UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

DALLAS COBBS, #164276,

Plaintiff,

v.

GEORGE J. PRAMSTALLER, *et al.*,

Defendants.

Case No.: 07-cv-14644
Honorable Anna Diggs Taylor
Magistrate Judge Charles E. Binder

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DEFENDANTS, CORRECTIONAL MEDICAL SERVICES, INC., CRAIG HUTCHINSON, M.D., AND BENCY MATHAI, M.D.'S MOTION FOR SUMMARY JUDGMENT PURSUANT TO FED. R. CIV. P. 56

NOW COME the Defendants, CORRECTIONAL MEDICAL SERVICES, INC., CRAIG HUTCHINSON, M.D., and BENCY MATHAI, M.D., by and through their attorneys, THE JUIP RICHTARCIK LAW FIRM, and for their Motion For Summary Judgment Pursuant To Fed. R. Civ. P. 56, state as follows:

1. On or about June 10, 2008, Plaintiff filed his Amended Complaint pursuant to 42 U.S.C. § 1983 alleging claims of deliberate indifference to his serious medical

needs, specifically a cataract in his left eye, which Plaintiff alleges should have been removed earlier than it was removed.

2. With respect to Correctional Medical Services, Inc., Plaintiff alleges that its "utilization review unit approves or denies requests for specialty care, and in this case repeatedly denied Mr. Cobb's physicians' requests for surgical specialty care." (**Dkt #38, ¶13**).

3. With respect to Craig Hutchinson, M.D., Plaintiff alleges that he "was the state medical director for Correctional Medical Services, Inc. (CMS), and a member of the Medical Services Advisory Committee." (**Dkt #38, ¶11**).

4. With respect to Bency Mathai, M.D., Plaintiff alleges that she was a member "of the MSAC when the committee denied Mr. Cobbs' physicians' requests for a second cataract surgery." (**Dkt #38, ¶16**).

5. For the following reasons, the moving Defendants are entitled to summary judgment as a matter of law pursuant to Fed. R. Civ. P. 56:

   a. There is no evidence that either Dr. Hutchinson or Dr. Mathai had any personal involvement in the incidents that form the basis of Plaintiff's Complaint;

   b. There is no evidence that Plaintiff's left eye cataract ever rose to the level of being an objectively serious medical need warranting protection by the Eighth Amendment, or that either Dr. Hutchinson or Dr. Mathai ever subjectively knew and believed that Plaintiff's left eye cataract posed a serious risk of substantial harm to Plaintiff, which they deliberately disregarded.

c. Vicarious liability is not a viable theory of liability under 42 U.S.C. § 1983 and there is no evidence that Defendant CMS ever maintained any policy, practice, or procedure, that anyone ever relied upon any such policy, practice, or procedure in the course of providing medical care and treatment to Plaintiff, or that the execution of any such policy, practice, or procedure proximately caused any injury or harm to Plaintiff.

6. The moving Defendants rely upon the facts and arguments set forth in their attached supporting brief as if more fully restated herein.

7. Counsel for the moving Defendants contacted counsel for Plaintiff pursuant to E.D. Mich. LR 7.1(a) in order to obtain the concurrence of Plaintiff's counsel in the relief requested herein, and same was denied.

WHEREFORE, the Defendants, CORRECTIONAL MEDICAL SERVICES, INC., CRAIG HUTCHINSON, M.D., and BENCY MATHAI, M.D., pray that this Honorable Court shall grant their Motion For Summary Judgment Pursuant To Fed. R. Civ. P. 56, enter summary judgment in their favor as a matter of law, dismiss Plaintiff's claims against them in their entirety with prejudice, and tax all reasonable costs and attorney fees against Plaintiff where permitted.

Respectfully submitted,

Dated: December 1, 2009

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DEFENDANTS, CORRECTIONAL MEDICAL SERVICES, INC., CRAIG HUTCHINSON, M.D., AND BENCY MATHAI, M.D.'S BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT PURSUANT TO FED. R. CIV. P. 56

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ISSUES PRESENTED

WHETHER DEFENDANTS CMS, DR. HUTCHINSON, AND DR. MATHAI SHOULD BE GRANTED SUMMARY JUDGEMENT SINCE THE EVIDENCE IS INSUFFICIENT FOR REASONABLE PERSONS TO CONCLUDE THAT THEY HAD SUFFICIENT PERSONAL INVOLVEMENT IN THE ALLEGED INCIDENTS FORMING THE BASIS OF PLAINTIFF'S CLAIMS.

Defendants Answer:	Yes.
Plaintiff Answers:	No.

WHETHER DEFENDANTS CMS, DR. HUTCHINSON, AND DR. MATHAI SHOULD BE GRANTED SUMMARY JUDGEMENT SINCE THE EVIDENCE IS INSUFFICIENT FOR REASONABLE PERSONS TO CONCLUDE THEY HAD AUTHORITY TO PROVIDE SECOND EYE CATARACT SURGERY TO PLAINTIFF UNDER THE CIRCUMSTANCES.

Defendants Answer:	Yes.
Plaintiff Answers:	No.

WHETHER DEFENDANTS CMS, DR. HUTCHINSON, AND DR. MATHAI SHOULD BE GRANTED SUMMARY JUDGEMENT SINCE THE EVIDENCE IS INSUFFICIENT FOR REASONABLE PERSONS TO CONCLUDE: THAT PLAINTIFF'S LEFT EYE CATARACT WAS AN OJBECTIVELY SERIOUS MEDICAL NEED WARRANTING PROTECTION BY THE EIGHTH AMENDMENT; OR THAT DEFENDANTS SUBJECTIVELY KNEW AND BELIEVED THAT PLAINITFF'S LEFT EYE CATARACT POSED A SERIOUS RISK OF SUBSTANTIAL HARM TO PLAINTIFF THAT THEY DELIBERATELY DISREGARDED.

Defendants Answer:	Yes.
Plaintiff Answers:	No.

WHETHER DEFENDANT CMS SHOULD BE GRANTED SUMMARY JUDGEMENT SINCE THE EVIDENCE IS INSUFFICIENT FOR REASONABLE PERSONS TO CONCLUDE: THAT CMS MAINTAINED AN UNCONSTITUTIONAL POLICY, PRACTICE, OR PROCEDURE; THAT ANYONE RELIED UPON AN UNCONSTITUTIONAL POLICY, PRACTICE, OR PROCEDURE BY CMS; OR THAT THE EXECUTION OF ANY POLICY, PRACTICE, OR PROCEDURE BY CMS PROXIMATELY CAUSED ANY HARM OR INJURY TO PLAINTIFF.

Defendants Answer:	Yes.
Plaintiff Answers:	No.

CONTROLLING/APPROPRIATE AUTHORITY FOR RELIEF SOUGHT

The two essential elements for a claim under 42 U.S.C. § 1983 are: (1) deprivation or violation of a federally protected right, privilege, or immunity, and (2) the fact that the action of the defendant in violating the federal protected right was taken under color of state law. Gomez v. Toledo, 446 U.S. 635 (1980); United of Omaha Life Ins. Co. v. Solomon, 960 F.2d 31, 33 (6th Cir. 1992). A plaintiff must make a clear showing that each named defendant was personally involved in the activity that forms the basis of the complaint. Salehpour v. Univ. of Tenn., 159 F.3d 199, 206-207 (1998).

In order to state a § 1983 claim for a violation of a prisoner's Eighth Amendment rights due to inadequate medical care, the prisoner must allege facts evidencing a deliberate indifference to serious medical needs. Wilson v. Seiter, 501 U.S. 294, 297 (1991). In order to succeed on such a claim, a prisoner must satisfy two elements, an objective one and a subjective one. Comstock v. McCrary, 273 F.3d 693, 702 (6th Cir. 2001). In other words, the prisoner must show that he had a serious medical need, and he must show that the defendant, being aware of that need, acted with deliberate indifference to it. Wilson, 501 U.S. at 300.

While municipalities may be subject to suit under 42 U.S.C. § 1983, it is not enough for a Plaintiff to merely allege liability on a theory of *respondeat superior*. Monell v. Dep't of Social Services of New York City, 436 U.S. 658, 691, 98 S.Ct. 2018 (1978). "Instead it is when execution of a government's policy . . . inflicts the injury that the government as an entity is responsible under § 1983." *Id.* at 694. In order to satisfy the requirements set forth in Monell, a Plaintiff must identify a particular policy, connect the policy to the municipality, and demonstrate that the particular constitutional violation alleged resulted from the execution of that policy. Garner v. Memphis Police Dep't, 8 F.3d 358, 364 (6th Cir. 1993).

INTRODUCTION

Plaintiff's Amended Complaint pursuant to 42 U.S.C. § 1983 alleges Defendants were deliberately indifferent to his serious medical needs by failing to provide him cataract surgery in a timely manner. Plaintiff's claims against Defendants Correctional Medical Services, Inc. (CMS), Dr. Hutchinson, and Dr. Mathai should fail because the evidence demonstrates that all decisions whether Plaintiff would receive second eye cataract surgery were made by the Chief Medical Officer of the MDOC based on medical criteria established by the MDOC. Therefore, Defendants CMS, Dr. Hutchinson and Dr. Mathai had insufficient personal involvement in any decision to deny Plaintiff's second eye cataract surgery, and they were not a proximate cause of any injuries alleged by Plaintiff. In the alternative, even if this court finds that Defendants CMS, Dr. Hutchinson and/or Dr. Mathai had sufficient personal involvement to support a claim for deliberate indifference to a serious medical need, Plaintiff's second eye cataract did not constitute an objectively serious medical need under the circumstances, consistent with established legal precedent.

STATEMENT OF FACTS

A. Substantive History

Plaintiff, Dallas Cobbs, #164276, is a 54-year-old, male who is currently incarcerated by the Michigan Department of Corrections (hereinafter "MDOC") at the Ryan Correctional Facility, located in Detroit, Michigan. (**Ex. A**).[1] This case concern incidents that occurred between 2004 and 2008 while Plaintiff was incarcerated at the MDOC's Ryan Correctional

[1] On December 12, 1985, Plaintiff was sentenced to life in prison. (**Ex. B**).

