NOTE

Positive Law[1]: Providing Adequate Medical Care for HIV-Positive Immigration Detainees

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Abstract

Despite recent improvements, the level of medical care that U.S. Immigration and Customs Enforcement ("ICE") provides to detainees in its custody remains poor. This lack of effective care has a particularly harsh impact on HIV-positive detainees, who must have consistent access to antiretroviral medications and other basic treatments to stem the progression of that disease. This Note argues that although the United States has obligated itself under the United Nations Convention Against Torture to provide minimally adequate medical care and to guarantee an adequate remedy for any failure to provide such care, no effective remedy is yet available under United States law. This Note proposes a federal statute that accomplishes two goals. First, the statute would require ICE to implement binding regulations that will guarantee essential treatment to HIV-positive detainees. Second, the statute would provide a private right of action to detainees against those ICE agents who fail to conform to these regulations.

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1 Whereas "natural law" is the law of an ideal world discernible through reason, "positive law" is the law human beings establish by legislative enactment and judicial interpretation. Black's Law Dictionary 1127, 1280 (9th ed. 2009).

* J.D., May 2013, The George Washington University Law School. With many thanks to my family and friends; and all those who have made this piece possible.

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INTRODUCTION

U.S. Immigration and Customs Enforcement ("ICE") arrested Charles B., a healthy, HIV-positive,[2] legal permanent resident who had emigrated from Jamaica, in September 2000.[3] By the time he was granted asylum almost five years later, his condition had deteriorated to nearly full-blown AIDS.[4] Thirteen common HIV prescriptions became ineffective for Charles because the medical staff at the detention center provided his doses too sporadically.[5] He also developed a permanent disability that prevents him from continuing his work as an auto mechanic because the staff prescribed additional medications with known, dangerous drug interactions.[6] Alarmingly, the medical staff observed his continuing deterioration but did nothing.[7]

Unfortunately, Charles's story is not unique. For example, in 2007, a transgender, HIV-positive detainee died from an opportunistic infection of meningitis after only eight weeks in custody because she received no HIV medications.[8] Similarly in 2011, an asylum seeker from Peru had difficulty receiving medication for six weeks because he was kept in solitary confinement for no reason other than his HIV-positive status.[9]

The Supreme Court has recognized that the Due Process Clause of the Fifth Amendment requires federal officials to care for the serious medical needs of those in their custody, even immigrants.[10] This

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2 The human immunodeficiency virus ("HIV") is defined and described in greater detail *infra* at notes 13–17.

3 This story is drawn from a recent Human Rights Watch report. *See* HUMAN RIGHTS WATCH, CHRONIC INDIFFERENCE: HIV/AIDS SERVICES FOR IMMIGRANTS DETAINED BY THE UNITED STATES 38–39 (2007), *available at* http://www.hrw.org/sites/default/files/reports/us1207web.pdf [hereinafter HRW, CHRONIC INDIFFERENCE].

4 *Id.* at 38.

5 *Id.* at 39.

6 *Id.*

7 See *Id.*

8 FLA. IMMIGRANT ADVOCACY CTR., DYING FOR DECENT CARE: BAD MEDICINE IN IMMIGRATION CUSTODY 20–21 (2009), *available at* http://www.aijustice.org/docs/reports/DyingForDecentCare.pdf; Sandra Hernandez, Op-Ed., *A Lethal Limbo*, L.A. TIMES, June 1, 2008, at M8.

9 Press Release, Heartland Alliance Nat'l Immigrant Justice Ctr., Mass Civil Rights Complaint Details Systemic Abuse of Sexual Minorities in U.S. Immigration Detention (Apr. 13, 2011), http://www.immigrantjustice.org/press_releases/mass-civil-rights-complaint-details-systemic-abuse-sexual-minorities-us-immigration-d. Stories of poor medical treatment in detention centers generated extensive media attention in 2008. *See, e.g.*, Dana Priest & Amy Goldstein, *Careless Detention* (pts. 1–4), WASH. POST, May 11, 2008, at A1, WASH. POST, May 12, 2008, at A1, WASH. POST, May 13, 2008, at A1, WASH. POST, May 14, 2008, at A1.

10 *See* Zadvydas v. Davis, 533 U.S. 678, 690, 693–96 (2001) (holding that the Fifth Amendment protects certain immigration detainees); *see also* Clark v. Martinez, 543 U.S. 371, 377–78 (2005) (extending the holding of *Zadvydas* to *all* immigration detainees); Carlson v. Green, 446

Note argues, however, that current domestic remedies under the Constitution do not provide sufficient protection for HIV-positive detainees. This Note will demonstrate that two international obligations binding on the United States—the right to be free from cruel, inhuman, or degrading treatment or punishment ("cruel treatment") and the right to an effective remedy—require that ICE provide HIV-positive detainees proper minimum care.

This Note proposes a federal statute that applies a two-pronged strategy. First, it will require ICE to promulgate and regularly update binding regulations regarding proper medical treatment informed by current medical standards and supervised by Congress. Second, it will provide detainees with a private right of action that allows compensatory damages for violations of these new regulations as well as injunctive relief if those regulations become too outdated.

Part I discusses current medical standards for HIV care and demonstrates that ICE falls short of this mark. Part II reviews the causes of action currently available to detainees under the Fifth Amendment and the obstacles that limit their usefulness. Part III demonstrates that the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Torture Convention")[11] and the right to an effective remedy require a comprehensive approach to treating HIV-positive detainees. Part IV discusses the proposed statute. Part V addresses and responds to the most significant arguments against this proposal. Finally, the proposed statute is presented in the Appendix.

I. ICE Detention Medical Care and HIV-Positive Detainees

This Part will describe the commonly accepted medical guidelines for HIV treatment and demonstrate that even recent improvements in ICE's informal policies do not guarantee this minimum standard of care.

U.S. 14, 20 (1980) (permitting suit for compensatory and "constitutional" damages—additional compensation for the harm caused by the violation of a constitutional right itself); *see also* Estelle v. Gamble, 429 U.S. 97, 104–05 (1976) (holding that the Eighth Amendment forbids "deliberate indifference to serious medical needs"). In this context, the standard is the same under both the Fifth and Eighth Amendments. *See infra* note 90.

11 United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, 1465 U.N.T.S. 113 (entered into force June 26, 1987) [hereinafter "Torture Convention"].

A. *Current Medical Standards for HIV Treatment*

Although many advanced treatments for HIV are now available,[12] the medical profession recognizes certain basic steps as the minimum level of care required to prevent suffering or lasting injury from HIV.[13] HIV disables the immune system by infecting and destroying T-cells.[14] T-cells identify potentially harmful foreign objects so that other white blood cells can capture and destroy them.[15] Because HIV has no cure,[16] current medical treatment focuses on medication and monitoring the progression of the disease.[17]

The primary prescription medications used to treat HIV are antiretroviral medications ("ARVs").[18] The current minimum standard of care is a combination of three drugs.[19] Typically, each of these drugs targets a different stage in the viral replication process.[20] Physicians cannot select an appropriate regimen without complete knowledge of a patient's medical history.[21] An appropriate regimen of

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12 For example, HIV treatment at a family doctor in the United States would likely involve genetic testing of both the patient and his or her viral samples to avoid drug resistance and excessive side effects. *See* Press Release, Harvard Sch. of Pub. Health, Genetic Testing of HIV to Identify Resistance to Drug Treatment Found to Be Cost-Effective (Mar. 19, 2001), *available at* http://www.hsph.harvard.edu/news/press-releases/archives/2001-releases/press03192001.html.

13 *See* Charles Flexner, *Antiretroviral Agents and Treatment of HIV Infection*, *in* GOODMAN & GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 1623, 1626–28 (Laurence L. Brunton et al. eds., 12th ed. 2011) (characterizing several aspects of HIV treatment as the "minimum" standard of care or as part of any current treatment).

14 ELI BENJAMINI, RICHARD COICO & GEOFFREY SUNSHINE, IMMUNOLOGY: A SHORT COURSE 362 (4th ed. 2000); MICHAEL B.A. OLDSTONE, VIRUSES, PLAGUES, & HISTORY 269–70 (rev. ed. 2010).

15 *See* OLDSTONE, *supra* note 14, at 253; BENJAMINI ET AL., *supra* note 14, at 195–96.

16 *See* BENJAMINI ET AL., *supra* note 14, at 368. *But see* Richard Knox, *Two More Nearing AIDS 'Cure' After Bone Marrow Transplants, Doctors Say*, NPR (July 26, 2012, 7:50PM), http://www.npr.org/blogs/health/2012/07/26/157444649/two-more-nearing-aids-cure-after-bone-marrow-transplants-doctors-say (describing doctors' hope that a cure for HIV may be accomplished within a decade).

17 *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., GUIDELINES FOR THE USE OF ANTIRETROVIRAL AGENTS IN HIV-1-INFECTED ADULTS AND ADOLESCENTS, at C-1 to -5, D-1 to -2 (2013) [hereinafter HHS, ARV GUIDELINES], *available at* http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf.

18 Flexner, *supra* note 13, at 1626 (defining ARVs as drugs that suppress viral replication).

19 *Id.* at 1623, 1627. Prescribing a single drug will often lead to resistance against that drug in only a matter of weeks because of how rapidly HIV mutates. *Id.*

20 HHS, ARV GUIDELINES, *supra* note 17, at P-1 to -14 (listing various classes of ARVs); OLDSTONE, *supra* note 14, at 253–54. In brief, the virus replicates by attaching to the T-cell wall and injecting its genetic material, which incorporates itself into the T-cell's DNA, causing the T-cell to create thousands of copies of the virus until the T-cell bursts and these new copies escape into the bloodstream. *See* BENJAMINI ET AL., *supra* note 14, at 362–64.

21 Flexner, *supra* note 13, at 1628 (stating that women provided with a single dose of nevirapine to prevent transmission of the virus in childbirth were much more likely to rapidly

ARVs should be administered as soon as possible after an HIV-positive diagnosis.[22] ARVs must not be interrupted or discontinued unless otherwise medically necessary.[23] In fact, most ARVs must be taken as prescribed with at least ninety-five percent consistency to be effective.[24]

Once a doctor finds an ARV regimen that works for a patient, the doctor must regularly perform blood tests that measure "T-cell count" and "viral load."[25] T-cell count is the number of T-cells found in a microliter of a patient's blood.[26] Viral load is the number of copies of the virus found in the same sample.[27] Ideally, viral load will be "undetectable," meaning no copies were found in the sample taken, and T-cell count will be around 500.[28] When a patient's T-cell count falls below 200, the patient is diagnosed with AIDS.[29]

Such monitoring is also essential to prevent opportunistic infections and drug resistance. Opportunistic infections are diseases that would be no match for a healthy immune system but can be deadly to someone with HIV.[30] Resistance emerges because HIV is constantly mutating, and new strains that are less affected by a patient's ARV regimen multiply.[31] If ARVs are interrupted or the regimen is improper, resistance can emerge in only a matter of weeks.[32] When re-

develop complete resistance to nevirapine if it became part of their regimen, risking developing a resistance to the other two drugs in their regimen).

22 HHS, ARV GUIDELINES, *supra* note 17, at i, C-5 (noting change from prior belief that it was best to wait to treat until the immune system begins to fail). Treatment is lifelong and patients can achieve near-normal life expectancy. Flexner, *supra* note 13, at 1623; *see also* Ctrs. for Disease Control & Prevention, *Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents*, 58 MMRW RECOMMENDATIONS & REPORTS, Apr. 2009, at 1, 4–6 (noting that ARVs also help decrease the likelihood of opportunistic infection).

23 *See* HHS, ARV GUIDELINES, *supra* note 17, at H-19 to -21 (describing situations where interrupting ARVs may be considered and cautioning against interruption).

24 *See id.* at K-1 to -3.

25 *See id.* at C-2 tbl.3 (listing tests and intervals at which each should be administered). Early in the search for HIV treatments, researchers discovered these two measures to be excellent descriptors of the progression of the disease. *Id.* at C-4, -6; Flexner, *supra* note 13, at 1625.

26 *See* BENJAMINI ET AL., *supra* note 14, at 367.

27 *See* HHS, ARV GUIDELINES, *supra* note 17, at C-7.

28 *Id.* at E-1 to -4, E-12, H-4. The virus can still be "undetectable" at viral loads below fifty copies per microliter. Flexner, *supra* note 13, at 1627.

