IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

MUMIA ABU-JAMAL,	:	Civil Action No. 3:15-CV-00967
Plaintiff	:	
	:	(Judge Mariani)
v.	:	
	:	(Magistrate Judge Mehalchick)
JOHN KERESTES, et al.,	:	
Defendants	:	FILED ELECTRONICALLY

CORRECTIONS DEFENDANTS' BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Respectfully submitted,

Office of General Counsel

Dated: March 11, 2016

by /s/ Laura J. Neal

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STATEMENT OF THE CASE

A. Identity of the Parties and Nature of the Action

The Plaintiff, Mumia Abu Jamal ("Plaintiff"), is an inmate confined within the state correctional system at the State Correctional Institution at Mahanoy ("SCI-Mahanoy"). The Defendants currently identified in the action are: Geisinger Medical Center, Department Bureau of Health Care Services Director Christopher Oppman, SCI-Mahanoy Superintendent John Kerestes, SCI-Mahanoy Health Care Administrator John Steinhart, and the following contract medical providers: Dr. John Lisiak, Dr. Shaista Khanum, and Physician Assistant Scott Saxon.

In his amended and supplemental complaint (doc. 57), brought pursuant to 42 U.S.C. § 1983 and state tort law, Plaintiff asserts First, Fifth, Eighth and Fourteenth Amendment claims, as well as negligence claims. As set forth by Plaintiff, the claims are based upon a denial of attorney and family visits during a one-week hospitalization at Geisinger Medical Center, as well as alleged improper care for his blood sugar, skin and hepatitis C conditions. Presently before the Court is Plaintiff's motion for preliminary injunction seeking an order for: (1) immediate treatment of Plaintiff's hepatitis C with "the latest direct acting anti-viral drugs"; (2) immediate treatment of "his skin condition…with zinc supplementation and Protopic cream"; and 3) an in-person examination by an independent physician of Plaintiff's choosing….." (Doc. 23 at 1.)

B. Relevant Procedural History

Plaintiff initiated the instant action through counsel on May 18, 2015. (Doc. 1.) His complaint, which named only Geisinger Medical Center ("GMC") and Superintendent Kerestes, asserted violations of his First, Fifth and Fourteenth Amendment rights based on a denial of visits during a one-week hospitalization at GMC. Defendants Kerestes and GMC subsequently waived service of summons.

On August 3, 2015, Plaintiff filed a motion for leave to amend his complaint to add Defendants Oppman, Steinhart, Lisiak, Khanum, and Saxon and claims for negligence and Eighth Amendment violations associated with his medical care. (Doc. 21.)

On August 24, 2015, Plaintiff filed the preliminary injunction motion at issue here. (Doc. 23.) By Report and Recommendation issued September 18, 2015, it was recommended that Plaintiff's motion be denied. (Doc. 39.) Plaintiff filed objections to the Report, along with additional supporting exhibits and declarations. (Doc. 42.) Defendant Kerestes filed a response (doc. 47), and Plaintiff subsequently filed a reply (doc. 48).

By Order issued November 23, 2015, Plaintiff's motion for leave to amend was denied; however, he was granted leave to file a new proposed amended complaint. (Doc. 56.) Plaintiff re-filed his amended complaint the following day (doc. 57). An oral argument on Plaintiff's motion for leave to amend and an

evidentiary hearing on his preliminary injunction motion was held on December 18, 2015. (*See* Doc. 60.) Defendants Oppman and Steinhart waived service of summons on February 3, 2016.

C. Statement of Relevant Facts

1. Background – Hepatitis C

Hepatitis C ("HCV") is a virus that infects the liver cells. (v.1[1] at 111.) Approximately 15-25 percent of individuals infected with HCV will spontaneously clear the virus and it will no longer exist in their blood. (v.1 at 112, v.2 at 199-200.) The remaining 75-85 percent will develop chronic HCV, which is an inflammation of the liver. (v.1 at 112, v.2 at 199.) This inflammation can lead to fibrosis, which is scarring of the liver. (v.1 at 111, v.2 at 199-201.) The degree of fibrosis sustained is measured on a Metavir scale, which ranges from F0 (indicating no fibrosis) to F4 (indicating cirrhosis). (v.2 at 23, 202.)

Of those people who develop chronic HCV, only 20 to 30 percent will develop cirrhosis. (v.2 at 199-200.) Only 2 to 7 percent of individuals with cirrhosis will ever develop hepatocellular carcinoma (liver cancer) or end-stage liver disease ("ESLD"). (v.2 at 199-200.) Because of its progressive nature, it generally takes cirrhosis approximately 10 to 20 years to develop. (v.2 at 199.) Cirrhosis is characterized by a distortion in the liver's architecture and impairment of the liver's

[1] References to "v.__" are to the evidentiary hearing transcript volume.

daily functions. (v.2 at 201.) As fibrosis progresses toward cirrhosis, the amount of scarring in the liver increases, slowing the circulation of blood through the liver. (v.2 at 204-205.) This, in turn, causes a backup of blood platelets in the spleen, and a resulting decrease of platelets in the blood stream. (v.2 at 204-205.) Thus, individuals with fibrosis will show decreasing platelet levels as the degree of scarring increases. (v.2 at 204-205.) Additionally, the inflammation associated with chronic HCV will cause an increase in the liver enzyme aspartate aminotransferase ("AST"). (v.2 at 203-204.) For that reason, clinicians use blood tests measuring platelet count and AST levels to assess the degree of fibrosis. (v.2 at 202.)

