HEPATITIS C IN PRISONS: EVOLVING TOWARD DECENCY THROUGH ADEQUATE MEDICAL CARE AND PUBLIC HEALTH REFORM

by

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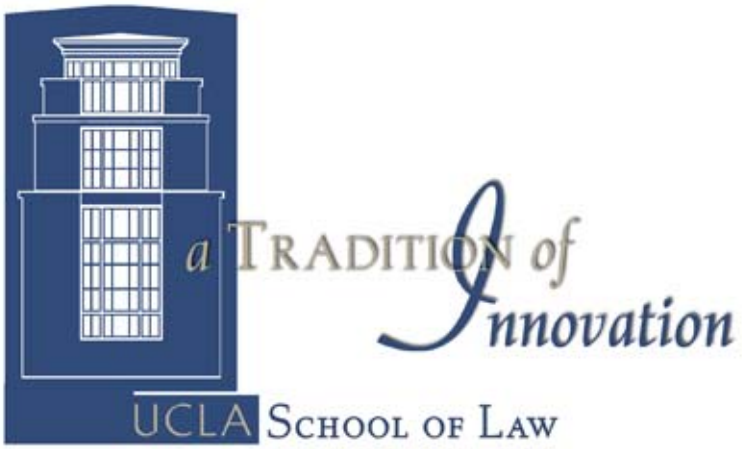

HEPATITIS C IN PRISONS: EVOLVING TOWARD DECENCY THROUGH ADEQUATE MEDICAL CARE AND PUBLIC HEALTH REFORM

Andrew Brunsden*

Hepatitis C (HCV) in prisons is a public health crisis tied to current drug policy's emphasis on the mass incarceration of drug users. Prison policy acts as a barrier to HCV care by limiting medical care for the infected, especially drug users, and by inhibiting public health measures addressing the epidemic. This Comment argues that courts mistakenly limit prisoners' Eighth Amendment right to basic medical care when they defer to prisons that apply HCV policies as categorical rules of treatment. Where current standards of care mandate individualized patient evaluation for treatment, prison policies that eschew this principle exhibit deliberate indifference to prisoners' medical needs. Additionally, this Comment looks beyond deliberate indifference to contemporary standards of adequate medical care and prisoner reentry, proposing that evolving standards of decency require greater care than existing Eighth Amendment standards articulated by the U.S. Supreme Court, and that prisoner reentry policy holds the potential for a shift toward public health reform of prisons. Ultimately, this Comment argues that HCV in prisons implicates a set of critical challenges calling for a fundamental rethinking of the prison as a medical provider, a public health institution, and a part of the community.

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INTRODUCTION

Current drug policy drives the simultaneous rise of prison populations and communicable-disease infection in prisons—mass incarceration of drug users means America chooses to imprison large numbers of infected persons.[1] Hepatitis C (HCV), the United States' most common bloodborne viral infection and leading cause of death from liver disease,[2] is concentrated in prisons due in part to a drug policy that focuses on imprisonment. Since HCV is primarily transmitted by injection drug use, the mass incarceration of drug users concentrates HCV-infected persons in prisons.[3] At present, 16 to 41 percent of

1. As the U.S. prison population has exploded to upward of two million people, fueled in part by the "War on Drugs," so has the communicable-disease concentration in prisons. As of June 30, 2005, U.S. prisons contained 2.186 million inmates with average annual increases of 3.4 percent in the total inmate population from 1995 to 2005. PAIGE M. HARRISON & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, BULLETIN: PRISON AND JAIL INMATES AT MIDYEAR 2005, at 2 (May 2006), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim05.pdf. Racial minorities are disproportionately represented in the U.S. prison population (which is 38.9 percent black and 15 percent Hispanic). *Id.* at 8. Disproportionate minority incarceration and limited access to health services in poor communities of color coalesce to create a higher incidence of communicable diseases in prison than in the general population. *See* 2 NAT'L COMM'N ON CORR. HEALTH CARE, THE HEALTH OF SOON-TO-BE RELEASED INMATES 21 (2002), *available at* http://www.ncchc.org/stbr/Volume2/Health%20Status%20(vol%202).pdf; Cynthia Golembeski & Robert Fullilove, *Criminal (In)Justice in the City and Its Associated Health Consequences*, 95 AM. J. PUB. HEALTH 1701, 1702–03 (2005); Theodore M. Hammett et al., *Health-Related Issues in Prisoner Reentry*, 47 CRIME & DELINQ. 390, 391 (2001).

2. *See* Doris B. Strader et al., *Diagnosis, Management, and Treatment of Hepatitis C*, 39 HEPATOLOGY 1147, 1147 (2004) [hereinafter AASLD GUIDELINES].

3. *See* Amy E. Boutwell et al., *Opportunities to Address the Hepatitis C Epidemic in the Correctional Setting*, 40 CLINICAL INFECTIOUS DISEASES S367, S367 (Apr. 15, 2005). Some estimates indicate that as many as 83 percent of the United States' approximately two million intravenous drug

incarcerated persons have HCV, as compared with roughly 2 percent in the general population.[4] Known as the "silent epidemic," HCV can lie dormant as long as twenty to thirty years before the manifestation of symptoms.[5] A lack of public discourse mirrors the silent course of the disease despite estimates that HCV incidence will increase fourfold by 2015.[6] While public health experts have pointed out the need for a coordinated approach to HCV in prisons, legal scholarship has yet to address the problem. HCV in prisons illustrates the consequences of a punitive drug policy and implicates a set of critical challenges at the intersection of drug law, prison reform, prisoners' rights to basic medical care, public health, and prisoner reentry.

Mass incarceration of HCV-infected persons raises serious questions about the ability of prisons to provide necessary medical care and to implement public health measures that control HCV transmission risks. The U.S. Supreme Court has recognized basic healthcare for prisoners as a constitutional right, but the Eighth Amendment as currently interpreted guarantees prisoners only limited access to medical care. When challenging medical care as inadequate, prisoners must show "deliberate indifference" by prison officials, a legal standard that entitles prisoners to relief only when prison officials show conscious disregard of a prisoner's medical needs.[7] Courts are hesitant to order expanded access to medical care, deferring to prison administration in the formulation of healthcare policy.[8] In a world of minimal constitutional obligations and deference to prison policy, prisons are accorded wide latitude to structure HCV protocols, which proffer guidelines for screening, testing, monitoring, and treatment of the disease. As a result, courts generally uphold failures to provide HCV care when prisons have followed HCV protocols.

This Comment argues that courts, accepting adherence to prison HCV protocols as a ground for withholding care, employ a mistaken interpretation of deliberate indifference. National guidelines for HCV care have been published,

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users are imprisoned at some period in their lives. *See* Richard K. Sterling et al., *The Spectrum of Chronic Hepatitis C Virus Infection in the Virginia Correctional System: Development of a Strategy for the Evaluation and Treatment of Inmates with HCV*, 100 AM. J. GASTROENTEROLOGY 313, 313 (2005).

4. *See* Scott A. Allen et al., *Hepatitis C Among Offenders—Correctional Challenge and Public Health Opportunity*, 67 FED. PROBATION 22, 22 (Sept. 2003).

5. Silja J.A. Talvi, *Hepatitis C: A 'Silent Epidemic' Strikes U.S. Prisons*, *in* PRISON NATION: THE WAREHOUSING OF AMERICA'S POOR 181, 181 (Tara Herivel & Paul Wright eds., 2003).

6. Nat'l Insts. of Health, *Management of Hepatitis C*, NIH CONSENSUS STATEMENT, June 10–12, 2002, at 9 [hereinafter NIH GUIDELINES 2002], *available at* http://consensus.nih.gov/2002/2002HepatitisC2002116pdf.pdf.

7. In *Estelle v. Gamble*, 429 U.S. 97 (1976), the U.S. Supreme Court established a right to adequate medical care and created the deliberate indifference standard for prisoners' legal claims. *See infra* Part II.A.1.

8. *See infra* Part II.A.2.

and state prison systems have been advised to develop HCV treatment protocols consistent therewith for inmate care.[9] Many state prison systems, however, have implemented restrictive HCV treatment protocols that diverge from national guidelines in some important respects, withholding care from individuals otherwise qualified based on existing standards of care.[10] Whereas national guidelines call for medical decisions based on individualized, case-by-case patient evaluation, some prison systems apply HCV protocols as categorical rules of treatment.[11] This is problematic because HCV care is complicated by a number of factors such that medical decisionmaking for HCV-infected patients is necessarily a discretionary enterprise requiring attention to the individual patient's circumstances. Although every HCV-infected patient may not need antiviral therapy, many do require such treatment. Ideally, HCV protocols are consistent with national guidelines in guiding discretionary decisions given uncertainties in particular cases about what treatment, if any, is appropriate.[12]

Prisons counter that low expectations of adherence to treatment and reinfection concerns support restrictive HCV protocols.[13] Further, prisons maintain that any inappropriate failures to provide care amount only to negligence, not deliberate indifference, and therefore do not constitute cognizable Eighth Amendment violations.[14] Cost concerns are also suggested as prisons' motivation for use of restrictive HCV protocols as barriers to care. Given the prevalence rates in prisons, state prisons are concerned that liberalized HCV protocols could result in expanded care and higher costs.[15] Thus, HCV highlights a larger problem that results from the incarceration explosion: how to pay for—or avoid paying for—the burgeoning medical costs of a growing prison population?[16]

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9. National Hepatitis C (HCV) care guidelines explain existing standards of care. Guidelines have been issued by the National Institutes of Health (NIH) and, most recently, the American Association for the Study of Liver Diseases (AASLD). *See* AASLD GUIDELINES, *supra* note 2; NIH GUIDELINES 2002, *supra* note 6, at S3.

10. For review of common provisions contained in HCV protocols, see *infra* Part I.C.

11. AASLD GUIDELINES, *supra* note 2, at 1155. Drug users, in particular, historically have been denied medical care based on prejudicial attitudes, but often require HCV care due to the high prevalence rates in this at-risk group. *See* Brian R. Edlin et al., *Overcoming Barriers to Prevention, Care, and Treatment of Hepatitis C in Illicit Drug Users*, 40 CLINICAL INFECTIOUS DISEASES S276, S276–80 (Apr. 15, 2005).

12. *See infra* Part I.

13. *See* Johnson v. Wright, 412 F.3d 398, 401 (2d Cir. 2005) (discussing these arguments by the New York state prison system). *But see* Edlin et al., *supra* note 11, at S279–80.

14. *See* Estelle v. Gamble, 429 U.S. 97, 106 (1976) (stating that negligent medical care does not state an Eighth Amendment violation).

15. HCV antiviral therapy ranges from $7000 to $20,000. *See* Allen et al., *supra* note 4, at 23.

16. In fiscal year 2001, it cost $29.5 billion to operate state prisons, an increase of $5.5 billion from 1996. Twelve percent, or $3.3 billion, of state operating expenditures were for prison medical

This Comment argues that prisons following HCV protocols as categorical rules of treatment, rather than as guidelines for care, act with deliberate indifference. Where national HCV guidelines, along with basic principles of medical professional judgment, call for individualized patient evaluation, prisons following HCV protocols as categorical rules deviate from recognized standards of care and may be liable for deliberate indifference to prisoners' medical needs. Still, existing Eighth Amendment standards provide only limited grounds for courts to order expanded care. Legal advocacy should look beyond the deliberate indifference standard to the advancement of legal and public health policy arguments based on "evolving standards of decency."[17] As the Court has indicated, the Eighth Amendment requires law to change with shifts in contemporary values. These arguments suggest that contemporary standards of adequate care call for more expansive care than required by the deliberate indifference standard.[18] Medical ethics, disability rights protections, and international law are instructive authorities for understanding society's definition of adequate HCV care.

Further, this Comment addresses the large HCV concentration in prison as a significant public health opportunity amidst growing concerns about prisoner reentry.[19] Where the majority of inmates are released, mass incarceration means rising numbers of ex-offenders reentering the community.[20] In 2004, nearly 650,000 people were released from prisons, and over seven million people were released from jails.[21] Prison inmates exhibit higher burdens of disease than the general population, an unsurprising fact since prisons disproportionately

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care. That averages out to $2625 per inmate in a year as compared with $4370 average individual health care expenditures by U.S. residents. In 2001, five states spent above $4000 per inmate (Alaska, California, Maine, Massachusetts, and New Mexico) whereas three states spent below $1000 per inmate (Kentucky, Louisiana, and Montana). *See* JAMES J. STEPHAN, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: STATE PRISON EXPENDITURES, 2001, at 1–6 (June 2004), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf. Cost concerns have driven the privatization of prison medical care. Criticized as a race to the bottom that privileges reducing costs over quality of care, in 2003 private medical companies ran prison health care in ten states and ran particular facilities in another seventeen states. *See generally* Wil S. Hylton, *Sick on the Inside: Correctional HMOs and the Coming Prison Plague*, HARPER'S MAG., Aug. 2003, at 43, 45–49.

17. The Eighth Amendment "draw[s] its meaning from the evolving standards of decency." Trop v. Dulles, 356 U.S. 86, 101 (1958).

18. *See infra* Part III (discussing the evolving standards framework for determination of prisoners' Eighth Amendment rights and the Court's recent decision in *Roper v. Simmons*, 543 U.S. 551 (2005)).

19. *See* Allen et al., *supra* note 4, at 22.

20. Ninety-five percent of state prison inmates will ultimately be released. Timothy Hughes & Doris James Wilson, Bureau of Justice Statistics, Reentry Trends in the United States (Aug. 20, 2003), http://www.ojp.usdoj.gov/bjs/reentry/reentry.htm.