29 CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., LIVING WITH HIV/AIDS (2007), *available at* http://www.cdc.gov/hiv/resources/brochures/print/livingwithhiv.htm.

30 BENJAMINI ET AL., *supra* note 14, at 365–68 (noting infections actually speed up the death of T-cells, furthering the debilitation of the immune system).

31 OLDSTONE, *supra*, note 14, at 259; Flexner, *supra* note 13, at 1627.

32 Flexner, *supra* note 13, at 1627.

sistance occurs, doctors must adjust the regimen until the virus is again under control.[33]

These steps represent only the bare minimum of treatment for HIV. Many clinics and hospitals regularly provide such care;[34] thus, a medical center would have no difficulty providing this level of care. Many ICE facilities, however, are state and local jails with limited medical staff.[35] Selecting appropriate ARVs to prescribe in a combination while avoiding drug interactions is a challenge for primary care physicians,[36] let alone the ICE personnel who face such limited resources.[37]

B. *The Impact of the Detention System on HIV-Positive Detainees*

In recent years, ICE has made several admirable strides to improve the medical care it provides to those in its custody. However, these recent changes have not addressed the underlying causes that render this care inadequate. This Subpart will discuss the structure of ICE, its historic practices and new medical policies, and the continuing problems detainees face nationwide.

1. *How ICE Provides Medical Care*

The increasing focus on the use of detention in immigration policy has posed a special challenge to ICE, an agency with a poor record of medical care.[38] ICE, as a bureau of the Department of Homeland Security ("DHS"),[39] is responsible for enforcing United States immigration laws through investigation, arrest, detention, and prosecu-

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33 *See id.* at 1628 (advising that the failing regimen be maintained in order to conduct testing necessary to avoid future resistance, and then prescribing three completely new drugs).

34 *See, e.g., Getting HIV Care: What You Need to Know*, POZ (Dec. 2010), http://www.poz.com/factsheets/fs_2010_12_access.pdf (noting that many clinics and hospitals provide a variety of services for HIV patients).

35 *See infra* notes 42, 74 and accompanying text.

36 *See* Flexner, *supra* note 13, at 1660 ("[B]ecause mistakes can have dire and irreversible consequences for the patient, the prescribing of these drugs should be limited to those with specialized training."); *id.* at 1628 (noting complexity of possible drug interactions between ARVs and other necessary medicines).

37 *See* Dana Priest & Amy Goldstein, *Careless Detention: A System of Neglect* (pt. 1), WASH. POST, May 11, 2008, at A1 (noting medical staff shortages of up to thirty percent).

38 *See* Edwidge Danticat, Op-Ed., *Detention Is No Holiday*, N.Y. TIMES, Mar. 28, 2012, at A27; *see also* AM. CIVIL LIBERTIES UNION OF ARIZ., IMMIGRATION DETENTION IN ARIZONA 2 (2010), http://acluaz.org/sites/default/files/documents/Detention%20in%20Arizona%20One-Pager%202-24-10.pdf.

39 *See* 6 U.S.C. §§ 251, 291(a) (2006); *id.* § 252 note (Change of Name) (noting agency name change from Bureau of Border Security to ICE).

tion.[40] As a practical matter, ICE detains over 400,000 people annually[41] in over 250 detention centers nationwide, although it runs very few of these centers directly.[42] The average stay for detainees is thirty days, and at least one percent of detainees are held for more than a year.[43]

The ICE Health Service Corps ("IHSC") is the department responsible for supervising and funding detainee medical care.[44] Until 2011, IHSC regularly highlighted the cost savings it achieved by denying authorization for medical treatment.[45] IHSC's prior official policy required on-site doctors to obtain IHSC approval before providing any nonemergency care and discouraged unnecessary services.[46] In fiscal year 2005, for example, IHSC calculated that it had saved

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40 *See id.* §§ 251–252.

41 ICE arrested 642,000 foreign nationals in fiscal year 2011, placed 429,247 in detention, and removed 391,953 from the United States. JOHN SIMANSKI & LESLEY M. SAPP, OFFICE OF IMMIGRATION STATISTICS, U.S. DEP'T OF HOMELAND SEC., IMMIGRATION ENFORCEMENT ACTIONS: 2011, at 1, 5 (2012), *available at* http://www.dhs.gov/sites/default/files/publications/immigration-statistics/enforcement_ar_2011.pdf. Detention is mandatory for many groups. *See* 8 U.S.C. §§ 1225, 1226–26a, 1231 (2006) (listing groups). ICE often uses its discretionary power to detain the rest. *See* Sarah Gryll, Comment, *Immigration Detention Reform: No Band-Aid Desired*, 60 EMORY L.J. 1211, 1231–32 (2011).

42 *Fact Sheet: Detention Management*, ICE (Nov. 10, 2011), http://www.ice.gov/news/library/factsheets/detention-mgmt.htm (indicating that state and local agencies run sixty-seven percent of all facilities, private companies run seventeen percent, the Bureau of Prisons runs three percent, and ICE directly runs only thirteen percent). This breakdown does not reveal that these few ICE-owned facilities house approximately half of all ICE detainees. Kirk Semple & Tim Eaton, *Detention for Immigrants That Looks Less Like Prison*, N.Y. TIMES, Mar. 14, 2012, at A17.

43 *Compare* DORA SCHRIRO, U.S. DEP'T OF HOMELAND SEC., IMMIGRATION DETENTION OVERVIEW AND RECOMMENDATIONS 6 (2009), *available at* http://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf (presenting official ICE data), *with* Annette De La Torre, Note, *Is Ze an American or a Foreigner? Male or Female? Ze's Trapped!*, 17 CARDOZO J.L. & GENDER 389, 401 (2011) (noting data might omit asylum-seekers, whose applications regularly take years to be processed), *and* AM. CIVIL LIBERTIES UNION OF ARIZ., *supra* note 38, at 1 (stating the average length of stay in Arizona is 129 days).

44 *See* ICE HEALTH SERV. CORPS, U.S. IMMIGRATION & CUSTOMS ENFORCEMENT, ENFORCEMENT AND REMOVAL OPERATIONS: DETAINEE COVERED SERVICES 2 (2010), *available at* http://www.icehealth.org/ManagedCare/IHSC%202010%20Detainee%20Covered%20Service%20Package_12-28-10.pdf.

45 *See, e.g.*, FLA. IMMIGRANT ADVOCACY CTR., *supra* note 8, at 10–11.

46 *Id.* at 11; Kelsey E. Papst, Comment, *Protecting the Voiceless: Ensuring ICE's Compliance with Standards that Protect Immigration Detainees*, 40 MCGEORGE L. REV. 261, 277 n.153 (2009) (quoting DIHS, MEDICAL DENTAL DETAINEE COVERED SERVICES PACKAGE 1 (2005), *available at* http://www.docstoc.com/docs/26810403/DIHS-Medical-Dental-Detainee-Covered-Services-Package).

$129,713.62 by denying requested HIV treatment.[47] IHSC continued this practice despite the DHS's disapproval of the system.[48]

Since ICE was created in 2003,[49] 131 detainees have died in its custody,[50] six of whom had AIDS as the listed cause of death.[51] At most facilities during this time, staff failed to provide medication as prescribed, to ensure that medication and medical records followed a detainee who was transferred to a new facility, to protect confidentiality, or to perform regular testing essential to proper HIV treatment.[52] To be sure, the continuing inadequacy of ICE's medical care system poses serious concerns given ICE's increasing emphasis on detention.

2. *Recent Improvements in ICE Medical Care*

Recognizing the harm caused by its earlier approach, ICE has made several promising strides to improve health care in the detention system. In 2008, ICE drafted the Performance-Based National Detention Standards ("2008 PBNDS"),[53] which were revised in 2011 ("2011 PBNDS").[54] The PBNDS recommendations on medical care

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47 *TAR Cost Savings Based on Denials* (Sept. 30, 2006), http://media.washingtonpost.com/wp-srv/nation/specials/immigration/day2_tardocs.pdf.

48 *See* SCHRIRO, *supra* note 43, at 19, 22, 26.

49 Name Change from the Bureau of Immigration and Customs Enforcement to U.S. Immigration and Customs Enforcement, and the Bureau of Customs and Border Protection to U.S. Customs and Border Protection, 72 Fed. Reg. 20,131 (Apr. 23, 2007).

50 ICE HEALTH SERV. CORPS, U.S. IMMIGRATION & CUSTOMS ENFORCEMENT, LIST OF DEATHS IN ICE CUSTODY: OCTOBER 2003–DECEMBER 6, 2012 (2012), *available at* http://www.ice.gov/doclib/foia/reports/detaineedeaths2003-present.pdf; *see also* Spencer Bruck, Note, *The Impact of Constitutional Liability and Private Contracting on Health Care Services for Immigrants in Civil Detention*, 25 GEO. IMMIGR. L.J. 487, 493 (2011) (noting that the ICE figures omit detainees who suffered permanent disabilities or died after being released from custody). Previous reports that ICE covered up several detainee deaths indicate that this list may be incomplete. Nina Bernstein, *Officials Obscured Truth of Migrant Deaths in Jail*, N.Y. TIMES, Jan. 10, 2010, at A1.

51 ICE HEALTH SERV. CORPS, *supra* note 50. Of course, AIDS is not always listed as the cause of death even when the illness that proved fatal was AIDS-related. *See, e.g.*, RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC 62, 137 (1988).

52 *See* HRW, CHRONIC INDIFFERENCE, *supra* note 3, at 19–21; *see also Problems with Immigration Detainee Medical Care: Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Sec. & Int'l Law of the H. Comm. on the Judiciary*, 110th Cong. 32–33 (2008) (statement of Richard M. Stana, Dir., Homeland Sec. & Justice Issues, Gov't Accountability Office) (noting ICE and independent investigations found substantial noncompliance with ICE policies, and commenting that eleven percent of all detainee complaints filed regarded medical care).

53 U.S. DEP'T OF HOMELAND SEC., OPERATIONS MANUAL ICE PERFORMANCE BASED NATIONAL DETENTION STANDARDS (PBNDS) (2008).

54 U.S. IMMIGRATION & CUSTOMS ENFORCEMENT, U.S. DEP'T OF HOMELAND SEC., PER-

differ from their predecessors by prioritizing consistent and timely treatment.[55] The PBNDS recommend that every detainee receive an intake medical exam.[56] The PBNDS further indicate that licensed medical professionals should make all medical decisions, develop a complete medical record on each detainee, protect confidentiality, and respect informed consent.[57] Additionally, medications should be dispensed exactly as prescribed.[58]

Detention facility operators should also ensure that there is no interruption in appropriate care by notifying medical staff of upcoming transfers.[59] The 2011 PBNDS further requires that officials transporting the detainee bring an adequate supply of prescription medication, as well as the detainee's complete medical record in a sealed envelope indicating its confidentiality.[60] The 2011 PBNDS specifically recommends that facilities provide HIV tests upon request, closely guard confidentiality of HIV status, and carefully monitor and manage HIV treatment.[61] In addition, the 2011 PBNDS requires each facility to develop a written plan for maintaining the confidentiality of HIV status.[62] The PBNDS encourage administering ARVs and providing an adequate supply of those prescriptions upon release.[63] Further, they exhort facilities to follow a number of "national recommendations and guidelines" on HIV/AIDS medical care.[64]

In late 2010, IHSC issued its own improved coverage guidelines.[65] Significantly, the new guidelines permit on-site medical personnel to make all treatment decisions.[66] The guidelines encourage medical staff to "provide medically appropriate treatment . . . [for] serious medical needs" and to exercise prudent professional care.[67] Although

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FORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 (2011) [hereinafter ICE, 2011 PBNDS] (as modified by February 2013 Errata).

55 *See id.* at 233–34. The previous guidelines had similar wording but were limited in reality by IHSC's policy of approving only emergency and other relatively inexpensive care. *See* ALISON SISKIN, CONG. RESEARCH SERV., RL34556, HEALTH CARE FOR NONCITIZENS IN IMMIGRATION DETENTION 10–11 (2008).

56 *See* ICE, 2011 PBNDS, *supra* note 54, at 234, 242–44.

57 *See id.* at 235, 237, 250–53.

58 *See id.* at 234–35, 248–49.

59 *See id.* at 252–53.

60 *See id.* at 250, 252–53.

61 *See id.* at 284.

62 *See id.* at 239.