One of these tests is the Aspartate aminotransferase-to-Platelet-Ratio-Index ("APRI") test.[2] (v.2 at 202-3.) Generally, the possibility of advanced fibrosis or cirrhosis is directly proportional to the APRI score—the higher the APRI score, the greater the possibility of advanced fibrosis. (v.2 at 205-206.) According to Dr. Cowan, the hepatologist who provided expert testimony on behalf of Defendant Kerestes, an APRI score of less than or equal to 0.3 is consistent with unlikely significant fibrosis or cirrhosis; a score of greater than 0.3 and less than 0.5 indicates

[2] The APRI is obtained by drawing the individual's blood and conducting distinct blood tests—comprehensive metabolic panel ("CMP") and Complete Blood Count ("CBC"). (v.2 at 205, 209-10.) The platelet level is determined in the CBC lab and the AST levels are determined in the CMP lab. (v.2 at 209-210.) The APRI score is calculated by dividing the AST level by the upper limits of normal AST, then dividing that quotient by the platelet count (AST/upper limit of normal considered/platelet count). (v.2 at 203.)

a possibility of significant fibrosis, with cirrhosis unlikely; a score greater than 0.5 but less than or equal to 1.5 represents significant fibrosis or cirrhosis possible; greater than 1.5 and less than or equal to 2 represents likely fibrosis, cirrhosis possible; greater than 2 represents likely cirrhosis. (v.2 at 206.) At the time of the hearing in this matter, Plaintiff's APRI score, based on his most recent bloodwork, was 0.392. (v.2 at 210.) There is generally not much risk that an individual with Plaintiff's APRI score will develop physical complications associated with HCV. (v.2 at 207-8.) Further, damage to the liver is not considered to be irreversible until an individual reaches the late stages of cirrhosis. (v.3 at 78.)

Another frequently used diagnostic tool is the Halt-C score, which is a calculation based on platelet level, AST and ALT enzyme levels. (v.2 at 211, v.3 at 110.) The Halt-C score indicates the percentage of probability that an individual has cirrhosis. (v.3 at 110.)

2. Nonhepatic Manifestations

Great debate exists regarding what nonhepatic conditions are caused by, or directly related to HCV. Diabetes mellitus has been associated with chronic HCV; however, the "relationship…is complex and incompletely understood" and it is not clear that the two conditions are related. (v.1 at 125; Ex. P2 at 8.) Certain skin conditions such as cryoglobulinemia, porphyria cutanea tarda ("PCT"), and lichen planus are generally accepted among experts as associated with HCV. (v.1 at 115,

116, vol. 2 at 60, 106, 217, v.3 at 43, Ex. P2 at 5, 8-9.) However, the American Association for the Study of Liver Diseases ("AASLD") has stated that there is insufficient evidence that successfully treating HCV will resolve PCT or lichen planus. (Ex. P2 at 9.) On the contrary, some studies have shown that Interferon-based treatment actually exacerbated lichen planus in some cases. (Ex. P2 at 9.)

Although some journal articles have reported a relationship between HCV and other skin conditions, such as necrolytic acral erythema ("NAE") and psoriasis, experts do not agree that there is a confirmed relationship between HCV and those conditions. (v.2 at 27-28, 91-2.)[3] Indeed, the AASLD does not identify these conditions as extrahepatic manifestations of HCV. (Ex. P2, P18.)

3. HCV Treatment With Direct-Acting Antiviral Medication

Prior to 2011, HCV was primarily treated with an injectable medication, Interferon, and related oral agents. (v.1 at 118, v.2 at 213, Ex. P17 at 5.) However, those medications generally had severe negative side-effects, had a lengthy treatment period, and offered only limited efficacy.[4] (v.1 at 118-120, v.2 at 213.) Because of the severe side effects and limited efficacy of those medications, patients

[3] Further, Plaintiff's expert, Dr. Harris, agrees that there have only been approximately 80 cases of NAE diagnosed worldwide, only 3 of which have been in the United States, and at least one study noted that NAE appeared without HCV infection, which has furthered debate over whether any relationship exists with HCV. (v.2 at 27-28.)

[4] Plaintiff's expert, Dr. Harris, estimates that the cure rate for African-Americans using these medications was approximately 20 percent.

who had not developed cirrhosis, and were not otherwise severely compromised, were monitored until new medications were developed. (v.1 at 121.) Such monitoring, also referred to as "active surveillance", consisted of regular blood tests to monitor liver enzymes and viral load. (v.1 at 121.) Periodic liver biopsies could also be done. (v.1 at 121.) Recently, however, new medications have been developed that are classified as direct-acting antivirals. (v.1 at 119, v.3 at 71.) The development of new medications continues and, as a result, HCV treatment is a rapidly changing field. (v.3 at 71.)

