty created by the extraordinary dependency forced upon a prisoner by the fact of imprisonment. Just as a jail disease linked the fate of prisoners to the well-being of the public, the emerging correctional health care crisis produced by the concentration of chronically ill and geriatric prisoners threatens to exacerbate a broader crisis of chronic illness in America's aging society.

We are far too close to the precipitating events to know whether *Plata* and the problem of correctional geriatrics foretell a fundamental reframing of the correctional enterprise or some lesser transformation, but the constitutional obligation to address the chronic illness problem in prison certainly forecasts a reinjection of medical professionals, ideas, and values into the penal field as dramatic as that which occurred during the heyday of Model 3 in the 1960s. Accordingly, Model 5, a speculative projection on the dynamic surface of the present, is an attempt to identify the main elements that might coalesce into a post-mass incarceration recasting of the prison enterprise.

¹² From 1980 to 2010, the national incarceration rate increased by 250% (from 139 to 486 per 100,000 residents). In California during that same time period, the incarceration rate increased by 365% (from 98 to 456 per 100,000 residents). See SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS ONLINE TABLE 6.29.2010 (2010), available at <http://www.albany.edu/sourcebook/pdf/t6292010.pdf>.

¹³ Andrew P. Wilper et al., *The Health and Health Care of U.S. Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 666 (2009).

¹⁴ Brie A. Williams et al., *Addressing the Aging Crisis in U.S. Criminal Justice Health Care*, 60 J. AM. GERIATRICS ASS'N 1150, 1151–52 (2012).

This Article then posits two moments and four medical models (plus a moment of “anti-medicine”). The rest of the Article will examine these two moments and describe the medical models that emerged from the first, as well as offer a speculative look at an emerging “next” model. Both of these moments of change, including our own, belong within a complex historical context that we cannot develop at length here, but that we also must not ignore. Instead, we focus on five features that characterize these episodes of disease and prisons, and out of which have emerged significant transformations.

- (1) A high-profile disease that highlights problematic features of the dominant penal practices and connects the prisoner as medical subject, broadly construed, to the general human vulnerabilities of a particular age. It is not every medical scandal that can shake the legitimacy of the prevailing penology and impel change. Indeed, in some cases, medical scandals can reinforce the direction of development already underway. Those that do lead to broader shifts in penology are those that link the dominant model of the prison, and the fate of prisoners, to an emerging public health threat.
- (2) A robust medical theory (or theories) that provides a basis for articulating the links between prison health and public health, and that points the way toward practical solutions. If there is no solution, there is no problem (at least of legitimacy).
- (3) A striking penal innovation that is capable of addressing the disease threat, and of offering new optimism toward reforming prisoners and preventing crime.
- (4) A new penal ideal that generalizes insights about prisons and humanity, derives from the problem of disease, and rearticulates the legitimate objectives of the prison.
- (5) A constitutional expression that marks a boundary, implicit or explicit, around legitimate and humane punishment. Since the mid-twentieth century, this has focused on the Supreme Court’s interpretation of the Eighth Amendment.¹⁵

We do not mean to exaggerate the importance of disease as a problem or medicine as a rational force in directing the development of the prison in the United States. Historians persuasively suggest a more influential role for the problems of labor,¹⁶ race, and immigration in determining both the quan-

¹⁵ Although the practice of evaluating state inmates’ challenges to prison conditions by assessing conditions of imprisonment through the lens of the Eighth Amendment only found wide acceptance during the last two periods, we can discern evidence of a constitutional recognition of these shifts in the medical model of the prison — a recognition that in time came to inform the meaning of the Eighth Amendment’s prohibition on “cruel and unusual punishments.” See *infra* notes 73–90.

¹⁶ See generally, e.g., GEORG RUSCHE & OTTO KIRCHHEIMER, PUNISHMENT AND SOCIAL STRUCTURE (2003) (revising GEORG RUSCHE, LABOR MARKET AND PENAL SANCTION: THOUGHTS ON THE SOCIOLOGY OF CRIMINAL JUSTICE (1939)); WILLIAM J. STUNTZ, THE COLLAPSE OF AMERICAN CRIMINAL JUSTICE (2011).

tity and the quality of imprisonment.¹⁷ Rather, here we want to focus on a narrower but important problem for the American prison — one that is foundational historically and, most importantly, has an ongoing constitutional significance today, largely invested in the Eighth Amendment. Is the prison humane? Is it compatible with recognition of the essential human dignity of the prisoners? Why? It is here that, in bringing the prison into public scrutiny periodically and decisively, disease has played a central role in shaping episodes of public controversy about the humanity of punishment. Disease has a distinctive power to strip away the general invisibility of life that takes place behind the walls of prison, and narrow the gulf that normally separates the fate of prisoners from the imagination of the free. These moments have been particularly consequential because of their potential to motivate legal elites, on the bench and in academia and government, to “see” the existing penal regime anew and actively to reimagine the American prison.¹⁸

I. JOHN HOWARD AND JAIL FEVER

The first model arose at the end of the eighteenth century, and was contemporaneous with both the birth of the modern penitentiary-style prison and the framing of the Constitution. To a significant extent, both of these institutions bear the imprint of a historically specific shock of horror and disgust shared among educated classes throughout the Atlantic society of the eighteenth century, which was associated with the discovery of jail disease. In the case of the penitentiary — that amazingly venerable design of cells stacked in tiers within a fortified building designed both to contain and ventilate the cells, and which we will call a “ventilated fortress” — this influence was explicit and undeniable. In the case of the Eighth Amendment, the language taken directly from the English Bill of Rights from a century earlier had little to say directly about imprisonment, but the specter of jail disease nonetheless began in that very moment to shape the constitutional legitimacy of penitentiary imprisonment.

Jail disease was a nightmare repeatedly witnessed and widely publicized by an Englishman who became the most famous prison observer in the

¹⁷ See generally, e.g., REBECCA McLENNAN, *THE CRISIS OF IMPRISONMENT: PROTEST, POLITICS, AND THE MAKING OF THE AMERICAN PENAL STATES* (2008); MARIE GOTTSCHALK, *THE PRISON AND THE GALLOWES: THE POLITICS OF MASS INCARCERATION IN AMERICA* (2006); CHARLES BRIGHT, *THE POWERS THAT PUNISH: PRISONS AND POLITICS IN THE ERA OF THE “BIG HOUSE,” 1920–1955* (1996). For information on social and political factors influencing incarceration rates, see generally BRUCE WESTERN, *PUNISHMENT AND INEQUALITY IN AMERICA* (2006); Vesla M. Weaver, *Frontlash: Race and the Development of Punitive Crime Policy*, 21 *STUD. IN AM. POL. DEV.* 230 (2007).

¹⁸ The Atlantic movement for penal reform coincided with the American Revolution, and after independence, many Americans viewed the new model prisons that were being developed as an expression of the democratic ethos of the state. See generally THOMAS L. DUMM, *DEMOCRACY AND PUNISHMENT: DISCIPLINARY ORIGINS OF THE UNITED STATES* (1987); MICHAEL MERANZE, *LABORATORIES OF VIRTUE: PUNISHMENT, REVOLUTION AND AUTHORITY IN PHILADELPHIA, 1760–1835* (1996).

eighteenth-century world: John Howard, whose two books on conditions in jails and other places of detention throughout England and Europe helped define jail fever as a peril that linked the fate of all.¹⁹ Howard came from a wealthy family of intense religious values.²⁰ He turned a minor hereditary role as a local sheriff into an occasion to visit and inspect jails and other detention facilities throughout England and Scotland. Appalled by the conditions he saw there, he devoted the rest of his life to publicizing the need for prison reform.²¹ His detailed notes were published in 1777 as *The State of the Prisons*, which focused a great deal on the disease-inducing qualities of confinement, especially the lack of ventilation.²² Howard provided a detailed inventory of the physical layout and condition of each jail in the country along with recommendations for reform.²³ His account placed jail fever at the very center of his contention that detention ignored the humanity of prisoners and endangered society.

Despite (or perhaps because of) the grim topic and notwithstanding its repetitive descriptions, the book joined Beccaria's *On Crimes and Punishments* (1763) as one of the most influential tracts on criminal justice in the eighteenth century. Beccaria's critique of the scaffold is today closely associated with the movement among the Atlantic legal and political elite against capital punishment, but Howard was probably equally important among the same audience, especially for criminal justice reformers in the Atlantic world.²⁴ His exposé of the jail — a seemingly less cruel but parallel and

¹⁹ IGNATIEFF, *supra* note 3, at 52–57 (discussing Howard's influence).

²⁰ *Id.* at 48.

²¹ *Id.* at 52.

²² JOHN HOWARD, THE STATE OF THE PRISONS IN ENGLAND AND WALES WITH PRELIMINARY OBSERVATIONS, AND AN ACCOUNT OF SOME FOREIGN PRISONS 12–15 (1777), available at <http://books.google.com/books/reader?id=4EhNAAAAYAAJ&printsec=frontcover&output=reader&pg=GBS.PP7>.

²³ Howard's second book, AN ACCOUNT OF THE PRINCIPAL LAZARETTOS OF EUROPE (2d ed. 1791), appeared posthumously in 1789.

²⁴ There has been extensive research by legal scholars and historians on the influence of Beccaria among the Framers. John Adams quoted from Beccaria's text in his defense of the British soldiers indicted for the Boston massacre, and Thomas Jefferson owned it in his library. See generally Deborah Schwartz & Jay Wishgrad, *The Eighth Amendment, Beccaria, and the Enlightenment: An Historical Justification for the Weems v. United States Excessive Punishment Doctrine*, 24 BUFF. L. REV. 783 (1974–75) (arguing that Beccaria's ideas directly influenced the Eighth Amendment); John F. Stinneford, *Rethinking Proportionality Under the Cruel and Unusual Punishments Clause*, 97 VA. L. REV. 899 (2011) (arguing that Beccaria was well known to the Framers and probably influenced their positive legislative proposals more than the Eighth Amendment); McLENNAN, *supra* note 17, at 21 (describing Beccaria's strong influence on the Revolutionary generation). There has been less interest in Howard by historians and legal scholars, and those who have examined his influence in the Atlantic world of the late eighteenth century have been more interested in his following among British and American penal reformers. See IGNATIEFF, *supra* note 3; MERANZE, *supra* note 18, at 140–41. There has also been less focus on Howard's influence on constitutional thinking; however, there is strong evidence that Thomas Jefferson both ordered Howard's book for his library, presumably during his work on the Virginia penal code reform, and read it carefully enough that it may have influenced his plans for the University of Virginia. See Mary N. Woods, *Thomas Jefferson and the University of Virginia: Planning the Academic Village*, 44 J. Soc'Y ARCHITECTURAL HISTORIANS 266, 275 (1985).

companion institution to the scaffold — helped discredit the institution most readily available to replace the scaffold.

A. *Miasma Medicine*

Howard, a religious dissenter, objected on moral grounds to the whole jail regime that was then typical of detention facilities in Europe and North America, mixing prisoners of all states and statuses — for example, felons and debtors, men and women, children and adults — and subjecting them to a disorderly and often lewd and immoral environment.²⁵ Like other prison reformers of this period, Howard imagined a disciplinary environment as far more appropriate to the tasks of punishment. The core of Howard's critique, however, was his depiction of jail disease and the priority he gave to a medical solution: "[M]y attention was principally fixed by *gaol-fever*, and the *small-pox*, which saw prevailing to the destruction of multitudes, not only of felons in their dungeons, but of debtors also."²⁶

With Beccaria's readers no doubt in mind, Howard noted the irony that "[m]any more were destroyed by [jail fever], than were put to death by all the public executions in the kingdom."²⁷ With a cruelty unknown to capital punishment, death by jail fever struck not only felons but debtors and numerous prison charitable workers whom Howard mentioned in the text.²⁸ But its impact was not limited to the prisons. Howard noted that among its likely victims were sailors and those in America who came into contact with prisoners transported from English jails already infected (a risk cut off by the American Revolution): "Multitudes catch the distemper by going to their relatives and acquaintances in the Gaols: many others from prisoners discharged and not a few in the courts of judicature."²⁹

What made Howard's book and the subsequent reform campaign so influential was the very real threat that infectious disease posed to populations throughout Europe and its New World satellites, including the United States. By associating jails with these prevalent infectious diseases and its own distinctive disease, typhus, described tellingly as "jail fever," Howard forged a remarkable link between the lives of prisoners and the general public health. The association was so strong that nearly three quarters of a century later, Charles Dickens depicted London's Old Bailey courthouse in the 1780s, shortly after Howard's *The State of the Prisons* came out, as "bestrewn with herbs and sprinkled with vinegar, as a precaution against gaol air and gaol fever."³⁰

²⁵ See generally IGNATIEFF, *supra* note 3.

