

No. 25-417

IN THE
Supreme Court of the United States

FRANCIS NIELSEN,

Petitioner,

v.

KEKAI WATANABE,

Respondent.

**On Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit**

**BRIEF OF MEDICAL JUSTICE ALLIANCE,
MEDICAL JUSTICE ALLIANCE-MASSACHU-
SETTS, GEORGIA HUMAN RIGHTS CLINIC,
CHICAGO MEDICAL LEGAL COLLABORATIVE
AND STOP CRIMINALIZATION OF OUR
PATIENTS AS *AMICI CURIAE*
IN SUPPORT OF RESPONDENT**

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INTEREST OF *AMICI CURIAE*¹

The Medical Justice Alliance (“MJA”) is a nonprofit organization with a network of over 940 clinicians and other healthcare professionals who volunteer their medical expertise, pro bono, in legal matters involving incarcerated patients. MJA’s volunteers review medical records and provide written or oral testimony for attorneys seeking appropriate medical care or compassionate release for their clients. MJA’s volunteer network includes clinicians across 30 different specialties who are employed by many of the top hospitals and academic institutions across the country. MJA physicians also educate courts, policymakers, clinicians, and the public about healthcare in carceral settings and advocate for improved access to care. MJA is strongly committed to the medical profession and to ensuring effective medical care for incarcerated persons. MJA’s work gives it a perspective distinct from that of the parties in this case. Its clinicians have reviewed hundreds of matters involving medical care in federal custody. That work exposes them to the practical mechanics of obtaining care in prison: how a patient reports symptoms, how records and laboratory results are reviewed, how referrals are made, how outside treatment is scheduled, and how delays can alter a patient’s prognosis.

The Medical Justice Alliance-Massachusetts (“MJA-MA”) is a state chapter of the national Medical Justice Alliance. MJA-MA is a group of more than 50

¹ Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for any party authored this brief in whole or in part, and that no entity or person other than *amici* and their counsel made any monetary contribution toward the preparation and submission of this brief.

healthcare providers, social workers, public health researchers, and advocates who care deeply about improving medical care and conditions of confinement for those incarcerated across the Commonwealth. They partner with legal advocacy groups, grassroots organizations, and incarcerated people and their loved ones to seek change through three main avenues of advocacy: Individual and Systemic Advocacy, Legislative and Policy Advocacy, and Advocacy for the Rights of Incarcerated People in Hospitals. MJA-MA also runs a biweekly carceral health case review clinic in which they advise advocates on the community standard of care for medical issues that incarcerated people encounter.

The Georgia Human Rights Clinic (“GHRC”) is committed to ensuring all residents of Georgia, regardless of legal status, have access to basic rights including but not limited to: healthcare, legal representation, and personal and family support. This is accomplished through working with local legal organizations to provide forensic medical evaluations, medical chart reviews, and advocating for adequate medical care in detention facilities. Through grassroots organizing and collaborations with community partners across the state, GHRC is committed to ensuring patient rights are protected and advanced.

The Chicago Medical Legal Collaborative (“CMLC”) equips clinicians and clinician-learners with the skills, relationships, and grounding to move between medical care, legal advocacy, and collective action in defense of life. Through community-centered forensic work, mentorship, and education, CMLC supports people impacted by social and political forces that disrupt health. CMLC is building toward a future where this kind of practice is no longer rare—but a shared stand-

ard of how clinicians are trained, supported, and engaged in the world. CMLC is also known as the Chicago People’s Rights Collaborative (“CPRC”).

Stop Criminalization Of Our Patients (“SCOOP”) is an organization of healthcare and public health workers whose research and education initiatives analyze the intersections between the criminal legal system and health. SCOOP’s curricular materials have been integral to the education of hundreds of medical students and medical residents, informing them about the complexities of healthcare within jails and prisons as well as providing best-practice guidance for the care of in-custody patients in community hospitals and clinics. SCOOP members have cared for dozens of in-custody patients in a hospital-based setting and reviewed thousands of patient medical records in support of medical release cases including from the local, state, and federal system.