The first of these medications, Sovaldi, was approved for use in HCV treatment by the Food and Drug Administration ("FDA") on December 2013. (v.2 at 201.) Another medication, Harvoni, was approved in October 2014. (*Id.*) Both are administered orally once per day, generally over an eight- to twelve-week period. (v.1 at 119.) The medications have a reported cure rate of at least 90 percent and relatively low side-effects. (v.1 at 119-20, v.2 at 213.) However, treatment with these medications costs between $84,000 and $90,000 per patient. (v.1 at 142.)

Both the Center for Disease Control ("CDC") and the AASLD have published guidance on the testing and treatment of HCV. (v.2 at 7-9.) The CDC has advised that use of direct-acting antiviral agents that include Sovaldi and Harvoni, rather than Interferon-based regiments, is the standard of care. (Ex. P17 at 6.) The CDC has further advised that guidance for testing and treatment of HCV is available

through the AASLD. In June 2015, the AASLD issued treatment guidelines that recommended prioritizing treatment for individuals with HCV, giving highest priority to those individuals with advanced fibrosis (Metavir scale F3), compensated cirrhosis (F4), liver transplant recipients, and the following severe extrahepatic symptoms: lymphoma, cryoglobulinemic vasculitis, and proteinuria. (Ex. P2 at 3, 5.) The AASLD explained the rationale for this prioritization:

> When the US Food and Drug Administration (FDA) approved the first IFN-sparing treatment for HCV infection, many patients who had previously been "warehoused" sought treatment, and the infrastructure (experienced practitioners, budgeted health-care dollars, etc) did not yet exist to treat all patients immediately. Thus, the [AASLD] offered guidance for prioritizing treatment first to those with the greatest need.

Ex. P18 at 1.

However, on October 22, 2015, only four months later, the AASLD updated its treatment guidelines, noting that, since its prior guidelines, there had been opportunities to treat those at highest risk and "accumulate real-world experience of the tolerability and safety of [the] newer HCV medications" beyond clinical trials. Thus, it noted that it was removing the prioritization tables. (Ex. P18.) However, in the press release accompanying the guidelines, the AASLD stated, "***Because of the cost of the new drugs, or regional availability of appropriate health care providers, a practitioner may still need to decide which patients should be treated first.***"[5]

[5] "Hepatitis C Guidance Underscores the Importance of Treating HCV Infection:

The current guidelines continue to acknowledge that "in certain settings there remain factors that impact access to medications and the ability to deliver them to patients. In these settings, practitioners may still need to decide which patients should be treated first."[6]

In fact, prioritization remains the practice in the community with insurance companies (v.3 at 72), Medicaid (v.2 at 18), the United States Veterans Administration (v.2 at 214-15, v.3 at 64, 73), and the Federal Bureau of Prisons (v.3 at 64, 72-73, Ex. D13.)

Consistently, the Pennsylvania Department of Corrections has an interim Hepatitis C treatment protocol that prioritizes treatment for inmates with HCV infection. (v.3 at 102, Ex. P30.) The Department currently has approximately 7,000 inmates who have tested positive for HCV. (v.3 at 103.) No inmate is precluded from treatment; rather, the Department's HCV treatment protocol is designed to identify and treat those inmates with the most serious liver disease first. (v.3 at 102-3.)

Panel Recommends Direct-Acting Drugs for Nearly All Patients with Chronic Hepatitis C" (Oct. 22, 2015), available at http://hcvguidelines.org/sites/default/files/when-and-in-whom-to-treat-press-release-october-2015.pdf. (Attached for ease of reference as Ex. A) The Court is requested to take judicial notice of the press release pursuant to F.R.E. 201.

[6] "When And In Whom To Initiate Hcv Therapy" (revised Feb. 24, 2016), available at http://hcvguidelines.org/full-report/when-and-whom-initiate-hcv-therapy. (Attached for ease of reference as Ex. B) The Court is requested to take judicial notice of the referenced version of the guidelines pursuant to F.R.E. 201.

Pursuant to the protocol, all inmates in the Department's custody are screened for presence of the HCV antibody. (v.3 at 104.) Those who test positive for the antibody are given a viral load test to determine if they have spontaneously cleared the virus. (*Id.*) If presence of viral load is detected, they are identified as having chronic HCV and will then be placed on the chronic care clinic for regular monitoring. (*Id*.)

The chronic care clinic monitoring consists of: a face-to-face interview between a physician and the inmate; a physical examination focused on the signs or symptoms of complications associated with chronic HCV; blood tests (CBC and metabolic panel) to assess progression of the disease; education by an infectious control nurse; and administration of any necessary immunizations. (v.3 at 106, 108.) The frequency with which inmates are seen is dependent upon the progression of their condition. (v.3 at 106.) Pursuant to the protocol, inmates are seen in the chronic care clinic at least annually in the early stages of the condition. (*Id*.) However, when an inmate begins to develop advanced fibrosis, the inmate is seen at least every six months. (*Id*.) Additionally, the treating physician has discretion to schedule an inmate for more frequent monitoring. (*Id*.)

