UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK
--X
ROBERT HILTON, on behalf of himself and all others similarly situated,

Plaintiff,

–against–

Case No. 9:05cv1038 (LEK) (GJD)

LESTER N. WRIGHT, M.D., M.P.H., Associate Commissioner/ Chief Medical Officer, for the New York State Department of Correctional Services; and the NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES,

Defendants.
--X

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF APPLICATION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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Centers for Disease Control and Prevention, "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease" (1998) (available at http://www.cdc.gov/mmwr/PDF/RR/RR4719.pdf) 20

Georg M. Lauer and Bruce D. Walker, Hepatitis C Virus Infection, 345 New Engl. J. Med. 41 (2001) 21

National Institute of Diabetes and Digestive and Kidney Diseases, Chronic Hepatitis C: Current Disease Management, NIH Pub. No. 03-4230 (May 1999) (available at http://www.medhelp.org/NIHlib/GF-483.html) 21

National Institutes of Health, Consensus Development Conference Statement, "Management of Hepatitis C" (2002) (available at http://www.hepprograms.org/drug/hepcconfer.pdf) 3, 4, 21

National Institutes of Health, Consensus Development Conference Statement, "Management of Hepatitis C" (1997) (available at http://consensus.nih.gov/cons/105/105_intro.htm) 21

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PRELIMINARY STATEMENT

Plaintiff Robert Hilton, a prisoner in the custody of the New York State Department of Correctional Services ("DOCS"), seeks a temporary restraining order and preliminary injunction compelling defendants to authorize a standard course of antiviral therapy to stop the progressive liver deterioration he suffers as a result of a chronic Hepatitis C infection. Prison physicians employed by DOCS have uniformly recommended that Mr. Hilton receive such treatment without delay. Nonetheless, defendants have denied the treatment under a policy that categorically requires inmates such as Mr. Hilton to enroll and participate in substance abuse programming before receiving medically indicated antiviral therapy. The policy was recently declared unconstitutional by New York State's Appellate Division, Second Department. The United States Court of Appeals for the Second Circuit has likewise affirmed in recent months that conditioning Hepatitis C treatment on uniform substance abuse criteria, rather than particularized medical judgment, violates the Eighth Amendment. Because defendants refuse to alter their longstanding policy, resulting in the denial of necessary medical care for a progressive and potentially fatal disease, Mr. Hilton brings this action under, inter alia, 42 U.S.C. § 1983, to challenge the violation of his rights under the Eighth and Fourteenth Amendments to the United States Constitution.

Hepatitis C is a blood-borne virus that attacks and, if not treated, commonly destroys the liver. Liver damage progresses through a series of stages beginning with isolated fibrosis, or scarring, and often culminating in cirrhosis, or pervasive scarring and inflammation. If treated soon enough with the course of antiviral therapy prescribed by Mr. Hilton's doctors, Hepatitis C can be contained before liver function becomes impaired. Yet once a patient crosses an identifiable clinical threshold to exhibit "decompensated" cirrhosis, liver function deteriorates

beyond repair, leaving organ replacement as the only treatment capable of restoring a patient to health. The development of cirrhosis is not only life-threatening in and of itself, but also increases the risk that a patient will develop hepatocellular carcinoma, a type of cancer.

Under DOCS policy, any prisoner suspected to have a history of illicit substance use, no matter how ancient the history or limited the use, must at the discretion of defendant Lester Wright, Chief Medical Officer for defendant Department of Correctional Services, enroll and participate in substance abuse programming to qualify for antiviral therapy. As shown in the declaration of Dr. Brian R. Edlin, submitted herewith, this policy is not supported by any medical rationale in the case of prisoners like Mr. Hilton. Rather, the application of established clinical criteria properly led DOCS' own consulting physician to recommend in April of this year that Mr. Hilton begin antiviral therapy. Notwithstanding the efforts of Mr. Hilton's primary care providers to carry out the prescribed regimen, treatment has been denied because Mr. Hilton, who last used an illicit drug more than 13 years ago, has been refused enrollment in the requisite substance abuse programming. Absent the provisional remedies of a temporary restraining order ("TRO") and preliminary injunction, the DOCS policy denying medically indicated antiviral therapy will cause irreparable injury stemming from Mr. Hilton's progressive liver deterioration and the prospect for it to become incurable.

Mr. Hilton is likely to succeed on the merits of his claims in light of the medical consensus that antiviral therapy is indicated for his condition, as well as a string of recent decisions applying established Eighth Amendment principles to bar defendants from conditioning Hepatitis C treatment on medically inessential substance abuse criteria. See Johnson v. Wright, 412 F.3d 398 (2d Cir. 2005); McKenna v. Wright, 386 F.3d 432 (2d Cir. 2004); Domenech v. Goord, 797 N.Y.S.2d 313, 314 (2d Dept. 2005), affirming 766 N.Y.S.2d

287 (Sup. Ct. 2003); Morgan v. Koenigsmann, No. 03 Civ. 3987 (S.D.N.Y. Sept. 30, 2004) (annexed hereto) (appeal pending).

Plaintiff accordingly asks the Court to grant injunctive relief compelling the defendants to authorize the prescribed treatment immediately.

STATEMENT OF FACTS

Mr. Hilton suffers from a chronic infection with the Hepatitis C virus, Type 1 genotype. See Affirmation of Alexander A. Reinert, Esq. ("Reinert Aff.") at Ex. E (Final Report dated Nov 5, 2004). From the time of his commitment to DOCS custody in August 2004,[1] standard clinical criteria have indicated treatment with a 48-week course of medication combining two antiviral agents, pegylated interferon and ribavirin. Reinert Aff. ¶¶ 2, 5-11, Ex. A-F; see generally National Institutes of Health, Consensus Development Conference Statement, "Management of Hepatitis C: 2002" [hereinafter NIH Consensus Statement] (available at http://www.hepprograms.org/drug/hepcconfer.pdf). The use of such "combination" interferon-ribavirin therapy is now generally considered the standard of care for the treatment of Hepatitis C in patients whose liver deterioration has not reached the stage of decompensated cirrhosis. See NIH Consensus Statement at 14. When successful, combination antiviral therapy can effectively cure sufferers of Hepatitis C, rendering the disease no longer a threat to their health. See NIH Consensus Statement at 15-16. Once a patient develops decompensated cirrhosis, however, antiviral therapy becomes ineffective and Hepatitis C incurable by any means short of liver transplant. See NIH Consensus Statement at 7. Moreover, even in patients who have not developed decompensated cirrhosis, combination antiviral therapy becomes less effective as the

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[1]Before DOCS assumed custody, Mr. Hilton had spent three months at Rikers Island in New York City. See Reinert Aff. ¶ 6.

liver disease progresses. See NIH Consensus Statement at 20-21; DOCS Primary Care Practice Guideline, attached as Ex. I to Reinert Aff., at 5 ¶ 4.

Prior to his commitment to DOCS custody, Mr. Hilton submitted in December 1999 to a liver biopsy to assess the extent of histological deterioration associated with his Hepatitis C infection. Reinert Aff. ¶ 10, Ex. F. At that time, the damage to Mr. Hilton's liver was diagnosed as Grade 2, Stage 2. Id. That designation reflects the standard classification spectrum developed to grade the progress of liver deterioration, whereby incipient damage rates at Grade 1, Stage 1 and pervasive inflammation and scarring, or cirrhosis, rates at Grade 4, Stage 4. Declaration of Brian R. Edlin, M.D. [hereinafter "Edlin Decl."], attached as Ex. A to Reinert Aff., at ¶ 13. As of Mr. Hilton's December 1999 assessment, there remained two clinically recognized thresholds between the fibrosis observed in his liver and the condition of patients in whom liver damage has progressed to the point of requiring a transplant. Id.

As stated in the Declaration of Dr. Brian R. Edlin, there is no reliable means, apart from biopsy, of detecting whether Hepatitis C has progressed in a particular patient from Grade 2, Stage 2 to decompensated cirrhosis. Edlin Decl. ¶ 13. It is clear, however, that Mr. Hilton is among the category of patients at an increased risk for progression to cirrhosis, as indicated by HCV RNA (ribonucleic acid) levels higher than 50 IU/mL, a liver biopsy with portal or bridging fibrosis, and at least moderate inflammation and necrosis. NIH Consensus Statement at 19; Edlin Decl. ¶ 13. A laboratory analysis conducted on blood drawn from Mr. Hilton on March 30, 2005 showed him to have an HCV RNA level of more than 2.54 million IU/mL. Reinert Aff. Ex. E (Final Report dated April 5, 2005). Mr. Hilton's 1999 biopsy revealed both portal fibrosis and portal inflammation. Reinert Aff. Ex. F. In light of these symptoms, a medical consensus recognizes combination antiviral therapy to be indicated. NIH Consensus Statement at 19.

On April 22, 2005, pursuant to a referral from Mr. Hilton's doctor at the Altona Correctional Facility, a DOCS consulting physician examined Mr. Hilton and conducted a review of his medical history, including the 1999 liver biopsy and March 2005 lab results. Reinert Aff. ¶ 10, Ex. F. The physician determined that Mr. Hilton should begin receiving combination therapy with pegylated interferon and ribavirin. Id. Upon receiving the consultant's recommendation, Mr. Hilton's health care providers at the Altona facility secured Mr. Hilton's consent to treatment and sought departmental approval for the recommended antiviral therapy. Reinert Aff. ¶ 11, Ex. D, G-H.

On or about May 2, a provider at Altona completed a "Health Services Hepatitis C Form," which designated spaces for information relating to various criteria, such as blood-work measures of viral infection and liver function. Reinert Aff. Ex. E (bearing handwritten notation of date). One space on the form, which Mr. Hilton's providers did not complete, sought confirmation of the inmate's participation in substance abuse programming, which DOCS refers to as "ASAT" or "RSAT" for, respectively, "Alcohol and Substance Abuse Treatment" and "Residential Substance Abuse Treatment." At the time of the form's completion, Mr. Hilton had not used any illicit drug for more than a decade. Affidavit of Robert Hilton [hereinafter "Hilton Affidavit"], attached as Ex. M to Reinert Aff., at ¶¶ 3-6. Some twelve years earlier, however, in 1993, Mr. Hilton had admitted to DOCS personnel that he had, as a teenager, smoked marijuana and sniffed cocaine. Hilton Affidavit ¶ 16. Over the following years of confinement and parole, Mr. Hilton submitted to drug tests that uniformly showed him to be drug free. Id. ¶¶ 3, 5. DOCS own communications with Mr. Hilton make clear that corrections personnel regard his 1993 statement and his assessment at that time via the Michigan Alcohol Screening Test ("MAST") as the only indication of drug use. Reinert Aff. ¶ 27-28, Ex. Q.