Amici submit this brief to explain why the closed nature of prison healthcare, the systemic constraints under which clinicians work in prisons, and the medical consequences of delayed or deferred care make the narrow remedy recognized in *Carlson v. Green*, 446 U.S. 14 (1980), an important accountability backstop when federal officials are deliberately indifferent to serious medical needs.

SUMMARY OF ARGUMENT

The Court should affirm the straightforward application of *Carlson*’s narrow but important accountability function below.

When the government incarcerates a person, it assumes responsibility for and controls all aspects of that person’s medical care. An incarcerated patient can initiate the process by submitting a sick-call request, but

from that point forward has little ability to direct, accelerate, or supplement the course of care. The institution controls when, or if, the patient will be seen, whether diagnostic testing or medication will be ordered, and whether specialty or hospital care will be authorized. Unlike a patient outside of prison, an incarcerated patient cannot obtain an earlier appointment from another provider, seek testing or treatment independently, visit an urgent-care clinic or emergency department, or choose a different physician or competing healthcare system. Specialty or hospital care requires still more institutional action, including medical review and approval, scheduling with an outside provider, secure transportation, and staff escorts. Those steps may serve legitimate clinical and security purposes. But because incarcerated patients cannot bypass or supplement them, they are at risk of serious medical consequences from compounding delays that can impact the entire course of their diagnosis and treatment.

Amici have witnessed countless cases where delayed treatment led to emergency surgery, disease progression, and even death. A condition may not be life-threatening on the day it first appears, but it can become irreversible after months without diagnosis or proper treatment. Belated care may mitigate injury, but it cannot restore lost organ function, erase prolonged pain, or reverse the narrowing of treatment options caused by delay. In a system where patients cannot independently seek treatment, *Carlson* supplies a narrow but important accountability backstop to deter unconstitutionally deficient care.

Because respondent's claim falls squarely within *Carlson*'s existing context rather than a new one, the judgment below should be affirmed.

ARGUMENT

I. INCARCERATED PATIENTS ARE WHOLLY DEPENDENT ON THE FEDERAL PRISON HEALTHCARE SYSTEM FOR PHYSICAL MEDICAL CARE.

Incarcerated patients depend on the government for medical care, cannot obtain substitute care on their own, and must navigate a sequence of institutional decisions before treatment can occur. Because such patients cannot exit the system, *Carlson* is essential to incentivize attention to serious medical needs and reinforce the Eighth Amendment’s constitutional floor.

A. The Governing Legal Framework Reflects the Unique Dependence on Federal Prison Healthcare Created by Incarceration.

A person outside prison can ordinarily obtain medical care without government permission; a person in custody cannot. In *Estelle v. Gamble*, the Court recognized that prisoners must rely on prison authorities to treat medical needs. 429 U.S. 97, 103–04 (1976). If prison authorities do not provide that care, the need may simply go unmet. *Id.* The Court has repeatedly found that when confinement prevents a person from caring for himself or seeking outside aid, the government assumes responsibility for basic needs, including medical care. See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 199–200 (1989) (explaining that when the government takes a person into custody, “the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being”); see also *Farmer v. Brennan*, 511 U.S. 825, 833 (1994); *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982); *Brown v. Plata*, 563 U.S. 493, 510–11 (2011). That enforced dependence is why the

government's obligation to provide medical care is not merely aspirational; deliberate indifference to a serious medical need constitutes cruel and unusual punishment where inadequate medical care results in pain and suffering that serves no penological purpose. *Estelle*, 429 U.S. at 104.

In *Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics*, 403 U.S. 388 (1971), the Court recognized an implied cause of action against federal officials for Fourth Amendment violations. *Carlson* extended *Bivens*, holding that federal officials can be subject to damages for Eighth Amendment violations where they are deliberately indifferent to a prisoner's serious medical needs. 446 U.S. at 18–23. Key to the Court's holding was the recognition that it is “almost axiomatic that the threat of damages has a deterrent effect” and is essential to remediate unconstitutional conduct and hold federal officials accountable for inadequate medical care. *Id.* at 21.

The constitutional standard is demanding. A poor outcome does not itself show deliberate indifference. Nor do negligence, medical malpractice, an inadvertent failure to provide adequate care, or a good-faith disagreement over the proper course of treatment. *Estelle*, 429 U.S. at 105–07. A plaintiff must show both an objectively serious and substantial risk of serious harm and that the official knew of and disregarded that risk. *Farmer*, 511 U.S. at 834–37.