63 *See id.*

64 *See id.*

65 ICE HEALTH SERV. CORPS, *supra* note 44.

66 *See id.* at 2.

67 *Id.*

the guidelines do not specifically mention HIV, that condition likely qualifies as a "serious medical need."[68]

Although the improved ICE and IHSC policies are laudable, problems continue because these policies are not legally binding and provide no direct cause of action for detainees.[69] As such, these policies cannot sufficiently address the ongoing issues in treating HIV-positive detainees.

3. *Continuing Problems*

ICE has been slow in implementing these policies,[70] and many facilities continue to deviate widely.[71] There are several reasons for this deviation. The language of the PBNDS explicitly contemplates that facilities may "adopt, adapt or establish alternative[ ] [rules], provided they meet or exceed the intent represented by these procedures."[72] Additionally, the ICE officers' union opposes the implementation of the 2011 PBNDS, arguing that many aspects of the policy threaten officer and detainee safety.[73] One of the union's concerns is that ordinary ICE officials would be required to conduct the more thorough medical intake exams the PBNDS require—a task for which they acknowledge they are not qualified.[74] The union gave two top ICE officials a vote of no confidence, stating that the 2011 PBNDS were "aimed at providing resort-like living conditions for criminal

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68 *See id.* (defining serious medical need as one that, if "left untreated . . . could result in further significant injury or the unnecessary infliction of pain").

69 *See* HEARTLAND ALLIANCE NAT'L IMMIGRANT JUSTICE CTR., NOT TOO LATE FOR REFORM 5 (2011), *available at* http://immigrantjustice.org/sites/immigrantjustice.org/files/NIJC-MCHR%20Not%20Too%20Late%20for%20Reform%20Report%202011%20FINAL.pdf; Bruck, *supra* note 50, at 508; Papst, *supra* note 46, at 270–72, 275–76; Danticat, *supra* note 38.

70 *See, e.g.*, *Holiday on ICE: The U.S. Department of Homeland Security's New Immigration Detention Standards: Hearing Before the Subcomm. on Immigration Policy & Enforcement of the H. Comm. on the Judiciary*, 112th Cong. 13 (2012) [hereinafter *Holiday on ICE*] (statement of Rep. Pedro R. Pierluisi, Member, H. Comm. on the Judiciary) (noting lack of implementation of the PBNDS and continued opposition to their implementation).

71 AM. CIVIL LIBERTIES UNION OF ARIZ., IN THEIR OWN WORDS: ENDURING ABUSE IN ARIZONA IMMIGRATION DETENTION CENTERS 28 (2011), *available at* http://www.acluaz.org/sites/default/files/documents/detention%20report%202011.pdf.

72 *See* ICE, 2011 PBNDS, *supra* note 54, at 233.

73 Julia Preston, *Union Chief Says New U.S. Rules for Immigration Detention Are Flawed*, N.Y. TIMES, Mar. 29, 2012, at A18. The union also opposes other proposed changes that would make aliens accused of committing crimes the focus of detention, placing others in alternatives to detention. Julia Preston, *Agents' Union Delays Training on New Policy on Deportation*, N.Y. TIMES, Jan. 8, 2012, at A15.

74 Preston, *Union Chief Says New U.S. Rules for Immigration Detention Are Flawed*, *supra* note 73, at A18.

aliens."[75] U.S. Representative Lamar Smith recently held a hearing of the House Judiciary Committee caustically titled "Holiday on ICE," in which he derided the 2011 PBNDS as amounting to "hospitality" for criminals.[76]

Further, each detention facility is subject to the contract it has with ICE, not to ICE's most recent policy. Many facilities are still governed by the standards of the former Immigration and Naturalization Service from 2000.[77] In fact, the most recently constructed detention facility—touted by the administration as the new and more humane face of immigrant detention[78]—will open under the 2008 PBNDS and only adopt the 2011 PBNDS, if it so chooses, a full year later.[79]

A final obstacle is the continuing lack of effective oversight and enforcement. ICE's stated practice is to evaluate each detention facility annually.[80] In reality, however, ICE performs evaluations less frequently and continues to use facilities despite low ratings.[81]

Reports from many facilities remain troubling. One nonprofit organization recently filed seventeen complaints with the DHS Office of Civil Rights and Civil Liberties charging systemic abuse against sexual- and gender-identity minorities, including unnecessary prolonged solitary detention, sexual abuse, harassment, and denial of needed mental health and medical treatment.[82] One of these complaints deals with the asylum-seeker from Peru mentioned in the Introduction, who was kept in solitary confinement for six weeks for no reason other

75 Meghan Rhoad, *Immigration Detention Reform: A Matter of Life and Death*, RH REALITY CHECK (May 11, 2011, 8:00 PM), http://www.rhrealitycheck.org/blog/2011/05/03/immigration-detention-reformmatter-life-death.

76 *Holiday on ICE*, *supra* note 71, at 11 (statement of Rep. Lamar Smith, Chairman, H. Comm. on the Judiciary); *see also* Danticat, *supra* note 38; *The Loose Rules of Detention*, Editorial, L.A. TIMES, Mar. 18, 2012, at A27.

77 *See* HEARTLAND ALLIANCE NAT'L IMMIGRANT JUSTICE CTR., *supra* note 69, at 5; *The Loose Rules of Detention*, *supra* note 76, at A27.

78 Semple & Eaton, *supra* note 42.

79 *The Loose Rules of Detention*, *supra* note 76.

80 OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC., OIG-07-01, TREATMENT OF IMMIGRATION DETAINEES HOUSED AT IMMIGRATION AND CUSTOMS ENFORCEMENT FACILITIES 36 (2006), *available at* http://trac.syr.edu/immigration/library/P1598.pdf.

81 *Id.*; *Problems with Immigration Detainee Medical Care*, *supra* note 52, at 2; HEARTLAND ALLIANCE NAT'L IMMIGRANT JUSTICE CTR. ET AL., YEAR ONE REPORT CARD: HUMAN RIGHTS & THE OBAMA ADMINISTRATION'S IMMIGRATION DETENTION REFORMS 3, 11, 14, 23–25 (2010), *available at* http://www.immigrantjustice.org/sites/immigrantjustice.org/files/ICE%20report%20card%20FULL%20FINAL%202010%2010%2006.pdf.

82 *See* Ian Thompson, *Trauma Compounded: The Plight of LGBT Immigration Detainees*, HUFFINGTON POST (Nov. 2, 2011, 8:59 AM), http://www.huffingtonpost.com/end-ice-abuse/trauma-compounded-the-pli_b_1069537.html.

than his HIV-positive status, making it impossible for him to receive his scheduled prescription doses.[83] Another nonprofit investigating detention facilities in Arizona found that medical requests are often not communicated to medical staff, treatment is often inconsistent, and delays in treatment are excessive.[84]

Finding little recourse in the United States, one detainee suffering from multiple life-threatening conditions appealed to the United Nations.[85] Officials accused him of "faking" his ailments, a frequent occurrence in detention facilities nationwide.[86] Another detainee in Illinois informed two separate medical professionals that he was HIV-positive immediately upon arrival, but still had not received any medications six weeks later.[87] Ultimately, the stories of HIV-positive detainees after 2011 are indistinguishable from those preceding 2008.[88] ICE must take an active role to ensure facilities and officials follow its recommendations.[89]

II. Limitations on Constitutional Protections for HIV-Positive Detainees

Although detainees have access to certain rights and remedies under the United States Constitution for failure to provide adequate medical care, this relief is too limited to require detention centers to provide even the minimum treatment described in Part I.A. Specifically, the Due Process Clause of the Fifth Amendment[90] forbids an

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83 Press Release, Heartland Alliance Nat'l Immigrant Justice Ctr., *supra* note 9.

84 Am. Civil Liberties Union of Ariz., In Their Own Words, *supra* note 71, at 28 (commenting on variation in the level of care provided by different detention centers, despite all being within twenty-two miles of each other).

85 Nina Bernstein, *Sick Detained Immigrant to Appeal to U.N. for Help*, N.Y. Times, June 25, 2010, at A27.

86 *See id.*; Fla. Immigrant Advocacy Ctr., *supra* note 8, *passim.*

87 Heartland Alliance Nat'l Immigrant Justice Ctr., *supra* note 69, at 7.

88 *E.g.*, Rhoad, *supra* note 75.

89 *See infra* Part IV. Although beyond the scope of this Note, it is useful to compare ICE medical care to that which the federal government provides in federal prisons. The Bureau of Prisons has detailed guidelines that instruct practitioners on the current medical standards for everything from HIV testing to what medications are available. *See generally* Fed. Bureau of Prisons, Management of HIV: Federal Bureau of Prisons Clinical Practice Guidelines (2011), http://www.bop.gov/news/PDFs/mgmt_hiv.pdf. However these, too, are only informational and nonbinding. *Id.* at 1.

90 This Note speaks only of the Fifth Amendment because that is the standard that applies to immigrant detainees. *See, e.g.*, Zadvydas v. Davis, 533 U.S. 678, 690 (2001). It should be noted, however, that many of the cases that follow allege violations of the Eighth or Fourteenth Amendments instead. The standard under all three is identical. *E.g.*, Caiozzo v. Koreman, 581 F.3d 63, 70–72 (2d Cir. 2009) (collecting authorities).

official at a detention center[91] from responding to a detainee's "serious medical need" with "deliberate indifference."[92] The first case to introduce this standard, *Estelle v. Gamble*,[93] defined neither term.[94] Each has evolved into its own term of art.[95] This Part will define each term and explain the limitations that prevent HIV-positive detainees from using this standard to obtain basic treatment.

A. *The Obstacles to Showing a "Serious Medical Need"*

To violate the due process guarantee of the Fifth Amendment, there must be a deprivation of a "sufficiently serious" need.[96] Whether a deprivation of medical care is sufficiently serious is an objective inquiry.[97] A serious medical need is one "diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention;"[98] or one which, "if left unattended, pos[es] a substantial risk of serious harm."[99] Most courts that have recently addressed the question have found that staff who were aware that a detainee was HIV-positive but provided no treatment ignored a "serious medical

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91 Private parties working for ICE engage in state action because they carry out a governmental duty. *Compare* West v. Atkins, 487 U.S. 42, 49–53 (1988) (providing prison medical care is a governmental duty), *with* S.F. Arts & Athletics, Inc. v. U.S. Olympic Comm., 483 U.S. 522, 542–47 (1987) (U.S. Olympic Committee enforcement of its exclusive use of the word "Olympics" is not a governmental duty).

92 Clark v. Martinez, 543 U.S. 371, 378 (2005) (citing *Zadvydas*, 533 U.S. at 689–90) (Fifth Amendment protects all immigrant detainees); Farmer v. Brennan (*Farmer I*), 511 U.S. 825, 832 (1994) (stating that prison officials must "provide humane conditions of confinement . . . [and] ensure that inmates receive adequate . . . medical care"); Estelle v. Gamble, 429 U.S. 97, 104–05 (1976) (holding that deliberate indifference to serious medical needs is cruel and unusual punishment).

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

94 *See id.* at 103–06; *see also Farmer I*, 511 U.S. at 835 (noting that the term "deliberate indifference" has never been explained).

95 *See, e.g.*, Kelly v. Hunt, No. CV 08-94-M-DWM-JCL, 2008 WL 4198512, at *2 (D. Mont. July 17, 2008).

96 Salahuddin v. Goord, 467 F.3d 263, 279 (2d Cir. 2006).

97 *See Farmer I*, 511 U.S. at 834.

98 *E.g.*, Gaudreault v. Municipality of Salem, 923 F.2d 203, 208 (1st Cir. 1990) (citation omitted).

