

## *Atkins v. Parker*. Maximizing Treatments in a "Cruel World" of Limited Resources or Minimizing Constitutional Rights

Emily McGowan

Follow this and additional works at: <https://digitalcommons.law.umaryland.edu/jhclp>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Emily McGowan, *Atkins v. Parker: Maximizing Treatments in a "Cruel World" of Limited Resources or Minimizing Constitutional Rights*, 25 J. Health Care L. & Pol'y 313 (2022).

Available at: <https://digitalcommons.law.umaryland.edu/jhclp/vol25/iss2/6>

This Notes & Comments is brought to you for free and open access by the Academic Journals at DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized editor of DigitalCommons@UM Carey Law. For more information, please contact [smccarty@law.umaryland.edu](mailto:smccarty@law.umaryland.edu).

***ATKINS v. PARKER: MAXIMIZING TREATMENT IN A “CRUEL  
WORLD” OF LIMITED RESOURCES OR MINIMIZING  
CONSTITUTIONAL RIGHTS?***

EMILY MCGOWAN\*

In *Atkins v. Parker*, the Sixth Circuit addressed whether the chief medical director of the Tennessee Department of Corrections (TDOC) was liable for deliberate indifference to inmates’ chronic hepatitis C (HCV) needs under his overhauled 2019 HCV Guidance.<sup>1</sup> In sole consideration of whether the chief medical director’s failure to provide direct-acting antivirals (DAAs) to every infected inmate in the Tennessee system violated the Eighth Amendment, the Court held that the chief medical director’s 2019 HCV Guidance sought to best maximize treatment in a world of “finite” resources, and thus did not violate the Eighth Amendment.<sup>2</sup> By upholding the TDOC prioritization scheme, the Sixth Circuit incorrectly disregarded the serious medical needs of prisoners and modern professional medical guidance.<sup>3</sup> The Court has also dangerously signaled that state prisons that prioritize HCV treatment amongst prisoners due to funding restrictions will likely prevail against an Eighth Amendment claim using an inadequate resources defense.<sup>4</sup> In response, state legislatures must take action to protect the health and safety of their incarcerated populations.<sup>5</sup>

I. THE CASE

*Atkins v. Parker* is a class action suit of Tennessee prisoners who challenged TDOC policies concerning the medical treatment for state inmates diagnosed with HCV.<sup>6</sup> The class sued two TDOC officials, the Commissioner,

---

©2022 Emily McGowan

\* J.D. 2022, University of Maryland Francis King Carey School of Law. I would like to thank the editors from the *Journal of Health Care Law and Policy* for their extensive review and constructive feedback. I dedicate this Note to my family and friends for their enthusiasm, encouragement, and support throughout this journey.

1. *Atkins v. Parker*, 972 F.3d 734, 736–37 (6th Cir. 2020), *cert. denied sub nom. Atkins v. Williams*, 141 S. Ct. 2512 (2021) (mem.).

2. *Id.* at 739–40.

3. *See infra* Section IV.A.

4. *See infra* Section IV.B.

5. *See infra* Section IV.C.

6. *Atkins v. Parker*, 412 F. Supp. 3d 761, 764 (M.D. Tenn. 2019), *aff’d*, 972 F.3d 734 (6th Cir. 2020).

Tony Parker, and the Medical Director, Dr. Kenneth Williams (Dr. Williams).<sup>7</sup> The plaintiffs alleged that the “officials acted with deliberate indifference to the class’s serious medical needs in violation of the Eighth Amendment’s prohibition on cruel and unusual punishment.”<sup>8</sup> This section will first provide background information on HCV and explain the current medical standard for treatment.<sup>9</sup> Then, this section will explain the changes in TDOC HCV policies, which occurred after the prisoners initiated litigation.<sup>10</sup> Finally, the section will briefly summarize the lower court’s holding.<sup>11</sup>

### A. Background Information on HCV

HCV is a progressive virus that spreads through contact with bodily fluids containing contagious blood.<sup>12</sup> It can cause two types of infections—acute or chronic.<sup>13</sup> When the infection is acute, a person may have symptoms for up to six months, but the person’s body is able to fight off the infection.<sup>14</sup> If the body does not fight off the infection after six months, the infection becomes chronic.<sup>15</sup> Although some infected persons recover from an acute infection, about 75 to 85% of people will develop chronic HCV and, unless treated, may remain infected for life.<sup>16</sup>

Over time, the virus progressively scars the liver, causing it to deteriorate, which can lead to cirrhosis<sup>17</sup> and liver cancer.<sup>18</sup> The rate of liver scarring, known

---

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

8. *Id.*

9. *See infra* Section I.A.

10. *See infra* Section I.B.

11. *See infra* Section I.C.

12. *Atkins*, 972 F.3d at 736; *see generally Hepatitis C Questions and Answers for Health Professionals*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm> (last visited Nov. 25, 2020) [hereinafter *Hepatitis C Questions and Answers*] (addressing general questions about HCV transmission). Most commonly, HCV is transmitted through injection-drug use, sharing of personal items with bodily fluids on them (like razors or toothbrushes), unsterilized tools or inks used for tattooing or piercing, and unprotected sex. *Hepatitis C Questions and Answers*, *supra* note 12; *see also Hepatitis C*, NAT’L INST. DIABETES & DIGESTIVE & KIDNEY DISEASES, <https://www.niddk.nih.gov/health-information/liver-disease/viral-hepatitis/hepatitis-c> (last updated Mar. 2020) [hereinafter *Hepatitis C*] (explaining common modes of transmission for HCV).

13. *Hepatitis C*, *supra* note 12.

14. *Id.*

15. *Id.*

16. *See Atkins*, 972 F.3d at 736 (noting that between 15 to 25% of infected persons recover from acute infection); *Hepatitis C*, *supra* note 12.

17. *Cirrhosis*, NAT’L INST. DIABETES & DIGESTIVE & KIDNEY DISEASES, <https://www.niddk.nih.gov/health-information/liver-disease/cirrhosis> (last visited Jan. 14, 2022). Cirrhosis is a condition where the “liver is scarred and permanently damaged.” *Id.* As the condition progresses, scar tissue replaces normal tissue and prevents the liver from working normally. *Id.* It eventually leads to liver failure. *Id.* Of cases that reach the chronic stage, 20 to 40% of people develop cirrhosis. *Atkins*, 972 F.3d at 736.

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

as fibrosis, varies from person to person.<sup>19</sup> To measure the degree of fibrosis, doctors use a five-point score: F0 (no fibrosis), F1 (mild fibrosis), F2 (moderate fibrosis), F3 (advanced fibrosis), and F4 (cirrhosis).<sup>20</sup> As the disease progresses, some HCV-infected patients may develop symptoms, including fatigue, depression, jaundice, nausea, severe inflammation, skin lesions, and cognitive impairment.<sup>21</sup> However, many patients, including those with severe scarring, remain asymptomatic.<sup>22</sup> The possible lack of symptoms increases the importance of finding the disease and treating it early.<sup>23</sup> Unless tested, people who are HCV-positive may not know of their condition for decades.<sup>24</sup>

No vaccine currently exists for HCV.<sup>25</sup> Prior to 2011, the standard treatment for chronic HCV involved injections of a drug called interferon.<sup>26</sup> This treatment had low success rates, severe side effects, and the treatment process took a long time.<sup>27</sup> In 2011, the U.S. Food and Drug Administration approved a new treatment for HCV: DAAs.<sup>28</sup> DAAs are taken as a pill once a day for eight to twelve weeks, have minimal side effects, and have an incredible success rate of over ninety percent.<sup>29</sup> DAAs are so effective that “interferon treatment for HCV [has been] effectively abandoned.”<sup>30</sup> Despite their success, DAAs remain very expensive.<sup>31</sup> For instance, during the *Atkins* trial in 2019, the price per single course of treatment was between \$13,000 and \$32,000.<sup>32</sup>

### B. TDOC Changes to 2016 HCV Guidance

When the *Atkins* plaintiffs brought their suit, TDOC operated under its 2016 HCV Guidance.<sup>33</sup> The 2016 Guidance “specified that [TDOC] would provide the

---

19. *Id.*; see generally *Assessment of Liver Fibrosis*, U.S. DEP’T VETERANS AFFS., <https://www.hepatitis.va.gov/hcv/liver-fibrosis.asp> (last updated Oct. 23, 2018) [hereinafter *Assessment of Liver Fibrosis*] (describing fibrosis progression).