Facility. During the period in question, Defendant Correctional Medical Services, Inc. (hereinafter "CMS") contracted with the State of Michigan to provide certain health care services to inmates incarcerated by the MDOC. Defendant Craig Hutchinson, M.D. was employed by CMS as its Senior Regional Medical Director in Michigan from July 1999 until July 2007. (**Ex. C, pp. 9-10**). Dr. Hutchinson also contracted with CMS to perform full-time clinical practice in infectious diseases from July 2007 until March 31, 2009. (**Ex. C, p. 10**). Defendant Bency Mathai, M.D was an independent contractor of CMS prior to September 2007 after which she succeeded Dr. Hutchinson as CMS's Senior Regional Medical Director in Michigan until March 31, 2009. Neither Dr. Hutchinson, nor Dr. Mathai had any contact in any form with Plaintiff.

Plaintiff transferred into the Ryan Correctional Facility May 28, 1998. (**Ex. E**). On March 31, 2004, Plaintiff underwent an optometric vision screening with Michael McGrath, O.D., an optometrist. (**Ex. F, pp. 136, 370**). Plaintiff's visual acuity[2] in his right eye was 20/200 and his best corrected visual acuity in his left eye was 20/40. (**Ex. F, p. 370**). Dr. McGrath assessed Plaintiff with bilateral cataracts.[3] (**Ex. F, p. 370**). Dr. McGrath then submitted a routine consultation request to CMS's utilization review department for Plaintiff to see an ophthalmologist within one month. Plaintiff's vision in his right eye had changed from 20/20[4] with correction to 20/200 due to a dense cataract on his right eye, and Plaintiff had early intraocular clouding in the left eye with a best corrected visual acuity of 20/40. (**Ex. F, p. 353**). On April 1, 2004, Dr. DeMasi, a utilization review physician employed by CMS, responded that the ophthalmology consultation was not authorized because Plaintiff still had a best corrected

[2] "Visual acuity" is a "measure of the resolving power of the eye. It is usually determined by one's ability to read letters of various sizes at a standard distance from the test chart. The result is expressed as a compaison: for example, 20/20 is normal vision, meaning the subject's eye has the ability to see from a distance of 20 ft (6.1m) what a person with normal vision should see at that distance. Visual acuity of 20/40 means that a person sees at 20 ft (6.1m) what a person with normal vision sees from a distance of 40ft (12.2m)." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

[3] "Cataract" is "an opacity of the lens of the eye." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

[4] On September 11, 2002, Plaintiff had a visual acuity in his right of 20/20. (**Ex. F, p. 371**).

overall visual acuity of 20/40. (**Ex. F, p. 350**). On May 10, 2004, Paul Piper, M.D., Plaintiff's medical service provider (hereinafter "MSP") at Ryan Correctional Facility, initiated an appeal of the April 1, 2004 denial, noting that Plaintiff's visual acuity in his right eye had changed from 20/20 to 2/200 due to a dense, right eye cataract. (**Ex. F, p. 350**). The appeal process is governed by MDOC Operating Procedures. [5] On May 12, 2004, Dr. DeMasi responded to the appeal, and again explained that the request was not authorized because Plaintiff's visual acuity in his left eye was still 20/40. (**Ex. F, p. 350**). On May 12, 2004, Dr. Piper noted in the progress notes that the "ophthalmology referral denied by Dr. DeMasi-CMS as inmate is legally blind in O.D.[6] from dense cataract and has 20/40 vision O.S.[7] I think cataract surg[ery] is indicated if it

[5] MDOC Operating Procedure 03.04.100 further provides that the MSP is responsible for providing all necessary prisoner medical care within their level of expertise and the capabilities of the respective facility. (**Ex. H, ¶B**). If the level of care that a prisoner requires is beyond the primary level of care provided at his institution, the MSP is responsible for making referral to the Network Provider for offsite specialty care. (**Ex. H, ¶C**). In the present case, the Network Provider was Correctional Medical Services, Inc. ("CMS"). (**Ex. I, pp. 18-19**). CMS responsible for receiving the referral request from the MSP and screening it against approved MDOC criteria for the provision of off-site specialty care. (**Ex. H, ¶ E.3**). In the present case, the referral request was first reviewed by a CMS utilization review nurse, who screened the request to determine if it was clearly medically necessary based on upon the nurse's review of certain criteria. (**Ex. C, p. 16**). If the requested referral was clearly medically necessary, the nurse could authorize the referral. (**Ex. C, p. 16**). If the nurse was uncertain as to whether the requested referral was medically necessary, the nurse could pend the request for additional information, and could then make a determination as to medical necessity upon receipt of further information. (**Ex. C, pp. 16-17**). A utilization review nurse only had the authority to authorize a request or pend it for more information. (**Ex. C, p. 17**). The nurse did not have the authority to not authorize a request; only a physician could not authorize a request. (**Ex. C, p.17**). If the referral request did not meet the criteria, CMS's utilization review nurse referred the request to its utilization review physician. (**Ex. H, ¶E.8**). The utilization review physician then reviewed the case and made a determination. (**Ex. H, ¶E.9**). If the request was not authorized, the MSP could then initiate the appeals process if he, in his best medical judgment, believed that the non-approval was unwarranted. (**Ex. H, ¶E.11**). If the MSP appealed the non-approval, CMS's utilization review physician again reviewed the appeal and any additional documentation submitted with it, and again determined whether it should be approved. (**Ex. H, ¶E.15**). If the request was again not authorized, and the MSP disagreed with the non-authorization, the MSP could then forward the second step appeal to the MDOC Regional Medical Officer. (**Ex. H, ¶E.20**). The Regional Medical Officer then reviewed the appeal for completeness and forwarded it to the Chief Medical Officer ("CMO") of the MDOC, which in this case was Dr. Pramstaller, with a request that the case be placed on the next MSAC Agenda. (**Ex. H, ¶¶ E.21, E.22**). The MSAC (Medical Services Advisory Committee) was chaired by the CMO, and consisted of the Regional Medical Officers, the Director of Medical Services at Duane L. Waters Hospital, and others as determined by the Bureau of Health Care Services ("BHCS"). (**Ex. G, ¶ L**). The CMO had the ultimate authority to decide the outcome of the second appeal. (**Ex. H, ¶E.26; Ex. C, pp. 60-61**). None of the other members of the MSAC had a vote in the ultimate outcome. (**Ex. I, p. 43; Ex. C, pp. 60-61**). Dr. Pramstaller also testified that not all of the members of the MSAC always participated in every discussion. (**Ex. I, p. 43**). The CMO then notified the MSP of the MSAC decision by memo. (**Ex. H, ¶E.27**)

[6] "O.D" is an optometric abbreviation for "right eye." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

[7] "O.S." is an optometric abbreviation for "left eye." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

will correct vision." (**Ex. F, p. 134**). On May 18, 2004, Dr. Piper completed the next step in the MDOC appeal process by completing an appeal form, which was sent to the Regional Medical Director employed by the MDOC, Dr. Clark. (**Ex. F, pp. 134, 490**). On June 22, 2004, Dr. Clark forwarded the appeal to the MDOC's Medical Services Advisory Committee (MSAC). The MDOC Chief Medical Officer is the chief physician of the MDOC, and pursuant to MDOC Operating Procedure 03.04.100 has the final authority concerning what medical care should be provided. The MSAC conducted a meeting during which it discussed Plaintiff's ophthalmology consultation request. (**Ex. F, pp. 349, 350**). As CMO, Dr. Pramstaller then decided that Plaintiff should be approved for cataract surgery on his right eye based upon his "lifer status." (**Ex. F, pp. 349, 350**). An ophthalmology consultation was then scheduled for July 27, 2004 to evaluate Plaintiff's dense cataract in his right eye. (**Ex. F, p. 350**).

On July 27, 2004, Plaintiff received an ophthalmology consultation with Ghulam Dastgir, M.D. (**Ex. F, pp. 132, 348, 341-342**). Plaintiff's best corrected visual acuity was hand motion to finger counting at ½ foot in his right eye and 20/70 in the left eye. (**Ex. F, pp. 341-342**). Dr. Dastgir assessed Plaintiff with 1) a hypermature cataract of the right eye, and 2) a dense posterior subcapsular cataract in the left eye. (**Ex. F, pp. 341-342**). Dr. Dastgir recommended an A and B scan of Plaintiff's right and left eyes at the Parkside Eye Clinic and cataract extraction with lens implants in both eyes, the right eye being first. (**Ex. F, pp. 341-342**). Dr. Dastgir also scheduled Plaintiff to have both surgeries, although the MSAC authorize surgery in the right eye only. (**Ex. F, pp. 341-342**).

On July 29, 2004, Dr. Piper submitted a routine authorization request for Plaintiff to undergo bilateral cataract extractions with lens implants. (**Ex. F, p. 345**). On August 3, 2004, the request for A and B scans of Plaintiff's right eye and the cataract extraction of Plaintiff's

right eye with a lens implant was non-authorized by Dr. Forshee, another utilization review physician for CMS. (**Ex. F, p. 344**).[8] But, Dr. Forshee agreed Plaintiff should receive the A scan of Plaintiff's left eye, cataract removal in Plaintiff's left eye with lens implant, a one day post-op follow-up, and a one week follow-up appointment. (**Ex. F, p. 344**).[9]

On August 23, 2004, Plaintiff underwent A and B scans of his right eye and an A scan of his left eye at the Parkside Eye Clinic. (**Ex. F, p. 337**). On August 30, 2004, Plaintiff underwent cataract surgery on his right eye. (**Ex. F, p. 131**). On August 31, 2004, Plaintiff returned to see Dr. Dastgir for his one-day follow-up, as scheduled, and his visual acuity in his right eye had improved to 20/70 without correction. (**Ex. F, p. 333**). Dr. Dastgir then assessed Plaintiff with 1) pseudophakia[10] of the right eye, and 2) dense posterior subcapsular cataract of the left eye. (**Ex. F, p. 333**). Dr. Dastgir requested that Plaintiff be brought back for cataract extraction with lens implant in his left eye, although the MSAC still had not authorized the second surgery. (**Ex. F, p. 333**).