99 Brown v. Johnson, 387 F.3d 1344, 1351 (11th Cir. 2004) (alteration in original) (internal quotation marks omitted); *see also* Montgomery v. Pinchak, 294 F.3d 492, 500 (3d Cir. 2002) (defining serious medical need as any condition that "can be life threatening if not properly treated").

need."[100] Similarly, when the treatment provided was certain to be ineffective, the detainee had an untreated "serious medical need."[101]

Because the "need" depends on the care the detainee alleges he or she did not receive, most cases do not rest on the seriousness of the detainee's diagnosis. When the detainee receives some ongoing care but disputes the appropriateness of the course of treatment, or complains of a delay or interruption in treatment, the question becomes whether this discrepancy is itself "sufficiently serious."[102] There is no right to top-notch care,[103] or even necessarily to direct one's own treatment.[104]

The seriousness inquiry is highly fact-specific,[105] and courts have reached widely divergent results as to whether particular treatments for HIV are "sufficiently serious" in isolation. Courts have disagreed even as to whether providing medication for HIV at all is a serious medical need.[106] Courts are reluctant to protect the confidentiality of

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100 *See, e.g.*, Sandifer v. Green, 126 F. App'x 908, 911 (10th Cir. 2005); *Brown*, 387 F.3d at 1351; *Montgomery*, 294 F.3d at 500; Owens v. O'Dea, No. 97-5517, 1998 WL 344063, at *3 (6th Cir. May 27, 1998) (finding denial of any medication for HIV "[c]learly . . . sufficiently serious"); Baires v. United States, No. C 09-05171 CRB, 2011 WL 1743224 (N.D. Cal. May 6, 2011) (finding HIV-positive status alone sufficient to show serious medical need).

101 *E.g.*, *Brown*, 387 F.3d at 1351 ("[W]hen the need for treatment is obvious, medical care which is so cursory as to amount to no treatment at all may amount to deliberate indifference." (quoting McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999))). Examples include complete withdrawal of a previous course of treatment, *id.* at 1351, deciding a certain course of treatment is necessary but not starting or needlessly delaying it, *e.g.*, Skillern v. Ga. Dep't of Corr., 191 Fed. App'x 847, 852 (11th Cir. 2006) (heart prescription never filled); *Montgomery*, 294 F.3d at 500–01 (holding claim had been stated where physicians developed course of treatment for HIV and heart condition but administered none for nine months), or choosing "an easier but less efficacious course of treatment," *Brown*, 387 F.3d at 1351 (internal quotation marks omitted).

102 *See, e.g.*, Smith v. Carpenter, 316 F.3d 178, 185–86 (2d Cir. 2003). An extensive delay is taken as a refusal to provide treatment, however, and the underlying condition again becomes the appropriate focus. *See, e.g.*, Harrison v. Barkley, 219 F.3d 132, 137 (2d Cir. 2000); Gonzalez v. Jones, No. 07 Civ. 2126(LAP), 2010 WL 533856, at *17 (S.D.N.Y. Feb. 11, 2010) (citing Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998)) (finding there is a serious medical need where failure to treat promptly causes the condition to "degenerate or persist unnecessarily").

103 *See* Farmer v. Brennan (*Farmer I*), 511 U.S. 825, 837–838 (1994) (rejecting an objective test for "deliberate indifference," reasoning that "[t]he Eighth Amendment does not outlaw cruel and unusual 'conditions'; it outlaws cruel and unusual 'punishments'"); Estelle v. Gamble, 429 U.S. 97, 103–05 (1976) (prohibiting only what results in "unnecessary suffering"); Salahuddin v. Goord, 467 F.3d 263, 279–80 (2d Cir. 2006) (prison official's duty is only to provide reasonable care).

104 *See, e.g.*, Hill v. Curcione, 657 F.3d 116, 123 (2d Cir. 2011) (collecting authorities); Perkins v. Kan. Dep't of Corr., 165 F.3d 803, 811 (10th Cir. 1999) (mere disagreement with diagnosis or course of treatment is no violation); *Chance*, 143 F.3d at 703.

105 *See* Hudson v. McMillian, 503 U.S. 1, 8 (1992); Johnson v. Lewis, 217 F.3d 726, 731 (9th Cir. 2000) (urging consideration of "circumstances, nature, and duration of a deprivation").

106 *Compare* Sullivan v. Cnty. of Pierce, No. 98-35399, 2000 WL 432368, at *1–3 (9th Cir.

HIV status, and often limit that protection when faced with "penological justifications."[107] In very few circumstances will a court order an official to transfer a detainee to a facility capable of providing care the current facility cannot.[108] Courts rarely require officials to keep complete medical records,[109] perform medical intake exams,[110] administer an HIV test upon request,[111] or remain readily accessible to the detainees.[112] As a result, a plaintiff like Charles B.[113] who receives inconsistent treatment must demonstrate that the care he *did not* receive posed a substantial risk to his health in order to show he had any serious medical need in the first place.

B. *The "Deliberate Indifference" Standard and its Procedural Obstacles*

Additional procedural and substantive barriers make it difficult to prove that medical staff acted with a sufficiently culpable mental state. Medical malpractice—even gross negligence—does not become a constitutional violation simply because the patient is detained.[114]

Apr. 21, 2000) (stating that deprivation of medication to advanced AIDS patient for over forty-eight hours is serious) *and* Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 181, 194-96, 206-09 (D.P.R. 1998) (failing to administer twenty percent of HIV medication doses is serious), *with Smith*, 316 F.3d at 187 (interruption of medication not serious because of lack of resulting injury).

107 *Compare* Doe v. Delie, 257 F.3d 309, 317 (3d Cir. 2001) (recognizing a privacy right for prisoners, but allowing facilities to limit this right by offering penological justifications), *with* Harris v. Thigpen, 941 F.2d 1495, 1521 (11th Cir. 1991) (declining to decide if there is a right to privacy because prison had a legitimate penological interest in preventing harm that may befall HIV-positive inmates if the prison that revealed their status by segregating them restored integration).

108 *E.g.*, Haitian Ctrs. Council, Inc. v. Sale, 823 F. Supp. 1028, 1044 (E.D.N.Y. 1993) (holding Attorney General deliberately indifferent for failing to exercise discretion to parole HIV-positive Haitian asylum seekers into the United States for the limited purpose of medical treatment when military doctors at Guantánamo Bay determined this was necessary for those with T-cell counts below 200—i.e., AIDS patients).

109 *E.g.*, *Feliciano*, 13 F. Supp. 2d at 160, 212 (ordering the utilization of an "integrated health system" based on complete medical records).

110 *Compare* Comstock v. McCrary, 273 F.3d 693, 702 (6th Cir. 2001) (no right to be screened correctly for illness), *and* Farmer v. Kavanagh (*Farmer II*), 494 F. Supp. 2d 345, 370–71 & n.49 (D. Md. 2007) (failure to screen is mere negligence), *with Feliciano*, 13 F. Supp. 2d at 208–09 (finding deliberate indifference in failure to screen inmates for actively infectious diseases such as tuberculosis and failure to collect inmate medical histories).

111 *E.g.*, St. Hilaire v. Lewis, No. 93-15129, 1994 WL 245614, at *3 (9th Cir. June 7, 1994) (not deliberate indifference to refuse to perform a blood test for HIV where inmate conceded he was not in a high risk group nor had he been exposed to the virus).

112 *Farmer II*, 494 F. Supp. 2d at 361 n.35 (being moved to solitary confinement, where access to medical staff was more difficult, is not sufficient by itself to state a deliberate indifference claim).

113 *See supra* text accompanying notes 3–7 (describing Charles B.'s story).

114 Estelle v. Gamble, 429 U.S. 97, 106 (1976).

The Supreme Court consequently declined to adopt an objective standard, such as the judgment of a reasonable doctor.[115] Rather, an official must behave recklessly to violate the Fifth Amendment—that is, he or she must choose to ignore a risk of which he or she is actually aware.[116] For example, evidence that certain detention centers had received low ratings on ICE evaluations (including provision of prescriptions and medical care) did not make the transfer staff actually aware of a particular danger to HIV-positive detainees.[117] Similarly, knowledge of possible mental health complications that would result from inaccessibility to prescriptions did not constitute knowledge of the danger this inaccessibility would pose to the inmate's physical health.[118]

A further complication is that all three causes of action[119] that could allow a detainee to raise a Fifth Amendment claim must be based entirely on the defendant's individual actions and knowledge.[120] As a result, the plaintiff must prove each defendant *individually* knew of a risk to the plaintiff's health, *individually* disregarded that risk in a manner that was more than negligent, by means *individually* sufficient to cause the plaintiff harm.[121] In *Zentmyer v. Kendall County*,[122] for instance, the staff was not informed that an inmate suffering from an

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115 Farmer v. Brennan (*Farmer I*), 511 U.S. 825, 837 (1994); *see also* Walker v. Peters, 233 F.3d 494, 499 (7th Cir. 2000).

116 *Farmer I*, 511 U.S. at 837–38; *see also* Natale v. Camden Cnty. Corr. Facility, 318 F.3d 575, 582 (3d Cir. 2003) (delay in treatment for nonmedical reasons likely reckless); Johnson v. Lewis, 217 F.3d 726, 734 (9th Cir. 2000) (deliberate refusal to meet plaintiff's basic human needs of shelter, sanitation, and rest likely reckless).

117 Baires v. United States, No. C 09-05171 CRB, 2011 WL 1743224, at *5 (N.D. Cal. May 6, 2011). Two detainees received no ARVs; regrettably, only one of them survived. *Id.* at *1.

118 Farmer v. Kavanagh (*Farmer II*), 494 F. Supp. 2d 345, 364–65 (D. Md. 2007).

119 The three causes of action are (1) the Civil Rights Act, 42 U.S.C. § 1983 (2006), which allows a claim against a state official; (2) a *Bivens* action, which is a cause of action implied from the Constitution itself allowing for money damages for the violation of a constitutional right by a federal official, *see* Carlson v. Green, 446 U.S. 14, 18–22 (1980) (recognizing a *Bivens* remedy for a claim of deliberate indifference); Bivens v. Six Unknown Named Agents of the Fed. Bureau of Narcotics, 403 U.S. 388 (1971); and (3) the Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 1346(b), 2671–80 (2006), which allows tort claims to be brought against the United States.

120 *See* 28 U.S.C. § 2674 ("The United States shall be liable . . . in the same manner and to the same extent as a private individual under like circumstances . . . ."); Ashcroft v. Iqbal, 556 U.S. 662, 675–77 (2009) (requiring individual knowledge in a *Bivens* action); Leavitt v. Corr. Med. Servs., Inc., 645 F.3d 484, 501–02 (1st Cir. 2011) (requiring the same under the Civil Rights Act).

121 *See Farmer I*, 511 U.S. at 837–39 (actor must know of risk or engage in willful blindness, choosing not to verify what he already suspects); Brown v. Johnson, 387 F.3d 1344, 1351–52 (11th Cir. 2004).

122 Zentmyer v. Kendall Cnty., 220 F.3d 805 (7th Cir. 2000).

ear infection must not miss any doses.[123] Despite losing his ability to hear, the inmate's claim was dismissed because he did "not present evidence that any individual defendant failed to administer so many doses that [the individual] defendant's actions by themselves instantiate deliberate indifference."[124] Similarly, where an irresponsible employee was fired after detainees complained, the employee's superiors were not liable because they acted reasonably based on what they individually knew.[125]

Although individual officers cannot remain willfully blind once they become aware of a serious medical need,[126] officers do have incentive to avoid discovering the need or at least to be willfully ignorant about the potential consequences.[127] Even if a detainee demonstrates an official's individual awareness, courts defer heavily to medical staff's professional judgment.[128] Where the staff takes some steps, a discrepancy between the staff's actions and "ideal" treatment is presumed to be nothing more than negligent.[129] A detainee is unlikely to be able to rebut this presumption unless the staff's decision is obviously beyond the pale of accepted medical practice.[130]

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123 *Id.* at 811.

124 *Id.* (noting mismanagement of the prescription was not intentional).

125 Campbell v. Sheahan, No. 94-1184, 1995 WL 649920, at *3 (7th Cir. Nov. 2, 1995) (current staff who generate treatment plans not liable for former staff member who negligently failed to refer an inmate to specialist treatment); Farmer v. Kavanagh (*Farmer II*), 494 F. Supp. 2d 345, 365 (D. Md. 2007) (no liability of prison management where they fired the irresponsible employee upon receiving complaints); *see also Iqbal*, 556 U.S. at 683 (rejecting respondeat superior liability in *Bivens* action).

126 Comstock v. McCrary, 273 F.3d 693, 702 (6th Cir. 2001); *see also* Stinson v. Galaza, 73 Fed. App'x 312, 313 (9th Cir. 2003) (official is deliberately indifferent "when he ignores the instructions of the prisoner's treating physician," (quoting Wakefield v. Thompson, 177 F.3d 1160, 1165 (9th Cir. 1999) (internal quotations marks omitted)).

127 *See, e.g.*, Salahuddin v. Goord, 467 F.3d 263, 281 (2d Cir. 2006) ("The defendant's belief that his conduct poses no risk of serious harm (or an insubstantial risk of serious harm) need not be sound so long as it is sincere.").