20. *Atkins*, 412 F. Supp. 3d at 766; see generally *Assessment of Liver Fibrosis*, *supra* note 19 (describing fibrosis progression).

21. *Atkins*, 972 F.3d at 736; see also *Hepatitis C*, *supra* note 12 (describing symptoms of HCV).

22. *Atkins*, 412 F. Supp. 3d at 766; *Hepatitis C*, *supra* note 12.

23. See *Hepatitis C*, *supra* note 12 (explaining the importance of screening for finding and treating HCV early).

24. *Hepatitis C*, WORLD HEALTH ORG. (July 27, 2021) <https://www.who.int/news-room/fact-sheets/detail/hepatitis-c> [hereinafter WHO, *Hepatitis C*].

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

26. *Atkins*, 412 F. Supp. 3d at 767.

27. *Id.*

28. *Id.*

29. *Id.*; *Hepatitis C Questions and Answers*, *supra* note 12 (“Over 90% of people infected with hepatitis C virus (HCV) can be cured of their infection . . . with 8–12 weeks of oral therapy.”).

30. *Atkins*, 412 F. Supp. 3d at 767.

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

32. See *id.* at 736–37 (noting that, in 2019, approximately 4,740 of 21,000 TDOC inmates had known HCV infections).

33. *Id.*

antivirals only to infected inmates with severe liver scarring.”<sup>34</sup> Therefore, inmates in lower fibrosis stages were completely barred from antiviral treatment.<sup>35</sup> In 2019, during *Atkins* litigation, TDOC amended its 2016 Guidance to reflect the prevalence of HCV amongst its incarcerated population and the decreasing costs of DAAs.<sup>36</sup> Afterwards, both sides of the litigation agreed to focus solely on the amended guidance.<sup>37</sup>

The 2019 HCV Guidance controls “the testing, evaluation, staging, prioritization, treatment, and monitoring of TDOC inmates with chronic HCV.”<sup>38</sup> The goal of the 2019 Guidance was to provide the best treatment in a cost-effective manner for the greatest number of prisoners.<sup>39</sup> This policy continued the prioritization of treating the sickest people first (those in the F3 and F4 stages) but opened the door to the possibility of also treating people at lower fibrosis stages (those in the F1 and F2 stages).<sup>40</sup> These protocols became the baseline for all providers within the TDOC system—deviations from the 2019 Guidelines could only happen with the permission of Dr. Williams.<sup>41</sup>

TDOC implemented four major changes with the 2019 Guidance to better address the needs of inmates diagnosed with HCV. The first major change was the adoption of an “opt-out,” as opposed to an “opt-in” testing policy.<sup>42</sup> At intake, TDOC requires inmates to be tested for HCV unless they specifically make an informed refusal to “opt-out.”<sup>43</sup> If an inmate tests positive, the individual undergoes a baseline evaluation and medical providers assess the best treatment regime for that patient.<sup>44</sup>

The second major change requires consideration of *all* HCV-diagnosed inmates for DAA treatment regardless of fibrosis stage, but prioritizes DAA treatment for those in the most advanced stages.<sup>45</sup> By contrast, the 2016 HCV Guidance limited DAA treatment eligibility only to inmates in severe stages of

---

34. *Id.* at 737.

35. *Id.*

36. *Id.*

37. *Id.* at 738.

38. *Atkins*, 412 F. Supp. 3d at 771.

39. *Id.* at 770–71.

40. *Id.* at 771–72.

41. *Id.* at 771. The TDOC system includes both private and state-operated facilities. *Id.*

42. *Id.*

43. *Id.* Upon a refusal of treatment, the health care provider “must advise the inmate of the potential health consequences of [the] refusal.” STATE OF TENN. DEP’T OF CORR., 113.51, CONSENT/REFUSAL OF TREATMENT 5 (2019). After, the inmate signs a Refusal of Medical Services that demonstrates that he or she has been advised of these consequences. *Id.* The individual maintains the right to later change his or her mind and accept the treatment. *Id.* at 6.

44. *Atkins*, 412 F. Supp. 3d at 771. For the baseline evaluation, medical providers conduct a physical examination and collect the patient’s history to determine the likely date of infection, other causes of liver disease, symptoms, past HCV treatment, and the patient’s stage of fibrosis. *Id.* at 771–72.

45. *Atkins*, 412 F. Supp. 3d at 772.

fibrosis.<sup>46</sup> This 2019 HCV Guidance structure is similar to the U.S. Bureau of Prisons (BOP) 2018 HCV Guidance, which also classified patients with priority based on the inmate's stage of fibrosis.<sup>47</sup> Notably, BOP's 2018 Guidance references the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) HCV guidance in its policy recommendations.<sup>48</sup>

Most medical providers in the U.S. who treat HCV follow the AASLD/IDSA guidance.<sup>49</sup> This guidance is considered the “best practice”—the medical standard of care—for the treatment of HCV.<sup>50</sup> At the time of the *Atkins* trial, AASLD/IDSA guidance recommended early treatment to all diagnosed patients with DAAs, but provided that prioritization to treat those with the greatest risk of complications was permissible in circumstances of limited resources.<sup>51</sup> AASLD/IDSA later altered their standards to recommend that all patients with HCV be treated, except those with a short life expectancy, and that medical providers treat patients early in the course of the disease.<sup>52</sup>

The third major change was the installment of a medical committee—TDOC Advisory Committee on HIV and Viral Hepatitis Prevention and Treatment (TACHH)—that provides individualized assessments and ongoing

---

46. *Id.*

47. *Id.* at 773–74; *see also* FED. BUREAU OF PRISONS, EVALUATION AND MANAGEMENT OF CHRONIC HEPATITIS C VIRUS (HCV) INFECTION 2, 8–10 (2018) [hereinafter BOP 2018 GUIDANCE] (recommending an “opt out” approach to testing and DAA treatment, with the caveat that “when more than one regimen is appropriate for an individual case, the most cost-effective regimen is recommended,” and establishing priority criteria “to ensure that inmates with greatest need are identified and treated first”); U.S. DEP’T OF JUST., FEDERAL PRISON SYSTEM: FY 2020 PERFORMANCE BUDGET CONGRESSIONAL SUBMISSION 23 (2019) (“The most recent update to hepatitis treatment guidance recommends treatment of all inmates testing positive for HCV.”). In 2021, after the *Atkins* decision, BOP made “major revisions” to its HCV guidance. FED. BUREAU OF PRISONS, EVALUATION AND MANAGEMENT OF CHRONIC HEPATITIS C VIRUS (HCV) INFECTION 1 (2021) [hereinafter BOP 2021 GUIDANCE]. Of these major revisions, BOP removed its priority level recommendations based on fibrosis score and now simply recommends considering all HCV-diagnosed inmates for the most appropriate and “cost-effective” DAA regimen. *Id.* at 12, 15–16.

48. BOP 2018 GUIDANCE, *supra* note 47, at i (“Recommended HCV treatment regimens have been updated to reflect the current guidance from the American Association for the Study of Liver Diseases.”).

49. *Atkins*, 412 F. Supp. 3d at 768; *see generally* Introduction, in *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*, AM. ASS’N FOR THE STUDY OF LIVER DISEASE & INFECTIOUS DISEASES SOC’Y OF AM., <https://www.hcvguidelines.org/contents/welcome> (last updated Nov. 6, 2019) (describing role of web-based processes in medical community).

50. *Atkins*, 412 F. Supp. 3d at 768.

51. *Id.* at 774.