Notwithstanding Mr. Hilton's abstinence from drug use for well over a decade, he was required, pursuant to a Hepatitis C Primary Care Practice Guideline adopted by DOCS ("Guideline"), to enroll in Altona's RSAT program as a condition of receiving antiviral therapy. Reinert Aff. ¶¶ 24, 26, 29 Ex. N, P, S. Mr. Hilton elected to comply with the Guideline in an effort to expedite his treatment, even though substance abuse counseling was wholly extraneous both to the treatment indicated for his Hepatitis C and to his general health. Hilton Affidavit ¶¶ 10-11, 21-22. Although Mr. Hilton promptly had his name placed on Altona's RSAT waiting list, he was subsequently informed by Thomas Flynn, a supervising nurse, that his antiviral therapy would not commence until enough spaces opened in the program to permit his enrollment. Reinert Aff. Ex. N. In a May 10 memorandum to Mr. Hilton, Nurse Flynn advised as follows:

> Dr. Wright will not approve the medication order until you are actively enrolled in RSAT. I thought the waiting list would be good enough. As soon as you start RSAT let me know and I will try again.

Id. Nurse Flynn subsequently advised another DOCS health care provider that Mr. Hilton "was not approved by Dr. Wright because he is not enrolled in ASAT," and that "until he is in ASAT [he] cannot resubmit for approval per Dr. Wright." Reinert Aff. ¶ 29, Ex. S.

On or about May 16, 2005, Mr. Hilton was transferred from Altona to the Washington Correctional Facility. Reinert Aff. ¶ 26. There, he filed a grievance pursuant to N.Y. Corr. L. § 139 demanding immediate antiviral treatment. Id. ¶ 26, Ex. O. The facility's Inmate Grievance Resolution Committee, which included two members of the prison's staff, see 7 N.Y.C.R.R. 701.4, found Mr. Hilton's complaint warranted and recommended that antiviral therapy be commenced. Reinert Aff. ¶ 26, Ex. O. On June 8, the committee's recommendation was rejected by Superintendent James Plescia, who stated that, pursuant to defendants' policy, Mr.

Hilton could not receive Hepatitis C treatment unless he enrolled in ASAT or RSAT. Id. ¶ 26, Ex. P. Superintendent Plescia's decision was upheld on July 6 by the DOCS Central Office Review Committee upon Mr. Hilton's appeal. Id. ¶ 26.

Subsequent to the rejection of Mr. Hilton's grievance by the Central Office Review Committee, he was for a second time denied enrollment in the substance abuse treatment program imposed as a necessary prerequisite to Hepatitis C treatment. Specifically, on or about July 26, Mr. Hilton was informed that he could not enroll in Washington's ASAT program because his parole eligibility date of November 2 creates a possibility that he might not be confined throughout the six-month term of participation generally required of enrollees.[2] Reinert Aff. ¶ 28, Ex. R; Hilton Affidavit ¶¶ 20-21.

Mr. Hilton therefore continues to be denied combination antiviral therapy prescribed by a consulting physician, and sought by his doctors at Altona and Washington, because DOCS has predicated his eligibility for treatment on enrollment in unrelated, unnecessary, and, in fact, unavailable substance abuse programming. As antiviral treatment eludes Mr. Hilton on the basis of this Catch 22, his liver deterioration continues unimpeded.

ARGUMENT

I. A Temporary Restraining Order Is Necessary to Ensure That Mr. Hilton's Liver Disease Progresses No Further During the Pendency of His Application for a Preliminary Injunction

"[T]he purpose of a temporary restraining order is to preserve the status quo and prevent irreparable harm until the court has an opportunity to pass on the merits of the demand for a preliminary injunction." Miller v. Fisher, No. 92-CV-973, 1993 WL 438761 at *1 (N.D.N.Y.

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[2]Mr. Hilton will be incarcerated until October 30, 2008, if he is not granted parole. Reinert Aff. ¶ 3.

Oct. 26, 1993) (Report and Recommendation adopted by order of Mar. 23, 1995) (citation omitted).

In order to preserve the status quo, the Court may in its discretion order DOCS to take the affirmative step of initiating medical treatment. Doe v. Barron, 92 F. Supp. 2d 694, 696 (S.D. Ohio 1999) (confirming TRO compelling prison personnel to transport plaintiff to medical provider for abortion services); McLaughlin v. Williams, 801 F. Supp. 633 (S.D. Fla. 1992) (confirming TRO compelling defendant to facilitate plaintiff's placement on waiting list for liver transplant); cf. Detroit Medical Center v. GEAC Computer Systems, Inc., 103 F. Supp. 2d 1019 (E.D. Mich. 2000) (enjoining contractor to resume maintenance of computer systems); Reynolds v. Giuliani, 35 F. Supp. 2d 331 (S.D.N.Y. 1999) (confirming TRO compelling defendant to provide emergency food stamps and cash assistance); Belknap v. Leary, 314 F. Supp. 574, 575 (S.D.N.Y.) (enjoining New York City Police Department "to take all reasonable precaution and means" to protect anti-war protesters who had been attacked by private citizens at earlier demonstration), rev'd and vacated on other ground, 472 F.2d 496 (2d Cir. 1970).

In the context of health risks whereby a known harm may come to pass at an unknown time, an application for a temporary restraining order need not establish the exact hour and minute at which health will deteriorate beyond repair. For example, in Rabin v. Wilson-Coker, No. 03 Civ. 555, 2003 WL 1741883 at *1 (D. Conn. 2003), the Court ordered the defendant to maintain plaintiffs' Medicaid eligibility because termination of benefits created a serious risk that, on losing access to health care, plaintiffs would develop "significant adverse consequences" including seizures, swelling, and pain. Similarly, in Doe v. Barron, 92 F. Supp. 2d 694, 696 (S.D. Ohio 1999), the court compelled a defendant to provide the plaintiff immediate access to an abortion provider because "a delay will unnecessarily increase the health risks imposed on

Plaintiff." The court expressly rejected the defendant's argument that the several weeks remaining in plaintiff's first trimester could accommodate a later hearing date. Id.

Due notice of plaintiff's application for a temporary restraining order (TRO) has been given. See Reinert Aff. ¶ 33; Fed. R. Civ. P. R. 65(b), advisory committee note to 1966 amendment (recognizing proper role of informal notice in TRO proceedings); Environmental Defense Fund, Inc. v. EPA, 485 F.2d 780, 784 n.2 (D.C. Cir. 1980) (actual notice of TRO sufficient to bind non-party).

The temporary retraining order sought by plaintiff should issue because it is necessary to preserve the status quo. In light of the progressive course of Hepatitis C, maintenance of the status quo requires the immediate commencement of antiviral treatment. The longer Mr. Hilton awaits treatment, the less likely that treatment is to be effective once commenced, a danger recognized in DOCS' own treatment guidelines. See Edlin Decl. ¶ 13; Hepatitis C Primary Care Practice Guideline, attached to Reinert Aff. as Ex. I, at 5 ¶ 4. Furthermore, the danger of decompensated cirrhosis, incurable without liver transplant, threatens to alter the critical feature of plaintiff's present medical condition, namely, his opportunity to permanently contain his Hepatitis C infection by adhering to a 48-week course of medication. The possibility that a delay in treatment will upend this status quo vests this Court with full discretion to temporarily restrain defendants in the manner requested by plaintiff.

Pursuant to the immediacy of the harm demonstrated by plaintiff and the actual notice afforded to defendant, the determination of plaintiff's TRO application should be guided by the same substantive standard controlling his application for a preliminary injunction. Grant v. United States, 282 F.2d 165, 167-68 (2d Cir. 1960) (discussing circumstances under which TRO may be functional equivalent of preliminary injunction); Synder v. Farnsworth, 896 F. Supp. 96,

98 (N.D.N.Y. 1995) (Cholakis, J.). The distinction is simply that a TRO is needed to protect Mr. Hilton from irreparable injury pending determination of his application for a preliminary injunction, whereas a preliminary injunction is needed to protect him pending final determination of his statutory and constitutional claims.[3] Plaintiff will hereinafter discuss the pertinent standard under the rubric of "preliminary injunctive relief," which phrase plaintiff uses to encompass both the TRO and the preliminary injunction presently sought.

II. Preliminary Injunctive Relief is Warranted by Mr. Hilton's Demonstration of Irreparable Injury and His Potent Probability of Success on the Merits

"The standard for issuing a preliminary injunction is well-settled in this Circuit. The moving party must show (1) irreparable harm and (2) either (a) likelihood of success on the merits or (b) sufficiently serious questions going to the merits and a balance of hardships tipping decidedly toward the party seeking the injunctive relief." Covino v. Patrissi, 967 F.2d 73, 76-77 (2d Cir. 1992). The irreparable harm Mr. Hilton will suffer absent immediate treatment is sufficient to satisfy the first prong of this standard, while his likelihood of success is assured by the medical consensus that his condition warrants treatment with antiviral therapy and the preclusive and precedential force of federal and state decisions issued over the past ten months. See, e.g., Domenech v. Goord, 797 N.Y.S.2d 313, 314 (2d Dept. 2005), affirming 766 N.Y.S.2d 287 (Sup. Ct. 2003); Morgan v. Koenigsmann, No. 03 Civ. 3987 (S.D.N.Y. Sept. 30, 2004) (annexed hereto).

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[3]Insofar as the Court is ready to decide plaintiff's motion for a preliminary injunction at the conclusion of argument on an Order to Show Cause, plaintiff's TRO application will become moot. If, however, the Court requires further opportunity to deliberate, plaintiff asks the Court to enter a temporary restraining order forthwith.

A. Mr. Hilton's Progressive Liver Deterioration, Mental Anguish, and Subjection to Cruel and Unusual Punishment Are Each Irreparable Injuries Warranting Injunctive Relief

Defendants' policy of conditioning antiviral treatment on participation in ASAT programming causes Mr. Hilton irreparable injury stemming from his progressive liver deterioration.

"To establish irreparable harm, a party seeking preliminary injunctive relief must show that there is a continuing harm which cannot be adequately redressed by final relief on the merits and for which money damages cannot provide adequate compensation." Kamerling v. Massanari, 295 F.3d 206, 214 (2d Cir. 2002) (citations omitted). In other words, the injury must be "present, actual, and not calculable." Galusha v. New York State Dep't of Env. Conservation, 27 F. Supp. 2d 117, 122 (N.D.N.Y. 1998) (Kahn, J.). The prosecution of injunctive and damages claims in tandem does not foreclose a showing that the damages sought will not adequately remedy the incalcuable, non-monetary component of the contemplated harm. See, e.g., Roso-Lino Beverage Distributors v. Coca-Cola Bottling Co., 749 F.2d 124, 125-26 (2d Cir. 1984) (granting preliminary injunction because "loss of. . . an ongoing business representing many years of effort and the livelihood of its husband and wife owners. . . cannot be fully compensated by subsequent monetary damages"). Examples of irreparable harm recognized by this Court include, among others, a student's suspension from school, Snyder, 896 F. Supp. at 98, and the exclusion of disabled persons from portions of a public park closed to motor vehicle traffic, Galusha, 27 F. Supp. 2d at 122.

Plaintiff has satisfied the first prong of the test for preliminary injunctive relief in at least three ways. First, Mr. Hilton's ongoing liver deterioration as his Hepatitis C goes untreated is an irreparable injury. See Harris v. Blue Cross Blue Shield, 995 F.2d 877, 879 (8th Cir. 1993)

(exhorting that "[w]e entertain no question but that irreparable injury existed" at time plaintiff challenged denial of treatment for metastatic breast cancer).

