UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

DALLAS COBBS, #164276,

Plaintiff,

vs.

GEORGE J. PRAMSTALLER, *et al.*,

Defendants.

File No. 07-CV-14644

Hon. Anna Diggs Taylor

Mag. Judge Charles E. Binder

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PLAINTIFF'S BRIEF IN RESPONSE
TO MDOC AND CMS DEFENDANTS' MOTIONS FOR SUMMARY JUDGMENT

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STATEMENT OF ISSUES PRESENTED

1. Did the MDOC and CMS defendants' denial of Mr. Cobbs' left-eye cataract surgery from 2004 to 2008 constitute deliberate indifference to his serious medical needs in violation of his Eighth Amendment rights?

   The plaintiff says yes.

2. Did the senior MDOC and CMS defendants participate directly in denying treatment?

   The plaintiff says yes.

3. Were the customs and policies of the MDOC and CMS, Inc., as applied by senior MDOC and CMS officials, a proximate cause of the denial of treatment?

   The plaintiff says yes.

4. Was the law clearly established in 2004 that failure to treat an obvious serious medical need is a violation of the Eighth Amendment, such that MDOC officials are not entitled to qualified immunity?

   The plaintiff says yes.

THE LEGAL STANDARD AND CONTROLLING AUTHORITIES

For summary judgment to be granted, the defendants must show that there are no genuine issues of material fact and that they are entitled to judgment as a matter of law. *Celotex Corp. v. Catrett,* 477 U.S. 317, 322 (1986); *Horton v. Potter*, 369 F.3d 906, 909 (6th Cir. 2004). The evidence and all reasonable inferences must be construed in the light most favorable to the plaintiff. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp*., 475 U.S. 574, 587 (1986). Any direct evidence offered by the plaintiff in response to a summary judgment motion must be accepted as true. *Muhammad v. Close*, 379 F.3d 413, 416 (6th Cir. 2004).

To prove an Eighth Amendment claim, the plaintiff must show that the defendants were deliberately indifferent to his serious medical needs. *See Estelle v. Gamble,* 429 U.S. 97, 104 (1976); *City of Canton v. Harris*, 489 U.S. 378, 392 (1989). A serious medical need is a medical need "that has been diagnosed by a physician as mandating treatment." *Perez v. Oakland County*, 466 F.3d 416, 423 (6th Cir. 2006).

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INTRODUCTION AND PROCEEDINGS TO DATE

Plaintiff Dallas Cobbs filed this § 1983 lawsuit *in pro per* in October 2007, after failing to get cataract surgery for almost four years. He named as defendants Michigan Department of Corrections (MDOC) chief medical officer Dr. George Pramstaller, the Bureau of Health Care Services, the Medical Services Advisory Committee (MSAC – which makes the final decision to grant or deny "specialty care" that cannot be provided internally by medical staff), and various unknown John Doe defendants. Mr. Cobbs sought damages and injunctive relief for the defendants' collective failure to approve cataract surgery that his treating doctors, as well as all consulting eye specialists, had unanimously been requesting since the spring of 2004.

Instead of reviewing the case and conceding that the denials were in error, defendant Pramstaller filed a motion to dismiss in January 2008. The motion stated that Pramstaller had nothing to do with the decision to deny the surgery and could not be held liable on a theory of *respondeat superior*. *See* R. 12, Defendant's Motion for Summary Judgment. Mr. Cobbs' responded by filing a motion to stay Pramstaller's summary judgment motion so that he could get limited discovery to prepare a response brief and identify the other members of the MSAC who had denied his doctors' surgery requests. *See* R. 17, Motion for Stay. Mr. Cobbs attached documents showing that Pramstaller and the MSAC had reviewed his doctors' repeated requests for the cataract surgery, and had denied them. *Id.*

In February 2008 the undersigned counsel agreed to represent Mr. Cobbs, and so notified the defendants' counsel. Shortly thereafter, Mr. Cobbs was informed that his cataract surgery had been approved. In April 2008, following a status conference, the Court issued a series of orders. Defendant Pramstaller's pending motion to dismiss was withdrawn, and motions filed by the *pro se* plaintiff were also withdrawn. *See* R. 29 and 34. On June 4, 2008, the Court granted

leave for Mr. Cobbs to file an amended complaint and to conduct limited discovery. *See* R. 37 Order.

In June 2008, now by the undersigned counsel, Mr. Cobbs filed his amended complaint. *See* R. 38. He dropped the Bureau of Health Care Services and the MSAC as separately named defendants, while adding the individual MSAC members (who had since been identified by the defendants, *see* R. 34, Request for Identification of John Does), as well as the contract medical provider Correctional Medical Services, Inc., (CMS) and its state medical director Dr. Craig Hutchinson.[1]

After limited discovery, in September 2008 the MDOC defendants filed a motion for summary judgment, arguing that Mr. Cobbs had failed to make out a constitutional claim, and that the state defendants were shielded from liability by the doctrine of qualified immunity. R. 66, MDOC Defs' Motion for Summary Judgment. In December 2008, Magistrate Judge Charles E. Binder entered a report and recommendation granting the motion as to injunctive relief (because by then Mr. Cobbs' cataract had finally been removed), but denying the motion in all other respects. *See* R. 77, Report & Recommendation. Following objections, in February 2009 the Court adopted the R&R. *See* R. 82, Order Adopting R&R. Full discovery then commenced.

In May 2009, the CMS defendants filed a motion to dismiss on the grounds that Mr. Cobbs had failed to exhaust his administrative remedies and/or had failed to follow procedural requirements of the prison grievance process. *See* R. 86, CMS Defs' Motion to Dismiss. After full briefing, in July 2009, the Magistrate Judge issued a second R&R denying the motion. *See* R. 94, R&R. Following another round of objections, in September 2009 the Court adopted the

[1] At all relevant times, CMS contracted with the MDOC to provide medical care to Michigan prisoners, including primary care within the prisons and specialty care on the outside. Mr. Cobbs' counsel suspected, but as of the filing of the amended complaint could not yet know or prove, that MDOC/CMS customs and policies (as to cataracts) were at least in part to blame for the repeated denials of his cataract surgery.

R&R. *See* R. 97, Order Adopting R&R. In the meantime, Mr. Cobbs voluntarily dismissed his claims against four individual defendants (two psychiatrists and two dentists), once it was established that they did not participate in the Medical Services Advisory Committee's denials of the requests for eye surgery. *See* R. 90 and 105, Stipulations and Orders to Dismiss.

In November 2009 the parties completed discovery. As will be shown below, the plaintiff submits that, based on the document discovery, as well as the depositions of Pramstaller and Hutchinson, the primary care physician Dr. Paul Piper, the optometrist Dr. Robert McGrath, an interview with the opthmalogist Dr. Ghulam Dastgir, and the deposition of CMS utilization review nurse Brenda Jones, Mr. Cobb's case is now far stronger than it was when the Court denied the defendants' first motion for summary judgment.

STATEMENT OF FACTS

A. Background Information and the Off-Site Review Process

At all relevant times Dallas Cobbs was in the custody of the MDOC at the Ryan Correctional Facility in Detroit. *See* Updated Cobbs Declaration (12/09), Exh. A, at 1; *and* R. 38, First Amended Complaint, at ¶ 6. In 2004, Mr. Cobbs began having significant vision problems due to cataracts in both eyes.[2] *See* Medical Records, Exh. C, at 3. It is undisputed that the only treatment for cataracts is surgical removal. Such treatment is virtually automatic in the U.S. with the patient's consent, absent a medical reason that would counsel against the surgery. *See* Decl. of MDOC Contract Ophthalmologist (Ghulam Dastgir), Exh. M, at 1; Decl. of Pl's Expert (Ophthalmologist Alan Sugar), Exh. N, at 2-3. It is also undisputed that all times Mr. Cobbs wanted the surgery, and that there was no *medical* reason that would counsel against the surgery.

[2] For all Michigan prisoners, "Health care…shall be available…*consistent with contemporary standards of medical practice in the community*, as set forth in PD 03.04.100 „Health Services.' Health care shall be available, accessible and organized for delivery in a humane, cost-effective and efficient manner." *See* Policy Directive 03.03.130, Exh. B, at 2, ¶ G (emphasis added).

Because cataract surgery is a kind of care that MDOC/CMS doctors do not perform themselves, a request for "specialty care" must be submitted to CMS by the prisoner-patient's treating doctor (or medical staff) for such care. *See* Pramstaller Dep., Exh. H, at 18-22; Hutchinson Dep., Exh. I, at 14-16; OP 03.04.100 (Review and Appeals Process for Off-Site Health), Exh. B, at 14-16; Jones Dep, Exh. J, at 19-22.

The MDOC/CMS off-site specialty care review process works as follows. The treating physician (or a consulting specialist) typically must submit a form to CMS's utilization review (UR) department, requesting any specialty care that is not provided on site by MDOC/CMS doctors. *Id.* Pursuant to CMS's own policies, UR nurses can approve certain treatments but can never deny treatment. *See* Jones Dep., Exh. J, at 31-32, 40, 71 Denials are made by a CMS supervisory doctor in the UR department, or by the CMS state medical director.[3] *Id.,* also at 27.

