Hepatitis C Treatment in Prisons: How the Sixth Circuit's Interpretation of the Deliberate Indifference Standard Fails To Protect Healthcare Rights Under the Eighth Amendment*

The conditions within U.S. prisons have long been a concern among human rights advocates and a source of litigation under the Eighth Amendment. While an issue long before COVID-19, the pandemic brought the state of healthcare services in prisons to the public's attention. Many people incarcerated in state and federal prisons suffer from chronic disease, and Hepatitis C is especially widespread. Despite its prevalence, effective treatment for Hepatitis C in prisons is rare, and ample legal hurdles exist to prevent incarcerated people from challenging insufficient treatment. In two recent cases from the Sixth Circuit, the court made it more difficult for incarcerated people with chronic disease to get the care that they need by holding that prisons can deny otherwise widely accepted forms of treatment on the basis of cost. Both cases not only ignore prior holdings to the contrary, but also incentivize prison officials to turn a blind eye to patients' chronic conditions and refuse providing any care or treatment at all. Furthermore, because of the impacts of mass incarceration and the imposition of longer sentences, the Sixth Circuit's decisions will potentially leave people serving long sentences in prison with no means of treating their chronic disease. This Recent Development will address the faults in both the court's analysis of the legal issues involved in these cases, as well as their implications for healthcare and human rights in prisons.

INTRODUCTION

The dismal conditions of the U.S. prison system have raised serious concerns about human rights violations of people who are incarcerated.[1] Particularly alarming, as further brought to light by the COVID-19 pandemic,

1. *See, e.g.*, Ruth Delaney, Ram Subramanian, Alison Shames & Nicolas Turner, *Examining Prisons Today*, VERA INST. JUST. (Sept. 2018), https://www.vera.org/reimagining-prison-web-report/examining-prisons-today [https://perma.cc/F2QC-7PTX]. Throughout this Recent Development, I use person-centered language (i.e., incarcerated person, people in prison, instead of prisoner, inmates, etc.), but many of the sources and cases that I have cited do not. Recent scholarship suggests that using person-first language is critical to overcoming the stigma associated with incarceration as well as with substance use and infectious diseases. *See generally* Brendan L. Harney, Mo Korchinski, Pam Young, Marnie Scow, Kathryn Jack, Paul Linsley, Claire Bodkin, Thomas D. Brothers, Michael Curtis, Peter Higgs, Tania Sawicki Mead, Aaron Hart, Debbie Kilroy, Matthew Bonn & Sofia R. Bartlett, *It Is Time for Us All To Embrace Person-Centred Language for People in Prison and People Who Were Formerly in Prison*, 99 INT'L J. DRUG POL'Y, Jan. 2022, at 1 (arguing that person-centered language "is a much-needed step in efforts to overcome the continued stigma that people in prison face while incarcerated from prison officers and other employees, including healthcare providers").

is the state of healthcare in U.S. prisons.[2] Like many other diseases,[3] the Hepatitis C virus ("Hepatitis C") disproportionately affects prison populations compared to the general population,[4] but it uniquely affects the prison context because of the significant population of those who have Hepatitis C and will be incarcerated at some point during infection.[5] It is estimated that thirty to forty percent of people in prisons in the United States are infected with Hepatitis C,[6] both as a result of being infected before incarceration and contracting the disease during incarceration.[7] Despite ample research on the pervasiveness of Hepatitis C in prisons and how best to prevent and manage infections among prison populations, effective treatment within prisons is rare,[8] with only three to five percent of people in prisons receiving any treatment.[9]

2. *See, e.g.*, Josiah D. Rich, Scott A. Allen & Brie A. Williams, *The Need for Higher Standards in Correctional Healthcare To Improve Public Health*, 30 J. GEN. INTERNAL MED. 503, 503 (2014); Carlos Franco-Paredes, Katherine Jankousky, Jonathan Schultz, Jessica Bernfeld, Kimberly Cullen, Nicolas G. Quan, Shelley Kon, Peter Hotez, Andrés F. Henao-Martínez & Martin Krsak, *COVID-19 in Jails and Prisons: A Neglected Infection in a Marginalized Population*, 14 PLOS NEGLECTED TROPICAL DISEASES 1, 3 (2020).

3. Both chronic and infectious diseases are significantly more common among prison populations than in the general population. LAURA M. MARUSCHAK, MARCUS BERZOFSKY & JENNIFER UNANGST, U.S. DEP'T OF JUST., NCJ 248491, MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES, 2011–12, at 1 (2016). For example, tuberculosis, Hepatitis B and C, HIV, and other infectious diseases are all more prevalent in prison populations than in the general population. *Id.* at 3. Since the beginning of the COVID-19 pandemic, people in prisons have also been at high risk of contracting COVID—"a majority of the largest, single-site outbreaks since the beginning of the pandemic have been in jails and prisons." *The COVID Prison Project Tracks Data and Policy Across the Country To Monitor COVID-19 in Prisons*, COVID PRISON PROJECT (Sept. 27, 2022), https://covidprisonproject.com/#:~:text=People%20who%20live%20in%20correctional,been%20in%20jails%20and%20prisons [https://perma.cc/2XS5-URZT].

4. Howard J. Worman, *Diagnosis and Treatment of Chronic Hepatitis C in Incarcerated Patients*, 10 VIRTUAL MENTOR 102, 102 (2008).

5. *See* Adam L. Beckman, Alyssa Bilinski, Ryan Boyko, George M. Camp, A.T. Wall, Joseph K. Lim, Emily A. Wang, R. Douglas Bruce & Gregg S. Gonsalves, *New Hepatitis C Drugs Are Very Costly and Unavailable to Many State Prisoners*, 10 HEALTH AFFS. 1893, 1893 (2016) ("Nearly one-third of all Americans with hepatitis C spend at least part of the year in a correctional facility.").