Second, the prospects associated with further delay cause Mr. Hilton to suffer the additional actual harms of acute anxiety, mental anguish, helplessness, and frustration. Delay in the commencement of antiviral therapy decreases the probability of ever containing Mr. Hilton's life-threatening illness. Should liver deterioration continue unimpeded, Mr. Hilton's survival may come to depend upon an expensive, intrusive, and uncertain liver transplant, which he is by no means assured of receiving either in prison or out.[4] As a result, Mr. Hilton suffers emotional and mental hardship which, like the deterioration of his health, is a continuing harm that can be adequately redressed only by the immediate provision of antiviral therapy, not by any final relief on the merits in the nature of money damages.[5]

Third, the denial of a constitutional right is itself irreparable injury. Jolly v. Coughlin, 76 F.3d 468, 482 (2d Cir. 1996). Plaintiff has been denied recommended medical treatment for a serious medical need, which is a textbook Eighth Amendment violation. See Estelle v. Gamble, 429 U.S. 97, 104 (1976); McKenna v. Wright, 386 F.3d 432, 436-37 (2d Cir. 2004). Indeed, as

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[4]Data published by the Organ Procurement and Transplantation Network, which maintains a national organ transplant waiting list pursuant to statutory authority, see 42 U.S.C. § 274(b)(2), indicates that more than 17,000 persons currently await liver transplants in the United States. See Organ Procurement and Transplantation Network, Data, available at http://www.optn.org/latestData/advancedData.asp (visited Aug. 15, 2005). More than 40 percent of these candidates have been waiting for three or more years. Id.

[5]The uniquely definitive and fundamental injury caused by failing to halt the course of a progressive, life-threatening disease is so serious that this Court may relax the showing to which Mr. Hilton is held on the likelihood-of-success prong. See Kamine/Besicorp Allegany L.P. v. Rochester Gas & Electric Corp., 908 F. Supp. 1180, 1187 (W.D.N.Y. 1995). For the reasons set forth in the following subpart, however, Plaintiff has in any event demonstrated a sufficient likelihood of success on the merits to obtain injunctive relief no matter how rigorously the second prong is applied.

indicated above and discussed more fully in the next sub-part, authoritative precedent published in recent months expressly holds that defendants have violated the Eighth Amendment by conditioning Mr. Hilton's access to Hepatitis C treatment on ASAT programming. Accordingly, Mr. Hilton has suffered and continues to suffer irreparable injury in his subjection to a condition of confinement that cannot be reconciled with "the evolving standards of decency that mark the progress of a maturing society." Trop v. Dulles, 356 U.S. 86, 101 (1958).

B. Mr. Hilton Is Likely to Succeed on the Merits Under the Doctrine of Collateral Estoppel And Recently Decided Eighth Amendment Precedent

A likelihood of success entitling Mr. Hilton to preliminary injunctive relief, see Covino, 967 F.2d at 76-77, is assured by four recent decisions and a medical consensus that Mr. Hilton's condition warrants treatment with antiviral therapy.[6]

1. The Defendants' Prior Litigation of Eighth Amendment Challenges to the ASAT Requirement Entitles Mr. Hilton to Prevail Under the Doctrine of Collateral Estoppel

Defendants have in recent months defended a string of federal and state actions addressing the constitutionality, under the Eighth Amendment, of conditioning Hepatitis C treatment on criteria related to substance abuse, including the requirement that candidates for antiviral therapy participate in ASAT programming if they have ever used any illicit drug. Most recently, in Domenech v. Goord, 797 N.Y.S.2d 313, 314 (2d Dept. 2005), the Appellate Division of the New York Supreme Court held that defendants' policy of conditioning medical treatment on ASAT participation violates the Eighth Amendment bar on cruel and unusual punishments.

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[6]Plaintiff submits that the discussion hereinafter indicates his "substantial" likelihood of success on the merits insofar as this Court deems the relief he seeks to be in the nature of a "mandatory" injunction warranting application of that heightened standard. Compare Fair Housing in Huntington Comm. v. Town of Huntington, 316 F.3d 357, 365 (2d Cir. 2003).

Over the preceding nine months, the Second Circuit U.S. Court of Appeals had likewise instructed, in two published decisions, that defendants violate inmates' constitutional rights insofar as they condition Hepatitis C treatment on substance abuse criteria not essential to the determination of whether antiviral therapy is medically indicated. Johnson v. Wright, 412 F.3d 398 (2d Cir. 2005); McKenna v. Wright, 386 F.3d 432 (2d Cir. 2004). Shortly before the earlier Second Circuit decision, Judge Kimba M. Wood of the Southern District of New York had also recognized an Eighth Amendment violation to inhere in any policy requiring an inmate who had abstained from drug use for 13 years to enroll in ASAT programming before receiving antiviral therapy. Morgan v. Koenigsmann, No. 03 Civ. 3987 (S.D.N.Y. Sept. 30, 2004) (annexed hereto).

While the freestanding authority and rationale of these precedents, as discussed more fully below, demonstrates Mr. Hilton's substantial likelihood of success, Dr. Wright's prior litigation of the merits simultaneously triggers application of the doctrine of collateral estoppel, also known as issue preclusion. See Parklane Hosiery Co. v. Shore, 439 U.S. 322 (1979). Under this doctrine, Mr. Hilton is assured a substantial likelihood of success because defendants are barred from again revisiting the constitutionality of the ASAT requirement.

A prior decision's resolution of an issue of law may merit preclusive effect. Kremer v. Chemical Construction Corp., 456 U.S. 461, 466-67 n.6 (1982) (citing cases). For the doctrine of collateral estoppel to apply, "(1) the issues in both proceedings must be identical; (2) the issue in the prior proceeding must have been actually litigated and actually decided; (3) there must have been a full and fair opportunity for litigation in the prior proceeding; and (4) the issue previously litigated must have been necessary to support a valid and final judgment on the merits." SEC v. Monarch Funding Corp., 192 F.3d 295, 304 (2d Cir. 1999).

Each of the requisite elements obtains here. The recent cases litigated by defendants have

addressed the constitutionality of denying Hepatitis C treatment on the basis of substance abuse criteria not essential to the determination of whether antiviral therapy is medically indicated. See Johnson, 412 F.3d at 405-06; McKenna, 386 F.3d at 437; Domenech v. Goord, 766 N.Y.S.2d 287, 293 (Sup. Ct. 2003), aff'd, 797 N.Y.S.2d 313; Morgan, No. 03 Civ. 3987 at 19-22. That issue was actually litigated and decided against defendants in each action, and the range of procedural rights asserted by defendants in the several proceedings amply confirms their full and fair opportunity for litigation. Compare McKenna, 386 F.3d at 433 (appeal from denial of motion under Rule 12(b)(6)) with Johnson, 412 F.3d at 403 (appeal from denial of summary judgment) with Domenech, 797 N.Y.S.2d at 313-14 (appeal from judgment in Article 78 proceeding). The constitutionality of conditioning antiviral therapy on criteria relating to substance abuse was the core substantive issue addressed on each appeal, and as such was plainly necessary to support valid and final judgments on the merits.

At a minimum, the Domenech and Morgan decisions held unconstitutional any reflexive application of the ASAT requirement to prisoners who have not used alcohol or drugs for many years. In Domenech, the court specifically relied on the absence of any evidence that the petitioner inmate was currently abusing drugs or alcohol, 766 N.Y.S.2d at 288, as well as the indication in defendants' own records that the inmate had not used drugs or alcohol within the preceding two years, id. at 293, to hold that conditioning medically indicated antiviral therapy on ASAT participation "is arbitrary and capricious and results in a deliberate denial of medical attention to [the inmate's] serious medical condition in violation of the Eighth Amendment." Id. at 294, aff'd, 797 N.Y.S. 2d 313. The court reasoned that participation in ASAT is "irrelevant" and that defendants "cannot, as a matter of law, provide a medical justification for the continued

denial of medical treatment." Domenech, 766 N.Y.S.2d at 293.[7] Similarly, in Morgan, the court held that reflexive application of the ASAT requirement to an inmate who had been drug-free for 13 years would amount to a "denial of necessary medical care to plaintiff without any medical justification" and could thus support a jury's conclusion that defendants acted with deliberate indifference. Morgan, No. 03 Civ. 3987 at 21-22 & n.23 (annexed hereto) (appeal pending).[8]

The same facts defining the constitutional issue decided against defendants in Domenech and Morgan hold here. There is no evidence that Mr. Hilton has used drugs at any time since he was a teenager, see Hilton Affidavit, attached as Ex. M to Reinert Aff., at ¶¶ 3-6, 16, and DOCS' own records corroborate his abstinence since entering custody in 1993. See Reinert Aff. Ex. Q (correction counselor's memorandum reciting drug use history considered in evaluation of Mr. Hilton's application to enroll in ASAT).

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[7]Above and beyond the federal doctrine of collateral estoppel, Article IV of the United States Constitution and 28 U.S.C. § 1738 require that the state court decision in Domenech be given the same preclusive effect in this proceeding as it would have under state law. Kremer, 456 U.S. at 466. Under New York law, the "doctrine of collateral estoppel precludes a party from relitigating an issue which has previously been decided against him in a proceeding in which he had a fair opportunity to fully litigate the point." Kaufman v. Eli Lilly & Co., 65 N.Y.2d 449, 455 (1985) (citation omitted). The state doctrine imposes "but two requirements": the "identical issue necessarily must have been decided in the prior action and be decisive of the present action," and "the party to be precluded from relitigating the issue must have had a full and fair opportunity to contest the prior determination." Id.; In re Abady, __ N.Y.S.2d ___, 2005 WL 1529725 at *7 (1st Dept. 2005). New York law also affords full preclusive effect to a judgment notwithstanding the pendency of an appeal therefrom. Anonymous v. Dobbs Ferry Union Free School District, 797 N.Y.S.2d 120, 121 (2d Dept. 2005). Because New York law is for purposes of this case functionally equivalent to the federal doctrine of collateral estoppel, plaintiff rests on the discussion in this memorandum's text with respect to the Domenech decision.

[8]For collateral estoppel purposes, "a judgment may be final, despite the fact that an appeal from it has not been decided." McFarlane v. Village of Scotia, 86 F. Supp. 2d 60, 65 (N.D.N.Y. 2000) (Hurd, J.); see also Erebia v. Chrysler Plastic Products Corp., 891 F.2d 1212, 1215 n.1 (6th Cir. 1989) ("[T]he established rule in the federal courts is that a final judgment retains all of its preclusive effect pending appeal.").

That Mr. Hilton was not party to the previous litigation does not deprive him of opportunity to rely on the collateral estoppel bar. Notwithstanding the traditional requirement of "privity," the Supreme Court has made clear that neither courts nor new plaintiffs should be required to expend resources in the needless litigation of issues previously resolved pursuant to a defendant's full and fair opportunity to be heard. Parklane Hosiery, 439 U.S. at 326-27, 332-33. Only insofar as special considerations warrant rehearing is a district court deprived of broad discretion to preclude a defendant from the serial re-litigation of the same issue against new plaintiffs. Among these special considerations are the ease with which a plaintiff might have joined the prior action, the existence of multiple judgments resolving the same issue inconsistently, and such circumstances as may have prevented or discouraged a defendant from contesting the prior action with due vigor. Id. at 330-31.