21. *See* RE-ENTRY POLICY COUNCIL, REPORT OF THE RE-ENTRY POLICY COUNCIL CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 1 (2004), *available at* http://www.reentrypolicy.com/reentry/Document_Viewer.aspx?DocumentID=245.

contain poor, minority populations that have traditionally lacked access to adequate health services.[22] Because prisoners are a captive audience, medical care and preventive measures can focus on this underserved, at-risk population.[23] If left unidentified, untreated, and uneducated about the disease, HCV-infected inmates reentering society present a transmission risk to the community and are less likely to achieve successful reintegration.[24] As a result, policymakers from a range of political perspectives have embraced successful prisoner reentry as a rational policy goal. Since medical care and public health interventions for prisoners are considered tantamount to better health outcomes for the general population, prisoner-reentry advocates recommend a systematic approach to HCV in prisons—including screening, testing, monitoring, and treatment of the disease—to address the HCV public health crisis.[25]

In this Comment, I examine the legal and policy issues raised by HCV in prisons. Part I describes the comorbid medical conditions of HCV infection and drug addiction, the current standards of HCV care, and HCV protocols as barriers to HCV care in prisons. Part II considers the limited ability of HCV litigation to expand care due to the stringent deliberate indifference standard, court deference to prison policy, and courts' unwillingness to find deliberate indifference when prisons follow HCV protocols. After a review of HCV cases, I then analyze a recent Second Circuit Court of Appeals case, *Johnson v. Wright*,[26] as a basis for challenging HCV policies that eschew individualized patient care when applied as categorical rules. Part III situates adequate medical care and public health reform in the context of two policy paradigms: evolving standards of decency and prisoner reentry. This discussion suggests a rethinking of the law's approach to HCV in prisons by reference to contemporary standards of adequate care. Finally, this Comment concludes with remarks on how framing access to HCV care in terms of the emerging consensus on prisoner-reentry policy coheres with a broader public health orientation toward prison reform and a harm-reduction approach to drug problems. This approach conceives of law as a social institution that propels reform only when a larger movement for social change influences its direction.

22. *See supra* note 1.

23. *See* Boutwell et al., *supra* note 3, at S368; Hammett et al., *supra* note 1, at 399.

24. *See* 2 NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 1, at 13; Boutwell et al., *supra* note 3, at S368; Hammett et al., *supra* note 1, at 391–92.

25. *See, e.g.*, Boutwell et al., *supra* note 3, at S368–69; Hammett et al., *supra* note 1, at 392–95.

26. 412 F.3d 398, 401 (2d Cir. 2005).

I. HEPATITIS C IN PRISON AS A MEDICAL NEED AND A PUBLIC HEALTH CHALLENGE

HCV is the most common bloodborne viral infection and the leading cause of death from liver disease in the United States.[27] While four million people—1.8 percent of the general population—are identified as HCV-infected, these statistics have underestimated HCV incidence by exclusion of prison inmates, the homeless, and institutionalized persons in calculation of the figure.[28] As large numbers of undiagnosed individuals are identified in the coming years, HCV incidence is expected to rise dramatically.[29]

HCV is transmitted through exposure to infected blood, with injection drug use as the primary mode of transmission.[30] Under the auspices of the "War on Drugs," the number of persons in prison for drug crimes has risen significantly in the past two decades.[31] Because many persons arrested for drug-related crimes are drug users, it is no surprise that prisons exhibit HCV prevalence rates eight to twenty times the HCV incidence in the general population.[32] The high concentration of HCV in prisons is a critical problem from both medical and public health perspectives[33]: First, prisons contain individuals with significant medical needs, and second, reentry of prisoners to society poses dangerous transmission risks to the general population.[34]

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27. Each year, between 10,000 and 12,000 persons die as a result of HCV-related cirrhosis of the liver. *See* AASLD GUIDELINES, *supra* note 2, at 1147.

28. *See* NIH GUIDELINES 2002, *supra* note 6, at 5.

29. An increase of four times the current estimates of adults diagnosed with chronic HCV infection is projected from 1990 to 2015. *See id.*

30. The prevalence of HCV among older injection drug users is estimated to be between 80 and 90 percent. *See* Edlin et al., *supra* note 11, at S276. HCV and drug addiction are often described as comorbid conditions because it is not unusual for HCV-infected individuals to also suffer from drug addiction. Other common conditions comorbid with HCV include human immunodeficiency virus (HIV) and mental illness. *See* AASLD GUIDELINES, *supra* note 2, at 1155.

31. *See supra* note 1.

32. *See* Allen et al., *supra* note 4. Data suggest that roughly one out of every four state prison inmates has a history of injection drug use. *See* NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUM. UNIV., BEHIND BARS: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION 182 (1998).

33. As a medical problem, HCV care addresses the health of the individual patient. As a public health problem, HCV care is considered necessary as a public health strategy. The public health perspective, however, more broadly focuses on diagnosis and education in addition to medical treatment. *See* Allen et al., *supra* note 4, at 24. For a discussion on the difference between medical and public health approaches, see generally Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights*, *in* HEALTH AND HUMAN RIGHTS 441–47 (Jonathan M. Mann et al. eds., 1999).

34. According to the Centers for Disease Control and Prevention (CDC), in 1996, 1.3 million HCV-infected inmates were released from prisons and jails. *See* Allen et al., *supra* note 4, at 24.

While prisons have faced similar problems with the human immunodeficiency virus (HIV) epidemic, the sheer magnitude of HCV prevalence is alarming.[35] Standards for HIV care are more settled than are standards for HCV care,[36] and whereas HIV in prisons has been the subject of legal scholarship and advocacy,[37] the problem of HCV in prisons has yet to receive similar attention.[38] Medical uncertainty regarding appropriate HCV care complicates the development and evaluation of prison policies. Since HCV was only discovered in 1989, HCV care is still a relatively new area of medical research. Although several national organizations have published HCV care guidelines, these guidelines are often revised in light of changing standards of care.[39] The current medical consensus accepts a degree of ambiguity as to what constitutes appropriate care for individual HCV-infected patients. Treatment is not recommended for every HCV-infected person, but rather is recommended only on a case-by-case basis.[40] Thus, the existing challenge is to expand the provision of HCV care for those determined to need it while recognizing that HCV treatment is unnecessary for many HCV-infected persons.[41]

Current standards of care recognize individualized patient care as the principle to mediate medical uncertainty, advising that each patient be evaluated

35. HIV prevalence rates in state prisons are about 2 percent. *See* LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, BULLETIN: HIV IN PRISONS, 2003, at 1 (Sept. 2005), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/hivp03.pdf. HCV prevalence rates range between 16 and 41 percent. *See* Allen et al., *supra* note 4, at 22.

36. *See Correctional Systems Weigh New Consensus Statement: Debate HCV Treatment Approaches and Options*, POSITIVE POPULATIONS vol. 4, no. 3, at 1, 3 (2002) [hereinafter *Correctional Systems*], *available at* http://www.positivepopulations.org/newsletters/V4N3.pdf. HIV and HCV also exhibit some notable differences in transmission routes. Whereas HIV transmission is quite efficient through unprotected sexual activity, HCV infection is less likely to result from sex. However, HCV is ten times more efficient at transmitting through injection drug use than is HIV. *See* Edlin et al., *supra* note 11, at S277.

37. *See generally* Donald H.J. Hermann, *The Development of AIDS Federal Civil Rights Law: Anti-Discrimination Law Protection of Persons Infected With Human Immunodeficiency Virus*, 33 IND. L. REV. 783 (2000); Kathleen Knepper, *Responsibility of Correctional Officials in Responding to the Incidence of the HIV Virus in Jails and Prisons*, 21 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 45 (1995); D. Stuart Sowder, *AIDS in Prison: Judicial Indifference to the AIDS Epidemic in Correctional Facilities Threatens the Constitutionality of Incarceration*, 37 N.Y.L. SCH. L. REV. 663 (1992); Sarah E. Frink, Note, *AIDS Behind Bars: Judicial Barriers to Prisoners' Constitutional Claims*, 45 DRAKE L. REV. 527 (1997).

38. *But see* Talvi, *supra* note 5; Fox Butterfield, *Infections in Newly Freed Inmates Are a Rising Concern*, N.Y. TIMES, Jan. 28, 2003, at A14; David Rohde, *A Health Danger From a Needle Becomes a Scourge Behind Bars*, N.Y. TIMES, Aug. 6, 2001, at A1.

39. The most recent set of evidence-based medical guidelines for HCV care were published by the AASLD. AASLD GUIDELINES, *supra* note 2, at 1166 ("The issue of treatment of chronic hepatitis C is in constant flux. There is highly active clinical research in this area, and new information appears with increasing frequency.").

40. *See id.* at 1155.

41. *See* Edlin et al., *supra* note 11, at S280.

for care based on a personalized assessment of risks and benefits.[42] Individualized care ensures that every HCV-infected individual is a candidate for HCV antiviral therapy, even though every candidate will not in fact be treated. However, contrary to the prevailing understanding contained in evidence-based national guidelines, many prisons have implemented restrictive HCV treatment protocols that operate as barriers to individualized HCV care.[43] Although national guidelines do not recommend treatment for every HCV-infected patient, neither do they support HCV protocols designed or applied as indefensible barriers to care based on prejudicial attitudes toward drug users, persons with HIV, or the mentally ill, a desire for cost-savings, or any other unacceptable "non-medical reason."[44]

To explore HCV in prison as a medical and public health problem, it is first necessary to understand current standards of HCV care and the nature of drug addiction. Public health literature articulates two normative strategies for HCV management: (1) Care should not be withheld from current and former drug users; and (2) care should focus on prison populations. The following discussion situates HCV in the appropriate context and then addresses these normative strategies.

A. Understanding Hepatitis C and Drug Addiction

1. The Hepatitis C Virus and Its Treatment

The natural history of HCV follows one of two general paths: acute infection or chronic infection. Acute HCV infection occurs immediately following exposure. While infection can spontaneously clear during this stage, 55 to 85 percent of HCV-infected persons proceed to the chronic HCV stage. Chronic HCV is defined as persistent HCV infection for longer than six months.[45] During this stage, HCV-infected persons experience varying degrees of liver fibrosis (scarring) and inflammation.[46] Five to 20 percent of HCV-infected

42. *See, e.g.*, AASLD GUIDELINES, *supra* note 2, at 1155; Brian R. Edlin, *Prevention and Treatment of Hepatitis C in Injection Drug Users*, 36 HEPATOLOGY S210, S210 (2002) ("Decisions about the treatment of hepatitis C . . . should be made by the patients together with their physicians based on individualized risk-benefit assessments.").

43. Evidence-based guidelines, such as the AASLD Guidelines, articulate the consensus of medical and public health professionals for HCV care, and are based upon an analysis of current science and medical practice. *See* AASLD GUIDELINES, *supra* note 2, at 1147.

44. Monmouth County Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 346 (3d Cir. 1987) (citing Ancata v. Prison Health Servs., Inc., 769 F.2d 700, 704 (11th Cir. 1985)). The denial of medical care on the basis of "non-medical reasons," such as financial considerations, has been found by courts to be deliberate indifference. *See, e.g.*, *id.* at 336–37.

45. *See* NIH GUIDELINES 2002, *supra* note 6, at 10.

46. *See* AASLD GUIDELINES, *supra* note 2, at 1151.

persons develop cirrhosis of the liver, which represents a significant risk for developing end-stage liver disease.[47] For those who reach end-stage liver disease, the only available treatment option is liver transplantation, a costly and often unavailable procedure.[48] As the natural history of HCV makes clear, HCV impacts infected individuals differently. HCV care for the individual patient will vary depending on a number of circumstances, making effective screening and monitoring necessary to determine appropriate treatment decisions.

According to the American Association for the Study of Liver Disease (AASLD) Guidelines, HCV screening should focus on at-risk populations, and tests should be conducted on individuals that report "an identifiable risk factor."[49] Since injection drug use is the primary mode of transmission, anyone with a history of such drug use qualifies for testing.[50] HCV testing is also recommended for anyone exhibiting high aminotransferase (ALT) levels.[51] Patient monitoring determines the timing and substance of treatment interventions. Physicians are asked to consider several factors in determining a patient's qualification for HCV treatment and evaluating the probability of treatment response. First, a patient's HCV genotype should be identified, as it both predicts expected success in treatment and guides the appropriate length of treatment.[52] Second, evaluation of the stage of the disease helps determine the "relative urgency of therapy."[53] The stage of the disease is often assessed through a procedure known as a liver biopsy.[54] Thus, current standards of care consider screening and testing for the disease in at-risk individuals as well as liver biopsies necessary for identification, monitoring, treatment, and prevention of the disease.

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47. *See id*.

48. A liver transplant's estimated cost is $250,000. *See Correctional Systems*, *supra* note 36, at 5.

49. AASLD GUIDELINES, *supra* note 2, at 1147.

50. For a discussion of other possible modes of transmission, see generally *id*. at 1147–48.

51. *Id*. at 1148. The aminotransferase (ALT) level is the measure of a liver enzyme that spills into the blood when there is liver damage and that, if elevated, may indicate HCV infection. When ALT levels of HCV-infected patients have remained persistently high over a period of time, these patients historically have been deemed qualified for treatment. *Id*. at 1148, 1155.

52. *Id*. at 1150. There are six identified HCV genotypes. HCV-infected persons with genotype 1 have demonstrated successful treatment response rates of 42 to 46 percent, while response rates for genotypes 2 and 3 have ranged from 76 to 82 percent. There is a lack of data on treatment response for genotypes 4, 5, and 6. *Id*. at 1154.

53. *Id*. at 1150.

54. *Id*. A liver biopsy is a procedure where a needle is inserted through the skin over the right upper abdomen to obtain a thin strand of liver tissue to be examined under a microscope and evaluated. While the need for a liver biopsy before initiation of treatment is a matter of debate, the AASLD resolves doubts in favor of performing a biopsy to formulate the optimal treatment decision. However, because individuals with genotype 2 and 3 respond well to antiviral therapy, a biopsy may be unnecessary before this group of patients receives treatment. *Id*. at 1150–51.

The AASLD Guidelines explain that HCV treatment decisions are properly determined according to a broad medical ethic of individualized patient care: "As with all clinical decisions, selection of patients for HCV treatment requires accurate assessment of both therapeutic risk and benefit."[55] HCV treatment decisions are individualized according to a patient's HCV genotype, severity of liver disease, the presence of side effects,[56] and the existence of comorbid conditions such as HIV co-infection, drug addiction, alcoholism, or mental illness.[57] Like most factor tests, HCV treatment decisions balance various concerns. Thus, no single factor, whether HIV co-infection, drug use, or mental illness, leads to an absolute exclusion from treatment.[58]

The purpose of HCV treatment is "to prevent complications of HCV infection[;] this is principally achieved by eradication of infection."[59] HCV-infected persons left untreated are at risk for liver cirrhosis, end-stage liver disease, and death.[60] While HCV is currently not curable, treatment can eradicate infection by reducing HCV to undetectable levels, avoiding death and other HCV complications.[61] More broadly, HCV care aims at preventing transmission of the disease. Health education, substance abuse treatment, and syringe exchange programs are recommended public health interventions.[62]

Several treatments for HCV exist. The optimal course of treatment is a combination antiviral therapy regimen of weekly injections of pegylated interferon and oral ribarivin.[63] The cost for a round of treatment ranges from $7000 to $20,000.[64] HCV treatment is effective in producing HCV clearance, leading to undetectable HCV levels in many cases or reduced levels with improvement in fibrosis.[65] Nevertheless, the AASLD Guidelines make clear that treatment

55. *Id.* at 1155.