128 *See* Sain v. Wood, 512 F.3d 886, 895 (7th Cir. 2008) ("A medical professional acting in his professional capacity may be held to have displayed deliberate indifference only if the decision . . . is such a substantial departure from accepted professional judgment, practice, or standards, as to demonstrate that the person responsible actually did not base the decision on such a judgment." (internal quotation marks omitted)); United States v. Derbes, 369 F.3d 579, 583 (1st Cir. 2004) (the constitutional obligation is only to provide medical services at "a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards" (internal quotations marks omitted)).

129 *E.g.*, *Farmer II*, 494 F. Supp. 2d at 365, 368, 370 (stating that because "steps were taken to fix the inadequate delivery of medications" and these steps did not exhibit a "callous lack of concern," there is no liability for treatment that was not "ideal" and "could have harmful consequences").

130 *See supra* note 128.

As an additional hurdle, the Public Health Services Act ("PHSA")[131] grants absolute immunity to IHSC and ICE officials who are also Public Health Service employees.[132] If sued, the Federal Tort Claims Act ("FTCA") substitutes the United States as the defendant.[133] As a result, such an officer has little incentive to avoid wrongdoing, as no plaintiff can make the official pay compensatory or punitive damages, even if they are deserved.[134]

Charles B.'s claims would be barred because they allege harm arising from a grossly mismanaged medical care system rather than the acts of a single individual.[135] These substantive and procedural hurdles prevent HIV-positive detainees from obtaining meaningful relief for substandard care under the Fifth Amendment even if lasting injury can be shown.

III. International Protections for HIV-Positive Detainees

As Part II demonstrated, the rights and remedies available under the United States Constitution are too limited to protect HIV-positive detainees. Two international norms that are binding on the United States, however, can be used to chart the way to a solution: the Torture Convention and the right to an effective remedy.

A. *The Right to Adequate Medical Treatment Under the Torture Convention*

The first international right to which this Part turns is the Torture Convention's prohibition on cruel treatment, which is violated when a detainee suffers present injury or lasting harm, even if the official acts only negligently. This Part will show that the United States is bound by this prohibition, and that ICE is violating this norm by failing to properly treat HIV-positive detainees. Furthermore, there is currently no way to enforce this norm in United States courts, leaving detainees without any remedy.

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131 42 U.S.C. § 233 (2006).

132 Hui v. Castaneda, 130 S. Ct. 1845, 1851 (2010) (holding that 42 U.S.C. § 233(a), grants "absolute immunity" to officials and makes the FTCA the "exclusive remedy" for detainees).

133 *See* 28 U.S.C. § 1346(b)(1) (2006) .

134 *See id.* § 2674 (prohibiting punitive damages); Kate Bowles, Note, *Is the Doctor In? The Contemptible Condition of Immigrant Detainee Healthcare in the U.S. and the Need for a Constitutional Remedy*, 31 J. Nat'l Ass'n Admin. L. Judiciary 169, 194, 210–11 (2011) (commenting that defendants' payment of punitive damages is necessary for a detainee who lost his penis and later his life because those defendants intentionally denied cancer treatment).

135 *See supra* text accompanying notes 3–7 (describing Charles B.'s story).

1. *The United States Is Bound to Abide by the Torture Convention*

The United States has accepted and never disclaimed the norms pronounced in the Torture Convention and therefore must abide by its mandates. The United States ratified the Torture Convention in 1990.[136] Ratification is a nation's complete acceptance of a treaty's legal obligations.[137] To limit these legal obligations, a nation must issue a reservation—a formal statement that the nation declines to accept a particular obligation—at the time of ratification.[138] The United States did not issue any reservation purporting to limit its obligation to prevent and punish cruel treatment perpetrated by its officials.[139]

Even if the ratification of the relevant international instruments were not enough, cruel treatment has long been prohibited by customary international law.[140] Customary international law arises over time from a persistent, (nearly) universal practice that nations follow out of a sense of legal obligation.[141] A custom binds all nations once it is followed persistently and widely enough.[142] To avoid becoming bound to a new custom, a nation must object during the custom's formation by expressing through diplomatic channels that it does not believe the practice is legally required.[143] Objections raised after a custom emerges have no legal effect,[144] and assertions that merely quibble over the *facts* required to show a violation without challenging the *legal* obligation itself are not considered objections at all.[145]

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136 136 CONG. REC. 36,192, 36,198–99 (1990). The United States has also ratified another treaty prohibiting cruel treatment. International Covenant on Civil and Political Rights art. 7, *adopted* Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); 138 CONG. REC. 8068, 8070 (1992) (ratifying the International Covenant on Civil and Political Rights).

137 *See* BARRY E. CARTER, PHILLIP R. TRIMBLE & ALLEN S. WEINER, INTERNATIONAL LAW 107-12 (5th ed. 2007).

138 Frédéric Mégret, *Nature of Obligations*, *in* INTERNATIONAL HUMAN RIGHTS LAW 124, 134–40 (Daniel Moeckli et al. eds., 2010).

139 *See* 136 CONG. REC. 36,192–99.

140 *See, e.g.*, Filartiga v. Pena-Irala, 630 F.2d 876, 884–85 (2d Cir. 1980) (holding that customary international law prohibits torture and cruel treatment even when conducted under color of law).

141 CARTER ET AL., *supra* note 137, at 123–24.

142 *Id.* at 93–97, 123–27.

143 *Id.* at 128–31.

144 *See, e.g.*, Fisheries Case (U.K. v. Nor.), 1951 I.C.J. 116, 130–43 (Dec. 18) (nation failed to persistently object to other nation's delimitation practice and thus demonstrated "they did not consider [the practice] to be contrary to international law").

145 *See* Military and Paramilitary Activities in and Against Nicaragua (Nicar. v. U.S.), 1986 I.C.J. 14, 97–98 (June 27) (reasoning that a defense invoking a custom's exceptions or justifications only strengthens the conclusion that the rule binds the defendant).

The United States considered itself bound by customary international law to prevent and punish cruel treatment as early as 1980.[146] Although the United States has recently asserted that enhanced interrogation does not violate the Torture Convention,[147] this is not an objection and does not free the United States from any obligation under the treaty for two reasons. First, the custom already emerged long ago.[148] Second, the United States' assertion debates the *facts* that constitute torture without attempting to disclaim the *legal obligation* to prevent and punish cruel treatment.[149] Consequently, the United States remains bound to the absolute prohibition of cruel treatment.[150]

2. *ICE Violates the Torture Convention by Failing to Provide Adequate Medical Care*

The Torture Convention requires ratifying nations to prevent and punish all forms of cruel treatment inflicted "with the consent or acquiescence" of an official, including the failure to provide adequate medical care.[151] When the Senate gave its advice and consent for the President to ratify the Torture Convention, it analogized this wording to the phrase "under color of law" in the Civil Rights Act.[152] The Senate noted that for purposes of the Act, a plaintiff must show the defendant "exercised power possessed by virtue of state [or federal] law and made possible only because the wrongdoer is clothed with the authority of [that] law."[153]

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146 *See* Filartiga v. Pena-Irala, 630 F.2d 876, 884 (2d Cir. 1980) (stating that "no government has asserted a right to torture its own nationals" (quoting Brief of the United States as Amicus Curiae, Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir. 1980) (No. 79-6090))).

147 *See, e.g.*, Memorandum from John C. Yoo, Deputy Assistant Attorney Gen., to William J. Haynes II, Gen. Counsel, U.S. Dep't of Def. 55–74 (Mar. 14, 2003), *available at* http://www.aclu.org/pdfs/safefree/yoo_army_torture_memo.pdf.

148 *See supra* notes 140, 146; *see also* RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES § 702 (1986) (noting that the prohibition of cruel treatment is one of the few universal and absolute customs).

149 *See supra* note 145 and accompanying text.

150 *See, e.g.*, Torture Convention, *supra* note 11, at 114 (describing prohibition as absolute); Comm. Against Torture, Gen. Comment No. 2, U.N. Doc. CAT/C/GC/2, 1–2 (Jan. 24, 2008) (stating the same). Although there are doctrines that limit the application of international norms in United States courts, domestic law provides no excuse for a violation of an international obligation. Vienna Convention on the Law of Treaties art. 27, *adopted* May 23, 1969, 1155 U.N.T.S. 331 (entered into force Jan. 27, 1980).

151 *See* Torture Convention, *supra* note 11, at 113–16. "Torture" has numerous additional elements. *Id.* at 113–14. However, because the problems with ICE medical care constitute cruel treatment, this Note does not comment on whether these failings also rise to the level of torture.

152 S. EXEC. REP. No. 101-30, at 14 (1990).

153 United States v. Belfast, 611 F.3d 783, 808 (11th Cir. 2010) (quoting West v. Atkins, 487 U.S. 42, 49 (1988)) (internal quotation marks omitted).

The first element of the Torture Convention analysis is easily satisfied in the context of HIV-positive detainee treatment because everyone who plays a part in the delivery of ICE medical care does so under the authority of federal law.[154] Demonstrating that the injuries the detainee suffered amounted to cruel treatment is more complex. The Convention does not explicitly define what constitutes cruel treatment,[155] so a detainee must refer to international jurisprudence on the subject just as a claimant in the United States looks to caselaw to define "cruel and unusual punishment."

The primary obligation of nations under this jurisprudence is to "protect the physical well-being of persons deprived of their liberty."[156] This obligation requires available medical staff to pay close attention to foreseeable risks. For example, in one case, a prisoner's condition was not correctly diagnosed as tuberculosis for almost two and a half months, causing lung damage and risking transmission to others.[157] The court concluded this was cruel treatment because the medical care the physicians provided was neither timely nor adequate in light of "the seriousness of the disease and its consequences for his health."[158] Similarly, treating physicians engaged in cruel treatment by failing to detect and begin treating the hepatitis infection contracted by a prisoner who was prescribed a drug that can cause liver damage.[159]

Once a condition is diagnosed, doctors must continue to monitor that condition and ensure that treatments remain effective.[160] In fact, detention facility staff must not discontinue or interrupt treatment

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154 *See supra* Part I.B.1 (discussing structure and authority of ICE); *see also supra* note 91 (reasoning ICE officials are state actors for constitutional purposes); *cf.* Velásquez Rodríguez v. Honduras, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 4, ¶¶ 166, 172 (July 29, 1988) (stating that a government is liable for failing to investigate and correct past human rights violations and create systems that prevent future violations, even those of private actors).

155 *See* Torture Convention, *supra* note 11, at 116.

156 *See* Khudobin v. Russia, App. No. 59696/00, Eur. Ct. H.R. ¶ 93 (2006), http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-77692#{%22itemid%22:[%22001-77692%22]}.

157 *See* Melnik v. Ukraine, App. No. 72286/01, Eur. Ct. H.R. ¶¶ 51, 104 (2006), http://hudoc.echr.coe.int/webservices/content/pdf/001-72886?TID=mpgzmaxpcu.

158 *See id.* ¶ 106.

159 Mechenkov v. Russia, App. No. 35421/05, Eur. Ct. H.R. ¶¶ 105–09, 111–12 (2008), http://hudoc.echr.coe.int/webservices/content/pdf/001-84896?TID=mpgzmaxpcu.

160 *See, e.g.*, Moskalyuk v. Russia, App. No. 3267/03, Eur. Ct. H.R. ¶¶ 67–68 (2010), http://hudoc.echr.coe.int/webservices/content/pdf/001-96699?TID=mpgzmaxpcu (finding cruel treatment where planned in-patient treatment was discontinued, including necessary X-rays to monitor effectiveness of previous treatment). This includes follow-up testing. *Mechenkov*, App. No. 35421/05, ¶¶ 104–06.

without sufficient medical indications to do so.[161] Staff must maintain careful medical records on the detainee[162] and preserve confidentiality, especially in cases of HIV.[163] Confidentiality is an essential aspect of proper medical care because without it, persons needing treatment may be deterred from seeking medical assistance, thereby endangering their health and that of others.[164]

Both the Fifth Amendment and the Torture Convention recognize that detention facilities do not need to be especially comfortable or provide world-class care.[165] But the two standards differ in a critical way. Unlike the Fifth Amendment jurisprudence, which requires actual individual knowledge of a risk of serious harm to find deliberate indifference,[166] negligence can be sufficient to violate the Torture Convention's prohibition on cruel treatment.[167] The Torture Convention expects officials to be knowledgeable enough to provide the level of medical care necessary to prevent injury and unnecessary suffering.[168] For HIV, this means "regular and specialised medical supervision" of the disease's progression, timely prescribing and dispensing ARVs, and the timely diagnosis and treatment of any opportunistic

161 *See Moskalyuk*, App. No. 3267/03, ¶¶ 70–71.