²⁶ HOWARD, *supra* note 22, at 7.

²⁷ *Id.* at 14.

²⁸ *Id.* at 18.

²⁹ *Id.* at 17.

³⁰ CHARLES DICKENS, *A TALE OF TWO CITIES* 66 (Penguin Classics 2000) (1879).

Howard's account resonated with American experiences of the jail fever problem. American prisoners during the Revolutionary War suffered enormous losses due to disease while in British detention facilities — whether in hulks in New York harbor, or on quarter rations in special sections of British military prisons. Smallpox and cholera regularly threatened large American cities like Philadelphia in the early nineteenth century.³¹

Drawing on the prevailing miasma theory, which constituted essentially an environmental view of disease causation, Howard understood jails to be dangerous because of their filthiness, intermingling of prisoners and outsiders, and lack of fresh air and water.³² For Howard and his followers, the ideal prison would be one in which all these vectors of disease were countered: keeping prisoners individually celled at night, assuring that any common spaces were spacious and well-ventilated, and designing and locating buildings to maximize access to abundant fresh air and water.³³ Howard himself designed prisons to meet this ideal, including Coldbath Fields Prison, which originally opened as the Middlesex House of Corrections in 1794.³⁴

In the United States, the early adoption of the penitentiary was almost certainly due to Howard's influence.³⁵ Progressive-era American correctional reformer O. F. Lewis described Howard's work as standing out with "spectacular singleness" at the origins of American corrections, and wrote that: "It is likely that ultimately, when this early period of our penal history is fully explored, it will be found that John Howard was in many respects a founder of our American prison system."³⁶

Lewis noted that leading early American prison reformers, including Caleb Lownes and William Bradford, were clearly influenced by Howard.³⁷ He quotes from the *Encyclopedia Americana*, which described the reception of Howard's book in religious terms: "[T]here was a universal outcry of horror and indignation which was heard throughout the civilized world, when he disclosed the misery everywhere suffered by the prisoners."³⁸

³¹ MERANZE, *supra* note 18, at 233 ("Yellow fever and small pox struck the city recurrently throughout the early nineteenth century.").

³² HOWARD, *supra* note 22, at 12–14.

³³ *Id.* at 40–43.

³⁴ See generally MAYHEW & BINNY, *supra* note 4, at 277–352.

³⁵ Benjamin Rush, perhaps the most important figure to push American penal reform toward disciplined, penitentiary-style prisons and away from public outdoor punishment (one of the major alternative methods for criminal punishment), was a physician himself who freely drew on both miasma theory and Lockean psychology to develop his own approach, which also had links to Howard. See MERANZE, *supra* note 18, at 138–46.

³⁶ LEWIS, *supra* note 4, at 33. As Meranze points out, Howard's Christ-like self-sacrifice epitomized the image of virtuous patriotic reform that combined deep religious piousness with confident assertion of public authority through secular institutions. MERANZE, *supra* note 18, at 140.

³⁷ LEWIS, *supra* note 4, at 33.

³⁸ *Id.* (quoting 10 ENCYCLOPEDIA AMERICANA 342 (1st ed. 1832)).

Thus, the prisons that spread across all regions of the United States in the nineteenth century would reflect, at their core, Howard's strategy against jail fever and his reform penology based on removal of criminals to well-disciplined, controlled spaces of purity and health.³⁹ In this way, the wave of reforms in prison design that began in the 1790s had been centrally about disease prevention.⁴⁰

B. *Disciplinary Punishment*

Along with the penitentiary-style prison, jail fever would help spread a penology based on hard but highly controlled disciplinary routines inside a fortified work place, which eventually became a dominant theme for punishment through the nineteenth and twentieth centuries across the industrialized world.⁴¹ Thanks to Michel Foucault's influential study of the penitentiary as a form of political "technology," the disciplinary logic of the nineteenth-century prison is today well known, but its connection to jail fever is not.⁴² This disciplinary logic, which Howard took from the European model of workhouses for the poor, was not itself a medical idea; rather, it was applied to prevent disease from spreading inside prisons through the application of precise movement subject to review and revision.

Jeremy Bentham, the English political philosopher and legal theorist whose own design for an ideal prison in a 1791 pamphlet, *The Panopticon; or the Inspection House*, provided Foucault his central example of discipline as a technology of power (indeed, he describes it in the book as "panopticism"), clearly had jail fever in mind when he framed health as a distinct priority for prison managers in his prospectus.

³⁹ American penology was famously split between advocates of the Philadelphia, or "solitary," model, in which prisoners were maintained in complete isolation and anonymity to one another, and the Auburn, New York, or "congregate," model, in which prisoners were kept isolated in cells at night. Both sides of this debate, however, accepted Howard's principles and included them in their designs, which is one reason why both models end up looking quite similar (both are ventilated fortresses). On Auburn, see generally LEWIS, *supra* note 4, at 77–106, 182. On Philadelphia, see generally MERANZE, *supra* note 18, at 253–65. The South was slower to develop penitentiaries due to the fact that punishment of slaves was largely a private matter of plantation discipline. After the Civil War, all Southern states would develop Howard-like penitentiaries for white prisoners, but would continue to place their African American prisoners in private labor contracts whose conditions were far worse and frequently deeply unhealthy. On the South, see generally ALEX LICHTENSTEIN, *TWICE THE WORK OF FREE LABOR: THE POLITICAL ECONOMY OF CONVICT LABOR IN THE NEW SOUTH* (1996).

⁴⁰ MERANZE, *supra* note 18, at 210.

⁴¹ See generally FOUCAULT, *supra* note 5 (describing the shift of penal justice from scaffold execution or torture to imprisonment as marking the rise of new disciplinary technologies of power that were crucial to governing society in the Industrial Age).

⁴² *Id.* Ironically, Foucault had discussed Howard at length in his earlier history of the problem of madness in European societies, see MICHEL FOUCAULT, *HISTORY OF MADNESS* 53–54 (Jonathan Murphy & Jean Khalifa trans., 2006) (1972) (discussing Howard's books), but did not mention his connection to the penitentiary in *Discipline and Punish*.

A *Penitentiary-house*, more particularly is, (I am sorry I must correct myself, and say *was* to have been) what every prison might, and in some degree at least ought to be, designed at once as a place of *Safe Custody*, and a place of *labour*. Every such place must necessarily be, whether designed or not, an *Hospital*: a place where sickness will be found at least, whether provision be or be not made for its relief.⁴³

Much was hoped for disciplinary punishment. In the form that became the American standard, the “congregate labor system,” disciplinary control took the form of a “lock-step” by which prisoners were forced to walk in lines together, stepping in coordination with knees aligned back to forward; silent industrial labor, overseen by guards, was intended to turn them into docile and useful laborers upon release.⁴⁴ But along with the premise of solitary confinement at night in small cells, this system for the movement of prisoners inside the prison (as much as its rival, the “separate system” of total solitary confinement) had as its prime directive the prevention of disease from taking hold or spreading inside the prison and among the confined population. By the end of the nineteenth century, both objectives, reform and health, would remain largely unfulfilled as the nation became concerned about a crime wave associated with mass immigration, and prisons themselves became notoriously unhealthy places in an age of infectious diseases, like tuberculosis.⁴⁵ But medicine, renewed by new theoretical and empirical developments, would endure as both a critical source of authority inside the prison,⁴⁶ and, through metaphoric extension to the prisons, its role as a treatment for crime in society would continue into the twentieth century.

C. *Extensions of the Medical Model: “The Eugenic Asylum” and the “Therapeutic Community”*

Beginning in the late nineteenth century, Americans again reimagined the prison as new legal forms emerged (like parole, probation, and juvenile courts), and a new generation of prisons was realized. Historians have noted the influence of a number of different factors on the development of penal thinking in this era, including the new scientific criminology, social work,

⁴³ JEREMY BENTHAM, *PANOPTICON; OR, THE INSPECTION-HOUSE* 31 (1791).

⁴⁴ DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* 79–88 (1971) (describing the congregate system and its main rival, “the separate system” of Philadelphia, in which prisoners were confined in large cells for the full duration of their term with no intercourse with other prisoners).

⁴⁵ On the sense of failure surrounding the American prison in the last decades of the nineteenth century, see generally ROTHMAN, *supra* note 9; McCLENNAN, *supra* note 17.

⁴⁶ For the British case, and for the general importance of medicine as a source of authority in the modern prison, see JOE SIM, *MEDICAL POWER IN PRISONS: THE PRISON MEDICAL SERVICE IN ENGLAND 1794–1989* 12 (1990) (describing Howard’s influence on the founding of the medical service and on the early British prison generally).

and eugenics.⁴⁷ All of these drew substantially on one or both of two major scientific developments in the late nineteenth century: the consolidation of “germ theory”⁴⁸ as the primary explanation of disease etiology and Darwin’s theory of evolution.⁴⁹

One wing of the movement associated with social work and psychological causes of crime and delinquency placed primary emphasis on preventive interventions with juveniles and penal treatment for criminal adults. This “therapeutic” wing became increasingly influential after World War II, but at the turn of the twentieth century, it coalesced comfortably with a racist-biological wing concerned with the racial degeneration of the American population and fueled by eugenic spin-offs of Darwinian evolutionary biology.⁵⁰

In the decades between the Civil War and World War II, this eugenic dimension cast the dominant light on the penitentiary-style prison system that American states had cultivated since the end of the eighteenth century. The prison became a kind of eugenic asylum, expected not to transform its inmates, but to sort those who should be incapacitated from committing crimes and reproducing. Physicians and other well-educated reformers, influenced by both eugenic and therapeutic aspects of the disease model, were increasingly ready to see behavioral abnormalities, including crime, as rooted in individual biological anomalies that evidenced degeneration to earlier evolutionary stages of development.⁵¹ From this perspective, the primary purpose of institutions like prisons and mental hospitals was to prevent defective individuals from engaging in biological reproduction. If that could be achieved by sterilization, regularly upheld by the Supreme Court in that era, custodial populations could drop (or at least grow less rapidly, given the significant population growth from immigration).

1. *Degeneracy and the Big House Prison.*

If legal elites in the late nineteenth century were no longer as worried by the prospect of infectious disease as reformers in the early republic had been, they still had their own medicalized fears associated with the problems of industrialism and immigration. One axis of that concern focused on the “racial threat” posed to the native white Protestant majority by massive immigration from Southern and Eastern Europe after 1870, which was made up of a lower-class population that was viewed as inferior in almost every

⁴⁷ See generally ROTHMAN, *supra* note 9 (discussing U.S. developments); GARLAND, *supra* note 9 (discussing British developments).

⁴⁸ See *supra* note 8.

⁴⁹ PLATT, *supra* note 7, at 27–28.

⁵⁰ See ROTHMAN, *supra* note 9, at 56–59 (describing how Progressives comfortably mixed both eugenic ideas with new reform strategies based on emerging psychological ideas about deviance).

⁵¹ The classic representation of this “degeneration” theory in the literature of the common law world was *The Strange Case of Dr. Jekyll and Mr. Hyde*, by the Scottish author Robert Louis Stevenson, published in 1886.

sense.⁵² Naturally, many young immigrants or children of immigrant parents found themselves caught up in the criminal justice system as large cities throughout the North and West created municipal police departments in response to nativist concerns about foreigners' crime.⁵³ A second axis concerned the prison itself, which, contrary to the hopes of Howard's generation, had not been shown effective in reforming prisoners. That prisons and jails increasingly contained young immigrants and first-generation Americans of immigrant backgrounds melded the two problems.

