UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

EVERETT HADIX, et al.,	)	
	)	
Plaintiffs,	)	
	)	**Case No. 4:92-CV-110**
v.	)	
	)	**HONORABLE RICHARD A. ENSLEN**
PERRY JOHNSON, et al.,	)	
	)	
Defendants.	)	
	)	

BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I. INTRODUCTION

The Consent Decree in this case has been in place for twenty years, yet medical care continues to violate the Eighth Amendment, and indeed is deteriorating. The Court has conducted three hearings on medical care subsequent to the effective date of the Prison Litigation Reform Act ("PLRA"). *See* Opinion and Order ("Findings I"), Nov. 18, 1996, appeal dismissed, No. 96-2548 (6th Cir., Jan. 22, 1998); Findings of Fact and Conclusions of Law ("Findings II"), Feb. 18, 2000; Findings of Fact ("Findings III"), Oct. 29, 2002. In each hearing, the Court has identified a number of violations regarding medical care, including failures to provide necessary medications (Findings I at 31-32; Findings II at 35; Findings III at 83-99); failures to provide for the chronically ill (Findings I at 31-34; Findings II at 31-32; Findings III at 79-111); and failures to provide appropriate staff supervision (including failures to assure timely specialty referrals) (Findings I at 25-26; Findings II at 33-36; Findings III at

111-148).

At Defendants' initial request, the Court appointed an Associate Monitor for Medical Care to assist in addressing the constitutional violations regarding medical care. Findings III at 263-64; Order, April 21, 2003. As set forth below, the Third Report of the Monitor on Medical Care ("Third Report") documents worsening problems, including a number on instances in which repeated failures to provide necessary care appear to have hastened a patient's death.

In light of the fact that neither the Consent Decree provisions, the previous findings of the Court, nor the thorough and incisive work of Associate Monitor Robert Cohen, M.D., have succeeded in eliminating the constitutional violations, and that it is two decades since the Consent Decree was entered, it is time to provide an interim remedy that finally grants some concrete relief to the class.

Of note, Plaintiffs filed a similar motion after a previous report from Dr. Cohen demonstrated serious continuing problems. Following a status conference in February 2005, Defendants agreed to address a number of problems identified in that report. Defendants agreed to file a written document confirming their agreement in February, but did not even file that document until August of this year. Further, Dr. Cohen's report makes clear that the agreements reached following that status conference were worthless in protecting the health of the most vulnerable members of the class. Plaintiffs' counsel cannot sit back and continue to watch members of the class die.

II. STAFF ARE NOT APPROPRIATELY SUPERVISED

In the Second Report of the Associate Monitor Regarding Medical Services at the

Hadix facilities, January 11, 2005, Dr. Cohen reported that, although Correctional Medical Services ("CMS") had hired Dr. Arthur Austin as an Associate Medical Director for the Jackson Medical Complex to supervise and evaluate the work of the medical service providers ("MSPs") in the Jackson complex, Dr. Austin was not supervising the MSPs in either Duane Waters Hospital ("DWH") or C Unit, the medical units where the chronically ill who are most at risk are housed. Subsequently, in connection with the status conference of February 10, 2005, Defendants developed written plans that addressed various problems identified in that report, but did not address the overall supervisory issue. The only area in which Defendants purported to address the problem was in C Unit, where Defendants stated that additional physician time would be provided, and that Dr. Austin would be involved in chart review. Attachment 1, Plan for C Unit, at 1. On August 10, 2005, Defendants, about six months after they had promised to do so, submitted a letter to Plaintiffs in which they stated that they had fully implemented their plans for C Unit. Attachment 2, letter from Govorchin to Streeter, Aug. 16, 2005, at 1. In fact, the Third Report indicates the following:

> Although the crisis in MSP staffing and severe deficiencies in quality of care w[ere] acknowledged by MDOC staff in March, 2005, the actual full time medical staff available to C-Unit, DWH and the DWH ER decreased this spring, exacerbating a dangerous situation. The Regional Director for the Jackson Region, although based at Dwayne Waters Hospital, did not recognize these serious ongoing problems, and made no effort to identify the source of the problems nor correct them. The CMS Deputy Medical Director, Dr. Austin, although responsible for supervising the MSP staff in the *Hadix* facilities, did not supervise the C-Unit or DWH staff.

Third Report at 13. Similarly, the Third Report noted the "significant instability in the

Correctional Medical Services (CMS) administration of their MDOC contract at the [*Hadix*] facilities" and "[a]n effective program of MSP supervision by CMS has not yet been developed." *Id.* at 2-3.