None of these considerations is present here. As a confined prisoner with neither regular counsel nor opportunity to monitor newly filed claims in state and federal courts, Mr. Hilton had no means of learning that other prisoners, confined in other facilities, had challenged denials of treatment under defendants' ASAT requirement. Even were Mr. Hilton to have learned of such an action, the limitations which the fact of confinement imposes on inmates' access to courts would have impaired his ability to navigate the procedural requirements governing intervention. See, e.g., Lewis v. Casey, 518 U.S. 343, 362 (1996) (delays in delivery of legal materials not of "constitutional significance" so long as they owe to "prison regulations reasonably related to legitimate penological interests"); Fed. R. Civ. P. R. 24 (conditioning intervention on "timely application"). For both reasons, it cannot be said that he might "easily have joined" in the prior actions. Parklane Hosiery, 439 U.S. at 331.

As already discussed, the decisions hold that defendants violate the Eighth Amendment

insofar as they apply the ASAT requirement to withhold medically indicated treatment.[9] Thus application of the doctrine of collateral estoppel will not limit the judicial encounter with any constitutional question nor work any inequity upon defendants.

Finally, defendants can point to no circumstances that prevented or discouraged them from vigorously defending the prior actions by which has been established the constitutional infirmity in their policy. They have been ably represented in each action by counsel from the Office of the Attorney General, whose special expertise in defending representatives of the Department of Correctional Services has been noted by this Court. Miller v. Fisher, No. 92 Civ. 973, 1993 WL 438761 at *6 (N.D.N.Y. Oct. 26, 1993) (Hurd, J.) (Report and Recommendation adopted by order of Mar. 23, 1995). The inmates who prosecuted the prior actions have sought both damages and injunctive relief. Compare, e.g., Domenech, 766 N.Y.S.2d at 288 with Morgan, 03 Civ. 3987 at 1. The lengthy periods of time over which defendants allegedly acted with deliberate indifference to progressive, ongoing liver deterioration provided ample notice of

[9]Although several pro se challenges to the ASAT requirement have been unsuccessful, none of these cases has examined a denial of medically indicated treatment on the basis of a past drug history. See Rose v. Alves, No. 01 Civ. 0648, 2004 WL 2026481 at *6-7 (W.D.N.Y. Sept. 9, 2004) (plaintiff did not dispute material fact that numerous factors contraindicated Hepatitis C treatment); Lewis v. Alves, No. 01 Civ. 0640, 2004 WL 941532 at *6 (W.D.N.Y. Mar. 22, 2004) (plaintiff had tested positive for drug use while in prison and therefore doctor concluded that treatment was contraindicated); Verley v. Goord, No. 02 Civ.1182, 2004 WL 526740 at *20 (S.D.N.Y. Jan. 23, 2004) (prisoner had completed ASAT program and therefore did not have standing to challenge ASAT requirement); People ex rel. Sandson v. Duncan, 761 N.Y.S.2d 369, 371 (3d Dept. 2003) (inmate's "medical condition has been continuously assessed and monitored by health care professionals" and inmate "has continued to abuse controlled substances during his incarceration"). One court has remarked in dictum that the ASAT requirement appears "highly rational" insofar as active substance abuse can cause life-threatening consequences, see Graham v. Wright, No. 01 Civ. 9613, 2003 WL 22126764 at *2 n.5 (S.D.N.Y. Sept. 12, 2003), but the reasoning of that court's confessed "aside" has now been rejected by the Second Circuit. See Johnson, 412 F.3d at 405-06; McKenna, 386 F.3d at 437. It is plain from the unpublished decisions in the pro se cases that the inmates failed to raise and brief the Eighth Amendment issue that has been decided against defendants by every court to have considered it.

the substantial damages that might be claimed. See Johnson, 412 F.3d at 402 (indicating delay of 18 months following consulting physician's initial recommendation, such that prescribed therapy did not commence until 39 months after liver biopsy showed fibrosis); Domenech, 766 N.Y.S.2d at 288 (indicating delay of 15 months after biopsy showing fibrosis); Morgan, No. 03 Civ. 3987 at 4, 7 (indicating ongoing delay of nearly five years after biopsy showing fibrosis). Indeed, in McKenna, the court read the inmate's complaint to allege that delay had rendered antiviral therapy entirely unavailable. McKenna, 386 F.3d at 434-35.

Because Mr. Hilton could not easily have intervened in the prior actions, which Doctor Wright vigorously defended on the merits and which have concluded with judgments against him, the doctrine of collateral estoppel should be applied to save both Mr. Hilton and this Court the effort of establishing the rule of law which defendants have unsuccessfully resisted on a sustained basis. Mr. Hilton has thus shown a substantial likelihood of success on his Eighth Amendment claim.

2. The Mandatory Substance Abuse Programming Requirement Violates the Eighth Amendment

Independently of the doctrine of collateral estoppel, Mr. Hilton has a substantial likelihood of success under well-settled case law interpreting the Eighth Amendment, as recognized in the recently decided challenges to the defendants' substance abuse criteria. It is uncontroversial that the Eight Amendment's bar on cruel and unusual punishments protects inmates from deliberate indifference to their serious medical needs on the part of prison officials. Estelle v. Gamble, 429 U.S. 97, 104 (1976); McKenna v. Wright, 386 F.3d at 436-37. The series of federal and state challenges decided over the last ten months have each recognized "deliberate

indifference" in any categorical policy conditioning Hepatitis C treatment on substance abuse criteria not essential to the determination of whether antiviral therapy is medically indicated. See Johnson, 412 F.3d at 405-06; McKenna, 386 F.3d at 437; Domenech, 766 N.Y.S.2d at 293, aff'd, 797 N.Y.S.2d 313; Morgan, No. 03 Civ. 3987 at 19-22.

The cases have been decided in the context of a medical consensus that past drug use has no bearing on whether combination antiviral therapy is medically indicated. See Morgan, No. 03 Civ. 3987 at 19 (explaining that medical authorities "all indicate that complications may arise when treatment is given to persons who actively use drugs or alcohol") (emphasis in original). As noted by Judge Wood, the authorities contemplate only that a patient's ongoing, active substance abuse may be a counter-indication to antiviral therapy. Simply put, the "use of alcohol or substance abuse treatment as a prerequisite for hepatitis C treatment in patients who are past alcohol or substance users is not consistent with the standard of care for hepatitis C." Edlin Decl. ¶ 9, attached as Ex. A to Reinert Aff.

The very medical authorities referenced in defendants' own Hepatitis C Primary Care Practice Guideline confirm this judgment. See Reinert Aff. Ex. I at 8. For instance, the Guideline refers to recommendations published by the Centers for Disease Control and Prevention ("CDC") in 1998, but that publication expressly promotes treatment for individuals, like Mr. Hilton, who are at the greatest risk of progressing to cirrhosis and who have not actively used intravenous drugs or alcohol for more than six months. See CDC, "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease" at 14 (1998) (available at http://www.cdc.gov/mmwr/PDF/RR/RR4719.pdf). Similarly, a 2003 CDC report referenced by the Guideline, addressing Hepatitis C in correctional settings,

specifically recommends that candidates for antiviral therapy participate concurrently in substance abuse treatment only insofar as they are actively engaged in drug or alcohol abuse. See CDC, Recommendations for Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings (2003) (available at http://www.cdc.gov/mmwr/PDF/rr/rr5201.pdf).

A 1997 National Institutes of Health ("NIH") Consensus Statement referenced by the Guideline is to the same effect, sounding a cautionary note only with respect to individuals who have used illicit drugs or alcohol within six months of contemplated antiviral therapy. See NIH, Consensus Development Conference Statement, "Management of Hepatitis C" (1997) (available at http://consensus.nih.gov/cons/105/105_intro.htm). An updated NIH Consensus Statement is even less supportive of defendants' policy in that it expressly recommends efforts to increase the availability of antiviral therapy to injecting drug users and further declares that active drug use "in and of itself [should] not be used to exclude such patients from antiviral therapy." See NIH Consensus Development Conference Statement, "Management of Hepatitis C" at 19 (2002) (available at http://www.hepprograms.org/drug/hepcconfer.pdf).

The two remaining medical references relied upon by the Guideline similarly establish, at most, that active, not past, substance abuse may be a contraindication to antiviral therapy in some patients. See National Institute of Diabetes and Digestive and Kidney Diseases, Chronic Hepatitis C: Current Disease Management, NIH Pub. No. 03-4230 (May 1999) (available at http://www.medhelp.org/NIHlib/GF-483.html); Georg M. Lauer and Bruce D. Walker, Hepatitis C Virus Infection, 345 New Engl. J. Med. 41 (2001), attached to Reinert Aff. as Ex. K. In sum, the very medical references cited in defendants' own Guideline uniformly indicate that substance abuse programming is not necessarily a favored concomitant, much less a proper condition, of

antiviral therapy indicated for individuals who, like Mr. Hilton, have not used drugs for substantial periods of time.

Consistent with the medical consensus, courts have found deliberate indifference in any reflexive application of substance abuse criteria that neglects a patient's particular circumstances. As discussed in the previous subpart, the Domenech and Morgan decisions both make clear that the Eighth Amendment forbids defendants from applying the ASAT requirement to inmates whose lengthy abstinence from drug use plainly renders substance abuse programming medically irrelevant. Domenech, 766 N.Y.S.2d at 293; Morgan, No. 03 Civ. 3987 at 21-22 & n.23. A recent precedent of the Second Circuit establishes that abstinence of far shorter duration may also suffice to demonstrate deliberate indifference. In Johnson v. Wright, an inmate at the Green Haven and Great Meadow correctional facilities brought a Section 1983 action challenging the denial of antiviral therapy under a criterion requiring that patients have engaged in no active alcohol or substance abuse within the past two years. Johnson, 412 F.3d at 401. Mr. Johnson had tested positive for marijuana use roughly one year before defendants applied the criterion to overrule the unanimous recommendation of treating physicians that he receive antiviral therapy. Id. Yet if defendants had "reflexively follow[ed] the Guideline's substance abuse policy in the face of the unanimous, express, and repeated recommendations of plaintiff's treating physicians, including prison physicians," then even recent, confirmed marijuana use could not excuse the deliberate indifference manifest in failing to provide medically indicated treatment. Id. at 406.

In the present case, Mr. Hilton's personal and medical history is composed of facts materially indistinguishable from those cited in the recent federal and state decisions. DOCS' own records indicate no drug use more recent than 1993. See Reinert Aff. at Ex. ____

(correction counselor's memorandum reciting drug use history pursuant to which Mr. Hilton's ASAT application was reviewed). Mr. Hilton's affidavit confirms that he has in fact never used drugs since an even earlier period in his life. Hilton Affidavit ¶¶ 3-6, 16. Each of the physicians engaged by DOCS has recommended that he receive combination therapy without further delay, only to see their unanimous recommendation rejected by defendants on the basis of a categorical policy lacking medical justification in Mr. Hilton's case. In light of Mr. Hilton's lengthy abstinence from drug use and the medical consensus that antiviral therapy is indicated, defendants' reliance on the ASAT requirement to withhold needed treatment is intolerable under the Eighth Amendment.