6. Robert W. Reindollar, *Hepatitis C and the Correctional Population*, 107 AM. J. MED. 100S, 100S (1999).

7. *Id.*

8. *See, e.g.*, Rosa Zampino, Nicola Coppola, Caterina Sagnelli, Giovanni Di Caprio & Evangelista Sagnelli, *Hepatitis C Virus Infection and Prisoners: Epidemiology, Outcome and Treatment*, 7 WORLD J. HEPATOLOGY 2323, 2324 (2015); Reindollar, *supra* note 6, at 101S–102S.

9. *See* Sanam Hariri, Heidar Sharaf, Mahdi Sheikh, Shahin Merat, Farnaz Hashemi, Fatemeh Azimian, Babak Tamadoni, Rashid Ramazani, Mohammad Mehdi Gouya, Behzad Abbasi, Mehrzad Tashakorian, Ramin Alasvand, Seyed Moayed Alavian, Hossein Poustchi & Reza Malekzadeh, *Continuum of Hepatitis C Care Cascade in Prison and Following Release in the Direct-Acting Antivirals Era*, 17 HARM REDUCTION J. 1, 6 (2020).

Further complicating the issue, the United States has relatively few mechanisms in place for regulating prisons as compared to other countries.[10] Litigation is the primary tool for prison regulation because of the "paralysis of other political avenues for reshaping prison policy in order to produce acceptable prison conditions."[11] Its utility, however, has been severely limited both by courts' current interpretation of Eighth Amendment law[12] and direct measures to reduce prison litigation that have hampered the effectiveness of litigation-based reform.[13]

Two recent prison litigation cases heard in the Sixth Circuit Court of Appeals, *Atkins v. Parker*[14] and *Woodcock v. Correct Care Solutions*,[15] demonstrate both the lack of sufficient healthcare treatment for people at risk of or living with Hepatitis C in prison, as well as the enduring legal challenges that people in prison face even when they do overcome the systemic barriers to presenting their case in front of a judge.[16] While inadequate healthcare claims by people who are incarcerated are rarely successful,[17] these decisions go a step further by

10. *See* Dirk van Zyl Smit, *Regulation of Prison Conditions*, 39 CRIME & JUST. 503, 549 (2010). Germany, for example, has a much more robust system in place for regulating prisons and giving people in prison the ability to raise legal challenges relating to their treatment. *See id.* at 537–38. "Prisoners have a constitutional right to challenge any decision that affects their legal rights before a court," and such claims are first heard in courts that specialize in prison matters. *Id.* at 538. Many Western European countries also have an office of the ombudsman, and although the power and duties of the office vary across countries, it often provides an additional layer of oversight and enforcement of prison regulations. *Id.* at 543–44.

11. *Id.* at 551–52.

12. *Id.* at 552.

13. The Prison Litigation Reform Act, a federal law that "all but foreclosed access to the federal courts for indigent prisoners who previously have filed three non-meritorious complaints," is a significant example of such efforts to reduce the ability of people in prison to succeed in litigation. Joseph T. Lukens, *The Prison Litigation Reform Act: Three Strikes and You're Out of Court—It May Be Effective, but Is It Constitutional?*, 70 TEMP. L. REV. 471, 471 (1997).

14. 972 F.3d 734 (6th Cir. 2020), *cert. denied sub nom.* Atkins v. Williams, 141 S. Ct. 2512 (2021).

15. 861 F. App'x. 654 (6th Cir. 2021). This case, along with several other cases cited in this Recent Development, is an unpublished opinion. Some scholars have noted that as judges' caseloads increase, unpublished opinions have become a tool for them to manage their cases—specifically, it has been postulated that judges route certain types of cases to the unpublished docket that they see as less important; prison litigation has been identified as one of these categories of cases. *See, e.g.*, Marin K. Levy, *Judicial Attention as a Scarce Resource: A Preliminary Defense of How Judges Allocate Time Across Cases in the Federal Courts of Appeals*, 81 GEO. WASH. L. REV. 401, 421 (2013) (finding that the way courts use certain case management techniques, including routing cases to the unpublished docket, creates "two separate and unequal tracks," wherein "judges focus on 'elite cases' and not those involving ordinary citizens"); David A. Hoffman, Alan J. Izenman & Jeffrey R. Lidicker, *Docketology, District Courts, and Doctrine*, 85 WASH. U. L. REV. 681, 719 (2007) (finding that certain case types, including habeas petitions from incarcerated people, were significantly less likely to result in written opinions than on average).

16. *See Atkins*, 972 F.3d at 736–37; *Woodcock*, 861 F. App'x. at 655.

17. In 2015, the success rate for prison civil rights cases in federal district courts was 12.6%—this rate has not gone above 16.7% in any year since 1988. Margo Schlanger, *Trends in Prisoner Litigation as the PLRA Approaches 20*, 28 CORR. L. REP. 69, 84 (2017).

suggesting that prisons can withhold medical treatment solely on the basis of cost[18]—a holding that could have devastating effects on the health and civil rights of people who are incarcerated.

This Recent Development will proceed in four parts: Part I will discuss the constitutional standards for the right to healthcare treatment for people who are incarcerated; Part II will summarize the Sixth Circuit's holdings in *Atkins v. Parker* and *Woodcock v. Correct Care Solutions*; Part III will give background on the issue of Hepatitis C in prisons; Part IV will examine the legal and medical implications of these cases and argue for stronger legal standards for the right to healthcare treatment for people in prison under the Eighth Amendment.

I. LEGAL STANDARDS FOR HEALTHCARE IN PRISONS

The Eighth Amendment's "deliberate indifference" standard governs claims of inadequate medical care for people who are incarcerated.[19] In defining this standard, the Supreme Court said that it "constitutes the 'unnecessary and wanton infliction of pain,'" regardless of "whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed."[20] To be found liable for denying an incarcerated person humane conditions of confinement, the official must "know[] of and disregard[] 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."[21]

To make a successful deliberate indifference claim in the Sixth Circuit, an incarcerated person must show "both that the alleged wrongdoing was objectively harmful enough to establish a constitutional violation and that the official acted with a culpable enough state of mind, rising above gross negligence."[22] This standard requires even more egregious behavior from prison officials than that of other circuits, most of which have not required that the official's conduct surpass gross negligence.[23] The Sixth Circuit has historically given wide deference to the judgment of medical professionals, so that "[a] doctor is not liable under the Eighth Amendment if he or she provides

18. *See Atkins*, 972 F.3d at 740; *Woodcock*, 861 F. App'x at 665 (Stranch, J., concurring in part and dissenting in part).