The threats of racial degeneracy from immigration and the problem of persistent criminality from recidivism were seen by many among America's progressive educated classes as medical problems with clear biological foundations and effects, as well as questions of public law and policy.⁵⁴ Social extensions of Darwin's theories of evolution found ready audiences in the United States during this period. Among the most popular and productive were biological theories of crime associated with the Italian criminologist (and physician) Cesare Lombroso.⁵⁵ Lombroso believed America's high crime rate was in large part a product of its high immigration, which he viewed as a process that removed the criminal classes of Europe to the New World.⁵⁶ His argument that prisons ought to be focused on incapacitating those fated to criminality by biology found a warm reception among American prosecutors and legislatures.⁵⁷

Between its eugenic and its social wings, the revivalist "new penology" that stirred American corrections at the end of the nineteenth century forged a new medical model that differed greatly from the eighteenth-century concern about eliminating corruption in the environment. This new model was roughly translated from the new science of microorganisms, which was beginning to dominate medical theory and transform medical practice at the end of the nineteenth century.⁵⁸ In medicine, germ theory meant that the generalized cleansing and separating recommended by miasma medicine was far less important than diagnosing the correct microorganism involved, and deploying a therapy designed to destroy it. In corrections, this called for a careful effort to examine the individual offender in all his biological, psychological, and sociological specificity.⁵⁹ The prison administration and cor-

⁵² See PLATT, *supra* note 7, at 36 (describing how crime came to be blamed on poorly educated urban immigrants).

⁵³ See STUNTZ, *supra* note 16, at 23–25.

⁵⁴ ROTHMAN, *supra* note 9, at 71.

⁵⁵ PLATT, *supra* note 7; Jonathan Simon, *Positively Punitive: How the Inventor of Scientific Criminology Who Died at the Beginning of the Twentieth Century Continues to Haunt American Crime Control at the Beginning of the Twenty-First*, 84 TEX. L. REV. 2135, 2140 (2006).

⁵⁶ Simon, *supra* note 55, at 2155.

⁵⁷ *Id.* at 2145.

⁵⁸ See ROTHMAN, *supra* note 9, at 58 (noting that even those most concerned with eugenics took an individualized and optimistic approach to penal strategies).

⁵⁹ *Id.* at 54 (citing psychologist William Healey and his book, *The Individual Delinquent* (1915), as a signal expression of this model).

rections official needed to know about and act upon this particular individual, and not merely the undifferentiated convicted legal subject who had been the focus of nineteenth-century incarceration.⁶⁰

2. *Deviance and the Correctional Institution.*

A third wave of prison reform in the United States began after World War II,⁶¹ which crested during the 1970s and into the 1980s as federal courts read the Eighth Amendment to encompass modern standards set by rehabilitation-oriented national correctional associations.⁶² The new threat was social deviance, which threatened to spawn crime in the midst of unprecedented economic opportunity and was epitomized by thrill-seeking crimes and juvenile delinquency. It was in this period that many American states — mostly in the Northeast, West, and Midwest — adopted what is conventionally referred to as the “medical model,” in which rehabilitation and treatment were the primary objectives of the penal system, new sentencing laws permitting a greater degree of individualization to allow for a more clinical approach were enacted, and new prisons that permitted individualized treatment (as well as isolation of the most dangerous) were designed.⁶³

This third medical model had a subtler influence on the physical structure of prisons. One popular model, known as a “telephone pole,” linked prison dormitories with educational facilities, treatment centers, and workshops all along a wide corridor connecting all the buildings; it was an approach that involved a relaxation of the old disciplines and required inmates who needed to be on the move to complete individual programs.⁶⁴ Psychologists and psychiatrists had already played a significant role in the prisons of the first half of the twentieth century, but mostly in a classifying role;⁶⁵ beginning after World War II, though, state and federal prisoners began to encounter group therapy (individual therapy being far too expensive for prisons staffed with only a single professional psychologist or a limited

⁶⁰ See generally GARLAND, *supra* note 9 (noting that while Victorian penalty individuated through its emphasis on legal responsibility, the reform movement of the turn of the twentieth century individualized with an emphasis on the substantive features of the individual life history).

⁶¹ See JONATHAN SIMON, *POOR DISCIPLINE: PAROLE AND THE SOCIAL CONTROL OF THE UNDERCLASS, 1890–1990* 63 (1993); see also Edgardo Rotman, *The Failure of Reform: United States, 1865–1965*, in *THE OXFORD HISTORY OF THE PRISON*, *supra* note 4, at 169, 188–94.

⁶² See generally MALCOLM FEELEY & EDWARD RUBIN, *JUDICIAL POLICY MAKING AND THE MODERN STATE: HOW THE COURTS REFORMED AMERICA’S PRISONS* (1998) (tracing the importance of the American Correctional Association and the Federal Bureau of Prisons in creating enforceable norms with which to apply the Eighth Amendment to prison conditions).

⁶³ For a recent assessment of this trend and its limits, see LYNCH, *supra* note 6, at 4 (noting that Arizona represented one of the last states to adopt rehabilitation in the late 1960s, and one of the first to move abruptly toward the warehouse prisons typical of mass incarceration).

⁶⁴ NORMAN JOHNSTON, *THE HUMAN CAGE: A BRIEF HISTORY OF PRISON ARCHITECTURE* 41–42 (1973).

⁶⁵ Rotman, *supra* note 61, at 169, 178 (noting that by 1926, seventy-seven prisons had psychiatrists and forty-four had psychologists).

number of psychiatrists) and repurposed traditional activities like “bibliotherapy” (reading).⁶⁶ In the leading states like California, new prisons were built with an emphasis on education, therapy, and vocational training.⁶⁷

Perhaps the most optimistic version of the third medical model was the “therapeutic community.” In England, a new model of therapy developed around the problem of the under-productive worker whose untapped potential was suddenly valuable to a war-starved economy. Maxwell Jones, a psychiatrist, developed a method known as the “therapeutic community” in which patients and therapists formed a common commitment to address all issues of well-being facing the group.⁶⁸ By the 1960s, this was being eagerly imported by a number of American state prison systems.⁶⁹ California experimented with therapeutic community, devoting one of its new prisons, the Deuel Vocational Institution, to a therapeutic community regime for young offenders.⁷⁰

By the 1960s, the analogy between imprisonment and rehabilitative treatment was complete. American states varied greatly in the eagerness with which they embraced the new model.⁷¹ A good example of the acceptance of this penology was the influential Model Penal Code — a project of the American Law Institute, an association of elite judges, lawyers, and legal academics devoted to law reform, which had been commissioned to draft a comprehensive statement of American criminal law. The widely circulated draft of the Model Penal Code completed in 1962 used the term “treatment” repeatedly to describe punishment.⁷²

The interconnection between medicine and corrections — between the prison and the problem of disease — had moved from method to metaphor. The prison, once designed to prevent those imprisoned from succumbing to the diseases associated with incarceration itself, had now been redesigned,

⁶⁶ ERIC CUMMINS, *THE RISE AND FALL OF CALIFORNIA’S RADICAL PRISON MOVEMENT* 21–32 (1994).

⁶⁷ Rotman, *supra* note 61, at 170.

⁶⁸ Maxwell Jones, *The Concept of a Therapeutic Community*, 112 *AM. J. PSYCHIATRY* 647, 647–650 (1956).

⁶⁹ John M. Wilson, *The Role of the Therapeutic Community in Correctional Institutions of the Future*, in 2 *KEY ISSUES: A JOURNAL OF CONTROVERSIAL ISSUES IN CRIMINOLOGY* 63, 63–64 (1965) (discussing the future of imprisonment in a free society).

⁷⁰ See generally ELLIOT STUDDT ET AL., *C-UNIT: SEARCH FOR COMMUNITY IN PRISON* (1968); HANS TOCH, *THERAPEUTIC COMMUNITIES IN CORRECTIONS* (1980) (referring to California as one of the sites of a therapeutic community).

⁷¹ Many Southern states that had relied on plantation-style prisons never embraced this therapeutic model and invested in modern penitentiary-style prisons only due to pressure from federal courts in the 1970s and 1980s. By then, the therapeutic prison model was collapsing and the new prisons would operate largely on the warehouse model. For Arizona, see LYNCH, *supra* note 6, at 205; for Florida, see Heather Schoenfeld, *Mass Incarceration and the Paradox of Prison Conditions Litigation*, 44 *LAW & SOC’Y REV.* 731, 732–33 (2010) (prisoner advocates hoped litigation would push Florida lawmakers toward national rehabilitation consensus and less reliance on prisons, but ended up producing prisons for mass incarceration).

⁷² The draft was adopted by the American Law Institute in 1975, and a final published version appeared in 1981. See MARKUS DUBBER, *CRIMINAL LAW: MODEL PENAL CODE 11* (2002) (describing adherence of the Code to treatmentism).

almost beyond recognition, to be a “treatment” for those whose sickness led to crime. With a rising economy destined to remove most of the material motivations for criminality, and effective therapeutic techniques under research, the “medical model” seemed a stable penology for modern society.

D. Disease and the Constitutional Problem of Humane Punishment

The constitutional status of penitentiary discipline remained largely unexamined during the nineteenth century and for much of the twentieth because state prisoners could not bring Eighth Amendment challenges to contest their punishment, and federal prisoners had little hope of overcoming the widely held view that the Amendment’s ban on “cruel and unusual punishment” was limited to punishments involving physical mutilation or torture.⁷³ Most of the empirical reality of prisons, especially those in the South where the term penitentiary hid the far more lethal convict lease system, was utterly denied by the legal system, which simply refused to recognize the actual fate of most prisoners and especially prisoners of color.⁷⁴ Even when the Supreme Court held a prison sentence to be “cruel and unusual punishment” in 1910,⁷⁵ citing evolving norms of decency,⁷⁶ the Amendment would only episodically be invoked and almost never against a normal state prison sentence.

Yet by the end of the nineteenth century, we can discern traces of recognition that the penitentiary and its disciplinary punishment constituted an acceptable form of serious punishment that was severe enough to replace the death penalty for many felonies, but not so severe as to be cruel and unusual. But implicit in that latter point was recognition that, as in the case of jail fever, if incarceration should become a threat to the physical or mental health of the prisoner, it could violate the Constitution.

We can see a trace of both ideas in *In re Medley*, an 1890 case where the Supreme Court considered the plight of a Colorado death row inmate, which contrasted the penitentiary-style prison under the dominant congregate regime with both the jail and solitary confinement of the sort practiced in the “separate system.”⁷⁷ Under the Colorado first-degree murder statute

⁷³ See generally *Wilkerson v. Utah*, 99 U.S. 130 (1879) (holding that the Eighth Amendment does not prohibit execution by firing squad).

⁷⁴ The convict lease system was never successfully challenged on constitutional grounds, despite subjecting prisoners to extraordinarily high rates of death and ill health. See LICHTENSTEIN, *supra* note 39, at 36 (noting that the legal framework of Reconstruction accepted convict lease). The fate of African American prisoners in the convict lease systems of the South may be the closest nineteenth-century approximation to the dehumanization of prisoners in the era of mass incarceration. See DAVID OSHINSKY, *WORSE THAN SLAVERY: PARCHMAN FARM AND THE ORDEAL OF JIM CROW JUSTICE* 46 (1996) (annual mortality rate for Mississippi’s virtually all-black convict population in the 1880s was 9–16%).

⁷⁵ *Weems v. United States*, 217 U.S. 349, 382 (1910) (holding a sentence of fifteen years of “cadena,” or hard labor, disproportionate to the crime of forging government documents).

⁷⁶ *Id.* at 369.