52. *See When and in Whom to Initiate HCV Therapy*, in *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*, AM. ASS’N FOR THE STUDY OF LIVER DISEASE & INFECTIOUS DISEASES SOC’Y OF AM., <https://www.hcvguidelines.org/evaluate/when-whom> (last updated Nov. 6, 2019) (suggesting that successfully treating patients with a low fibrosis score resulted in a better long-term survival rate).

monitoring of all HCV cases and approves treatment in each case.<sup>53</sup> Finally, the fourth major change included a HCV treatment workflow outline, which advises all health care providers within the TDOC system on how to implement these guidelines.<sup>54</sup>

To properly implement the 2019 HCV guidelines, TDOC required additional funding.<sup>55</sup> Throughout the course of the 2016–2017 and 2017–2018 legislative years, TDOC had secured recurring funds of \$4.6 million for DAA treatment.<sup>56</sup> For the 2019–2020 fiscal year, TDOC, at Dr. William’s request, obtained a one-time allocation of \$26.4 million for DAAs.<sup>57</sup> Of the 4,740 Tennessee inmates diagnosed with HCV, Dr. Williams believed that the funding secured for the 2019–2020 fiscal year could provide treatment for approximately 1,800 to 1,900 inmates.<sup>58</sup>

### *C. The Lower Court Opinion and its Procedural Posture*

In 2016, Gregory Atkins and his fellow plaintiffs sought prospective injunctive and declaratory relief under 42 U.S.C. § 1983 against Tony Parker and Dr. Kenneth Williams.<sup>59</sup> The Section 1983 claim provides a federal cause of action against government officials who, while acting under the color of state law, deprived the plaintiffs of rights secured by the U.S. Constitution.<sup>60</sup> Here, plaintiffs alleged that they were deprived adequate treatment for their serious medical needs under the Eighth and Fourteenth Amendments.<sup>61</sup> More specifically, the plaintiffs argued that the prioritization approach used in the 2016, and subsequently 2019, TDOC HCV Guidance constituted deliberate indifference because the protocols failed to reach the current medical standards of care and subjected HCV-positive inmates to a substantial risk of harm or death.<sup>62</sup>

The U.S. District Court for the Middle District of Tennessee held that neither Parker nor Dr. Williams was liable for deliberate indifference under the Eighth Amendment.<sup>63</sup> In Parker’s case, the court found that the plaintiffs had

---

53. See *Atkins*, 412 F. Supp. 3d at 772–74 (explaining that TACHH meets regularly to assess each HCV-diagnosed patient and sets treatment priority based on several factors including fibrosis stage and symptoms).

54. See *id.* at 774–75 (explaining that the workflow sets the expectations and steps for how health care providers must test, diagnose, prioritize, treat, and monitor inmates with HCV).

55. *Id.* at 783.

56. *Id.* at 777.

57. *Id.*

58. *Id.* at 765, 777.

59. *Id.* at 764.

60. 42 U.S.C. § 1983.

61. *Atkins*, 412 F. Supp. 3d at 764.

62. *Id.*

63. *Id.* at 764–65. See *infra* Section II.A.

failed to establish that Parker was liable because he had no involvement in the administration of HCV policies nor did he have a sufficiently culpable state of mind.<sup>64</sup> Because Parker had no medical training or medical knowledge and relied exclusively on TDOC medical health care professionals for the creation and implementation of the HCV 2019 Guidance, the court found that he could not possess a mental state that exceeded the necessary bar of gross negligence.<sup>65</sup>

The lower court also dismissed the case against Dr. Williams.<sup>66</sup> Although the court found that HCV constituted a “serious medical condition,” Dr. Williams’ new 2019 Guidance met constitutional obligations because the guidance “serve[d] the dual goals of maximizing and prioritizing treatment for [infected] inmates.”<sup>67</sup> Because Dr. Williams took precautions in his guidance that were “not so unreasonable or so contrary to medical standards that no competent medical professional would make similar choices” with the limited resources available to TDOC, the court concluded that plaintiffs had failed to meet their burden.<sup>68</sup> The plaintiffs appealed this decision to the Sixth Circuit.

## II. LEGAL BACKGROUND

The Eighth Amendment protects against the infliction of “cruel and unusual punishments.”<sup>69</sup> The U.S. Supreme Court has understood the Eighth Amendment to embody “broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . . against which [it] evaluate[s] penal measures.”<sup>70</sup> As society’s standards of decency evolve, the standards of what constitutes “cruel” and “unusual” do too.<sup>71</sup> These principles underly the government’s obligation to provide medical care to incarcerated individuals.<sup>72</sup> Due to the prisoner’s reliance on the government for medical services, the government is obligated to provide adequate medical care to prevent pain and suffering that serves no penological purpose.<sup>73</sup> Section II explores the Eighth Amendment standard of deliberate indifference. Section II.A explains the two-part analysis of the standard that evolved from the U.S. Supreme Court case, *Estelle v. Gamble*.<sup>74</sup> Section II.B

---

64. *Id.* at 780–81.

65. *Id.* at 781.

66. *Id.* at 785.

67. *Id.* at 781, 783.

68. *Id.* at 783.

69. U.S. CONST. amend. VIII.

70. *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (internal quotations omitted) (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)).

71. *See id.* (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)) (explaining that the Court has held Eighth Amendment punishments that are incompatible with the “evolving standards of decency that mark the progress of a maturing society” unconstitutional).

72. *Estelle*, 429 U.S. at 103.

73. *Id.*

74. *See infra* Section II.A.

explores the application of the standard in circuit and district courts, particularly in the context of HCV litigation.<sup>75</sup> Finally, Section II.C describes the legal background of the inadequate resources defense within the context of constitutional claims.<sup>76</sup>

#### A. The “Deliberate Indifference” Standard

In *Estelle v. Gamble*, the U.S. Supreme Court concluded that “deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain.”<sup>77</sup> To bring a deliberate indifference claim, “a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”<sup>78</sup> This “indifference” is what offends society’s “evolving standards of decency in violation of the Eighth Amendment.”<sup>79</sup> Thus, certain claims of inadequate medical care—like accidents or instances of medical malpractice—do not rise to a level of “wanton infliction of unnecessary pain.”<sup>80</sup> For example, the *Estelle* case involved a back injury that Gamble, an inmate, suffered while unloading a truck.<sup>81</sup> As the injury failed to improve, Gamble consistently sought treatment from medical personnel for several months but found that their prescriptions of pain relievers and bed rest were inadequate to improve his injury.<sup>82</sup> The Court held that Gamble had failed to show that medical personnel exhibited deliberate indifference to his serious medical needs because he had been seen, diagnosed, and treated by medical personnel on multiple occasions.<sup>83</sup> The issue was a matter of medical judgment, which amounted to no more than medical malpractice—not cruel and unusual punishment.<sup>84</sup>

---

75. See *infra* Section II.B.

76. See *infra* Section II.C.

77. *Estelle*, 429 U.S. at 104. This standard applies to government actors including prison doctors in response to a medical issue, and prison officials or guards in denying or delaying proper access to care. *Id.* at 104–05.

78. *Estelle*, 429 U.S. at 106.

79. *Id.* at 105–06 (internal quotations omitted).

80. *Id.*

81. *Id.* at 99.

82. *Id.* at 99–100.

83. *Id.* at 107. Gamble was also treated for several other medical issues in addition to his back injury, including heart problems and high blood pressure. *Id.*

84. *Estelle*, 429 U.S. at 107. Gamble had argued, and the U.S. Court of Appeals for the Fifth Circuit had agreed, that the prison should have done more, like take an x-ray of Gamble’s lower back. *Id.* However, the Court rejected that argument, stating: “[T]he question whether an X-ray or additional diagnostic techniques or forms of treatment is indicated is a classic example of a matter for medical judgment. A medical decision not to order an X-ray . . . does not represent cruel and unusual punishment.” *Id.*

Since *Estelle*, the Court has outlined a two-pronged test for deliberate indifference consisting of an objective and subjective component.<sup>85</sup> First, for the objective component, an inmate must show that the deprivation of a medical need or condition poses a substantial or a “sufficiently serious” risk of harm.<sup>86</sup> Harm includes both immediate and future threats to an individual’s health or safety.<sup>87</sup> For instance, prison officials cannot ignore conditions of confinement that could cause or contribute to a serious future health issue, like excessive exposure to secondhand smoke or unsafe drinking water.<sup>88</sup>

Second, for the subjective component, an inmate must show that a prison official had a “sufficiently culpable state of mind” when he deprived an inmate of medical treatment.<sup>89</sup> In other words, the official must know of and disregard an excessive risk to inmate health and safety, thus inflicting cruel and unusual punishment.<sup>90</sup> This state of mind is akin to a finding of criminal recklessness.<sup>91</sup> For example, in *Farmer v. Brennan*, a transexual woman brought a deliberate indifference action alleging that prison officials knowingly placed her at high risk for sexual assault when they moved her into general population at a men’s high-security prison.<sup>92</sup> The Court explained that the subjective prong required a finding that the prison officials knew that the risk to the inmate’s safety existed when they placed her in general population.<sup>93</sup> An official who lacks knowledge of the risk—even an obvious risk—cannot be found to have inflicted punishment.<sup>94</sup> The subjective prong, in particular, sets a high bar for a plaintiff trying to bring a successful Eighth Amendment claim.<sup>95</sup>

The Sixth Circuit has further developed the deliberate indifference test in its own jurisprudence. For the objective prong, a plaintiff can either show that the prison failed to provide any treatment for a diagnosed ailment or show that an ongoing treatment for his or her condition is “so grossly incompetent . . . to

---

85. See *Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (explaining the two-prong test); *Wilson v. Seiter*, 501 U.S. 294, 298–99 (1991) (establishing the subjective component for an Eighth Amendment claim).