The consequences of this lack of supervision have been horrifying, with the Third Report documenting many cases of death, unimaginable pain and unnecessary suffering resulting from gross failures of medical care. Although every case cited in the Third Report is an example of the lack of any effective supervision of medical care at the prison, two illustrative cases involve Patient 1 (the patient died of "neglect, MRSA,[1] and gastro-intestinal bleeding") (*id.* at 11) and Patient 2 (the patient had advanced HIV, but did not get the soft diet he needed; he received delayed and incorrect treatment for an opportunistic herpes zoster infection; he did not have his pancreatitis monitored; and he was given the wrong combination of HIV medications). *Id.* at 16-20. Dr. Cohen further reports in connection with Patient 2 that it was routine in DWH for nurses to request that physicians examine patients but for the physicians not to come–a shocking failure that Dr. Cohen, who has examined numerous prison systems, had never before encountered. *Id.* at 20. A third example is Patient 3, a 29 year-old with HIV, who despite symptoms of colo-rectal cancer waited five months for a simple diagnostic test, and three months after diagnosis before radiation therapy was begun. *Id.* at 20-23.

Significantly, these are not the first cases Dr. Cohen had identified as marking a dysfunctional system in need of clinical supervision. In the transcript of the January 13, 2005

[1] Methicillin-resistant *staphylococcus aureus.*

status conference, Dr. Cohen noted the following about a patient with prostate cancer whose case is not included in the Third Report:

> DR. COHEN: Somebody constantly reapproved the delay in consultation.
> MR.GOVORCHIN: The MSP?
> DR. COHEN: I assume so, yes, because it was six months before it happened, so someone was, you know, you have this system in place–which I think is a stupid system as I've described, not stupid, but ill-conceived and likely to cause harm. . . . You should have leadership at the facility which would look at this and say, oh my God, what is wrong with this person.
> MR. GOVORCHIN: Right.
> DR. COHEN: But you know who would have acted on it and someone who would have picked this up before because if someone is delayed that long, why wasn't a supervisor involved you know. In this case the supervisor was Dr. Hutchinson. Dr. Hutchinson's responsible for the consultations, he is the supervisor. . . .[W]hy does the medical staff not do something when they see something as disturbing as this going on?. . . .I think the, you know, one of the solutions is on-site leadership which cannot tolerate this.

Attachment 3, T., Jan. 13, 2005, at 47-49. Sadly, this case involved a named plaintiff who also was not given a test to diagnose his cancer for six months, and who was then also significantly delayed in receiving radiation therapy, despite assurances to Plaintiffs' counsel.

III. SPECIALTY REFERRALS DO NOT TAKE PLACE IN A TIMELY MANNER

Another facet of the issue of staff supervision, also noted in the Third Report, is the failure to provide for timely specialty referrals. CMS did not oversee the quality of its staff follow-up for specialty care. Indeed, in the first six months of 2005, 41% of initial consults and 45% of completed follow-up consults were not completed within the time requested by the referring physician. Dr. Cohen characterized this performance as "unacceptable," and noted that it resulted in delays in the diagnosis and management of life-threatening illnesses.

Third Report at 9. One of the specific problems noted in the Third Report is CMS' refusal to process consultation forms until the forms are typed. *Id.* at 10.

The Third Report documents that these routine delays in consultations have caused grievous harm. Among the prisoners who experienced delays in consultations were Patient 1 (failure to refer patient with multiple medical problems, including known MRSA, for appropriate consultations, including colonoscopy, endoscopy, and infectious disease consultations; patient was found dead in cell) (*id.* at 47-51); Patient 2 (an appointment with an Infectious Diseases specialist for the patient, who had advanced HIV, was canceled; no access to emergency dentistry because the patient was in DWH; he also did not receive necessary studies such as ultrasound or CT scan, and had no gastroenterology consultation) (*id.* at 16-20); Patient 3 (seven-month delay in treating HIV patient with colo-rectal cancer because of delays in specialty consultations and testing); Patient 4 (patient with history of stroke and seriously abnormal renal studies was not scheduled for a nephrology consultation for 2 ½ months, although the consultation was marked urgent; that appointment was not kept; the patient was actually not seen for 4 ½ months; CT scan referral designated as urgent was pended by CMS; follow-up appointment with specialist was not timely requested; patient discovered close to death in cell three weeks before follow-up appointment) (*id.* at 23-29); Patient 5 (patient with HIV kept from Infectious Disease appointment because in Quarantine status; staff failed to take him to second scheduled Infectious Disease appointment; patient was not taken to optometry appointment) (*id.* at 30-32); Patient 6 (Foote Hospital note indicates that a concern in discharging patient with Non-Hodgkin's Lymphoma back to the prison was that CMS would not want to pay for in-patient care) (*id.* at 32-43); Patient 8

(despite efforts by physician's assistant, biopsy and CT scan testing were delayed; there were delays in receiving an x-ray result and a surgical biopsy, and in responding to the biopsy result; there was no attempt by the patient's physician to assure timely diagnostic evaluation) (*id.* at 44-47); and Patient 9 (patient with poorly controlled diabetes and severe hypertension with deteriorating renal function never received specialty care despite urgent referral; no request for endocrine consultation) (*id.* at 51-52).