⁷⁷ 134 U.S. 160, 168 (1890).

enforced at the time of Medley's crime, the defendant should have been held in the county jail prior to hanging, just as he would have been in Howard's days. There, he might have had access to virtually anyone, including his lawyer, physician, and family (albeit at the sheriff's discretion). Instead, under the new statute, Medley faced his last days in solitary confinement in the penitentiary, where the distant location and tight discipline meant he might not get to see much of his family or his legal, medical, or spiritual advisers. Over a dissent by two Justices who found the differences between the two statutes too minimal given the capital nature of the sentences, the majority readily agreed that the new statute represented significant additional punishment and thus violated the Ex Post Facto Clause of the Constitution.⁷⁸ What is important to note is the emphasis given to the disciplinary qualities of imprisonment:

Instead of confinement in the ordinary county prison of the place where he and his friends reside; where they may, under the control of the sheriff, see him and visit him; where the sheriff and his attendants must see him; where his religious adviser and his legal counsel may often visit him without any hindrance of law on the subject, the convict is transferred to a place where imprisonment always implies disgrace . . . is itself an infamous punishment.⁷⁹

Much of the *Medley* opinion is concerned with solitary confinement:

The peculiarities of this system were the complete isolation of the prisoner from all human society, and his confinement in a cell of considerable size, so arranged that he had no direct intercourse with or sight of any human being, and no employment or instruction. Other prisons on the same plan, which were less liberal in the size of their cells and the perfection of their appliances, were erected in Massachusetts, New Jersey, Maryland, and some of the other states. But experience demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community. It became evident that some changes must be made in the system, and the separate system was

⁷⁸ *Id.* at 173. See also U.S. CONST. art. I, § 10, cl. 1 ("No State shall enter into any Treaty, Alliance, or Confederation; grant Letters of Marque and Reprisal; coin Money; emit Bills of Credit; make any Thing but gold and silver Coin a Tender in Payment of Debts; pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.").

⁷⁹ *Medley*, 134 U.S. at 168–69.

originated by the Philadelphia Society for Ameliorating the Miseries of Public Prisons, founded in 1787. The article then gives a great variety of instances in which the system is somewhat modified and it is within the memory of many persons interested in prison discipline that some 30 or 40 years ago the whole subject attracted the general public attention, and its main feature of solitary confinement was found to be too severe.⁸⁰

Medley suggests that two important features of the jail fever scandal had now established themselves in constitutional culture, if not yet in the Eighth Amendment. First, the penitentiary had by 1890 become accepted as serious, infamous, perhaps even severe (even when being explicitly compared with capital punishment), but constitutional punishment. Second, the Court's approving discussion of the abandonment of solitary confinement because of its health effects strongly suggests (although it does not establish, even as dicta), that the Eighth Amendment would be offended by a prison regime that exposed inmates to physical or psychological destruction.⁸¹

It would not be until the decades after World War II that the courts would revisit the relevance of the Eighth Amendment to prison sentences. Although most of the action would unfold in federal district courts, the Supreme Court seems to have opened the door in this regard in the 1958 case of *Trop v. Dulles*.⁸² Trop had been stripped of his citizenship as a result of wartime desertion under the harsh provisions of the Nationality Act of 1940. Although he was convicted in 1944, the issue did not arise until he sought a passport in 1952.⁸³ In invalidating Trop's denial of citizenship, the Court spoke in some of its broadest terms regarding the meaning of the Eighth Amendment's ban on "cruel and unusual" punishments:

The basic concept underlying the Eighth Amendment is nothing less than the dignity of man. While the State has the power to punish, the Amendment stands to assure that this power be exercised within the limits of civilized standards. Fines, imprisonment and even execution may be imposed depending upon the enormity of the crime, but any technique outside the bounds of these traditional penalties is constitutionally suspect. This Court has had little occasion to give precise content to the Eighth Amendment, and, in an enlightened democracy such as ours, this is not surprising.

⁸⁰ *Id.* at 168. It is remarkable, given the highly negative conclusion about the results of prolonged exposure to solitary confinement that had been settled by the end of the nineteenth century, that the practice made a comeback in the late twentieth century. For a detailed analysis of *Medley* as a window into the status of solitary confinement, see Keramet Reiter, Most Restrictive Alternative: The Origins, Functions, Control, and Ethical Implications of the Supermax Prison, 1976–2010 31 (Spring 2012) (unpublished Ph.D. dissertation, University of California, Berkeley) (on file with the Harvard Law School Library).

⁸¹ *Medley*, 134 U.S. at 168.

⁸² 356 U.S. 86, 86 (1958).

⁸³ *Id.* at 87–88.

But when the Court was confronted with a punishment of 12 years in irons at hard and painful labor imposed for the crime of falsifying public records, it did not hesitate to declare that the penalty was cruel in its excessiveness and unusual in its character. The Court recognized in that case [*Weems v. United States*⁸⁴] that the words of the Amendment are not precise, and that their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.⁸⁵

The medical model may have had its most important Eighth Amendment expression in persuading federal courts to require prison conditions to be brought up to national standards. Until the 1960s, federal courts had generally avoided considering Eighth Amendment challenges to the conditions of imprisonment (as opposed to the sentence itself or its legality), adopting what would come to be known as the “hands off” doctrine.⁸⁶ Beginning in that decade, however, a number of federal district courts began to hear such challenges.⁸⁷ According to the leading study of this jurisprudence, national consensus around rehabilitation and individualized treatment (fruits of the third medical model) were critical to the willingness of courts to venture into reviewing prison conditions under the Eighth Amendment.⁸⁸ The Federal Bureau of Prisons, which enjoyed special prestige among state prison systems, and the American Correctional Association, the leading national penological organization, were leaders in developing this consensus position.⁸⁹ Both organizations provided substantive standards for modern correctional facilities (the new term for prisons) that courts could use to fill the cavernously empty language of the Eighth Amendment.⁹⁰

The Supreme Court gave its imprimatur to this direction in the 1976 case of *Estelle v. Gamble*, which involved, aptly, the adequacy of medical care in prison.⁹¹ The Court held that the Texas prisoner-plaintiff was free to bring a § 1983 claim if he could show “deliberate indifference” to his substantial medical needs:

These elementary principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce

⁸⁴ 217 U.S. 349, 369 (1910).

⁸⁵ *Trop*, 356 U.S. at 100–01.

⁸⁶ *Cf. FEELEY & RUBIN, supra* note 62, at 31.

⁸⁷ *Id.* at 37.

⁸⁸ *Id.* at 265.

⁸⁹ *Id.* at 162.

⁹⁰ *Id.* at 163–64.

⁹¹ 429 U.S. 97, 97 (1976).

physical “torture or a lingering death,” the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common-law view that “(i)t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.”⁹²

The Court made no direct mention of the medical model, but noted that no one could suggest that indifference to medical pain “would serve any penological purpose.”⁹³ In analyzing “contemporary standards of decency,”⁹⁴ the Court in a footnote (omitted) cited “modern legislation”⁹⁵ and included the following national and international correctional standards that had embraced the penal therapy model:

Model correctional legislation and proposed minimum standards are all in accord. *See* American Law Institute, Model Penal Code §§ 303.4, 304.5 (1962); National Advisory Commission on Criminal Justice Standards and Goals, Standards on Rights of Offenders, Standard 2.6 (1973); National Council on Crime and Delinquency, Model Act for the Protection of Rights of Prisoners, § 1(b) (1972); National Sheriffs’ Association, Standards for Inmates’ Legal Rights, Right No. 3 (1974); Fourth United Nations Congress on Prevention of Crime and Treatment of Offenders, Standard Minimum Rules for the Treatment of Prisoners, Rules 22-26 (1955). The foregoing may all be found in U.S. Dept. of Justice, Law Enforcement Assistance Administration Compendium of Model Correctional Legislation and Standards (2d ed. 1975).⁹⁶

E. Summary

In the 1970s and 1980s, the “medical model” would come under heavy criticism from both the political right and left. From the right, politicians like Ronald Reagan successfully attacked the medical model as “soft social theories” and “pseudo intellectual apologies for crime,” undermining the deterrent impact of criminal law and avoiding the moral responsibility that

⁹² *Id.* at 103–04 (citations omitted) (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890); *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926)).

⁹³ *Id.* at 103.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.* at 103 n.8.

criminals individually bore for their unlawful acts.⁹⁷ From the left, prisoners' rights advocates and many academics in law and the social sciences viewed the medical model as more than a little totalitarian in its claims to know and to be able to fix the "self" that motivated acts of lawbreaking.⁹⁸ The claims that criminals were sick and that prisons were hospitals designed to arrest disease and create the conditions necessary for appropriate treatment came to seem both too soft on crime and too hard on liberty.

By then, the earlier medical models had largely been forgotten. The prison as a eugenic asylum was an embarrassing chapter in the history of the modern prison that both the state and its critics were happy to forget. More problematically, the foundational and constitutional obligation of the prison to do no harm to the mental and physical condition of its prisoners was not so much forgotten as presumed. The last stages of the medical model, coupled with the court-ordered institutional reforms carried out in many states, left a presumption that modern prisons were humane — indeed, if we believed the critics, to a fault.

II. QUARANTINE: THE EXPULSION OF MEDICINE FROM THE PENAL FIELD

During the 1970s and 1980s, rehabilitation collapsed as a consensus penal ideal among American states, largely undermining much of the Eighth Amendment law that had developed around prison conditions and evolving standards of decency. Legal scholars and sociologists traced this decline to a variety of social factors,⁹⁹ including growing cultural heterogeneity, high crime rates, and loss of confidence by the educated elites that had previously embraced the penal treatment model.¹⁰⁰ Yet, as in previous episodes of profound penal change, longstanding objections to the dominant penology coalesced only after the emergence of exemplary threats linking the prison and public health or safety. In the 1970s and 1980s, that threat came from the perception, not altogether unjustified, that predatory criminals, incapable of being deterred or rehabilitated, were highly effective at manipulating the penal treatment regime and winning early parole.¹⁰¹

⁹⁷ DAVID GARLAND, *THE CULTURE OF CONTROL: CRIME AND SOCIAL ORDER IN CONTEMPORARY SOCIETY* 131 (2001) (citing Reagan's effective political criticisms of rehabilitative penology).

⁹⁸ AM. FRIENDS SERV. COMM., *STRUGGLE FOR JUSTICE* 41–42 (1971); ANDREW VON HIRSCH, *DOING JUSTICE: THE CHOICE OF PUNISHMENTS* 4 (1976).

⁹⁹ *See, e.g.*, FRANCES A. ALLEN, *THE DECLINE OF THE REHABILITATIVE IDEAL: PENAL POLICY AND SOCIAL PURPOSE* (1981); FRANKLIN ZIMRING & GORDON HAWKINS, *INCAPACITATION: PENAL CONFINEMENT AND THE RESTRAINT OF CRIME* 9 (1995).

¹⁰⁰ ALLEN, *supra* note 99 (providing a prescient early account of that decline of rehabilitation as a penal ideal and emphasizing the growing cultural heterogeneity and tolerance of deviance in undermining the logic of penal treatment); for the leading account, see GARLAND, *supra* note 97, at 75–76.

¹⁰¹ Convicted murderers in California during the 1960s and 1970s could expect to spend fewer than ten years in prison (and a good deal less for second-degree murder). *See* JOHN IRWIN, *LIFERS: SEEKING REDEMPTION IN PRISON* 7 (2009) (stating that, until 1985, first-degree murderers served an average of twelve years, a practice that had gone back to the 1950s).

While no penal rationale today has enjoyed the kind of monopoly that penal treatment had for much of the middle of the twentieth century, and while most states promise to pursue all rationales, the emergence of mass incarceration is associated with the increasing prominence of penal incapacitation — a return in some ways to the preventive objectives of the “eugenic asylum” model of the prison in the 1920s, but now focused on preventing crime in real time rather than improving a future generation. This new penology emphasized the risk of future crime and embraced penal practices that aimed to maximize the ability of prison to prevent directly prisoners from harming the public.¹⁰²

Few contemporaries in the 1970s or 1980s thought that, in rejecting what was then known as “the medical model” (but which we have referred to here as the third medical model of “penal treatment”), they were rejecting the importance of the individual to modern corrections, let alone the humanitarian requirements of care already clearly mandated by the Court’s Eighth Amendment decisions.¹⁰³

The abandoned ambition to implement punishment via a penal treatment model in the 1970s became, in time, a full-scale expulsion of medicine. Eventually, in California, the resulting humanitarian medical crisis came before the Court in *Brown v. Plata*.¹⁰⁴ This new penology came to dominate American corrections, and it took little cognizance of individual treatment in crucial respects: in the decision to imprison someone, in how long to imprison that person, and in the internal management of prisoners.¹⁰⁵ Instead, partially as a result of the increase in incarceration to many times the historic level and partially as a cause of that increase, correctional systems since the 1980s have framed prisoners in masses that represent undifferentiated security threats.¹⁰⁶ Such a shift, along with the punitive “war on crime” tone of

¹⁰² Jonathan Simon, *Total Incapacitation: The Penal Imaginary and the Rise of an Extreme Penal Rationale in California in the 1970s*, in *INCAPACITATION: TRENDS AND NEW PERSPECTIVES* 4–5 (Marijke Malsch & Marius Duker eds., forthcoming 2012) (introducing the concept of “total incapacitation” to describe the extreme version of penal incapacitation that some American states, including California, have adopted); ZIMRING & HAWKINS, *supra* note 99 (explaining the surprising emergence of penal incapacitation as the dominant penal rationale in American states).