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

20. *Id.* (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

21. Farmer v. Brennan, 511 U.S. 825, 837 (1994).

22. Rhinehart v. Scutt, 894 F.3d 721, 737 (6th Cir. 2018) (citing *Farmer*, 511 U.S. at 834–35).

23. *See, e.g.*, Vega v. Semple, 963 F.3d 259, 273 (2d Cir. 2020); Gibson v. Collier, 920 F.3d 212, 219 (5th Cir. 2019); Thomas v. Blackard, 2 F.4th 716, 719–20 (7th Cir. 2021).

reasonable treatment, even if the outcome of the treatment is insufficient or even harmful."[24]

The deliberate indifference standard has been criticized for both its ambiguity[25] and its ineffectiveness[26] in protecting the rights of people in prisons. The recent COVID-19 pandemic demonstrated these shortcomings as courts had to grapple with what measures were "reasonable" in light of a novel and highly infectious disease.[27] Even in cases of severe COVID-19 outbreaks in prisons, federal courts accepted any measures taken by prison officials to mitigate the risk as adequate, even where the measures were not effective or even failed to prevent death.[28]

II. RECENT SIXTH CIRCUIT HOLDINGS

Two cases decided by the Sixth Circuit Court of Appeals in 2020 and 2021 both centered on claims made by people living with Hepatitis C in prison, who argued that the prison's system for monitoring and triaging treatment for Hepatitis C violated the Eighth Amendment's "deliberate indifference" standard.[29] These two cases demonstrate how the weakening of this standard has allowed prisons across the country to provide effectively no medical treatment or grossly negligent medical treatment to people who are incarcerated without any constitutional consequences.[30]

A. Atkins v. Parker

In the first case, *Atkins v. Parker*, a group of people who were incarcerated in a Tennessee state prison and infected with Hepatitis C appealed from their rejected claim against the state Department of Corrections, alleging that prison officials "acted with deliberate indifference to the class's serious medical needs

24. *Rhinehart*, 894 F.3d at 738 (citing *Farmer*, 511 U.S. at 834).

25. *See, e.g.*, Michael Cameron Friedman, Comment, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 931 (1992).

26. *See, e.g.*, Jason M. Groth & Sara Wolovick, *Overcoming Deliberate Indifference to the COVID-19 Pandemic*, 5 UTAH J. CRIM. L. 11, 15 (2021).

27. *Id.*

28. *Id.* at 17–18 ("While the efficacy of prison or jail responses do not exclusively determine their reasonableness, they are certainly relevant. As time goes on, we learn more and more about COVID-19: how it spreads, which activities and spaces are highest risk, and which preventative measures do not work. But some courts have ignored this valuable information and refused to grapple with the question of how one determines whether a response to a risk is reasonable. Instead, they assume that any preventive measure a correctional facility takes must be inherently reasonable.").

29. Atkins v. Parker, 972 F.3d 734, 736 (6th Cir. 2020), *cert. denied sub nom.* Atkins v. Williams, 141 S. Ct. 2512 (2021); Woodcock v. Correct Care Sols., 861 F. App'x. 654, 655 (6th Cir. 2021).

30. *See, e.g.*, Reilly v. Vadlamudi, 680 F.3d 617, 624 (6th Cir. 2012) ("Deliberate indifference . . . cannot be predicated on negligence, inadvertence, or good faith error." (citing Whitley v. Albers, 475 U.S. 312, 319 (1986))); Loeber v. Andem, 487 F. App'x. 548, 549 (11th Cir. 2012) ("[N]egligence in diagnosis or treatment, or medical malpractice, without more, fails to state a cognizable deliberate indifference claim." (citing Estelle v. Gamble, 429 U.S. 97, 104 (1976))).

in violation of the Eighth Amendment's prohibition on cruel and unusual punishment."[31] At issue was the prison's protocol for treating patients who had Hepatitis C with direct-acting antivirals ("DAAs"), a type of drug approved by the Food and Drug Administration in 2011 that "halt[s] the progress of hepatitis C and eventually cause[s] the virus to disappear completely."[32] Per the prison's policy, whether an infected patient was treated with the antivirals was left to an advisory committee made up of healthcare professionals and chaired by the prison medical director.[33] Plaintiffs alleged that this "prioritization" approach, which provided treatment with antivirals only for the most advanced cases,[34] violated the Eighth Amendment, and presented evidence that "the best practice is to treat chronic hepatitis C with direct-acting antivirals as early as possible or in a timely manner, regardless of the extent of scarring on a patient's liver."[35]

The Sixth Circuit affirmed the district court's decision, largely on the grounds that the prison medical director's actions did not rise to deliberate indifference because he "sought to employ the finite resources at his disposal to maximize their benefit for the inmates in his care."[36] Essentially, the director's in-depth evaluation of patients infected with Hepatitis C and monitoring of their liver scarring, along with the use of the advisory committee to "make individualized decisions regarding treatment for every infected inmate . . . reflected anything but indifference."[37] The court accepted this argument even though this scheme only led to antiviral treatment for 450 of the 1,374 people who were suffering from advanced Hepatitis C in the Tennessee Department of Corrections at the time of trial.[38]

In his dissent, Judge Gilman criticized the majority's reasoning for both "fail[ing] to consider the serious harm caused by delaying treatment for chronic hepatitis C" and justifying the medical director's decision as reasonable because of the prison's insufficient funding.[39] He pointed to the fact that the prison medical director ignored professional guidance on the treatment of Hepatitis C and delayed treatment for patients with chronic Hepatitis C, "causing precisely the type of 'substantial risk of serious harm' routinely recognized in the Eighth Amendment context."[40] Judge Gilman also argued that the medical director was

31. *Atkins*, 972 F.3d at 736.

32. *Id.*

33. *Id.* at 737.