On September 15, 2004, Plaintiff again saw Dr. McGrath for an optometric examination. (**Ex. F, p. 369**). Dr. McGrath noted that Plaintiff had cataract surgery on his right eye two weeks ago, and that Plaintiff was a candidate for cataract surgery on his left eye. (**Ex. F, p. 369**).

On October 7, 2004, Dr. Piper submitted a routine consultation request for Plaintiff to see the ophthalmologist, as recommended by Dr. Dastgir. (**Ex. F, p. 328**). On October 11, 2004, the consultation request was pended by Dr. Forshee, who noted that the request was sent to the

[8] It appears that Dr. Forshee meant to deny the A and B scans and the cataract extraction with lens implant of Plaintiff's left eye, even though he indicated that his denial was with respect to Plaintiff's right eye.
[9] Again, it appears that Dr. Forshee confused the right and left eye and intended to authorize the A scan and cataract extraction of Plaintiff's right eye.
[10] "Pseudophakia" is the "condition in which an artificial lens has been implanted in the eye, e.g., after cataract surgery to remove a cloudy lens." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

MSAC for evaluation.[11] (**Ex. F, p. 329**). On October 26, 2004, the MSAC conducted a meeting during which it discussed the request for an extraction of Plaintiff's left eye cataract. (**Ex. F, p. 326**). Dr. Pramstaller then issued a memorandum directing that the request for a cataract extraction for Plaintiff's left eye was not approved. (**Ex. F, p. 326**).

On May 10, 2005, Plaintiff saw Sean Connolly, O.D., another optometrist at Ryan Correctional Facility, for an optometric evaluation. (**Ex. F, p. 368**). Dr. Connolly noted that Plaintiff had cataract surgery on his right eye in August, 2004 and wanted cataract surgery on his left eye, but was previously denied by the MSAC. (**Ex. F, p. 368**). Dr. Connolly then submitted a routine specialty consultation request for Plaintiff to be evaluated for cataracts and possible surgery, noting that Plaintiff's best corrected visual acuity was 20/30. (**Ex. F, p. 325**). On May 18, 2005, the ophthalmology consultation request was pended with a request for the optometry notes from May 10, 2005. (**Ex. F, p. 323**). On May 31, 2005, after Dr. Connolly's optometry notes were submitted to CMS' utilization review department, the ophthalmology consultation was non-authorized by Keith Ivens, M.D., a utilization review physician for CMS, because the MSAC had already denied the surgery on 10/26/2004. (**Ex. F, p. 323**).

Plaintiff was next seen on December 14, 2005 by Dr. McGrath who recommended that Plaintiff receive cataract surgery on his left eye. (**Ex. F, p. 124**). Dr. McGrath submitted a

[11] Dr. Pramstaller explained that generally all requests for second eye cataract removal surgeries had to go through the MSAC. (**Ex. I, p. 79**). Dr. Pramstaller explained that cases brought before the MSAC were reviewed on a case by case basis. (**Ex. I, p. 77**). Dr. Pramstaller explained that in determining whether to authorize a second eye cataract, it was determined whether it was medically necessary to authorize the surgery immediately or whether it could be deferred to a later date without any danger to the patient or any adverse effect on the ability to perform the surgery at a later date. (**Ex. I, p. 53**). Dr. Pramstaller explained that the conditions that would put the patient at risk if the surgery was not authorized are: 1) if the patient has diabetic retinopathy; 2) if the patient experienced posterior subcapsular glare; and 3) if the patient had a great discrepancy in vision. (**Ex. I, pp. 54-58**). Dr. Pramstaller explained that if a patient had one of the three conditions outlined above, cataract surgery would be authorized. (**Ex. I, p. 76**). Dr. Pramstaller also explained that if none of the above three conditions are a concern for a patient with a second eye cataract, the risk of harm to the patient is minimal. (**Ex. I, p. 80**). Dr. Pramstaller developed these criteria in conjunction with ophthalmologists. (**Ex. I, p. 81**). Again, while the MSAC discussed the requested referrals presented to it, the members of the MSAC had no vote in the ultimate decision, and the final decision was made solely by Dr. Pramstaller. (**Ex. H, ¶E.26; Ex. C, pp. 60-61; Ex. I, p. 43**).

routine ophthalmology consultation request, noting that Plaintiff's best corrected vision in his left eye was only 20/600 and that he had trouble with depth perception. (**Ex. F, p. 322**). Dr. McGrath also noted that it was not possible to view the lens or retina in Plaintiff's left eye and that Plaintiff alleged he walked into an object on his left side. (**Ex. F, p. 322**). On December 27, 2005, the ophthalmology consultation was non-authorized by Dr. Ivens because Plaintiff responded well to the surgery on his right eye thereby providing excellent best corrected visual acuity and the MSAC had already reviewed Plaintiff's case and denied the left eye cataract surgery. (**Ex. F, p. 321**). On January 11, 2006, Dr. McGrath noted that Plaintiff should return to optometry in 2 months to rule out secondary glaucoma. (**Ex. F, p. 321**).

Two months later, on March 1, 2006, Plaintiff returned to see Dr. McGrath for a follow-up optometry examination. (**Ex. F, p. 367**). Plaintiff's visual acuity in his right eye was 20/20 and his left eye was 20/CF.[12] (**Ex. F, p. 367**). Dr. McGrath then submitted another routine ophthalmology consultation request for Plaintiff to have cataract surgery to remove his left eye cataract. (**Ex. F, p. 320**). Dr. McGrath noted that Plaintiff had a dense left eye cataract with possible secondary glaucoma as a risk factor. (**Ex. F, p. 320**).

On March 15, 2006, the ophthalmology request was again non-authorized by Dr. Ivens because Plaintiff responded well to the right eye surgery with a best corrected visual acuity of 20/20 and the MSAC already reviewed the case and had already denied another ophthalmology consultation. (**Ex. F, p. 314**). On March 29, 2006, Dr. McGrath appealed the non-authorization, explaining that surgery was advised to prevent secondary glaucoma and that it was not possible to visually examine the back of Plaintiff's eye because his left retina was not visible. (**Ex. F, p. 314**). On April 3, 2006, the request was pended by Dr. Ivens and was sent back to the MSAC for review. (**Ex. F, p. 314**). On April 25, 2006, Dr. Pramstaller issued another memo directing that

[12] "CF" is an abbreviation for counting fingers.

the previous non-approval of another ophthalmology consult was upheld. (**Ex. F, p. 313**). The memo also directed that Plaintiff's intraocular pressure[13] should be monitored closely to rule out glaucoma and that a request should be resubmitted if the pressure increased. (**Ex. F, p. 313**).[14]

On July 27, 2006, Plaintiff was seen by Dr. Piper, who noted that Plaintiff had markedly decreased vision in his left eye and that a review of the medical chart revealed a deterioration of vision in the left eye from 20/40 in 2004 to 20/400 in December, 2005. (**Ex. F, p. 122**). Dr. Piper then submitted a routine ophthalmology request, noting that Plaintiff had a presumed diagnosis of decreased vision in his left eye with a cataract. (**Ex. F, p. 312**). On August 8, 2006, the authorization request was pended by Brenda Jones, RN, a utilization review nurse, with a request for more information as follows: "Dr. Piper – MSAC not authorized ophthalmology for Lt eye cataract on 4-25-06. Did you (the prison) receive that information? If not, I could resend it. Would you like to withdraw?" (**Ex. F, p. 307**). Dr. Piper responded that same day that according to the optometrist, Plaintiff's vision in his left eye has deteriorated significantly secondary to cataract and that he did not see anything in the chart from the MSAC dated 4/25/06. (**Ex. F, p. 307**). On August 11, 2006, the authorization request was again pended by RN Jones, noting that the April, 2006 decision form and the MSAC memorandum were faxed to Dr. Piper. (**Ex. F, p. 307**). Dr. Piper did not pursue the authorization request further and it was automatically denied for lack of a response. (**E Ex. F, p. 307**).

On December 4, 2006, Dr. Piper performed a medical chart review and noted that he would refer Plaintiff to the optometrist to measure his eye pressure to determine any significant increase since the previous year, as recommended by Dr. Pramstaller on 4/25/06. (**Ex. F, pp.**

[13] Intraocular pressure is measured in mmHg (millimeters of mercury). The normal range for intraocular pressure is 10-21 mmHg. "Tonometry," National Institutes of Health, http://www.nlm.nih.gov/MEDLINEPLUS/ency/article/003447.htm. Measuring the intraocular pressure is one of two ways to evaluate a patient for glaucoma. (**Ex. C, p. 103**).

[14] Plaintiff's intraocular pressure never became abnormal in his left eye, and Plaintiff never developed glaucoma.

114, 313). On December 13, 2006, Plaintiff had an optometry examination with Dr. McGrath. (**Ex. F, p. 365**). Plaintiff's visual acuity in his right eye was 20/20. (**Ex. F, p. 365**). Dr. McGrath noted that he had no view of Plaintiff's left eye, which had a visual acuity of CF. (**Ex. F, p. 365**). Plaintiff's intraocular pressure in both his right and left eyes was 11 mmHg, which was well within the normal range. (**Ex. F, p. 364**). Dr. McGrath assessed Plaintiff with a left eye cataract and recommended that Plaintiff be referred to the ophthalmologist. (**Ex. F, p. 365**). On that same day, Dr. McGrath submitted a routine ophthalmology consultation authorization request form, noting that Plaintiff had a dense cataract on his left eye and that he could not view Plaintiff's retina. (**Ex. F, p. 297**). Dr. McGrath also noted that Plaintiff developed anemia and that the health of his left eye could not be evaluated. [15] (**Ex. F, p. 297**).