162 *See* Khudobin v. Russia, App. No. 59696/00, Eur. Ct. H.R. ¶ 83 (2006), http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-77692#{%22itemid%22:[%22001-77692%22]}.

163 *See* Z. v. Finland, 1997-I Eur. Ct. H.R. 323, 347–48; *see also* Zielinski v. Poland, App. No. 3390/05, Eur. Ct. H.R. ¶ 64 (2011), http://hudoc.echr.coe.int/webservices/content/pdf/001-106257?TID=ompdsvpxnp.

164 Z v. Finland, 1997-I Eur. Ct. H.R. 323, 347–48 (applying this principal to detention medical care).

165 *See, e.g.*, Farmer v. Brennan (*Farmer I*), 511 U.S. 825, 832 (1994) ("The Constitution does not mandate comfortable prisons . . . ." (quoting Rhodes v. Chapman, 452 U.S. 337, 349 (1981)) (internal quotation marks omitted)); *Moskalyuk*, App. No. 3267/03, ¶¶ 39, 59–60 (rejecting the submission that the Torture Convention requires that governments provide "every detained person medical assistance of the same level as 'in the best civilian clinics'") (citation omitted).

166 *See supra* notes 120–27 and accompanying text.

167 *See, e.g.*, Hummatov v. Azerbaijan, App. Nos. 9852/03 & 13413/04, Eur. Ct. H.R. ¶ 120 (2007), http://hudoc.echr.coe.int/webservices/content/pdf/001-83588?TID=mpgzmaxpcu (citing V. v. United Kingdom, 1999-IX Eur. Ct. H.R. 111, 143, and Peers v. Greece, 2001-III Eur. Ct. H.R. 275, 297).

168 *E.g.*, Nevmerzhitsky v. Ukraine, 2005-II Eur. Ct. H.R. 307, 320–21, 324–26 (exerpts) (using international medical professional standards to define the obligation); Nevmerzhitsky v. Ukraine, App. No. 54825/00, Eur. Ct. H.R. ¶ 81 (2005), http://hudoc.echr.coe.int/webservices/content/pdf/001-68715?TID=nzgvhghnkd (holding that the State must preserve human dignity, while acknowledging there will be some unavoidable level of suffering from the fact of detention itself); *see also* Jalloh v. Germany, 2006-IX Eur. Ct. H.R. 281, 298, 311 (finding a violation of the prohibition against cruel treatment where medications were forcibly administered for nonmedical purposes and contrary to professional medical standards).

infections.[169] By failing to guarantee consistent and medically necessary treatment to detainees, ICE violates the Torture Convention.[170]

3. *Procedural Barriers to Enforcing These International Rights in United States Courts*

Although the right to be free from cruel treatment encompasses a right to adequate medical care for those who are detained by a ratifying country's government, there are several major obstacles to bringing such a claim in United States courts. In theory, such a claim might be brought under the Torture Convention itself or under the Alien Tort Statute ("ATS").[171]

In reality, a claim cannot be brought under the Torture Convention directly because that treaty is not self-executing. Unless a treaty shows on its face that it was intended to have immediate effect, it is not self-executing and cannot be given effect in United States courts unless and until Congress passes legislation "implementing" the treaty.[172] When the Senate gave its advice and consent for the President to ratify the Torture Convention, it explicitly declared that the Convention was not self-executing.[173] Further, all legislative enactments related to the Torture Convention have been carefully limited to apply only to acts of torture or cruel treatment that take place outside of United States territory.[174] Therefore, detainees would not be able to bring a claim under the Torture Convention in United States courts based on conduct occurring in ICE detention centers.

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169 Kozhokar v. Russia, App. No. 33099/08, Eur. Ct. H.R. ¶ 108 (2010), http://hudoc.echr.coe.int/webservices/content/pdf/001-102237?TID=ywxanvlbcn.

170 *Cf.* Aleksanyan v. Russia, App. No. 46468/06, Eur. Ct. H.R. ¶¶ 133–58 (2008), http://hudoc.echr.coe.int/webservices/content/pdf/001-90390?TID=pfhaeefsng (stating countries "are bound to provide all medical care that their resources might permit," and finding violation where HIV-positive detainee did not receive prescribed care).

171 28 U.S.C. § 1350 (2006).

172 *See, e.g.*, Medellín v. Texas, 552 U.S. 491, 504–06 (2008). For a discussion of the factors that make a treaty (not) self-executing, see Carlos Manuel Vazquez, *The Four Doctrines of Self-Executing Treaties*, 89 AM. J. INT'L L. 695, 722–23 (1995).

173 136 CONG. REC. 36,192, 36,198 (1990); *see also* United States v. Belfast, 611 F.3d 783, 802 (11th Cir. 2010) (discussing the limitations Congress imposed); *id.* at 802 n.1.

174 There are three partial implementations of the Torture Convention. First, anyone subject to personal jurisdiction can be prosecuted for committing torture abroad. Foreign Relations Authorization Act, Fiscal Years 1994 & 1995 § 506, 18 U.S.C. §§ 2340–2340B (2006). Second, aliens involved in torture abroad can be deported more easily. Immigration and Nationality Act of 1952 §§ 212(a)(3)(E)(iii)(I), 241(b)(3)(B), 8 U.S.C. §§ 1182(a)(3)(E)(iii)(I), 1231(b)(3)(B) (2006). Finally, there is a private cause of action for United States citizens tortured abroad to sue their tormentors, subject to several procedural limitations. 28 U.S.C. § 1350 note (2006) (Torture Victim Protection).

Detainees would likely not be able to bring a claim under the ATS either. The ATS provides federal jurisdiction over claims (1) by an alien (2) alleging a tort[175] (3) that also violates customary international law or a treaty ratified by the United States.[176] The ATS is primarily a jurisdictional statute and only provides an implied cause of action for violation of a "specific, universal, and obligatory" norm.[177] Although torture meets this standard, cruel treatment is less accepted because it is deemed not to be a sufficiently "specific" norm.[178] For instance, in *Sarei v. Rio Tinto, PLC*,[179] the Ninth Circuit ruled that a two-year blockade of a village that prevented delivery of food and medical supplies and resulted in the preventable deaths of at least 12,000 people was not subject to a sufficiently specific norm because the relevant treaties did not explicitly list such conduct.[180] If other courts follow this strict approach, a detainee's ATS claim may fail simply because the Torture Convention does not mention adequate medical care as part of the obligation to prevent and punish cruel treatment.[181] Therefore, the Torture Convention cannot be effectively enforced in United States courts even though it binds the nation.

B. *The Right to an Effective Remedy*

In addition to defining substantive human rights, international law also describes what constitutes an adequate remedy for a violation. Nations that accept human rights obligations under international law undertake not only to avoid violating those rights directly, but also to "prevent, investigate, and punish" any violation of those rights, even by private actors.[182] The right to an effective remedy—directly codified in the Torture Convention itself[183]—is a fundamental aspect

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175 Because the statute does not specify which kinds of torts qualify, 28 U.S.C. § 1350, it includes those torts defined by state law as well as the "constitutional torts" litigated under the Civil Rights Act and *Bivens*. William R. Casto, *Notes on Official Immunity in ATS Litigation*, 80 FORDHAM L. REV. 573, 586–89 (2011).

176 28 U.S.C. § 1350.

177 Sosa v. Alvarez-Machain, 542 U.S. 692, 732 (2004) (internal quotations marks omitted).

178 *See id.* at 728, 732 (collecting authorities in support of a norm against "torture").

179 Sarei v. Rio Tinto, PLC, 671 F.3d 736 (9th Cir. 2011), *petition for cert. filed*, 2011 WL 5909911 (U.S. Nov. 23, 2011) (,No. 11-649).

180 *Id.* at 767–68; *but see id.* at 775–77 (Pregerson, J., dissenting).

181 *See* Torture Convention, *supra* note 11, at 116 (prohibiting but not defining cruel treatment).

182 Velásquez Rodríguez v. Honduras, Judgment, Inter.-Am. Ct. H.R. (ser. C) No. 4, ¶¶ 166, 172 (July 29, 1988).

183 Torture Convention, *supra* note 11, at 116 (applying articles 10–13 to cruel treatment as well as torture, which require, inter alia, educating law enforcement about cruel treatment, explicitly prohibiting cruel treatment in all rules related to detention, prompt and impartial investi-

of this duty to both protect and punish.[184] The right to an effective remedy requires that a person alleging a human rights violation receive due process, and that the remedy itself is substantively adequate.[185] To be adequate, a proposed remedy must not only be able to repair fully the real harm of the violation in principle, but also be capable of achieving that result in practice.[186]

For instance, in the context of a forced disappearance where an individual is forcibly taken from his loved ones,[187] a remedy must allow someone to demand that his location be revealed and to seek his release.[188] With most human rights violations, there is a procedure that can provide sufficient declarative, injunctive, or compensatory relief.[189] In this example, habeas corpus[190] will repair the real harm so long as the nation's judiciary is impartial and respected.[191]

Otherwise, the nation will fail to provide an effective remedy—even if the court might provide relief in some cases—because future violations remain likely. The right to an effective remedy rests on the duty of nations to "organize the governmental apparatus and, in general, all the structures through which public power is exercised, so that

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gation of all complaints of cruel treatment, and prompt and impartial examination of the claim by a competent court); *see also id.* at 116 (requiring that "fair and adequate compensation, including the means for as full rehabilitation as possible" be guaranteed to victims); U.N. Comm. Against Torture, Rep., 46th Sess., May 9–June 3, 2011, *Working Document on Article 14 for Comments* (2012) (draft of a third General Comment, describing the many aspects that an effective remedy for cruel treatment might include).

184 *See* Sherrie L. Russell-Brown, *Out of the Crooked Timber of Humanity: The Conflict Between South Africa's Truth and Reconciliation Commission and International Human Rights Norms Regarding "Effective Remedies,"* 26 HASTINGS INT'L & COMP. L. REV. 227, 233–34, 237–38, 249 (2003).

185 Sonja B. Starr, *Rethinking "Effective Remedies": Remedial Deterrence in International Courts*, 83 N.Y.U. L. REV. 693, 700–01 (2008).

186 *See* Russell-Brown, *supra* note 184, at 239–40 (collecting cases).

187 In a forced disappearance, state or private actors kidnap a person and the state denies the person is actually missing despite having some knowledge of the kidnapping. *See* Inter-American Convention on the Forced Disappearance of Persons art. 2, June 9, 1994, 33 I.L.M. 1529, 1530.

188 *See id.*

189 *See* Starr, *supra* note 185, at 699–702 (discussing the "full remedy rule," in which compensation must be able to reimburse the actual costs of the harm and may include an additional amount that represents the harm inherent in the rights violation itself).

190 The writ of habeas corpus enables a person to challenge the legality of an arrest or detention and request the court to order immediate release. *See, e.g.*, Harrington v. Richter, 131 S. Ct. 770, 780 (2011).

191 *See* Ophelia Claude, *A Comparative Approach to Enforced Disappearances in the Inter-American Court of Human Rights and the European Court of Human Rights Jurisprudence*, 5 INTERCULTURAL HUM. RTS. L. REV. 407, 449–51 (2010) (collecting cases).

they are capable of juridically ensuring the free and full enjoyment of human rights."[192]

The only truly effective remedy, therefore, is one that rectifies past violations and prevents future incidents. In terms of forced disappearances, for example, a court must not only be able resolve the disappearance at hand but also reaffirm the overall competence of the judicial system by ensuring that the government obeys its order.[193] Similarly, an effective remedy for HIV-positive ICE detainees cannot simply assist those who presently receive inadequate medical care. It must also change the structure of the ICE medical system to ensure that ICE consistently provides adequate care and penalizes violators.[194] Because no existing remedy can accomplish this result, a new approach is needed.