The UR department has three choices: it can approve the request; it can deny the request; or it can "pend" the request for more information. *Id.*; OP 03.04.100, Exh. B, at 14-15. In making the decision whether or not to approve specialty care, CMS relies in part on proprietary commercial UR services (InterQual and Millman & Robertson) that provide standardized utilization practices via computer access. Jones Dep., Exh. J, at 18-19, 24-27. For almost any specialty care, the UR nurses access these services, or rely on books that serve much the same purpose, and recommend approval or denial based in part on them. *Id.*

If the request is approved, the off-site referral will be scheduled and the patient will be called out and transported to the provider on the appointed day. The CMS request and response forms become part of the prisoner's medical record. Piper Dep., Exh. G, at 14-15.

If the request is "pended," the requesting medical provider will submit whatever new or

[3] Defendant Hutchinson was the CMS state medical director from 2004 to 2007, and defendant Mathai was the CMS state medical director from 2007 to 2008. Hutchinson Dep., Exh. I, at 10, 13.

additional information the UR department asks for, at which point the UR office will make a decision. *See* OP 03.04.100, Exh. B, at 14-16.

If the request is denied, the requesting medical provider can appeal the decision. The first-level appeal (done by filling out another part of the request form) goes to CMS's UR medical director/supervisor (typically the same person who denied the case initially). *Id.* If that doctor denies the request again, the requesting medical provider can submit a second appeal to the MDOC's regional medical officer. That person makes sure the file is complete, and then forwards the request to the chief medical officer (Pramstaller), who brings it to the Medical Services Advisory Committee at its next monthly meeting. *Id.*

Contrary to what the CMS defendants state, *see* CMS Defs' Brief, at 4, the MSAC then decides the appeal by consensus. If consensus cannot be reached, then (and only then) does the chief medical officer decide the case himself. *See* Operating Procedure 03.04.100, Exh. B, at 16, ¶¶ 26-27; Pramstaller Dep., Exh. H, at 42-43.

B. The Facts of Mr. Cobbs' Case

The plaintiff mostly agrees with the CMS defendants' account of his medical history from 2004 to 2008. It will be re-summarized here, however, because the CMS defendants paraphrase many reports that are more telling when they are quoted, and the defendants characterize certain acts or omissions inaccurately.

In March 2004, Mr. Cobbs' saw a CMS contract optometrist to address his worsening vision caused by the cataracts in both his eyes. The optometrist, Dr. Michael McGrath, recommended that he be seen by an ophthalmologist. CMS denied the request because Mr. Cobbs' vision in his left eye (the eye with the less-advanced cataract) was 20/40. Medical Records, Exh. C, at 5. Mr. Cobbs' primary care physician (Dr. Paul Piper) appealed the CMS denial. *Id.* CMS

again denied the request for the same reason: "Not authorized ophthalmology consult for cataracts. Criteria for cataract removal not met since vision [left eye] = 20/40." *Id.*; *see also* Care Enhance Records, Exh. L, at 1.

Dr. Piper appealed again, noting that Mr. Cobbs was legally blind in his right eye and had 20/40 vision in his left eye. "I think cataract surgery is indicated if it will correct vision." Medical Records, Exh. C, at 6. The appeal went to the MDOC regional medical director, and then to the MSAC.

On June 22, 2004, the MSAC issued a memorandum approving the ophthalmology consult and the cataract surgery for the more advanced right-eye cataract.[4] The MSAC's decision is hard to explain, because at this point the vision in Mr. Cobbs's left eye was still 20/40. That is, nothing had changed from the earlier decisions, which had denied the ophthalmology consult *because* the vision in Mr. Cobbs' good left eye was 20/40. Thus, if the standard to be applied was that first-eye cataract surgery would not be approved until the better eye was 20/50 or worse, *see* Hutchinson Dep., Exh. I, at 27, then the right-eye cataract surgery should have been denied by the MSAC *on that basis*.

In fact, the MSAC did not approve the cataract surgery based on any new *medical* reason, but rather because of Mr. Cobbs' "lifer status." Medical Record, Exh. C, at 8; Piper Dep., Exh. G, at 51-53. The implication of the decision is that since Mr. Cobbs was not going to be released any time soon, and because he was legally blind in his right eye, he might as well have the surgery, even though he did *not* meet the MDOC/CMS criteria for first-eye surgery because his best corrected vision in his less-affected left eye was still better than 20/50.

[4] The plaintiff agrees with the CMS defendants that for this approval it appears that the MSAC and/or CMS's UR people mistakenly approved tests and treatment for Mr. Cobbs' *left* eye when they meant to approve tests and treatment for his right eye, which may have caused the ophthalmologist to believe that preliminary approval for both eyes had been granted. *See* CMS Defs' Brief, at 5, notes 8 and 9.

On July 27, 2004, Mr. Cobbs had a consultation with ophthalmologist Dr. Ghulam Dastgir. *Id*., Exh. C, at 11-14. By that time the examination showed a "hypermature nuclear and posterior sub-capsular cataract in the right eye" and "a dense posterior sub-capsular cataract" in the left eye. By July Mr. Cobbs' best corrected vision in his right eye had regressed to "hand motion to finger counting" at six inches, while the left eye was "down to 20/70 ... with glasses, *but with glare it dropped down to 20/400*." *Id.,* at 13*;* Piper Dep., Exh. G, at 55, 60-61 (emphasis added). Dr. Dastgir also noted that Mr. Cobbs was unable to see out of his right eye and "has *double vision with [left eye] – 6 months – it is getting worse*." "*[Patient] going blind.*" Medical Records, 7/27/09, Exh. C at 12, 13 (emphasis added); Piper Dep., Exh. G, at 57-58 (interpreting Dr. Dastgir's difficult handwriting). Dr. Dastgir recommended cataract surgery and lens implants in *both* eyes, the right eye first and the left to follow "a few weeks later," and scheduled Mr. Cobbs for scans of both eyes in preparation for the surgery. *Id.,* Exh. G, 59-60; Medical Records, Exh. C, at 13-14. Dr. Piper sent a follow-up authorization request for Dr. Dastgir's "plan of management" to CMS, which approved the cataract removal surgery and lens implant for the left eye.[5] Medical Records, Exh. C, at 10, 15.

On August 23, 2004, Dr. Dastgir performed scans on Mr. Cobbs' left and right eyes, and had him sign a "consent for cataract extraction with lens implant[s] in both eyes." *Id*., at 15, 18. Dr. Dastgir noted that Mr. Cobbs would undergo both operations "in the very near future." *Id.* On August 30, 2004, Dr. Dastgir performed the cataract surgery on Mr. Cobbs' right eye at the Blake Woods Surgery Center. Exh. C, at 19. Dr. Dastgir saw Mr. Cobbs the following day and told him that the left-eye surgery would be scheduled shortly and that Mr. Cobbs would return for removal of his left-eye cataract according to the original treatment plan. *Id*., at 19, 22, 24.

[5] *See* note 4: the CMS UR approvals were apparently for the wrong eye.

That same day, Dr. Piper similarly noted on Mr. Cobbs' medical chart that he was to have cataract surgery on his left eye. *Id.* at 25; Piper Dep., Exh. G, at 65-66.

On September 7, 2004, Mr. Cobbs was told that the surgery on his left eye needed to be re-scheduled because it had been inadvertently set for the Labor Day holiday.[6] *See* Grievances, Exh. D, at 1. When six weeks passed without Mr. Cobbs hearing anything about the surgery, he sent an inquiry to health services. *See* Health Care Requests (Kites), Exh. E, at 1. On September 15, 2004, Mr. Cobbs saw the optometrist Dr. McGrath to get new glasses following his right-eye surgery. Dr. McGrath wrote in his progress notes, "Patient *needs* surgery for cataract [left eye] – F/U [follow-up] for cataract surgery." Medical Records, Exh. C, at 26. On October 7, 2004, Dr. Piper examined Mr. Cobbs at Ryan, and sent an ophthalmology request to CMS, citing Dr. Dastgir's treatment plan that Mr. Cobbs was to have the second cataract operation. Medical Records, Exh. C, at 27.

At that point (October 7, 2004), based on records that had already been submitted to CMS, the CMS UR office knew that the vision in Mr. Cobbs' left eye had deteriorated *as of July* to at least 20/70 without glare, to 20/400 with glare, that he had had double vision in his left eye *as of July* for six months that was getting worse, and that he had a dense posterior sub-capsular cataract. *See* Medical Records, Dastgir Exam and Opth. Notes of 7/27/04, Exh. C, at 12-13.

CMS "pended" the request and then forwarded it directly to the MSAC. Dr. Pramstaller testified that the MSAC would approve second cataract surgeries if the patient suffered from sub-capsular glare or if the patient had a great discrepancy in vision. *See* Pramstaller Dep., Exh. H, at 54-58. Despite Dr. McGrath's request for surgery, Dr. Piper's request for surgery, Dr. Dastgir's treatment plan for surgery, and the undisputed fact that Mr. Cobbs suffered from sub-cap-

[6] Mr. Cobbs' memory has differed as to exactly when the left eye surgery was to occur, but plainly it was to be relatively soon after the first surgery was completed on August 31, 2004. *Compare* Exh. A, Cobbs Updated Declaration, ¶ 6 (about six weeks later) *and* Grievances, Exh. D, at 1 (about one week later).

sular glare *and* had a huge disparity in vision *and* had suffered from double vision in his left eye for six months as of July 2007, the MSAC denied the left-eye surgery by consensus on October 26, 2004. *See* Pramstaller Memo, Medical Records, Exh. C, at 29.[7] The denial form said only that the denial was issued because "criteria not met." *Id.* Boilerplate language on the form said, "should other information become available, the MSAC will be happy to re-evaluate." *Id.*

On November 29, 2004, Mr. Cobbs sent another health care request (kite) asking if his surgery had been scheduled. Kites, Exh. E, at 1. To this point no one had told Mr. Cobbs that his left-eye surgery had been denied, nor had he been given a reason for the ongoing delay. When he learned that the MSAC had denied his surgery, he filed a grievance, citing Dr. Dastgir's treatment plan and asking for an explanation or clarification. Grievances, Exh. D, at 1. Mr. Cobbs' grievance was rejected and he exhausted the two appeals available to him. His first appeal noted that he needed the surgery because the vision in his "left eye is getting worse by the day." *Id.,* Exh. D, at 3. The appeal was denied, citing the MSAC disapproval of 10/26/04, and stating that any "further (left) eye concerns should be directed to [Ryan medical staff] to determine if and when another surgery request will be made." *Id.,* Exh. D, at 4. His second appeal noted that his treating doctors had already said that he needed removal of his left-eye cataract. *Id.* The final denial acknowledged that the MSAC had previously approved the left eye surgery, but had rescinded that approval and that Mr. Cobbs could pay for the surgery himself if he disagreed. *Id.,* Exh. D, at 5.