On February 14, 2007, it was noted that the ophthalmology request dated December 13, 2006 was received on February 6, 2007. (**Ex. F, p. 355**). The authorization request was pended by RN Jones as follows: "Is there an optometry exam from 12/13/06? Need visual acuity." (**Ex. F, p. 355**). On February 21, 2007, the December 12, 2006 authorization request was pended again by Dr. Hutchinson, who requested a translation of a word on the authorization request form. (**Ex. F, p. 355**). On February 28, 2007, Dr. McGrath responded by noting that the word was "anemia." (**Ex. F, p. 355**). On March 6, 2007, the ophthalmology request was non-authorized by Dr. Hutchinson because Plaintiff's visual acuity in his right eye was 20/20. (**Ex. F, p. 354**).

[15] Dr. McGrath testified at his deposition that his concern for the health of the left eye concerned evaluation for glaucoma and retinopathy. Dr. McGrath stated was able to adequately monitor Plaintiff's eye for glaucoma by monitoring his interocular eye pressure which always remained within normal range. Plaintiff was not a threat for diabetic retinopathy since Plaintiff did not have diabetes. Non-diabetic retinopathy is rare, and even rarer in only one eye, therefore he could adequately monitor Plaintiff's corrected eye for retinopathy. Plaintiff never developed either glaucoma or retinopathy. (**Ex. D, p. 130-132**).

On May 30, 2007, Plaintiff had another optometry examination with Dr. McGrath. (**Ex. F, p. 364**). Plaintiff reported to Dr. McGrath that he experienced monocular double vision, in his right eye, for the past two months. (**Ex. F, p. 364**). Dr. McGrath then examined Plaintiff's eyes and determined that he had a slight secondary cataract on his right eye and a dense cataract on his left eye. (**Ex. F, p. 364**). Plaintiff's visual acuity in his right eye was 20/50 and his visual acuity in his left eye was CF. (**Ex. F, p. 364**). Plaintiff's intraocular pressure in each eye was measured twice and revealed readings of 13 mmHg then 14 mmHg in each eye, within normal limits. (**Ex. F, p. 364**). Dr. McGrath then determined that Plaintiff should be referred to ophthalmology and he submitted an ophthalmology consultation request form, noting that Plaintiff had decreased vision in his right eye and a dense cataract in his left eye. (**Ex. F, pp. 364, 240**). The request did not mention Plaintiff's complaint of monocular double vision in his right eye. [16] (**Ex. F, p. 240**). On June 15, 2007, Dr. Ivens non-authorized the ophthalmology consult request on the grounds that no reason was given for an appeal of the previous decision to not authorize an ophthalmology request form based on the MSAC's decision. (**Ex. F, p. 293**). On July 15, 2007, Dr. McGrath responded that he could not view Plaintiff's retina to evaluate the health of Plaintiff's left eye due to a dense cataract. (**Ex. F, p. 293**). On July 19, 2007, the authorization request was pended by RN Jones for the reason that an ophthalmology consultation for Plaintiff's left eye was already denied on two occasions and that Dr. McGrath's next step was to appeal it to the MDOC's RMO/MSAC. (**Ex. F, p. 293**). Dr. McGrath did not appeal the consultation request to the RMO or the MSAC.

On September 31, 2007, Plaintiff submitted a kite regarding his eye, and an appointment with a nurse was scheduled for October 5, 2007. (**Ex. F, p. 113**). On October 5, 2007, Plaintiff

[16] Dr. McGrath testified at his deposition that Plaintiff's reported monocular double vision was not affected by the cataract in his left eye. (**Ex. D, p. 130-132**).

saw Linda Butts, RN, as scheduled. (**Ex. F, p. 64**). Nurse Butts noted that Plaintiff complained of frequent episodes of eye strain which sometimes caused him to have headaches, as well as episodes of blurry vision. (**Ex. F, p. 64**). RN Butts then gave Plaintiff an eye patch to wear over his left eye. (**Ex. F, p. 64**).

On November 8, 2007, Plaintiff submitted another kite regarding his left eye and nursing noted that he had an appointment scheduled with a nurse on 11/13/07. (**Ex. F, p. 113**). On November 13, 2007, Plaintiff was again seen by RN Butts, as scheduled. (**Ex. F, p. 61**). Plaintiff complained that he had headaches that he believed were caused by the strain that he experienced from trying to see out of his right eye only. (**Ex. F, p. 61**). Plaintiff also stated that he reads a lot. (**Ex. F, p. 61**). RN Butts instructed Plaintiff to decrease his reading time, to take frequent breaks, and to blink while reading to reduce the strain. (**Ex. F, p. 61**). RN Butts concluded that Plaintiff with alteration in comfort secondary to headache and limited vision and provided him with Acetaminophen. (**Ex. F, p. 61**).

On February 6, 2008, Plaintiff was again seen by Dr. McGrath for an optometry examination and Dr. McGrath noted that Plaintiff was wearing an eye patch on his left eye due to his cataract. (**Ex. F, p. 363**). Plaintiff's visual acuity in his right eye was 20/30 after laser surgery and his visual acuity in his left eye was CF. (**Ex. F, p. 363**). Plaintiff's intraocular pressure in both eyes was 14 mmHg. (**Ex. F, p. 363**). Dr. McGrath submitted another routine ophthalmology consultation request form, noting that Plaintiff now complained of binocular double vision. (**Ex. F, p. 180**). On February 12, 2008, the ophthalmology consultation request was approved by Dr. Ivens because Plaintiff appeared to have binocular double vision, and an appointment was scheduled for Plaintiff to see Dr. Dastgir on February 26, 2008. (**Ex. F, p. 180**).

On February 26, 2008, Plaintiff had an ophthalmology consultation with Dr. Dastgir as scheduled. (**Ex. F, pp. 35-36**). Plaintiff's visual acuity in his right eye decreased to 20/50 and he experienced barely light perception in his left eye at ¼ foot. (**Ex. F, pp. 35-36**). Dr. Dastgir assessed Plaintiff with 1) hypermature chalk white cataract of the left eye with inability to see the fundus,[17] 2) pseudophakia of the right eye, and 3) diplopia[18] due to exotropia[19] of the left eye. (**Ex. F, pp. 35-36**). Dr. Dastgir recommended A and B scans of Plaintiff's left eye and cataract extraction of the left eye with lens implant. (**Ex. F, pp. 35-36**).

On March 10, 2008, Dr. Piper submitted a consultation request for the procedures recommended by Dr. Dastgir. (**Ex. F, pp. 31, 32**). On March 14, 2008, the consultation request, as well as two post-operative, follow-up appointments, were approved at the request of the MSAC, due to the decrease in Plaintiff's best visual acuity to 20/50 and in consideration of his complaints of double vision.[20] (**Ex. F, p. 32**). On April 14, 2008, Plaintiff underwent a cataract

[17] The "fundus" is the "posterior part of the eye including the retina and optic nerve." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

[18] "Diplopia" is a synonym for "double vision." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

[19] "Exotropia" refers to an "abnormal turning outward of one or both eyes." Taber's Cyclopedic Medical Dictionary, 21st Edition, 2009.

[20] It should be noted that Plaintiff's second-eye cataract surgery was authorized at the same or at a less advanced stage than is required by other similar organizations, as well as organizations providing coverage for procedures for unincarcerated persons. According to the Federal Bureau of Prisons' guidelines, for example, a prisoner may only receive second eye cataract surgery if they have a documented, best corrected visual acuity of 20/100 or worse, or under certain exceptional circumstances, which Plaintiff would not have satisfied. (**Ex. J**). Plaintiff did not meet these requirements. According to the policy established by Aetna, a leading national insurance company, cataract surgery is considered medically necessary for members with a visual acuity of 20/50 or worse if the member perceives that his ability to carry out daily functions (i.e., driving, watching television, occupation/vocational needs, etc.) is impaired, the member has a visual acuity of 20/50 or worse in the affected eye, and the member is educated about the risks and benefits of cataract surgery as well as alternatives, or if the member has some other condition, such as a lens-induced disease (e.g., certain types of glaucoma) or there is a need to visualize the retina in patients with conditions, such as diabetes.. (**Ex. K**). Here, Plaintiff received cataract surgery on his left eye at the same time as he would have been eligible under Aetna's guidelines. Finally, according to the Local Coverage Determination guidelines established by the Centers for Medicare and Medicaid Services, which are applicable to Medicare/Medicaid eligible persons in Michigan, cataract removal surgery is medically necessary for patients who have decreased ability to carry out activities of daily living (e.g., reading, watching television, driving, or meeting occupational/vocational expectations), a visual acuity of 20/50 or worse, the patient has determined that he can no longer function adequately with the current visual function, other eye diseases have been ruled out as the primary cause of visual function, significant improvement in visual function can be expected as a result of the surgery, the patient has been educated about the risks and benefits of cataract surgery and alternatives, and the patient has

extraction and lens implant on his left eye. (**Ex. F, p. 190**). On April 15, 2008, the day after Plaintiff underwent a cataract extraction and lens implant in his left eye, Plaintiff had a follow-up visit with Dr. Dastgir, as scheduled. (**Ex. F, pp. 111, 190**). Dr. Dastgir noted that a suture was placed in Plaintiff's left eye because the surgical wound was leaking. (**Ex. F, p. 190**). Dr. Dastgir recommended that Plaintiff return in one week to have his suture removed. (**Ex. F, p. 190**). On April 22, 2008, Plaintiff had another follow-up visit with Dr. Dastgir. (**Ex. F, p. 16**). Dr. Dastgir noted that Plaintiff's visual acuity was 20/200, and that Plaintiff seemed to be stable. (**Ex. F, p. 16**). Dr. Dastgir also removed the sutures from Plaintiff's left eye, but the wound started to leak again. (**Ex. F, p. 16**). Dr. Dastgir then patched Plaintiff's left eye with a pressure patch and recommended that Plaintiff return to the Parkside Eye Clinic the following morning to recheck his eye. (**Ex. F, p. 16**).