IV. Protecting the Rights of HIV-Positive Detainees

The above discussion has demonstrated that (1) someone with HIV must receive a minimum standard of medical treatment to preserve his or her health,[195] (2) ICE is violating the Torture Convention by failing to provide adequate medical care to HIV-positive detainees,[196] and (3) no cause of action yet supplies detainees with an effective remedy for any cruel treatment they may endure.[197] A proper solution, therefore, will require that detention centers provide the current minimum level of care and keep pace with medical progress. This Part proposes a statute that can achieve such a remedy.

The proposed statute, titled the "CARING Act,"[198] aims to change actual ICE medical practice through a gradual process of three overlapping stages: (1) initial rulemaking, (2) annual reports, and (3) private lawsuits. In the initial rulemaking stage, ICE will investigate current medical standards and sources of international law. ICE

192 Velásquez Rodríguez v. Honduras, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 4, ¶¶ 166, 172 (July 29, 1988).

193 *See* Russell-Brown, *supra* note 184, at 239–40.

194 *Cf.* Donnelly v. United Kingdom, 4 Eur. Comm'n H.R. Dec. & Rep. 4, 78–79 (1975) (holding that compensation alone is never an effective remedy where torture or cruel treatment "were to be authorised by domestic law" or "if the higher authorities of the State pursued a policy or administrative practice whereby they authorised or tolerated [that] conduct" by failing to take reasonable steps to prevent "as far as possible the occurrence or repetition of the acts in question").

195 *See supra* Part I.A.

196 *See supra* Part III.A.2.

197 *See supra* Parts II, III.A.3–III.B.

198 *See infra* Appendix.

will then promulgate binding regulations[199] that will apply to all facilities that confine individuals on behalf of ICE.[200] The other two stages will help to monitor ICE's progress in implementing the regulations and to ensure that individuals harmed by ICE's actions can seek relief.

A. *Promulgating Binding Regulations*

The regulations required by the CARING Act will provide the minimum standard of medical care outlined in Part I.A by ensuring that the care provided to each detainee meets specific, legally binding standards. Although the content of these standards differs little from the PBNDS, these standards will not be mere recommendations but will instead carry the force of law.[201] Each facility will be required to, at a minimum, (1) perform all tests necessary to make a proper diagnosis, (2) craft a long-term treatment plan, (3) follow prescriptions, (4) avoid interruption of those prescriptions, and (5) perform follow-up medical monitoring to regularly reevaluate the treatment plan;[202] and officers at those facilities will be required to (6) respect confidentiality and (7) maintain complete medical records.[203]

Although these seven core requirements will not change over time, the actual procedures the medical officials use (as well as those the regulations prescribe) can evolve alongside best medical practices. ICE and medical officials will be required to refer to three comprehensive and regularly updated sources that compile the best practices for treating HIV.[204] By listing three sources, the CARING Act preserves some flexibility for ICE officials while limiting an evidentiary problem present in many deliberate indifference cases: determining which medical decisions are left to professional discretion and which are mandatory.[205] Here, an official may rely on any course of action within the recommendations that any one of these sources contains at the time of the decision. If, however, no source recommends the course of action taken or all three recommend against it, the official's action is presumed to be an improper treatment.[206] In this way, ICE

199 *See* CARING Act § 3(a)–(b), *infra* App.

200 *See id.* § 2(b)–(c), (f).

201 *See supra* text accompanying note 69 (discussing the PBNDS's lack of enforceability).

202 CARING Act § 3(b)(1), *infra* App.

203 *Id.* § 3(b)(2)–(3).

204 *See id.* § 2(d); *see also* ICE, 2011 PBNDS, *supra* note 54, at 235–36 (referring detention officials to various medical guides).

205 *See supra* note 128 and accompanying text.

206 *See* CARING Act § 2(d), *infra* App.

officials can use their professional judgment to decide how to treat individual detainees while providing at least minimum care.

B. *Facilitating the Evolution of the Regulations*

The other two stages in the CARING Act—annual reports and litigation—facilitate revision of the regulations so that they evolve with medical practice and international law. Under the CARING Act, ICE must report to Congress yearly on its oversight of the detention facilities to demonstrate how well the facilities are complying with these regulations and what steps ICE has taken to repair any shortcomings.[207] In this report, ICE must also review the regulations to confirm that they represent up-to-date medical science.[208] The Inspector General of DHS will review this report and compose his or her own report that evaluates ICE from an independent perspective.[209] The Committee of each House of Congress primarily responsible for immigration law will review both reports and hold hearings.[210] As a result, ICE will engage regularly in oversight of its facilities, and Congress will have a ready means by which to direct ICE to improve its practices where they fall short.

The CARING Act's third prong recognizes that even when ICE and Congress work together, some cases may fall through the cracks. Section 5 of the CARING Act therefore provides a carefully tailored right to sue, which actually reaches all detainees who suffer cruel treatment, regardless of whether the detainee has HIV.[211] As such, the Act will not privilege HIV over other serious conditions, but instead will fully respect the United States' international obligations.[212] This right will allow victims of cruel treatment to have their day in court. Unlike the three causes of action presently available, this one draws directly on international jurisprudence.[213] An official is liable even where the cruel treatment is only negligent,[214] or where the cruel treatment arises from the separate failures of several people.[215] The

207 *See id.* § 4(a).

208 *See id.*

209 *Id.* § 4(b).

210 *Id.* § 4(c).

211 *See id.* § 5.

212 *See supra* Part III.A (discussing the human right of proper medical treatment).

213 *See* CARING Act § 5(b)(1)(A), *infra* App.

214 *See id.* § 5(b)(1)(C).

215 *See id.*; *cf.* Zentmyer v. Kendall Cnty., 220 F.3d 805, 811 (7th Cir. 2000) (staff escaped liability under the Fifth Amendment because doctor did not inform them of specific dangers of failing to provide correct doses of medication at correct times, and no single individual made enough mistakes to cause harm on his own).

statute also permits punitive damages where appropriate.[216] Finally, the CARING Act strips ICE and IHSC officials of the absolute immunity the PHSA confers on Public Health Service employees.[217] Because many detainees know little about their rights,[218] the CARING Act also requires ICE to inform detainees about their CARING Act rights, and enlists Congress to ensure that ICE follows through.[219]

Nonetheless, the CARING Act also builds in several protections for ICE employees. ICE officers will not be liable for compensatory or punitive damages if they reasonably rely on the ICE regulations in force at the time when making treatment decisions.[220] The CARING Act also includes a statute of limitations[221] and does not apply retroactively.[222] Upper-level officials can protect their qualified or absolute immunity by substituting the relevant agency as a party defendant in their place.[223] The United States also protects its sovereign immunity because no agency can be forced to pay compensatory or punitive damages.[224]

Although the CARING Act safeguards some immunity,[225] it nevertheless provides a mechanism for detainees to obtain proper care. Regardless of any immunity from liability for damages, a plaintiff can still obtain declaratory or injunctive relief.[226] Through this mechanism, the court can order medical staff to provide a particular type of treatment or order ICE to amend its regulations to incorporate a principle derived from medicine or international law. Finally, this cause of action is not exclusive, permitting simultaneous (but not duplicative) recovery under any other legal theories.[227]

The benefits of the CARING Act are most apparent when considered in light of the enormous difference these provisions would

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216 *See* CARING Act § 5(b)(2), *infra* App.

217 *See id.* § 5(d); *supra* notes 132–34 and accompanying text (describing the procedural limitations under the PHSA and FTCA).

218 Jacob Chin et al., *Attorney's Perspectives on the Rights of Detained Immigrants in Minnesota*, 40 CURA REP. 16, 17 (2010).

219 *See* CARING Act §§ 3(b)(4), 4(c), *infra* App.

220 *See id.* § 5(b)(6).

221 *See id.* § 5(b)(3) (five years).

222 *See id.* § 5(b)(1)(C).

223 *See id.* § 5(b)(4) (allowing an official to substitute the United States for himself, provided the officer was not directly involved in causing the plaintiff harm).

224 *See id.* § 5(b)(5).

225 *See* Ashcroft v. Iqbal, 556 U.S. 662, 672 (2009) (describing the policy interests behind the qualified immunity doctrine).

226 *See* CARING Act § 5(b)(4)–(5), *infra* App.

227 *See id.* § 5(c); *supra* note 119 (discussing the other relevant causes of action).

have made for Charles B.[228] His detention center would have recognized the importance of his HIV-positive status and started an appropriate ARV regimen right away. Charles would have been given his doses on time each day, and the doctors would have regularly performed the blood work necessary to avoid resistance and opportunistic infection. Charles would have left the detention center in 2005 with resistance to very few if any ARVs, and would likely never have contracted his permanent disability. And, if his detention center had not provided proper treatment, Charles could have immediately sued for injunctive relief ordering proper treatment. Alternatively, he could have sued after the fact to obtain compensatory and perhaps punitive damages for his lasting injuries, even if those injuries were caused collectively or negligently.

ICE medical care has proven woefully inadequate for the 400,000 or more detainees that ICE holds each year.[229] The CARING Act provides for a relatively minor change that will guarantee improvement at all facilities and will provide a practical enforcement mechanism.[230] This small step will secure to everyone deprived of liberty the essential right to keep one's dignity and health.

V. Considering Policy Concerns

After confronting the problem of inadequate medical care in ICE detention and its particular effect on HIV-positive detainees, it is appropriate to consider other policy goals that the CARING Act may affect.

A. *The Financial Burden of Medical Care*

Certainly, the strongest objection to the CARING Act may be the cost of filling prescriptions, performing regular testing, and protecting the confidentiality of medical records. For example, IHSC estimated that it would cost approximately $7630 per detainee to provide a one year supply of ARVs.[231] Although ICE might consider no longer detaining persons with serious medical needs at all,[232] ICE remains obligated to care for the immigrants it insists upon detaining[233] regardless of the cost.[234]

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228 *See supra* text accompanying notes 3–7 (describing Charles B.'s story).

229 *See supra* note 41.

230 *See supra* Part I.B.

231 *See TAR Cost Savings Based on Denials*, *supra* note 47.

232 There is an increasing movement for "alternatives to detention." *See generally* Gryll, *supra* note 41, at 1215–17, 1248–55; Fla. Immigrant Advocacy Ctr., *supra* note 8, at 9, 57.

233 Detention is unlikely to disappear from immigration policy anytime soon. *See* President

There are two possibilities that could lessen this financial burden. First, ICE could permit individuals to use their own health insurance to pay for treatment while they are detained.[235] Second, ICE facilities may be able to obtain private coverage for uninsured detainees who have serious medical conditions under the Pre-Existing Condition Insurance Plan of the Affordable Health Care Act.[236] These two steps would pool the risk and the cost across a wider number of actors, ultimately reducing the federal government's bill.

B. The Importance of HIV

Another obvious question is why HIV deserves such special attention. HIV is one of the few serious illnesses that Fifth Amendment jurisprudence has not specifically addressed.[237] The impact of this discrepancy is that HIV-positive detainees cannot use the Fifth Amendment to ensure that they receive adequate care even though their fellow detainees with other serious medical conditions can.[238] Certainly, nothing proposed in this Note would preclude ICE from promulgating regulations for all serious medical conditions. Further,

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Barack Obama, State of the Union Address before the United States Congress Assembled (Feb. 12, 2013), *available at* http://www.washingtonpost.com/politics/state-of-the-union-2013-president-obamas-address-to-congress-transcript/2013/02/12/d429b574-7574-11e2-95e4-6148e45d7adb_story.html (stating that "real reform" will provide new legal paths to citizenship but tough enforcement policies will continue); *Oversight of the U.S. Department of Homeland Security: Hearing Before the S. Comm. on the Judiciary*, 112th Cong. 6 (2011) (statement of Janet Napolitano, Sec'y of the U.S. Dep't of Homeland Sec.) (describing efforts to expand immigration control efforts, including detention).

234 *Cf.* Leavitt v. Corr. Med. Servs., Inc., 645 F.3d 484, 498–99 (1st Cir. 2011) (financial interest of contractor in cutting price to remain competitive for contract renewal can be used as evidence of deliberate indifference); Harris v. Thigpen, 941 F.2d 1495, 1509 (11th Cir. 1991) (budgetary concerns do not excuse constitutional violations); Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 210 (D.P.R. 1998) (stating the same).

235 *See* FLA. IMMIGRANT ADVOCACY CTR., *supra* note 8, at 7, 25–26 (noting that use of private insurance is currently prohibited).