This framework creates an essential but narrow accountability mechanism for patients dependent on prison officials to obtain treatment for serious medical conditions.

B. Prison Healthcare Lacks the Choices and Incentives That Are Ordinarily Present in the Healthcare Market.

Carlson serves an essential function because the accountability mechanisms that operate in other healthcare settings are missing from the prison healthcare system. See Ira P. Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. Crim. L. & Criminology 195, 197 (1999) (explaining that “[c]oncerns regarding inadequate health care are magnified in a prison setting, in which inmates have no choice about health care and cannot seek outside advice,” and where prisoners are left to the discretion of the chosen health care provider).

Outside prison, market forces, including competition, help regulate healthcare systems while promoting higher quality care. See Fed. Trade Comm’n & U.S. Dep’t of Just., *Improving Health Care: A Dose of Competition* 4 (2004) (explaining that competition can broaden access and promote higher quality care). A community patient who believes that care is inadequate generally has options. The patient may seek a second opinion, change providers, visit an urgent-care clinic or emergency department, obtain an independent diagnostic test, obtain at-home care, or leave a healthcare system that is not responsive. For example, a second opinion—which is not available to incarcerated patients—can confirm the initial assessment, identify a different diagnosis or treatment approach, and provide the patient with additional information before making consequential healthcare decisions. See Velma L. Payne et al., *Patient-Initiated Second Opinions: Systematic Review of Characteristics and Impact on Diagnosis, Treatment, and Satisfaction*, 89 Mayo

Clinic Procs. 687, 687 (2014) (finding that 10 to 62 percent of second opinions resulted in a major change in diagnosis, treatment, or prognosis).

Those options do not guarantee adequate care. But patient choice and market competition create incentives for healthcare providers to improve quality and lower costs. See U.S. Dep’t of Health & Hum. Servs., U.S. Dep’t of Treasury & U.S. Dep’t of Lab., *Reforming America’s Healthcare System Through Choice and Competition* 8 (2018) (explaining that consumer choice gives firms incentives to improve quality and lower costs and that, without competitive pressure, incentives to improve quality and innovation diminish).

There are no comparable incentives in the prison healthcare system. The Federal Bureau of Prisons’ (“BOP”) current Patient Care Program Statement provides that inmates ordinarily may not use non-contracted community providers, including physicians who treated them before incarceration. See Fed. Bureau of Prisons, U.S. Dep’t of Just., Program Statement No. 6031.06, *Patient Care* § 5(a) (June 22, 2026) [hereinafter BOP Patient Care Statement]. The institution’s Health Services Unit oversees primary, ancillary, and specialty services delivered on site, through telehealth, or by contractors. *Id.* § 2(j). Thus, when care is delayed or a patient’s condition worsens, the patient cannot simply schedule an appointment with another doctor or pay for a different course of treatment. Ordinary market pressures that encourage responsiveness and quality care are entirely absent from the prison healthcare system.

Incarcerated patients thus must rely on outside forces to create incentives for the provision of constitutionally adequate care. *Carlson* is essential among those forces because the risk of individual liability creates an incentive for prison officials to address known,

serious medical risks in a system they know the patient cannot exit.

II. SYSTEMIC CAPACITY LIMITATIONS AND MULTI-STEP INTERNAL PROCESSES INCREASE THE RISK OF DELAYED DIAGNOSIS AND TREATMENT FOR INCARCERATED PATIENTS.

System-wide capacity constraints and a multi-step internal process can delay care for incarcerated patients, with potentially serious medical consequences. Staffing shortages, limited specialty care access, transportation demands, and coordination failures do not themselves establish deliberate indifference, but they can create bottlenecks at every stage of the care pathway and allow a serious condition to worsen before a provider intervenes. Likewise, internal clinical review procedures can delay diagnosis and treatment for incarcerated patients. Those structural problems are not what *Carlson* remedies—a damages action cannot add clinicians, expand diagnostic capacity, or rewrite BOP’s referral procedures. Their relevance is narrower but critical. In a closed system, these constraints increase the importance of each official’s response to a known serious risk because the patient cannot obtain substitute care. Against this backdrop, *Carlson* incentivizes attention to the serious medical risk that delayed care can create and preserves a remedy in the exceptional case when an official knowingly disregards that risk.