86. *Farmer*, 511 U.S. at 834; *Wilson*, 501 U.S. at 298.

87. See *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (“It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.”).

88. *Id.* at 33–35.

89. *Farmer*, 511 U.S. at 834; see also *Wilson*, 501 U.S. at 298, 300 (“The source of the intent requirement is not the predilections of this court, but the Eighth Amendment itself, which bans only cruel and unusual punishment. If the pain inflicted is not formally meted out as punishment by the statute or the sentencing judge, some mental element must be attributed to the inflicting officer before it can qualify.”).

90. *Farmer*, 511 U.S. at 837.

91. *Id.* at 839–40.

92. *Id.* at 829–30.

93. *Id.* at 845–46.

94. *Id.* at 844.

95. *Rhinehart v. Scutt*, 894 F.3d 721, 738–39 (6th Cir. 2018).

shock the conscience.”<sup>96</sup> To prove subjective recklessness, the plaintiff must prove that each defendant knew enough of the facts to infer risk to the inmate, drew the inference, and then disregarded that risk by failing to take reasonable measures to abate it.<sup>97</sup>

### B. HCV Litigation in Other Courts

As a result of the success of DAA treatment, lower courts have been responding to deliberate indifference claims against prison policies regarding HCV treatment.<sup>98</sup> As courts order injunctions and approve class action settlements, courts have created constitutional “guideposts” for HCV treatment in prisons.<sup>99</sup> For instance, courts have responded favorably to opt-out testing policies because this policy requires that when a prisoner first undergoes a medical examination upon entering a facility, that prisoner must specifically request to “opt-out” of HCV testing.<sup>100</sup> Therefore, opt-out policies allow for greater comprehensive testing and follow the professional medical guidelines that endorse broad screening policies.<sup>101</sup> Courts also seek some form of individualized medical treatment and consistent monitoring of inmates who have tested positive of HCV.<sup>102</sup>

---

96. *Id.* at 737.

97. *Id.* at 738.

98. *E.g.*, *Hoffer v. Inch*, 382 F. Supp. 3d 1288, 1314 (N.D. Fla. 2019) (noting the efficacy of DAA treatment by stating “[i]f it were up to this court . . . every non-contraindicated inmate with chronic HCV would be immediately treated with DAAs”), *vacated in part by Hoffer v. Sec’y, Fla. Dep’t of Corrs.*, 973 F.3d 1263 (11th Cir. 2020).

99. *See generally* Joshua Kleppin, Note, *Making a Deliberate Difference: Creating a Constitutional Solution to Hepatitis C in Prisons*, 8 BELMONT L. REV. 265, 292–98 (2020) (observing HCV litigation outcomes and how these outcomes can act as guideposts for states to create Constitutional policies through systematic testing, individualized medical determinations, prioritization based on individual medical determinations, dedicated funding requirements, and third-party monitoring).

100. *See, e.g.*, *Inch*, 382 F. Supp. 3d at 1298 (listing “opt-out” testing as one of two options for the prison to adopt regarding inmate screenings).

101. *See id.* at 1299–300 (ordering FDC to choose between opt-out testing with an aggressive notice campaign or to maintain opt-in testing with peer education); *HCV Testing and Treatment in Correctional Settings*, in *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*, AM. ASS’N FOR THE STUDY OF LIVER DISEASE & INFECTIOUS DISEASES SOC’Y OF AM., <https://www.hcvguidelines.org/unique-populations/correctional> (last updated Nov. 6, 2019) (“Prisons should implement opt-out HCV testing . . . Interventions to reduce HCV transmission and HCV-related liver disease can only be implemented if infected patients are diagnosed . . . Universal opt-out testing of inmates for chronic HCV is highly cost-effective and has been shown to reduce ongoing HCV transmission and the incidence of advanced liver disease.”).

102. *See Inch*, 382 F. Supp. 3d at 1312–13 (ordering FDC to provide monthly reports that monitor testing, treatment, and fibrosis levels of inmates); *see also* *Gordon v. Schilling*, 937 F.3d 348, 357–61 (4th Cir. 2019) (finding that a genuine dispute of material fact existed regarding plaintiff’s deliberate indifference claim when plaintiff presented evidence demonstrating that a reasonable jury could find that the Virginia Department of Corrections officials had failed to regularly monitor and treat HCV-diagnosed parole-eligible inmates); *Black v. Ala. Dep’t of Corrs.*, 578 F. App’x. 794, 795–96 (11th Cir. 2014) (per

Finally, and most contentiously, when individualized and continuous monitoring are present in a prison's HCV guidance, courts have upheld prioritization schemes as a means to deal with finite resources.<sup>103</sup> For example, in *Hoffer v. Secretary, Florida Department of Corrections*, the Eleventh Circuit upheld a prioritization scheme that treats inmates with rapidly progressing symptoms and those in advanced stages of fibrosis with DAAs before allocating their DAA treatments to inmates in lower stages of fibrosis.<sup>104</sup> Although the Florida policy delayed treatment for individuals in lower stages of fibrosis, the court emphasized that because the Florida Department of Corrections (FDC) consistently monitored those individuals for progressing symptoms, the policy did not violate the Eighth Amendment because prisons are only required to provide "minimally adequate care" (not "perfect" care).<sup>105</sup> As long as the FDC met the constitutional minimum for care, the prison could weigh cost considerations in providing HCV treatment.<sup>106</sup>

### C. Inadequate Resources Defense

Although the Supreme Court has never decided on whether state prisons could use an inadequate resources defense, the Court has briefly raised and discussed the matter in dicta.<sup>107</sup> In *Wilson v. Seiter*, Justice Scalia, writing for the majority, speculated whether officials, in the subjective prong, could use a defense that "despite good-faith efforts to obtain funding, fiscal constraints beyond [the official's] control prevent[ed] the elimination of inhumane conditions."<sup>108</sup> Justice Scalia noted that it would be hard to understand how this

---

curiam) (noting that an inmate received regular monitoring to determine his eligibility for admission to the "Hepatitis C Treatment Program").

103. See, e.g., *Atkins*, 972 F.3d at 740 (holding that a prison could prioritize inmates for DAA treatment when the prison's HCV guidance included extensive monitoring and individualized treatment for each infected inmate, and officials requested budget increases for treatment); *Hoffer v. Sec'y, Fla. Dep't of Corrs.*, 973 F.3d 1263, 1272–73 (11th Cir. 2020) (holding that consistent monitoring of F0 and F1 level patients is enough to meet the constitutional standard of care); *Woodcock v. Correct Care Solutions*, No. 20-5170, 2021 WL 2799978, at \*5–6 (6th Cir. Jul. 6, 2021) (holding that plaintiffs had failed to show that the prison's HCV guidance put them at a substantial risk of serious harm when the plan provided for regular monitoring, diagnosis, and a flexible prioritization system); *Roy v. Lawson*, 739 F. App'x. 266, 266–67 (5th Cir. 2018) (per curiam) (explaining that regular monitoring and testing met the constitutional baseline for treatment as opposed to administering "drugs with a high cure rate"). *But see Pfaller v. Clarke*, 630 B.R. 197, 213–14 (E.D. Va. 2021) ("Although the [Virginia Department of Corrections] Guidelines provided for monitoring these inmates, as the Fourth Circuit taught in [*Gordon v. Schilling*, 937 F.3d 348 (4th Cir. 2019)], monitoring is not treatment. The treatment—the cure—for Hepatitis C is DAAs.").

104. *Hoffer*, 973 F.3d at 1277–78.

105. *Id.* at 1272–73, 1277.