56. A range of side effects can occur in conjunction with HCV treatment, including irritability, memory disturbances, depression, fatigue, headaches, nausea, vomiting, skin irritation, weight loss, fever, and insomnia. *Id.* at 1154.

57. *Id.* at 1155.

58. *Id.* The AASLD Guidelines classify patients into three categories for the purposes of treatment qualification: persons for whom therapy is widely accepted, persons for whom therapy should be individualized, and persons for whom therapy is contraindicated. *Id.*

59. *Id.* at 1152.

60. *Id.* at 1151.

61. When treatment eradicates infection to undetectable levels, a patient is defined as having a "sustained virologic response." *Id.* at 1152.

62. *See, e.g.*, Boutwell et al., *supra* note 3, at S369; Edlin et al., *supra* note 11, at S278–79; Edlin, *supra* note 42, at S215.

63. Since HCV-infected persons with genotype 1 have a more resistant strain of the virus, the recommended therapy is forty-eight weeks of pegylated interferon, whereas the recommended course of treatment for those with genotypes 2 and 3 is twenty-four weeks of pegylated interferon. *Id.* at 1152–54.

64. *See* Allen et al., *supra* note 4, at 23.

65. AASLD GUIDELINES, *supra* note 2, at 1152.

of all HCV-infected persons is not necessarily advisable. The AASLD Guidelines offer only "recommendations" reflecting the current medical consensus for HCV treatment, not categorical rules of treatment. Since HCV guidelines are not to be followed as categorical rules, appropriate HCV care is a decision arrived at through case-by-case analysis of the individual patient.[66]

2. Drug Addiction and Its Treatment

HCV care is intimately linked to caring for current and former injection drug users.[67] HCV care for this group is complicated by the misperception that drug use renders a patient ineligible for treatment.[68] Yet drug users are eligible and can benefit from HCV care, in addition to public health interventions directed at preventing transmission.[69] To improve drug users' access to medical care and public health programs, dispelling the myths about drug addiction is a necessary enterprise.

Despite popular conceptions of drug addiction as a moral problem, scientists and policymakers view drug addiction as a disease.[70] Drug addiction leads to changes in brain chemistry produced by excessive drug use and characterized by an uncontrollable compulsion to use drugs despite adverse consequences.[71] As with other chronic illnesses,[72] the medical community recognizes that "[d]rug use is a complex behavior with multidimensional determinants, including social, psychological, cultural, economic, and biological factors."[73] Drug addiction is similar to other chronic illnesses such as diabetes, heart disease, and lung cancer in that voluntary yet socially conditioned behaviors, such as diet or smoking, can lead to the onset and development of the disease.[74]

Thus, when Congress enacted the Americans with Disabilities Act of 1990,[75] it included drug addiction among other "diseases or conditions" that are "physical or mental impairment[s]" entitled to antidiscrimination protection

66. *Id.* at 1155.
67. *See* Edlin et al., *supra* note 11, at S276; *supra* note 4 and accompanying text.
68. *See, e.g.*, Edlin et al., *supra* note 11, at S276.
69. *See id.*
70. *See, e.g.*, Alan I. Leshner, *Science-Based Views of Drug Addiction and Its Treatment*, 282 J. AM. MED. ASS'N 1314 (1999).
71. *See id.*
72. Chronic illness is distinguished from a curable acute condition. Individuals with drug addiction usually require multiple rounds of treatment, and the possibility of relapse always remains. *See* Ellen M. Weber, *Bridging the Barriers: Public Health Strategies For Expanding Drug Treatment in Communities*, 57 RUTGERS L. REV. 631, 641–42 (2005).
73. Edlin et al., *supra* note 11, at S276.
74. *See* Weber, *supra* note 72, at 641–42.
75. 42 U.S.C. §§ 12101–12213 (2000).

under the law.[76] This congressional recognition of drug addiction as a disability demonstrates that drug addiction is to be treated as a medical problem, even if public policy remains somewhat schizophrenically committed to punitive prohibition.[77] Understanding drug addiction as a disease helps to advance policy arguments for increased drug treatment resources, as well as political demands for abandoning a punitive drug policy.[78] But independent of whether one views punishment for drug crimes as proper from a criminal justice perspective, it is well-established that addressing drug addiction as a disease is the medically appropriate course of action.[79]

Drug treatment is "as successful as treatment of other chronic illnesses," reducing drug use by 40 to 60 percent.[80] As with other medical treatments, drug-treatment plans require individualized consideration of a patient's

76. *See* H.R. REP. NO. 101-485(II), at 51 (1990); 28 C.F.R. § 35.104(1)(ii) (2006) ("The phrase *physical or mental impairment* includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, *emotional illness*, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, *drug addiction*, and *alcoholism*.") (emphasis added).

77. The Controlled Substances Act, 21 U.S.C. § 802(1) (2000), both in 1990 and today, defines an "addict" as "any individual who habitually uses any narcotic drug . . . or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction." This definition is consistent with the view that drug addiction is a disease that has roots in social and biological factors beyond the individual will. *See, e.g.*, Laura L. Hirschfeld, *Legal Drugs? Not Without Legal Reform: The Impact of Drug Legalization on Employers Under Current Theories of Enterprise Liability*, 7 CORNELL J.L. & PUB. POL'Y 757, 776 (1998).

78. *Cf.* Craig Reinarman, *Addiction as Accomplishment: The Discursive Construction of Disease*, 13 ADDICTION RES. & THEORY 307 (2005). Critics reject the idea that drug addiction is a disease on philosophical grounds, pointing to the initiation of drug abuse as a voluntary act exhibiting a weakness of will. *See, e.g.*, Sally Satel, *Is Drug Addiction a Brain Disease?*, *in* ONE HUNDRED YEARS OF HEROIN 55, 55–57 (David F. Musto ed., 2002). The addiction-as-disease proponents have addressed these criticisms through a kind of soft determinism that reconciles the voluntary choice to use drugs with the social and biological basis that conditions this choice. *See* Leshner, *supra* note 70, at 1314–15.

79. The American Medical Association (AMA) has authoritatively adopted a resolution expressing this view:

> The AMA
>
> 1. endorses the proposition that drug dependencies, including alcoholism, are diseases and that their treatment is a legitimate part of medical practice, and
> 2. encourages physicians, other health professionals, medical and other health related organizations, and government and other policymakers to become more well informed about drug dependencies, and to base their policies and activities on the recognition that drug dependencies are, in fact, diseases.

Am. Med. Ass'n, Definitions, H-95.983 Drug Dependencies as Diseases (Nov. 24, 2003), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/388/alcoholism_treatable.pdf.

80. Leshner, *supra* note 70, at 1316. This means that drug users respond to medical treatments and relapse at similar rates to other chronic illnesses.

needs.[81] A range of substance abuse treatment options are available, including twelve-step counseling programs, outpatient methadone programs, and residential or inpatient programs.[82] Furthermore, a comprehensive drug-treatment regime links programs directly targeting drug abuse with associated mental health services, medical care for communicable diseases, educational programs, and legal and other services.[83]

Despite substantial support for treating drug addiction as a disease, drug treatment and other proven methods for reducing the harms of drug use are not sufficiently available to individuals in need. Punitive drug policy reinforces discriminatory attitudes toward drug users and inhibits their access to necessary health services.[84] To provide effective HCV care for drug users, it must be oriented to addressing the root causes of infection and transmission. In addition to drug treatment, public health education aims to increase knowledge of transmission risks and encourage safe injection practices. At the same time, eligibility for HCV care is not conditional on drug users' participation in drug treatment or other programs.[85] Consistent with the approach that understands drug addiction as a disease and a condition comorbid with HCV, practitioners advocate HCV care tailored to drug users' needs.[86]

B. Public Health Strategy for Hepatitis C in Prison

As a result of the high concentration of HCV and drug users in prisons, public health specialists have articulated two related normative strategies for HCV management: (1) Care should not be withheld from current and former drug users;[87] and (2) care should focus on prison populations.[88]

1. Care Should Not be Withheld From Current and Former Drug Users

As one public health expert has noted, "Substantial barriers to providing effective care and treatment for [injection drug users] with hepatitis C stem from characteristics of the disease, patients, providers, and the health care

81. *See* NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 3 (1999), *available at* http://www.drugabuse.gov/PDF/PODAT/PODAT.pdf.

82. Leshner, *supra* note 70, at 1315–16.

83. *Id.* Of course, financial resources constrain the ability of most substance abuse treatment programs to provide comprehensive services.

84. *See* Weber, *supra* note 72, at 649–56.

85. *See, e.g.*, Edlin et al., *supra* note 11.

86. *See id.*

87. *See id.* at S277–80.

88. *See, e.g.*, Boutwell et al., *supra* note 3, at S367.

system."[89] In addition to medical uncertainty surrounding appropriate HCV care, the efficacy of HCV treatment for drug users has been questioned on grounds of poor adherence, inability to cope with side effects, and the risk of reinfection when drug use continues during HCV therapy.[90] Until recently, national guidelines, such as those of the National Institutes of Health (NIH), viewed current drug use as a reason to withhold therapy unless a person achieved six months of abstinence.[91] However, the general consensus, since adopted by the NIH, is that injection drug users may be qualified candidates for HCV treatment on a case-by-case basis.[92]

The movement toward individualized care for drug users has been the product of public health advocacy. Informed by science and medical ethics, public health specialists have argued that drug users are prime candidates for HCV care due to their status as the highest risk group and should not be denied treatment on the basis of their stigmatized drug-user status.[93] Furthermore, research supports the argument that restrictive guidelines should not exclude drug users from HCV care since studies have shown that drug users can positively adhere to HCV treatment, handle treatment side effects, and avoid reinfection.[94]

2. Focusing Care on Prison Populations

The mass incarceration of drug users and prisoner reentry converge to create both utilitarian and humanitarian grounds for addressing the HCV epidemic: "Viewed from a public health perspective, this incredible movement of people through the nation's prisons and jails provides an opportunity and obligation to reach millions of persons at high risk of HCV infection who are traditionally outside the reach of the mainstream public health and medical

89. Edlin et al., *supra* note 11, at S276.

90. Edlin, *supra* note 42, at S211–13.

91. *Compare* NIH GUIDELINES 2002, *supra* note 6, at S10 ("[A]ctive injection drug use in and of itself [should] not be used to exclude such patients from antiviral therapy."), *with* Nat'l Insts. of Health, *Management of Hepatitis C*, NIH CONSENSUS STATEMENT, Mar. 24–26, 1997, at 18 [hereinafter NIH GUIDELINES 1997], *available at* http://consensus.nih.gov/1997/1997HepatitisC105pdf.pdf ("[T]reatment of patients . . . who are actively using illicit drugs should be delayed until these habits are discontinued for at least six months.").

92. NIH GUIDELINES 2002, *supra* note 6, at S10.

93. *See* Brian R. Edlin et al., *Is it Justifiable to Withhold Treatment for Hepatitis C From Illicit-Drug Users?*, 345 NEW ENG. J. MED. 211 (2001).

94. *See* Scott A. Allen et al., *Treatment of Chronic Hepatitis C in a State Correctional Facility*, 138 ANNALS INTERNAL MED. 187 (2003); John Farley et al., *Feasibility and Outcome of HCV Treatment in a Canadian Federal Prison Population*, 95 AM. J. PUB. HEALTH 1737 (2005); *see also* Markus Backmund et al., *Infrequent Reinfection After Successful Treatment for Hepatitis C Virus Infection in Injection Drug Users*, 39 CLINICAL INFECTIOUS DISEASES 1540 (Nov. 15, 2004) (arguing that few injection drug users in the study became reinfected after successful treatment).

systems."[95] Focusing HCV care on prison populations is a public health strategy that draws not only from humanitarian arguments regarding prisoners' individual rights to medical treatment, but that also appeals to instrumental utilitarian reasoning that help for prison inmates means improvement to community health generally. Where the effects of mass incarceration and prisoner reentry on the general population increasingly impinge on the public consciousness as a matter of serious concern, focusing care on prison populations becomes a rational and politically viable possibility.[96]

The utilitarian argument offers strong reasons why providing care to prison populations leads to better health outcomes for the general population. Prison inmates' collective status as a captive audience in a controlled environment means they can be reached effectively by public health intervention. For instance, prison populations allow for mass screening and tests, inmate behavior can be closely monitored for treatment compliance, and inmates identified as HCV-infected can be educated about transmission risks.[97]

Furthermore, a comprehensive approach to HCV in prisons can be cost-effective while expanding care. A health intervention is cost-effective when "the benefits it will achieve are worth the price."[98] HCV monitoring and treatment in prisons is cost-effective because it can prevent infected persons' progression to cirrhosis, end-stage liver disease, and death.[99] This not only saves lives, but it may avoid the significant medical costs of liver transplantation and end-of-life care in excess of lower cost HCV treatment.[100] Given the high number of unidentified infections and the expectation of sharp increases in HCV incidence in the general population,[101] HCV screening and testing in prisons is also cost-effective. When HCV-infected persons are identified, their transmission risks can be addressed through public health measures such as

95. Boutwell et al., *supra* note 3, at S368.

96. *See, e.g.*, John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 468–70 (2005).

97. *See, e.g.*, Allen et al., *supra* note 4, at 24; Hammett et al., *supra* note 1, at 399.

98. 1 NAT'L COMM'N ON CORR. HEALTH CARE, THE HEALTH OF SOON-TO-BE RELEASED INMATES, at xiii (2002), *available at* www.ncchc.org/stbr/Volume1/Health%20Status%20(vol%201).pdf. Thus, cost-effectiveness is not synonymous with cost savings. *See id.*

99. *See supra* Part I.A.1.