A. System-wide Capacity Constraints Can Impede and Delay Care.

The federal prison healthcare system has limited resources. Even as BOP has sought and received some additional resources to address staffing and healthcare costs, federal prison healthcare continues

to face staffing shortages and operational constraints that can delay routine appointments, diagnostic testing, specialty care, and transportation to outside providers. See Off. of the Inspector Gen., U.S. Dep’t of Just., *Top Management and Performance Challenges Facing the Department of Justice 2025* 2–3, 14–15 (2025) [hereinafter Top Management Report] (describing supplemental funding for hiring employees, including medical professionals, and explaining that addressing long-term staffing shortages will require additional appropriations). The BOP’s own policy recognizes that Health Services staffing varies by institution and that, when vacancies occur, medical leadership must set priorities among intake screenings, comprehensive evaluations, and the sickest patients. See BOP Patient Care Statement §§ 3(c), 6. In a closed system, such triage can mean that a lower-acuity concern waits while the institution attends to an emergency. However, a condition’s acuity may not be known until an examination, test, or specialist consultation occurs, and for certain conditions, that delay can be the difference between a treatable diagnosis and a terminal one.

Recent inspections by the Office of the Inspector General (“OIG”) illustrate these constraints. At Federal Detention Center SeaTac, the OIG found that only 10 of 20 authorized Health Services positions were filled, while a BOP staffing tool estimated that 40 positions were needed—30 more positions than were filled at the time. Off. of the Inspector Gen., U.S. Dep’t of Just., *Inspection of the Federal Bureau of Prisons’ Federal Detention Center SeaTac*, No. 25-081, at 4–7 (Sep. 2025) [hereinafter SeaTac Inspection]. Health Services leaders reported that they had to prioritize emergency care over day-to-day health needs. *Id.* at 3. Among 29 of the most serious documented sick-call re-

quests the OIG reviewed, including complaints of respiratory illness and severe pain, 18 showed no evidence that a healthcare provider had addressed the complaint. *Id.* at 6. For the 11 patients who were eventually seen, the average wait was 2.4 months. *Id.* Outside care presented an additional bottleneck. At SeaTac, 121 approved outside appointments were pending; 91 of those approved appointments had not yet been scheduled and had been pending for an average of 7.4 months. *Id.* at 7.

At Federal Medical Center Devens, a facility with a medical mission, the OIG found only 113 of 149 Health Services positions filled. Off. of the Inspector Gen., U.S. Dep't of Just., *Inspection of the Federal Bureau of Prisons' Federal Medical Center Devens*, No. 25-009, at i (Dec. 2024) [hereinafter Devens Inspection]. It also found 57 outside appointments that were overdue by an average of 53 days. *Id.* at ii. The OIG attributed this in part to a lack of staff available to escort patients while maintaining required institutional posts. *Id.* at 17. These reports reflect a wider trend across BOP facilities. See Top Management Report at 2–3 (identifying staffing shortages and deficiencies in inmate healthcare as persistent challenges facing BOP). In a system with limited resources, the referral, scheduling, record transmission, transportation, and staffing procedures are not abstract considerations. Each can determine whether a patient receives adequate and timely care. See SeaTac Inspection at 7–8; Devens Inspection at 11, 17–18.

These system-wide constraints therefore provide context, not a standalone basis for liability. They help explain why individual accountability remains important when an official is actually aware of a serious medical risk and the patient lacks an independent route to care.

B. The Prison System's Multi-step Institutional Process Delays Care And Increases Medical Risks For Incarcerated Patients.

Incarcerated patients who need medical attention must navigate a complex institutional process that can delay diagnosis and treatment, with potentially serious consequences.