On April 22, 2008, Dr. Piper submitted a consultation request for Plaintiff to be seen by Dr. Dastgir to follow-up on Plaintiff's left eye leakage after Dr. Dastgir removed the sutures from that eye. (**Ex. F, p. 196**). On April 23, 2008, Plaintiff was seen by Dr. Dastgir at Duane Waters Hospital who repaired the leaking wound in Plaintiff's left eye lateral limbal area. (**Ex. F, p. 189**).

On April 24, 2008, Dr. Piper submitted another consultation request for Plaintiff to see Dr. Dastgir for a follow-up appointment on April 29, 2008. (**Ex. F, p. 192**). On April 25, 2008, the consultation request was authorized. (**Ex. F, p. 192**). On April 29, 2008, Plaintiff returned to see Dr. Dastgir as scheduled. (**Ex. F, p. 187**). Plaintiff's visual acuity had improved to 20/80. (**Ex. F, p. 187**). Dr. Dastgir recommended that Plaintiff return to see him in four weeks. (**Ex. F, p. 187**).

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undergone an appropriate preoperative ophthalmologic evaluation. (**Ex. L**). In the present case, Plaintiff received his second eye cataract when his condition met these criteria.

On May 27, 2008, Plaintiff was again seen by Dr. Dastgir status post repair of a leaking wound following his left eye cataract extraction with lens implant. (**Ex. F, p. 14**). Plaintiff's visual acuity in his left eye improved to 20/40 and Dr. Dastgir noted that the eye looked excellent. (**Ex. F, p. 14**).

On May 28, 2008, Dr. Piper noted that Plaintiff had a suture repair of a leaking wound in his left eye on 5/27/08 and that he was to return to ophthalmology in 2 weeks. (**Ex. F, p. 108**). Dr. Piper submitted a consultation request for Plaintiff to return to the ophthalmology clinic for a follow-up visit and suture removal. (**Ex. F, p. 176**). On June 2, 2008, the request was approved, and an appointment was scheduled for June 17, 2008. (**Ex. F, p. 176**). On June 17, 2008, Plaintiff had an ophthalmology consultation with Dr. Dastgir for a recheck and suture removal, as scheduled. (**Ex. F, p. 183**). Dr. Dastgir noted that after the suture removal, Plaintiff's visual acuity improved to 20/25. (**Ex. F, p. 183**). Dr. Dastgir then recommended that Plaintiff receive glasses and return for a follow-up visit in three months. (**Ex. F, p. 183**). On June 26, 2008, Dr. Piper submitted a consultation request for Plaintiff to return to see Dr. Dastgir in 3 months. (**Ex. F, p. 4**). The request was approved on July 9, 2008. (**Ex. F, p. 4**).

On July 18, 2008, Plaintiff was seen by Mark J. Cook, O.D. for an optometric vision screening. (**Ex. F, p. 362**). Plaintiff's visual acuity in both his right and left eyes was 20/25. (**Ex. F, p. 362**).

B. Procedural History

On or about June 10, 2008, Plaintiff filed his First Amended Complaint pursuant to 42 U.S.C. § 1983. (**Dkt. #38**). Plaintiff alleges claims of deliberate indifference to Plaintiff's his alleged serious medical need, a cataract in his left eye, in violation of the Eighth Amendment. (**Dkt. #38**). Plaintiff's First Amended Complaint names 14 Defendants, including CMS, Dr.

Hutchinson and Dr. Mathai. (**Dkt. #38**). With respect to CMS, Plaintiff alleges that their "utilization review unit approves or denies requests for specialty care, and in this case repeatedly denied Mr. Cobbs' physicians' requests for surgical specialty care." (**Dkt. #38, ¶13**). With respect to Dr. Hutchinson, Plaintiff alleges that he "was the state medical director for CMS and a member of the MSAC." (**Dkt. #38, ¶11**). With respect to Dr. Mathai, Plaintiff alleges that she was a member "of the MSAC when the committee denied Mr. Cobbs' physicians' requests for a second cataract surgery." (**Dkt. #38, ¶16**).

Plaintiff alleges that in 2004, he had cataracts in both eyes and was scheduled for surgery. (**Dkt. #38, ¶2**). Plaintiff alleges that an ophthalmologist removed the cataract from his right eye and told him that he would have the second surgery in six weeks. (**Dkt. #38, ¶3**). Plaintiff then alleges that the second surgery was canceled and that the Defendants denied him the second surgery from October 26, 2004 until mid-April 2008. (**Dkt. #38, ¶¶4, 5**). Plaintiff alleges that the Defendants repeatedly refused to approve the second cataract surgery despite actual knowledge that he faced an increased risk of glaucoma without the surgery and that he was effectively blind in his left eye from 2006 until 2008. (**Dkt. #38, ¶83**). Plaintiff alleges that the Defendants failed to provide treatment, or failed to authorize treatment despite their knowledge of a substantial risk of serious harm, which constituted deliberate indifference to Plaintiff's alleged serious medical needs and which was the proximate cause of physical injury to Plaintiff in the form of cataract-induced blindness in one eye, headaches, vision problems, and eye strain. (**Dkt. #38, ¶¶84, 85**). Plaintiff alleges that he suffered the following damages as a proximate result of the alleged acts and omissions of Defendants:

> a thick, dense cataract on his left eye that effectively blinded him in that eye and forced him to wear an eye-patch; headaches, vision problems; eye strain, inability to work his previous job as a locksmith; an increased risk of glaucoma and an increased risk of

> complications from surgery when the cataract was finally removed; long-term loss of the use of his left eye; walking into walls and other people for lack of left-side and peripheral vision; loss of depth perception; anxiety; pain and suffering; humiliation and mental and emotional distress.

(**Dkt. #38, ¶89**).

Plaintiff seeks 1) a declaratory judgment that the Defendants' alleged denial of medical care constituted deliberate indifference, 2) an injunction ordering the Defendants to provide all needed follow-up ophthalmological care to ensure that Plaintiff's vision is fully restored,[21] 3) nominal, compensatory, and punitive damages, 4) interest, costs, and actual attorney's fees, and 5) any other relief the court deems appropriate. (**Dkt #38**, **p. 11**).

STANDARD OF REVIEW

According to Fed. R. Civ. P. 56, summary judgment must be entered if the moving party demonstrates that there is no genuine issue of material fact. "[T]he plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof." Celotex Corp. v. Catrett, 477 U.S. 317, 322, 106 S. Ct. 2548 (1986). Rule 56(e)(2) provides that "[w]hen a motion for summary judgment is properly made and supported, an opposing party may not rely merely on allegations or denials in its own pleading; rather, its response must—by affidavits or as otherwise provided in this rule—set out specific facts showing a genuine issue for trial. Thus, a party responding to a motion for summary judgment must put forth more than a "mere scintilla of evidence" in support of his position; he must put forth evidence on which the jury could

[21] The moving Defendants consider this requested relief to be dismissed as the Court Ordered, and Plaintiff conceded, that the request for injunctive relief is moot as Plaintiff has been provided with cataract surgery and follow-up care for his left eye, and his vision is now restored. (**Dkt #77, p. 7; Dkt #71, p.7**).

reasonably find in his favor. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252, 106 S. Ct. 2505 (1986). In other words, "[t]he respondent cannot rely on the hope that the trier of fact will disbelieve the movant's denial of a disputed fact, but must present affirmative evidence in order to defeat a properly supported motion for summary judgment." Street v. J.C. Bradford & Co., 886 F.2d 1472, 1479 (6th Cir. 1989) (internal quotation marks omitted). "[W]here the record taken as a whole could not lead a rational trier of fact to find for the respondent, the motion should be granted." Id. at 1480, *quoting* Matsushita Electrical Industrial Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S. Ct. 1348 (1986).

ARGUMENTS

Argument I: Defendants Should Be Granted Summary Judgment Because The Evidence Shows They Had Insufficient Personal Involvement In Deciding When Plaintiff Would Receive His Second Eye Cataract Surgery And They Were Not A Proximate Cause Of Plaintiff's Alleged Injury.

In the present case, neither Dr. Hutchinson nor Dr. Mathai had any personal involvement in Plaintiff's medical care and treatment or any determinations concerning whether Plaintiff's recommended cataract surgery on his left eye would be non-authorized. There is no evidence Dr. Mathai participated in any MSAC decision not to authorize Plaintiff's cataract surgery. While Dr. Hutchinson testified he sat on one or more of the respective MSAC meetings involved in this matter, the evidence is clear that only the MDOC CMO had the final authority to provide Plaintiff's second eye cataract surgery based on criteria established by the MSAC. Under 42 U.S.C. § 1983, liability must be based upon a clear showing of active personal involvement. Therefore, summary judgment should be entered in favor of Dr. Hutchinson and Dr. Mathai as a matter of law.

The two essential elements for a claim under 42 U.S.C. § 1983 are: (1) deprivation or violation of a federally protected right, privilege, or immunity, and (2) the fact that the action of the defendant in violating the federal protected right was taken under color of state law. Gomez v. Toledo, 446 U.S. 635 (1980); United of Omaha Life Ins. Co. v. Solomon, 960 F.2d 31, 33 (6th Cir. 1992). A plaintiff must make a clear showing that each named defendant was personally involved in the activity that forms the basis of the complaint. Salehpour v. Univ. of Tenn., 159 F.3d 199, 206-207 (1998). In other words, liability under 42 U.S.C. § 1983 must be based upon active unconstitutional behavior and cannot be based upon "a mere failure to act." Shehee v. Luttrell, 199 F.3d 295, 300 (1998), *citing* Salehpour, 195 F.3d at 206. Therefore, it naturally follows that liability under 42 U.S.C. § 1983 must be based on more than the right to control employees. Shehee, 199 F.3d at 300. Furthermore, allegations based upon *respondeat superior* liability are foreclosed in § 1983 actions. For instance, in the case of Bellamy v. Bradley, the Sixth Circuit explained that in order to impose liability on supervisory personnel, a Plaintiff must show more than having brought offending conduct to the attention of supervisory officials:

> In Hays v. Jefferson County, 668 F.2d 869 (6th Cir. 1982), we held that the § 1983 liability of supervisory personnel must be based on more than the right to control employees. Section 1983 liability will not be imposed solely upon the basis of respondeat superior. There must be a showing that the supervisor encouraged the specific incident of misconduct or in some other way directly participated in it. At a minimum, a § 1983 plaintiff must show that a supervisory official at least implicitly authorized, approved or knowingly acquiesced in the unconstitutional conduct of the offending subordinate. Hays, 668 F.2d at 872-74.