100. A liver transplant is estimated to cost $250,000, whereas a round of HCV treatment ranges from $7000 to $20,000. *See Correctional Systems*, *supra* note 36, at 5; Allen et al., *supra* note 4, at 23; *see also* Hammett et al., *supra* note 1, at 391–92.

101. *See* Boutwell et al., *supra* note 3, at S368 (noting that "at least 50% of people infected with HCV in the United States have not been identified") (citation omitted).

education.[102] This staves off the spread of the disease both among prison inmates and within the community, and as a result, contains future costs of health care.[103]

In response, critics argue that the public health opportunity argument is an ideal that does not make sense as a possible reality, since prison inmates are difficult patients and prisons are bad places to pursue public health objectives. Because HCV-infected inmates suffer from a range of comorbid conditions, critics argue, inmates are less likely to adhere to antiviral therapy than patients in the general population. Drug users, for example, may respond negatively to the use of needles during treatment and may continue using drugs in prison, putting them at risk of reinfection.[104] Also, prisons lack institutional competence to advance public health solutions.[105] The impracticability of focusing care on prison populations thus undermines the prudence of public health solutions.

Even if public health intervention has been underdeveloped, this does not discredit the utilitarian argument underlying the public health strategy of focusing care on prison populations. National HCV guidelines, in harmony with broader principles of medical care, reject a priori generalizations that classes of individuals make bad patients. While factors such as a patient's comorbid conditions are relevant considerations for evaluation, individualized care is important precisely because of the differences between patients in prison populations. Drug use, mental illness, and HIV co-infection are afflictions that vary in degree, requiring patient evaluations calibrated to the individual patient's particular history and qualifications for care.[106] Moreover, evidence of success in focusing care on prison populations lends credence to integration of public health programs in prisons.[107] While questions of implementation and resources remain, whether prisons accept responsibility for integrating public health strategies into their central mission appears as much a question of priorities and political will as it is a practical dilemma.

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102. *See supra* Part I.A.1.

103. *See* Allen et al., *supra* note 94, at 189–90; Boutwell et al., *supra* note 3, at S368; Hammett et al., *supra* note 1, at 391–92; *see also* Joshua A. Salomon et al., *Cost-effectiveness of Treatment for Chronic Hepatitis C Infection in an Evolving Patient Population*, 290 J. AM. MED. ASS'N 228 (2003).

104. *See* Johnson v. Wright, 412 F.3d 398, 405 (2d Cir. 2005) (discussing New York state prison system's arguments that adherence and reinfection concerns justify restrictive HCV protocol); Edlin et al., *supra* note 11 (summarizing these arguments).

105. *See* Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME & JUST. 427, 438–45 (1999). Douglas McDonald points to a number of institutional problems that limit prison systems from expanding medical care and public health intervention. Rather than a lack of commitment or professional standards, McDonald views the problem of poor medical care in prisons as a practical issue of needing to recruit qualified physicians and improve inadequate facilities. *Id*.

106. *See* AASLD GUIDELINES, *supra* note 2, at 1154–55; Edlin et al., *supra* note 11, at S276–80.

107. *See* Boutwell et al., *supra* note 3, at 5368–69.

C. Current Prison Policy as a Barrier to Hepatitis C Care

Prison policy provides an objective indicator of a state prison system's commitment to existing standards of care for comparison with medical and public health authorities. In the past, the problem was the absence of HCV protocols. HCV was discovered in 1989, and national HCV guidelines were published first in 1997. However, many prison systems have since established HCV protocols. Because the 1997 national guidelines—which were more restrictive than current standards of care—sanctioned withholding HCV care from drug users and other at-risk patients, prison systems reasonably formed protocols adopting provisions withholding care.[108] The present problem is prisons' failure to update HCV protocols in light of evolving standards of care.

The 2002 Guidelines liberalized eligibility criteria for access to HCV care. For example, whereas the 1997 Guidelines categorically excluded drug users from consideration for treatment, the 2002 Guidelines allowed HCV care for drug users according to case-by-case decisionmaking.[109] Also, the 1997 NIH guidelines had accepted that high ALT levels indicated when an infected person needed treatment. Conversely, revised guidelines find a liver biopsy to be the best indicator for treatment decisions, even though the procedure is not recommended for all HCV-infected persons.[110] What's more, even persons with normal ALT levels should receive individualized treatment decisions.[111] Although the 2002 national guidelines liberalized eligibility criteria for HCV care, several prison systems have maintained the restrictive provisions from 1997.

The failure of some prison systems to update HCV protocols in light of current standards of care is unreasonable. For example, a common HCV prison policy requires that inmates be drug free for at least six months before receiving HCV treatment, and it mandates substance abuse treatment for anyone with a drug-use history.[112] Another common prison policy requires that HCV-infected inmates exhibit elevated ALT levels at several intervals before being

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108. *See* NIH GUIDELINES 1997, *supra* note 91.

109. *Compare id.*, *with* NIH GUIDELINES 2002, *supra* note 6.

110. *See* AASLD GUIDELINES, *supra* note 2, at 1150–51; *see also* Sterling et al., *supra* note 3, at 320 ("In the absence of a liver biopsy, treating those inmates with elevated ALT is an acceptable, but less-effective alternative.").

111. AASLD GUIDELINES, *supra* note 2, at 1155.

112. *See, e.g.*, N.Y. DEP'T OF CORR., HEPATITIS C PRIMARY CARE PRACTICE GUIDELINE (2004); COLORADO DEP'T OF CORR., HEPATITIS C: GASTROENTEROLOGY (2000); MONT. DEP'T OF CORR., HEALTH SERVICES STANDARD OPERATING PROCEDURES: HEPATITIS C (2002); VA. DEP'T OF CORR., STANDARD TREATMENT GUIDELINES HEPATITIS C (2002). Several state prison system guidelines are collected on the website of the National HCV Prison Coalition, http://hcvinprison.org/new/state_guidelines.html (last visited Oct. 17, 2006).

qualified for treatment.[113] It is also not unusual for prisons to set minimum incarceration periods for an inmate to be eligible for treatment.[114] Finally, many prison systems reportedly offer limited HCV screening of inmates to investigate their risk factors, fail to test at-risk inmates, and restrict the use of liver biopsies as a method of determining timely treatment interventions.[115]

Current standards of care do not endorse blanket policies that limit drug users', or individuals with other comorbid conditions, access to HCV care. While ALT levels are an indicator of the severity of the disease, current standards of care do not specify specific ALT levels over a period of time as a trigger for particular treatment interventions; rather, elevated ALT levels over time are merely one factor for evaluation. The appropriateness of the minimum-sentence policy is less clear, but at the very least, individualized care suggests evaluation for care even when an individual's incarceration period is brief. The limitations on care resulting from application of restrictive HCV protocols have prompted prisoners to challenge these barriers. While seeking to enforce rights to basic healthcare, these challenges invite the legal and correctional systems to weigh the medical and public health implications of HCV in prisons.

II. EIGHTH AMENDMENT LITIGATION TO EXPAND HEPATITIS C CARE

HCV-infected inmates have challenged barriers to HCV care on Eighth Amendment grounds, arguing that prison policies and practices do not meet constitutional guarantees of basic medical care. Although the Eighth Amendment was not interpreted originally to stand for a right to medical

113. *See, e.g.*, VA. DEP'T OF CORR., *supra* note 112.

114. *See* McKenna v. Wright, 386 F.3d 432 (2d Cir. 2004); *Correctional Systems*, *supra* note 36, at 2–4 (describing the minimum-incarceration-period policy for receiving medical treatment).

115. In 2003, the CDC issued guidelines for addressing HCV in prisons. Among other things, the CDC recommended testing of any inmates reporting a history of injection drug use. Ctrs. for Disease Control & Prevention, *Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings*, MORBIDITY & MORTALITY WKLY. REP., Jan. 24, 2003, at 24, *available at* http://www.cdc.gov/mmwr/PDF/rr/rr5201.pdf. The data on HCV testing and treatment in prisons contains unclear results. *See* ALLEN J. BECK & LAURA MARUSCHAK, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: HEPATITIS TESTING AND TREATMENT IN STATE PRISONS 1 (Apr. 2004), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/httsp.pdf. In a recent Bureau of Justice Statistics survey, 79 percent of state prisons claimed to have an HCV testing policy. The majority of HCV tests, however, were conducted in twenty-three states, leaving it unclear whether other state prison systems are conducting HCV tests. While 70 percent of state prisons reported having a treatment policy, roughly two-thirds of inmates receiving HCV treatment were from only nine state prison systems. *See id.* at 1–3. The statistics also do not seem to match anecdotal reports that prison systems are not sufficiently screening and testing for the disease. *See supra* note 37.

care,[116] the Court stated in a 1958 case, *Trop v. Dulles*,[117] that the Eighth Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[118] On this basis, the Court later found, in *Estelle v. Gamble*,[119] that prisons have an affirmative duty to provide inmates with adequate medical care.[120] The Court, however, circumscribed the right by articulation of the "deliberate indifference" standard,[121] requiring that prison officials consciously disregard a prisoner's serious medical needs to establish an Eighth Amendment violation.[122] In other words, "adequate" medical care is defined by the seriousness of the prisoner's medical needs and the subjective state of mind of prison officials providing care.

Prisoners' rights litigation for adequate medical care is confronted by several obstacles. The deliberate indifference standard itself is a stringent test for prisoners seeking expanded medical care. Courts are also hesitant to order expanded medical care due to deference to prison policy, a principle that considers prison officials most competent to manage prison affairs. And even if prisoners establish an Eighth Amendment violation, the qualified immunity defense may bar prisoners from obtaining relief.[123] Moreover, adequate-medical-care claims proceed in a political climate that questions the legitimacy of much prisoner rights litigation. The Prison Litigation Reform Act of 1995,[124] for example, enacted significant constraints on prisoners' ability to bring Eighth Amendment claims and on courts' power to consider such claims.[125]

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116. U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.").

117. 356 U.S. 86 (1958).

118. *Id.* at 101.

119. 429 U.S. 97 (1976).

120. *Id.* at 104. Although only Justice Stevens's dissent made reference to the "State's duty to provide *adequate* medical care," *id.* at 109 (Stevens, J., dissenting) (emphasis added), the Court has accepted that prisons have "a constitutional obligation . . . to provide adequate medical care to those whom it has incarcerated." West v. Atkins, 487 U.S. 42, 54 (1988).

121. *Estelle*, 429 U.S. at 104. Deliberate indifference is also the standard in failure to protect and conditions of confinement cases. *See, e.g.*, Wilson v. Seiter, 501 U.S. 294, 303 (1991).

122. *See* Farmer v. Brennan, 511 U.S. 825 (1994); *Wilson*, 501 U.S. 294.

123. The qualified immunity doctrine is available as a defense for government officials performing discretionary functions. *See* Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982) (explaining prison officials are entitled to qualified immunity when their acts do "not violate clearly established statutory or constitutional rights of which [a] reasonable person would not have known").

124. Prison Litigation Reform Act of 1995 (PLRA), Pub. L. No. 104-134, tit. VIII, 110 Stat. 1321-66 (2006).

125. Prisoners' Eighth Amendment claims of inadequate medical care are brought under 42 U.S.C. § 1983, which allows prisoners to sue any person who, under color of state law, deprives them of their constitutional or statutory rights. 42 U.S.C. § 1983 (2000). Congress sought to reduce prisoners' rights litigation by enacting the PLRA. *See* Brian J. Ostrom et al., *Congress, Courts and Corrections: An Empirical Perspective on the Prison Litigation Reform Act*, 78 NOTRE DAME L. REV. 1525, 1526 (2003) (attributing a 40 percent decrease in prisoner lawsuits, as of 2000, to the PLRA). The PLRA succeeded

The deliberate indifference standard and deference to prison policy, along with other obstacles to prisoner litigation,[126] limit prisoners' ability to challenge inadequate HCV care by bringing Eighth Amendment litigation. When prisons follow HCV policies, courts have been hesitant to infer the reckless disregard to medical needs required to show deliberate indifference. Courts have likely felt an impulse to defer to prison officials' healthcare policies amidst medical uncertainty about appropriate HCV care in particular circumstances.[127] As a result, courts generally have chosen not to intervene rather than to address prison policy as a barrier to HCV care.

However, current standards of care advance individualized patient care as a principle to mediate the medical uncertainty surrounding HCV care. This suggests that courts may become more willing to find deliberate indifference when prison officials follow HCV protocols in a manner inconsistent with current standards of care. To grasp the dynamics of Eighth Amendment litigation in HCV cases, the deliberate indifference standard and deference to prison policy must first be outlined. A review of HCV cases demonstrates courts' reluctance to find deliberate indifference when prisons follow policy amidst HCV medical uncertainty. However, the recent Second Circuit case, *Johnson v. Wright*, offers an alternative perspective on deliberate indifference that invites courts to expand HCV care when prisons follow HCV policy in violation of professional standards of individualized care.[128]

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by, among other things, mandating exhaustion of administrative remedies before inmates may proceed with § 1983 claims, restrictions on attorneys' fees, and a "three-strikes" provision barring lawsuits after a prisoner had three previous claims dismissed. The PLRA is also conceptualized as a device that takes away courts' ability to reform prisons. *See generally* John Boston, *The Prison Litigation Reform Act: The New Face of Court Stripping*, 67 BROOK. L. REV. 429 (2001). However, a court may hear a prisoner's inadequate-medical-care claim, despite a prisoner having three strikes for previous dismissed claims, when the prisoner "is under imminent danger of serious physical injury." 28 U.S.C. § 1915(g) (2000). Courts have found that a prisoner's allegations of a failure to provide adequate care for HCV satisfies the "imminent danger" exception and allows a court to hear the claim. Ibrahim v. District of Columbia, No. 05-5370, 2006 U.S. App. LEXIS 22841, *8–*9 (D.C. Cir. Sept. 8, 2006); Ciarpaglini v. Saini, 352 F.3d 328, 330 (7th Cir. 2003).

126. In addition to the PLRA, prisoners often lack legal representation and struggle to bring claims on a pro se basis. Further, even if a court hears a prisoner's claim, legal standards in prisoners' rights cases place high thresholds on inmates, and prisoners' success rates are accordingly low. *See generally* Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555 (2003).