¹⁰³ The leading critic from the left, Andrew von Hirsch, saw the danger very early on that a focus on incapacitation, once unmoored from any focus on individuals, could lead to very long sentences and very high prison populations. See VON HIRSCH, *supra* note 98, at 25. Those advocating incapacitation, like Harvard’s James Q. Wilson, expected only modest increases in incarceration would follow, producing modest reductions in crime. No one foresaw the scale of mass incarceration. See JAMES Q. WILSON, *THINKING ABOUT CRIME* 159 (1975). On failure to anticipate the scale of mass incarceration, see Garland, *supra* note 10.

¹⁰⁴ 131 S. Ct. 1910 (2011).

¹⁰⁵ Malcolm M. Feeley & Jonathan Simon, *The New Penology: Notes on the Emerging Strategy of Corrections and its Implications*, 30 *CRIMINOLOGY* 449, 452 (1992) (suggesting that penology shifted away not only from rehabilitation but also from the individual as a subject of deterrence or justice, and towards management of risk at the aggregate level).

¹⁰⁶ *Id.* at 460–61. On the overall explanations for the shift in scale and specifically pointing to internal changes in justice policy (rather than increases in crime), see ZIMRING & HAWKINS, *supra* note 10, at 156–57.

state and federal law enforcement, ensured that aggregate security concerns¹⁰⁷ would outweigh consideration of the prisoner as an individual,¹⁰⁸ or even as a human being.¹⁰⁹

A. *Super-Predators*

The leading advocates of mass incarceration, like the late James Q. Wilson,¹¹⁰ initially made a more traditional case for an increase in the application and length of prison sentences to restore credible deterrence and incapacitate repeat offenders.¹¹¹ For Wilson and others advocating increasing imprisonment, criminal behavior was best understood as economic behavior, and the crime wave of the 1960s and 1970s was best explained by the declining incarceration and arrest rates during a massive increase in crime.¹¹² Yet a closer reading of Wilson's seminal *Thinking About Crime* shows that, rhetorically, much of his argument focused on crime by young minority males and drug addicts — both categories that had already been

¹⁰⁷ The Supreme Court endorsed a balancing test that would place a hefty weight on “legitimate penological interests” of the prisons. *Turner v. Safley*, 482 U.S. 78, 89 (1987) (“Subjecting the day-to-day judgments of prison officials to an inflexible strict scrutiny analysis would seriously hamper their ability to anticipate security problems and to adopt innovative solutions to the intractable problems of prison administration.”).

¹⁰⁸ The reasons for California's extreme version of mass incarceration are discussed in my forthcoming book. See JONATHAN SIMON, *The Mississippi of Mass Incarceration*, in MASS INCARCERATION ON TRIAL: AMERICA'S COURTS AND THE FUTURE OF IMPRISONMENT (forthcoming 2012) (showing that California's rate of imprisonment grew faster than that of any other region of the country for much of the 1980s and 1990s, and moved from having a rate consistent with the least punitive region of the country (the Northeast) to one closest to the most punitive (the South)). Rejecting the “medical model” did not logically imply that a state would reject the relevance of medicine, let alone the humane treatment of prison inmates by prison management. However, twenty-five years of litigation around medical care in California prisons, culminating in *Brown v. Plata*, suggest that this is just what happened. While California is arguably an extreme model of mass incarceration, its anti-medical model is potentially a far broader risk.

¹⁰⁹ That this mentality is still pervasive in California corrections facilities was evident from a recent report discussing recommended ways to reform the state's notorious supermax units (known in California as Secure Housing Units). These units house a large number of inmates who have been assigned there for the duration of their sentence based on the belief that they are gang members. Indeed, the report refers to these individuals throughout as “Security Threat Group[s].” See Reiter, *supra* note 80, at 156–57; CAL. DEP'T OF CORR. & REHAB., SECURITY THREAT GROUP PREVENTION, IDENTIFICATION AND MANAGEMENT STRATEGY 7–8 (2012).

¹¹⁰ The Harvard (and later UCLA) political scientist published a highly influential book in 1975, *Thinking About Crime*, which made the case that the nation's rehabilitation-focused penal system had failed to deliver sufficient deterrence and incapacitation to prevent a rise in crime despite enormous economic opportunity in the 1960s.

¹¹¹ See generally WILSON, *supra* note 103 (advocating longer prison sentences to reduce crime).

¹¹² *Id.* at 117–44 (explaining that crime responds to rewards and costs, and attributing increasing crime in the 1960s to diminishing cost of crime). For a current account also arguing that declining incarceration rates in the 1960s and early 1970s encouraged crime, see generally STUNTZ, *supra* note 16.

substantially demonized as beyond normal deterrence or rehabilitation.¹¹³ In 1996, as the national panic around violent crime reached its peak (even as crime was trending down), John DiIulio, one of Wilson's students, teamed up with William Bennett, a drug official in the Reagan Administration, to write a highly polemical book titled, *Body Count: Moral Poverty . . . and How to Win America's War Against Crime and Drugs*.¹¹⁴ The book continued the demonization of minority youth, now tagged "super-predators," and warned of a coming wave of violence unless harsh new policies were introduced.¹¹⁵

The juvenile super-predator was the fullest expression of this transformed vision of criminal offenders as a direct biological threat to the public — one insufficiently contained by penal therapy prisons.¹¹⁶ In past moments when the understanding of the prison project has been recast, the failures of jails and prisons were shown to be a threat to public health and safety through a nexus of disease. In the era of mass incarceration, it was as if prisoners themselves became a kind of disease threat to the public — not as a vector of contamination, as in the case of the hapless victim of jail fever who spreads it to his judges and prosecutors in court, but as a "zombie," a monster transformed by disease-like events into a direct engine of the destruction of others.¹¹⁷

B. Supermax Prisons and Total Incapacitation

During the 1980s and 1990s, American states carried out the largest prison building boom in American history.¹¹⁸ These new mass incarceration prisons were "purpose built" to deal with an anticipated — indeed, planned — increase in imprisonment of unprecedented scale.¹¹⁹ These new prisons were characterized by three features: (1) Outsized: an imperative to hold as

¹¹³ Indeed, the index in Wilson's book contains dozens of entries for heroin, Blacks, and youth (categorized as "age structure"). WILSON, *supra* note 103.

¹¹⁴ WILLIAM BENNETT ET AL., *BODY COUNT: MORAL POVERTY . . . AND HOW TO WIN AMERICA'S WAR AGAINST CRIME AND DRUGS* (1996) (warning against the coming tide of juvenile crime).

¹¹⁵ *Id.* at 27.

¹¹⁶ See BARRY FELD, *BAD KIDS: RACE AND THE TRANSFORMATION OF THE JUVENILE COURT* 208 (1999) (discussing how politicians demonized youth in order to support laws waiving juvenile status in cases of violent crime).

¹¹⁷ The notion of violence as a public health threat to be combatted by public health-style interventions (based on detailed research regarding the contexts of violence) has long been advocated by some social scientists. But while the predator metaphor focuses on the individual offender as the source of violence, the public health approach emphasizes neighborhood effects. See Robert J. Sampson et al., *Social Anatomy of Racial and Ethnic Disparities in Violence*, 95 AM. J. PUB. HEALTH 224, 224–32 (2005); Alex Kotlowitz, *Blocking the Transmission of Violence*, N.Y. TIMES MAG., May 4, 2008, at 54.

¹¹⁸ GARLAND, *supra* note 97, at 81–89. On California, see RUTH WILSON GILMORE, *GOLDEN GULAG: PRISONS, SURPLUS, CRISIS, AND OPPOSITION IN GLOBALIZING CALIFORNIA* (2007) (describing the build up and explaining the political economy of prison building during the boom years). On Arizona, see LYNCH, *supra* note 6. On Florida, see Schoenfeld, *supra* note 71.

¹¹⁹ See Reiter, *supra* note 80, at 79.

many prisoners as inexpensively as possible due to budget constraints, which militated in favor of very large prisons, (2) Hyper-security: a tendency to create ever more security-oriented prisons, and to skew the overall penal estate toward high-security prisons,¹²⁰ and (3) “Deliberate Indifference”: prisoner planners chose to ignore the obvious health needs of the large population they anticipated incarcerating, a remarkable development given the precedents of the three previous medical models.¹²¹

Recent data from California suggests that in authorizing the billions of dollars in state spending and indebtedness required to construct these new prisons, the state legislature gave little direction, leaving correctional officials with nearly complete discretion to decide how to design the new prisons.¹²² Other than seeking to maximize the scale of incarceration that could be achieved, however, the only systematic considerations officials made focused on the overall security level of the prisons and ensuring a sufficient supply of higher-security prisons to deal with a population that the state clearly anticipated would be composed of dangerous and violent inmates.¹²³

Indeed, California became one of the first states to embrace the new “supermax” level of security — the controversial lockdown model in which prisoners are cut off from virtually all programs and kept in their cells twenty-three hours a day.¹²⁴ These prisons reflect to an extraordinary extent the dual commitments to mass incarceration and risk management that characterized the “quarantine” approach to penology in the 1980s and 1990s. The enthusiasm with which California and many other states embraced the supermax idea indicates that they expected prison systems to contain a growing number of monstrous offenders unmanageable with the traditional tools of corrections.¹²⁵

¹²⁰ See *id.* at 63–65; Feeley & Simon, *supra* note 105, at 451–52.

¹²¹ While the Supreme Court in *Brown v. Plata* did not review the underlying Eighth Amendment findings in the two class actions, it must surely have helped win Justice Kennedy’s crucial fifth vote for the population cap that in both cases, the evidence was staggeringly strong that California officials were fully aware that they were electing not to address health needs. See *Coleman v. Wilson*, 912 F. Supp. 1282, 1316–17 (E.D. Cal. 1995) (“Defendants’ knowledge of the risk of harm to these inmates is evident throughout this record.”); *Plata v. Davis*, No. 3:01-cv-01351 (N.D. Cal. Apr. 5, 2001) (now denominated *Plata v. Brown*) (entering a stipulated settlement in 2002 with the State of California essentially admitting all claims).

¹²² Reiter, *supra* note 80, at 90.

¹²³ See *id.* at 70–71 (arguing that California’s decision to invest in a supermax facility was linked to fear of violent inmates epitomized in California by Black Panther leader George Jackson, who died in 1971 at San Quentin during a takeover he was apparently leading).

¹²⁴ On supermax, see SHARON SHALEV, SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT 3 (2009). California was the second state, behind Arizona, to adopt the supermax model and did so on a scale far larger than any other state, creating two large units that could hold over two thousand inmates each, as well as several smaller ones. See Reiter, *supra* note 80, at 41.

¹²⁵ For examples of monstrous offenders, one need look no further than the convict revolutionaries that were involved in incidents like the murder of three correctional officers during the 1971 takeover of San Quentin prison. See generally *Spain v. Rushen*, 883 F.2d 712 (9th Cir. 1989) (describing the events of the takeover in detail); see also Reiter, *supra* note 80, at 59

California's supermax prisons also evidenced a complete lack of consideration to the medical and mental health needs of its prison population. This was not an oversight. Despite total discretion and abundant funding to construct the prisons it wanted, California chose to build and staff those prisons with minimal provisions for maintaining the mental health or physical health care of its prisoners.¹²⁶ This coincided with a massive reduction in mental hospitals, which meant that state officials would soon see greater numbers of prisoners suffering from serious mental illnesses.¹²⁷ Human Immunodeficiency Virus (HIV) and hepatitis were also prevalent during this time period among the drug-using population that was being targeted for incarceration.¹²⁸ California's blatant disregard of prisoners' mental and medical afflictions thus reflects a view of potential prisoners as lacking normal human features and vulnerabilities.