Furthermore, defendants have denied treatment while simultaneously thwarting Mr. Hilton's best efforts to comply with the pointless ASAT requirement. Despite his lengthy record of abstinence from drug use, Mr. Hilton has sought at both the Altona and Washington correctional facilities to participate in substance abuse programming, only to be placed on a waiting list and then informed that his upcoming eligibility for parole disqualifies him from enrollment. Compare Domenech, 766 N.Y.S.2d at 288-89 & n.1 (inmate enrolled in, but failed to complete, ASAT programming), Morgan, No. 03 Civ. 3987, at 8-9 & n.10 (inmate sought to avoid ASAT programming entirely). The irony of this record cruelly underscores the evidence showing that application of the ASAT requirement owes in Mr. Hilton's case not to medical judgment, but to a categorical policy developed without regard for the health of prisoners known to require immediate treatment to remedy a progressive, life-threatening illness.

Both because defendants are barred by the doctrine of issue preclusion from defending the constitutionality of applying the ASAT requirement to Mr. Hilton, and because the precedents

uniformly recognize that it violates the Eighth Amendment to condition Hepatitis C treatment on medically inessential substance abuse criteria, Mr. Hilton has shown a likelihood of success on the merits of his claims. Along with the irreparable injury he will suffer absent treatment, this showing entitles him to preliminary injunctive relief.

CONCLUSION

For the reasons stated in the foregoing, plaintiff Robert Hilton asks the Court to enter a temporary restraining order and preliminary injunction compelling defendants to approve immediate commencement of the course of combination antiviral therapy which Mr. Hilton's physicians have prescribed to treat Hepatitis C.

Dated: New York, New York
August 17, 2005

KOOB & MAGOOLAGHAN

/s/ Keith M. Donoghue
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UNPUBLISHED AUTHORITY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
-----------------------------------X
JOHN MORGAN,

Plaintiff,

-against-

03-CIV-3987(KMW)(AJP)
ORDER

CARL J. KOENIGSMANN, M.D., Medical Director Green Haven C.F., and LESTER N. WRIGHT, M.D., Associate Commissioner Chief Medical Officer.

Defendants.
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WOOD, U.S.D.J.:

Plaintiff John Morgan, pro se, sues defendants pursuant to 42 U.S.C. § 1983. Plaintiff alleges that defendants Carl J. Koenigsmann, M.D. ("Koenigsmann") and Lester N. Wright, M.D. ("Wright") have been deliberately indifferent to plaintiff's serious medical needs, in violation of his constitutional rights under the Eighth Amendment to the United States Constitution. Plaintiff seeks a declaratory judgment, an injunction ordering defendants to immediately treat plaintiff's hepatitis C,[1] and compensatory and punitive damages in the amount of $10 million. Defendants moved for summary judgment, arguing (1) that defendants lack the personal involvement required to be liable, (2) that plaintiff cannot prove that defendants acted with deliberate indifference toward him, and (3) that defendants are entitled to

[1] Plaintiff's complaint seeks "declaratory relief in the form of immediate treatment for his condition." (Complaint, 6). The Court construes pro se plaintiff's complaint liberally, see Branham v. Meachum, 77 F.3d 626, 628-29 (2d Cir. 1996), and treats this as a request for both declaratory and injunctive relief.

qualified immunity. For the reasons stated below, defendants' motion is granted with respect to defendant Koenigsmann and denied with respect to defendant Wright.

I. Factual Background

Unless otherwise noted, the following facts are undisputed, and are derived from the parties' Rule 56.1 statements, affidavits, and other submissions.[2]

A. The Parties

Plaintiff is an inmate in the custody of the New York State Department of Correctional Services ("DOCS"), and is currently incarcerated in Green Haven Correctional Facility ("Green Haven"). Prior to his transfer to Green Haven in September 1996, plaintiff had been incarcerated in Attica Correctional Facility ("Attica") since, at least, 1992. (Defs' 56.1 Stmt., ¶ 1; Plaintiff's Statement Pursuant to United States District Court Rules Southern and Eastern District of New York, Civil Rule 56.1. ("Plnt's 56.1 Stmt."), dated Apr. 9, 2004, ¶ 1). Plaintiff was diagnosed with the Hepatitis C virus ("HCV") in 1992, and alleges that defendants have denied him treatment for that illness over the past five years on the ground that plaintiff has not enrolled in DOCS' Alcohol and

[2] The Court requested and received from defense counsel in August 2004 unexcerpted copies of all DOCS Hepatitis C Primary Care Practice Guidelines, as well as several medical reports referred to in Defendants' Statement Pursuant to Local Civil Rule 56.1 ("Defs' 56.1 Stmt."), dated Jan. 30, 2004, ¶ 18. The Court has placed a copy of these documents in the court file. When possible, the Court will refer to the documents by reference to their Bates stamp numbers.

Substance Abuse Treatment ("ASAT") program.[3] Plaintiff argues that there is no basis for conditioning his treatment for HCV on his enrollment in an ASAT program. Plaintiff admits that he used drugs and alcohol prior to his incarceration, but claims that he has been free of both drugs and alcohol for the past thirteen years. (Plnt's 56.1 Stmt. ¶ 2).[4]

Defendant Koenigsmann is a medical doctor, licensed to practice medicine in the State of New York. (Declaration of Carl Koenigsmann ("Koenigsmann Decl."), dated Jan. 29, 2004, ¶ 2). From March 1999 until April 17, 2003, Koenigsmann served as Facility Health Services Director ("FHSD") at Green Haven. In that capacity, Koenigsmann "reviewed the care rendered by Green Haven

[3] The term "ASAT" is used interchangeably with the term "RSAT", which refers to DOCS' Residential Substance Abuse Treatment program. The Court will refer to both programs using the term "ASAT."

[4] Defendants argue that plaintiff should not be taken "at his word," and suggest that plaintiff's claim to be drug- and alcohol-free is "absurd[]" in light of his "steadfast refusal to participate in the drug treatment programs made available by DOCS." (Reply Memorandum of Law in Further Support of Defendants' Motion for Summary Judgment ("Defs' Reply Memo"), dated May 24, 2004, at 2). Plaintiff does not ask to be taken "at his word." Plaintiff has provided (1) a Certificate of Participation, indicating that he successfully completed a twelve-step Alcoholics Anonymous program in October 1992, and (2) a Certificate of Completion, indicating that he successfully completed a twelve-step Narcotics Anonymous program in March 2000. (Plnt's 56.1 Stmt. Exh. 10). Plaintiff has also submitted evidence that in September 2003, he was ordered to submit to a urinalysis test for marijuana by C.O. Haywood, following Haywood's claim that "Inmate Morgan's eyes appeared glossy, and Inmate was emanating an odor of marijuana." (Id., at Exh. 1). Plaintiff's urinalysis test came back negative. (Id.). Finally, plaintiff has submitted disciplinary records from his period of incarceration at both Green Haven and Attica, which indicate that there is no record that plaintiff has ever been disciplined for alcohol or drug use. (Id., at Exh. 2). Defendants have presented no evidence to the contrary. In fact, the record indicates that the only reason defendants know that plaintiff used drugs and alcohol prior to his incarceration is that plaintiff freely admitted it when his medical history was being prepared, (see Medical History, Declaration of Donald Nowve ("Nowve Decl."), dated Jan. 29, 2004, Exh. B), and he has continued to admit it in this case, (see Defs' 56.1 Stmt., ¶ 2; Plnt's 56.1 Stmt., ¶ 2).

primary care providers and also reviewed and approved all requests by Green Haven primary care providers for specialty care services by outside medical providers, including surgeons, medical specialists, physical therapists, procedures and diagnostic studies." (Id. at ¶ 4).

Defendant Wright is also a medical doctor. Wright has held the position of Deputy Commissioner and Chief Medical Officer of the DOCS throughout plaintiff's incarceration at Green Haven. Wright's primary responsibility at DOCS is "to set the overall direction for [DOCS'] provision of health care." Brock v. Wright, 315 F.3d 158, 165 (2d Cir. 2003) (unrelated case).

B. Plaintiff's Illness

In 1992, while incarcerated in Attica, plaintiff was diagnosed with HCV, a chronic liver disease that can result in inflammation, scarring, and ultimately cirrhosis of the liver.[5] (Defs' 56.1 Stmt. ¶ 11; Plnt's 56.1 Stmt. ¶ 5). On or about December 3, 1999, plaintiff underwent a liver biopsy to gauge the severity of his illness. (Defs' 56.1 Stmt. ¶ 13; Plnt's 56.1 Stmt. ¶ 7). The liver biopsy revealed that plaintiff had developed fibrosis, and

[5] Defendants appear to assume that how plaintiff became infected is relevant (defendants state that plaintiff contracted the virus, and developed liver fibrosis, "due to plaintiff's history of substance abuse." (Defs' 56.1 Stmt. ¶ 14)). Their contention not only is irrelevant, but also is without evidentiary basis. Defendants provide no support for this claim; defendants presumably base their assumption on the fact that plaintiff admits that in the past he engaged in intravenous drug use, and intravenous drug use is a primary route of infection for HCV. Plaintiff denies that he contracted HCV as a result of his drug use, because he claims that although he did use heroin intravenously for a period of two weeks in 1983, he used "sterile syringes and did not share his needle with anyone else and did not use the same needle twice." (Affidavit of John Morgan ("Morgan Aff."), dated Apr. 12, 2004, ¶ 3). Whatever the cause, the issue of treatment is a separate matter altogether.

chronic hepatitis, grade 2, stage 2. (St. Agnes Hospital Surgical Pathology Report, Bates stamp number SA8, Nowve Decl., Exh. B).

C. DOCS Hepatitis C Primary Care Practice Guidelines[6]

On March 31, 1999, DOCS Division of Health Services released a practice guideline regarding the screening of inmates for HCV, and the treatment of inmates diagnosed with HCV. (Defs' 56.1 Stmt. ¶ 16; Hepatitis C Primary Care Practice Guideline, dated Mar. 31, 1999 ("March 1999 Guideline"), Nowve Decl., Exh. D). The March 1999 Guideline was developed by a committee consisting of medical doctors and nurses, and purported to be consistent with "community standards of care." (Id. at 1). It also recognized "the need for periodic reviews and revisions . . . to insure that this Guideline remains current." (Id.) The March 1999 Guideline provided that treatment for Hepatitis C "should be considered in accordance with the following criteria." (Id. at 2). These criteria included, inter alia:

> 10. No evidence of active substance abuse (drugs and/or alcohol) during the past 2 years (check urine toxicology screen if drug use is suspected).
>
> 11. Successful completion of an ASAT program (the inmate may be enrolled concurrently with hepatitis C treatment if time does not allow for prior completion of the program).

(Id. at 3)

The March 1999 Guideline was revised on December 17, 1999. (Defs' 56.1 Stmt. ¶ 16; Hepatitis C Primary Care Practice

[6] The Court will refer to the numerous versions of the Practice Guideline collectively as the "Practice Guidelines." However, the Court will refer to each version of the Guideline by month and year when it is necessary to reference the language contained in a particular version of the Guideline.