Mr. Cobbs' vision in his left eye continued to fail. As a result of the surgery on his right eye and the worsening vision in his left eye, Mr. Cobbs requested new glasses in March 2005. Kites, Exh. E, at 2. He had an optometry exam at Ryan on May 10, 2005. Medical Records,

[7] The participating members of the MSAC included defendants Borgerding, Clark, Hutchinson, Naylor, and Pramstaller. *See* Identification of John Does, Exh. K.

Exh. C, at 31-32. Dr. Connolly, the examining optometrist, noted that Mr. Cobbs had a posterior sub-capsular cataract and nuclear sclerosis in his left eye. *Id.*; McGrath Dep., Exh. F, at 38. Dr. Connolly told Mr. Cobbs that he could not get a new prescription until the cataract was removed because glasses would not improve the vision in his left eye. Kites, Exh. E, at 3; Medical Records, Exh. C, at 32; McGrath Dep., Exh. F, at 38-39 (interpreting Dr. Connolly's handwritten notes). Dr. Connolly requested a specialist's evaluation (a prerequisite for surgery). Medical Records, Exh. C, at 31. Dr. Connolly's request was denied by CMS based on the denial the MSAC had issued eight months earlier (in October 2004), despite the fact that Mr. Cobbs' vision was "getting worse by the day." *Id.,* Exh. C, at 33; Grievances, Exh. D, at 3.

After submitting two more kites without getting a responsive answer, Mr. Cobbs filed another grievance on June 24, 2005, explaining his dilemma: he couldn't see without glasses, but he couldn't get glasses until he had the surgery. Grievances, Exh. D, at 6. He got a grievance response on July 14 stating that the surgery was not approved and that the optometrist he saw in May had recommended that he be re-evaluated in 6-12 months. *Id.* In fact, Dr. Connolly had recommended and requested "cataract eval and possible surgery." Medical Records, Exh. C, at 32. Mr. Cobbs' vision continued to worsen. On November 2, 2005 – 18 months after his left-eye cataract surgery was first requested – Mr. Cobbs again asked to see a doctor stating: "The vision in my left eye has gotten so bad that it has thrown off my balance and keeps me dizzy." Kites, Exh. E, at 4.

In December 2005, Mr. Cobbs had another optometry exam performed at Ryan. Medical Records, Exh. C, at 34. Dr. McGrath evaluated Mr. Cobbs and also concluded that "cataract surgery [was] *needed*." *Id.* (emphasis added). Dr. McGrath's report shows that Mr. Cobbs' best corrected visual acuity in his left eye had deteriorated to 20/600 in just seven months. *Id;* Mc-

Grath Dep, Exh. F, at 49-51. By now the cataract had become so thick that it was impossible for the doctor to view the retina in the left eye.[8] *Id.,* Exh. C, at 34; McGrath Dep., Exh. F, at 50. Dr. McGrath also reported serious side effects of Mr. Cobbs' rapidly decreasing vision: "patient has trouble w/ depth perception; … patient has also walked into objects on left side." Medical Record, Exh. C, at 34.

Again, CMS denied the doctor's request on December 28, 2005, based on the 10/26/04 MSAC denial and the fact that Mr. Cobbs "had a good response to surgery on his [right] eye." *Id.,* Exh. C, at 35; McGrath Dep., Exh. F, at 64. Dr. McGrath appealed the CMS denial on January 1, 2006, explaining that he could not screen for secondary glaucoma (because the cataract prevented him from seeing into the eye) and requesting much more frequent follow-up visits if CMS again denied the cataract surgery. Medical Records, Exh. C, at 35; McGrath Dep., Exh. F, at 65-66. (The bi-monthly and monthly follow-up visits that Dr. McGrath requested to check for glaucoma were never scheduled.)

On March 1, 2006, Mr. Cobbs had yet another eye exam at Ryan. Medical Records, Exh. C, at 36. Dr. McGrath's notes once again indicate that Mr. Cobbs *needed* left eye surgery. *Id.,* at 37. Dr. McGrath's request said, "Please approve cataract surgery [left eye]. Patient has dense cataract [left eye] with possible [secondary] glaucoma a risk factor; [left eye] no lens helps, 20/600." *Id.* CMS again denied Dr. McGrath's request on March 15, 2006, on the basis that the "MDOC/MSAC already reviewed this case [in October 2004] and have not authorized." *Id.,* Exh. C, at 38. Dr. McGrath appealed on March 29 to the MSAC, stating, "surgery advised to prevent secondary glaucoma … *no view* of left retina possible to check eye health." *Id.* (emphasis in original). On April 3, 2006, CMS sent the case to the MSAC with the note "already not

[8] Dr. McGrath's report read: "Please evaluate *dense* cataract [left eye]. … Cataract surgery needed. No view of retina in left eye." Exh. C, at 37 (emphasis in original).

authorized x 2 @ CMS." *Id.,* Exh. C, at 39. Dr. McGrath wrote on the appeal form, "patient needs cataract surgery – hypermature cataract surgery is more complicated and there is risk of [secondary] glaucoma – if denied monthly [follow-up] advised." *Id.,* Exh. C, at 39.

Nevertheless, on April 25, 2006, the MSAC "upheld non-approval for ophthalmology consult for cataract [left eye]." *Id.,* Exh. C, at 40 (emphasis in original, entry signed by Dr. Pramstaller).[9] The MSAC denial memo said only "upheld non-approval." The comments section read: "monitor closely for increase in interocular [sic] pressure and resubmit if pressure increases." Intraocular pressure is used to monitor for glaucoma. Pramstaller Dep., Exh. H, at 57. It had nothing to do with Mr. Cobbs' failed vision in his left eye or the resulting side effects.

From the end of 2004 to the spring of 2006, as the cataract in his left eye worsened, Mr. Cobbs suffered from double vision, headaches, eye strain, and glare. He bumped into things and people. He had trouble reading and watching TV or doing anything that required concentration. Cobbs' Updated Decl., Exh. A, at 8-9. By the spring or early summer of 2006, Mr. Cobbs' vision was bad enough in his left eye that he started wearing an eye patch all the time. *Id.* On May, 27, 2006, Mr. Cobbs sent a health care request stating, "I can no longer see out of the [left] eye." Kites, Exh. E, at 5. He sent another kite on June 21, 2006, saying:

> I sent a kite to see the doctor on 5/27/06 but I haven't been on call. I don't want to see the optometrist because I can't get any results to my problem seeing him. The lack of sight in my left eye is a protracted problem and something has to be done about it.

Id., Exh. E, at 5. He filed yet another kite on July 16, 2006, saying, "I have sent kite after kite to health care concerning the vision in my left eye. I need immediate attention because I can no longer see out of that eye." *Id.,* Exh. E, at 7.

Mr. Cobbs was again seen by Dr. Piper on July 27, 2006. Dr. Piper noted that Mr. Cobbs

[9] This time the participating MSAC members included defendants Clark, Ivens, Hutchinson, Mathai, Pandya, Pramstaller, and Samy. *See* Identification of John Does, Exh. K.

"has [history] of losing sight in left eye" and advised CMS to take note of the significant deterioration of Mr. Cobbs' vision since 2004. Medical Records, Exh. C, at 42. But Dr. Piper's recommendation that Mr. Cobbs be revaluated by an ophthalmologist was again denied based on the MSAC's April 25, 2006, decision not to authorize an ophthalmology consult. *Id.,* Exh. C, at 43.

Later that summer, Mr. Cobbs' father tried to intervene by writing directly to Dr. Pramstaller. Although we don't have a copy of that letter, we have a copy of the response, dated September 13, 2006. The administrator of the Bureau of Health Care Services wrote:

> Your recent correspondence to Dr. Pramstaller regarding your son Dallas Cobbs #164276 has been referred to me for response. You have asked for Dr. Pramstaller's intervention to approve and schedule surgery for [your son's] cataract ….
> Review of your son's medical records indicates that he is being monitored closely. Multiple physicians have reviewed his case and all agree with the current treatment plan.

Kites and Letters, Exh. E, at 8. The letter shows that again in the late summer of 2006, Dr. Pramstaller and senior MDOC health officials were fully aware of Mr. Cobbs' case. Moreover, what they reported to Mr. Cobbs' father was false. In fact, *every doctor, optometrist, and ophthalmologist who had examined Mr. Cobbs* <u>*disagreed*</u> with the defendants' "current treatment plan" – which was to deny surgery (and to deny even an evaluation by an ophthalmologist).