If an inmate's blood tests indicate a platelet count of less than 100,000 or a Halt-C score of greater than 60 percent,[7] he is identified for further evaluation and

[7] According to Dr. Noel, the Department's Chief of Clinical Services, use of a Halt-

his case is then referred to the Department's Central Office for review by the Hepatitis C Review Committee ("HCVC"). (v.3 at 104-5.) The HCVC reviews the inmate's medical chart in conjunction with additional information provided by the treating physician. (*Id*. at 105.) At that point, additional testing may be ordered and a decision is made regarding the need to schedule the inmate for an esophageal gastroendoscopy ("EGD") to determine if they have esophageal varices, which is a direct indication of advanced progression. (*Id*.) Individuals are identified for the direct-acting antivirals in order of priority, with the sickest individuals treated first. (v.3 at 102, Ex. P30.)

3. Plaintiff's Medical Conditions and Treatment

It is undisputed that Plaintiff experienced elevated blood sugar in March 2015. However, Plaintiff has well controlled blood sugars without medication, and his blood sugars continue to be monitored with daily finger sticks. (v.1 at 96, v.3 at 93-4.) In the opinion of Dr. Noel, Plaintiff's increased blood sugar in March 2015 was hyperglycemia, and was not the onset of diabetes mellitus. (v.1 at 93.) Dr. Noel bases this opinion on the fact that Plaintiff's blood sugars are controlled without medication. (*Id*.)

C score of 60 is based on the score used by the Veterans Administration to identify patients for further review. This score was adopted based on a determination that the score was significant enough to justify further review without waiting too long. (v.3 at 110.)

With respect to Plaintiff's anemia, it is undisputed that Plaintiff was anemic. However, Plaintiff was examined by his treating physicians at SCI-Mahanoy and his condition was monitored on a regular basis from the time the abnormal hemoglobin and hematocrit levels appeared on Plaintiff's lab results in February 17, 2015. (Ex. D-1 at 133, 141, 182-186, 385-400, 598-607.) He was also referred to an oncologist, Dr. Maholtra, who has evaluated Plaintiff on several occasions (Ex. D-1 at 211, 212-13, 409, 422, 424, 426-27, 430, 442, 656). Dr. Maholtra recommended treatment with iron therapy and Procrit.[8] (Ex. D-1 at 656, v.3 at 57.) Plaintiff's blood levels improved on this treatment and, as result the Procrit was stopped on September 2, 2015. (Ex. D-1 at 409.) After the Procrit was stopped, his blood levels continued to improve, and Plaintiff informed the oncologist that he was "feel[ing] better." (Ex. D-1 at 409.) Plaintiff admits that Dr. Maholtra informed him that his hemoglobin levels had improved. (v.1 at 97.) Although Plaintiff's latest blood tests showed that his blood levels were below the normal limit, the tests indicated that he was only mildly anemic. (Ex. D-1 at 385, v.2 at 58, 78.)

Although anemia can appear in individuals with HCV, Dr. Cowan opined that Plaintiff's anemia was not likely related to Plaintiff's HCV. (v.2 at 218, v.3 at 78-9.) Dr. Cowan bases that opinion on the improvement of Plaintiff's blood

[8] He was also referred for a bone marrow biopsy (Ex. D-1 at 200) as well as a sonogram of the liver (ex. D-1 at 656) to further treat and evaluate his condition.

hemoglobin and hematocrit levels in the absence of treatment for Plaintiff's HCV. (*Id*.) It is Dr. Cowan's opinion that the anemia is likely caused by Plaintiff's skin condition and the cyclosporine, which is a strong medication that can affect the bone marrow, that was used to treat Plaintiff's skin condition. (v.2 at 218, v.3 at 56-58.)

With respect to Plaintiff's skin condition, he admits that he has been followed by a consulting dermatologist, Dr. Schleicher, and has been receiving treatment for his skin condition. (v.1 at 90.) Following a skin biopsy that was evaluated by a dermatopathologist on June 23, 2015, Plaintiff was diagnosed with "psoriasis, but possibly nummular eczema." (v.2 at 27, 70, Ex. D-1 at 415.) Dr. Schleicher has proceeded with treating Plaintiff for that condition. (v.2 at 70-73.) Plaintiff admits that, under Dr. Schleicher's care, he has been treated with baths, triamcinolone cream, Vaseline, and phototherapy sessions. (v.1 at 91.) As a result of these treatments, Plaintiff admits that his skin condition, and the itching associated with it, has improved. (v.1 at 90-1.) At Plaintiff's last dermatology consultation prior to the hearing in this matter, he informed Dr. Schleicher that he felt "great". (v.1 at 90.)

According to Dr. Schleicher, Plaintiff's skin condition has improved significantly, possibly by about 90 percent, since Dr. Schleicher first examined him. (v.2 at 70.) Based on this improvement, Dr. Schleicher plans to reduce Plaintiff's

phototherapy treatments (v.2 at 77); however, he plans to continue to treat Plaintiff for his condition (*id*. at 78).