34. Patients would not be considered for treatment with DAAs until their liver scarring met a severe enough threshold, at which point they were given a "priority level" for drugs and essentially were in line for treatment, behind the other patients with severe scarring. *See id.* at 737–38.

35. *Id.* at 738 (internal quotations omitted).

36. *Id.* at 740.

37. *See id.*

38. *Id.* at 742 (Gilman, J., dissenting).

39. *Id.* at 740.

40. *Id.* at 741 (quoting Farmer v. Brennan, 511 U.S. 825, 837 (1994)) (citation omitted).

"obviously aware" of the risk of death from Hepatitis C because he "has seen 81 inmates die from hepatitis C since direct-acting antivirals became available."[41] However, since this decision, federal district courts across the Sixth Circuit have relied on the majority's reasoning in *Atkins* to hold that prisons are not obligated to provide efficacious treatment for people who are incarcerated and diagnosed with Hepatitis C.[42] *Atkins* also means that any future outbreaks of infectious diseases will be subject to this same standard unless a state legislature mandates testing and treatment of specific diseases.[43]

B. Woodcock v. Correct Care Solutions

Less than one year later, the Sixth Circuit came to a similar conclusion in *Woodcock v. Correct Care Solutions*.[44] In that case, the plaintiffs included 1,200 people who were incarcerated and diagnosed with Hepatitis C in Kentucky state prisons.[45] They brought a similar claim against prison officials under the Eighth and Fourteenth Amendments on the grounds that defendants "acted with deliberate indifference to their serious medical needs," along with other federal and state law claims.[46] Their argument centered on the prison's treatment plan, which, like the protocol in *Atkins*, screened and monitored patients.[47] However, because the plan only "treat[ed] with [antivirals] those inmates in serious need of immediate antiviral treatment," it did not alleviate or cure them of Hepatitis C.[48]

The court found no constitutional violation and reasoned that the plan did not put the plaintiffs "at substantial risk of serious harm," thus "they [could not] show that [d]efendants were deliberately indifferent."[49] The court also asserted that the Kentucky Department of Corrections ("KDOC") was "provid[ing] treatment for Plaintiffs that consisted of several protocols to diagnose and monitor [Hepatitis C] inmates and ultimately administer the expensive DAA

41. *Id.* at 742.

42. *See, e.g.*, Johnson v. Peterson, No. 3:18-cv-331, 2022 U.S. Dist. LEXIS 57556, at *6 (N.D. Ohio Mar. 29, 2022) (citing *Atkins*, 972 F.3d at 739); McAllister v. Maier, No. 5:20-cv-2556, 2022 U.S. Dist. LEXIS 39099, at *6 (N.D. Ohio Mar. 4, 2022) (citing *Atkins*, 972 F.3d at 736–40); Bower v. Aiken, No. 2:21-cv-226, 2022 U.S. Dist. LEXIS 33732, at *12 (W.D. Mich. Feb. 25, 2022) (citing *Atkins*, 972 F.3d at 736).

43. *See, e.g.*, 10A N.C. ADMIN. CODE 41A.0205(b)(3) (2022) (mandating testing for tuberculosis for anyone in the custody of the Department of Public Safety or the Division of Adult Correction).

44. Woodcock v. Correct Care Sols., 861 F. App'x. 654, 655 (6th Cir. 2021).

45. *Id.*

46. *Id.* at 657. Plaintiffs also brought claims under the Americans with Disabilities Act and the Rehabilitation Act of 1978 for failure to reasonably accommodate their medical needs, as well as state-law tort claims of negligence, gross negligence, and intentional infliction of emotional distress. *Id.*

47. *Id.* at 660–61.

48. *Id.*

49. *Id.* at 661.

treatments to those in immediate need."[50] Therefore, the court found, the KDOC is not obliged to provide direct-acting antivirals to people in prison with Hepatitis C.[51]

The dissenting opinion focused on the majority's disregard for accepted standards of treatment for Hepatitis C and argued that there was enough evidence for a jury to conclude that the provided "treatment" was constitutionally inadequate.[52] Specifically, the dissent relied on evidence showing that the defendants knew the long-term risks of Hepatitis C infection, that DAAs were the medically recommended treatment option, and that the defendants still chose not to administer DAAs because of their cost.[53] Judge Stranch, like the dissenting judge in *Atkins*, also argued that "it is an impermissible decision to avoid providing 'the only effective treatment' to most inmates on the sole basis that rationing care is 'easier' and cheaper."[54] Indeed, Judge Stranch found that the KDOC's decision "not to administer DAAs to all inmates because of the cost of the drugs" was not a medical decision that could be granted deference because "a lack of funding is no excuse for a constitutional violation."[55]

III. HEPATITIS C IN PRISONS

Hepatitis C has been identified as a major healthcare issue in U.S. prisons,[56] exposing the inadequacy of prison healthcare and prison healthcare's applicable legal standards. When Hepatitis C was first recognized in correctional facilities in the 1990s, between twelve and thirty-five percent of people in prisons were already infected.[57] Hepatitis C is a viral liver infection spread through contact with blood from an infected person.[58] "For some people, hepatitis C is a short-term illness, but for more than half of people who become infected with the hepatitis C virus, it becomes a long-term, chronic infection" that "can result in serious, even life-threatening health problems like cirrhosis and liver cancer."[59] However, over ninety percent of people infected with

50. *Id.* at 660.

51. *See id.* at 660–61.

52. *See id.* at 662 (Stranch, J., concurring in part and dissenting in part).

53. *See id.* at 665.

54. *Id.* (quoting Darrah v. Krisher, 865 F.3d 361, 372 (6th Cir. 2017)).

55. *Id.* (citing Atkins v. Parker, 972 F.3d 734, 742–46 (6th Cir. 2020) (Gilman, J., dissenting), *cert. denied sub nom.* Atkins v. Williams, 141 S. Ct. 2512 (2021)).

56. *See* Rich et al., *supra* note 2, at 503.

57. *Id.*

58. *Hepatitis C*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 28, 2020), https://www.cdc.gov/hepatitis/hcv/index.htm [https://perma.cc/P6A9-U9T8].