127. *See, e.g.*, Glick v. Henderson, 855 F.2d 536, 541 (8th Cir. 1988) ("It is the rare case in which a court should venture forth to establish medical procedures and guidelines in an area where the medical profession has not yet been able to ascertain what they should be.").

128. Johnson v. Wright, 412 F.3d 398, 401 (2d Cir. 2005).

A. The U.S. Supreme Court's Articulation of Prisoners' Right to Adequate Medical Care

1. The Deliberate Indifference Standard

In *Estelle v. Gamble*, the Court established that a prisoner's right to adequate medical care has been violated when prison officials exhibit "deliberate indifference to serious medical needs."[129] The Court predicated the constitutional right to basic medical care on the fact that inmates stripped of liberty are dependent on prisons to provide care.[130] However, the Court emphasized that "[t]his conclusion does not mean . . . that every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment."[131] While stating that a prison official's negligent failure to provide adequate medical care does not constitute an Eighth Amendment violation, the Court did not further define deliberate indifference.[132]

Subsequent case law elaborated on the meaning of the deliberate indifference standard. In *Wilson v. Seiter*,[133] the Court determined that the deliberate indifference standard applies in all prison conditions of confinement cases.[134] In discussing the deliberate indifference test, the Court stated that an inmate must establish a "sufficiently serious" condition as a matter of objective evaluation.[135] Also, an inmate must show that prison officials acted with deliberate indifference, exhibiting a "sufficiently culpable [subjective] state of mind."[136] Ultimately, in *Farmer v. Brennan*,[137] the Court specified that the requisite state

129. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

130. *Id.* at 103–04 ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met . . . '[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.'"); *see also* DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 200 (1989) ("[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic needs—*e.g.*, food, clothing, shelter, medical care, and reasonable safety—it transgresses . . . the *Eighth Amendment* . . . .") (emphasis added).

131. *Estelle*, 429 U.S. at 105.

132. The Court did indirectly explain deliberate indifference by providing a list of illustrative cases. *Id.* at 104 n.10.

133. 501 U.S. 294 (1991).

134. *Id.* at 303.

135. *See id.* at 298. In medical-care cases, lower courts have found that a medical need is serious when it is (1) diagnosed by a physician as requiring treatment; (2) "one that is so obvious that even a layperson would easily recognize the necessity for doctor's attention"; and, more broadly, (3) if the condition may result in a life-long handicap or permanent injury. *See generally* 1 MICHAEL B. MUSHLIN, RIGHTS OF PRISONERS 376–77 (3d ed., 2002).

136. *Wilson*, 501 U.S. at 298.

137. 511 U.S. 825 (1994).

of mind for proof of deliberate indifference is the criminal recklessness standard of conscious disregard for a substantial risk of harm.[138] To establish an Eighth Amendment violation for inadequate medical care, an inmate must show that "the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[139]

The Court's articulation of deliberate indifference understands adequate medical care as a function of the subjective state of mind from which prison officials provide care. In formulating an intent requirement as the test of deliberate indifference, the Court sought to tie the right to medical care to the Eighth Amendment's prohibition on "inflictions of [cruel and unusual] punishments."[140] At once progressive and conservative, the Court interpreted the Eighth Amendment right to adequate medical care as proscribing medical neglect while denying a cognizable claim for objectively inadequate care.[141]

The line between negligence and deliberate indifference, a constitutionally excusable omission and an unconstitutional omission, has been drawn by reference to whether professional judgment was exercised with respect to an inmate's care. While negligence may suggest poor judgment, deliberate indifference is a form of punishment that rises to the level of an Eighth Amendment violation because it suggests medical neglect. Federal courts generally will not find deliberate indifference when a doctor is found to have exercised professional

138. *Id.* at 836–37.

139. *Id.* at 837.

140. *Id.* at 841; *see also* Thomas K. Landry, *"Punishment" and the Eighth Amendment*, 57 OHIO ST. L.J. 1607, 1619 (1996) (discussing the Court's interest in linking the deliberate indifference standard to the Eighth Amendment's textual limitation to "punishment").

141. For arguments critiquing deliberate indifference as a subjective standard, see *Farmer*, 511 U.S. at 854–55 (Blackmun, J., concurring) ("'Punishment' does not necessarily imply a culpable state of mind on the part of an identifiable punisher. A prisoner may experience punishment when he suffers 'severe, rough, or disastrous treatment' . . . regardless of whether a state actor intended the cruel treatment to chastise or deter."); Rhodes v. Chapman, 452 U.S. 337, 364 (1981) (Brennan, J., concurring) ("In determining when prison conditions [including medical care] pass beyond legitimate punishment and become cruel and unusual, the 'touchstone is the effect on the imprisoned.'" (quoting Laaman v. Helgemoe, 437 F. Supp. 269, 323 (N.H. 1977))); Estelle v. Gamble, 429 U.S. 97, 116 (1976) (Stevens, J., dissenting) ("[W]hether the constitutional standard [of the Eighth Amendment] has been violated should turn on the character of the punishment rather than the motivation of the individual who inflicted it."); *see also* United States v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987) (defining 'adequate' medical care to mean "services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards"); Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 946–48 (1992).

judgment regarding an inmate's care, but they will find deliberate indifference when prison officials choose not to provide care in conformity with that judgment.[142] If decisions about medical care are based on considerations unrelated to professional standards, this can support a finding of deliberate indifference.[143] For example, courts may find deliberate indifference when the medical care provided was the "easier and less efficacious treatment."[144] Some circuits find that a claim of deliberate indifference is stated when necessary medical care has been delayed for nonmedical reasons.[145] Cost considerations, for example, have generally been denied as a defense for withholding basic medical care.[146] Although objectively inadequate care is not itself enough to establish an Eighth Amendment violation, objectively inadequate care that flows from improper subjective motivation is covered by the deliberate indifference standard. A failure to exercise professional judgment, based on recognized current standards of care, should be a ground for finding deliberate indifference.[147]

2. Deference to Prison Policy and the Eighth Amendment

The Court has repeatedly affirmed principles of deference to prison policymaking decisions, advising judicial restraint where prison administrators

142. *See* Marc J. Posner, *The* Estelle *Medical Professional Judgment Standard: The Right of Those in State Custody to Receive High-Cost Medical Treatments*, 18 AM. J.L. & MED. 347, 351–53 (1992) (suggesting that a medical judgment cuts against a finding of deliberate indifference because professional decisionmaking is driven by the patient's best interest).

143. *See, e.g.*, Hathaway v. Coughlin, 99 F.3d 550, 553 (2d Cir. 1996) (stating that "certain instances of medical malpractice may rise to the level of deliberate indifference; namely, when the malpractice involves culpable recklessness").

144. Estelle v. Gamble, 429 U.S. 97, 104 n.10 (1976) (quoting Williams v. Vincent, 508 F.2d 541 (2d Cir. 1974)).

145. *See, e.g.*, Monmouth County Corr. Inst. Inmates v. Lanzaro, 834 F.2d 326, 346–47 (3d Cir. 1987) ("Short of absolute denial, 'if necessary medical treatment [is] delayed for non-medical reasons, a case of deliberate indifference has been made out.'" (quoting Ancata v. Prison Health Servs., Inc., 769 F.2d 700, 704 (11th Cir. 1985))).

146. *See, e.g.*, *Farmer*, 511 U.S. at 855 (Blackmun, J., concurring) ("Where a legislature refuses to fund a prison adequately, the resulting barbaric conditions should not be immune from constitutional scrutiny simply because no prison official acted culpably."); *Ancata*, 769 F.2d at 705 ("Lack of funds for facilities cannot justify an unconstitutional lack of competent medical care and treatment for inmates."). *But see* Wilson v. Seiter, 501 U.S. 294, 302 (1991) (choosing not to rule on the availability to prisons of a cost defense); *see also* Barbara Kritchevsky, *Is There a Cost Defense? Budgetary Constraints as a Defense in Civil Rights Litigation*, 35 RUTGERS L.J. 483, 551–53 (2004) (arguing that the *Wilson* decision encourages a cost defense).

147. *See* Eric Neisser, *Is There a Doctor in the Joint? The Search for Constitutional Standards for Prison Health Care*, 63 VA. L. REV. 921, 956–57 (1977) ("The state, at a minimum, must ensure that decisions concerning the nature and timing of medical care are made by medical personnel . . . for reasons that are purely medical.").

are the experts in security and punishment.[148] In *Turner v. Safley*,[149] the Court extended informal principles of deference while explaining that protection of prisoners' rights is subject to a "lesser standard of scrutiny."[150] Under *Turner*, "when a prison regulation impinges on an inmate's constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests."[151] Thus, the *Turner* standard seems to constrain courts' power to enforce prisoner rights.[152]

When Eighth Amendment rights are at issue, however, the Court has recently qualified its support for deference to prison policy. First, in *Overton v. Bazzetta*,[153] the Court upheld a prison policy restricting visitation privileges for substance abuse violations. The Court applied the *Turner* standard only in connection with the prisoner's First Amendment claim. The Court did not, however, apply the *Turner* standard when evaluating the inmate's Eighth Amendment claim, suggesting that Eighth Amendment standards are not subject to *Turner*.[154] Then, this past term in *Johnson v. California*,[155] the Court more clearly limited the applicability of deference to prison policy depending on the right at issue. Finding the *Turner* standard inapplicable to the evaluation of prisoners' Fourteenth Amendment right to be free from race discrimination, the Court in *Johnson* explained that deference is not required when the right "is not [one] that need necessarily be compromised for the sake of proper prison administration . . . [and] also bolsters the legitimacy of the entire criminal justice system."[156] The Court then noted that "[f]or similar reasons, we have not used *Turner* to evaluate Eighth Amendment claims of cruel and unusual punishment in prison [because we] judge violations of that Amendment under the 'deliberate indifference' standard, rather than *Turner*'s 'reasonably related' standard."[157]

Therefore, when the Eighth Amendment is at issue, no countervailing standard of deference controls the enforcement of those rights because the

148. *See, e.g.*, Bell v. Wolfish, 441 U.S. 520, 521 ("Prison administrators should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security.").

149. 482 U.S. 78 (1987).

150. *Id.* at 81.

151. *Id.* at 89.

152. *Id.* ("[S]uch a standard is necessary if 'prison administrators . . . , and not the courts, [are] to make the difficult judgments concerning institutional operations.'" (quoting Jones v. North Carolina Prisoners' Union, 433 U.S. 119, 128 (1977))).

153. 539 U.S. 126 (2003).

154. *Id.*

155. 543 U.S. 499 (2005).

156. *Id.* at 510–11.

157. *Id.* at 511.

very purpose of the Eighth Amendment is to ensure the constitutionality of punishments.[158] Whereas institutional security and safety may call for greater deference in certain cases, the Court has recognized that provision of adequate medical care will rarely compromise other administrative objectives.[159] The Court effectively has found that legal challenges to the adequacy of medical care should be judged against existing Eighth Amendment standards without special deference to prison policy.[160]

B. The Limits of Hepatitis C Litigation

HCV-infected inmates have challenged prison policies and practices by arguing that prison failures to screen, test, monitor, or treat HCV constitute deliberate indifference. Courts have been reluctant to question prisons' HCV care in these cases. Just as courts express unwillingness to become engaged in prison management, courts are likely hesitant to intervene in disputes about prison health-care policies because they are not experts in medicine or public health.[161] This concern about legitimate intervention is compounded where existing standards of care are evolving and uncertain. As long as prisons have followed HCV policies showing some medical judgment, courts generally have granted prisons the benefit of the doubt and denied prisoners' claims.[162]

1. Failure to Diagnose Hepatitis C-Infected Inmates

Communicable disease control and individual treatment decisions depend on identification of infected individuals. A majority of state prison systems have been documented as conducting some form of HCV screening and testing.[163] Nevertheless, public health experts report that the scope of HCV

158. *Id.* The special status of the Eighth Amendment belies "[m]echanical deference to the findings of state prison officials . . . [as this] would reduce that provision to a nullity in precisely the context where it is most necessary." *Id.*

159. *See* Wilson v. Seiter, 501 U.S. 294, 302 ("[T]he State's responsibility to attend to the medical needs of prisoners does not ordinarily clash with other equally important governmental responsibilities." (quoting Whitley v. Albers, 475 U.S. 312, 320 (1986))).

160. *See Johnson*, 543 U.S. at 510–11.

161. *See* Scott Burris, *Prisons, Law and Public Health: The Case for a Coordinated Response to Epidemic Disease Behind Bars*, 47 U. MIAMI L. REV. 291, 327 (1992).

162. Because much prison litigation is either unpublished or subject to "no-citation rules," some citations in this Comment are to LEXIS or to the Federal Appendix. It is important to note that no-citation rules raise issues of judicial accountability, the value of precedent, due process, and free speech. *See generally* JESSIE ALLEN, THE RIGHT TO CITE: WHY FAIR AND ACCOUNTABLE COURTS SHOULD ABANDON NO-CITATION RULES (2005), *available at* http://www.brennancenter.org/resources/ji/ji6.pdf.

163. *See* BECK & MARUSCHAK, *supra* note 115, at 1.

testing has been limited relative to the high prevalence of the disease.[164] Although courts have found a failure to screen and test inmates for diagnosis of communicable diseases to demonstrate deliberate indifference,[165] courts tend to give prisons wide latitude to implement screening and testing procedures.[166]

Screening and testing cases have focused on delays in treatment that resulted from prison failures to screen or test HCV-infected inmates. For the most part, courts have avoided the question of deliberate indifference by asking whether a delay in HCV diagnosis caused actual harm to the inmate. For instance, in *Graham v. Wright*,[167] the inmate exhibited elevated ALT levels—an indication of possible HCV infection—but was not tested for HCV.[168] After testing HCV-positive in 2001, and suffering a delay in treatment until 2003, Graham did not respond to therapy. The Second Circuit evaluated the inmate's deliberate indifference claim by inquiring into the impact of the delay on the inmate's well-being.[169] In denying the claim, the court reasoned that the inmate could not prove he would have responded to earlier treatment.[170]

In applying this reasoning, the court found that the effect of the delay was dispositive for determining the seriousness of the medical need. Lost in the discussion was the fact that the inmate should have been tested and treated for HCV several years earlier. In focusing on the inmate's low probability of response to earlier therapy, the court did not address the source of the delay in the prison's failure to properly screen and test the inmate. Several other courts have followed this approach when prisons have failed to identify an inmate's HCV infection.[171] Thus, medical uncertainty as to a patient's probability of treatment response has become a defense to treatment delays that result from failures to identify the disease.