With respect to Plaintiff's request for treatment with Protopic, Dr. Schleicher explained that the Protopic was initially recommended as a non-steroidal alternative to the triamcinolone cream, which can affect blood sugar. (Id. at 68.) However, Plaintiff refused that medication. (*Id*. at 66-67; Ex. D-1 at 119-131.) After Plaintiff was admitted to GMC for treatment of a flare in his skin condition, physicians at that facility advised against using the Protopic. (v.2 at 69, Ex. D-1 at 166-67.) Dr. Schleicher does not recommend treatment with that medication at this point based on Plaintiff's improvement on his current treatment. (*Id*. at 68.)[9] Dr. Cowan does not believe that a relationship exists between Plaintiff's condition and his HCV because there is insufficient development of such a relationship in accepted medical journals. (v.2 at 217-18.)

Finally, as regards Plaintiff's hepatitis C condition, it is undisputed that he has chronic HCV. He tested positive for Hepatitis C in 2012. (Ex. D-1 at 167.) Because Plaintiff refused prior offers for testing during his incarceration, it is not possible to determine when he may have been exposed to the virus. (Ex. D-1 757.) Following the HCV antibody test in 2012, Plaintiff was tested for a viral load and his HCV

[9] Further, Plaintiff has admitted receiving triamcinolone, the topical steroid medication that the Protopic was intended to replace. (v.1 at 91.)

genotype was assessed. (v.2 at 48, Ex. D-1 at 397-8.) Since then, his platelets have been monitored monthly. (v.2 at 28, Ex. D-1 at 385-400.)

Additionally, two CT scans and two ultrasounds were performed to further assess Plaintiff's condition. (Ex. D-1 at 434, 637, 640, Ex. P-75.) Although the CT from May 2015, performed at GMC, indicated "an irregular appearance of the liver" (Ex. P-75), the earlier CT from April 2015, performed at Schuylkill Medical Center, did not note an irregular appearance. Rather, the report issued for that CT noted that there was a "[s]lightly diminished attenuation…which could relate to a very mild fatty infiltration." (Ex. D-1 at 637.) Plaintiff's expert agrees that the second CT scan noting an irregularity could simply be attributed to a difference in the doctor reading the scan. (v.2 at 25.)

Both Dr. Cowan and Dr. Harris estimate that Plaintiff's degree of fibrosis is approximately F2 on the Metavir scale. (v.2 at 22, v.3 at 75.) He has a calculated APRI score of 0.392 (v.2 at 210) and a Halt-C score of 63 (v.3 at 120). These scores indicate that Plaintiff has a possibility of significant fibrosis, with cirrhosis unlikely. (v.2 at 211.) Using the Halt-C score, he has a 63 percent possibility of cirrhosis. (v.3 at 155.) Applying both of these numbers, and all of the additional information regarding Plaintiff's current medical condition, neither Dr. Cowan nor Dr. Noel believe that Plaintiff has developed advanced fibrosis or cirrhosis. (v.2 at 211, v.3 at 75, 121, 155.) Further, Plaintiff is unlikely to suffer any irreparable injury to his

liver unless he reaches a state of advanced cirrhosis. (v.3 at 78.) Thus, it is the opinion of Dr. Cowan that Plaintiff can appropriately be treated at this point by monitoring his condition through blood work and monitoring his symptoms. (v.2 at 219.)

In fact, Dr. Noel has stated that this is exactly the plan established for Plaintiff. He will remain on the roster for the hepatitis C chronic care clinic and, as a result, will receive regular monitoring and evaluation for his condition. (v.3 at 121.)

Statement of Questions Presented

I. Whether Plaintiff's Motion For Preliminary Injunction Should Be Denied Where Plaintiff Has Not Established An Imminent, Irreparable Injury?

II. Whether Plaintiff's Motion Should Be Denied Where Plaintiff Has Not Established A Reasonable Likelihood Of Success On The Merits?

III. Whether Plaintiff's Motion Should Be Denied Where, If Granted, It Will Have Significant Negative Impacts on Public Policy And Institutional Administration?

Argument

A preliminary injunction is an extraordinary remedy which is not granted as a matter of right. *Kershner v. Mazurkiewicz*, 670 F.2d 440, 443 (3d Cir. 1982). The moving party must clearly establish the right to relief. *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997). To establish the right, the moving party must show: (1) a reasonable probability of success on the merits; (2) that the movant will be irreparably injured by denial of the relief, (3) that granting the relief will not result

in even greater harm to the nonmoving party; and (4) that granting the preliminary relief will not adversely affect the public interest. *Gerardi v. Pelullo*, 16 F.3d 1363, 1373 (3d Cir. 1994). If the moving party fails to carry his burden on these elements, the motion should be denied. *Hohe v. Casey*, 868 F.2d 69, 72 (3d Cir. 1989).

"[T]he irreparable harm must be actual and imminent, not merely speculative." *Angstadt ex rel. Angstadt v. Midd-West Sch.*, 182 F. Supp. 2d 435, 437 (M.D. Pa. 2002); *Hohe*, 868 F.2d at 72 (same). An injunction is not issued "simply to eliminate the possibility of a remote future injury." *Acierno v. New Castle County*, 40 F.3d 645, 655 (3d Cir. 1994).