Mr. Cobbs saw an optometrist again (this time Dr. Cook) on August 25, 2006. Dr. Cook recommended that Mr. Cobbs be referred for cataract surgery on his left eye; Dr. Cook crossed out the box labeled "routine" and marked the referral as "urgent." Exh. C, at 44. Doctor Cook noted that the left eye was "opaque" and that Mr. Cobbs suffered from "extreme photophopia[10] – subjective *and objectively*" and "[wore] patch on left eye to function." *Id.* (emphasis added). Dr. Cook also noted that the "[left eye] cataract is approaching hypermaturity – condition may pre-

[10] "Photophopia" is an "aversion to light." Hutchinson Dep., Exh. I, at 109.

clude use of phacoemulsification."[11] Dr. Cook's request for cataract surgery was denied with the simple note, "See MSAC response," apparently referring to the MSAC decision of April 25, 2006. *Id.*

On October 26, 2006, Mr. Cobbs sent another kite to health care: "The loss of sight in my left eye is causing me considerable strain on my right eye and is further causing me blurred vision in my right eye, headaches, dizziness, and a loss of balance." Kites, Exh. E, at 9.

Mr. Cobbs saw the optometrist again on December 13, 2006. Dr. McGrath again filed a request for specialty care, stating, "Please evaluate & order cataract surgery [left eye]. Patient has dense cataract [left eye]. I cannot view retina and patient has developed anemia. Eye health of left eye cannot be evaluated." *Id*., Exh. C, at 46. In March 2007, CMS denied the request for surgery "based on 20/20 vision in the right eye." *Id.,* Exh. C, at 49.

As noted, in addition to his examining doctors' requests, Mr. Cobbs himself sought help repeatedly by filing numerous kites, grievances, and appeals. Amended Complaint, ¶¶ 18-86; Cobbs Updated Decl., Exh. A, ¶¶ 9-60. His 2005 requests documented his worsening eyesight. Kites, Exh. D, at 2, 3. He repeatedly conveyed his fear that if he did not have the surgery soon, he would lose all vision in his left eye. Grievances, Exh. D, at 7, 8, and 10. In 2005 and 2006, his requests described the side effects he was suffering, including headaches, dizziness, blurry or double vision in his right eye, loss of balance, loss of depth perception, and loss of peripheral vision. Kites, Exh. D, at 4, 6. As a result of these side effects, Mr. Cobbs had difficulty doing daily functions like reading, watching TV, and going up and down stairs. Decl., Exh. A, at 8-9. Mr. Cobbs' requests increased in urgency as the side effects got worse.

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[11] "Phacoemulsification" refers to the common technique used in cataract surgery in which the clouded lens is broken up or liquefied using a tiny ultrasonic tool and a suction device, which makes the surgery safer. Eye Surgery Education Council: http://www.eyesurgeryeducation.com/Phacoemulsification.html

On April 21, 2007, Mr. Cobbs sent another kite to health care, stating: "I'm experiencing double vision in my right eye. Also, I can hardly focus in my right eye." Kites, Exh. E, at 10. He had another eye exam on May 30, 2007. Med. Records, Exh. C, at 50-51. Dr. McGrath confirmed what Mr. Cobbs had been saying: the best corrected vision in his *right* eye had dropped to 20/50, which Dr. McGrath attributed in part to a small "secondary cataract" that Dr. McGrath thought was forming in the right eye. *Id.*; McGrath Dep., Exh. F, at 126. Dr. McGrath also noted that Mr. Cobbs complained of double vision in his right eye for the last two months. *Id.,* Exh. C, at 51. For the second time, an optometrist made an "urgent" referral to ophthalmology. *Id.,* Exh. C, at 50.

Despite the urgency of the request, the "dense cataract" in Mr. Cobbs' left eye, the drop in the best corrected vision in his good right eye to 20/50, the double vision in his good right eye, and the possibility of the formation of a secondary cataract in his good right eye, the request was again denied by CMS.[12] Exh. C, at 52; Care Enhance Forms, Exh. L, at 21.

In the meantime, Mr. Cobbs' pain and discomfort worsened. Mr. Cobbs sent another kite to health care on September 28, 2007, saying, "The cataract on my left eye continues to strain my right eye and is still causing me severe headaches, dizziness, and blurred vision in my right eye." Kites, Exh. E, at 11. He saw a nurse on October 5, 2007, who documented the same complaints. Medical Records, Exh. C, at 53. On October 29, 2007, he sent another kite to health care, noting that "I saw [the nurse] on [10/5/07] because I was experiencing severe headaches and dizziness.

[12] This denial is telling, because if the MDOC/CMS standard was that second cataract surgery would be approved when the vision in the good eye was worse than 20/40, *see* Hutchinson Dep. Exh. I, at 27, then this request should have been instantly granted. UR nurse Brenda Jones said that no request for cataract surgery was reviewed without consulting the accompanying optometrist's notes. Exh. J, at 40, 71. Here the optometrist's report plainly showed that the vision in the good right eye had fallen to 20/50, *and* that Mr. Cobbs had double vision in his right eye. Exh. C, at 50-51. Yet CMS routinely denied the request again in the spring of 2007, just as it had every time before!

I was not called out to see Dr. Piper as scheduled and I am still experiencing severe headaches and dizziness. I haven't been given anything for pain…." Kites, Exh. E, at 12.

On October 30, 2007, Mr. Cobbs filed this lawsuit, *in pro per*. In October and November 2007, he filed more kites and was examined by nurses at Ryan three times for severe headaches. Kites, Exh. E, at 12-13; Medical Records, Exh. C, at 55-58. Indeed, one report noted that Mr. Cobbs experienced a headache that he rated as 8 out of 10 on a pain scale. Medical Records, Exh. C, at 56; Piper Dep., Exh. G, at 90. Mr. Cobbs was not scheduled for an ophthalmology consult or for cataract surgery, based on the previous denials.

In early February 2008, Mr. Cobbs' counsel contacted the MDOC defendants' counsel about the possibility of representing the plaintiff in this action.

On February 6, 2008, Mr. Cobbs saw the optometrist Dr. McGrath again. Dr. McGrath filed the same request for an ophthalmology consult and surgery that he had been filing for four years: "Please evaluate double vision, patient is wearing patch to eliminate double vision." [13] *See* Medical Records, Exh. C, at 59. CMS approved the request on February 12, 2008. Care Enhance Records, Exh. L, at 23.

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[13] In deposition, on leading questions from his own counsel, Dr. McGrath (at various times) described Mr. Cobbs' double vision in February 2008 as both "monocular" (meaning that he was getting a double image in his right eye) *and* as "binocular" (meaning that he was getting a double image from both eyes). *See* McGrath Dep., Exh. F, at 126 and 128-29. The CMS defendants suggest, *see* CMS Defs' Brief at 11, that this was somehow something "new" that at long last justified CMS's approval of an ophthalmology consult after four years of denials. The Court should not be taken in by this argument, for two reasons. First, Mr. Cobbs had been effectively blind in his left eye since at least early 2006. His complaints thereafter had always been of blurred and double vision *in his good right eye* (caused by the strain on that eye). In February 2008 he could not have had "binocular" double vision because he couldn't see out of his left eye at all. Second, the paperwork on the ophthalmology consult request of 2/7/08 did not highlight that the complaint was of a new or different nature. Medical Records, Exh. C, at 59-60. Indeed, the paperwork was unusual only for (1) the speed with which CMS approved it, and (2) the fact CMS did not ask for supplemental information. Indeed, the paperwork was nearly identical to the April 2007 request (that had been routinely denied), as well as to what Mr. Cobbs and his treating doctors had been providing for the past four years. *Id.* The *only* thing that had changed was that Mr. Cobbs was about to get a lawyer, and/or that Dr. Pramstaller's motion to dismiss was about to be denied because he had participated in the denial of care.

On February 26, 2008 – after almost four years of waiting – Mr. Cobbs finally saw the ophthalmologist (Dr. Datsgir) again. Medical Records, Exh. C, at 62-65. Dr. Datsgir noted that Mr. Cobbs had complained of "headache & double vision [for] 3 years," and requested left-eye cataract surgery. *Id.* On March 13, 2008, CMS finally approved the left-eye surgery. Medical Records, Exh. C, at 67.

Mr. Cobbs' second cataract surgery was finally performed in April 2008, three years and eight months after the original surgery was scheduled to occur, in September 2004. As Dr. Dastgir had predicted, *see* Dastgir Decl., Exh. M, at 2, 4-8, the surgery and recovery were rougher than the first time around. Mr. Cobbs had painful pressure in his eye following the surgery, and he had to return for a follow-up procedure to stop the wound from leaking. Medical Reports, Exh. C, at 77-82; Cobbs Decl., Exh A, at 10-11. Mr. Cobbs seeks damages for the denial of care from 2004 to 2008.

ARGUMENT

I. MR. COBBS HAS MADE OUT AN EIGHTH AMENDMENT CLAIM

The defendants argue that Mr. Cobbs' left-eye cataract did not constitute a serious medical need. This is wrong both as a matter of law, and as a matter of fact based on the record in this case. Rather, a reasonable jury could find that the defendants acted with deliberate indifference by denying Mr. Cobbs' left-eye cataract surgery. Accordingly, the Court should deny the defendants' motion for summary judgment on the plaintiff's Eighth Amendment claim.