Under BOP policy, sick call is the process through which an inmate initiates a visit for an acute medical issue. BOP Patient Care Statement § 19. The request ordinarily must be made in person, assessed and triaged by a qualified provider, and documented in the electronic health record with the patient's history, vital signs, examination, and disposition—the decision about next steps. *Id.* Urgent conditions are to be treated expeditiously; non-urgent complaints may be scheduled for later follow-up or the next chronic-care clinic. *Id.* If the same unresolved complaint recurs on three distinct occasions without a diagnosis or response to treatment, the policy calls for referral to the Clinical Director or a physician. *Id.*

Diagnostic and specialty care create additional handoffs. Routine clinical services, medication administration, testing, and specialty clinics are generally scheduled through the Health Services Unit. See *id.* § 7(a), (d). Before an outside specialist referral, a physician or other authorized provider ordinarily must review the electronic health record and examine the patient. The request then goes to the Clinical Director, another trained clinician, or the Utilization Review Committee for review and disposition. *Id.* § 4(e). If approved, the institution or its contractor must locate and schedule a provider, arrange secure transportation, and assign personnel to escort and supervise the patient. BOP policy directs facilities to use telehealth

when clinically appropriate in part to reduce the staffing and transportation demands associated with outside medical trips. *Id.* § 29.

The BOP Patient Care Statement does not identify a fixed deadline for reviewing or completing a non-emergency consultation. An inmate may challenge a delay through BOP's general Administrative Remedy Program, but that process ordinarily begins with informal resolution and may proceed through institutional, regional, and Central Office review. Once a request or appeal is filed, the regulations allow response periods of 20, 30, and 40 calendar days at those respective levels, subject to extensions. See 28 C.F.R. §§ 542.13–542.15, 542.18.

None of these bureaucratic steps is inherently problematic. Clinical review helps ensure that referrals are medically necessary; scheduling and escorts address legitimate security needs; and coordination with outside providers is unavoidable when a prison does not offer a specialty on site. But these procedures can impede prompt treatment and diagnosis for serious medical conditions.

For example, a 2025 OIG evaluation of BOP's colorectal-cancer screening and follow-up practices found that delays often occurred. Among 133 inmates included in its timeliness analysis, the average interval between a positive screening and a colonoscopy was eight months. See Off. of the Inspector Gen., U.S. Dep't of Just., *Evaluation of the Federal Bureau of Prisons' Colorectal Cancer Screening Practices for Inmates and Its Clinical Follow-up on Screenings*, No. 25-057, at ii, 24 (May 2025). Only 12 received a colonoscopy within 90 days, and eight waited more than 18 months. *Id.* Inmates who first had to complete a separate pre-colonoscopy evaluation waited an average of ten months, compared with six months for inmates who did not. *Id.*

at 25–26. Both averages substantially exceeded the 90-day period that community practice generally aims to meet following a positive screening. *Id.* at ii, 24.

C. Delays in Diagnosis and Treatment Can Worsen Disease and Narrow Available Treatment Options.

Delays in diagnosis and treatment standing alone will not give rise to a viable claim under *Carlson*, but the risk of individual liability incentivizes attention to the risks that delay can create for an individual patient with serious medical needs. Indeed, many serious conditions are manageable when detected and treated promptly. For example, kidney disease may require laboratory monitoring and kidney care before organ function declines. Cancer treatment depends on early diagnosis and treatment while meaningful options remain. Respiratory disease may require pulmonary testing, specialist evaluation, and daily treatment before repeated symptoms become a crisis. In many cases, delay can change not only a patient’s prognosis but also the treatment options that remain available. See, e.g., World Health Org., *Guide to Cancer Early Diagnosis* 1, 6, 8 (2017) (explaining that cancer identified early is more likely to respond to effective and less complex treatment and may be detected at a potentially curable stage); Linan Cheng et al., *Early Versus Late Nephrology Referral and Patient Outcomes in Chronic Kidney Disease: An Updated Systematic Review and Meta-Analysis*, 26 BMC Nephrology 1, art. 25, at 1–2 (2025) (finding that early nephrology referral was associated with fewer emergency dialysis starts, more kidney transplants, and better preparation for kidney-replacement therapy). The same timing principle applies to physical injuries. A recent systematic review explained that missed physical injuries

“remain a significant and potentially preventable complication in trauma care, often associated with increased morbidity, mortality, [and] prolonged hospitalization[.]” Lucas Fontenelle Vieira et al., *Missed Injuries in Trauma Care: An Analysis of Mechanisms and Prevention of One of the Surgeon’s Worst Nightmares*, 56 Inj. 112600, 1 (2025).