729 F.2d 416, 421 (6th Cir. 1984). Similarly, merely being aware of a prisoner's complaint and failing to take corrective action is insufficient to impose liability on supervisory personnel under 42 U.S.C. § 1983. Poe v. Haydon, 853 F.2d 418, 429 (6th Cir. 1988). Instead, the plaintiff must demonstrate that the supervisor directly participated in the alleged wrongful conduct. Id. ("a

supervisory official's failure to control or train the offending individual is not actionable, unless the supervisor 'either encouraged the specific incident of misconduct or in some other way directly participated in it.'").

In the present case, neither Dr. Hutchinson, nor Dr. Mathai, had any personal involvement in the MSAC CMO's decision not to authorized Plaintiff's left eye cataract surgery during MSAC meetings on 6/22/04, 10/26/04, 4/25/06, and/or in 2008 when the surgery was approved.. They did not directly participate in the alleged wrongful conduct. There is no evidence that either Dr. Hutchinson or Dr. Mathai authorized, approved, knowingly acquiesced in, or in any way encouraged any alleged wrongful conduct with respect to Plaintiff. Neither Dr. Hutchinson nor Dr. Mathai were personally involved in the treatment and care of Plaintiff, with two exceptions: Dr. Hutchinson acted as the utilization review physician who did not authorized an ophthalmology consultation on 12/12/06 because it was previously denied by the MSAC and Plaintiff's condition did not deteriorate as his best corrected visual acuity was 20/20 (**Ex. F, pp. 354-355**); and Dr. Mathai was the action Medical Director for CMS in Michigan on 3/14/2008 when the MSAC authorized Plaintiff's left eye cataract extraction because his best corrected visual acuity decreased to 20/50 and Dr. Dastgir reported Plaintiff experienced binocular double vision (**Ex. F, pp. 32-36**). Dr. Hutchinson testified he sat on the MDOC MSAC, an administrative body that is responsible for, among other things, reviewing second appeals of off-site specialty consultation requests. However there is no evidence Dr. Mathai was on any of the MSAC panels that reviewed this case and non-authorized the second eye cataract surgery on 6/22/04, 10/26/04 and/or 4/25/06. While the CMS Medical Director typically sat on the MSAC, Dr. Mathai did not assume that position with CMS until September 2007. Although there is evidence Dr. Hutchinson sat on the MSAC, he had no vote in the ultimate decision to deny or

authorize the requested off-site referrals, and there is absolutely no evidence that his participation on the MSAC controlled the decision by the CMO regarding whether Plaintiff would receive second eye cataract surgery prior to March 2008. (**Ex. I, p. 43; Ex. C, pp. 60-61**).

The ultimate authority to decide the outcome of an appeal to the MSAC rested solely with the Chief Medical Officer of the MDOC, which, in this case was Defendant Dr. Pramstaller (**Ex. H, ¶E.26; Ex. C, pp. 60-61**). It is not enough that Dr. Hutchinson and Dr. Mathai may have become aware of Plaintiff's complaints as the Medical Director for CMS in Michigan and/or through participation with the MSAC. *See* Poe, 853 F.2d at 429. Plaintiff must put forth affirmative evidence demonstrating that Dr. Hutchinson and Dr. Mathai were personally involved in the events that form the basis of his Amended Complaint in order to survive summary judgment. Street, 886 F.2d at 1479; Salehpour, 159 F.3d at 206-207. In the present case, there is absolutely no evidence that either Dr. Hutchinson or Dr. Mathai had any personal involvement in the non-authorization of Plaintiff's left eye cataract surgery by the MSAC CMO. Therefore, summary judgment should be entered in their favor as a matter of law.

Argument II: Defendants Should Be Granted Summary Judgment Because Plaintiff's Left Eye Cataract Was Not An Objectively Serious Medical Need And Defendants Did Not Believe That Plaintiff's Left Eye Cataract Posed A Serious Risk Of Substantial Harm To Plaintiff.

Even if, assuming *arguendo*, the Court determines that CMS, Dr. Hutchinson and/or Dr. Mathai were personally involved, there is no evidence that they violated Plaintiff's Eighth Amendment rights because his left eye cataract did not constitute a serious medical need during the relevant times in question. Therefore, summary judgment should be entered in their favor as a matter of law.

It is well settled that the Eighth Amendment guarantee to be free from cruel and unusual punishment encompasses a prisoner's right to medical care for serious medical needs. *See* Estelle v. Gamble, 429 U.S. 97 (1976). However, the Eighth Amendment prohibits mistreatment only where it equates to "punishment," and, therefore, the courts have imposed liability upon prison officials, including health care providers, only where their actions are so deliberately indifferent to the serious medical needs of a prisoner that they constitute unnecessary and wanton infliction of pain. Perez v. Oakland County, 466 F.3d 416, 423 (6th Cir. 2006).

In order to state a § 1983 claim for a violation of a prisoner's Eighth Amendment rights due to inadequate medical care, the prisoner must allege facts evidencing a deliberate indifference to serious medical needs. Wilson v. Seiter, 501 U.S. 294, 297 (1991). In order to succeed on such a claim, a prisoner must satisfy two elements, an objective one and a subjective one. Comstock v. McCrary, 273 F.3d 693, 702 (6th Cir. 2001). In other words, the prisoner must show that he had a serious medical need, and he must show that the defendant, being aware of that need, acted with deliberate indifference to it. Wilson, 501 U.S. at 300. In the present case, Plaintiff is unable to make a showing with respect to either element.

A. There Is No Objectively Serious Medical Need

In order to successfully satisfy the objective element of a deliberate indifference claim, the prisoner-plaintiff must first demonstrate that from an objective standpoint, he had a "sufficiently serious" medical need. Farmer v. Brennan, 511 U.S. 825, 834 (1994). A medical need is "objectively serious" if it is "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." Blackmore v. Kalamazoo County, 390 F.3d 890, 895 (6th Cir. 2004). In other words, an objectively serious medical need requires immediate attention or is potentially

life-threatening: "A 'serious' medical need exists if the failure to treat a prisoner's condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.'" McGuckin v. Smith, 974 F.2d 1050, 1059 (9th Cir. 1992). However, in cases involving minor maladies or non-obvious complaints of a serious need for medical care, the Plaintiff must put forth verifying medical evidence in order to demonstrate that the alleged delay in treatment caused a serious medical injury. Blackmore, 390 F.3d at 898, *citing* Napier v. Madison County, 238 F.3d 739, 742 (6th Cir. 2001) ("an inmate who complains that delay in medical treatment rose to a constitutional violation must place verifying medical evidence in the record to establish the detrimental effect of the delay in medical treatment to succeed.").

Upon information and belief, the Sixth Circuit Court of Appeals has never specifically addressed the issue of whether a cataract constitutes an objectively serious medical need. However, numerous other Federal Courts have addressed the issue under both categories discussed in Blackmore. Under the first strand of Blackmore, where the injury requires immediate medical attention or is potentially life-threatening, numerous Courts have found that a cataract does not qualify as an objectively serious medical need. 390 F.3d at 895. For example, in the case of Edwards v. Bradford, the court was faced with an action in which the prisoner plaintiff claimed that his Eighth Amendment rights were violated when he was denied cataract surgery. 1997 U.S. Dist. LEXIS 15089 (S.D. Ala. July 16, 1997) (**Ex. M**). There the evidence revealed that the plaintiff had an opaque cataract on his right eye that the plaintiff alleged caused him to become blind in that eye, caused him to have difficulty with the tasks of daily living, and may have forced him to withdraw from trade school, and that the plaintiff had excellent distance vision in his other eye and age-related decreased reading vision. Id. at *5 (**Ex. M**). After reviewing the evidence before it, the Court found that the plaintiff "failed to demonstrate that he

has a serious medical need" because the "evidence demonstrates that [the plaintiff] has a cataract on his right eye, that he has been examined regularly by medical personnel for the cataract, and that the cataract has not, does not, and will not cause any damage or harm to that eye, the other eye, or to any other aspect of [the plaintiff's] health." Id. at *9-10 (**Ex. M**). Similarly, in the case of Hurt v. Mahon, the court found that the prisoner plaintiff in a deliberate indifference action regarding an alleged denial of cataract surgery failed to allege an objectively serious medical need because the cataract was not a painful condition, and dismissed the Plaintiff's complaint with prejudice. 2009 U.S. Dist. LEXIS 279295, *7-9 (E.D. Va. Aug. 31, 2009) (**Ex. N**).

Furthermore, other federal courts faced with a plaintiff complaining of cataracts and an alleged denial of cataract removal surgery have found that a cataract does not constitute an objectively serious medical need under framework of the second leg of Blackmore. 390 F.3d 898. For instance, in the case of Williams v. Shelton, the Court was faced with facts, very similar to those at issue in the present case. 2008 U.S. Dist. LEXIS 54394 (D. Or. July 16, 2008) (**Ex. O**). There, the Plaintiff had bilateral cataracts, with the right eye being worse than the left. Id. at *8 (**Ex. O**). The right eye cataract was removed, and an ophthalmologist recommended that the left eye cataract be removed as well. Id. at *8-9 (**Ex. O**). The prison's Therapeutic Level of Care Committee denied the cataract surgery on the plaintiff's left eye for more than a year, however, eventually approved the surgery.[22] Id. at *9 (**Ex. O**). The prisoner complained that the defendants were deliberately indifferent to his serious medical needs due to the delay in treatment, however, the Court entered summary judgment in favor of the defendants because there was no evidence that the delay in the surgery caused any harm, much less substantial harm. Id. at *8-9 (**Ex. O**); *see also* Leyser v. D'Amico, 182 Fed. Appx. 897 (9th Cir. 2006) (holding

[22] It is uncertain whether the surgery ever occurred. Williams, 2008 U.S. Dist. LEXIS 54394, at *9 (**Ex. O**).

that the District Court properly granted summary judgment in favor of the prison officials where the record contained no evidence that the denial by the prisoner's utilization review panel of Plaintiff's recommended cataract surgery led to further injury to the Plaintiff's eye) (**Ex. P**); Dupuis v. Caskey, 2009 U.S. Dist. LEXIS 89002, *13-14 (S.D. Miss. Sept. 28, 2009) (finding that a cataract did not amount to an objectively serious medical need where a delay in cataract surgery resulted in no substantial harm to the inmate or his eye) (**Ex. Q**); Rylee v. Bureau of Prisons, 2009 U.S. Dist. LEXIS 24609 (D. S.C. Mar. 9, 2009) (finding no Eighth Amendment violation where the prison officials delayed cataract surgery but monitored the prisoner-plaintiff's condition, even though an optometrist recommended surgery) (**Ex. R**).