106. See *id.* at 1277 ("While it is clear that cost can (and often will) be a relevant criterion in determining what the Eighth Amendment requires in a particular circumstance . . . it is also clear that cost can never be an absolute defense to what the Constitution otherwise requires.").

107. *Wilson*, 501 U.S. at 301–02.

108. *Id.* at 301.

defense could work in a “cruel and unusual punishment” claim because of the implicit “intent” requirement in the word “punishment.”<sup>109</sup> Using funding as an excuse for poor conditions would undermine the “state-of-mind” component of this analysis because then the constitutional claim could be subject to economic considerations.<sup>110</sup> Regardless, Justice Scalia set the defense aside noting that a “cost” defense was not raised nor had there been any indication that other officials had sought to use this defense to avoid the holding of *Estelle*.<sup>111</sup>

In his *Wilson* concurrence, Justice White responded to Justice Scalia’s consideration of a cost defense.<sup>112</sup> Justice White emphasized that a funding defense would undermine the deliberate indifference standard because it would excuse officials from adhering to a constitutional minimum: “In my view, having chosen to use imprisonment as a form of punishment, a state must ensure that the conditions in its prisons comport with the “contemporary standard of decency” required by the Eighth Amendment.”<sup>113</sup> Budgetary concerns cannot excuse a failure to comport with a constitutional standard.<sup>114</sup>

Lower courts have also advised against an inadequate funding defense. Writing in dicta, the Eleventh Circuit, in *Harris v. Thigpen*, disagreed with allowing financial questions to weigh on the determination of the reasonableness of inmates’ medical care: “We do not agree that financial considerations must be considered in determining the reasonableness of inmates’ medical care to the extent that such a rationale could ever be used by so-called ‘poor states’ to deny a prisoner the minimally adequate care to which he or she is entitled.”<sup>115</sup> Similarly, the Ninth Circuit has characterized a lack of resources as an invalid defense to a claim for prospective relief.<sup>116</sup> In *Peralta v. Dillard*, the court noted, a “[l]ack of resources is not a defense to a claim for prospective relief because

---

109. *Id.*

110. *See id.* at 301–02 (finding that the intent requirement “cannot be alternately required and ignored as policy considerations might dictate”).

111. *Id.* at 302.

112. *Wilson*, 501 U.S. at 311 (White, J., concurring).

113. *Id.*

114. *See Watson v. City of Memphis*, 373 U.S. 526, 537–38 (1963) (dismissing the city’s argument that budgetary concerns could allow for the postponement of desegregating local playgrounds); *see also Farmer v. Brennan*, 511 U.S. at 855–56 (Blackmun, J., concurring) (arguing that legislatures have a responsibility to adequately fund prisons and are as culpable as prison officials when prison conditions fail to meet constitutional standards).

115. *Harris v. Thigpen*, 941 F.2d 1495, 1509 (11th Cir. 1991); *see also Smith v. Sullivan*, 611 F.2d 1039, 1043–44 (5th Cir. 1980) (“It is well established that inadequate funding will not excuse the perpetuation of unconstitutional conditions of confinement.”); *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) (“If necessary medical treatment has been delayed for non-medical reasons, a case of deliberate indifference has been made out.”); *Chimenti v. Wetzel*, No. 15-3333, 2018 WL 3388305, at \*9 (E.D. Penn. Jul. 12, 2018) (finding that when cost was the main underlying factor to further restrict inmate care, the court could not rule in summary judgment in favor of the prison because the cost factor may be indicative of a delay in necessary medical treatment for a non-medical reason).

116. *Peralta v. Dillard*, 744 F.3d 1076, 1083 (9th Cir. 2014).

prison officials may be compelled to expand the pool of existing resources in order to remedy continuing Eighth Amendment violations.”<sup>117</sup>

A week after the Sixth Circuit decided *Atkins*, the Eleventh Circuit considered the issue of cost in *Hoffer v. Secretary, Florida Department of Corrections*.<sup>118</sup> In *Hoffer*, the Eleventh Circuit rejected the plaintiff’s argument that failing to provide DAA treatment to all HCV-diagnosed inmates due to cost is per-se deliberate indifference.<sup>119</sup> The *Hoffer* court framed the issue as “whether, at what point, and to what extent the cost of a particular medical treatment should factor into an Eighth Amendment deliberate-indifference analysis.”<sup>120</sup> The court expressly embraced that prison officials could consider cost when determining the type of medical care a prisoner could receive.<sup>121</sup> It noted that that “the civilized minimum level of care required by the Eighth Amendment is a function both of objective need *and cost*.”<sup>122</sup> In other words, prison officials may make decisions regarding patient care with cost in mind, but cost cannot act as a complete defense to adhering to the constitutional floor.<sup>123</sup> The court opined, “[e]very minute of every day[,] ordinary Americans forgo or delay beneficial . . . medical treatment because it’s just too expensive . . . Healthcare can be expensive—sadly, sometimes prohibitively so. What a topsyturvy world it would be if incarcerated inmates were somehow immune from that cold—and sometimes cruel—reality.”<sup>124</sup> If prison authorities were required to provide “the best” care for inmates, the court concluded that “prohibiting the

---

117. *Id.* (citing *Wright v. Rushen*, 642 F.2d 1129, 1134 (9th Cir. 1981)) (“[C]osts cannot be permitted to stand in the way of eliminating conditions below Eighth Amendment standards.”).

118. *Hoffer*, 973 F.3d at 1275. Because the court held that the constitutional minimum for adequate care did not require the FDC to provide DAA treatment for all inmates diagnosed with HCV, the court never directly addressed a cost “defense.” *Id.* at 1277.

119. *Hoffer*, 973 F.3d at 1273–74.

120. *Id.* at 1275.

121. *Id.*

122. *Id.* at 1276 (emphasis added) (internal quotations omitted) (quoting *Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999)).

123. See *id.* at 1277 (“[I]f a particular course of treatment is indeed essential to ‘minimally adequate care,’ prison authorities can’t plead poverty as an excuse for refusing to provide it.”); *id.* at 1286 (Martin, J., dissenting) (“[N]othing precludes a prison from considering cost, but ‘cost can never be an absolute defense to what the Constitution otherwise requires.’”); see also *Petties v. Carter*, 836 F.3d 722, 730 (7th Cir. 2016) (“While the cost of treatment is a factor in determining what constitutes adequate, minimum-level care, medical personnel cannot simply resort to an easier course of treatment that they know is ineffective.”); *Winslow v. Prison Health Servs.*, 406 F. App’x 671, 675–76 (3d Cir. 2011) (“[Plaintiff] does not have a constitutional right to unlimited medical care of his choosing, free from all considerations of cost.”).

124. *Hoffer*, 973 F.3d at 1277 (citing *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997)). *But see Estelle*, 429 U.S. at 103 (“[E]lementary principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met . . . [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.”).

state from raising cost as a defense would be inconceivable—and unsustainable.”<sup>125</sup>

### III. COURT’S REASONING

Writing for a 2-1 majority, Judge Raymond Kethledge first identified the sole issue on appeal: whether Dr. Williams’s failure to “provide direct-acting antivirals to every infected inmate amounted to deliberate indifference in violation of the Eighth Amendment.”<sup>126</sup> The court held that the plaintiffs’ argument that Dr. Williams needed to provide DAAs to every infected inmate failed because, although HCV is a serious medical condition and Dr. Williams understood the risks of the disease, Dr. Williams took reasonable measures with the “finite resources” available to him to maximize the treatment of inmates in his care, and therefore did not consciously disregard the substantial risk that HCV posed to infected inmates.<sup>127</sup>

In consideration of this claim, the court accepted that “hepatitis C is an objectively serious medical condition,” and only considered whether Dr. Williams consciously disregarded the prisoners’ serious medical needs.<sup>128</sup> The court concluded that Dr. Williams’ changes to the 2019 HCV Guidance—especially the extensive monitoring and individualized assessment of all inmates—and his repeated attempts to secure full funding for DAAs demonstrated that he had not recklessly ignored the risk of HCV.<sup>129</sup> Although the “best practice” was to treat all chronic HCV patients with DAAs, the majority noted that Dr. Williams’ inability to adhere to this “best practice” did not equate to a constitutional violation because limited resources prevented him from doing so.<sup>130</sup> Likewise, the court added that the Constitution did not require Dr. Williams to ask the Tennessee legislature for enough funds to treat all TDOC prisoners with chronic HCV.<sup>131</sup> Rather, his efforts in seeking budget increases to treat his patients were enough to meet the reasonableness standard under the Eighth Amendment.<sup>132</sup>

---

125. *Hoffer*, 973 F.3d at 1277.