IV. DEFENDANTS FAIL TO PROVIDE NECESSARY CHRONIC CARE

The Third Report notes that Defendants' chronic care program is not functioning in the locations with the highest concentrations of chronically ill patients–DWH and C Unit–and that the program is also not functioning in administrative segregation. *Id.* at 4-5. Indeed, the Third Report characterizes medical care in administrative segregation as follows:

> Based upon my review of patients in segregation in April and May, care for these patients is still very problematic. Patients with critical life threatening illnesses were completely ignored, treated inadequately. Patients with extreme pain and massive weight loss are not properly evaluated and treated. There seem to be many psychotic inmates in segregation, and they have significant medical problems but have difficulty expressing their medical needs. There is a significant problem with provider continuity.

Id. at 12.

Similarly, the Third Report characterizes care on C Unit as "chaotic" because of significant understaffing affecting patients who often have multiple chronic illnesses and are too sick to live in the general population. *Id.* at 12. Although the Third Report indicates that Defendants acknowledged the staffing crises and severe deficiencies in March 2005, the actual full-time staff available on C Unit and DWH then declined. Despite an announcement by

CMS in June that it would provide care at C Unit and DWH directly rather than continue to employ subcontractors to run the units, as of August 2005 no new staff had been hired. *Id.* at 13.

The problem is at least equally critical at DWH. The hospital is so backlogged with patients that it cannot maintain available beds for patients with acute problems. Patients who need hospital beds are sent back to their housing units, or seen only monthly by a physician when they need a higher level of care. Indeed, the Report notes that a patient with bilateral pneumonia who had not responded to a course of antibiotics and needed intravenous antibiotics and close nursing supervision was nonetheless sent back to JMF, where he died. *Id.* at 15.

In addition, the dialysis program for patients in chronic renal failure has serious deficiencies. Defendants' own audits of the dialysis program indicated that, in 40% to 50% of the cases audited, there were specific deficiencies, such as a lack of treatment response to significant post-dialysis hypertension, a failure to address poorly controlled hypertension, and a failure to address ineffective dialysis. *Id.* at 5. These problems are exacerbated by failures to provide effective specialist oversight of the program and the unavailability of the electronic medical records system (SERAPIS) on the unit. They are also exacerbated by the unresolved failure to assure patients' access to routine and emergency vascular surgery consultations, which is critical to assuring that patients' grafts remain functional to allow dialysis. *Id.* at 5-6.

Further, chronic medications are still disrupted, presumably related to the failure of integration of SERAPIS with the paper pharmacy records. Prisoners file approximately forty kites a month because of problems with medication renewals. *Id.* at 7.

Among the Third Report's examples of grossly deficient chronic care are the following: Patient 1 (patient arrived in RGC with a history of a heart attack, three coronary by-pass grafts, diabetes, high cholesterol, hypertension, gout, as well as current acute MRSA; he was transferred to Foote Hospital, where he was found to be severely anemic with blood in his stool; Foote Hospital decided that the work-up of the anemia and possible bleed could be done in the Gastrointestinal Chronic Care Clinic; his chart was not available when he was first seen back at the prison and the physician examined only his leg (the location of the MRSA infection); the physician did not note most of his chronic problems; the patient was housed in the segregation unit, where he died "without any medical attention to his multiple serious life threatening medical problems") (*id*. at 47-51); Patient 2 (patient with HIV and chronic Hepatitis B and C was evaluated in the Infectious Disease Chronic Care Clinic by Dr. Faghihnia, who classified the patient as stable, despite the loss of about 10% of the patient's body weight since his previous appointment; patient was not provided with the special diet that he needed to help maintain his weight; despite another physician's attempt to transfer the patient to a chronic care unit, he stayed in segregation; after a year delay, when the patient was finally admitted to the DWH chronic care unit, he was not given an appropriate medical examination or history review; the patient was not given appropriate physician care in DWH; a physician ordered inappropriate medications for herpes zoster, an extremely painful disease; the patient received incorrect HIV medications for 18 months; his pancreatitis was not appropriately monitored; he was not provided with appropriate diagnostic studies until Dr. Cohen specifically intervened on his behalf; physicians failed to respond to nursing requests for their attention; "Patients in chronic status are at DWH to die") (*id.* at 16-20); Patient 3