Guideline, dated Dec. 17, 1999 ("December 1999 Guideline"), Nowve Decl., Exh. D). The only revision relevant to plaintiff's claim is the revision of the tenth criterion. Instead of requiring "no evidence of active substance abuse . . . during the past 2 years", (March 1999 Guideline, 3) (emphasis added), the December 1999 Guideline required "no evidence of active substance abuse . . . during the past 6 months . . . ." (December 1999 Guideline, 3) (emphasis added).

The December 1999 Guideline was in turn revised on December 13, 2000, when the tenth and eleventh criteria were merged into a single paragraph. (Defs' 56.1 Stmt. ¶ 16; Hepatitis C Primary Care Practice Guideline, dated Dec. 13, 2000 ("December 2000 Guideline"), Nowve Decl., Exh. D).

> 10. No evidence of active substance abuse (drug and/or alcohol) during the past 6 months (check urine toxicology screen if drug use is suspected). Those who have a substance use history must successfully complete or be enrolled in an ASAT program.

(December 2000 Guideline, 3)

The Practice Guideline was most recently updated on March 10, 2003. (Defs' 56.1 Stmt. ¶ 16; Hepatitis C Primary Care Practice Guideline, dated Mar. 10, 2003 ("March 2003 Guideline"), Nowve Decl., Exh. D). No changes have been made to the ASAT requirement since December 2000.

D. Plaintiff's Refusal to Participate in an ASAT Program, and his Subsequent Denial of Treatment

Plaintiff claims that he was first offered treatment for his hepatitis C in 1997, but that his attending physician at Green

Haven advised him to refuse the treatment in anticipation of a new, less intrusive treatment with fewer side effects. (Plnt's 56.1 Stmt., ¶ 15).

The full factual picture pertaining to plaintiff's subsequent and continuing efforts to obtain treatment for his condition is difficult to discern from the record.[7] All parties agree that following plaintiff's liver biopsy in 1999, plaintiff's treating physicians requested that plaintiff (1) receive drug therapy for his illness, (2) be referred to a liver specialist, and (3) receive an updated liver biopsy to track the progression of his illness.

Each of these requests was ultimately denied by defendant Koenigsmann, who cited plaintiff's refusal to participate in an ASAT program as the reason for the denial.[8] Koenigsmann's position was that because plaintiff used drugs and alcohol in the past, he was required by the Practice Guidelines to participate in an ASAT program as a pre-condition to being treated for hepatitis C, which treatment would presumably include drug therapy, a referral to a

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[7] Defendants' papers do not make any attempt to chronicle these efforts. Plaintiff has attempted to collect records of these incidents to document the number of times Dr. Koenigsmann denied plaintiff's, and plaintiff's treating physicians', requests for treatment and referral to a specialist. (See generally Plnt's 56.1 Stmt., Exh. 3). Plaintiff has also attempted to collect records of his grievances pertaining to these incidents. (See generally id. at Exh. 9).

[8] For instance, Koenigsmann denied the request by plaintiff's treating physician that plaintiff received an "updated liver biopsy to assess [the] progression of chronic HCV" because treatment was "out of the question" unless plaintiff agreed to participate in an ASAT program. (Koenigsmann Denial, Bates stamp number GHM 75, dated May 23, 2003, Plnt's 56.1 Stmt. Exh. 3).

liver specialist, and an updated liver biopsy.[9]

On August 27, 2002, plaintiff wrote to defendant Wright, complaining about Dr. Koenigsmann's denial of his requests for treatment. (See Letter to Dr. Wright, dated Aug. 27, 2002, Plnt's 56.1 Stmt. Exh. 4). On September 30, 2002, Marc F. Stern, Regional Medical Director, responded to plaintiff's letter, on behalf of Dr. Wright. (See Letter to Mr. Morgan, dated Sept. 30, 2002, Plnt's 56.1 Stmt. Exh. 5). Stern's letter stated that the reason plaintiff was being denied treatment was that he had not yet participated in a drug abuse prevention program, and that participation is "required by our Guidelines and is non-negotiable." (Id.). Stern's letter also stated that "[i]f you are seriously interested in beginning treatment for your Hepatitis C infection, I would strongly encourage you to agree to participate in the drug treatment program. It is a worthwhile program, but at the very least, it should not be harmful." (Id.).

In this lawsuit, plaintiff has offered no reason to refuse to

[9] Because the record does not clearly indicate when plaintiff and his treating physicians made each of their requests, it is unclear which version of the Practice Guidelines was in place each time Koenigsmann denied the requests due to plaintiff's failure to enroll in an ASAT program. Defendants gloss over this fact, stating that "all of the Guidelines uniformly providee [sic], in essence, that in order for an inmate to be eligible for antiviral drug therapy for Hepatitis C, there must be no evidence of active substance abuse (drug and/or alcohol) for a specified period of time. Those who have a history of substance abuse must 'successfully complete or be enrolled in [ASAT]' as a co-requisite for antiviral treatment." (Defs' 56.1 Stmt. ¶ 19). In fact, until the December 2000 Guideline, the Practice Guidelines did not specify who must participate in an ASAT program as a prerequisite for treatment. It was not until the December 2000 Guideline that persons with a "substance use history" were specifically required to participate in an ASAT program. The Practice Guidelines do not define the term "substance use history."

participate in an ASAT program.[10] In 2002 or 2003, plaintiff appears to have placed his name on the waiting list for an ASAT program, but he subsequently withdrew his name from the list. The record contains an undated, handwritten letter from plaintiff asking that his name be withdrawn from the waiting list.[11] (Plaintiff's Withdrawal Letter, Bates stamp number D0091, undated, Nowve Decl., Exh. C). In that letter, plaintiff states that he expects the requirement to be eliminated "in the near future":

> [I] received a letter from the law firm of White & Case requesting permission to obtain my medical records from the medical department at Green Haven. I gave them my permission to access the records. They are for the purpose of assisting White & Case in their class action law suit against all medical Departments in D.O.C.S. The purpose of this law suit is to remove all medical department policies that require patients infected with cronic [sic] Hepatitis-C to participate in A.R.S.A.T. or any other voluntary drug rehabilitation program in order to receive medical treatment for this deadly disease.
>
> It is my belief that in the near future I will not be required to be enrolled in the A.R.S.A.T. program in order to receive medical treatment for my cronic [sic] Hepatitis-C infection! That is my motivation for withdrawing my application to participate in A.R.S.A.T.

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[10] One reason an inmate might not want to enroll in an ASAT program, particularly if that inmate has successfully completed other rehabilitation programs, is that participating in an ASAT program can be very time-consuming. See Domenech v. Goord, 196 Misc. 2d 522, 524 n.1, 766 N.Y.S.2d 287 (N.Y. Sup. Ct. May 28, 2003) ("ASAT is a six-month rehabilitation program for substance abusers which apparently requires full-day attendance. This time commitment would evidently interfere with petitioner's full schedule of attending school during the day and working as a porter at night.")

[11] It is unclear from the record when plaintiff signed up for, and withdrew his name from, the ASAT waiting list. In plaintiff's deposition, he acknowledged that he refused "ASAT participation" in 2002. (Defs' 56.1 Stmt., ¶ 26). However, the record contains a letter to plaintiff from E. Mamane, dated May 9, 2003, acknowledging receipt of plaintiff's request to withdraw his application for the ASAT program. (Mamane's Acknowledgment Letter, Bates stamp number D0092, May 9, 2003, Nowve Decl., Exh. C).

Id. (emphasis in original)

II. Discussion

A. Summary Judgment Standard

To prevail on a motion for summary judgment, the moving party must demonstrate that there are no genuine issues of material fact to be tried, and that it is entitled to judgment as a matter of law. See Fed. R. Civ. Pro. 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986); Citizens' Bank v. Hunt, 927 F.2d 707, 710 (2d Cir. 1991). The moving party "bears the initial responsibility of informing the district court of the basis for its motion"; that responsibility includes identifying the materials in the record that the moving party believes demonstrate the absence of a genuine issue of material fact. Celotex Corp., 477 U.S. at 323. Once a motion for summary judgment is made and supported, the non-moving party must set forth specific facts to be tried. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). An issue is genuine if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Id.; Mitchell v. Shane, 350 F.3d 39, 47 (2d Cir. 2003).

B. Section 1983 and Personal Involvement

In order for a plaintiff to obtain damages against a defendant in a Section 1983 action, the plaintiff must prove that that defendant was personally involved in the constitutional deprivation. See Colon v. Coughlin, 58 F.3d 865, 873 (2d Cir. 1995). Defendants argue that because they did not personally

render treatment to plaintiff, plaintiff cannot prove that they were personally involved in the alleged, constitutional deprivation.

Defendants' argument misses the point. Plaintiff does not contend that his treating physicians denied him a constitutional right; instead, he contends that defendants, who were supervisory officials, denied him that right. A supervisory official may be shown to have sufficient personal involvement if:

> (1) the defendant participated directly in the alleged constitutional violation, (2) the defendant, after being informed of the violation through a report or appeal, failed to remedy the wrong, (3) the defendant created a policy or custom under which unconstitutional practices occurred, or allowed the continuance of such a policy or custom, (4) the defendant was grossly negligent in supervising subordinates who committed the wrongful acts, or (5) the defendant exhibited deliberate indifference to the rights of inmates by failing to act on information indicating that unconstitutional acts were occurring.

Id. (citing Wright v. Smith, 21 F.3d 496, 501 (2d Cir. 1994)

Defendant Koenigsmann was the FSHD at Green Haven. In this capacity, Koenigsmann reviewed the care rendered to inmates, and he either approved or denied requests for specialty care services, procedures, and diagnostic studies. (Koenigsmann Decl., ¶ 4). Plaintiff has produced evidence that Koenigsmann, who is himself a medical doctor, repeatedly denied requests by plaintiff's primary care physicians that plaintiff receive drug therapy, a referral to a liver specialist, and an additional biopsy for diagnostic purposes. (See generally Plnt's 56.1 Stmt., Exh. 3). Koenigsmann's personal involvement does not, therefore, rest

impermissibly on a theory of respondeat superior. See Hernandez v. Keane, 341 F.3d 137, 144 (2d Cir. 2003). Rather, plaintiff has offered evidence that Koenigsmann participated directly in the alleged constitutional violation, by deciding to withhold treatment from plaintiff.