Further, "when the preliminary injunction is directed not merely at preserving the status quo but . . . at providing mandatory relief, the burden on the moving party is particularly heavy." *Punnett v. Carter*, 621 F.2d 578, 582 (3d Cir. 1980). Mandatory injunctions should be used sparingly and, where sought in the prison context, "must always be viewed with great caution because judicial restraint is especially called for in dealing with the complex and intractable problems of prison administration." *Goff v. Harper*, 60 F.3d 518 (3d Cir. 1995). In the prison context, preliminary injunctive relief "must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice

system caused by the preliminary relief and shall respect the principles of comity…." 18 U.S.C § 3626 (a) (2).

I. Plaintiff's Motion For Preliminary Injunction Should Be Denied Because He Has Not Established An Imminent, Irreparable Injury

Plaintiff has not established that he will suffer an irreparable injury if the requested relief is not granted. An irreparable injury is one incapable of redress through law or other equitable relief. *Instant Air Freight Co. v. C.F. Air Freight, Inc.*, 882 F.2d 797, 801 (3d Cir.1989). "The possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm." *Id.* (quoting *Sampson v. Murray*, 415 U.S. 61, 90 (1974); *see also* Wright, Miller, Kane, 11A Fed. Prac. & Proc. Civ. § 2948.1 (3d ed.) ("if a trial on the merits can be conducted before the injury would occur there is no need for interlocutory relief.") Thus, where a plaintiff's motion for preliminary injunction seeks the ultimate relief requested in the action, irreparable harm is not established since the ultimate issue presented will be decided by the court during the course of litigation. *Kelly v. Merrill*, No. 1:14-CV-2322, 2014 U.S. Dist. LEXIS 181621, *8-9, (M.D. Pa. Dec. 11, 2014) (quoting *Messner v. Bunner*, 2009 U.S. Dist. LEXIS 128910 (W.D. Pa. Jan. 26, 2009), *report and recommendation adopted* (M.D. Pa. Feb. 3, 2015).

In a matter similar to the motion at issue, *Harrell v. California Forensic Medical Group, Inc.*, 2015 U.S. Dist. LEXIS 165220 (E.D. Ca. Dec. 9, 2015), the

inmate-plaintiff moved for a temporary restraining order compelling the defendants to prescribe Harvoni to treat his chronic HCV. The plaintiff asserted that he would continue to suffer from Hepatitis C symptoms. He further asserted the possibility that he could infect others with the virus and, ultimately, could develop cirrhosis. The court ruled that Plaintiff failed to establish immediate, irreparable injury because he had not shown a likelihood that he would develop cirrhosis or other irreparable harm prior to disposition of the matter.

Similarly, in the matter at issue, Plaintiff has not shown that he is likely to be irreparably harmed prior to a final disposition of this matter. The experts appearing in this matter agree that progression to cirrhosis generally takes decades, and only about and 20 to 30 percent of individuals with chronic HCV will actually develop cirrhosis. Both Plaintiff's expert and Dr. Cowan agree that Plaintiff is likely somewhere between a 2 and 2.5 on the Metavir scale, indicating a middle range of fibrosis. His APRI score, established through his most recent bloodwork, indicates that cirrhosis is unlikely at this point. Further, Dr. Noel and Dr. Cowan both rendered opinions that, viewing Plaintiff's bloodwork and his overall condition, they do not believe Plaintiff has developed cirrhosis. Additionally, Dr. Cowan testified that irreparable liver damage does not occur until an individual reaches late stage cirrhosis.

Finally, all of the experts in this matter have agreed that, when treated with direct-acting antivirals, there is a cure rate that exceeds 90 percent. Plaintiff has been identified for monitoring and treatment under the Department's interim protocol, that prioritizes treatment for the sickest individuals first. Although the AASLD guidelines introduced by Plaintiff indicate that treating HCV at earlier stages of fibrosis may increase the likelihood of a sustained virologic response, Plaintiff has offered no evidence that he is unlikely to successfully clear the virus if he is not treated prior to disposition of this matter. Given Plaintiff's estimate degree of fibrosis, the low risk that Plaintiff has developed cirrhosis, and the slow progression of the disease, it is clear that Plaintiff will not suffer any irreparable harm prior to a final disposition in this matter.

Additionally, it is clear that Plaintiff has failed to establish that he is likely to suffer immediate, irreparable harm associated with any of his remaining medical conditions. As an initial matter, Plaintiff has not established that any of remaining conditions are associated with his HCV. Plaintiff offered only speculation that he might have diabetes, as opposed to hyperglycemia. Further, even if he had diabetes, Plaintiff's expert agrees that the relationship between diabetes and HCV has not been established. It is Dr. Cowan's opinion that Plaintiff's anemia is likely related to his skin condition and the cyclosporine that was previously used to treat it.

Regarding Plaintiff's skin condition, it is clear that Plaintiff's expert does not have a settled diagnosis regarding his skin condition. He stated that the condition was most appropriately confirmed by the dermatopathologist who has confirmed a diagnosis of psoriasis. Although Plaintiff offered numerous journal articles regarding relationships between various skin conditions and HCV, a relationship between psoriasis and HCV is clearly uncertain. By contrast, Dr. Cowan testified that, in his opinion, the skin condition and HCV are not related.