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164. *See supra* Part I.B.

165. *See, e.g.*, Laaman v. Helgemoe, 437 F. Supp. 269, 312 (D.N.H. 1977).

166. *Compare* Harris v. Thigpen, 941 F.2d 1495 (11th Cir. 1991) (upholding state prison system's mandatory HIV testing policy), *with* Jarrett v. Faulkner, 662 F. Supp. 928 (S.D. Ind. 1987) (refusing to order mass HIV testing for all Indiana prison inmates).

167. Graham v. Wright, No. 01 Civ. 9613 (NRB), 2004 U.S. Dist. LEXIS 15738 (S.D.N.Y. Aug. 9, 2004).

168. Graham had ALT levels that were one and a half and three times normal in 1991 and 1992, respectively. In an additional test in 1998, Graham was two times above normal levels. *Id.* at *5–*7.

169. *Id.* at *12 ("[I]t is appropriate to focus on the challenged *delay* or *interruption* in treatment rather than the prisoner's *underlying medical condition* alone. . . .").

170. *Id.* at *15–*16. Because Graham failed to respond in 2003 to updated forms of therapy with 30 percent success rates, the court reasoned that Graham was unlikely to have responded if he was diagnosed earlier when therapy had only a 5 percent success rate. *Id.*

171. *See* Hamlin v. Prison Health Servs., No. Civ.03-169-B-W, 2004 U.S. Dist. LEXIS 25865 (D. Me. Dec. 22, 2004) (finding that a prison official may have been negligent in not ordering timely HCV tests, but not finding deliberate indifference since no harm to the inmate resulted from diagnostic delay); Love v. Taft, 30 F. App'x 336, 337–38 (6th Cir. 2002) (holding no deliberate indifference because inmate failed to show "actual detrimental effect" even though inmate had elevated liver enzymes in 1994 and was not diagnosed with HCV until 2000).

2. Failure to Monitor or Treat Hepatitis C-Infected Inmates

Medical treatment decisions require regular supervision of disease progression and individualized evaluation of factors that qualify patients for treatment. In cases that concern monitoring disease progression, prisoners have sought redress of prison failures to perform liver biopsies as a way to evaluate inmates' qualification for treatment. Courts have usually restricted their inquiry to whether prisons acted in compliance with their own protocols, finding compliance tantamount to professional medical judgment. For example, in an Iowa state prison case, *Charette v. Duffy*,[172] the court relied on the prison's adherence to its protocol in finding no deliberate indifference when an inmate was denied a liver biopsy. The Iowa protocol—like that of many other state prison systems—required that an inmate have ALT levels several times above the normal limit to qualify for a liver biopsy.[173] Although the inmate had significantly elevated ALT levels, he did not meet the levels set by the protocol.[174] After reviewing evidence showing medical disagreement about whether a biopsy was appropriate,[175] the court determined that such "differences of opinion" did not constitute deliberate indifference.[176] The court situated its judgment within the medical uncertainty about HCV care, noting that standards of care are "continuing to evolve" and that biopsies are not necessary for treatment in every case.[177] The court then endorsed the prison's following of its HCV protocol: "Given the state of knowledge regarding Hepatitis C and its treatment during the period in question, the court finds it was reasonable and appropriate for the [prison] to utilize the protocol it had

172. Charette v. Duffy, No. C03-0023-MWB, 2004 U.S. Dist. LEXIS 15094 (N.D. Iowa Aug. 4, 2004).

173. *Id.* at *10–*15.

174. *Id.* at *10–*11.

175. *Id.* at *20–*41. The court considered the expert testimony of two doctors. The prison's expert discussed the slow course of the disease and the low percentage of patients needing treatment. He also argued that Charette could not use his elevated ALT levels as evidence of a serious medical need because "ALT values can not be used as a reliable, surrogate indicator for progressive liver disease from HCV." *Id.* at *37. Interestingly, Charette was requesting a liver biopsy precisely so that he could determine the seriousness of his medical need. On the other hand, Charette's expert criticized the policy that an inmate must exhibit elevated ALT levels on several occasions to receive a liver biopsy. *Id.* at *24 (quoting Charette's expert as saying, "People with ongoing . . . hepatitis C infection may have enzyme levels that fluctuate between normal and high. The medical question is not, 'Are they high *today*?', the medical question is 'Have they been high?'").

176. *Id.* at *50.

177. *Id.* Other courts, too, have downplayed the severity of delays in providing biopsies and cited challenges of prison management to explain the delays. *See, e.g.*, Zimmerman v. Prison Health Servs., 36 F. App'x 202, 203 (2002) ("[T]he evidence presented to the district court here suggested that the delayed biopsy stemmed not from deliberate indifference but rather bureaucratic obstacles and perhaps negligence—scheduling difficulties, prison staff errors . . . and Zimmerman's transfer . . . .").

developed . . . ."[178] Although courts acknowledge that denials or delays of a liver biopsy are "conservative" courses of treatment,[179] courts rarely have mandated more aggressive HCV care.[180]

Treatment cases reveal that prisoners may be disqualified from treatment by the operation of several provisions within HCV protocols. In *McKenna v. Wright*,[181] the New York Department of Corrections (DOCS) refused the inmate's request for HCV treatment under two different policies. First, prison policy denied treatment to any inmate that would not be in prison for longer than twelve months. As McKenna was scheduled to have a parole hearing in less than a year, HCV treatment was denied. Second, after denial of parole, McKenna was denied treatment based on a policy stating that any former drug-using inmate had to enroll in and ultimately complete substance abuse treatment before being eligible for HCV treatment. The following year, a prison doctor informed McKenna that he no longer qualified for treatment because he had untreatable, decompensated cirrhosis. Another doctor later determined he had treatable liver cirrhosis. When McKenna then sought treatment, his request was again denied on the basis of the substance abuse policy. Although McKenna finally enrolled in substance abuse treatment, the HCV progression rendered him too weak to handle the side effects of treatment.[182] The court determined that the denial of treatment based on the twelve-month incarceration policy sufficiently stated a claim of deliberate indifference.[183]

Despite the *McKenna* court's holding, other courts have tended to apply minimal scrutiny to prisons that follow HCV treatment protocols.[184] Other

178. *Charette*, 2004 U.S. Dist. LEXIS 15094, at *53.

179. *See id.* at *59–*60 ("While the course of treatment was conservative, allegations do not rise to the level of deliberate indifference." (quoting Sherrer v. Stephens, 50 F.3d 496, 497 (8th Cir. 1994))); Joiner v. Johnson, No. 99-CV-00341, 2001 U.S. Dist. LEXIS 21645, at *25 (N.D. Tex. July 23, 2001) ("[A]lthough plaintiff disagrees with . . . conservative treatment prison physicians have provided for his Hepatitis C . . . this disagreement does not rise to the level of deliberate indifference.").

180. *See* Jordan v. Delaware, No. 04-1334-KAJ, 2006 U.S. Dist. LEXIS 37983, at *16–*18 (D. Del. June 9, 2006); Thomas v. Bruce, 428 F. Supp. 2d 1161, 1170 (D. Kan. 2006). *But see* Tatum v. Winslow, 122 F. App'x 309, 311–12 (9th Cir. 2005).

181. 386 F.3d 432 (2d Cir. 2004).

182. *Id.* at 434–35.

183. *Id.* at 437.

184. For instance, in *Bender v. Regier*, 385 F.3d 1133 (8th Cir. 2004), a South Dakota prison doctor believed that he was not authorized to order treatment in the absence of an HCV protocol. After a protocol was adopted, the inmate became ineligible for treatment on the basis of three policies: an inmate's liver biopsy had to show Grade 2 and Stage 2 inflammation and fibrosis to commence treatment; an inmate had to have eighteen months remaining on his sentence; and the inmate had to exhibit drug and alcohol abstinence. In determining that prison officials committed no violation, the court indicated that medical uncertainty resulting in prison failures to treat did not constitute deliberate indifference: "The summary judgment record does reflect confusion or miscommunication

circuits should find *McKenna* instructive, as the Second Circuit properly found that following HCV policy alone does not insulate the prison from a deliberate indifference claim.[185] The *McKenna* case highlights that the deliberate indifference standard can allow for more searching scrutiny than many courts have been willing to apply to HCV protocols, and that medical uncertainty and deference to prison policy will not insulate prisons from liability.

C. The Deliberate Indifference of Hepatitis C Protocols Applied as Categorical Rules

Despite limited intervention by courts to date, a proper application of the deliberate indifference standard demands that courts investigate the appropriateness of HCV protocols according to current standards of HCV care. Communicable-disease protocols are welcome developments insofar as they are consistent with current standards of care and public health strategies. Protocols become problematic when prison administrators adopt provisions that do not conform to existing standards and then follow those provisions as categorical rules of treatment. When this happens, protocols become barriers that filter out candidates qualified for care. To the extent that prison officials ignore standards of care in formulation and application of HCV protocols, this can show deliberate indifference to prisoners' medical needs. The Second Circuit's recent decision in *Johnson v. Wright* shows proper application of the deliberate indifference standard and suggests an approach to challenge application of HCV protocols as categorical rules.[186]

In *Johnson*, the court held that a denial of medical care dictated by prison policy could constitute deliberate indifference where providing treatment was determined to be the appropriate course of action.[187] New York DOCS denied an inmate, Johnson, HCV treatment based on a policy requiring that inmates show no "evidence of active substance abuse."[188] Johnson was initially approved for HCV therapy but was later denied after testing positive for marijuana use. While physicians reiterated their recommendation that "Johnson should be [treated] in spite of drug policy," New York DOCS denied Johnson treatment, citing the policy and concerns that an active drug user may fail to

among the medical professionals while the Department of Health protocol was being developed . . . . This confusion does not establish an Eighth Amendment violation." *Id.* at 1135–38.

185. *Compare McKenna*, 386 F.3d at 437, *with* Neely v. McGarry, No. 03-CV-00616-EWN-PAC, 2006 U.S. Dist. LEXIS 42005, at *36–*37 (D. Colo. June 22, 2006).

186. Johnson v. Wright, 412 F.3d 398, 401 (2d Cir. 2005).

187. *Id.* at 406.

188. *Id.* at 400–01.

comply with the treatment.[189] Johnson argued that New York DOCS' mechanical application of the policy constituted deliberate indifference. The court limited the scope of its inquiry, asking not whether the HCV protocol's substance abuse provision was unconstitutional per se, but rather whether "application of the policy in plaintiff's case" constituted deliberate indifference.[190]

Since the case concerned a summary judgment motion, the court was able to moderate its opinion by framing the issue around the jury's reasonable factual inferences. Furthermore, the facts allowed the court to situate its holding within existing Eighth Amendment law: A jury could conclude that following prison policy showed a conscious disregard for Johnson's medical needs because doctors' judgments that Johnson should be treated, in spite of policy, gave prison officials notice that treatment was the appropriate care.[191] The *Johnson* court's rationale, however, permits a broader reading of Eighth Amendment requirements, implying that adequate medical care demands individualized doctor-patient evaluations.

The *Johnson* court focused on the fact that prison officials "reflexively rel[ied] on the medical soundness of the Guideline's substance abuse policy" in spite of notice from doctors that treatment was the right course of action.[192] When discussing prison officials' stated concerns about alcohol and drug-abusing inmates' ability to comply with treatment, the court produced its own individualized evaluation of Johnson's qualification for therapy.[193] Most importantly, the court noted that doctors did not believe that the general-compliance concerns about drug users, nor Johnson's positive test for marijuana drug use, were sufficient reasons to withhold necessary treatment. The court emphasized that "there is no evidence suggesting that the defendants took any steps whatsoever to assure themselves that applying the Guideline in plaintiff's case was, in fact, a medically justifiable course of action."[194] Rather, prison officials "simply assumed the medical soundness of following the Guideline in plaintiff's case."[195]

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189. *Id.* at 402.

190. *Id.* at 404.

191. *Id.* at 406. Deliberate indifference can be found when prison officials ignore doctors' treatment recommendations. *See* Estelle v. Gamble, 429 U.S. 97, 104–05 (1976); Gill v. Mooney, 824 F.2d 192, 196 (2d Cir. 1987).

192. *Johnson*, 412 F.3d at 406.

193. *Id.* at 404 (analyzing Johnson's qualifications for HCV therapy based on a history of missed appointments versus his past success on HCV therapy).

194. *Id.* at 406.

195. *Id.* In addition to mechanical application of a protocol, courts may find deliberate indifference if prisons provide no guidelines for care. *See* Chimenti v. Kimber, 133 F. App'x 833, 835 (3d Cir. 2005) (finding prisoner stated a claim of deliberate indifference where the prison failed to provide an approved HCV treatment because the prison lacked an HCV protocol).

The Second Circuit was simply applying the existing deliberate indifference standard, finding deliberate indifference where prison officials ignored a medical professional judgment. While confining its analysis to the individual prisoner's case, the court's discussion of notice has potentially broader implications for HCV protocols that are inconsistent with current standards of care. National HCV guidelines, acknowledged as authoritative, place prisons on notice regarding the appropriate framework guiding professional judgments for provision of HCV care. When prison officials or prison doctors are aware of current standards of care—as well as of the dangers of deviating from those standards—yet they deviate nonetheless by applying improper protocols, the *Johnson* court's holding supports the broad proposition that following a policy rather than current standards of care can result in a finding of deliberate indifference. Following protocol in such a situation represents a failure to exercise professional judgment because individualized care is a fundamental principle of medical judgment.[196] If other circuits adopt the Second Circuit's approach to prison HCV policy, then prisons more likely will use treatment protocols as guidelines, rather than as categorical rules that dictate improper treatment decisions and eschew individualized care.[197]

III. BEYOND DELIBERATE INDIFFERENCE: RETHINKING LEGAL ADVOCACY FOR ADEQUATE MEDICAL CARE AND PUBLIC HEALTH REFORM IN PRISONS

Even though the previous part understands the deliberate indifference standard to proscribe HCV protocols applied as categorical rules and to require individualized care, existing law limits courts to finding care unconstitutional only when inadequate care issues from subjective deliberate indifference. Moreover, the judicial belief that courts are not capable institutionally of managing prisons does not disappear just because formal principles of deference to prison policy are deemed inapplicable in Eighth Amendment rights cases. As a result, courts are hesitant to order changes to prison healthcare policies, especially where lingering doubts about appropriate care persist due to medical uncertainty. When the stringent deliberate indifference standard, the looming influence of deference to prison policy, and judges' reservations

196. *See* Neisser, *supra* note 147, at 959 ("Implicit in the concept that decisions affecting health be made by qualified medical personnel is the requirement that these decisions be purely medical, that is, *made on an individual and professional basis*.") (emphasis added).