236 *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *Pre-Existing Condition Insurance Plan (PCIP)*, HEALTHCARE.GOV, http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/index.html (last updated Feb. 15, 2013). Detainees would no longer be able to access this plan once an immigration court rules they are not lawfully present in the United States. *See* Elise Foley, *Affordable Care Act Won't Apply to Immigrants Granted Deferred Action*, HUFFINGTON POST (Aug. 31, 2012 4:28 PM), http://www.huffingtonpost.com/2012/08/31/affordable-care-act-immigrants-deferred-action_n_1846485.html.

237 *See supra* Part II.

238 Diabetes is an example of a well-recognized serious medical need. *See, e.g.*, Ortiz v. City of Chicago, 656 F.3d 523, 527, 531 (7th Cir. 2011) (noting that a pretrial detainee had Type II diabetes and stating that the government must take a detainee's medical needs into account when she is a known diabetic and is separated from her life-sustaining drugs); Lolli v. Cnty. of Orange, 351 F.3d 410, 419–20 (9th Cir. 2003) (Type I diabetes).

the right to sue under Section 5 of the CARING Act extends to all detainees who suffer cruel treatment, and thereby provides a remedy for individuals with other serious medical needs unrecognized in constitutional jurisprudence.

C. *Unilaterally "Revising" Government Contracts*

Many of the current ICE contracts rely on previous versions of ICE's nonbinding detention guidelines.[239] Another concern, therefore, is whether ICE (or Congress for that matter) has sufficient authority to "revise" these contracts by imposing obligations that differ from what ICE and the facility originally agreed upon. To begin with, the intended third party beneficiary doctrine of contract law suggests that detention facility contracts always implicitly include an obligation to protect detainee health because such contracts are entered into for the detainees' benefit.[240] To avoid any further concern, however, Congress could allow ICE to delay implementation of the new regulations until all current contracts expire. Because the private right of action would have already come into effect, the economics of litigation would incentivize many operators to voluntarily adopt the new standards. ICE could then require any holdouts to accept the new standards as a condition of renewal.[241] ICE should therefore have little difficulty obtaining uniform acceptance of its improved standards regardless of the language in its existing contracts.

D. *The Relevance of International Norms to Domestic Law*

Lastly, it might seem inappropriate to allow international norms to influence United States domestic law. It has long been understood, however, that "[i]nternational law is part of our law" and should be respected whenever possible.[242] The Supreme Court has increasingly looked to international law for guidance, especially regarding the "evolving standards of decency" that underlie our Constitution's prohibition on cruel and unusual punishment.[243] In fact, if ICE is correct that its detainees are foreign citizens who have no right to remain in

239 *See supra* text accompanying notes 77–79.

240 Bruck, *supra* note 50, at 511–14.

241 Existing agreements between ICE and county jail facilities are discontinued if a facility receives less-than-satisfactory ratings for two consecutive years. SCHRIRO, *supra* note 43, at 10.

242 The Paquete Habana, 175 U.S. 677, 700 (1900); Murray v. The Schooner Charming Betsy, 6 U.S. (2 Cranch) 64, 76 (1804).

243 Roper v. Simmons, 543 U.S. 551, 561, 575–78 (2005); Lawrence v. Texas, 539 U.S. 558, 572–73, 576–77 (2003); Trop v. Dulles, 356 U.S. 86, 100–01 (1958).

the United States, considerations of comity strongly favor affording these individuals the minimum guarantees of international law.

Conclusion

HIV-positive detainees in ICE custody have so far received delayed, inconsistent, or inappropriate treatment that has caused unnecessary suffering and even death. By enacting the CARING Act, Congress will help guarantee that adequate medical care is the norm in detention centers nationwide.

APPENDIX

The following is the proposed language of an act that Congress should pass. A discussion of its primary aspects appears in Part IV above.

A BILL

To provide for appropriate medical care for detainees of United States Immigration and Customs Enforcement.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Section 1. Short Title.

This Act may be cited as "The Compliance with Affirmative Remedies and Inherent Normative Guarantees Act" ("CARING Act").

Section 2. Definitions.—THROUGHOUT THIS ACT:

(a) ADEQUATE MEDICAL CARE.—The term "adequate medical care" means, at a minimum, the level of medical—including psychiatric—treatment and attention reasonably necessary under commonly recognized prudent professional standards to prevent or minimize present pain and suffering, present or future injury, or lasting harm or disability.

(b) DETAINEE.—The term "detainee" means any natural person who is held at or in the custody of a detention center for at least forty-eight hours, or who is otherwise deprived of his liberty at a facility within the territorial United States under the authority of the Immigration and Nationality Act of 1952, as amended.

(c) DETENTION CENTER.—The term "detention center" means any facility operated in whole or in part by or under contract with U.S. Immigration and Customs Enforcement for the purpose of holding natural persons in custody, including but not limited to Service Processing Centers, Contract Detention Facilities, State or local government facilities using Intergovernmental Service Agreements, and Bureau of Prisons facilities.[244]

(d) PRUDENT PROFESSIONAL STANDARDS.—The term "prudent professional standards"[245] means, at a minimum, the strategies and

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[244] This definition of detention center is similar to that appearing in the Immigration Oversight and Fairness Act, H.R. 933, 112th Cong. § 2(b)(1) (2011).

[245] The district court in *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 208 (D.P.R. 1998), per-

considerations involved in the treatment of a given condition contained in any relevant guidelines of the Department of Health and Human Services,[246] the Centers for Disease Control, and the American Medical Association. This term allows for differences in professional opinion provided that such differences remain within the realm of recommendations contained in at least one of the sources listed.

(e) SECRETARY.—The term "Secretary" means the Secretary of the Department of Homeland Security.

(f) TERRITORIAL UNITED STATES.—The term "territorial United States" refers to any location within the geographic borders of the fifty States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

Section 3. Rulemaking.

(a) Not later than 120 days after the date of enactment of this Act, the Secretary shall issue a notice of proposed rulemaking and solicit public comment regarding the implementation of this Act.[247]

(b) Not later than one year after the date of enactment of this Act, the Secretary shall promulgate final regulations that apply to all detention centers which[248]—

(1) ensure adequate medical care to all detainees by requiring detention centers, at a minimum—

(A) to perform tests necessary to form a proper diagnosis, including providing an HIV test upon request,

(B) to create a treatment plan based on the diagnosis,

(C) to provide prescription medication in the exact doses and at the exact times the prescription indicates,

(D) to send a sufficient supply of prescription medication and instructions for its administration alongside the detainee if he or she is transferred to another detention center so that the detainee will have enough of a supply to last until the transferee detention center can obtain its own supply of those medications,

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formed a Fifth Amendment analysis of HIV treatment in prisons interpreting the then-applicable court of appeals standard using this terminology.

246 Therefore, the guidelines most likely to control for HIV are those which the Department of Health and Human Services regularly updates. *See* HHS, ARV GUIDELINES, *supra* note 17.

247 This provision is based on a similar provision in the Strong STANDARDS Act, H.R. 4470, 111th Cong. § 5(a)(1) (2010).

248 This provision is adapted from the subsequent section of that Act. *See id.* § 5(a)(2).

(E) to perform regular monitoring of serious conditions, including performing blood tests, taking samples, or performing a physical examination, in order to ensure that the current treatment plan is working and that no complications have developed,

(2) ensure confidentiality of detainee medical information,

(3) maintain complete medical records for all detainees, which will be sent alongside the detainee if he is transferred to another detention center,

(4) inform detainees of the right to bring suit under Section 5 of this Act.

Section 4. Annual Reports.

(a) The Secretary shall cause a report to be submitted to the Senate Committee on the Judiciary Subcommittee on Immigration, Refugees and Border Security and the House of Representatives Committee on the Judiciary Subcommittee on Immigration and Border Security no later than the August 15th preceding each new fiscal year.[249] This report shall describe the Secretary's actions to ensure compliance with this Act and demonstrate that all regulations in force represent the most current prudent professional standards for adequate medical care.[250]

(b) The Inspector General of the Department of Homeland Security, consistent with the Inspector General Act of 1978, as amended, shall review any report submitted under paragraph (a) for reasonableness and accuracy and submit to the same congressional committees listed in paragraph (a) a report on the results of such review alongside the original report.[251]

(c) After receiving reports under paragraphs (a)–(b), the congressional committees listed in paragraph (a) shall conduct oversight

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249 Bills of this nature often call for reports to be created and submitted to relevant congressional committees. *Cf.* Refugee Protection Act of 2011, S. 1202, 112th Cong. § 13(b) (calling for the report of a new commission to be submitted to six congressional committees).

250 Bills sometimes also require reports on the relevant agency's compliance with new mandates. *Cf.* Immigration Oversight and Fairness Act, H.R. 933, 112th Cong. § 2(a)(5)(A) (2011) (requiring the Secretary of Homeland Security to report on the extent to which a new notice provision is followed).

251 A similar structure was used in the original Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499, sec. 212, § 301, 100 Stat. 1613, 1726 (amending 42 U.S.C. § 9651), in which a report would be created by the relevant agency, then reviewed by that agency's inspector general, who would author her own review of the agency's report. Both reports would then be submitted to Congress.

hearings to ensure that this Act is being implemented according to the purposes of this Act and congressional intent in enacting this Act.[252]

Section 5. Private Cause of Action.

(a) The district courts shall have original jurisdiction of all civil actions described in subsection (b).[253]

(b) An individual or set of individuals shall be liable to a plaintiff in an action at law, suit in equity, or other proper proceeding for redress where—

(1) the plaintiff states a claim under the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment alleging that—

(A) the plaintiff suffered "cruel, inhuman, or degrading treatment or punishment," as defined by Article 16 of that Convention and interpreted by the Inter-American Court of Human Rights or its Commission, the European Court of Human Rights or its Commission, the African Court of Justice and Human Rights, the United Nations Human Rights Committee, or the United Nations Committee Against Torture;

(B) that occurred while the plaintiff was a detainee; and

(C) that resulted from the acts or omissions of an individual or set of individuals while acting within the scope of their employment or official duties, provided that such acts or omissions took place after the effective date of this Act.

(2) In an appropriate case, in the district court's sound discretion, punitive damages may be awarded in cases of wanton disregard for detainee health or safety or of intentional infliction of severe mental or physical harm.

(3) No action shall be maintained under this section unless it is commenced within five years after the cause of action arose.[254]

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252 This structure also explicitly required Congress to conduct "oversight hearings" based on the reports, allowing Congress to monitor for itself whether the agency is following Congress's intent. *Id.* sec. 212, § 301(h).

253 This is the language most commonly used in subject matter jurisdiction statutes to define the scope of the jurisdiction of federal district courts. 28 U.S.C. §§ 1331–1332 (2006).

254 Other causes of action based on international human rights law contain a similar statute of limitations. *Cf.* Torture Victim Protection Act of 1991 § 2(c), 28 U.S.C. § 1350 note (Torture Victim Protection).

(4) No action shall be maintained under this section against an officer of the United States[255] except in his or her official capacity and only for declaratory or injunctive relief.

(A) Upon motion of such an officer, if there are no allegations of any direct involvement by the officer, the agency in which that officer operates may be substituted for the officer and sued in its own name. The agency will be liable only in the same manner and to the same extent as the officer would have been.[256]

(B) An agency substituted as a defendant under this subsection may not raise any defense under Federal Rules of Civil Procedure 12 or 15 or the statute of limitations provided in Section 4(a)(3) of this Act unless the officer could raise such a defense were he or she still a party to the action.

(5) No action shall be maintained under this section against an agency of the United States or against the United States except for declaratory or injunctive relief.

(6) It shall be an affirmative defense under this section that the defendant acted reasonably in light of and conformed to the regulations and policies of U.S. Immigration and Customs Enforcement in force at the time. However, such affirmative defense will not preclude the award of declaratory or injunctive relief.

(c) This section and the remedies available under it are without prejudice to any other cause of action or source of relief.

(d) A civil action may be brought under this section notwithstanding the provisions of the Public Health Services Act, 42 U.S.C. § 233(a).

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255 This is a technical term arising from Article II of the United States Constitution. A discussion of its contours can be found in: Memorandum from Steven G. Bradbury, Acting Assistant Attorney Gen., Office of Legal Counsel, for the General Counsels of the Executive Branch (Apr. 16, 2007), *available at* http://www.justice.gov/olc/2007/appointmentsclausev10.pdf.

256 This limitation is very similar to the design of the FTCA, limiting the liability of the United States to the same amount the original defendants would have faced. *Cf.* 28 U.S.C. §§ 1346, 2674 (2006).