It is also clear that Plaintiff has failed to establish imminent, irreparable injury stemming from these conditions, independent of a relationship with HCV. Plaintiff has well controlled blood sugars without medication, and his blood sugars continue to be monitored with daily finger sticks. (v.1 at 96, v.3 at 93-4.) With respect to his anemia, he continues to receive medication for his anemia and, although his blood levels are below normal, they indicate that his blood levels have improved on his existing treatment and he is only mildly anemic. As regards his skin condition, Plaintiff has conceded that he continues to receive treatment for this condition. He also concedes that the degree of itching and the extent of his rash have improved. Notably, Plaintiff recently informed his treating dermatologist that he "feels great." Because Plaintiff has not established an immediate irreparable injury with respect to these conditions, his motion should be denied.

II. Plaintiff's Motion Should Be Denied Because He Has Not Established A Reasonable Likelihood Of Success On The Merits

Plaintiff has also failed to establish that he has a reasonable probability of success on the merits regarding on his medical claims. In order to establish an Eighth Amendment medical claim, the plaintiff must establish by a preponderance of the evidence that the defendant acted with deliberate indifference to his serious medical needs. *Estelle v. Gamble*, 429 U.S. 97 (1976). A prison official may be found deliberately indifferent only if the official "knows of and disregards an excessive risk to inmate health or safety." *Farmer v. Brennan*, 511 U.S. 825, 837 (U.S. 1994). The official "must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id*. The official must disregard that risk by failing to take reasonable measures to abate it. *Id*. "Prison officials who lacked knowledge of the risk cannot be said to have inflicted punishment." *Farmer*, 511 U.S. at 844. Similarly, those "who actually knew of a substantial risk to inmate health or safety may be found free of liability if they responded reasonably to the risk, even if harm ultimately was not averted." *Id*.

Prison officials, who are not physicians, are entitled to rely on the expertise of their institution's medical staff and cannot be considered deliberately indifferent simply because they failed to respond to the medical complaints of a prisoner who was already being treated by medical personnel of the prison. *Durmer v. O'Carroll*, 991 F.2d 64, 69 (3d Cir. 1993).

Prison medical authorities are given considerable latitude in the diagnosis and treatment of medical problems of inmates and courts will "disavow any attempt to second guess the propriety or adequacy of a particular course of treatment . . .which remains a question of sound professional judgment." *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 762 (3d Cir. 1979).

Furthermore, mere medical malpractice does not give rise to a violation of the Eighth Amendment. *White v. Napoleon,* 897 F.2d 103, 108 (3d Cir. 1990). "While the distinction between deliberate indifference and malpractice can be subtle, it is well established that as long as a physician exercises professional judgment his behavior will not violate a prisoner's constitutional rights." *Brown v. Borough of Chambersburg*, 903 F.2d 274, 278 (3d Cir. 1990).

Mere disagreement as to the proper medical treatment does not support an Eighth Amendment claim. *Monmouth County Correctional Institutional Inmates v. Lanzaro*, 834 F.2d 326, 346 (3d Cir. 1987); *Spruill v. Gillis*, 372 F.3d 218, 235 (3d Cir. 2004) (citations omitted). Inmates are not entitled to the treatment of their choice. *Colon-Montanez v. Pennsylvania Healthcare Serv. Staffs*, 530 Fed. Appx. 115 (3d Cir. 2013) (inmate not entitled to Hepatitis C treatment of his choice); *Birckbichler v. Butler County Prison*, 2009 U.S. Dist. LEXIS 84949 (W.D. Pa. Sept. 17, 2009) (summary judgment granted where inmate sued over the drugs he preferred for his AIDS treatment); *Ascenzi v. Diaz*, 2007 U.S. Dist. LEXIS 23475

(M.D. Pa. March 30, 2007) (medical decision not to order an X-ray, or like measure, does not represent cruel and unusual punishment). "[T]he key question . . . is whether defendants have provided plaintiff with some type of treatment, regardless of whether it is what plaintiff desires." *Farmer v. Carlson*, 685 F. Supp. 1335, 1339 (M.D. Pa. 1988) *quoting Lamb v. Maschner*, 633 F. Supp. 351, 353 (D. Kan. 1986).

At its core, Plaintiff's motion and his underlying medical claims amount to nothing more than a disagreement over the appropriate course of treatment for his various medical conditions. Defendants' experts offered evidence that Plaintiff's hyperglycemia, anemia and skin conditions are not related to his HCV. Plaintiff concedes that he has received treatment for these conditions and that they have all improved on the existing courses of treatment. Because it is clear that he has received treatment for these conditions and continues to be monitored and treated, his requests for specific forms of treatment should be denied.