A. The Record Demonstrates that Mr. Cobbs' Condition Constituted an Objectively Serious Medical Need

To prove an Eighth Amendment claim, the plaintiff must show that the defendants were deliberately indifferent to his serious medical needs. *See Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *City of Canton v. Harris*, 489 U.S. 378, 392 (1989). The plaintiff must demonstrate two

components, one objective and one subjective, to establish deliberate indifference. *Blackmore v. Kalamazoo County*, 390 F.3d 890, 895 (6th Cir. 2004) (citing *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). The objective component is a "serious medical need." *Id.* A medical need is sufficiently serious if "facts show an obvious need for medical care that laymen would readily discern as requiring prompt medical attention by competent care providers." *Blackmore*, 390 F.3d at 898. A medical need is both serious and obvious where a condition "has been diagnosed by a physician as mandating treatment." *Perez v. Oakland County*, 466 F.3d 416, 423 (6th Cir. 2006); *Blackmore*, 390 F.3d at 897. In these instances, "it is sufficient to show that [the inmate] actually experienced the need for medical treatment, and that the need was not addressed within a reasonable time frame." *Blackmore*, 390 F.3d at 900.

This Court has already found that "this case presents a situation where the condition that was known to the Defendants ... is obvious enough that a layperson would recognize the need [for the left eye cataract extraction]." R. 77, Report & Recommendation; R. 82, Order Adopting R&R. As early as 2004, and consistently thereafter, Mr. Cobbs' ophthalmologist, his primary care physician, and his optometrists were in unanimous agreement that he should have the left-eye cataract surgery. *See, e.g.*, Medical Records, Exh. C, at 34, 36, 37, 44, 50 (repeatedly saying that cataract surgery is *needed* or *required*). Indeed, Dr. Piper testified that he would not have referred Mr. Cobbs for specialty care unless he believed such a referral was medically necessary. *See* Piper Dep., Exh. G, at 32.

Second, as the two ophthalmologists make clear, the diagnosis and prescribed course of treatment for cataract removal meets the standard for a serious medical need, satisfying the objective component of an Eighth Amendment claim. *See* Sugar Decl., Exh. N, at 2. That is, in eye clinics throughout the country, cataract surgery is almost automatically recommended and

performed by doctors and covered by insurers, unless there is a *medical* reason not to do so. *See* Datsgir Decl., Exh. M, ¶ 7. Indeed, but for Mr. Cobbs' incarceration, any medical provider in southeast Michigan (if not in the country) would have done surgery immediately, back in 2004. *See* Sugar Decl., Exh. N, ¶ 5; *see also* Part I (B), below.

Third, the defendants' claim that Mr. Cobbs' condition did not constitute a serious medical need is contradicted by their own documents, their testimony, and the testimony of their employees and their co-defendants. During the course of discovery, the defendants produced a so-called "pass-through" sheet or list. *See* Exh. O. Dr. Hutchinson testified that this "CMS document" was "intended to enable the Utilization Review nurse [a CMS employee] to pass through or authorize a variety of services without the need to consult the Utilization Review physician." Hutchinson Dep., Exh. I, at 26-27; Jones Dep., Exh. J, at 30, 38-39. Dr. Hutchinson also testified that the "basic goal [of a Utilization Review nurse] is if it's *clearly medically necessary, they simply authorize* the procedure." Hutchinson Dep., Exh. I, at 16 (emphasis added); Jones, Dep., Exh. J, at 8-10 ("[The pass-through list] basically told us that when we receive a request for any of these services, we can go ahead and authorize it"). If CMS nurses can simply authorize the services that appear on the pass-through list, the inescapable conclusion is that such services are by definition medically necessary.

The pass-through list indicates that, according to the defendants' own criteria, a second cataract surgery is medically necessary for "(b) posterior sub-capsular glare" or "(c) great discrepancy in vision." Exh. O. Mr. Cobbs suffered from both posterior sub-capsular glare *and* a great discrepancy in vision dating all the way back to 2004. Based on the defendants' own criteria, Mr. Cobbs' left-eye cataract met the definition of a serious medical need.[14]

[14] Dr. Pramstaller concedes as much in his deposition. Exh. H, at 48-79. He cannot explain why the surgery was not approved, given the documented glare, double vision, discrepancy, and serious side effects.

The defendants were aware that Mr. Cobbs suffered from posterior sub-capsular glare as early as July 27, 2004. *See* Medical Records, Exh. C, at 11-14[15] And Dr. Hutchinson testified that glare would be a factor in considering whether a second cataract surgery is medically necessary. *See* Hutchinson Dep., Exh. I, at 75-76. Similarly, Dr. Pramstaller testified:

> Q: For someone who doesn't have diabetes, would there ever be a reason to remove a second cataract?
> A: Yes.
> Q: And what would that be?
> A: Well, *if they have a posterior sub-capsular cataract and it causes glare*, and the glare interferes with vision from the good eye and makes it difficult for them to visualize what's going on around them; therefore, they need that cataract taken out so that the glare disappears.
> Q: And do you assume that the standards that CMS applies would include what you just said, that if there is that kind of glare, then the cataract should be removed? [Objection omitted.]
> A: I assume that CMS was following that because we had discussed that on a number of occasions in the Medical Advisory Committee.

Pramstaller Dep., Exh. H, at 56.

Similarly, the defendants were aware that Mr. Cobbs was suffering from a great discrepancy in vision as early as December 2005. At that time, Dr. McGrath's report showed that Mr. Cobbs' best corrected visual acuity in his left eye had deteriorated to 20/600 in less than seven months, while his best corrected visual acuity in his right eye remained 20/20. Med. Records, Exh. C, at 34. Within a few months Mr. Cobbs was effectively blind in his left eye and began to wear an eye patch. There can be no greater discrepancy in vision than 20/20 vision in one eye and virtual blindness in the other eye. Indeed, Dr. Pramstaller testified:

> Q: What about vision in the good eye, does that indicate or contraindicate performing a second cataract surgery?
> A: … [I]f you have someone who is, has 20/20 vision in the first cataract eye, but the

[15] *See also* Datsgir Decl., Exh. M, at ¶¶ 20-21 ("The glare from a posterior sub-capsular cataract can impair vision in patients with good visual acuity in the other eye. Although a patient may test with good corrected binocular vision in a darkened lab, as soon as the patient is exposed to brighter light, and especially to sunlight, the glare from a posterior sub-capsular cataract can greatly interfere with vision in both eyes."). This is exactly what happened to Mr. Cobbs. *See* Cobbs Updated Decl., Exh. A, at 8-9.

second cataract eye is 20/400, and you can't see a thing out of that eye, the disparity in the visual cortex makes it difficult, so we would probably do that cataract, also.

Q: And I take it the CMS Chief of Utilization Review would know that, as well? [Objection omitted.]

A: He was present when we discussed these issues, yes.

* * * * * *

Q: … [O]nce the cataract has grown to the point that the patient can see nothing in that eye, at that point, do you do the surgery, or do you still wait?

A: No, you probably should do the surgery.

* * * * * *

Q: But I am saying if he's wearing a patch at the point where he's unable to discern objects, and can only discern light and dark, are we at the point where the cataract should be removed?

A: I would think all things being equal, yes.

Pramstaller Dep., Exh. H, at 57-59, 72.[16]

The "pass-through" list and the above testimony show that Mr. Cobbs' condition – a posterior sub-capsular cataract with glare and a great discrepancy in vision – constituted an obvious medical need that went untreated for almost four years. Moreover, Dr. Hutchinson testified as follows about the meaning of "medical necessity" within the MDOC/CMS:

Q [The MDOC policy] describes medically, presently medically necessary care as care

[16] Dr. Hutchinson disagrees with Dr. Pramstaller's testimony of what the phrase "great discrepancy in vision" means. According to Dr. Pramstaller, the phrase means what it says: "visual acuity in one eye versus the visual acuity in the other eye." Pramstaller Dep., Exh. H, at 49. According to Dr. Hutchinson's account, this "language was an attempt to capture [diplopia or double vision]." Hutchinson Dep., Exh. I, at 30. Dr. Hutchinson's attempt to work around the plain meaning of the phrase is largely incomprehensible. *Id.,* at 31. His position is also doubly inconsistent. First, he testified that the "pass-through" list "contains the MDOC directives on allowing second cataract authorizations to occur" and that the list "was compiled by CMS based on conversations, and in some cases, written communication with DOC." *Id.,* Exh. I, at 26-27. If that is true, then the MDOC medical director's (Dr. Pramstaller's) interpretation, of which CMS was aware, should prevail. And in that case, there is no doubt that Mr. Cobbs suffered from great discrepancy in vision for four years. Second, if the "pass-through" list contains purely CMS (rather than MDOC) policies – as Dr. Pramstaller suggests in his deposition, *see* Exh. H, at 49 – then Dr. Hutchinson's interpretation does not hold water. The "pass-through" list refers to diplopia in discussing contact lenses. *See* Exh. O, line 8(c). Thus, if CMS intended "great discrepancy in vision" to mean the same thing as "diplopia," CMS surely knew how to say what it meant. Finally, Mr. Cobbs suffered from double vision for years before his surgery was approved, thus satisfying even Dr. Hutchinson's interpretation of clear medical necessity. *See, e.g.*, Medical Records, Exh. C, at 12 (noting double vision in the left eye as early as July 2004); *and* at 64 (noting in 2008 that Mr. Cobbs had complained of double vision for three years).

without which the inmate could not be maintained *without significant risk of either further serious deterioration of the condition*, or significant reduction of the chance of possible repair after release, or *without significant pain or discomfort*. Yes?

A That's what it reads, yes.

Q All right. So there are really three reasons that something can be presently medically necessary, according to the definition that [CMS UR nurses] were taught to use?