In the present case, it is clear that Plaintiff's left eye cataract does not constitute a serious medical need under either category set forth by Blackmore. 390 F.3d at 898. First, it is clear that a cataract is not a medical condition that requires immediate or emergency medical treatment, such that a layperson would recognize the need for such treatment. In fact, in this case, each of Plaintiff's treaters that requested an ophthalmology consultation request noted that the request was routine, as opposed to urgent, indicating that the requested surgery was not urgent or emergent. Furthermore, there is absolutely no evidence that Plaintiff's left eye cataract posed any risk of serious harm or permanent damage to the health of his eye. There is also no evidence that Plaintiff's cataract caused him to suffer any pain in his left eye. Rather, the evidence demonstrates that Plaintiff's left eye cataract was naturally occurring, that it was regularly and adequately monitored by both optometrists and medical doctors, that Plaintiff's treaters never believed that Plaintiff's condition posed a threat of harm to his left eye, his right eye, or any other aspect of Plaintiff's health, and that Plaintiff had near perfect vision in his right eye at all times during the relevant period. Therefore, it is clear that Plaintiff's cataract does not

qualify as an objectively serious medical need under the first Blackmore category. 390 F.3d at 895.

Furthermore, it is also clear that Plaintiff's cataracts do not constitute an objectively serious medical need under the second category discussed in Blackmore. 390 F.3d at 898. There is absolutely no verifying medical evidence in this case that Plaintiff suffered any detrimental effect as a result of any alleged delay in medical treatment with respect to his left eye cataract. Rather, the evidence demonstrates that Plaintiff eventually underwent cataract removal surgery on his left eye once his best visual acuity decreased to 20/50 and Dr. Dastgir reported concern regarding Plaintiff's complaint of binocular double vision in February 2008. (**Ex. F, pp. 32-36**) Thereafter, cataract surgery performed on the left eye in the same manner as his right eye cataract surgery in 2004, and Plaintiff had near perfect results, with an improved visual acuity in his left eye of 20/25. (**Ex. F, p. 362**). Plaintiff underwent cataract surgery at an appropriate time and had excellent results. The decision process of the MSAC was consistent with similar guidelines relied on by the Federal Bureau of Prisons (**Ex. J**), Aetna (**Ex. K**), and Medicare/Medicaid (**Ex. L**). There is absolutely no evidence that Plaintiff suffered any detrimental effect of any alleged delay in receiving the second eye cataract surgery. Therefore, it is also clear that Plaintiff's left eye cataract did not constitute an objectively serious medical need under the second category contemplated by Blackmore. 290 F.3d at 898.

B. There Was No Subjective Knowledge Of A Risk Of Harm That Was Deliberately Disregarded

In order to succeed on his claim of deliberate indifference, Plaintiff must also satisfy a subjective element. Comstock, 273 F.3d at 702. In order to satisfy this subjective component, a prisoner must demonstrate that the official being sued subjectively perceived facts from which to infer substantial risk to the prisoner, that he did in fact draw the inference, and that he then

disregarded that risk. Farmer, 511 U.S. at 837. In other words, a plaintiff must show that "an official who actually knew of the serious medical need possessed a sufficiently culpable state of mind" Perez, 466 F.3d at 423. A prison official's subjective state of mind must manifest "deliberateness tantamount to intent to punish." Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994). Thus, the Supreme Court has held that "an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for condemnation, cannot . . . be condemned as the infliction of punishment." Farmer, 511 U.S. at 838.

A complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim under the Eighth Amendment. Estelle, 429 at 105-106. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. Id. Thus, it is well settled that courts do not typically intervene in questions of medical judgment. Youngberg v. Romeo, 457 U.S. 307, 321 (1982). "Where a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims which sound in state tort law." Westlake v. Lucas, 537 F.2d 857, 860 n. 5 (6th Cir. 1976). Therefore, mere disagreement with medical judgment is insufficient to establish deliberate indifference. *See* Estelle, 429 U.S. at 105-107.

For example, in Rowe v. Rivera, the Court was faced with an INS detainee's complaint that the defendants were deliberately indifferent to his serious medical needs. 2000 U.S. Dist. LEXIS 9097 (D. N.H. June 15, 2000) (**Ex. S**). The plaintiff was originally detained in INS custody in Merrimack County, New Hampshire, where he was diagnosed with a cataract in his right eye, a physician recommended that he undergo cataract surgery, and the surgery was authorized and scheduled. Id. at *3-6 (**Ex. S**). Before the surgery occurred, however, the

plaintiff was transferred to the Hillsborough County Department of Corrections. Id. at *6 (**Ex. S**). Although the physician at Hillsborough was notified that the plaintiff was previously authorized and scheduled to have cataract surgery, the physician examined the plaintiff, noted that his vision in his left eye was 20/20, expressed that he could not examine the back of the plaintiff's eye to determine whether there was retinal detachment, and recommended that the plaintiff be referred for surgery only after he was released from the jail. Id. at *7 (**Ex. S**). The physician then monitored the condition of the plaintiff's eye, found that the eye was stable, and that there was no rush for the surgery. Id. at *17 (**Ex. S**). The plaintiff was then released prior to receiving the surgery. Id. (**Ex. S**). The court, in addressing the merits of Plaintiff's claims held as follows:

> Based on the evidence provided for summary judgment, it is undisputed that [plaintiff] received medical attention pertaining to his cataract condition, although he did not receive surgery to remove the cataract. The record shows a difference of opinion among the doctors that examined [plaintiff] as to the appropriate course of treating the cataract. Disagreement among medical professionals as to the proper course of treatment does not give rise to a constitutional violation.

Id. at *19 (**Ex. S**). Similarly, in the case of Samonte v. Bauman, the Ninth Circuit Court of Appeals, held that the decision of a physician, who was the medical director of a correctional facility, to refuse to authorize cataract surgery after another physician previously determined that such surgery was an option amounted to a "difference of medical opinion," which was insufficient by itself to raise a triable issue of deliberate indifference. 264 Fed. Appx. 634, *3-4 (9th Cir. 2007) (**Ex. T**). *See also* Edwards, 1997 U.S. Dist. LEXIS 15089, at *9-10 (finding that the plaintiff's complaint that he was denied surgery to remove a cataract from his eye amounted to a disagreement with the medical judgment of his medical care provider, which failed to amount to deliberate indifference) (**Ex. M**); Espinosa v. Saladin, 2009 U.S. Dist. LEXIS 87199,

at *6-7 (W.D. Mich. Sept. 23, 2009) (finding that the decision of a medical doctor to deny cataract surgery, which was recommended by an ophthalmologist, when Plaintiff maintained acceptable vision in his other eye and the medical doctor believed that cataract surgery was not medically necessary amounted a matter of medical judgment, not deliberate indifference) (**Ex. U**); Williams v. Miles, 2009 U.S. Dist. LEXIS 57833 (S.D. Va. July 7, 2009) (finding that Plaintiff's complaints that he did not timely receive recommended cataract surgery amounted to differences of medical opinion that did not rise to the level of an Eighth Amendment violation where the plaintiff's cataract was monitored on numerous occasions by an eye doctor) (**Ex. V**).

In the present action, Plaintiff cannot satisfy his burden with respect to the subjective element of his claims against either Dr. Hutchinson or Dr. Mathai. As argued above, neither Dr. Hutchinson nor Dr. Mathai had sufficient personal involvement in the present action, as the authority to deny or authorize Plaintiff's cataract surgery rested solely with the MDOC CMO, Dr. Pramstaller. Even if, assuming *arguendo*, they were sufficiently personally involved, the MSAC CMO's decision to deny or approve Plaintiff's cataract surgery can not be attributed to them and was a question of medical judgment, not deliberate indifference. Plaintiff was not denied medical care throughout the period in question, and, in fact, was seen on numerous occasions by nurses, the MSP, various optometrists, and the ophthalmologist throughout the period in question, all of whom monitored the health of Plaintiff's eyes. The decisions of the MSAC concerning whether to provide Plaintiff left eye cataract surgery were consistent with national standards set forth in the Federal Bureau of Prisons (**Ex. J**), Aetna (**Ex. K**), and Medicare/Medicaid (**Ex. L**).

Plaintiff always maintained a visual acuity in his right eye of 20/20 to 20/30,[23] his intraocular pressure was always within the normal range (which demonstrated that Plaintiff did not have glaucoma), Plaintiff did not have diabetes and therefore was not at any appreciable risk for retinopathy, and Plaintiff's ocular health, as well as his overall health were continuously monitored through the period in question. While some of Plaintiff's treaters believed that Plaintiff was a candidate to undergo left eye cataract removal surgery, other medical doctors involved in his care and treatment determined that it was not medically necessary. This disagreement between Plaintiff's treaters does not amount to deliberate indifference. Rowe, 2000 U.S. Dist. LEXIS 9097, at *19 (**Ex. S**).