197. Prisons have incentive to reform when subjected to close judicial scrutiny. *See generally* Susan Sturm, *Resolving the Remedial Dilemma: Strategies of Judicial Intervention in Prisons*, 138 U. PA. L. REV. 805 (1990).

to intervene are considered in conjunction with a lack of political will supporting prisoners' rights, the hope for judicial oversight of prisons' medical and public health practices does not appear promising. Legal advocacy organized solely around existing Eighth Amendment interpretations, rather than around larger public health reform, will be limited in approach and potential to advance prison reform.[198] These observations suggest moving legal advocacy beyond existing Eighth Amendment standards in two ways: (1) by advancing arguments that "evolving standards of decency" call for revising Eighth Amendment standards of adequate medical care to provide more expansive treatment than is currently available under the deliberate indifference standard; and (2) by developing broader policy arguments that channel prisoner reentry proposals toward public health reform of prisons.

As a matter of constitutional interpretation, the Eighth Amendment has been viewed by the Court in nonoriginalist terms: "[T]he words of the [Eighth] Amendment are not precise, and . . . their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[199] According to larger shifts in societal thinking on humane treatment, the Court may expand the requirements and prohibitions of the Eighth Amendment in line with contemporary values.[200] At times, the Court's references to evolving standards have featured in opinions more as rhetorical flourish than substantive legal standard. But when the Court eliminated the juvenile death penalty this past term in *Roper v. Simmons*,[201] the Court approvingly invoked the evolving standards framework as a basis to redefine Eighth Amendment requirements.[202]

In *Roper*, the Court rejected a precedent established sixteen years earlier that had found that the Eighth Amendment did not prohibit the juvenile death penalty for offenders over sixteen years of age.[203] What had changed? The Court explained a two-step inquiry for determination of Eighth Amendment rights according to contemporary standards of decency: First, the Court must evaluate society's opinion of a practice by reviewing "objective indicia of [societal] consensus"; second, based upon the objective evidence, the Court must

198. *See* Burris, *supra* note 161, at 332–33.
199. Trop v. Dulles, 356 U.S. 86, 100–01 (1957).
200. *See* Hudson v. McMillan, 503 U.S. 1, 8 (1992) ("[T]he [Eighth Amendment] claim is therefore contextual and responsive to 'contemporary standards of decency.'" (quoting Estelle v. Gamble, 429 U.S. 97, 103 (1976))).
201. 543 U.S. 551 (2005), *overruling* Stanford v. Kentucky, 492 U.S. 361 (1989).
202. *Id.* at 574.
203. *Id.*

"exercise . . . independent judgment" to determine whether society has reached consensus on acceptability of the practice.[204]

After reviewing state law and finding a national consensus against the juvenile death penalty,[205] the Court addressed "the overwhelming weight of international opinion against the juvenile death penalty."[206] Noting that "the United States now stands alone in a world that has turned its face against the juvenile death penalty," the Court ruled the juvenile death penalty unconstitutional.[207]

Roper indicates that a change in societal consensus may alter Eighth Amendment interpretation. While the Court has stated that "society does not expect that prisoners will have unqualified access to health care,"[208] the evolving standards framework enables inquiry into whether society today defines adequate care to provide more expansive care than the minimal threshold currently required by the deliberate indifference standard. Whereas in *Roper* the Court focused on legislative enactments as objective evidence of consensus, adequate care for communicable diseases is a function not only of law, but also of medicine, ethics, and public health.[209] Even in the face of medical uncertainty about appropriate standards of care, fundamental considerations that transcend the aspects of any particular disease inform our current understandings of adequate care. Medical ethics, disability rights protections, and international law are instructive authorities for defining a societal consensus on adequate care.

Legal advocacy has a role not only in articulating legal arguments that employ the evolving standards framework, but also in advancing the evolution of contemporary values itself. In addition to medical ethics, disability rights protections, and international law, increasing interest in prisoner reentry indicates a progressive shift in contemporary values that recognizes prisoners as members of the community and sees failure to provide care to prisoners as inimical to the community's health interests.[210] Even if prisoner-reentry

204. *Id.* at 564 ("The beginning point is a review of objective indicia of consensus, as expressed in particular by the enactments of legislatures that have addressed the question. This data gives us essential instruction. We then must determine, in the exercise of our own independent judgment, whether the death penalty is a disproportionate punishment for juveniles.").

205. *Id.* at 564–75.

206. *Id.* at 578.

207. *Id.* at 577.

208. Hudson v. McMillan, 503 U.S. 1, 9 (1992).

209. For a discussion on the relationships between law, medicine, and public health in defining adequate care, see Lawrence O. Gostin, et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 79–80 (1999); Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL'Y 245, 263–79 (2000).

210. *See* Jacobi, *supra* note 96, at 468–70.

arguments are slow to change Eighth Amendment standards, legal advocacy that spearheads the prisoner-reentry movement has the potential to advance society further in the direction of a public health orientation toward prison management and a harm-reduction approach toward individuals with drug problems.[211] The following discussion offers only a broad outline of such arguments. Ultimately, the larger constitutional and policy implications of HCV in prisons raises questions beyond deliberate indifference, encouraging examination of the sustainability of existing drug and prison policy as well as the construction of public health alternatives.

A. Contemporary Standards of Adequate Medical Care

1. Medical Ethics

Contemporary standards of adequate medical care depend not only on the current knowledge and standards of care for a particular disease, but also on fundamental principles of human treatment. Whereas the law sets "ethical minimums," medical ethics aspires to "ethical maximums" for patient care.[212] Although not co-extensive, questions of medical ethics are often addressed by the law.[213] The law codifies basic principles of medical ethics, it is argued, when it "reflects an emerging societal consensus over how the ethical balance ought to be weighed between doctor and patient."[214] While medical ethics is a discipline fraught with unsettled questions, there is consensus on certain basic principles for the provision of adequate medical care.[215] These basic principles of care guide medical decisionmaking within the doctor-patient relationship. Medical ethics supports application of these basic principles of medical care to the prison context.[216]

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211. *Cf.* Burris, *supra* note 161, at 329–30.

212. *See* Scott, *supra* note 209, at 259–60. Medical ethics is "concerned with explaining, evaluating, and analyzing relevant moral norms, concepts, principles, and theories in order to guide decision making and policy formation in health care." BRYAN HILLIARD, THE U.S. SUPREME COURT AND MEDICAL ETHICS 7 (2004).

213. *See, e.g.*, Washington v. Glucksberg, 521 U.S. 702 (1997) (finding that a ban on assisted suicide was constitutionally permissible); Washington v. Harper, 494 U.S. 210 (1990) (giving drugs to an inmate against his will did not violate the inmate's right to refuse medical treatment).

214. Scott, *supra* note 209, at 263.

215. The law has enshrined some of these basic principles, including the right of informed consent and the right to refuse medical treatment. It has been noted that "[America] ha[s] never agreed . . . that, ethically, every person who needs medical treatment ought to be able to get it." *Id.* at 275. That said, America has agreed that prisoners are entitled to basic medical care, and the critical question raised in this Comment addresses the contours of that right.

216. The American Correctional Health Services Association (ACHSA) has developed a code of ethics for prison medical care. As its first principle, ACHSA's Code of Ethics states, "The correctional health professional should: Evaluate the inmate as a patient or client in each and every

Standard medical practice typically defines a medical professional's legal duties to patients.[217] Some argue that courts should "use [the professional] standards [of associations] as evidence of a duty of care, since a physician's legal duty is primarily defined by medical custom."[218] National guidelines, then, should be entitled to considerable weight in defining contemporary standards of adequate medical care for a particular disease. Moreover, basic principles of care have been found constitutive of the doctor-patient relationship. The American Medical Association (AMA) Code of Medical Ethics states that "[w]ithin the physician-patient relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount."[219] This provision arguably implies a principle of individualized care, as a patient's interests are served best by scientifically informed judgment based upon a personalized assessment of risks and benefits.[220]

Medical ethics suggests that prison medical care must conform to current standards of care for particular diseases. Further, individualized care does not mandate that medical professionals provide prisoners with particular treatments, but rather that they structure the doctor-patient relationship in a way that provides for a fair assessment of the risks and benefits of particular interventions.[221] Where prisons follow communicable-disease protocols as categorical rules of treatment, they violate the medical consensus that individualized care is a constitutive principle of the doctor-patient relationship.

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health care encounter." American Correctional Health Services Association, Code of Ethics, http://www.achsa.org/displaycommon.cfm?an=9 (last visited Oct. 17, 2006).

217. A medical professional is expected to act "as other qualified professionals would act in the same or similar circumstances." GEORGE ANNAS, STANDARDS OF CARE 122 (1993).

218. *Id.* at 126.

219. The American Medical Association (AMA) Code of Medical Ethics describes its principles as "standards of conduct which define the essentials of honorable behavior for the physician." AMA Code of Medical Ethics (June 17, 2001), http://www.ama-assn.org/ama/pub/category/2512.html. In 2001, the AMA Code of Medical Ethics was revised, and the changes added to the Preamble—which represents the most basic principles of medical care—are particularly notable:

> VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community *and the betterment of public health*.
>
> VIII. *A physician shall, while caring for a patient, regard responsibility to the patient as paramount.*
>
> IX. *A physician shall support access to medical care for all people*.

Id. (emphasis added).

220. *See supra* Part I.

221. This argument suggests consensus on the appropriate manner to approach medical decisions, as distinguished from consensus on separate questions of access. *Cf.* Scott, *supra* note 209, at 263.

2. Disability Law and Policy

As already discussed, the Eighth Amendment's conception of adequate medical care is unduly narrowed by the deliberate indifference standard's focus on the subjective motivation of prison officials. Antidiscrimination law, however, offers to expand the Eighth Amendment's conception of adequate medical care by incorporating its principles of nondiscrimination in the provision of health services to disabled persons. Where the Americans with Disabilities Act (ADA), like medical ethics, promotes individualized treatment, adequate medical care for prisoners is recast to guarantee fair treatment for disabled inmates.

When enacted, the ADA responded to a history of unconstitutional treatment against the disabled with a "comprehensive national mandate" to end discrimination.[222] Title II of the ADA prohibits discriminatory denials of public services to disabled persons by any "public entity."[223] State prison systems plainly fall within the statute's definition of "public entity."[224] Moreover, the ADA explicitly requires nondiscrimination in access to health services for current and former drug users.[225] Disability law reflects a consensus against withholding medical care or other services on the basis of an individual's disability, including communicable-disease infection, mental illness, or drug-use status.[226]

The courts have applied a rule of deference to public health authority in enforcement of ADA protections.[227] After an individual establishes disability-based exclusion, the ADA provides a direct-threat defense that releases a public entity from making reasonable accommodations if this would result in significant

222. 42 U.S.C. § 12101(b)(1) (2000). The Americans with Disabilities Act (ADA) prohibits discrimination against anyone with "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such an impairment." *Id.* § 12102(2).

223. *Id.* § 12132.

224. *Id.* § 12131(1)(3); *see also* Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 213 (1998) (holding that ADA Title II protects state prison inmates).

225. *Id.* § 12132; *see also id.* § 12210(c) ("Notwithstanding [ADA sections excluding current illegal drug use from protection], an individual *shall not be denied health services*, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services.") (emphasis added).

226. *See* 28 C.F.R. § 35.130(b)(8) (2005) ("A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."); *see also* Alexander v. Choate, 469 U.S. 287, 300 (1985).

227. *See* Samuel R. Bagenstos, *The Americans with Disabilities Act as Risk Regulation*, 101 COLUM. L. REV. 1479, 1490–1503 (2001).

risk to the health and safety of others[228] or the disabled individual.[229] In analyzing the direct-threat defense, the Court has established that "courts normally should defer to the reasonable medical judgments of public health officials."[230] Deference to public health authority mediates courts' dual concerns for protecting public safety while prohibiting stereotypical judgments that disadvantage the disabled.[231] Just as professional medical standards can indicate a consensus on appropriate care practices, disability law points to public health authority as an accepted societal standard for judging risk-based justifications of institutional policies or practices that exclude the disabled.[232]

Significantly, the ADA complements the Eighth Amendment as a basis for prisoners to challenge inadequate medical care by focusing on discriminatory denials of care.[233] HCV-infected prisoners, in particular, may be able to establish a "qualified disability" and prove discrimination on the basis of HCV status, substance abuse history, or mental illness.[234] The prison policy at issue in *Johnson* is a prime example of a policy ripe for ADA challenge since the ADA prohibits the denial of medical services to former or current drug users. Put simply, the New York state prison policy seems to contravene explicit language of the ADA by unreasonably conditioning the provision of HCV therapy on enrollment in, or completion of, a substance abuse treatment program—effectively granting critical health care to individuals who have never used drugs, while severely limiting health care availability or denying it altogether to current or former drug users. Ultimately, the Eighth Amendment can—and should—be read to require of prisons essentially the same thing as the ADA: adequate care defined in part as nondiscrimination in provision of health services to disabled inmates.[235]

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228. *See* 42 U.S.C. § 12182(b)(3); Bragdon v. Abbott, 524 U.S. 624, 648 (1998); Sch. Bd. of Nassau County v. Arline, 480 U.S. 273, 287 (1987).

229. *See* Chevron U.S.A. Inc. v. Echazabal, 536 U.S. 73 (2002).

230. *Arline*, 480 U.S. at 288.

231. *See* Bagenstos, *supra* note 227, at 1490–1503.

232. *See Bragdon*, 524 U.S. at 650 (noting the "special weight and authority" of public health agencies, including the CDC and the NIH, for evaluating disability exclusions).

233. For a discussion on the complementarity of the ADA and the Eighth Amendment, see generally James C. Harrington, *The ADA and Section 1983: Walking Hand in Hand*, 19 REV. LITIG. 435 (2000).