(patient with known HIV infection and known concern that he might have rectal cancer; seen by CMS gastroenterologist Dr. Hussain[2] (as a substitute for Gastrointestinal Chronic Care Clinic), but Dr. Hussain did not examine Patient 3's rectum; when Dr. Hussain again saw the patient, he declined to perform a colonscopy; for two subsequent months the foul odor of seepage from the patient's anal lesion spread through the prison before he had a biopsy that diagnosed rectal cancer) (*id.* at 20-23); Patient 4 (following a stroke resulting in a severe communicative disorder, the patient was enrolled in the Disabilities Chronic Care Clinic; he also had chronic renal disease, hypertension, and diabetes; when he was transferred from DWH to JMF, the nursing transfer receiving form failed to note his medical problems, record his medications, or record his vital signs; Dr. Faghihnia failed to adjust the patient's treatment plan, despite pain and swelling of unknown origin in the patient's arm; when the patient saw a nurse in the Disabilities Chronic Care Clinic, the nurse did not speak to or examine the patient; when Dr. Faghihnia actually examined the patient for the first time, he reported that the patient "speaks gibberish" and failed to order pain medication; the CT scan Dr. Faghihnia ordered was pended by CMS and never performed; when Dr. Faghihnia next saw the patient, he attributed the patient's symptoms to "drug-seeking behavior;" a telemedicine examination by a consultant resulted in minimal review of the patient's history and symptoms; Dr. Faghihnia did not obtain timely follow-up; Defendants' chart review failed to note the profound deficiencies in care for this patient; the patient eventually was transferred from administrative segregation to Foote Hospital when he was close to death; at the time of

[2] Plaintiffs' counsel discovered during a recent chart review that Dr. Hussain noted in another chart that the patient was not an appropriate candidate for a liver transplant because he was a prisoner.

admission to the hospital, the patient had massive edema of his legs, scrotum and penis, along with acute renal failure; he died about three weeks later) (*id.* at 23-30); Patient 6 (the patient was admitted to RGC and diagnosed with advanced HIV, chronic hepatitis, asthma, and ataxic gait that left the patient wheelchair-dependent; the patient was not started on anti-virals for more than three weeks after admission; it took three weeks to evaluate the patient for a wheelchair; although Dr. Faghihnia diagnosed "end-stage AIDS with painful neuropathy," he ordered no specific analgesics for the neuropathy; when Dr. Faghihnia next examined the patient, he found no leg weakness and canceled the wheelchair, as well as the patient's asthma medications; Dr. Faghihnia decreased the medication for a painful rash associated with HIV; when Dr. Faghihnia next saw the patient, he failed to treat the painful peripheral neuropathy he noted; there was more than a three-week delay in reviewing laboratory studies; the patient had no additional liver laboratory studies between mid-June and December, 2004, when he was hospitalized; a specialist recommendation that the patient be transferred to C Unit was not followed; when Dr. Faghihnia next saw the patient, he diagnosed sciatica, but prescribed nothing for the pain; Dr. Faghihnia did not review the patient's HIV laboratory studies from September 1, when they were received, until October 15; Patient 6 continued to complain of severe leg and hip pain after sciatica was diagnosed; Dr. Faghihnia described the patient's condition as stable without examining the patient; two days later the patient was sent to the DWH emergency room with a pulse rate of twice normal and was diagnosed with deep vein thrombosis; Dr. Faghihnia saw the patient five days later, when his pulse rate was still the same, in the Chronic Care Clinic; Dr. Faghihnia noted bilateral swelling of the legs and that the patient had managed to borrow a wheelchair but Dr. Faghihnia failed to look for the cause

of the pain and swelling or prescribe effective pain control; Dr. Faghihnia incorrectly reported as normal a study that had not yet been conducted; in December 2004, following another transfer to Foote Hospital, the patient was finally found to have his pelvis filled with tumor blocking his kidneys, as a result of Non-Hodgkin's Lymphoma; after the patient received chemotherapy and was returned to DWH, his ordered care was not provided; although Patient 6 was extremely ill, suffering from the effects of chemotherapy, decubitus ulcers, and severe pain, he was never seen again by an MSP after his last DWH admission) (*id.* at 32-43); Patient 8 (Dr. Faghihnia made no effort to assure follow-up chemotherapy and radiation, along with palliative care, for a patient with lung cancer; the patient was not provided with a supportive nursing environment at the end of his life).