C. Summary

Mass incarceration California-style, then, represented a repudiation of much of the modern approach to imprisonment that had developed over the course of the three earlier medical models: the first eighteenth-century medical model, with its emphasis on separating prisoners and maintaining healthful environmental conditions; the second medical model, with its emphasis on classification; and the third, late twentieth-century medical model, with its emphasis on the individual as the locus of complex and dynamic factors. These models were replaced with a new penology, which promoted the total incapacitation of prisoners, and presumed a high and unchanging degree of personal threat posed by them to the community.

The Supreme Court during this era rejected efforts to use the Eighth Amendment to challenge long, incapacitative sentences. California's mid-1990s "three strikes" law represents the high tide of fear about violent

(noting the significance of that incident to California's decision to adopt supermax-style imprisonment). Another "monster" category that was used to justify supermax prisons was provided by serial killers like Charles Manson. SHALEV, *supra* note 124, at 45.

¹²⁶ On the California Department of Corrections and Rehabilitation's discretion and funding, see Reiter, *supra* note 80, at 87.

¹²⁷ On the deinstitutionalization of the mentally ill in California and elsewhere, see PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 69 (1994). A careful statistical analysis found that the closing of hospitals was a contributor to the growth of the California prison population, but only a modest one. STEPHEN RAPHAEL & MICHAEL A. STOLL, *DO PRISONS MAKE US SAFER? THE BENEFITS AND COSTS OF THE PRISON BOOM* 47 (2009); see also *Coleman v. Wilson*, 912 F. Supp 1282, 1299 (E.D. Cal. 1995) (acknowledging the degree to which prisons have become the home of large numbers of the state's mentally ill, but without mentioning where they might once have resided).

¹²⁸ The continuing power of the link between disease, prison, and public health was reflected in periodic waves of public alarm about the disease burden in prisons. See McCLENNAN, *supra* note 17, at 50, 166. Still, reformers had little to turn to other than a greater effort to discipline or clean the prison. HIV, which initially triggered some demands for quarantine, proved to be an important turning point in the medical recognition of the distinctive challenges posed by chronic illnesses. See PETER BALDWIN, *DISEASE AND DEMOCRACY: THE INDUSTRIALIZED WORLD FACES AIDS* 18, 25–27 (2005).

predators and marks one of the most severe sentencing schemes ever enacted in American history, permitting a twenty-five-years-to-life sentence on a third felony of any kind when the defendant has already been convicted of two previous violent or serious felonies. The Court in *Ewing v. California*¹²⁹ explicitly recognized California's new penology of incapacitation: "California's three strikes law reflects a shift in the State's sentencing policies toward incapacitating and deterring repeat offenders who threaten public safety."¹³⁰ The plurality adopted Justice Kennedy's view in *Harmelin v. Michigan*¹³¹ that the Court's assessment of disproportionality must be filtered through a strong deference to legislative policy choices among a variety of legitimate penal objectives, including incapacitation.¹³² If California decides its criminals are zombies who do not respond to deterrence and rehabilitation but only total physical incapacitation, then who is to say what length of incapacitation is disproportionate to the danger? Thus, the Court concluded, "When the California Legislature enacted the three strikes law, it made a judgment that protecting the public safety requires incapacitating criminals who have already been convicted of at least one serious or violent crime. Nothing in the Eighth Amendment prohibits California from making that choice."¹³³

III. *BROWN V. PLATA* AND THE AGE OF CORRECTIONAL GERIATRICS

Today, we are in the midst of another moment in which prisons seem poised to be reimagined through the problem of disease. As a result of mass incarceration policies, prisons have accumulated and retain a population peculiarly vulnerable to the health problems of aging and chronic illness. As many as 40% of state prison inmates have been estimated to suffer from chronic illnesses,¹³⁴ and with prison populations rapidly aging,¹³⁵ it is likely that this ratio will rise steeply in coming decades. Prisons in the foreseeable future are likely to be reimagined around the problems of aging and dying prisoners, taking influence from principles of hospices and developing spaces devoted to reducing prisoner suffering and conserving inmate dignity.

The architects of mass incarceration had in mind no medical model, but the goals they possessed and the sentencing policies put in place in many states resulted in medical consequences that began, slowly, to become visible in legal challenges brought during the 1990s. Prisons accumulated more and more "lifestyle offenders," that is, persons whose criminal records were a product more and more of the intersection between criminal justice decisionmaking and their own noncriminal deviant lifestyles, including: drug

¹²⁹ 538 U.S. 11 (2003).

¹³⁰ *Id.* at 14.

¹³¹ 501 U.S. 957, 996–97 (1991) (Kennedy, J., concurring).

¹³² *Ewing*, 538 U.S. at 23–24.

¹³³ *Id.* at 25.

¹³⁴ Wilper et al., *supra* note 13, at 666–72.

¹³⁵ Williams et al., *supra* note 14, at 1150–56.

users returned on parole violations; homeless, formerly incarcerated people; people with mental illness; gang members targeted for long prison sentences; and recidivists with multiple past prison sentences. All of them shouldered heavy burdens of chronic illness that arose from or were made worse by prisoners' prior lifestyle choices. At the same time, prisons housed prisoners for longer periods of time, sometimes to the point where those previous lifestyle choices resulted in cascading consequences for organs like the kidneys, liver, heart, and lungs, and led to the onset of ailments like diabetes and hypertension.

The distinctive features of mass incarceration tend to concentrate populations afflicted with chronic illnesses, make the course of illnesses more difficult to manage, and produce conditions like chronic overcrowding that obstruct the very types of care that can prevent costs and illness from spiraling out of control.

Brown v. Plata seems to mark the moment when awareness of both the chronic illness burden that is accumulating inside mass incarceration prisons, and the vicious cycle created when chronic illness-prone individuals are concentrated in prisons designed simply to contain inmates without providing opportunities for meaningful activity, produced the kind of concern among the nation's legal elites that has been the hallmark of past transformations.¹³⁶ All of these elements were present in the record of California's correctional medical crisis, and the *Plata* opinion describes them with a palpable sense of humanitarian horror.

The degree of overcrowding in California's prisons is exceptional. California's prisons are designed to house a population just under 80,000, but at the time of the three-judge court's decision the population was almost double that. The State's prisons had operated at around 200% of design capacity for at least 11 years. Prisoners are crammed into spaces neither designed nor intended to house inmates. As many as 200 prisoners may live in a gymnasium, monitored by as few as two or three correctional officers. As many as 54 prisoners may share a single toilet.¹³⁷

California's prisons were designed to meet the medical needs of a population at 100% of design capacity and so have only half the clinical space needed to treat the current population. A correctional officer testified that, in one prison, up to 50 sick inmates may be held together in a 12-by 20-foot cage for up to five hours awaiting treatment. The number of staff is inadequate, and prison-

¹³⁶ In the period since *Brown v. Plata* was decided, media and human rights organizations have paid considerable attention to quality of life and aging in prison. See, e.g., Manny Fernandez, *Two Lawsuits Challenge the Lack of Air-Conditioning in Texas Prisons*, N.Y. TIMES, June 27, 2012, at A15; Timothy Williams, *Number of Older Prisoners Grows, Stressing Prisons*, N.Y. TIMES, Jan. 26, 2012, at A19.

¹³⁷ *Brown v. Plata*, 131 S. Ct. 1910, 1923–24 (2011) (citations omitted).

ers face significant delays in access to care. A prisoner with severe abdominal pain died after a 5-week delay in referral to a specialist; a prisoner with “constant and extreme” chest pain died after an 8-hour delay in evaluation by a doctor; and a prisoner died of testicular cancer after a “failure of MDs to work up for cancer in a young man with 17 months of testicular pain.”¹³⁸

These images of life inside mass incarceration prisons, including three photographs that were attached to the majority opinion,¹³⁹ carry special resonance because American prisons, like the rest of the nation, are entering an era of chronic illness — only faster and harder. Unlike the infectious diseases that dominated medical thinking and metaphors for much of the twentieth century, chronic illness in prison does not pose a risk of contagion to the general community. Rather, the shadow that chronic illness casts over society is one of human, social, and economic capital. The aggregating costs of individual lifestyle choices threaten the ability of aging societies to finance health care for rapidly increasing geriatric populations. In the context of this deepening crisis, the incarcerated population represents a kind of bombshell. This is most obviously true on the budgetary side where the incompatibility of incarceration with the kinds of routine health maintenance activities of prisoners, and the high premium on delivering intensive medical care, makes the relatively small portion of the geriatric population that is incarcerated or was incarcerated extraordinarily expensive.¹⁴⁰ But it is also true on the social side, where research on HIV in communities of high incarceration suggests that incarceration increased the HIV burden in communities by increasing the power of men remaining in those communities to disregard pressure for safe sexual practices.¹⁴¹ The issues raised in *Plata* about the essential dignity prisoners retain as human beings bear similarities to the fraught questions associated with the emergence of chronic illness as the dominant health problem in the United States and the problems it signals with lifestyles at all stages of the life course.¹⁴²

¹³⁸ *Id.* at 1925 (citations omitted) (quoting K. IMAI, CAL. PRISON HEALTH CARE RECEIVERSHIP CORP., ANALYSIS OF CDCR DEATH REVIEWS 2006 6–7 (2007)).

¹³⁹ Two of them depicted prisoners in bunk beds crammed into irregular spaces within California prisons. The third picture depicted a cage, approximately the size of a phone booth, for restraining psychotic prisoners. *Id.* at 1949–50 (2011) (Appendices).

¹⁴⁰ See Ashby Jones & Joanna Chung, *Care for Aging Inmates Puts Strains on Prisons*, WALL ST. J., Jan. 27, 2012, <http://online.wsj.com/article/SB1000142405297020336350477185362318111898.html>; HUMAN RIGHTS WATCH, OLD BEHIND BARS: THE AGING PRISON POPULATION IN THE UNITED STATES (2012), available at http://www.hrw.org/sites/default/files/reports/usprisons0112webcover_0.pdf.

¹⁴¹ Rucker C. Johnson & Steven Raphael, *The Effects of Male Incarceration Dynamics on Acquired Immune Deficiency Syndrome Infection Rates among African American Women and Men*, 52 J.L. & ECON. 251, 254 (2009).

¹⁴² On the emergence of chronic illness as the major disease challenge, see DIANA KUH & YOAV BEN-SHLOMO, A LIFE COURSE APPROACH TO CHRONIC DISEASE EPIDEMIOLOGY 3–4 (2004) (stating that a growing body of research suggests that chronic illness emerges from lifestyle choices at all stages of the life course).

John Howard's powerful study of jail fever transformed the face of modern punishment in the eighteenth century. The moral consensus that was forged against the whole regime of jail confinement, and in favor of a humane model of incarceration, has remained latent for generations in the Eighth Amendment's prohibition of cruel and unusual punishment. Today, chronic illness and correctional geriatrics await their John Howard. As courts engage with the ongoing correctional health care crisis, they have the opportunity to realize the potential of the Eighth Amendment to provide the kind of robust framework that would conserve the dignity of incarcerated populations, much like that which developed under the European Convention on Human Rights and the Charter of Fundamental Rights of the European Union.¹⁴³

A. *Chronic Illness and Correctional Geriatrics*

Whether or not the actual portion of chronically ill prisoners is the 40% estimated in some studies, the number seems destined to grow larger as states cut back on shorter sentences for younger offenders. It also seems virtually certain that this population will absorb a greater and greater share of state spending on corrections given the high inflation rate of medical expenses in the United States generally and in correctional settings specifically.¹⁴⁴ It follows that understanding this portion of the prison population is crucial to imagining the future of the prison and the role that medicine will likely have in shaping our penal strategies and evolving sense of decency.