Defendant Wright is the Deputy Commissioner and Chief Medical Officer of the DOCS. Plaintiff has offered evidence that Dr. Wright promulgated to health personnel within the DOCS system the Practice Guidelines that are central to this suit. (See Memorandum from Lester N. Wright, M.D., MPH, to Facility Health Services Directors, dated Mar. 25, 2003, Koenigsmann Decl., Exh. 1).[12] There is no dispute that treatment is being withheld from plaintiff as a result of the Guidelines that Dr. Wright promulgated; thus, to the extent that unconstitutional acts have occurred as a result of applying the Guidelines, a reasonable jury could conclude that Wright was personally involved in that deprivation, because he "created a policy or custom under which unconstitutional practices occurred, or allowed the continuance of such a policy or custom." Colon, 58 F.3d at 873. Cf. Brock, 315 F.3d at 165-66 (holding that a jury could conclude that Wright was personally involved in an alleged deprivation due to Wright's promulgation of the DOCS policy

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[12] The documents produced by defense counsel pursuant to the Court's request contain additional evidence that Dr. Wright promulgated and oversaw the implementation of the Guidelines. (See Memorandum from Lester N. Wright, M.D., MPH, Associate Commissioner/Chief Medical Officer, to Facility Health Services Directors, dated Apr. 12, 1999, Bates stamp numbers D0054-56; Memorandum from Lester N. Wright, M.D., MPH, Associate Commissioner/Chief Medical Officer, to Facility Health Services Directors, Nurse Administrators, Pharmacists, dated Sept. 27, 1999, Bates stamp numbers D0040-44).

at issue in that case).[13]

C. Eighth Amendment[14]

Plaintiff claims that defendants violated plaintiff's rights under the Eighth Amendment when they participated in the decision to withhold HCV treatment from him because he refuses to enroll in

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[13] Defendants cite Judge Buchwald's decision in Graham v. Wright as support for the proposition that Wright lacks the requisite personal involvement to be held liable. See Graham v. Wright, No. 01 Civ. 9613(NRB), 2003 WL 22126764, *2 (Sept. 12, 2003). In Graham, Judge Buchwald held that Wright lacked the personal involvement required to be held liable for money damages. Although Judge Buchwald took note of the fact that plaintiff there failed to allege that Wright personally treated him, her holding was based on the fact that plaintiff there actually lacked standing to challenge the Hepatitis C Practice Guidelines. The reason for this was that plaintiff there actually had completed an ASAT program, and was fully eligible to receive treatment for his HCV according to the Practice Guidelines. That case is thus distinguishable from the instant case.

[14] The Eighth Amendment states: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const. Amend. VIII. The Eighth Amendment was made applicable to the States through the Fourteenth Amendment. See Estelle v. Gamble, 429 U.S. 97, 101-02 (1976) (citing Robinson v. California, 370 U.S. 660 (1962)).

an ASAT program.[15, 16] "To establish an Eighth Amendment claim arising out of inadequate medical care, a prisoner must prove 'deliberate indifference to [his] serious medical needs.'" Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998) (quoting Estelle, 429 U.S. at 104). This requires that the prisoner prove both that

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[15] Other courts in this Circuit have considered similar claims by inmates infected with HCV. Many of those claims are distinguishable on their facts from the instant case. See, e.g., Johnson v. Wright, No. 01 Civ. 2122(GWG), 2004 WL 938299 (S.D.N.Y. May 3, 2004) (plaintiff there initially received one form of treatment for his HCV, but was denied a newer form of treatment by Wright pursuant to the March 1999 Guideline because plaintiff there actually tested positive for marijuana within the two-year period prior to his treating physician's request that he begin the new treatment. In addition, approximately two years after the plaintiff there tested positive for marijuana, Wright approved the plaintiff for the newer treatment -- there is no mention in Magistrate Judge Gorenstein's opinion that the plaintiff there ever enrolled in an ASAT program); Pabon v. Wright, No. 99 Civ. 2196(WHP), 2004 WL 628784 (S.D.N.Y. Mar. 29, 2004) (plaintiff there received treatment for his HCV, but complained (1) that he had not been informed about the drug's risks and side effects, and (2) that his treatment had been delayed because defendants required that he undergo a medically advised liver biopsy prior to receiving treatment); McKenna v. Wright, No. 01 Civ. 6571(HB), 2004 WL 102752 (S.D.N.Y. Jan. 21, 2004) (remaining defendants denied qualified immunity on a motion to dismiss); Graham, 2003 WL 22126764 (plaintiff there successfully completed ASAT program, and appeared to be otherwise eligible to receive treatment).

[16] The one case with facts most similar to the instance case is Conti v. Goord, an unpublished summary decision in which the Second Circuit noted that the prisoner there might be able to demonstrate at trial that the policy "manifests 'deliberate indifference,' insofar as it entails denying treatment to prisoners who completed substance-abuse programs in the past and have since displayed no signs of drug or alcohol use." Conti v. Goord, 59 Fed.Appx. 434, 436, 2003 WL 1228044 (2d Cir. Mar. 14, 2003). The plaintiff in Conti, like the plaintiff in this case, was denied treatment because he refused to enroll in an ASAT program notwithstanding his history of drug and alcohol use. Id. at 435. The plaintiff there claimed that he was "demonstrably 'clean' for more than ten years", and he produced evidence to the Second Circuit (but not to the district court) that he had successfully completed an ASAT program in 1991, as well as an Alcoholics Anonymous program in 1992. Id. at 436. The plaintiff there also produced a response by Wright to a grievance submitted by another inmate, in which Wright indicated that that inmate would receive HCV treatment once he could establish that he had been "clean" for six months -- no mention is made of whether enrollment in an ASAT program would also be required. See id. Finally, the plaintiff there produced affidavits from two inmates who presumably also had a history of drug or alcohol use, but who claimed to have been provided with HCV treatment without being required to participate in an ASAT program. See id. The Court does not cite Conti as precedential authority.

his medical condition is objectively serious, and that each defendant acted with the requisite deliberate indifference. See Brock, 315 F.3d at 162.

1. Serious Medical Condition

A condition is considered "sufficiently serious" for Eighth Amendment purposes if it is a "condition of urgency, one that may produce death, degeneration, or extreme pain." Morales v. Mackalm, 278 F.3d 126, 132 (2d Cir. 2002). Factors to be considered in making this decision include "(1) whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment, (2) whether the medical condition significantly affects daily activities, and (3) the existence of chronic and substantial pain." Brock, 315 F.3d at 162 (internal quotations omitted).

Defendants do not appear to deny, nor could they, that hepatitis C is, in general, a sufficiently serious medical condition for purposes of the Eighth Amendment. See, e.g., Pabon, 2004 WL 628784, at *5 ("It is well-established that Hepatitis C qualifies as a serious medical condition for purposes of an Eighth Amendment analysis."); Verley v. Goord, No. 02 Civ. 1182(PKC)(DF), 2004 WL 562740, at *10, n.11 (S.D.N.Y. Jan. 23, 2004) (Report and Recommendation adopted by order, dated June 2, 2004) (same); McKenna, 2002 WL 338375, at *6 (same).

Defendants argue, however, that when an inmate claims only that his treatment has been delayed, the relevant inquiry should

focus not only on whether the underlying condition is serious, but also on whether the challenged delay or interruption in treatment is objectively serious. See Smith v. Carpenter, 316 F.3d 178, 185-87 (2d Cir. 2003). In this case, defendants argue that plaintiff's treatment has merely been delayed, and that he has offered no evidence, such as "verifying medical evidence" or "expert evidence", to support his claim that his illness has gotten worse during the period in which treatment has been withheld from him. (Memorandum of Law in Support of Defendants' Motion for Summary Judgment ("Defs' Memo"), dated Jan. 30, 2004, at 12).

Plaintiff's claim in the instant case is distinguishable from the plaintiff's claim in Smith.[17] The plaintiff in this case is not complaining about a delay or interruption in his on-going treatment. Rather, plaintiff has never received any treatment for his illness, nor can he expect to receive any such treatment unless either he agrees to join an ASAT program, or the DOCS decides to provide such treatment notwithstanding plaintiff's failure to participate in such a program. Where, as here, a prisoner "alleges that prison officials have failed to provide general treatment for his medical condition," courts do not "distinguish between a prisoner's underlying 'serious medical condition' and the

[17] In Smith, the plaintiff was HIV-positive, and it was undisputed that he was receiving "appropriate on-going treatment for his condition." Smith, 316 F.3d at 185-86. The basis for Smith's Eighth Amendment claim was that defendants had interrupted his treatment for two short periods of 5 days and 7 days in duration. See id. at 185. The Court held that it was appropriate to consider not just the seriousness of Smith's illness (i.e., HIV), but also the seriousness of the two brief interruptions in Smith's treatment.

circumstances of his 'serious medical need.'" Id. at 185-86. Thus, on the facts of this case, plaintiff has sufficiently established that he has a serious medical condition simply by proving that he has hepatitis C, and that he has not received any treatment for this condition.

2. Deliberate Indifference

Mere negligence, even if it rises to the level of medical malpractice, is insufficient to establish a claim under the Eighth Amendment. See Estelle, 429 U.S. at 105-06. In order to prevail on plaintiff's Eighth Amendment claim, plaintiff must ultimately prove that each defendant "knew of and disregarded [his] serious medical needs." Chance, 143 F.3d at 703 (citing Farmer, 511 U.S. at 837). Actual knowledge of the risk may be proven either by direct evidence, or circumstantial evidence, such as "evidence that the risk was obvious or otherwise must have been known to a defendant." Brock, 315 F.3d at 164 (citing Farmer, 511 U.S. at 842). For the reasons stated below, the Court holds that a reasonable jury could find that defendant Wright knew of and disregarded plaintiff's serious medical needs, because he promulgated ambiguous Practice Guidelines that have been applied to plaintiff in an unconstitutional manner. However, because defendant Koenigsmann was merely charged with applying the Practice Guidelines, a reasonable jury could not conclude that Koenigsmann showed deliberate indifference to plaintiff's serious medical needs.

Defendants argue that plaintiff cannot prove that either was deliberately indifferent, because the decision to condition plaintiff's treatment on his participation in an ASAT program was required by the DOCS Hepatitis C Practice Guidelines. However, the Practice Guidelines do not unambiguously require an inmate like plaintiff to participate in an ASAT program in order to receive treatment for HCV. The March 1999 and December 1999 Practice Guidelines are ambiguous as to who must participate in an ASAT program.[18] Since December 2000, when the active substance abuse criterion was merged with the ASAT criterion, the Practice Guidelines have required inmates with "a substance use history" to satisfy the ASAT requirement, but the Practice Guidelines provide no guidance as to who qualifies as having "a substance use history." The ambiguity of the Practice Guidelines is evidenced by the fact that the ASAT requirement appears to be inconsistently applied.[19]

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[18] The March 1999 Guideline, which was in place at the time that plaintiff was referred for his first and only liver biopsy, states that one requirement in order to receive treatment is: "10. No evidence of active substance abuse (drugs and/or alcohol) during the past 2 years (check urine toxicology screen if drug use is suspected)." (March 1999 Guideline, 3). A separate requirement is: "11: Successful completion of an ASAT program (the inmate may be enrolled concurrently with hepatitis C treatment if time does not allow for prior completion of the program)." (Id.). The December 1999 Practice Guideline reduced the 2-year bar for evidence of active substance use to a period of 6-months. (See December 1999 Guideline, 3). Although these two versions of the Practice Guidelines could be read as requiring every inmate to enroll in an ASAT program--including those who have never used drugs or alcohol--defendants do not argue that the Practice Guidelines were intended to be applied in this manner.