V. MEDICAL RECORDS ARE NOT APPROPRIATELY MAINTAINED

The Third Report also documents significant failings of the medical records, in large part produced by the ongoing failure to combine SERAPIS with the traditional paper medical record. As the Third Report notes:

> New CMS physician and mid-level providers begin working in the *Hadix* facilities before they have been trained in the use of the SERAPIS system. They are therefore unable to use the system, and write their notes and orders in the medical record. CMS practitioners who work in more than one of the *Hadix* facilities are not permitted to log in to the SERAPIS system at both facilities. There is no SERAPIS terminal in the JMF Segregation Unit. There is no SERAPIS terminal in the Dialysis Unit.

Id. at 7.

Further, the DWH emergency room and C Unit also lack a SERAPIS terminal. Physicians in the dialysis unit, C Unit, DWH, and the DWH emergency room, among other locations, thus lack access to laboratory studies ordered in SERAPIS. MSPs cannot work in

SERAPIS in more than one facility. As a result of the two competing systems, the medical records are "voluminous, difficult to use and not in chronological order." *Id.*

While it is probably not possible to distinguish all the cases in which the deficiencies in the records harmed patients, one clear case is Patient 2. Patient 2 had advanced HIV disease and some degree of pancreatitis, along with severe wasting. His physician continued a regimen of anti-viral treatment that the Food and Drug Administration had warned against in September 2002, and the pharmacy records, which are not computerized or integrated with SERAPIS, has no system to pick up inappropriate HIV medication interactions. This failure may have been responsible for Patient 2's persistent weight loss and pain prior to his death. *Id.* at 19-20.

Similarly, the chart of Patient 1, who had MRSA, was not available when he was first seen. *Id.* at 47. Patient 4's care was compromised by the failure of the medical record to contain an appropriate nursing transfer note. *Id.* at 25. Patient 5's care was delayed because of the loss of records from his initial physical. *Id.* at 30. Patient 8's treatment was delayed because an urgent x-ray result showing cancer and a CT scan report were delayed in being added to the medical record. *Id.* at 46.

VI. MEDICAL CARE AT THE *HADIX* FACILITIES VIOLATES THE EIGHTH AMENDMENT

Prison officials have an affirmative obligation under the Eighth Amendment to provide prisoners with the basic necessities of life, including medical care. *Farmer v. Brennan,* 511 U.S. 825, 832 (1994); *Helling v. McKinney,* 509 U.S. 25, 31-32 (1993); *DeShaney v. Winnebago Co. Dep't of Soc. Servs.,* 489 U.S. 189, 200 (1989). The Eighth Amendment is accordingly violated when prison officials, with deliberate indifference, expose a prisoner to a

substantial risk of serious harm. *Farmer* at 836. In particular, a prison official who, acting with deliberate indifference, deprives a prisoner of medical care necessary to address a serious medical need violates the Eighth Amendment. *Estelle v. Gamble,* 429 U.S. 97, 104 (1976).

Plaintiffs' claims involve serious medical needs. *See, e.g., Brock v. Wright,* 315 F.3d 158, 162 (2d Cir. 2003) (stating that factors that should guide the analysis of whether a medical need is "serious" include, but are not limited to, "(1) whether a reasonable doctor or patient would perceive the medical need in question as important or worthy of comment or treatment; (2) whether the medical condition significantly affects daily activities, and (3) the existence of chronic and substantial pain.") (internal quotation marks and citations omitted). The medical conditions at issue in the Third Report, such as life-threatening cancer, HIV, MRSA, renal failure, deep vein thrombosis, a bleeding ulcer, and severe stroke, all qualify under any definition of serious medical needs.

Indeed, a survey of the cases indicates that far less significant conditions have been found to constitute "serious medical needs." *See, e.g., Talal v. White,* 403 F.3d 423, 425-26 (6th Cir. 2005) (need for a smoke-free environment by prisoner with smoke allergy); *Brock v. Wright*, 315 F.3d at 163-64 (painful keloids); *Clement v. Gomez,* 298 F.3d 898 (9th Cir. 2003) (effects of pepper spray on bystanders); *Ellis v. Butler,* 890 F.2d 1001, 1003 (8th Cir. 1989) (swollen, painful knee); *Chaney v. City of Chicago,* 901 F. Supp. 266, 270 (N.D. Ill. 1995) (post-surgical care of foot); *Bouchard v. Magnusson,* 715 F. Supp. 1146, 1148 (D. Me. 1989) (persistent back pain); *Smallwood v. Renfro,* 708 F. Supp. 182, 187 (N.D. Ill. 1989) (cut lip); *Henderson v. Harris,* 672 F. Supp. 1054, 1059 (N.D. Ill. 1987) (hemorrhoids); *Case v. Bixler,* 518 F. Supp. 1277, 1280 (S.D. Ohio 1981) (boil).