59. *Id.*

Hepatitis C can be cured of their infection with eight to twelve weeks of oral therapy, consisting of a pill typically taken once daily.[60]

A. *Means of Transmission and Stigma*

In both the prison system and the community at large, Hepatitis C is most often transmitted through the sharing of needles or other equipment used to prepare and inject drugs.[61] Those who are most at risk for contracting Hepatitis C—medically underserved and minority populations, people who use injection drugs or abuse alcohol, and people with multiple sex partners—are often concentrated within prison populations.[62] In fact, nearly a third of all Americans with Hepatitis C spend time in a correctional facility in any given year.[63] Additionally, a history of incarceration is considered a risk factor for Hepatitis C.[64] In the prison context, incidence of Hepatitis C is often seen as a sign of drug use.[65] Thus, people who are incarcerated who have Hepatitis C are severely stigmatized both as people living with addiction and people with criminal convictions.[66]

This compounded stigma has implications for how people with Hepatitis C are treated in prison settings, "afford[ing] prison officers another means by which differences between prisoners can be further classified and stigmatised in the service of power."[67] Prison officials often use the stigma of Hepatitis C as "a pretext for additional levels of surveillance and disciplinary attention" such as "the authorisation of strip-searches, cell raids, threatened disclosures to family members and so forth."[68] Indeed, stigma is at the forefront of the *Woodcock* opinion—the majority starts their discussion of the disease by saying that Hepatitis C "is a bloodborne virus commonly spread by sharing contaminated needles, using unsterilized tattoo equipment, and engaging in sexual behavior," emphasizing the "deviant" behaviors that stigmatize

60. *Overview and Statistics*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 28, 2020), https://www.cdc.gov/hepatitis/hcv/cfaq.htm#overview [https://perma.cc/NWP5-PBHK].

61. *See* Reindollar, *supra* note 6, at 101S; *Hepatitis C*, *supra* note 58. Hepatitis C can also spread through sex with an infected person, sharing personal items—such as toothbrushes—with an infected person, unregulated tattooing, or various invasive healthcare procedures. *Hepatitis C Questions and Answers for Health Professionals*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 7, 2020), https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#b1 [https://perma.cc/C8L4-H5DD].

62. *See* Reindollar, *supra* note 6, at 100S–101S.

63. Beckman et al., *supra* note 5, at 1893.

64. *Hepatitis C*, MAYO CLINIC (2021), https://www.mayoclinic.org/diseases-conditions/hepatitis-c/symptoms-causes/syc-20354278 [https://perma.cc/8U2N-YNH2].

65. *See* Jake Rance, Lise Lafferty & Carla Treloar, *'Behind Closed Doors, No One Sees, No One Knows': Hepatitis C, Stigma and Treatment-As-Prevention in Prison*, 30 CRITICAL PUB. HEALTH 130, 131 (2020).

66. *See id.* at 136. Stigma is recognized as a "core feature" of living with Hepatitis C, largely because of its enduring association with drug use. *Id.* at 131.

67. *Id.* at 136.

68. *Id.*

individuals who contract Hepatitis C, implying they are less worthy of expensive medical treatment.[69] Research suggests that some states even use a person's likelihood of recidivism or of engaging in risky behaviors as factors in determining whether or not to treat them in their prison facilities,[70] further indicating the harmful role that stigma plays in the lives of those living with Hepatitis C in prison.

B. *Intersections with Race and Mass Incarceration*

The issue of Hepatitis C in prisons also intersects with the broader issues of mass incarceration and racial justice, both because of the criminalization of drug addiction and the overrepresentation of Black people in prisons.[71] The "war on drugs,"[72] for example, has "implicitly targeted [Black, indigenous, people of color] individuals and led to higher conviction rates of Blacks for drug possession, [and has] exacerbate[d] these disparities by shunting people of color into jails and prisons rather than treatment, where the cycle of poor health continues."[73] In a review of studies on the prevalence of Hepatitis C in correctional settings, researchers found that the greatest numbers of people with Hepatitis C antibodies were members of racial or ethnic minority groups.[74]

Since the justifications for denying healthcare treatment to people who are incarcerated in *Atkins* and *Woodcock* included the cost of such care,[75] it is worth

69. *See* Woodcock v. Correct Care Sols., 861 F. App'x. 654, 655 (6th Cir. 2021).

70. Beckman et al., *supra* note 5, at 1897. In this study, twelve states reported that likelihood of reinfection, for example, as indicated by likelihood of engaging in risky behaviors, played a role in determining which patients were higher priority for Hepatitis C treatment. *Id.* This suggests that prison officials can use subjective opinions about someone's likelihood of continuing to use drugs, or engaging in other risky behaviors, as a justification for not treating their medical condition.

71. *See* Reindollar, *supra* note 6, at 101S ("Approximately 60% of federal prisoners and 25% of state prisoners are incarcerated for drug-related crimes."); Ashley Nellis, *The Color of Justice: Racial and Ethnic Disparity in State Prisons*, SENT'G PROJECT 4 (Oct. 13, 2021), https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/ [https://perma.cc/B5WF-HX3W] ("Black Americans are incarcerated in state prisons at nearly 5 times the rate of white Americans.").

72. The "war on drugs" refers to the antidrug policies and law enforcement practices originally put in place by the Reagan Administration in the 1980s and the variations on these policies that continued under subsequent administrations. Kenneth B. Nunn, *Race, Crime and the Pool of Surplus Criminality: Or Why the "War on Drugs" Was a "War on Blacks*," 6 J. GENDER RACE & JUST. 381, 386–87 (2002). These policies and practices have directly led to the disproportionate and mass incarceration of Black men. *Id.* at 392–93.

73. Lindsey A. Vandergrift & Paul P. Christopher, *Do Prisoners Trust the Healthcare System?*, 9 HEALTH & JUST. J. 1, 2 (2021).

74. Sarah Larney, Nickolas D. Zaller, Dora M. Dumont, Andrew Willcock & Louisa Degenhardt, *A Systematic Review and Meta-Analysis of Racial and Ethnic Disparities in Hepatitis C Antibody Prevalence in United States Correctional Populations*, 26 ANNALS EPIDEMIOLOGY 570, 577 (2016).