[19] The Court has already discussed instances in which inmates like plaintiff appear to have been given drug treatment notwithstanding the fact that they did not enroll in an ASAT program. See supra, n. 15 & 16. The fact that plaintiff in this case was referred to a liver specialist in 1999 for a liver biopsy also suggests that the Practice Guidelines have not always been

Defendants interpret the ambiguous provisions in the Practice Guidelines as requiring any inmate who has ever abused drugs and alcohol to enroll in an ASAT program. Thus, although there is no evidence that plaintiff has actively used drugs or alcohol in the past thirteen years, defendants interpret the Guidelines as requiring plaintiff to enroll in an ASAT program before receiving treatment.[20]

There is no medical justification for such a policy in any of the medical reports purportedly relied upon by the DOCS in fashioning its Practice Guidelines. The medical reports all indicate that complications may arise when treatment is given to persons who actively use drugs or alcohol. See National Institutes of Health, Consensus Development Conference Statement, Management of Hepatitis C: 1997 ("1997 NIH Consensus Statement"), dated Mar. 24-26, 1997, at 18 (available at http://consensus.nih.gov/cons/105/105_statement.pdf) (last visited

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applied consistently. According to defendants, because of plaintiff's "substance use history," it was just as true in 1999 as it is today, that plaintiff was required to enroll in an ASAT program in order to get treatment for his illness. Nonetheless, defendants admit that plaintiff received a liver biopsy in 1999, notwithstanding the fact that plaintiff was not enrolled in an ASAT program at that time. As discussed above, Koeingsmann has since denied plaintiff an updated liver biopsy because of plaintiff's failure to enroll in an ASAT program.

[20] The Court notes that a more logical interpretation of the language in the December 2000 Guideline (which is identical to the current version of the Practice Guidelines) is that no inmate may receive HCV treatment if there is evidence of active substance abuse in the past six months, and that any inmate against whom there is such evidence would be required to enroll in an ASAT program prior to receiving HCV treatment. This interpretation construes the sentence pertaining to inmates with a "substance use history" in conjunction with the immediately previous sentence pertaining to inmates against whom there is evidence of active substance abuse within the past six months. Such an interpretation appears to be reasonable in light of the DOCS' decision to merge those two criteria into a single paragraph in December 2000.

Aug. 4, 2004) ("[T]reatment of patients who are drinking significant amounts of alcohol or who are actively using illicit drugs should be delayed until these habits are discontinued for at least 6 months . . . . Treatment for addiction should be provided before treatment for hepatitis C.") (emphases added); Centers for Disease Control and Prevention, "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease" ("CDC Recommendations"), dated October 16, 1998, at 14 ("Treatment of patients who are drinking excessive amounts of alcohol or who are injecting illegal drugs should be delayed until these behaviors have been discontinued for ≥6 months.") (emphases added); G.L. Davis and J.R. Rodrigue, "Treatment of Chronic Hepatitis C in Active Drug Users", New Engl. J. Med., Vol. 354 No. 3, July 19, 2001 (noting that most physicians will withhold antiviral treatment until active drug use has stopped, and stating that consensus statements support resuming treatment for patients for whom treatment has stopped due to active drug use only after the patient has been referred for treatment of the addiction).[21]

The CDC Recommendations, which were issued shortly before the DOCS adopted the first version of the Practice Guidelines,

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[21] The 2002 NIH Consensus Statement recommends that the treatment of both inmates and active drug and alcohol users be expanded. (See National Institutes of Health, Consensus Development Conference Statement, Management of Hepatitis C: 2002 ("2002 NIH Consensus Statement"), dated Aug. 26, 2002, Defs' Reply Memo, Exh. C (also available at http://consensus.nih.gov/cons/116/hepatitis_c_consensus.pdf) (last visited Sept. 24, 2004), 22 & 25) ("[I]t is recommended that treatment of active injection drug use be considered on a case-by-case basis, and that active injection drug use in and of itself not be used to exclude such patients from antiviral therapy.") (emphases added).

specifically recommend that "[p]ersons who use or inject drugs . . . be advised to stop using and injecting drugs [and] to enter and complete substance-abuse treatment, including relapse-prevention programs." (CDC Recommendations, at 18) (emphasis added). Thus, the CDC recommended in 1998 that persons who were actively drinking excessive amounts of alcohol or were actively injecting drugs be denied treatment for a limited period of time until the behavior ceased, and that those people be encouraged to enter substance-abuse treatment programs, presumably for the purpose of successfully stopping the behavior that is delaying their ability to receive treatment.

A reasonable jury could conclude that defendant Wright promulgated an ambiguous set of Practice Guidelines that resulted in the denial of necessary medical care to plaintiff without any medical justification.[22] A reasonable jury could also conclude that defendant Wright was aware of the risk that the ambiguous Practice Guidelines would be interpreted to condition HCV treatment for a person such as plaintiff on enrollment in an ASAT program, and that

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[22] In addition to promulgating the Practice Guidelines, the Court notes that plaintiff notified Wright by letter of Koenigsmann's refusal to approve HCV treatment. (See Letter to Dr. Wright, dated Aug. 27, 2002, Plnt's 56.1 Stmt. Exh. 4). Marc Stern, responding on Wright's behalf, wrote: "Your participation in [an ASAT program] is required by our Guidelines and is non-negotiable . . . . While consultants may make other recommendations, ultimately the decisions about your medical care are made by your primary care physicians under the direction of the Facility Health Services Director and not the consultants. We appreciate their recommendations, but they are just that: recommendations." (See Letter to Mr. Morgan, dated Sept. 30, 2002, Plnt's 56.1 Stmt. Exh. 5). Given that plaintiff's primary care physicians made recommendations that were denied by the Facility Health Services Director (i.e., Koenigsmann) because of the Practice Guidelines promulgated by Wright, it is unclear in what way the "ultimate[]" decisions about plaintiff's medical care rested with the primary care physicians and the FHSD.

Wright was aware of the risk that people such as plaintiff would face as a result of such an interpretation. See Brock, 315 F.3d at 165-67. Cf. id. at 164 (stating that actual knowledge of the risk may be proven by circumstantial evidence, such as "evidence that the risk was obvious or otherwise must have been known to a defendant") (citing Farmer, 511 U.S. at 837). Dr. Wright could thus be held liable for the unconstitutional acts that occurred as a result of the ambiguity in the Practice Guidelines that he promulgated.[23]

In contrast, a reasonable jury could not conclude that Koenigsmann was deliberately indifferent to plaintiff's serious medical needs. Even if a jury believed that Koenigsmann, himself medical doctor, was negligent in applying the Practice Guidelines to plaintiff in a medically unsupportable manner, there is no evidence from which a jury could conclude that he did so with knowledge of, and disregard for, plaintiff's serious medical needs.

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[23] The Court notes that even if defendants were correct that the Practice Guidelines are unambiguous in imposing the requirement that plaintiff enroll in an ASAT program, Wright would still not be entitled to summary judgment. A reasonable jury would nevertheless be able to conclude that plaintiff's constitutional rights were violated as a result of a policy promulgated by Wright that is without medical justification and resulted in deliberate indifference toward plaintiff's serious medical needs. See Brock, 315 F.3d at 165-67 (holding that if a policy, "properly implemented," results in deliberate indifference toward an inmate's medical needs, the plaintiff may be able to prevail on a claim against the person who promulgated the policy). Cf. Domenech, 196 Misc. 2d at 531 (holding that as applied to the plaintiff in that case, the Practice Guidelines' requirement that the plaintiff there participate in an ASAT program "is arbitrary and capricious and results in a deliberate denial of medical attention to his serious medical condition in violation of the Eighth Amendment." The plaintiff in Domenech claimed to be drug- and alcohol-free for over 30 years, and respondents neither alleged, nor presented evidence to suggest, that he was currently using drugs or alcohol, or was likely to relapse. The Court thus concluded that "the ASAT program is irrelevant for this petitioner and cannot, as a matter of law, provide a medical justification for the continued denial of medical treatment.").

D. Qualified Immunity

The doctrine of qualified immunity protects state actors sued in their individual capacity from suits for monetary damages if "their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." Ford v. McGinnis, 352 F.3d 582, 596 (2d Cir. 2003) (quoting Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982)). Summary judgment is appropriate:

> only if the court finds that the asserted rights were not clearly established, or if the evidence is such that, even when it is viewed in the light most favorable to the plaintiff[] and with all permissible inferences drawn in [his] favor, no rational jury could fail to conclude that it was objectively reasonable for the defendants to believe that they were acting in a fashion that did not violate a clearly established right.

Ford, 352 F.3d at 597 (citation and internal quotation omitted).

The Eighth Amendment right that plaintiff claims was violated by defendants through their deliberate indifference to his serious medical needs was clearly established throughout the period covered in this suit. See Verley, 2004 WL 562740, at *17; McKenna v. Wright, No. 01 Civ. 6571(HB), 2004 WL 102752, at *7 (S.D.N.Y. Jan. 21, 2004) (citing Estelle, 429 U.S. at 106).

Because the right in question was clearly established, summary judgment may not be granted if a rational jury could conclude, on the evidence presented, that it was not objectively reasonable for Wright to believe that he was acting in a constitutional manner.[24]

[24] Because the Court has concluded that Koenigsmann is entitled to summary judgment with respect to liability, the Court need not consider whether he would otherwise be entitled to qualified immunity. The Court

Viewing the evidence in the light most favorable to plaintiff, and drawing all permissible inferences in plaintiff's favor, the Court cannot conclude that Wright's belief that his acts were constitutional was objectively reasonable as a matter of law.

As explained above, a rational jury could conclude that as a result of the ambiguity in the Practice Guidelines, plaintiff was denied necessary medical care for his serious, chronic illness, without medical justification. A rational jury could also conclude that it was not objectively reasonable for Wright to have believed that it was constitutional to promulgate such ambiguous set of Practice Guidelines that would permit such an interpretation.[25]

III. Conclusion

For the reasons set forth above, the Court grants defendants' motion for summary judgment with respect to defendant Koenigsmann, and denies defendants' motion with respect to defendant Wright. The parties shall submit a joint pretrial order no later than October 29, 2004. The parties are directed to adhere to this Court's Individual Rules governing the form of Joint Pretrial

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notes, however, that given the ambiguity present in the Practice Guidelines promulgated to Koenigsmann by Wright, no rational jury could fail to conclude that it was objectively reasonable for Koenigsmann to believe that he was acting in a constitutional manner.

[25] Even if the Practice Guidelines were not ambiguous, Wright would still not be entitled to qualified immunity. A rational jury could conclude that it was objectively unreasonable for Wright to believe that it was constitutional to promulgate a regulation that requires prison officials who know of an inmate's serious medical needs to disregard those needs, unless the inmate agrees to participate in an ASAT program. The fact that Wright is a medical doctor who is experienced at supervising the provision of medical services to inmates supports the Court's conclusion that a jury could find his actions objectively unreasonable. See Cuoco v. Moritsugu, 222 F.3d 99, 111 (2d Cir. 2000).

Orders. The Individual Rules are available at

http://www.nysd.uscourts.gov/Individual_Practices/Wood.pdf.

SO ORDERED.

Dated: New York, New York

September 30, 2004

Kimba M. Wood

Kimba M. Wood

United States District Judge

Copies of this Order have been mailed to *pro se* plaintiff and counsel for defendants.