A Yes.

Hutchinson Dep., Exh. I, at 18-19. Two of the three criteria fit Mr. Cobbs to a T, and the third is inapplicable because as a lifer Mr. Cobbs might never be released.

To bolster their argument, the CMS defendants assert that "each of Plaintiff's treaters who requested an ophthalmology consultation noted that the request was routine, as opposed to urgent." This, too, is untrue. The record shows that at least two requests were marked "urgent." Exh. C, at 24 (Aug. 25, 2006) and 30 (May 30, 2007).[17] Next, the defendants assert that there is "no evidence that Plaintiff's cataract caused him to suffer any pain in his left eye." Of course, this artfully dodges the point. The question is not whether Mr. Cobbs suffered pain *in his left eye* as a result of his cataract, but whether he suffered "significant pain or discomfort," and whether his poor vision caused him "difficulty in doing activities of daily living." Pramstaller Dep., Exh. H, at 53-54, 75-76 ("what sorts of functional disability [did] this [reduced] vision create?").

On these issues, the defendants simply ignore the record. There is no question that Mr. Cobbs experienced severe headaches, dizziness, loss of balance, eye strain, and (after early 2006) blurry and double vision in his right eye. *See* Grievances, Exh. D, at 4, 6; Kites, Exh. E, *passim*; Medical Records, *passim*; Cobbs Decl., Exh. A, at 8-9. From late 2005 or early 2006 he was effectively blind in his left eye and was forced to wear an eye-patch to function. Exh. A, at 8-9;

[17] The defendants also conflate "urgency" with "medical need." The MDOC's own regulations make it clear that all kinds of "serious medical needs" would not meet the MDOC's definition of "urgency." *See* PD 03.04.100, Exh. B, at 4, 10. "Urgency" for the MDOC has to do with the time within which a medical response is required, not the obviousness or seriousness of the medical need itself: an urgent condition is one that "needs to be treated as soon as possible and cannot wait for routine scheduling." *Id.* Thus, the failure to treat any obvious and serious medical condition for four-plus years would violate the Eighth Amendment, regardless of whether or not the condition would be classified as "urgent" by the MDOC.

Exh. C, at 24. Mr. Cobbs also suffered from extreme photophobia. Exh. C, at 44. There is no question that Mr. Cobbs was walking into walls, objects, and other people for lack of left-side and peripheral vision. Exh. A, at 8-10, Exh. C, at 34. Indeed, the plaintiff's expert confirms that posterior sub-capsular cataract symptoms can include loss of depth perception, blurred vision, glare, headaches, and poor balance. Sugar Decl., Exh. N, ¶ 19.

As a result of these side effects, Mr. Cobbs suffered significant problems in his daily life, including walking, reading, watching TV, concentrating, and going up and down stairs. Cobbs Decl., Exh. A, at 8-10. The record, especially viewed in the light most favorable to Mr. Cobbs, is more than sufficient to establish that his condition constituted an obvious, serious medical need. *Cf. Campbell v. Fry*, No. 89-6578, 1990 WL 15601, at *1 (4th Cir. Feb. 9, 1990) (vacating trial court grant of summary judgment in favor of defendant where approval for cataract surgery was denied "on the basis that it was elective in nature and delay would not cause any deterioration in the underlying condition as the cataracts could be successfully removed at a later date" where a doctor stated that plaintiff's "vision was deteriorating rapidly").

The defendants also claim that "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." In fact, the record contradicts this assertion. First, Mr. Cobbs' primary care physician and his optometrist repeatedly warned the defendants of the heightened risk of glaucoma. *See, e.g.*, Exh. C, at 18, 19. Second, the plaintiff's expert says that removing hypermature cataracts, like the one Mr. Cobbs had, increases the risk of complications from surgery, including the risk of puncturing or damaging the lens capsule, especially with posterior sub-capsular cataracts. Sugar Decl., Exh. N, ¶¶ 16-18. The MDOC's own contract ophthalmologist, Dr. Dastgir, repeatedly warned the defendants of the risks of delaying surgery until a cataract is hypermature: removing dense, thick,

hard cataracts is a recipe for surgical complication. Dastgir Decl., Exh. M, at 2, *and* Letters, *id.,* at 5-8. And those complications arose in this case. *See* Cobbs Decl., Exh. A, at 10; Medical Records, Exh. C, at 88.

In any case, "where a plaintiff's claims arise from an injury or illness so obvious that even a lay person would easily recognize the necessity for a doctor's attention," Mr. Cobbs need not present verifying medical evidence to show that, "even after the delayed necessary treatment, his medical condition worsened or deteriorated." *Blackmore*, 390 F.3d at 899-900. In essence, *Blackmore* stands for the proposition that where the seriousness of a prisoner's need for medical care is obvious, as here, the constitutional violation is not premised upon the detrimental effect of the delay, but rather that the delay alone creates a substantial risk of serious harm. *Id.* at 899. Here the delay caused years of unnecessary pain and suffering, serious limitations on Mr. Cobbs' basic functions of daily life, and ultimately surgery that was riskier, more painful, and that required follow-up procedures to complete. *See* Cobbs Decl., Exh A, at 10. *See also Boretti v. Wiscomb*, 930 F.2d 1150, 1154 (6th Cir. 1991) (having to endure physical pain and mental anguish during the time of delayed care constitutes cruel and unusual punishment within the meaning of the Eighth Amendment); *Parrish v. Johnson*, 800 F.2d 600, 610 (6th Cir. 1986) (actual injury is not a necessary predicate to damages for an Eighth Amendment violation). Mr. Cobbs' condition was obvious to anyone who saw him: as his doctors noted, the cataract in his left eye grew so dense his pupil was no longer visible. Thus, the injuries he suffered from 2004 to 2008 while he was denied the surgery are sufficient to sustain his Eighth Amendment claim.

Finally, even if this case were governed by *Napier v. Madison Co., Ky.*, 238 F.3d 739, 742 (6th Cir. 2001), such that the plaintiff would have to place "verifying medical evidence in the record to establish the detrimental effect of the delay in medical treatment to succeed," Mr.

Cobbs has easily met that standard as well. Mr. Cobbs' agrees with this Court's finding in the first Report and Recommendation that "[f]our years of needless suffering endured by the Plaintiff while repeated requests from doctors and from Plaintiff were superficially denied, the documented deterioration of his vision, his walking into objects, and the eventual donning of an eye patch, are the type of unnecessary infliction of pain contemplated by the Supreme Court in *Estelle*." R. 77, Report & Recommendation, at 13-14.

The defendants cite a number of cases from other jurisdictions for the proposition that a cataract does not qualify as an objectively serious medical need. *See* CMS Defs' Exhs. M-R. But those cases are distinguishable on their facts. First, *none* of the cases cited by the defendants involved a *posterior sub-capsular cataract with glare*, which the defendants here admit constitutes a serious medical need. Second, even the cases cited by the defendants distinguish between cases where there is evidence that the cataract *causes pain and affects the activities of daily living*, as Mr. Cobbs' cataract did here, and cases where there is no such evidence. *See, e.g.*, *Hurt v. Mahon*, 2009 U.S. Dist. LEXIS 279295, at *7 n.3 (E.D. Va. Aug. 31, 2009) ("Nowhere in any of his submissions to the Court does plaintiff claim to suffer pain as the result of his condition"); *Williams v. Shelton*, 2008 U.S. Dist. LEXIS 54394, at *7 (D. Or. July 16, 2008) ("The decision for surgical removal is usually based on the cataract's effect on the activities of daily living"); *Edwards v. Bradford*, 1997 U.S. Dist. LEXIS 15089, at *4 n.1 (D.S. Ala. July 16, 1997) (noting that plaintiff "has not stated, either generally or in detail, the nature of [the incidents complained of]" nor "has informed the Court how those incidents were related to his visual impairment").

Third, unlike the plaintiff in *Rylee v. Bureau of Prisons*, 2009 U.S. Dist. LEXIS 24609 (D.S.C. Mar. 9, 2009), Mr. Cobbs would have satisfied the Federal Bureau of Prison's ophthalmology guidelines. *See* Part I (B), below. Fourth, some of the cases cited apply law from other

circuits that is substantially different from the controlling law in this circuit. *Compare Leyster v. D'Amico*, 182 F.3d Appx. 697, at *2 (stating that "a delay in medical treatment must lead to further injury to support a claim for deliberate indifference") *with Blackmore*, 390 F.3d at 899-900 ("where a plaintiff's claims arise from an injury or illness so obvious that even a lay person would easily recognize the necessity for a doctor's attention, the plaintiff need not present verifying medical evidence to show that, even after the delayed necessary treatment, his medical condition worsened or deteriorated"). Finally, all of the cases cited by the CMS defendants were pursued by *pro se* plaintiffs. As a result, little or no record was developed, and the briefs were not prepared by trained attorneys. This Court should not rely on unpublished *pro se* cases to set the boundaries of important Eighth Amendment rights.

The defendants' argument also proves too much. In essence, the defendants appear to be arguing that a cataract can *never* be an objectively serious medical need (absent some specific danger to the patient). That cannot be the case, as the defendants' own documents show that if a cataract causes glare, or if there is a great discrepancy in vision, then the cataract surgery is medically necessary. *See* Pass-Through List, Exh. O. Thus, at most, the cases cited by the defendants stand for the proposition that in *those* particular cases, the standard for medical necessity was not met.