75. *See* Atkins v. Parker, 972 F.3d 734, 736–37 (6th Cir. 2020) ("In 2016, the efficacy—and cost—of direct-acting antivirals prompted the Department of Corrections to implement a treatment policy for hepatitis-C infected inmates."), *cert. denied sub nom.* Atkins v. Williams, 141 S. Ct. 2512 (2021);

noting that rising prison populations and longer sentences have both contributed to the skyrocketing of prison healthcare costs. This is because "[l]onger sentences and a decline in the number of prisoners granted parole [have] led to a generation of prisoners who would grow old behind bars," and "[o]lder prisoners consume more medical services because many have chronic diseases, disabilities, and greater vulnerability to injury and infection."[76] Thus, the criminal punishment system is incarcerating more people for longer. However, at the same time, the system refuses to invest additional money into providing adequate healthcare, creating a dearth of critical healthcare services available to people in prison, as demonstrated in these two cases.

C. *Treatment Within Prisons*

Notwithstanding the established effectiveness of DAAs in treating Hepatitis C, they are rarely the most common treatment for people living with Hepatitis C in prisons. As the dissenting judge in *Woodcock* pointed out, DAAs are the recommended and accepted treatment for Hepatitis C according to several health agencies, including the Centers for Disease Control, the Centers for Medicare & Medicaid Services, the Veteran's Administration, and multiple state Medicaid systems, including Kentucky's.[77] As a result of "the increased risk to life posed by late treatment, the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America . . . recommend administering DAAs—which are highly efficacious and nearly side-effect-free—to most patients with chronic Hepatitis C *without regard to their degree of fibrosis*."[78] In fact, "[n]o other treatment is recommended."[79] Ironically, because DAAs are the accepted and standard treatment for Hepatitis C, had the same patients gone to a doctor outside of prison, with the same level of scarring, they very likely would have received DAAs, even if they were using Medicaid to pay for them.[80] Ultimately, the state will end up paying for treatment either way, it is just a matter of when.[81] The state can therefore either pay for treatment when patients are in the early stages of the virus, or when they become sicker and

Woodcock v. Correct Care Sols., 861 F. App'x. 654, 660 (6th Cir. 2021) ("The 2018 [Hepatitis C] Treatment Plan provided treatment for Plaintiffs that consisted of several protocols to diagnose and monitor [Hepatitis C] inmates and ultimately administer the expensive DAA treatments to those in immediate need.").

76. Joel H. Thompson, *Today's Deliberate Indifference: Providing Attention Without Providing Treatment to Prisoners with Serious Medical Needs*, 45 HARV. C.R.-C.L. L. REV. 635, 638–39 (2010).

77. *Woodcock*, 861 F. App'x. at 663 (Stranch, J., concurring in part and dissenting in part).

78. *Id.* at 663 (emphasis added).

79. *Id.*

80. Zia Sherrell, *Will Medicaid Pay for Hepatitis C Treatment?*, MED. NEWS TODAY (May 30, 2022), https://www.medicalnewstoday.com/articles/will-medicaid-pay-for-hep-c-treatment [https://perma.cc/HYV3-EX4S].

81. *Id.*

develop complications that make treatment more expensive and likely less effective.[82]

Despite this widely accepted recommendation, the use of DAAs is not standard practice in most prisons. Three-quarters of state prisons do not even screen for Hepatitis C or test those who report high-risk behavior, likely leading to many missed cases.[83] Furthermore, although testing for Hepatitis C can be costly, research shows that it is ultimately cost-effective and could prevent 4,200 to 11,700 liver-related deaths, 300 to 900 liver transplantations, 3,000 to 8,600 cases of hepatocellular carcinoma, and 2,600 to 7,300 cases of decompensated cirrhosis in the next thirty years.[84] Research also suggests that Hepatitis C "screening in correctional settings may have an additional benefit of impacting on community-level health disparities," an impact that "can be maximized through provision of antiviral therapy in correctional settings, or for short-term detainees, development of referral pathways for treatment after release."[85]

In fact, prisons "can be the ideal environment to provide hepatitis C treatment" because "[m]edication adherence levels within corrections can usually exceed those in the community" due to the structure and resources of the prison system that may not be available for patients outside of prison.[86] Precisely because of the high prevalence of Hepatitis C in prison settings, prisons present a unique public health opportunity for mitigation—"scaling up DAA treatment in these settings can have a major impact on reducing [Hepatitis C] incidence and prevalence in communities," and could play a major role in eradicating Hepatitis C in the United States.[87] This is in part because

82. *See generally* Janet Weiner & Benjamin P. Linas, *Cost-Effective Screening and Treatment of Hepatitis C*, LEONARD DAVID INST. HEALTH ECON. (LDI)/CTR. FOR HEALTH ECON. TREATMENT INTERVENTIONS FOR SUBSTANCE USE DISORDER, HCV, & HIV (CHERISH) (Sept. 14, 2018), https://ldi.upenn.edu/our-work/research-updates/cost-effective-screening-and-treatment-of-hepatitis-c [https://perma.cc/6KVG-UW83] ("[T]reating early disease is likely cost-effective, and may even be cost-saving, because it prevents many years of decreased quality of life and increased health care costs associated with [Hepatitis C] infection.").

83. Tianhua He, Kan Li, Mark S. Roberts, Anne C. Spaulding, Turgay Ayer, John J. Grefenstette & Jagpreet Chhatwal, *Prevention of Hepatitis C by Screening and Treatment in U.S. Prisons*, 164 ANNALS INTERNAL MED. 84, 84 (2016).

84. *Id.* at 87. Chronic liver disease and cirrhosis cause 51,642 deaths in the United States each year. *Chronic Liver Disease and Cirrhosis*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 6, 2022), https://www.cdc.gov/nchs/fastats/liver-disease.htm [https://perma.cc/X5TC-YDGC]. More than 6,000 liver transplantations are performed every year, and at least 1,700 patients die each year waiting for a transplantation. *Living Donor Liver Transplant*, JOHNS HOPKINS MED. (2022), https://www.hopkinsmedicine.org/transplant/programs/liver/living-donor-liver-transplant/ [https://perma.cc/V3DL-9U7T].