At the moment, this takes an act of willful imagination. We think of prisoners all too often as young, healthy, strong, capable, and brimming with aggression.¹⁴⁵ Despite the relentless television images of seemingly fit and muscled prisoners on popular television shows like MSNBC's *Lockup*,¹⁴⁶ the same forces that have led to rising obesity in American communities also operate in the prison context: boredom, highly processed foods, television,

¹⁴³ See generally DIRK VAN ZYL SMIT & SONIA SNACKEN, *PRINCIPLES OF EUROPEAN PRISON LAW AND POLICY: PENOLOGY AND HUMAN RIGHTS* (2d ed. 2011) (describing a European penal ideal anchored in this human rights framework in which incarceration is to be as limited as possible and carried out with a comprehensive concern with human dignity).

¹⁴⁴ A report by the California State Auditor in 2010 placed the overall cost of correctional health care at around \$2.5 billion, or nearly a quarter of the correctional budget; specialty medical services for prisoners with the most serious health problems, a population of fewer than 1,200 prisoners, cost almost \$200 million. See CAL. STATE AUDITOR, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION: *INMATES SENTENCED UNDER THE THREE STRIKES LAW AND A SMALL NUMBER OF INMATES RECEIVING SPECIALTY HEALTH CARE REPRESENT SIGNIFICANT COSTS 35–38* (2010). The underlying health infrastructure deficit in California prisons, the issue at the heart of the *Plata* case, has been estimated to require \$4 to \$8 billion.

¹⁴⁵ Williams et al., *supra* note 14, at 1150.

¹⁴⁶ *Lockup*: MSNBC's *Prison Documentary Series* (MSNBC web broadcast 2012), available at <http://www.msnbc.msn.com/id/27118605/>.

and few opportunities for routine exercise.¹⁴⁷ The prisoner as disabled, aging, and dying has not been part of this picture until now.¹⁴⁸ Indeed, the question of whether the Justices could “see” the prisoners this way divided the court, with Justice Scalia explicitly referencing the physical strength of California prisoners: “Most of them will not be prisoners with medical conditions or severe mental illness; and many will undoubtedly be fine physical specimens who have developed intimidating muscles pumping iron in the prison gym.”¹⁴⁹

The dilemmas posed by chronically ill prisoners are exemplified by the fact that the portion of prisoners who are geriatric (i.e., over fifty) grew by 181% during the first decade of the twenty-first century, while the overall prison population grew by only 17%.¹⁵⁰ Even for those who did not arrive at prison with a chronic illness, most will acquire such illnesses when they enter geriatric years,¹⁵¹ especially given the difficulties of maintaining good health in mass incarceration prisons where overcrowding-driven lockdowns paralyze penal spaces that may already allow very little activity. Prisoners are often burdened with multiple chronic illness problems, including mental illness and dementia, and require sophisticated medical management that is extraordinarily expensive to deliver in a prison setting. At the same time, those prisoners are often serving lengthy or life sentences for violent crimes, and any effort to parole them, even on medical grounds, faces considerable reluctance from parole officials long disciplined by political fear of being soft on crime.¹⁵²

Geriatric prisoners have always been present in correctional settings, but until now they were very much the exception. This explains why prisoners’ right to health care never posed a substantial challenge to prison growth until now, even though the right was well established by the 1970s.¹⁵³ Even as states began to lengthen sentences and send more people to prison, prisoners remained overwhelmingly young and healthy, with most individuals spending relatively few years actually in prison. As the arc of mass incarceration has continued, however, it has become apparent that chronic illness and geriatric corrections are products (albeit unintended ones) of mass incarceration itself.

¹⁴⁷ See generally Meaghan A. Leddy et al., *Consequences of High Incarceration Rate and High Obesity Prevalence on the Prison System*, 15 J. CORRECTIONAL HEALTH CARE 318 (2009) (discussing the intersection of incarceration and the obesity boom).

¹⁴⁸ Importantly, in the pictures released by the Supreme Court and widely available on the web, you can see many older and disabled prisoners. See *Brown v. Plata*, 131 S. Ct. 1910, 1949–50 (2011).

¹⁴⁹ *Id.* at 1953 (Scalia, J., dissenting).

¹⁵⁰ Williams et al., *supra* note 14, at 1151.

¹⁵¹ *Id.*

¹⁵² On the plight of lifers in California, see IRWIN, *supra* note 101, at 9–14 (paroles reduced to a trickle in California despite statutory presumption for release).

¹⁵³ See generally *Estelle v. Gamble*, 429 U.S. 97 (1976) (holding that deliberate indifference to serious medical needs violates Eighth Amendment).

While the modern prison evolved into an effective environment for fighting infectious disease (at least when not overcrowded and when properly staffed) and limiting the injuries that result from simmering gang tensions, these prisons offer ineffective, highly dangerous environments when it comes to chronic illness. Mass incarceration only worsens this by reducing the flow of beneficial activity inside the prison, and by producing chronic overcrowding that exacerbates those features of incarceration that encourage chronic illness generally. It also exposes vastly greater portions of the population to what is, in essence, a chronic illness incubator.

Today, chronic illness in prison is directly tied to the larger crisis of health care in the United States. As the authors of a recent analysis of the correctional situation, featured in the leading journal of geriatric medicine, put it: "The increasing number of older prisoners is at the root of a health-care crisis in the U.S. criminal justice system that is spilling into communities and public healthcare systems. The field of geriatrics has an opportunity to help address this crisis."¹⁵⁴

B. Correctional Health Maintenance and Dignified Social Defense

Once we take account of chronic illness, we cannot view incarceration the same way. It is a form of punishment that, in any prolonged form, appears to aggravate actively the cumulative burden of chronic illness. This is certainly not true of all forms of punishment.¹⁵⁵ Just as Howard convinced his generation that sending someone to a jail could very well constitute a sentence of death — an achievement that ultimately resulted in the modern penitentiary prison — the recognition of the contemporary carceral-chronic illness connection is capable of transforming how we imagine acceptable punishments for serious crimes going forward.

American prisons will need to evolve in response to the problem of chronic illness and find ways to cope with the fiscal and humanitarian cost of incarcerating people with chronic illness. What might this chronic illness medical model look like?

First, it would be relentlessly preventive. If the mass incarceration prison was built with "deliberate indifference" to the mental health and bodily illness needs of medium- to long-term prisoners,¹⁵⁶ the new model, correctional geriatrics (since aging is the ultimate chronic illness), would focus on preventing, delaying, and diminishing both mental and physical illness (since both types of ailments produce chronic illness, and indeed often co-

¹⁵⁴ Williams et al., *supra* note 14, at 1150.

¹⁵⁵ Indeed, neither severe (but income proportionate) fines, nor non-damaging corporal punishment would actively aggravate the cumulative burden of chronic illness.

¹⁵⁶ See *Coleman v. Wilson*, 912 F. Supp. 1282, 1319 (E.D. Cal. 1995) (finding defendants "deliberately indifferent"); *Plata v. Schwarzenegger*, No. C01-1351 TEH, 2005 WL 2932253, at *19 (N.D. Cal. Oct. 3, 2005) ("[D]efendants have repeatedly delayed their progress and ultimately failed to achieve even a semblance of compliance.").

produce each other).¹⁵⁷ That means keeping more people out of prison where possible because incarceration directly exacerbates chronic illness patterns, but also making prisons as supportive of mental and physical health as possible.¹⁵⁸

Second, correctional geriatrics would emphasize personal involvement and responsibility by both the prisoner-patient and prison officers as the key to complying with the demanding dietary, exercise, and activity requirements of combating chronic illness effectively. Gerontological corrections must frame the penal subject as the central subject of their own narrative and should encourage the prison officer to view themselves as both medical and legal agents.

Third, correctional geriatrics would emphasize the involvement of the prisoners' families and communities, facilitating visits and planning for re-entry.¹⁵⁹ This would require the construction of smaller prisons located nearer to urban residents and digitally connected to the outside world through the Internet, social networking, and voice-over-Internet telephones — almost all of which are currently forbidden in American prisons.

Fourth, correctional geriatrics would change current forms of community corrections (parole and probation), which are heavily focused on detecting rule violations, into health maintenance organizations. With most prisoners poor enough to qualify for state-funded health care under the Affordable Care Act,¹⁶⁰ and with many of them on the path to or already dealing with chronic illness, formerly incarcerated individuals on parole and on probation should be required to participate in health-enhancing activities for their own benefit and literally to pay back their communities. Those without

¹⁵⁷ Indeed, one of the benefits of the larger chronic illness paradigm is that it erases many of the lines that have been drawn in medicine between mental and physical illnesses precisely because they so often appear in the same patients. See Danson R. Jones et al., *Prevalence, Severity, and Co-Occurrence of Chronic Physical Health Problems of Persons with Serious Mental Illness*, 55 *PSYCHIATRIC SERVS.* 1250, 1250 (2004) (in a sample of people with serious mental illness, 74% had at least one serious physical chronic illness, and 50% had two or more).

¹⁵⁸ This would be the polar opposite of mass incarceration prisons like the supermax Pelican Bay, which was deliberately built to deny prisoners almost any visual stimulation, leading to serious mental health problems. See Reiter, *supra* note 80, at 2–3, 218.

¹⁵⁹ Recent research suggests that families play a key role in fulfilling patient requirements within chronic illness treatment regimes. See generally Anne-Marie Rosland et al., *The Impact of Family Behaviors and Communication Patterns on Chronic Illness Outcomes*, 35 *J. BEHAV. MED.* 221 (2012).

¹⁶⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (codified as amended in scattered sections of 26 and 42 U.S.C.). The Act, for the first time, will reach poor people without children and also those making more than the poverty level. See generally Adam N. Hofer et al., *Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization*, 89 *MILBANK Q.* 69 (2011); Sara R. Collins, *How the Affordable Care Act will Help Low and Moderate Income Families*, SPOTLIGHT ON POVERTY AND OPPORTUNITY (June 14, 2010), available at <http://www.spotlightonpoverty.org/exclusivecommentary.aspx?id=BA21673c-b1ac-44b7-8f76-50e856cdb9b5> (noting that beginning in 2014, Medicaid will cover all legal residents to 133% of the poverty level regardless of whether they have children).

employment or active family responsibilities might be required to spend a portion of every day in correctional health maintenance centers exercising, getting their blood pressure checked, or taking classes on how to maintain their own health and that of their families. The right financial model could probably pay for what we now think of as reentry and probation through health expenditure savings.

Advocates for prisoners might well object to the revitalization of the paternalistic features of the third medical model with its requirement that prisoners or parolees participate in rehabilitative programming. While there are overlaps, the health maintenance orientation places primary responsibility on the person, patient, prisoner, or parolee/probationer to embrace their own health. The most effective regimes will be those that build on and nourish the dignity of the individual.¹⁶¹

These are the potential outcomes of a chronic illness or geriatric medical model for American corrections. It remains the task of another John Howard to explain what seems quite likely: that reshaping prisons and correctional systems along the lines of correctional geriatrics would be beneficial, both in terms of creating an internal prison order with sufficient legitimacy in the eyes of prisoners to reduce some of the costs of prison operation,¹⁶² and in improving the likelihood of desistance from crime.¹⁶³

C. *Animating the Eighth Amendment*

Brown v. Plata is the first case to begin to read the Eighth Amendment in light of the emerging crisis of chronic illness in prison. Unlike *Ewing*, where the Court elevated the state's penological choices and crime fears above any consideration of the humanity of prisoners,¹⁶⁴ here the Court emphatically condemned the denial of adequate medical care as outside the bounds of "civilized society," without regard to crime fear¹⁶⁵: "A prison that

¹⁶¹ This is one lesson that might be drawn from the fascinating experience of healing among some groups of highly marginalized AIDS patients in Brazil who have been attempting to survive their effective abandonment by the state through a unique collaboration of nongovernmental organizations, pharmaceutical corporations, and the patients. See JOÃO BIEHL, *VITA: LIFE IN A ZONE OF SOCIAL ABANDONMENT* (2005).