B. Mr. Cobbs Would Have Been Promptly Treated under the Private and Public Insurance Guidelines Cited by the CMS Defendants

Contrary to the defendants' assertions, the failure to treat Mr. Cobbs' left-eye cataract was not consistent with guidelines published by Aetna, Medicaid or Medicare, or the Federal Bureau of Prisons.

The defendants argue that "Plaintiff received cataract surgery on his left eye at the same time as he would have been eligible under Aetna's guidelines." CMS Defs' Brief, at 20. This is

patently untrue. For Aetna members with best corrected vision in their good eye of 20/50 or worse (on the Snellen eye chart),[18] "cataract surgery is medically necessary when all subjective, objective, and educational criteria are met." Aetna Standards, Def. Exh. K, at 2. The subjective criteria are met when "[t]he member perceives that his or her ability to carry out needed or desired activities is impaired." *Id.* Examples of such impaired activities include driving, viewing television, reading, and performing occupational activities. *Id.* Objective criteria are met when the "best correctable Snellen visual acuity *in the affected eye* is 20/50 or worse," an examination shows that the cataract is impairing the visual acuity, and the member's health permits surgery to be performed safely.[19] *Id.* (emphasis added). Educational criteria are satisfied when the patient is educated regarding the risks of cataract removal surgery. *Id.*

Without question, Mr. Cobbs would have met the private Aetna standards (in 2004 or 2005) precisely because they include *functional criteria* (as opposed to the eye-chart scores that CMS used exclusively). Moreover, for Aetna members with a Snellen acuity of 20/40 or better, cataract surgery is medically necessary when, in addition to the criteria listed above, there is subjective and objective evidence of "light-related visual loss" or "glare." *Id.* at 2-3. In Mr.

[18] "The Snellen eye chart has a series of letters or letters and numbers, with the largest at the top. As the person being tested reads down the chart, the letters gradually become smaller…. The Snellen fractions, 20/20, 20/30, *etc*., are measures of sharpness of sight. They relate to the ability to identify small letters with high contrast at a specified distance. … When checking visual acuity, one eye is covered at a time and the vision of each eye is recorded separately, as well as both eyes together. In the Snellen fraction 20/20, the first number represents the test distance, 20 feet. The second number represents the distance that the average eye can see the letters on a certain line of the eye chart. So, 20/20 means that the eye being tested can read a certain size letter when it is 20 feet away. If a person sees 20/40, at 20 feet from the chart that person can read letters that a person with 20/20 vision could read from 40 feet away. The 20/40 letters are twice the size of 20/20 letters; however, it does not mean 50% vision since 20/20 sounds like it is one half of 20/40. If 20/20 is considered 100% visual efficiency, 20/40 visual acuity is 85% efficient." Wendy Strouse Watt, O.D., *How Visual Acuity Is Measured*, October 2003, http://www.mdsupport.org/library/acuity.html.

[19] Curiously, the CMS defendants' brief repeatedly references Aetna's standard for medically necessary cataract removal as it pertains to "visual disability with a Snellen Acuity of 20/50 or worse," but never mentions the standard for "a visual disability with a Snellen Acuity of 20/40 or better."

Cobbs' case, there was evidence of light-related visual loss and glare going all the way back to the summer of 2004. Medical Records, Exh. C, at 12 (best corrected vision in left eye was 20/70 but dropped to 20/400 with glare); Piper Dep., Exh. G, at 60-61.

By 2005, Mr. Cobbs complained that his visual disability impaired depth perception to the point of walking into objects, and that he experienced wide range of daily problems. Cobbs Decl., Exh. A, 8-10. Mr. Cobbs also clearly satisfied the educational criteria as of 2004. Dr. Dastgir noted: "After fully and thoroughly explaining all of the risks and benefits and answering all of the patient's questions to his satisfaction, he decided to have cataract extraction with lens implants performed in both eyes and he was scheduled for the same." Exh. C, at 14.

Mr. Cobbs' cataract extraction was also "medically necessary" in 2004 under the Medicare/Medicaid standards. *See* Def. Exh. L, at 3-4. Cataract surgery, either for first or second cataracts, is "medically necessary" if the following criteria are met: [20]

> [1] Decreased ability to carry out daily living including (but not limited to): reading, watching television, driving, meeting occupational or vocational expectations, and
> [2] The patient has best corrected visual acuity of 20/50 or worse at distant or near; *or additional testing shows one of the following*:
> - Consensual light testing decreases visual acuity by two lines, or
> - *Glare testing decreases visual acuity by two lines*
>
> [3] The patient has determined that he/she is no longer able to function adequately with the correct visual function; and
> [4] Other eye disease(s) including, but not limited to macular degeneration or diabetic retinopathy, have been ruled out as the primary cause of decreased visual function; and
> [5] Significant improvement in visual function can be expected as a result of cataract extraction; and
> [6] The patient has been educated about the risks and benefits of cataract surgery and the alternative(s) to surgery (e.g., avoidance of glare, optimal eyeglass prescription, etc.); and
> [7] The patient has undergone an appropriate preoperative ophthalmologic evaluation that generally includes a comprehensive ophthalmologic exam and ophthalmic biometry.

Id. (emphasis added). Contrary to the defendants' assertions, Mr. Cobbs satisfied every one of these factors years before his cataract surgery was approved. As previously noted, Mr. Cobbs'

[20] Numbering has been added for ease of reference.

left-eye cataract decreased his ability to carry out daily living functions beginning in 2004 (satisfying factor #1 above). Mr. Cobbs underwent an appropriate preoperative ophthalmologic evaluation with Dr. Dastgir on July 27, 2004 (#7), at which time Dr. Dastgir determined that Mr. Cobbs was a good candidate for improved vision via cataract removal (#4 & #5). After having been educated about the risks (#6), Mr. Cobbs consented to surgery (#3). At that time Dr. Dastgir further noted that Mr. Cobbs' best corrected vision in the left eye was 20/70 and dropped to 20/400 with glare (#2). A patient's visual acuity must drop by "two lines" to satisfy the second criterion.[21] Therefore, Mr. Cobbs' cataract surgery was also "medically necessary" under the Medicare/ Medicaid standards as early as 2004.

Mr. Cobbs' left-eye cataract surgery arguably would have been approved even under the guidelines published by the Federal Bureau of Prisons. In February 2008, the Bureau published a pamphlet titled "Ophthalmology Guidance."[22] *See* Def. Exh. J. It indicates that referral for medical evaluations by an eye specialist is warranted when an inmate exhibits any of a number of visual symptoms, including "distortion of vision, obscured vision, loss of vision, double vision, [and] new onset of abnormalities or opacities in normal transparent media of the eye." *Id.* at 4-5. Mr. Cobbs exhibited all of these symptoms yet CMS denied every referral request for medical evaluation by an ophthalmologist for over four years. Evaluation by an ophthalmologist is also warranted if "[o]ther history, symptoms, or signs ... indicate the need for examination/ treatment by an ophthalmologist, as determined by a physician or mid-level practitioner." *Id.*, at 5. Every doctor and optometrist who examined Mr. Cobbs requested a referral for ophthalmological evaluation of his left eye, but CMS denied every such request from 2004 to 2008.

[21] Dropping two lines from 20/70 on a standard Snellen Eye Chart results in 20/200 vision. *See* Exh. P.

[22] It is unclear if this document is actually used by the Bureau of Prisons, or what other standards or policies accompany it.

The Bureau's "Ophthalmology Guidance" pamphlet also indicates that cataract surgery should be approved according to the following criteria:

> There must be documentation of a best-corrected visual acuity of less than 20/60 in both eyes with current (less than six months old) refraction. Second eye surgery requires a documented, best-corrected visual acuity of 20/100 or less.

Defs' Exh. K, at 5. The phrase "both eyes," in the context of this standard, probably means that each eye must have a best-corrected visual acuity of less than 20/60.[23] Unlike evaluation for first eye-surgery, however, evaluation for second-eye surgery is apparently not concerned with best corrected vision in "both eyes." The exclusion of the phrase from the standard for *second-eye* cataracts could well mean that the "best-corrected visual acuity of 20/100 or less" refers to the *affected eye*, the same as in the Aetna standards. By December 2005, Dr. McGrath's report shows that Mr. Cobbs' best corrected visual acuity in his left eye had deteriorated to 20/600 and that no lens helped. Medical Record, Exh. C, at 36. This certainly exceeds the 20/100 required for medical necessity in this context by the federal BOP. Therefore, Mr. Cobbs' second left-eye cataract surgery may well have met the BOP guidelines as early as 2004 or 2005.

Ultimately, it is not the plaintiff's role, nor goal, to establish that a cataract constitutes a serious medical need *in every case*. Rather, the plaintiff must present sufficient evidence to survive summary judgment demonstrating that *in this case* such a serious medical need was present. Mr. Cobbs has carried his burden.

C. Mr. Cobbs' Claim Also Satisfies the Subjective Component of an Eighth Amendment Claim

As noted above, the plaintiff must demonstrate two components, one objective and one subjective, to establish deliberate indifference. *Blackmore*, 390 F.3d at 895. The subjective component is a showing that the defendants had "a sufficiently culpable state of mind in denying

[23] Best corrected visual acuity can refer to the best visual acuity of the left eye, right eye, or both eyes. *See* McGrath Dep., Exh. F, at 18.

medical care." *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). To satisfy the subjective component, the defendants must be aware of facts from which the inference could be drawn that a substantial risk of harm exists, and they must draw such an inference. *Id.*, at 837.