85. Larney et al., *supra* note 74, at 577.

86. Lara B. Strick & Maria A. Corcorran, *Treatment of HCV in a Correctional Setting*, HEPATITIS C ONLINE 5 (2021), https://www.hepatitisc.uw.edu/go/key-populations-situations/treatment-corrections [https://perma.cc/8J7B-FXSS].

87. *Id.* at 8.

more than ninety percent of people in state prisons will eventually be released.[88] Thus, those who enter prison with Hepatitis C or contract it within prison and are not treated will re-enter the community infected.

IV. IMPLICATIONS OF "DELIBERATE INDIFFERENCE"

Prior case law rejects the notion that medical treatment can be withheld from people in prisons solely because of cost. The Sixth Circuit has previously held that "a prisoner who is needlessly allowed to suffer pain when relief is readily available does have a cause of action against those whose deliberate indifference is the cause of his suffering."[89] Despite the finding of the majorities in both *Atkins* and *Woodcock* that the prison's financial limitations preclude any other outcome, the Sixth and other federal circuits have previously identified constitutional violations in similar circumstances under the deliberate indifference standard.[90]

A. *Sixth Circuit Deliberate Indifference Cases*

Only a few years before *Atkins* and *Woodcock*, the Sixth Circuit considered a claim that a prison's treatment for a severe form of psoriasis was essentially no treatment because the drug given was ineffective.[91] The court permitted a jury to determine whether giving the ineffective drug constituted deliberate indifference.[92] The plaintiff argued that prison officials gave him the less effective drug "solely" because the other drug was more expensive, and that the "use of a non-medical factor as the sole reason for that determination was improper."[93] The court agreed, "recogniz[ing] that prisons have legitimate reasons to be concerned with the cost of medical treatment for inmates," but that because the defendants knew that the more expensive drug had treated the plaintiff effectively and instead chose a "less efficacious treatment option," they disregarded a serious risk of harm that could have amounted to deliberate indifference.[94] The court explained that "when prison officials are aware of a prisoner's obvious and serious need for medical treatment and delay medical

88. NATHAN JAMES, CONG. RSCH. SERV., RL34287, OFFENDER REENTRY: CORRECTIONAL STATISTICS, REINTEGRATION INTO THE COMMUNITY, AND RECIDIVISM 1 (2015).

89. Westlake v. Lucas, 537 F.2d 857, 860 (6th Cir. 1976).

90. *See infra* notes 91–103 and accompanying text.

91. Darrah v. Krisher, 865 F.3d 361, 370 (6th Cir. 2017) ("[The plaintiff] argues that Defendants were deliberately indifferent by insisting on prescribing Methotrexate while knowing that Soriatane was the only drug that had proven effective for his [medical condition].").

92. *Id.*

93. *Id.* at 372.

94. *Id.* at 372–73 (internal quotations omitted).

treatment of that condition for non-medical reasons, their conduct in causing the delay creates a constitutional infirmity."[95]

In another case, the Sixth Circuit came to the same conclusion when an incarcerated person had a severe toothache caused by a dental cavity that was not treated for over seven months, during which time he was only treated with ibuprofen.[96] The court said this treatment was not enough to defeat a claim of deliberate indifference because a reasonable jury "could find, based on other evidence in the record, that Dr. Place disregarded a risk of serious harm when he failed to temporarily fill McCarthy's cavity despite the fact that he knew of the pain McCarthy was experiencing and that he was familiar with more effective treatment options."[97]

B. *Deliberate Indifference in Other Circuits*

Other circuits have also rejected the Sixth Circuit's reasoning in *Atkins* and *Woodcock*. In a nearly identical case, the Third Circuit found facts sufficient to establish an Eighth Amendment deliberate indifference claim where a plaintiff "alleged that he did not receive *any* treatment for his Hepatitis C condition, that he was not placed on a newly developed Hepatitis C treatment regimen *solely* because it was cost-prohibitive, and that he was suffering medical complications as a result."[98] The court relied on a similar case from the Seventh Circuit, where four plaintiffs asserted claims of deliberate indifference after receiving no treatment for their Hepatitis C during their incarceration.[99] The court explained that "administrative convenience and cost may be, in appropriate circumstances, *permissible factors* for correctional systems to consider in making treatment decisions, [but] the Constitution is violated when they are considered to the exclusion of *reasonable medical judgment about inmate health*."[100] The Second Circuit reached a similar conclusion in a case where the plaintiff claimed he was denied treatment for Hepatitis C.[101] These circuit splits suggest that the Sixth Circuit's conclusion in *Atkins* and *Parker* was not the only possible

95. *Id.* at 370, 372 (internal quotations and alterations omitted) (quoting Blackmore v. Kalamazoo Cnty., 390 F.3d 890, 899 (6th Cir. 2004)).

96. *See* McCarthy v. Place, 313 F. App'x 810, 811, 814 (6th Cir. 2008).

97. *Id.* at 816.

98. Allah v. Thomas, 679 F. App'x 216, 220 (3d Cir. 2017) ("Here, [the plaintiff] alleged that he did not receive any treatment for his Hepatitis C condition, that he was not placed on a newly developed Hepatitis C treatment regimen solely because it was cost-prohibitive, and that he was suffering medical complications as a result. Accepting these allegations as true, we conclude that Allah plausibly alleged an Eighth Amendment violation.").

99. *See* Roe v. Elyea, 631 F.3d 843, 850–53 (7th Cir. 2011).

100. *Id.* at 863 (emphasis in original).

101. *See* McFadden v. Noeth, 827 F. App'x 20, 27 (2d Cir. 2020) (finding that a plaintiff sufficiently alleged that defendants treated him with deliberate indifference because they knew the risk of leaving him untreated but nonetheless completely deprived him of treatment).

outcome—other circuits have come to the opposite conclusion with very similar facts.