234. Under ADA Title II, a person is a "qualified individual with a disability" when he is: (1) an individual with a disability; and (2) eligible for the service provided by a public entity. 28 C.F.R. § 35.104 (2006). A prisoner's HCV or other comorbid conditions may establish disability. *See* H. REP. NO. 101-485(II), at 51 (1990); 28 C.F.R. § 35.104(1)(ii); *Chevron*, 536 U.S. at 77 n.2 (finding that defendant did not dispute that HCV and related liver condition established plaintiff's disability).

235. In *United States v. Georgia*, 126 S. Ct. 877 (2006), the Court asked whether ADA Title II validly abrogated the states' Eleventh Amendment sovereign immunity as the statute applies to state prison systems. While holding that Title II was a valid abrogation, the Court stated that Congress's abrogation

3. International Human Rights Law and Adequate Medical Care

The majority in *Roper* affirmed that world opinion, while not controlling, is persuasive authority for U.S. constitutional interpretation: "It does not lessen our fidelity to the Constitution or our pride in its origins to acknowledge that the express affirmation of certain fundamental rights by other nations and peoples simply underscores the centrality of those same rights within our own heritage of freedom."[236] The Court in *Roper* pointed to the national laws of other countries and international covenants that prohibit the juvenile death penalty.[237] Since adequate medical care has been a judicially defined right in the United States, international authorities with particular prohibitions or requirements for the administration of medical care are instructive for defining evolving standards of adequacy.

Several international legal authorities support broader conceptions of adequate medical care than that currently provided under U.S. constitutional interpretation. International law expressly mandates that prisoners receive medical care "of the same quality and standard as is afforded to those who are not imprisoned or detained"[238]—a greater level of protection than required under the deliberate indifference standard. In fact, international authority supports a higher standard of care than the deliberate indifference standard in several particular ways: obligations to screen inmates for diseases immediately upon admission, access to specialists when needed, daily evaluations of sick

power applies solely to "conduct that *actually* violates the Fourteenth Amendment." *Id.* at 882. In a concurring opinion, Justice Stevens explained that the Fourteenth Amendment protects "basic constitutional guarantees," including those provided by the Eighth Amendment. *Id.* at 883 (Stevens, J., concurring) (quoting Tennessee v. Lane, 541 U.S. 509, 522–23 (2004)).

236. Roper v. Simmons, 543 U.S. 551, 578 (2005). Since *Roper* and *Lawrence v. Texas*, 539 U.S. 558 (2003), the appropriate weight of international legal authority has become a central question for an evolving-standards conception of constitutional law. *See* Roger P. Alford, Roper v. Simmons *and Our Constitution in International Equipoise*, 53 UCLA L. REV. 1, 21–23 (2005); Anjuli Willis McReynolds, *What International Experience Can Tell U.S. Courts About Same-sex Marriage*, 53 UCLA L. REV. 1073 (2006). Although the debate is beyond this Comment's scope, that international legal authority shall have some relevant place in defining evolving standards of adequate care is assumed.

237. *Roper*, 543 U.S. at 575–78.

238. Principles of Medical Ethics, G.A. Res. 37/194, at 211, Annex, U.N. GAOR, 37th Sess., Supp. No. 51, U.N. Doc. A/37/51 (Dec. 18, 1982) ("Principle 1: Health personnel . . . have a duty to provide [prisoners] with . . . treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained."); *see also* Basic Principles for the Treatment of Prisoners, G.A. Res. 45/111, at 200, Annex, U.N. GAOR, 45th Sess., Supp. No. 49A, U.N. Doc. A/45/49 (Dec. 14, 1990) ("Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.").

prisoners, and special accommodations for female prisoners.[239] International authority also mandates necessary medical care irrespective of cost.[240]

The Court has viewed the Eighth Amendment right to freedom from cruel and unusual punishment as conditional on society's viewpoint with respect to the proper treatment of prisoners, a highly stigmatized group. This part has advanced the argument that proper treatment of prisoners cannot be disconnected from contemporary standards of adequate medical care, as defined by medical ethics, disability law, and international authority. Not only does this argument suggest that contemporary standards require medical care to meet current standards of care, but also that society is concerned with the public health implications of adequate medical care for prisoners, including the consequences of a failure to provide it.

B. Prisoner Reentry and Public Health Reform of Prisons

When prisoners are viewed in relation to the community, the perspective on prisoners' rights broadens to incorporate a larger spectrum of societal values. Inadequate medical care is both a failure to respect prisoners' individual rights and a failure to address the consequences for the community. This approach conceptualizes the prison not only as a purveyor of punishment, but also as a medical provider, a public health institution, and a part of the community itself. Legal advocacy is charged with articulating this conception of the prison to advance public health reform of prisons.[241]

HCV care has been improved in some prison systems where legal advocacy has focused attention on prison management of the disease. After *Johnson*, New York appropriately abandoned the requirement that former drug users undergo substance abuse treatment.[242] A class action lawsuit in Oregon

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239. Standard Minimum Rules for the Treatment of Prisoners, U.N. Doc. A/CONF/611, at 11, Annex I, E.S.C. res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, U.N. Doc. E/3048 (July 31, 1957), *amended* E.S.C. res. 2076, at 35, U.N. ESCOR, 62nd Sess., Supp. No. 1, U.N. Doc. E/5988 (May 13, 1977).

240. Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, G.A. Res. 43/173, at 298, Annex, U.N. GAOR, 43rd Sess., Supp. No. 49, U.N. Doc. A/43/49 (Dec. 9, 1988) (calling for necessary medical treatments irrespective of financial cost).

241. For a discussion on the role of legal advocacy for advancing public health, see Burris, *supra* note 161, at 332; Jacobi, *supra* note 96, at 469–70; Peter D. Jacobson & Soheil Soliman, *Litigation as Public Health Policy: Theory or Reality?*, 30 J.L. MED. & ETHICS 224, 233–35 (2002).

242. In spite of national guidelines, New York still requires a period of abstinence for current drug users. *See* Memorandum from Lester N. Wright, M.D., MPH, Deputy Comm'r, to Facility Health Servs. Dirs., Re: Hepatitis C Primary Care Practice Guideline (July 20, 2004), *available at* http://hcvinprison.org/new/state_info/newyork_072004.pdf. For a discussion on other prison systems changing HCV prison policy, see Mark Wilson, *Oregon HCV Class Action Settled; Limitations Period for Individual Damage Actions Tolled*, PRISON LEGAL NEWS, Feb. 2005, at 14, *available at*

resulted in a settlement establishing an independent panel of medical professionals to review and revise the state prison system's HCV protocols.[243] And after a federal judge ordered a receivership to oversee reform of California's prison healthcare,[244] California responded to the HCV crisis, likely due to the increased judicial and public scrutiny, by committing resources for screening, testing, and education.[245] The bottom line is that litigation, accompanied by courts' willingness to scrutinize prison policy against Eighth Amendment standards, has the potential not only to enforce constitutional rights, but to mobilize prisons to voluntarily comply with national standards and adopt policies that benefit the public health.[246]

While these are promising developments, legal advocacy enhances the potential to effect public health reform by facilitating the connection between prisoners' health and community health. Prisoner reentry provides a frame that empowers this approach. Prisoner reentry aims to maintain public safety while successfully reintegrating ex-offenders. Viewing the failure to provide care to inmates as a public health problem encourages policy change and mobilizes support for increased resources toward an otherwise invisible constituency.[247] In addition to supporting expanded health services, prisoner reentry focuses attention on the need for discharge planning, providing prisoners with continuity of health services during the critical period of their transition back into the community.[248] Although recognized as necessary, discharge planning remains an underdeveloped public health measure.[249] While HCV legal advocacy has necessarily focused on challenging communicable-disease protocols as barriers to medical care, legal advocacy can advance prison policies, such as discharge planning, by demanding both that prisons provide adequate medical care and that they develop positive steps to address the public health implications of communicable disease in prisons. Advocates

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http://www.prisonlegalnews.org; Bob Williams, *$50,000 HCV Settlement and New Treatment Protocol Approved in Colorado*, PRISON LEGAL NEWS, May 2004, at 7, *available at* http://www.prisonlegalnews.org.

243. *See* State v. Anstett, 884 P.2d 1231 (Or. Ct. App. 2004).

244. *See* Plata v. Schwarzenegger, No. C01-1351TEH, 2005 U.S. Dist. LEXIS 8878 (N.D. Cal. May 10, 2005).

245. *See* Assem. B. 296, 2005 Leg., 2005–2006 Sess. (Cal. 2005).

246. *See* B. JAYE ANNO, CORRECTIONAL HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM 52 (2001), *available at* http://www.nicic.org/pubs/2001/017521.pdf.

247. *See* Golembeski & Fullilove, *supra* note 1, at 1701; Jacobi, *supra* note 96, at 468.

248. *See* Hammett et al., *supra* note 1, at 392–98; 1 NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 98, at 63; Josiah D. Rich et al., *Successful Linkage of Medical Care and Community Services for HIV-Positive Offenders Being Released From Prison*, 78 J. URB. HEALTH 279, 280 (2001).

249. *See* Jacobi, *supra* note 96, at 469–70. Partnerships between prisons and public health agencies have been recommended as a way to coordinate ex-offenders' linkages to healthcare upon release to the community. *See* 1 NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 98, at 64.

should advance these arguments during settlement negotiations in the course of litigation and by actively participating in broader policy discussions that orient prisons toward the reentering prisoners' needs.

Legal advocacy centered on prisoner reentry's commitment to public health reform also suggests the growing viability of a harm-reduction approach to drug policy, aimed at mitigating the health consequences of drug use. Harm reduction represents the public health perspective that a rational drug policy must implement measures aimed at reducing the risk of harm to drug users.[250] In accepting that people use drugs and that the associated dangers of drug use should be minimized, harm reduction diverges from current drug policy's orientation toward "zero tolerance."[251] Instead, harm reduction pursues public health strategies of education, prevention, and treatment to inform drug users about disease transmission risks, encourage use of safe injection practices, and expand access to medical care.[252] For instance, expanding drug-treatment availability is part of harm-reduction philosophy since treatment both reduces the number of injection drug users and, at the very least, educates drug users about safer injection practices.[253] Prisoner reentry discourse's commitment to public health, a commitment that challenges the sustainability of current drug and prison policy, indicates a developing shift of societal values in support of public health reform. Communities, elected officials, and correctional departments can no longer address the connected problems of communicable disease and drug use just by locking it away.

250. *See* Don C. Des Jarlais, *Editorial: Harm Reduction—A Framework for Incorporating Science into Drug Policy*, 85 AM. J. PUB. HEALTH 10, 10–12 (1995).

251. *See* EVA BERTRAM ET AL., DRUG WAR POLITICS 168 (1996). A zero-tolerance drug policy is punitive in nature and imposes often severe penalties for noncompliance. Contrary to harm-reduction policy, zero-tolerance drug policy is predicated on the judgment that drug use is a moral failing that deserves stiff punishment. By identifying drug use as a moral failing and prioritizing punishment over care, zero tolerance fails to address the root causes of use.

252. *See* Des Jarlais, *supra* note 250, at 10–12 (describing a drug policy based on harm reduction as "pragmatic" rather than judgmental).

253. *See* Weber, *supra* note 72, at 641–44. Prisoners' access to drug treatment is widely unavailable even though need remains great; drug treatment works and is cost-effective. *See id.* 800,000 people in prisons need drug treatment, yet only 150,000 receive it. *See* NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUM. UNIV., TRENDS IN SUBSTANCE ABUSE AND TREATMENT NEEDS AMONG INMATES, at VI-3 to VI-8 (Aug. 2002), *available at* http://www.ncjrs.org/pdffiles1/nij/grants/197073.pdf. Also, wider availability of needle exchange programs, proven to reduce the spread of infectious diseases, promotes safer reintegration of prisoners that use drugs after release. The AMA and American Bar Association both have adopted policies calling for the eradication of legal barriers to needle exchange. *See* Letter from Robert E. Stein, Chair, AIDS Coordinating Comm., Am. Bar Ass'n (Jan. 28, 2000), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/36/aba_letter.pdf.

CONCLUSION

In 1991, the U.S. National Commission on AIDS stated that "by choosing mass imprisonment as the federal and state governments' response to use of drugs, we have created a *de facto* policy of incarcerating more and more individuals with HIV infection."[254] Fifteen years later, the same can be said of HCV. HCV in prisons results from a conscious policy choice to incarcerate drug users. As long as drug use is penalized by incarceration, prisons will be incubators of communicable diseases for which drug users have high prevalence rates. Drug users need access to adequate health services. Stereotypical attitudes toward drug users are likely to continue impeding necessary medical care and public health interventions. Furthermore, the rapid growth of prison populations, aging inmates, and rising health care costs will exert increasing pressure on prison health programs with limited resources to meet medical needs.[255]

As HCV prevalence rates rise in the coming decade, courts will persistently be asked to resolve disputes involving the constitutionality of prison medical care and to weigh in on communicable-disease policies with significant public health implications. The deliberate indifference standard, courts' deferential approach to prison management, and medical uncertainties may limit the ability of prisoners' litigation to initiate public health reform. Still, the deliberate indifference standard empowers courts to require that prisons institute evidence-based HCV protocols and apply protocols as guidelines for individualized patient evaluations, rather than as categorical rules of treatment. It remains an open question whether courts will realize that remedial power.

Finally, by framing the expansion of adequate medical care and public health as a question of evolving contemporary values and wise prisoner reentry policy, legal advocacy can improve access to necessary care while advancing prison reform and public education on the HCV crisis. Current drug laws and mass incarceration of drug users are unsustainable criminal justice practices because both policies promote the widespread violation of prisoners' constitutional right to adequate care and undermine public health approaches to drug use and disease. A paradigm shift in drug and prison policy is needed in response.

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254. Ralf Jurgens, *HIV/AIDS and Drug Use in Prisons: Moral and Legal Responsibilities of Prisons*, *in* DRUG USE AND PRISONS: AN INTERNATIONAL PERSPECTIVE 2 (David Shewan & John B. Davies eds., 2000).

255. For a discussion on the link between prison population growth, aging populations, and ethical and financial implications for prison health services, see generally Felicia Cohn, *The Ethics of End-of-Life Care for Prison Inmates*, 27 J.L. MED. & ETHICS 252 (1999).