Once it was determined that the second cataract surgery was medically necessary (when Plaintiff's visual acuity decreased to 20/50 and Dr. Dastgir was concerned about Plaintiff's newly reported binocular double vision), the MSAC authorized the surgery, Plaintiff's cataract was removed, and his best corrected visual acuity in both eyes improved to 20/25. While Plaintiff is apparently dissatisfied with having to live with a cataract on his left eye for a period of time, the determination of whether to authorize the second cataract surgery throughout the period in question was a matter of medical judgment. Plaintiff's medical condition was constantly monitored and the determination of whether to authorize the cataract surgery was considered numerous times until it was eventually determined to be medically necessary. Plaintiff's dissatisfaction amounts to a difference of medical opinion, which does not rise to the level of an Eighth Amendment violation. Therefore, as there is no genuine issue with respect to the subjective element of Plaintiff's deliberate indifference claim, summary judgment should be entered in favor of Dr. Hutchinson and Dr. Mathai.

[23] The only period of time in which Plaintiff's best corrected visual acuity in his right eye deteriorated beyond 20/30 was between May 30, 2007 and February 6, 2008, when Plaintiff developed a secondary cataract on his right eye, which was corrected with laser surgery. (**Ex. F, pp. 363, 364**).

Argument III: Defendant CMS Should Be Granted Summary Judgment Because The Evidence Is Insufficient For Reasonable Persons To Conclude: That They Maintained An Unconstitutional Policy, Practice, Or Procedure; That Anyone Relied Upon Any Such Policy, Practice, Or Procedure; Or That The Execution Of Any Such Policy, Practice, Or Procedure Proximately Caused Any Harm Or Injury To Plaintiff.

Finally, Defendant CMS is entitled to summary judgment as a matter of law because there is absolutely no evidence that CMS maintained an unconstitutional policy, practice, or procedure that anyone relied upon thereby resulting in injury to Plaintiff.

While municipalities may be subject to suit under 42 U.S.C. § 1983, it is not enough for a Plaintiff to merely allege liability on a theory of *respondeat superior*. Monell v. Dep't of Social Services of New York City, 436 U.S. 658, 691, 98 S.Ct. 2018 (1978). "Instead it is when execution of a government's policy . . . inflicts the injury that the government as an entity is responsible under § 1983." *Id.* at 694. In order to satisfy the requirements set forth in Monell, a Plaintiff must identify a particular policy, connect the policy to the municipality, and demonstrate that the particular constitutional violation alleged resulted from the execution of that policy. Garner v. Memphis Police Dep't, 8 F.3d 358, 364 (6th Cir. 1993). While Monell involved a municipality, it is clear that the holding extends to private corporations, such as CMS, as well. Street v. Corrections Corporation of America, 102 F.3d 810, 817-18 (6th Cir. 1996). Based upon these standards, it is clear that Plaintiff cannot establish liability as to CMS.

First, it is abundantly clear that any attempt by Plaintiff to hold CMS vicariously liable under a theory of *respondeat superior* must clearly fail as a matter of law. While CMS was under contract with the State of Michigan to provide certain health care services to certain inmates incarcerated within the MDOC system and employed/contracted with various healthcare

providers to provide those services, CMS may not be held liable under 42 U.S.C. § 1983 for any of the actions of any of its employees or independent contractors.

Furthermore, there is absolutely no evidence of any policy, practice, or procedure connected to CMS in any way that was at issue in this case. The only criteria at issue concerning authorization for second eye cataract surgery belongs to the MDOC. In fact, Plaintiff's Complaint is completely devoid of any such allegations and should be dismissed for failure to state a claim upon which relief can be granted against CMS as a result of such failure. There is also no evidence in this case that any particular person relied upon any such policy, practice, or procedure of CMS, or that any such reliance proximately caused any alleged injury suffered by Plaintiff. Therefore, Defendant CMS is entitled to summary judgment as a matter of law.

The only evidence of any policy, practice, or procedure that was at issue in any manner in this case is with respect to a set of criteria developed by and solely attributable to the MDOC. Dr. Pramstaller testified that all requests for second eye cataract removal surgeries had to go through the MSAC and the evidence demonstrates that Dr. Pramstaller, as the Chief Medical Officer of the MDOC was the only person on the MSAC with the authority to make a determination to authorize the requested surgery. (**Ex. I, p, 79; Ex. H, ¶E.26; Ex. C, pp. 60-61**). According to Dr. Pramstaller's criteria, a patient would be authorized to receive second eye cataract surgery if the patient had any of three conditions: 1) diabetic retinopathy; 2) posterior subcapsular glare; or 3) great discrepancy in vision. (**Ex. I, pp. 54-58, 76**). Removal of the cataract in the second eye could also be authorized if other circumstances made the surgery medically necessary, as authorization determinations were made on a case by case basis. (**Ex. I, p. 77**). In the present case, Plaintiff received his second eye cataract surgery in line with the

criteria established by Dr. Pramstaller as soon as it became known that Plaintiff satisfied the criteria (i.e., had a documented discrepancy in vision). (*See* **Ex. F, pp. 35-36, 31, 32**).

While Dr. Pramstaller developed criteria as to whether a second eye cataract surgery should be authorized, there is absolutely no evidence that the execution of Dr. Pramstaller's second eye cataract surgery criteria resulted in any harm or injury to Plaintiff. Plaintiff underwent cataract surgery on his left eye (the second eye) on April 15, 2008. (**Ex. F, p. 190**). Plaintiff's left eye cataract was removed with the exact same procedure as his right eye cataract was removed four years earlier. After his surgery was completed and his eye healed from the surgery, Plaintiff's best corrected visual acuity in both eyes improved to 20/25. (**Ex. F, p. 362**). The only evidence demonstrates that Plaintiff's second eye cataract surgery was successful and that Plaintiff suffered absolutely no harm as a result of the surgery. Therefore, the criteria established by and relied upon by Dr. Pramstaller is not unconstitutional.

Furthermore, the MDOC's criteria concerning cataract surgery is in line with and, in some cases, more accommodating than the criteria established by other organizations for purposes of determining whether second eye cataract surgery should be authorized. For instance, under the guidelines established by the Federal Bureau of Prisons ("FBOP"), a prisoner may only receive second eye cataract surgery if the prisoner has a documented best corrected visual acuity of 20/100, or under certain other exceptional circumstances, which would not apply to Plaintiff. (**Ex. J**). In the present case, Plaintiff received the second eye cataract surgery at an earlier stage than required under the FBOP guidelines, as his best corrected visual acuity was found to be 20/50 at the time in which he received his second eye cataract surgery. (*See* **Ex. F, pp. 35-36**).

The MDOC's criteria were also functionally the same as that established by Aetna, one of the nation's leading insurance companies. According to the policy established by Aetna,

cataract surgery is considered medically necessary for members with a best corrected visual acuity of 20/50 or worse if the member perceives that his ability to carry out daily functions (i.e., driving, watching television, occupation/vocational needs, etc.) is impaired, the member has a visual acuity of 20/50 or worse in the affected eye, and the member is educated about the risks and benefits of cataract surgery as well as alternatives, or if the member has some other condition, such as a lens-induced disease (e.g., certain types of glaucoma) or there is a need to visualize the retina in patients with conditions, such as diabetes. (**Ex. K**). Here, Plaintiff received his second eye cataract surgery at the same time that he would have been be eligible for the surgery under Aetna's guidelines. (**Ex. F, pp. 35-36**).

Finally, the MDOC's criteria were also functionally the same as the guidelines established by the Centers for Medicare and Medicaid Services applicable to Medicare/Medicaid eligible persons in Michigan. **(Ex. L)** According to the Medicare/Medicaid guidelines, cataract removal surgery is only medically necessary if the following criteria are met: 1) the patient has a decreased ability to carry out activities of daily living including reading, watching television, driving, or meeting occupational/vocational expectations; 2) the patient has a best corrected visual acuity of 20/50 or testing shows one of the following: a) consensual light testing decreases visual acuity by two lines or b) glare testing decreases visual acuity by two lines; 3) the patient has determined that he is no longer able to function adequately with current visual acuity; 4) other eye diseases (e.g., macular degeneration or diabetic retinopathy) have been ruled out as the primary cause of decreased visual acuity; 5) significant improvement in visual function can be expected as a result of cataract extraction; 6) the patient has been educated as to the risks and benefits of cataract surgery and the alternatives to surgery; and 7) the patient has undergone an appropriate preoperative ophthalmologic evaluation. (**Ex. L**). Furthermore, if the decision to

perform bilateral cataract extraction surgery is made, the documentation must support the medical necessity for each procedure to be performed. (**Ex. L**). Under these guidelines, Plaintiff received cataract surgery on his left eye the first time that Plaintiff's documented condition satisfied the Medicare/Medicaid guidelines.

There is absolutely no evidence in this case that CMS maintained any policy, practice, or procedure that was relied upon by anyone in providing medical care and treatment to Plaintiff and which resulted in any injury to Plaintiff. The only policy, practice, or procedure at issue was criteria established and relied upon solely by the MDOC, and the evidence demonstrates that the policy is consistent with recognized standards and execution of this policy did not proximately cause any injury or harm to Plaintiff. Furthermore, the criteria established by the MDOC are similar to or more accommodating than criteria established by other organizations dealing with both incarcerated and unincarcerated individuals. Defendant CMS is entitled to summary judgment as a matter of law.

RELIEF REQUESTED

WHEREFORE, the Defendants, CORRECTIONAL MEDICAL SERVICES, INC., CRAIG HUTCHINSON, M.D., and BENCY MATHAI, M.D., pray that this Honorable Court shall grant their Motion For Summary Judgment Pursuant To Fed. R. Civ. P. 56, enter summary judgment in their favor as a matter of law, dismiss Plaintiff's claims against them in their entirety with prejudice, and tax all reasonable costs and attorney fees against Plaintiff where permitted.

Respectfully submitted,

Dated: December 1, 2009

s/Brian J. Richtarcik
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PROOF OF SERVICE

I hereby certify that on December 1, 2009, I presented the foregoing paper to the Clerk of the Court for filing and uploading to the ECF system, which will send notification of such filing to the attorneys of record listed herein and I hereby certify that I have mailed by US Postal Service the document to the involved non participants.

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