With respect to his chronic HCV, Plaintiff asserts that he is entitled to treatment for this condition with direct-acting antivirals. He bases this assertion on a change in the AASLD's treatment guidelines on October 22, 2015 that removed prioritization tables as a recommended approach to treatment. In essence, Plaintiff asserts that these revised guidelines raise the standard of care and mandate immediate treatment for all individuals with chronic HCV. It is clear that, even were

this true, it would not be sufficient to state a viable Eighth Amendment claim against the Corrections Defendants in this action. *See Napoleon*, 897 F.2d at 108.

Regardless of Plaintiff's assertions, it is clear that the AASLD guidelines recognize that a continued need may exist to continue to prioritize treatment based on cost of the medication and availability of resources. Further, prioritization remains the practice in the community. Experts for Plaintiff and Defendants agree that insurance companies, Medicaid, the United States Veterans Administration, and the Federal Bureau of Prisons continue to prioritize treatment. Further, Plaintiff's own expert, Dr. Harris, testified that he had monitored patients with chronic HCV without administering direct-acting antivirals where the medications were not approved by insurance or Medicaid.

The Department's adoption of a similar prioritization approach is consistent with this practice. Plaintiff does not dispute that he has been monitored. He has received monthly blood tests to monitor his platelets and liver enzymes, and has had four CT scans and ultrasounds of his liver. Further, he continues to be monitored through a chronic care clinic under the Department's HCV treatment protocol. Other courts have held that such monitoring is constitutionally sound. *See Dulak v. Corizon*, No. 2015 Dist. LEXIS 131291 (E.D. Mich. July 10, 2015) *adopted at* 2015 U.S. Dist. LEXIS 129702 (E.D. Mich. Sept. 28, 2015) (denying preliminary injunction and finding no deliberate indifference where plaintiff was monitored

under prioritization protocol and denied antiviral therapy); *Harrell v. California Forensic Medical Group, Inc.*, No. 2015 U.S. Dist. LEXIS 149084 (E.D. Ca. Nov. 3, 2015) (denying preliminary injunction and dismissing complaint for failure to state a claim where plaintiff was denied direct-acting antivirals under prioritization protocol based on low fibrosis score); *Shabazz v. Schofield*, 2015 U.S. Dist. LEXIS 113082 (M.D. Tenn. Aug. 26, 2015) (denying preliminary injunction and finding that regular monitoring through chronic care program that monitored liver enzymes at least every three months was "consistent with generally accepted medical practices, regardless of whether the patient is incarcerated or is a free world patient.") Further, it is clear that Plaintiff has not established that his condition has progressed to such a degree that immediate treatment with the request medications is medically necessary to avoid irreparable harm. *See* Argument, *supra*. Because it is clear that Plaintiff continues to be monitored and reviewed for treatment under the Department's treatment protocol, his motion should be denied.

III. Plaintiff's Motion Should Be Denied Because, If Granted, It Will Have Significant Negative Impacts on Public Policy And Institutional Administration

Plaintiff seeks immediate treatment with the "latest direct acting anti-viral drugs". Plaintiff does not dispute that he is currently enrolled in a chronic care clinic that will monitor his condition while the sickest inmates in the state prison system are identified and treated. He seeks simply to have the treatment immediately. In

essence, he seeks to leap ahead of sicker inmates to receive the treatment he wants. Although this "line jumping" will, as a practical matter only result in pushing back one inmate, the policy message such an order would send is clear—prioritization is only meaningful for those who cannot get to the courthouse doors quickest.

Plaintiff's own expert and the AASLD guidelines recognize that large numbers of individuals with chronic HCV intentionally delayed treatment for their condition because they were waiting for newer medications with fewer deleterious side effects. As a result, large numbers of patients with chronic HCV, both inside and outside of the prison system, require treatment. Permitting any individual to move ahead of someone who is sicker and *needs* the medication immediately is fundamentally unfair.

Further, it is clear that prioritization is used by institutions other than correctional systems, including private insurance companies, Medicaid and the United States Veterans Administration. Permitting state inmates to proceed outside of prioritization protocols to receive immediate treatment while individuals outside the correctional system are forced to wait for treatment is unconscionable.

Finally, as a practical matter, ordering treatment for Plaintiff outside the treatment protocol would effectively end the use of the protocol in the state prison system. There simply is not enough money to treat every individual with chronic HCV immediately. Within the Pennsylvania prison system, there are approximately

7,000 inmates with chronic HCV. Treating all of these individuals at a cost of $84,000 to $90,000 per person would cost approximately $600 million. Such an expense would effectively cripple the Department from a budgetary standpoint and would significantly impact budgeting for other necessary expenses, such as other necessary medical care and institutional security.

Conclusion

WHEREFORE, for the foregoing reasons, Plaintiff's motion should be denied.

Respectfully submitted,

Office of General Counsel

Dated: March 11, 2016

By: /s/ Laura J. Neal

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

MUMIA ABU-JAMAL, et al.,	:	
Plaintiffs	:	Civil Action No. 3:15-CV-00967
	:	
v.	:	(Judge Mariani)
	:	
JOHN KERESTES, GEISINGER MEDICAL CENTER	:	(Magistrate Judge Mehalchick)
	:	
Defendants	:	FILED ELECTRONICALLY

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was served on counsel for all parties via ECF on the date of filing.

Dated: March 11, 2016

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