Further, there is no question but that Defendants have acted with deliberate indifference. In order to show deliberate indifference, Plaintiffs do not need to show that prison officials acted or failed to act believing that harm would actually befall prisoners; it is enough to show deliberate indifference that officials acted or failed to act despite knowledge of a substantial risk of serious harm. *Farmer v. Brennan*, 511 U.S. at 842. Further, in cases like this one concerned with prison officials' future conduct with regard to prison conditions, "[i]f those conditions are found to be objectively unconstitutional, then that finding [also satisfies] the subjective prong [of deliberate indifference] because the same information that would lead to the court's conclusion is available to prison officials." *Hadix v. Johnson,* 367 F.3d 513, 526 (6th Cir. 2004); *see also Farmer* at 846 n.9 ("If, for example, the evidence before the district court establishes an objectively intolerable risk of serious injury, the defendants could not plausibly persist in claiming lack of awareness. . . ."). Accordingly, the findings of the Third Report indicate that the current medical care provided to the *Hadix* class violates the Eighth Amendment.

VII. THE REQUESTED RELIEF IS CONSISTENT WITH THE REQUIREMENTS OF THE PLRA

A. The Requested Relief

Plaintiffs seek a preliminary injunction requiring Defendants to prepare a plan, in consultation with the Associate Monitor, to address the deficiencies documented in the Third Report. Plaintiffs ask that the plan be due thirty days after the date that the Court issues its injunction, and that the Court schedule a hearing to determine whether the plan should be approved. Further, Plaintiffs request an immediate preliminary injunction removing Dr. Faghihnia from direct clinical care of patients pending further order of the Court. For the reasons set forth

below, this relief is consistent with the requirements of the Prison Litigation Reform Act of 1995, 18 U.S.C. § 3626(a)(2) ("PLRA").

B. The Requirements of the PLRA

The relevant provisions of the PLRA require the following with regard to preliminary injunctions:

> **Preliminary injunctive relief.**–In any civil action with respect to prison conditions, to the extent otherwise authorized by law, the court may enter a temporary restraining order or an order for preliminary injunctive relief. 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 to correct that harm. The court shall give substantial weight to any adverse impact public safety or the operation of a criminal justice system caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief.[3]

18 U.S.C.§ 3626(a)(2).

All courts to address the issue have held that, with regard to litigated decrees, PLRA does not change the standards for issuance of an injunction. *Armstrong v. Davis,* 275 F.3d 849, 872 (9th Cir. 2001); *Smith v. Arkansas Dep't of Correction,* 103 F.3d 637, 647 (8th Cir. 1996) ("The Act merely codifies existing law and does not change the standards of whether to grant an injunction."); *Williams v. Edwards,* 87 F.3d 126, 133 n.21 (5th Cir. 1996) (same). This principle specifically applies to preliminary injunctions. *Jones'El v. Berge,*164 F. Supp. 2d 1096, 1116 (W.D. 2001). Further, the ninety-day time limitation imposed on the length of

[3] 18 U.S.C. § 3626(a)(1)(B) involves injunctive relief that violates state law. Essentially, that provision provides that relief that violates state law can be imposed only if such a remedy is the sole relief that will correct the violation of federal law.

preliminary injunctions imposed by PLRA does not affect the ability of a court to enter a series of preliminary injunctions, as long as relief is specifically re-entered at the appropriate times. *Mayweathers v. Newland,* 258 F.3d 930, 936 (9th Cir. 2001).

The general remedy requested by Plaintiffs is an order that Defendants prepare plans, so the proposed order intrinsically provides guarantees that it meets the PLRA requirements that such relief be narrowly drawn and no broader than necessary. Thus in *Armstrong v. Davis,* 275 F.3d 849 (9th Cir. 2001), the court of appeals rejected the defendants' argument that an order was insufficiently narrowly tailored when the order allowed the defendants to develop the policies and practices that would eliminate conditions that violate the rights of disabled prisoners, even though the resulting injunction included a number of quite detailed provisions. *Id*. at 872-73. For the same reasons given by the court of appeals in *Armstrong,* the order proposed by Plaintiffs meets the requirements of precise fit imposed by PLRA.