126. *Atkins*, 972 F.3d at 739.

127. *See id.* at 739–40 (detailing the actions Williams took in updating the 2019 HCV Guidance that the court found reasonable).

128. *Id.* at 739.

129. *Id.* at 740.

130. *Id.*

131. *Id.*

132. *See id.* (noting that the Eighth Amendment does not impose an obligation on state medical officials to lobby legislatures for “an unspecified quantum of funds, and that failing to ask the legislature for more money was not even “colorable ground” to reverse the district court). *But see id.* at 744 (Gilman, J., dissenting) (finding that nothing in the record showed that Dr. Williams had ever asked for full funding, despite his testimony that the TDOC Commissioner “never told [him] no” when he asked for more DAA money).

*A. Dissenting Opinion of Judge Gilman*

Judge Ronald Lee Gilman delivered a scathing dissent.<sup>133</sup> He argued that the majority failed to place enough emphasis on the serious harm that would result in the delay of treatment of HCV to individuals with lower fibrosis levels.<sup>134</sup> He explained that the rationing (or prioritization) scheme failed the deliberate indifference analysis because the delay of DAA treatment could lead to an inmate suffering from serious symptoms and, eventually, death.<sup>135</sup> Further, professional guidance on the HCV standard of care no longer endorsed the practice of prioritization because delaying treatment of HCV results in an increase in the “patient’s risk of liver-related death two-to-five-fold as compared to treating the infection at an earlier stage.”<sup>136</sup> Dr. Williams’ prioritization policy, which only provided guidance on treating patients with severe fibrosis, left patients in a lower stage of fibrosis to needlessly suffer the consequences of delaying treatment.<sup>137</sup>

Additionally, the dissent argued that a lack of funding was no excuse for the prioritization scheme.<sup>138</sup> Pointing to U.S. Supreme Court and other circuit court precedents, Judge Gilman emphasized that cost concerns must not obstruct the implementation of constitutional rights.<sup>139</sup> Therefore, TDOC would need to make either financial or population adjustments to adequately meet prisoners’ medical needs.<sup>140</sup> He also warned that claiming cost as a reasonable consideration in Tennessee ran contrary to other state decisions that had found cost to be an unreasonable consideration, and would result in a “patchwork application” of what constituted cruel and unusual punishment.<sup>141</sup> Finally, Judge Gilman concluded that the inadequate funds excuse fails because the state would

---

133. *Atkins*, 972 F.3d at 740 (Gilman, J., dissenting).

134. *Id.* at 740–41.

135. *See id.* at 741–42 (noting that, since DAAs became available, Dr. Williams had seen 81 inmates die in his care from HCV).

136. *Id.* (citing *Stafford v. Carter*, No. 1:17-CV-00289-JMS-MJD, 2018 WL 4361639, at \*17 (S.D. Ind. Sept. 13, 2018)).

137. *Atkins*, 972 F.3d at 742.

138. *Id.*

139. *Id.* at 742–43.

140. *See id.* (first citing *Watson v. City of Memphis*, 373 U.S. 526, 537 (1963); then citing *Peralta v. Dillard*, 744 F.3d 1076, 1083 (9th Cir. 2014) (en banc); then citing *Williams v. Bennett*, 689 F.2d 1370, 1388 (11th Cir. 1982); and then citing *Brown v. Plata*, 563 U.S. 493, 502 (2011)) (explaining that other courts had held that poor financing could not excuse unconstitutional conditions in prisons, and when prisons could not meet their constitutional burden, it was their duty to release or transfer prisoners “rather than continuing to subject them to unconstitutional conditions”).

141. *Id.* at 744 (“By claiming that cost is a reasonable consideration [in Tennessee], Dr. Williams is essentially arguing that what has been held to be cruel and unusual in Indiana is not cruel and unusual in Tennessee.”).

have to deal with the costs of HCV treatment regardless of whether that treatment is with DAAs or treating prisoners for cirrhosis or liver cancer.<sup>142</sup>

#### IV. ANALYSIS

In *Atkins v. Parker*, the Sixth Circuit held that Dr. Williams was not liable for deliberate indifference to inmates' HCV needs under his new 2019 HCV Guidance because these overhauled practices and protocols sought to best maximize treatment in a world of finite resources.<sup>143</sup> By upholding TDOC's prioritization scheme, the *Atkins* Court incorrectly disregarded the serious medical needs of prisoners and has dangerously signaled an approval of an inadequate resources defense. In response, state legislatures must take action to protect the health and safety of their incarcerated populations. Section IV.A argues that prioritization schemes are unreasonable measures when administering appropriate care for HCV. Therefore, the Sixth Circuit incorrectly concluded that Dr. Williams was not liable for deliberate indifference.<sup>144</sup> Next, Section IV.B addresses the Sixth Circuit's dangerous signaling that if a state prison system uses an inadequate resources defense, they will likely prevail.<sup>145</sup> Finally, Section IV.C discusses how some states have acted to treat *all* HCV-diagnosed inmates in their prison systems, and how these legislative and administrative actions complicate the inadequate resources defense.<sup>146</sup>

##### *A. The Court Incorrectly Disregarded the Serious Medical Needs of Prisoners and Professional Medical Guidance in Upholding Dr. Williams's Prioritization Scheme.*

Because the sole issue on appeal dealt with Dr. Williams' official actions, the Sixth Circuit accepted that HCV is an "objectively serious medical condition."<sup>147</sup> Thus, the Court only addressed the subjective prong, and concluded that Dr. Williams took reasonable actions in providing medical care to prisoners with HCV.<sup>148</sup> In doing so, the Court wrongly disregarded the serious medical needs of inmates and professional medical guidance in upholding the prioritization scheme.

The court—in concluding that Dr. Williams took reasonable actions in providing medical care to prisoners with HCV by upholding the prioritization

---

142. See *id.* (highlighting lower court findings that treating all inmates with chronic HCV now would likely save the state money when compared to the costly treatments associated with cirrhosis and liver cancer).

143. *Atkins*, 972 F.3d at 740.

144. See *infra* Section IV.A.

145. See *infra* Section IV.B.

146. See *infra* Section IV.C.

147. *Atkins*, 972 F.3d at 739.

148. *Id.* at 739–40.

scheme—effectively disregarded the serious medical needs of inmates in the lower stages of fibrosis. While HCV becomes more dangerous as the disease progresses, all stages of HCV are substantially serious because delaying treatment can cause significant damage to the liver and other organs.<sup>149</sup> Those with advanced scarring will require monitoring for liver cancer for the rest of their lives.<sup>150</sup> Likewise, even patients without severe liver scarring can experience serious symptoms.<sup>151</sup> These symptoms can include “depression, fatigue, sore muscles, joint pain, kidney injury, diabetes or glucose intolerance, certain types of rashes or autoimmune disease, lymphoma and leukemia.”<sup>152</sup> Courts have held that needlessly exposing prisoners to risks of serious harm, even if the symptoms are not immediately on display, violates the Eighth Amendment because it “constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency.”<sup>153</sup> As such, the prioritization scheme withholds highly effective treatment from individuals who now face significantly greater health risks.

Similarly, professional guidance indicates that the best practice for treating HCV is to treat early and treat all diagnosed patients.<sup>154</sup> Professional medical guidance has disbanded the use of prioritization tables in response to clear evidence that delaying treatment seriously harms people with chronic HCV.<sup>155</sup> The plaintiff’s expert testified that the Veteran’s Affairs Administration (VA), where he had worked, used a prioritization scheme until the VA realized the long-term benefits of early treatment.<sup>156</sup> Likewise, the AASLD/IDSA Guidance also removed prioritization tables from their treatment guidelines because of “the many benefits . . . that accompany HCV eradication.”<sup>157</sup> Although courts have

---

149. *Atkins*, 972 F.3d at 742 (Gilman, J., dissenting). See *supra* text accompanying notes 17–24.

150. *Atkins*, 972 F.3d at 742 (Gilman, J., dissenting).