The acute/chronic distinction does not reliably measure medical seriousness. For example, asthma—the condition at issue in *Carlson*—is a chronic disease that can produce acute or subacute exacerbations; severe exacerbations require urgent care and can be fatal even in people with infrequent baseline symptoms. See Glob. Initiative for Asthma, *Summary Guide for Asthma Management and Prevention* 5–6 (2025). Conversely, an acute traumatic injury can remain a serious medical need when pain persists or the injury remains undiagnosed. Whether a condition presents in an acute or chronic phase, the medically relevant questions concern the patient’s symptoms, the known risk of harm, and whether timely evaluation or escalation is warranted—not the label attached to the condition.

MJA’s clinicians have seen how delays in specialty evaluation and treatment can affect medical outcomes in practice. In one matter, a patient with clear signs of kidney disease did not receive a nephrology consultation—which MJA experts identified as the standard of care—for months until the patient required multiple emergency hospitalizations for kidney failure and sepsis. Before being granted compassionate release, the patient was placed on dialysis and also underwent urgent heart surgery, which carries a higher risk for patients with kidney disease. In another matter, an MJA physician reviewing records in connection with compassionate-release proceedings identified symptoms highly concerning for advanced cancer that had not

been acted upon; the patient died before the court ruled. In a third, a patient with chronic respiratory symptoms and a family history of COPD, asthma, and lung cancer, had not been referred to a pulmonologist until an MJA physician reviewed the records and recommended specialty care; the patient was then released to pursue evaluation and treatment in the community. MJA's materials do not identify whether these delays resulted from staffing shortages, referral or scheduling failures, limited diagnostic capacity, or other causes. These examples therefore are not offered to attribute the delays to any particular constraint or clinician; they illustrate the medical consequences when an incarcerated patient does not receive timely specialty review. See Med. Just. All., *Public Comment on 88 Fed. Reg. 7180 Proposed Amendment No. 1*, at 3–4 (Mar. 14, 2023).

When the institution controls the patient's only route to testing, specialty care, and treatment, an unaddressed warning sign or delayed referral can allow a manageable condition to become an emergency before prospective relief can help. *Carlson* preserves a remedy for the exceptional case in which an official knowingly disregards that serious medical risk, while leaving negligence and good-faith clinical judgment outside constitutional liability.

III. CARLSON PROVIDES AN IMPORTANT, BUT LIMITED, ACCOUNTABILITY MECHANISM WHEN SERIOUS MEDICAL NEEDS ARE MET WITH DELIBERATE INDIFFERENCE.

Carlson provides a narrow remedy for violations of a prisoner's right to adequate medical care. Individual liability creates incentives to address known, serious medical risks in a system the patient cannot exit, while the demanding deliberate-indifference standard

leaves negligence, malpractice, and good-faith clinical judgment or disagreement outside constitutional liability.

A. *Carlson* Supplies a Limited Accountability Mechanism Where Ordinary Healthcare Incentives Are Absent.

Carlson made plain that a *Bivens* remedy, in addition to compensating a person who has been injured, serves a crucial deterrent purpose. 446 U.S. at 20–21. The Court later reiterated that point in *Correctional Services Corp. v. Malesko*: “the purpose of *Bivens* is to deter individual federal officers from committing constitutional violations[,]” and “the threat of litigation and liability” provides that deterrence even when an officer may be indemnified or may assert qualified immunity. 534 U.S. 61, 70–71 (2001).