In addition, Plaintiffs are proposing minimally intrusive remedies. Rather than attempting to impose any particular solution to the constitutional failings, Plaintiffs' proposed order leaves decisions as to how to address the failings to Defendants. At the same time, the proposed order promises to address the constitutional failings by Defendants because the order requires Defendants to focus on critical constitutional violations and take actual, concrete steps to address them. By requiring that the plan be developed by Defendants, but that Defendants consult with the Associate Monitor and obtain court approval, the proposed order, like the order in *Armstrong,* is carefully designed to be minimally intrusive:

> By her injunction, the thorough and extremely patient district judge did not attempt to "micro manage" the Board's activities, but rather to set clear objectives for it to attempt to attain, and, in most circumstances, general methods whereby it would attain them.

Id. at 873.

Indeed, the history of violations would support more extensive and intrusive relief. *See Morales Feliciano v. Rullan,* 378 F.3d 42, 54-56 (1st Cir. 2004) (holding that an order requiring privatization of the prison health care system met PLRA requirements because the district court had previously attempted narrower, less intrusive remedies, but without success). Finally, the proposed order, by serving to promote constitutional levels of health care, will promote the public safety by removing a source of prisoner unrest. In *Johnson v. California,* 125 S. Ct. 1141 (2005), the Supreme Court noted, in connection with a challenge to prison racial segregation, that racial segregation may exacerbate hostility and violence among prisoners. *Id.* at 1147. It is even more apparent that a lack of medical care has the potential to lead to prison unrest.

The other order proposed by Plaintiffs–the temporary suspension of Dr. Faghihnia's clinical interactions with members of the class–is an intrusive remedy, even for a limited time period, but it is not an unnecessarily intrusive remedy. Long before the Third Report, Plaintiffs' counsel had held discussions with Defendants expressing their serious concerns about Dr. Faghihnia's interactions with prisoners, based on numerous complaints by members of the class.

The Third Report specifically points out failures by Dr. Faghihnia with regard to several of the cases chosen as examples. For example, Dr. Faghihnia classified Patient 2 as stable when he examined the patient in the Infectious Disease Chronic Care Clinic, although Patient 2 had lost 10% of his weight. Third Report at 16. Dr. Faghihnia failed to adjust Patient 4's treatment plan despite pain and swelling of unknown origin in the patient's arm.

The speech therapist had noted in the medical record that, because of Patient 4's stroke and resulting communicative disorders, Patient 4 had great difficulty speaking and was easily frustrated, and needed time to relax when upset or frustrated, which made his communications even more difficult. Working with an understanding of the patient's needs, she was able to increase his verbal production by 30%. *Id.* at 23-27. Nonetheless when Dr. Faghihnia first saw the patient, he recorded that the patient "spoke gibberish;" not surprisingly, Dr. Faghihnia also noted that the patient did not allow a complete examination. He apparently never checked on an ordered CT scan that in fact had not been performed, and he assumed that the patient's pain was simply drug-seeking behavior. He delayed consultation requests. *Id.* at 27-29. He did not change the treatment plan despite his patient's unexplained serious swelling, and the Third Report notes that it "is difficult to imagine the thought or logic behind Dr. Faghihnia's decision to do nothing." *Id.* at 26. While Patient 4 was hospitalized, Dr. Faghihnia agreed to delay a renal consult until June 15, 2005; as it happened the patient died on May 9. *Id.* at 29. This series of events represented a textbook case of deliberate indifference. *See Green v. Daley,* 414 F.3d 645, 655 (7th Cir. 2005) (Eighth Amendment is violated when provider "doggedly persist[s] in a course of treatment known to be ineffective"); *see also LeMarbe v. Wisneski*, 266 F.3d 429, 437-38 (6th Cir. 2001) (allegations that physician defendant failed to react to conditions that anyone with a medical education and most lay people would have known posed a substantial risk of serious harm to patient would, if established, show deliberate indifference).