151. *Id.*; see also *Chimenti*, 2018 WL 3388305, at \*12 (finding that inmates with low fibrosis, less than F2, have serious medical needs because “they may suffer from fatigue and other nonhepatic symptoms of their infections and, if not treated with DAAs before their disease progresses, may suffer from liver inflammation, liver fibrosis, liver cancer and liver-related mortality that they would not suffer if they were treated with DAAs”).

152. *Atkins*, 972 F.3d at 742 (Gilman, J., dissenting).

153. *Helling*, 509 U.S. at 32 (quoting *Estelle*, 429 U.S. at 104); see also *Boretti v. Wiscomb*, 930 F.2d 1150, 1154–55 (6th Cir. 1991) (finding that, despite the inmate’s wound healing on its own without prison medical care, the inmate had stated a claim for deliberate indifference because prison officials had needlessly denied the inmate relief by not providing daily dressing for the wound and the prescribed pain medication which was readily available).

154. *When and in Whom to Initiate HCV Therapy*, *supra* note 52.

155. *Id.*

156. *Atkins*, 972 F.3d at 741 (Gilman, J., dissenting).

157. *When and in Whom to Initiate HCV Therapy*, *supra* note 52; see also BOP 2021 GUIDANCE, *supra* note 47, at 1, 12 (removing its prioritization tables to reflect the updated AASLD/IDSA guidance). Notably, the AASLD/IDSA guidance does identify specific populations to help clinicians make more informed decisions regarding treatment and complications that may arise for those groups. *When and in Whom to Initiate HCV Therapy*, *supra* note 52.

held that prisons do not need to adhere to the “gold standard” of care in order to avoid a constitutional violation,<sup>158</sup> prison officials must not consciously expose an inmate to an excessive risk of serious harm.<sup>159</sup>

While officials may consider cost limitations in determining treatment options for inmates, delaying treatment is akin to no treatment.<sup>160</sup> Inmates have no other option but to depend on government resources for minimally adequate treatment for their medical needs.<sup>161</sup> Regardless of the stage of fibrosis progression, DAAs are the only professionally recommended course of treatment due to their high success rates.<sup>162</sup> Despite Dr. Williams’s “extensive monitoring” of inmates with chronic HCV,<sup>163</sup> a prioritization scheme fails as a reasonable measure to protect inmates from the virus’ progression, and thus falls below the constitutional “minimally adequate care” baseline.

*B. The Atkins Majority Has Dangerously Signaled an Approval for State Prisons to Use an Inadequate Resources Defense.*

The *Atkins* majority has signaled an approval for state prisons to use an inadequate resources defense, which could potentially have a dire impact on public health legal advocacy if courts are willing to justify treatment prioritization schemes due to lack of funding. In *Atkins*, the majority agreed that the premise of the plaintiffs’ “best practice” argument was true, but ultimately failed because the plaintiffs “demand[ed] that [Dr. Williams] spend money he did not have.”<sup>164</sup> The majority concluded that the U.S. Constitution did not require Dr. Williams to lobby the legislature for money.<sup>165</sup> This conclusion on the role that limited resources can play in prison health care is broad and open-ended. The Sixth Circuit is stating that if a prison does not have enough funds, then as long as that prison is maximizing that budget to meet the constitutional

---

158. See *Rhinehart*, 894 F.3d at 750 (“[T]he Eighth Amendment does not require prison medical providers to provide inmates with ‘unqualified access to health care.’ An inmate is entitled to adequate medical care, not the best care possible.”); see also *Estelle*, 429 U.S. at 107 (explaining that a medical decision, like not ordering an X-ray, does not constitute cruel and unusual punishment); *Dodson v. Wilkinson*, 304 F. App’x. 434, 440 (6th Cir. 2008) (finding that continuous testing and treatment since the inmate’s initial HCV-diagnosis is an acceptable medical judgment under the Eighth Amendment).

159. *Rhinehart*, 894 F.3d at 738–39.

160. See *Helling*, 509 U.S. at 33 (explaining that prisons cannot needlessly ignore a condition of confinement that is very likely to cause serious future health concerns); *Pfaller*, 630 B.R. at 213–14 (“[M]onitoring is not treatment.”).

161. See *Estelle*, 429 U.S. at 103 (“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.”).

162. *When and in Whom to Initiate HCV Therapy*, *supra* note 52.

163. *Atkins*, 972 F.3d at 740.

164. *Id.*

165. *Id.* But see *id.* at 744 (Gilman, J., dissenting) (arguing the final reasonable measure that Dr. Williams never took was to ask the legislature for enough funding to treat all HCV-diagnosed inmates).

minimum, the prison has met its constitutional obligations.<sup>166</sup> This proposition contradicts the fundamental principles established in *Estelle* of protecting prisoners from the deliberate indifference of prison officials.<sup>167</sup>

Moreover, in consideration of costs in a deliberate indifference claim, the Eleventh Circuit observed that “ordinary Americans forgo or delay beneficial . . . medical treatment because it’s just too expensive.”<sup>168</sup> The *Hoffer* Court remarked that prisoners were not immune to the “cruel reality” of expensive health care.<sup>169</sup> This argument is flawed because, unlike prisoners who are at the mercy of the state, the general population outside of prison can participate in the health care marketplace.<sup>170</sup> Prisoners, by contrast, rely solely on the state and the medical providers within the prison for their health care. Allowing a state greater leverage against Eighth Amendment protections places prisoners in an even more vulnerable position as they continue to rely on the state to provide for their basic needs.<sup>171</sup>

*C. If Courts Continue to Limit Access to DAAs in Approving Prioritization Schemes, State Legislatures Must Take Action to Address the HCV Endemic in Prisons.*

Judicial and legislative approval of the “insufficient funds” defense is dangerous because it would permit Eighth Amendment protections to vary from state to state based on the ability of state legislatures to provide adequate funding.<sup>172</sup> Notably, several states have secured funding to expand DAA treatment for inmates diagnosed with chronic HCV. For example, Louisiana, Michigan, and Washington State have signed “Netflix model” contracts with pharmaceutical companies.<sup>173</sup> Ideally, these contracts will allow states to pay a

---

166. *Atkins*, 972 F.3d at 740 (“The plaintiffs in essence demand that he spend money he did not have.”).

167. See *Estelle*, 429 U.S. at 102 (stating that the Eighth Amendment embodies “broad and idealistic concepts of dignity, civilized standards, humanity, and decency”); see also *Gordon*, 937 F.3d at 350–55 (finding that an inmate stated a claim when prison officials did not actively treat his HCV-diagnosis for about seven years due to his parole-eligible status); *Hoffer*, 973 F.3d at 1282 (Martin, J., dissenting) (noting that the majority wrongfully overlooked the fact that the lower court had found twice—with no contention from the Secretary—that “that the only reason [HCV] patients were not treated was due to lack of funding”).

168. *Hoffer*, 973 F.3d at 1276–77.

169. *Id.* at 1277.

170. The author is not arguing that American health care is accessible or affordable, only that outside of prison a health care marketplace exists.

171. See *Farmer*, 511 U.S. at 833 (“[H]aving stripped [prisoners] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course.”).

172. Robert Katz, *Hepatitis C Litigation: Healing Inmates as a Public Health Strategy*, 29 ANNALS HEALTH L. 127, 142 (2020).

173. *Id.* at 135; JoNel Aleccia et al., *Pharma Sells Washington State and Others on ‘Netflix Model’ to Wipe Out Hep C. But the Cost is Being Kept From the Public*, SEATTLE TIMES (Oct. 29, 2019, 6:00 AM),

base annual rate for an unlimited supply of the company's generic HCV medication.<sup>174</sup> All three states have signed onto the goal of eradicating HCV in their states, and this model allows them to reach their most vulnerable populations.<sup>175</sup> Other state legislatures have significantly increased their budgets or are actively debating budget increases to assist in the treatment of prisoners diagnosed with HCV.<sup>176</sup>

Similarly, several states have settled class action lawsuits with the promise of treating all or nearly all patients within their systems.<sup>177</sup> For example, in January 2020, South Carolina had been granted "preliminary" approval for a proposed settlement that promised testing and treatment for HCV to all inmates in South Carolina correctional facilities.<sup>178</sup> South Carolina's Department of Corrections also received ten million dollars in its 2019–2020 budget "to cover

---

<https://www.seattletimes.com/seattle-news/health/pharma-sells-washington-state-and-others-on-netflix-model-to-wipe-out-hep-c-but-the-cost-is-being-kept-from-the-public/>; O'NEILL INST. FOR NAT'L & GLOB. HEALTH L., *INNOVATIVE PAYMENT MODELS: AN ANALYSIS OF THE PROMISE AND PRACTICE OF NOVEL HEPATITIS C MEDICATION PROCUREMENT STRATEGIES IN THE U.S.* 6–7 (2021), <https://www.natap.org/2021/HCV/Innovative-Payment-Models.pdf>.