Carlson also anticipated that the potential for individual liability could influence institutional practice. In rejecting the argument that only liability against the United States would prompt corrective policies, the Court reasoned that responsible supervisors would likewise respond when an employee is found personally liable for violating constitutional rights. 446 U.S. at 21 (“[R]esponsible superiors are motivated not only by concern for the public fisc but also by concern for the Government’s integrity.”). That response has been observed in practice. In a national survey of 27 state prison systems and 44 large jails, approximately 70 percent of respondents in each group reported changing policies, procedures, or practices as a result of individual inmate lawsuits. Margo Schlanger, *Inmate Litigation: Results of a National Survey*, LJM Exch. 1, 1, 8–9 (2003). Medical and mental-health care were the most common subjects of the substantive operational changes respondents identified. *Id.*

Schlanger's corrections-focused research identifies concrete mechanisms for that response. She reports that correctional systems facing recurring litigation create incident reports, videotape cell extractions, maintain shift logs, adopt written policies, and develop procedures that allow supervisors to monitor line staff. See Margo Schlanger, *Inmate Litigation*, 116 Harv. L. Rev. 1555, 1666–68 (2003). More broadly, Schlanger concluded that inmate litigation has a “beneficial, if limited, tendency to encourage [correctional] agencies to comply with constitutional norms” and can prompt operational changes extending beyond the defense of any particular lawsuit. *Id.* at 1668. She also found that several large damages verdicts against the Federal Bureau of Prisons involving inmate suicides “prompted high-level review of suicide-prevention policies and practices.” *Id.* at 1677–83. Schlanger's later work describes how claims-management personnel can translate liability signals into changes in information gathering, specialized compliance functions, and operating practices. See Margo Schlanger, *Operationalizing Deterrence: Claims Management (In Hospitals, a Large Retailer, and Jails and Prisons)*, 2 J. Tort L. 1, art. 1, at 44–49 (2008). Those effects are not automatic, and amici do not contend that every suit changes institutional behavior. But a credible possibility of individual accountability can give the constitutional standard practical force.

That force is especially important in a closed healthcare system. Because incarcerated patients cannot obtain substitute care, an accountability mechanism can reinforce attention to serious complaints, contemporaneous documentation of clinical decisions, review of worsening symptoms, and timely escalation when a known risk warrants it.

B. The Demanding Standard Protects Legitimate Medical Judgment.

The demanding deliberate-indifference standard protects legitimate medical judgment, including difficult triage and treatment decisions made under constrained conditions. Systemic limitations may impede care even when clinicians act in good faith; constitutional liability arises only when an official knowingly disregards a substantial risk of serious harm. The standard therefore preserves room for reasonable clinical judgment while reaching exceptional constitutional violations.

Petitioner argues that *Carlson* liability may incentivize prison clinicians to act defensively by ordering unnecessary tests or hospital transfers. Pet. Br. 29. But the article petitioner cites does not support that extrapolation; the article studies state-law medical-malpractice liability and tort reform among elderly Medicare patients with serious heart disease, not prison healthcare or liability under the far more demanding constitutional deliberate-indifference standard. See Daniel P. Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. Econ. 353 (1996).

Thus, petitioner's concern misses the standard amici defend. Deliberate indifference does not impose liability for declining medically unnecessary care, choosing among reasonable diagnostic options, or making a good-faith triage decision; an official who responds reasonably to a known risk is not liable even if the harm is not ultimately averted. See *Farmer*, 511 U.S. at 844. From a clinician's perspective, the line is familiar: reasonable medical judgment remains protected, while conscious disregard of a known serious risk does not. *Carlson* therefore encourages attention to red

flags and timely escalation when clinically warranted—not indiscriminate testing or automatic hospital transfer.

Estelle expressly distinguished deliberate indifference from negligence and malpractice. 429 U.S. at 105–06. And *Farmer* requires proof that an official was aware of facts supporting an inference of a substantial risk, actually drew that inference, and nevertheless disregarded the risk. 511 U.S. at 837. A patient cannot prevail merely by showing that a different test should have been ordered, that a specialist would have selected another treatment, or that care did not produce the desired outcome.

That distinction matters for clinicians working under pressure. Medicine often involves uncertainty, triage, and competing reasonable approaches. *Carlson* does not authorize courts to replace clinical judgment with hindsight. It applies only after a plaintiff proves a serious need and culpable state of mind. Preserving this existing remedy therefore does not expose providers to liability for every delay or adverse result; it preserves accountability for conscious disregard of a serious medical need.

CONCLUSION

This Court should affirm the judgment of the Ninth Circuit.

Respectfully submitted,

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