¹⁶² On legitimacy in prisons and the difference it can make to the way prisons operate, see generally RICHARD SPARKS ET AL., *PRISONS AND THE PROBLEM OF ORDER* (1996); BERT USEEM & PETER KIMBALL, *STATES OF SIEGE: U.S. PRISON RIOTS, 1971–1986* (1989); Eamonn Carabine, *Prison Riots, Social Order and the Problem of Legitimacy*, 45 *BRIT. J. CRIMINOLOGY* 896 (2005); Richard Sparks, *Can Prisons be Legitimate?: Penal Politics, Privatization, and the Timeliness of an Old Idea*, 34 *BRIT. J. CRIMINOLOGY* 14, 14–28 (1994); J.R. Sparks & A.E. Bottoms, *Legitimacy and Order in Prisons*, 46 *BRIT. J. SOC.* 45 (1995).

¹⁶³ See generally SHADD MARUNA, *MAKING GOOD: HOW EX-CONVICTS REFORM AND REBUILD* (2001) (presenting empirical evidence that having a strong narrative is an important element of desistance for repeat offenders).

¹⁶⁴ *Ewing v. California*, 538 U.S. 11 (2003).

¹⁶⁵ The Court did not, however, omit entirely consideration of potential future crime. Indeed, one of the most important features of the posture in which the *Plata* case was decided is the fact that the court below took considerable cognizance of the crime risks posed by re-

deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.”¹⁶⁶ California’s strong penological choice to treat its prisoners as pure criminal threats requiring calibrated degrees of incapacitation was not held to permit disregard of the prisoner as a locus of psychological and biological threats to his or her own survival — in short, as a human being.¹⁶⁷

The strong sense of humanitarian anxiety or revulsion evidenced by members of the *Plata* majority toward California’s mass incarceration practices was reflected in language that invoked torture and produced some of the strongest language about dignity in the Eighth Amendment prison context since *Estelle v. Gamble*,¹⁶⁸ or perhaps *Trop v. Dulles*¹⁶⁹:

As a consequence of their own actions, prisoners may be deprived of rights that are fundamental to liberty. Yet the law and the Constitution demand recognition of certain other rights. Prisoners retain the essence of human dignity inherent in all persons. Respect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment. “‘The basic concept underlying the Eighth Amendment is nothing less than the dignity of man.’”¹⁷⁰

What other rights? The European Court of Human Rights has held that meaningful family contact, access to rehabilitative programming, and the right to vote (unless deprived of it by some meaningful judicial selection) are protected by the Convention, and in principle, these might include all other rights other than those whose denial is necessary to sustain the loss of liberty.¹⁷¹ But even if the Supreme Court declines to adopt the position of the European Court of Human Rights, it is nonetheless likely to be much more protective of prisoners’ rights than before *Brown v. Plata* identified political policies and pathologies of mass incarceration as crucial factors in California’s inability to control its prison population and implement acceptable medical care for its prisoners. Even for other states that have thus far avoided the type of overcrowding that resulted in California’s prisons achieving crisis status, the same mass incarceration policies (which are only now being questioned in many states, and only at the margins) still present

entering prisoners (or those who might avoid prison under a population cap). As such, the case presents a model of how risk and dignity should be properly integrated. *Brown v. Plata*, 131 S. Ct. 1910, 1941 (2011) (“[T]he three-judge court gave ‘substantial weight’ to any potential adverse impact on public safety from its order.”).

¹⁶⁶ *Id.* at 1928.

¹⁶⁷ In stark contrast, the Court had deferred to California’s penological judgment just a few years earlier in the “three-strikes” cases discussed in Part II.C. See generally *Ewing*, 538 U.S. 11; *Lockyer v. Andrade*, 538 U.S. 63 (2003).

¹⁶⁸ 429 U.S. 97 (1976).

¹⁶⁹ 356 U.S. 86 (1958).

¹⁷⁰ *Plata*, 131 S. Ct. at 1928 (quoting *Atkins v. Virginia*, 536 U.S. 304, 311 (2002) (quoting *Trop*, 356 U.S. at 100)).

¹⁷¹ VAN ZYL SMIT & SNACKEN, *supra* note 143, at 100–03, 178, 213.

long term fiscal and medical challenges as chronically ill prisoners converge in prisons that are, at best, designed to deliver acute medical care.

For states beyond California as well, *Brown v. Plata* suggests a constitutional future for prison health care. *Plata* reaffirms that John Howard's campaign for prisons that do not sicken or kill their prisoners must, in Bentham's terms, "necessarily be, whether designed or not, an Hospital: a place where sickness will be found at least, whether provision be or be not made for its relief."¹⁷² But because those prisons must increasingly care for chronically ill prisoners, Howard's solution of separating prisoners, regulating exposure, and increasing ventilation will not work. While Howard's campaign against jail fever helped establish the modern prison as severe punishment for serious crime that was not cruel and unusual, the crisis of chronic illness in American corrections today has once again thrown into question the Eighth Amendment's meaning for imprisonment.

Does "cruel and unusual punishment" only proscribe the most excessive sentences and the worst physical prison conditions? The dominant view in American law is that any such prohibition is quite limited.¹⁷³ This discounts, however, the increasing prominence of dignity as a value in American constitutional law,¹⁷⁴ and *Brown v. Plata*'s emphatic statement that dignity "animates the Eighth Amendment."¹⁷⁵ A new medical model can provide a meaningful context for interpreting the Eighth Amendment and the meaning of carceral punishment in such a manner that yields judicial standards that are both meaningfully tied to the Eighth Amendment's dignity mission and also provide the basis for self-limitation.

A parallel can be drawn to the wave of federal court reforms of prisons in the 1970s and 1980s. Then, the national consensus on rehabilitation and professional penal bureaucracies provided courts with a nationally relevant and self-limiting normative framework for determining constitutionally adequate conditions for prisoners.¹⁷⁶ Now, correctional geriatrics can provide courts with meaningful and limiting considerations for evaluating both sentences and prison conditions.

Brown v. Plata is a major step toward a constitutionalization of the third model insofar as it reinforces an Eighth Amendment right not just to individual care, but to an effective mental and medical health care system within the enlarged prison systems of every state. Coming after decades in which prisons and corrections generally have been more and more domi-

¹⁷² BENTHAM, *supra* note 43, at 34.

¹⁷³ See STUNTZ, *supra* note 16, at 77–78 (arguing that the Eighth Amendment provides marginal protections against egregious prison conditions and bemoaning the lack of substantive checks on populist punitiveness in America).

¹⁷⁴ See Leslie Meltzer Henry, *The Jurisprudence of Dignity*, 160 U. PA. L. REV. 169, 173 (2011).

¹⁷⁵ *Plata*, 131 S. Ct. at 1928.

¹⁷⁶ FEELEY & RUBIN, *supra* note 62, at 242–43 (noting the importance of limits for judicial policymaking to uphold the rule of law).

nated by custody staff and considerations of security,¹⁷⁷ *Brown v. Plata* mandates the insertion into the penal field of new medical professional personnel. These medical personnel and systems will bring new monitoring capacities and countervalues to the security-based values that have been unopposed in recent decades from within the penal bureaucracy. If they are litigation-based, they will also bring accountability to independent, national, professional experts, at least during the implementation of the court orders.

Federal district courts will determine in the first instance what kinds of imprisonment are compatible with a dignity-animated Eighth Amendment. A number of early challenges seem likely. One such challenge rallies against long-term segregation and isolation of prisoners, whether totally alone or with a cellmate but cut off from opportunities to leave the cell or access prison programs (i.e., the current “supermax” regime, which has been repeatedly upheld as constitutional in recent years).¹⁷⁸ These special prisons have been crucial to enforcing order in mass incarceration systems that provide few incentives for prisoners to cooperate, but must contend with lots of potentially threatening prison gangs (which is why courts have been so reluctant to find them unconstitutional). But assignment to a supermax prison, especially without substantial evidence linking the prisoner to a serious threat of violence or to a disciplinary offense, is a very troubling punishment when viewed through the geriatric medical lens and thus seen as a permanent loss of resilience in already mentally and biologically disadvantaged and compromised populations. This raises both Eighth Amendment and (because assignment to a supermax prison is done by administrative order without anything resembling court procedures) Fourteenth Amendment issues.

Life sentences, either without the possibility of parole or with only a remote chance that parole will be granted (both of which are common today), will continue to be challenged. By highlighting the very high personal cost of imprisonment to older and sicker prisoners, the geriatric view of the prisoner will make it more likely that courts find the denial of a realistic possibility of parole to be cruel and unusual.

Even if life sentences are found to be constitutional (and they are likely to survive any current challenges, at least as to adults), the Eighth Amendment may require that prisons demonstrate substantial efforts to conserve the human dignity of prisoners with no realistic hope of leaving prison alive, perhaps through the fostering of family relations, the creation of progressive autonomy within prison, and/or the possibility of greater integration with the outside world over time (even if permanently within a prison setting). The Eighth Amendment, on this reading, would be hard pressed to deny a pris-

¹⁷⁷ See generally JOSHUA PAGE, *THE TOUGHEST BEAT: POLITICS, PUNISHMENT, AND THE PRISON OFFICERS UNION IN CALIFORNIA* (2011).

¹⁷⁸ This statement, as noted earlier, does not extend to prisoners who already had a serious mental illness at the time of their assignment to a supermax prison. See generally *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995); see also Reiter, *supra* note 80, at 218.

oner who posed no threat to the community a right to die in a hospice, if not outside of prison, or at least in a place as un-prison-like as possible.

CONCLUSION

In this Article, we have described two momentous transformations of the American prison project that took place around the problem of disease, and four different medical models through which the prison has been offered as a humane and well-adapted form of punishment for modern civilized societies. The first moment of transformation took place in the late eighteenth century around the problem of the jail as a locus of jail disease and other infectious diseases. The humanitarian sensibilities mobilized by Howard's descriptions of jail fever, transposed through the lens of "miasma" medicine, helped redefine the idea of humane punishment at a moment when the whole system of scaffold executions, to which the jail was an essential, if less visible, adjunct, was undergoing strong criticism.

Arising out of that crisis came our modern image of the prison as a ventilated fortress composed of cellular enclosures, ideally for each individual prisoner. This cultural campaign, which was associated with John Howard's two books in 1777 and 1789, and which swept the educated and legal elites of the Atlantic world at the time the Eighth Amendment was adopted, was pivotal in helping to establish the penitentiary-style prison as the American contribution to the global movement toward prisons. It is thanks to Howard and jail fever that we have today the prison, and not some other form of punishment as the major replacement for capital punishment, which had begun to decline in the United States, outside the South, almost from the start of the republic. By discrediting the eighteenth-century local jail, which provided the most obvious and convenient alternative to scaffold executions and lesser corporal punishments or mutilations, Howard helped make the penitentiary-style prison the primary constitutionally legitimate punishment for felony offenses.

Brown v. Plata marks the opening of what may be the most profound medical remaking of prisons since the controversies unleashed by jail fever in the eighteenth century. A new kind of disease and a new logic of medicine — one associated with chronic illness and geriatrics — is likely to reshape the way we understand and use imprisonment, as well as the way prisons are designed and operated. These fields are also capable of helping to provide meaningful context for the broad language of the Eighth Amendment's prohibition on "cruel and unusual punishment," as well as its animating commitment to preserve the human dignity of the prisoner.¹⁷⁹

¹⁷⁹ Dignity is, after all, an equally broad and abstract term. Chronic illness and gerontological medicine, with their emphasis on the patient as an active participant in her own treatment and on sustaining personal connections, offer a productive source of meaning for dignity in the conditions of imprisonment.

No student of the American prison should be sanguine that such an opening, even if it should result in a fundamental reworking of imprisonment and broadening of constitutional protections for the human rights of prisoners, will by itself resolve the problems of mass incarceration. Above all, the great divide of race that has long placed prisoners of color behind a double veil from a public that generally does not see prisoners, and from a white plurality of the public (one of which both parties are quite enamored) that is less likely to empathize with the plight of prisoners of color, still persists. That divide stands to leave even the best post-*Brown v. Plata* renewal of penalty deformed and distorted along the lines of race.