174. Aleccia et al., *supra* note 173; see also *Louisiana Launches Hepatitis C Innovative Payment Model With Asequa Therapeutics, Aiming to Eliminate the Disease*, LA. DEP'T OF HEALTH (June 26, 2019), <https://ldh.la.gov/news/5181> (agreeing to a base rate to a period of five years); O'NEILL INST. FOR NAT'L & GLOB. HEALTH L., *supra* note 173, at 3–7 (describing the Louisiana, Washington, and Michigan contracts).

175. See O'NEILL INST. FOR NAT'L & GLOB. HEALTH L., *supra* note 173, at 3–5 (noting that Louisiana's goal is 2024 and Washington's is 2030); LA. DEP'T OF HEALTH, *supra* note 174; Aleccia et al., *supra* note 173; MICH. DEP'T OF HEALTH & HUM. SERVS., *MICHIGAN'S STATE PLAN ON ELIMINATING HEPATITIS C* 3–4 (2021), [https://www.michigan.gov/documents/mdhhs/MDHHS\\_State\\_Plan\\_on\\_Eliminating\\_HCV\\_Final\\_Draft\\_720817\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MDHHS_State_Plan_on_Eliminating_HCV_Final_Draft_720817_7.pdf) ("[T]he overarching goal [is] that Michigan residents will have equitable access to programs and services to prevent the spread of HCV, which will be a curable disease for all."); see also U.S. DEP'T OF HEALTH & HUM. SERVS., *VIRAL HEPATITIS NATIONAL STRATEGIC PLAN FOR THE UNITED STATES: A ROADMAP TO ELIMINATION 3* (2020), <https://www.hhs.gov/sites/default/files/Viral-Hepatitis-National-Strategic-Plan-2021-2025.pdf> (supporting a goal to eliminate viral hepatitis by 2030).

176. See, e.g., Adam L. Beckman et al., *Follow California's Lead: Treat Inmates with Hepatitis C*, HEALTH AFFAIRS BLOG (Jul. 24, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180724.396136/full> ("California passed a budget allocating \$105.8 million to treat 22,000 inmates with hepatitis C currently held in its state prisons."); Seth Klamann, *Corrections Department Asks for \$4 Million to Treat Wyoming Inmates With Hepatitis C*, CASPER STAR TRIBUNE (Feb. 9, 2020), <https://trib.com/news/state-and-regional/health/corrections-department-asks-for-4-million-to-treat-wyoming-inmates-with-hepatitis-c> (explaining that Wyoming's corrections officials asked the state legislature for \$4 million for HCV treatment); Ted Alcorn, *'Major milestone': Governor's Budget Targets Hepatitis C Epidemic in Prisons*, N.M. IN DEPTH (Jan. 16, 2020), <http://nmindepth.com/2020/01/16/major-milestone-governors-budget-target-hepatitis-c-epidemic-in-prisons> (noting that the governor "recommend[ed] \$30 million in new funding for the Corrections Department for treatment of [HCV]"); Lisa Backus, *Settlement in Hep C Suit Reached as 500 Inmates Cured*, CT NEWS JUNKIE (Jan. 14, 2021, 5:00 AM), [https://ctnewsjunkie.com/2021/01/14/20210114\\_settlement\\_in\\_hep\\_c\\_suit\\_reached\\_as\\_500\\_inmates\\_cured/](https://ctnewsjunkie.com/2021/01/14/20210114_settlement_in_hep_c_suit_reached_as_500_inmates_cured/) ("The legislature approved \$20 million for the treatment of Hep-C in the agency's 2021 fiscal year budget.").

177. Katz, *supra* note 172, at 129–30.

178. *Mandated Hep C Treatment for SC Inmates Gets Initial Consent*, AP NEWS (Jan. 14, 2020), <https://apnews.com/article/4051e68697444fd48b9dc7f2831b8f78>.

drugs, staffing, equipment and other expenses related to the testing and treatment for hepatitis C.”<sup>179</sup> Other states with similar settlements include Colorado, Connecticut, Massachusetts, Minnesota, and Pennsylvania.<sup>180</sup> Although these settlements provide significant improvements to HCV testing and treatment for inmates, legislatures are in a stronger position to negotiate with pharmaceutical companies for better drug pricing options. Likewise, legislatures can look beyond the immediate issue of HCV treatment to longer term goals of HCV eradication.<sup>181</sup>

As more states move to address HCV as a public health issue, the question remains how an inadequate resources defense may cause discrepancies in treatment across states as some states will find the funding to treat inmates, while others will not.<sup>182</sup> This disparity highlights a potential problem where an inmate in one state could receive DAA treatment immediately regardless of fibrosis level, while an inmate in another state could not receive DAA treatment if the state implemented a prioritization scheme, claiming inadequate resources. Moreover, even if courts continue to accept this defense, in the case of HCV treatment, Netflix model contracts and settlements that mandate treatment for *every* diagnosed inmate demonstrate that each state can find funding for DAA treatment. Thus, not providing those funds is an Eighth Amendment violation.<sup>183</sup>

## V. CONCLUSION

The *Estelle* Court articulated that the Eighth Amendment protects prisoners from unnecessary suffering contrary to contemporary standards of decency: “[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.”<sup>184</sup> Contemporary standards of decency must include the use of a highly effective and curative treatment as

---

179. *Id.*

180. Katz, *supra* note 172, at 129; *see generally* Kleppin, *supra* note 99, at 278–79 (explaining the settlement agreements for Colorado, Pennsylvania, Minnesota, and Massachusetts).

181. *See* WHO, *Hepatitis C*, *supra* note 24 (setting a goal to eliminate viral hepatitis as a public health problem by significantly reducing new infections and deaths by 2030); *HCV Testing and Treatment in Correctional Settings*, *supra* note 101 (“Returning inmates to their communities cured of chronic HCV would be an invaluable step toward HCV elimination.”).

182. *Compare Hoffer*, 973 F.3d at 1272 (“To be clear, ‘some medical attention’ doesn’t necessarily demand curative care.”), *with Pfaller*, 630 B.R. at 213–14 (“[M]onitoring is not treatment. The treatment—the cure—for Hepatitis C is DAAs.”), *and* LA. DEP’T OF HEALTH, *supra* note 174 (explaining that the goal is to “eliminate” the disease in Louisiana by providing accessible DAA treatment).

183. *See Farmer*, 511 U.S. at 855 (Stevens, J., dissenting) (“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.”).

184. *Estelle*, 429 U.S. at 104.

opposed to needlessly waiting for advanced liver scarring.<sup>185</sup> What a “topsy-turvy world” we must live in when individuals at the mercy of state action must wait and see if the state will elect to cure them.

In *Atkins*, the Sixth Circuit failed to protect the plaintiffs from unnecessary suffering in upholding Dr. Williams’ prioritization scheme as a reasonable measure in his 2019 HCV Guidance. In upholding the prioritization scheme, the Court minimized the serious medical needs of prisoners and disregarded the modern standards of care for HCV treatment.<sup>186</sup> *Atkins* also signifies a nod of approval for an inadequate resources defense for deliberate indifference claims.<sup>187</sup> This approval of an inadequate resources defense is concerning because the outer limits regarding how a state prison may use the defense remain undefined.<sup>188</sup> Finally, state legislatures must act to protect the health and safety of their incarcerated populations, and properly care for those individuals who must rely on state correctional institutions to meet their basic health care needs.<sup>189</sup>

---

185. See DEP’T OF HEALTH & HUM. SERVS., CONSULTATION REPORT: EXPERT CONSULTATION ON THE EVIDENCE FOR EARLY HEPATITIS C TREATMENT IN THE UNITED STATES 2 (2016) (describing DAAs as “highly effective” and “curative”).

186. See *supra* Section IV.A.

187. See *supra* Section IV.B.

188. See *supra* Section IV.B.

189. See *supra* Section IV.C.