C. *The Sixth Circuit's New Loophole for Denial of Medical Care*

In addition to case law from across the country supporting a different holding than those in *Atkins* and *Woodcock*, there are also issues with both the deliberate indifference standard and how the Sixth Circuit has applied it. Previous case law further suggests that the conclusion the Sixth Circuit came to in *Atkins* and *Woodcock* has no basis in precedent—the court itself held in 2017 that prison officials may not delay medical treatment for nonmedical reasons.[102] But the prison officials in Tennessee and Kentucky were doing exactly that—delaying medical treatment that they knew to be more effective than solely monitoring patients' conditions because of the cost of the treatment.[103] In doing so, they ignored widely accepted standards of care and caused years of additional suffering and liver scarring to thousands of incarcerated people living with chronic Hepatitis C, "despite the availability of early treatment with effective, easily tolerated alternatives that would prevent those long-term harms."[104]

The court in *Woodcock* in part relies on the distinction between the ongoing treatment and no-treatment standards, and ultimately decided that the defendants in that case were providing ongoing treatment based on the screening and monitoring procedures they employed.[105]

Under the no-treatment standard, when a physician diagnoses a serious medical need, "the plaintiff can establish the objective component by showing that the prison failed to provide treatment."[106] Alternatively, under the ongoing-treatment standard, a plaintiff can establish the objective component by showing that the treatment was so grossly incompetent, inadequate, or excessive as to shock the conscience or was intolerable to fundamental fairness.[107]

Thus, if the holdings in *Atkins* and *Woodcock* are followed, merely testing for a condition can be considered "ongoing treatment," creating a situation where "[i]f the provider has taken any action at all, a court may not be willing to find deliberate indifference."[108] This means that merely testing for Hepatitis C or monitoring patients who come into prison already infected could be

102. *See* Darrah v. Krisher, 865 F.3d 361, 372 (6th Cir. 2017).

103. *See supra* Part II.

104. Woodcock v. Correct Care Sols., 861 F. App'x. 654, 663 (6th Cir. 2021) (Stranch, J., concurring in part and dissenting in part).

105. *See id.* at 660.

106. *Id.* (internal quotations omitted) (quoting Rhinehart v. Scutt, 894 F.3d 721, 737–38, 740 (2018)).

107. *Id.*

108. Thompson, *supra* note 76, at 650.

enough to pass constitutional muster, even though neither of these measures actually lessen the disease's harmful effects.

In fact, this interpretation of the deliberate indifference standard may encourage prison officials to do even less. Both because the court has created a subjective standard for deliberate indifference, where prison officials must actually know of and consciously disregard a substantial risk to the incarcerated person,[109] and because the deliberate indifference standard requires so little in the way of actual treatment, prison officials are incentivized to not test people who are incarcerated or to perform only minimal testing to avoid liability.[110] Empirical data supports this theory: thirty-eight percent of people in state prisons report a "persistent medical condition," twenty percent of whom report that "the condition was not examined by medical personnel."[111] Thus, prison officials that "employ practices that functionally deny adequate care while appearing to address the medical concerns that prisoners have" can avoid liability under the Eighth Amendment.[112]

This appears to be the prevailing norm—a study of treatment standards in prisons found that less than one percent of people who were incarcerated with known Hepatitis C were receiving *any* form of treatment for the virus.[113] Following these two cases, prisons within the Sixth Circuit will be even more empowered to deny care for nonmedical reasons, and for cost-related reasons specifically. This serves to further weaken a standard for prison healthcare that, as the COVID-19 pandemic and the spread of other deadly diseases in prisons indicates, should be strengthened.

V. CONCLUSION

The prison litigation system is designed to limit incarcerated peoples' constitutional claims, but even if a claim is successfully made, Eighth Amendment rights are far from guaranteed. *Atkins* and *Woodcock* reveal a disturbing trend of unfettered judicial deference to prison officials under the deliberate indifference standard to withhold critical and effective healthcare from people in prison for nonmedical reasons. The case of Hepatitis C offers a

109. *See* Atkins v. Parker, 972 F.3d 734, 740–41 (2020) (Gilman, J., dissenting), *cert. denied sub nom.* Atkins v. Williams, 141 S. Ct. 2512 (2021).

110. Thompson, *supra* note 76, at 642–43 ("By not testing, a prison medical provider avoids knowledge of a condition that may require treatment and thereby minimizes treatment costs. . . . By performing at least one test, a prison medical provider can claim to be providing adequate treatment, even when the test does not provide any answers.").

111. David L. Rosen, Wizdom P. Hammond, David A. Wohl & Carol E. Golin, *Disease Prevalence and Use of Health Care Among a National Sample of Black and White Male State Prisoners*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 254, 255 (2012).

112. Thompson, *supra* note 76, at 652.

113. Beckman et al., *supra* note 5, at 1896 (reporting that 949 of the 106,266 (0.89%) inmates with known Hepatitis C were receiving any form of treatment).

unique opportunity for prisons to implement public health solutions with effects that could be felt in the larger community. The court-sanctioned denial of medical treatment for people living with Hepatitis C in prison is not only morally defunct, but will ultimately increase healthcare costs when patients are unable to get the care they need and their conditions worsen. If these two cases stand, prison officials will be further empowered to justify their denial of healthcare based on the prison system's limited financial resources. While the Eighth Amendment prohibits cruel and unusual punishment, this constitutional right continues to be gutted by federal courts across the country. With these cases, the Sixth Circuit, in contravention of both legal precedent and established medical protocols, is complicit in further weakening the right to healthcare for people who are incarcerated.

KATIE M. DEANGELIS**

** I would like to thank the entire board and staff of the *North Carolina Law Review* for all of the time and effort they put into the editing and publication of this piece. To my primary editor, Keegan Pace, thank you so much for your thoughtful edits and suggestions at every stage of the editing process. I am also deeply grateful to Professor Kathryn Sabbeth for her support in my early stages of writing this piece, and to Professor Em Seawell for their invaluable insights and comments, as well as for their endless advocacy on behalf of both marginalized law students and incarcerated people. To all the others who have shown me support and grace throughout this process, thank you—I could not have done it without you.