Dr. Faghihnia also failed to explore the causes for Patient 5's claimed refusals of health care, under circumstances that suggested the problem was segregation practices, not the

patient's lack of cooperation. Third Report at 30-32. For Patient 6, Dr. Faghihnia diagnosed end-stage AIDS with painful neuropathy, without providing pain relief. He canceled medications for Patient 6 without explanation, and canceled a wheelchair accommodation for a patient who reported leg swelling of unknown cause. He failed to treat peripheral neuropathy, and wrote, apparently without seeing the patient, that patient 6 was "stable and doing well." He did not review laboratory reports about the patient's HIV for six weeks. On August 9, 2004, Dr. Faghihnia recorded a normal examination of Patient 6's leg and hip and diagnosed sciatica. Patient 6 saw a physician's assistant on August 25, who sent him to Foote Hospital. When the physician's assistant referred Patient 6 to Dr. Faghihnia for follow-up, Dr. Faghihnia did not see the patient. Despite consult notes from an Infectious Diseases specialist who thought Patient 6 might have venous insufficiency, Dr. Faghihnia did not see the patient. A nurse diagnosed venous insufficiency in October, but Dr. Faghihnia did not see the patient and wrote a note that the patient was stable. When Dr. Faghihnia did see the patient, he had a pulse of 123. Nonetheless, Dr. Faghihnia did not schedule a prompt follow-up or make any effort to diagnose Patient 6's worsening pain and swelling. He initialed a November emergency room visit almost three weeks after it happened and never saw Patient 6 again. In December 2004, Patient 6 was diagnosed with Non-Hodgkin's Lymphoma; he died in February 2005. *Id.* at 32-43.

Similarly, as the Third Report discusses in detail, Dr. Faghihnia took no action regarding Patient 8, despite knowing of his probable cancer, in contrast to the physician assistant's unsuccessful efforts to obtain prompt care for his patient. *Id.* at 44-47.

The Third Report documents that Dr. Faghihnia is a serious danger to his patients.

There may be some appropriate medical role that he can play at the *Hadix* facilities, but on the current record, at least until Defendants submit their proposed plan to cure the medical deficiencies, the narrowest and least intrusive remedy is to remove him from direct patient care. Certainly this remedy, at least initially short-term, is far narrower than the order privatizing the Department of Corrections health care system upheld in *Morales Feliciano;* the reasoning of the First Circuit applies equally to this case:

> The increased intrusiveness and broader scope of the privatization remedy is a direct response to the unique need created by the Commonwealth's own failure–for more than twenty years–to correct serious constitutional inadequacies. Drastic times call for drastic measures.

Morales Feliciano, 378 F.3d at 55.

VIII. PLAINTIFFS MEET THE STANDARDS FOR ISSUANCE OF A PRELIMINARY INJUNCTION

The standards for issuance of a preliminary injunction are well-established. *See, e.g., Leary v. Daeschner,* 228 F.3d 729 (6th Cir. 2000):

> When deciding whether to issue a preliminary injunction, the district court considers four factors:
>
> (1) whether the movant has a "strong" likelihood of success on the merits; (2) whether the movant would otherwise suffer irreparable injury; (3) whether issuance of a preliminary injunction would cause substantial harm to others; and (4) whether the public interest would be served by issuance of a preliminary injunction.

Id. at 736. The purpose of a preliminary injunction is always to prevent irreparable injury so as to preserve the court's ability to render a meaningful decision on the merits, and the traditional preliminary injunction standard applies to mandatory as well as prohibitory preliminary injunctions. *United Food v. Southwest Ohio Reg'l Transit*, 163 F.3d 341, 348 (6th

Cir. 1998).

For the reasons given above, Plaintiffs have demonstrated a strong likelihood of success on the merits. The deaths and completely unnecessary suffering described in the Third Report also demonstrate the irreparable injury to the plaintiff class if the requested relief is not granted. Whatever cost might be occasioned to Defendants and CMS by requiring them to develop and implement practices conforming to their constitutional obligations should not weigh significantly in the balance, because Defendants and CMS should already be complying with these obligations, to which Defendants obligated themselves voluntarily when they agreed to the Consent Decree. While there may be more significant reputational and economic costs to Dr. Faghihnia if the proposed relief is granted, those possible costs are outweighed by the potential loss of life if the requested relief is not granted. Finally, the public interest is promoted by saving lives and avoiding unnecessary suffering. Indeed, as argued above, the public safety will be generally promoted by requiring Defendants to comply with their affirmative obligation to provide necessary health care, as such compliance will remove a potentially explosive occasion for unrest among prisoners.

IX. PLAINTIFFS SHOULD NOT BE REQUIRED TO POST A BOND

The Court has discretion to determine that Plaintiffs need not provide security in order to secure the issuance of a preliminary injunction. *Roth v. Bank of the Commonwealth,* 583 F.2d 527, 539 (6th Cir. 1978). Because the great majority of the members of the class are indigent, it would have the effect of denying access to the courts to require a bond in these circumstances.

X. CONCLUSION

Based upon the foregoing, Plaintiffs ask that the Court grant the request for preliminary relief as set forth above.

Respectfully submitted,

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