Mr. Cobbs' claim also satisfies the subjective component. In light of the treating doctors' and specialists' persistent detailed requests, this is not a case where the defendants were unaware of Mr. Cobbs' condition, or his symptoms, or the ongoing risks to his health. The clinic reports sent by his doctors, and the requests for medical help sent by Mr. Cobbs himself, meant that the defendants did not have to "infer" anything. They had direct notice that his vision was impaired, that he was suffering from headaches and double vision and other serious side effects like loss of balance and depth perception, that he was at risk of glaucoma and long-term loss of eyesight, and that he was functionally blind in one eye. The defendants didn't need to draw an inference – all they had to do was read the reports they were sent. A reasonable jury could find that the defendants *knew* from the medical facts not just that Mr. Cobbs was *at risk* of serious harm, but that he was *already suffering* serious harm. At the very least, the defendants could draw that inference.

Mr. Cobbs' case therefore satisfies both the objective and subjective component of an Eighth Amendment claim of deliberate indifference to serious medical needs.

The defendants correctly point out that an inmate may not establish an Eighth Amendment violation merely because of a disagreement over the treatment provided. *Napier v. Madison County*, 238 F.3d 739, 742 (6th Cir. 2001). But Mr. Cobbs is not arguing that he should have been prescribed a different course of treatment. He is arguing that he should have been *provided* the very course of treatment he *was prescribed*, first by Dr. Dastgir and subsequently by his primary care physician and the optometrists who observed his condition and implored the defendants to approve the left-eye cataract surgery.

The facts here are similar to those in *Titlow v. Corrections Medical Services*, 2008 WL 907450 (E.D. Mich. 3/31/08) (Exh. Q), another Eighth Amendment case involving the denial of medically necessary surgery. The plaintiff in *Titlow* was denied mastectomy surgery while she suffered from pain and likely infection due to leaking silicone breast implants. *Id.* at *1. Her treating doctors repeatedly recommended that she undergo a mastectomy, but the defendants rejected these recommendations as not medically necessary. The court denied the defendants' motion for summary judgment on the surgery claim and rejected the idea that the case was about a disagreement over treatment choice, pointing out that a denial of prescribed treatment is *not* a medical treatment decision because there is *no treatment*. *Id.* at *7 (*emphasis added*). Because every doctor who had actually examined and treated the plaintiff recommended the surgery, the court held that the defendants' denials "had nothing to do with the appropriate treatment of the plaintiff's individual condition." *Id.* The denials were "based on generalities having nothing to do with the actual … condition of the plaintiff." *Id.*

The same reasoning applies to Mr. Cobbs' case. His treating doctors made numerous requests for him to have surgery on his left eye. They noted the decline in Mr. Cobbs' health and well-being due to the side effects. They noted the increased risk of glaucoma. The defendants did not and could not have provided Mr. Cobbs with an alternative treatment because surgery is the only treatment for a cataract. Thus, this case does not center on a disagreement over the prescribed course of care. The defendants' denial of a surgery that Mr. Cobbs' doctors said was medically necessary constitutes deliberate indifference to his serious medical needs.

A reasonable jury could find that the defendants acted with deliberate indifference by denying Mr. Cobbs' second left-eye surgery. Even Dr. Pramstaller seems to agree. When asked: "Based on what you just said, it would make sense to say to every patient, Wear a patch, we're

never going to take [the cataract] off. Why don't you do that?" He responded: "That's not a very humane way to treat people." Pramstaller Dep., Exh. H, at 74. But that is exactly what the defendants did to Mr. Cobbs, for four years. The Court should deny the defendants' motion for summary judgment.

II. THE SUPERVISORY DEFENDANTS PARTICIPATED IN THE DECISIONS TO DENY MR. COBBS' SURGERY, AND WERE RESPONSIBLE FOR THE MDOC/CMS CUSTOMS AND POLICIES ON CATARACT SURGERY

This Court should deny summary judgment to all supervisory defendants because each was personally involved in the deprivation of Mr. Cobbs' Eighth Amendment rights. To hold senior officials liable in their individual capacity under § 1983, the plaintiff must show either (1) that the senior officials participated directly in the unconstitutional act, or (2) that there was a causal connection between the actions of the supervisory officials and the alleged constitutional deprivation. *See Shehee v. Luttrell*, 199 F.3d 295, 300 (6th Cir. 1999). As to the second, a causal connection can be proven by a showing that the supervisory officials' customs or policies resulted in deliberate indifference to the plaintiff's constitutional rights. *See e.g., Miller v. King,* 384 F.3d 1248, 1261, *vacated on other grounds*, 449 F.3d 1149 (11th Cir. 2006) (warden denied summary judgment where wheelchair-bound prisoner alleged ongoing failure of paraplegic medical care). Here, Mr. Cobbs has demonstrated both: that the defendants participated directly in decisions to deny treatment, and that their customs or policies on treatment caused or resulted in the deliberate indifference.

A. The Supervisory Defendants Participated in the Decisions to Deny Mr. Cobbs' Surgery

As noted above, Drs. Hutchinson and Pramstaller (as well as the members of the MSAC) were not treating physicians. Rather they served as part of the MDOC/CMS utilization review apparatus that denied the repeated requests for surgery made by Mr. Cobbs' hands-on treating

doctors. The individual supervisory MDOC/CMS defendants thus participated directly in the denial of treatment for Mr. Cobbs' obvious and serious medical needs. The MSAC was the last arbiter of utilization review decisions. Defendants Hutchinson and Pramstaller were present at both MSAC meetings, and Mr. Cobbs has retained as party defendants only those senior officials who *participated in the consensus agreement* at the two MSAC meeting when the requests for treatment were denied. *See* Exh. K, at 2-3; Pramstaller Dep., Exh. H, at 14-15 (identifying who comprises the MSAC), and Policy Directive 03.04.100, Exh. B, at 5, ¶ K (same). Dr. Hutchinson also personally conducted a CMS utilization reviews denying Mr. Cobbs' cataract surgery. *See* Medical Records, Exh. C, at 49 (denial signed by Hutchinson based on "20/20 vision in right eye"). Dr. Mathai took over the role of CMS medical director in 2007 when Dr. Hutchinson left. Hutchinson Dep., Exh. I, at 10, 13.

This is not a case where liability is premised on *respondeat superior*, as the defendants argue. *Cf. Grinter v. Knight*, 532 F.3d 567, 575-576 (6th Cir. Ky. 2008) (affirming dismissal of claims where the plaintiff argued that prison officials were personally liable merely because they held supervisory roles). The defendants' *participation* in various aspects of Mr. Cobbs' case distinguishes such rote claims. The defendants are not liable merely because they held supervisory positions, but because their *actions* and *decisions* while in those positions constituted deliberate indifference to Mr. Cobbs' medical needs. *See e.g.*, *Hafer v. Melo*, 502 U.S. 21, 25 (1991) (a casual relationship between the actions or decisions of a prison official and the deprivation of a federal right is sufficient to establish personal liability under §1983). Accordingly, the Court should deny summary judgment to the supervisory defendants because each participated in the decision to deny the surgery.

The CMS defendants argue that this Court should overlook their personal involvement in

Mr. Cobbs' case because others also took part in denying his surgery. They argue that Dr. Pramstaller, the MSAC chair, had the ultimate authority to decide the outcome. *See* CMS Defs' Brief, at 19; *see also* Hutchinson Dep., Exh. M, at 60 ("Pramstaller's vote is the only one that counts at the MSAC").

But that is *not* what Dr. Pramstaller says, and that is not what *his* counsel says, and that is not what the MDOC Operating Procedure says. Dr. Pramstaller testified as follows:

> Q: And when [the MSAC] made its decision, it made its decision as a committee; it wasn't George Pramstaller who made the decision, it was the committee who made-
> [Objection omitted.]
> Q: Is that right?
> A: Well, the Committee usually discussed the case and reached a consensus as to how things were going to be handled.
> Q: *But it was the Committee's consensus decision?*
> A: *Yes.*
> Q: Okay. Was there ever a formal vote around the table, or not?
> A: No, there was not.

Pramstaller Dep., Exh. M, at 42-43 (emphasis added). In Dr. Pramstaller's first motion for summary judgment, his counsel argued that when a CMS doctor decides that "a surgery is not medically necessary, the … appeal goes to the MSAC. In this case, the prisoner's appeal was denied by the MSAC, and not by Dr. Pramstaller." R. 12, Motion for Summary Judgment (later withdrawn) (emphasis added). Even Hutchinson conceded that the MSAC's meetings were "discussions" where each MSAC member expressed an opinion, and that such meetings rarely generated argument. "[I]t's usually a consensus." Hutchinson Dep., Exh. H, at 60-61.

All MSAC members had the responsibility to review the "cases prior to the MSAC" meeting and to "[d]iscuss each case … at the MSAC meeting." *See* Operating Procedure OP 03.04.100, Exh. B, at 3. Only in the event that consensus could not be reached did the chief medical officer (Pramstaller) have authority to decide the issue. *Id.* at 3, ¶ 26. There is nothing

in the record (other than Hutchinson's self-serving efforts to paint Pramstaller as the decision-maker) to support the CMS defendants' claim that they were not personally involved in the MSAC consensus decisions to deny Mr. Cobbs' surgery. Indeed, Dr. Pramstaller testified that the CMS representatives play an active role in MSAC decisions. *See* Pramstaller Dep., Exh. M, at 44 (MSAC reviews CMS's decision to deny treatment by first having the CMS representative explain the specific circumstances of the case). This Court should deny summary judgment to all the MDOC and CMS supervisory defendants because each was personally involved in the deprivation of Mr. Cobbs constitutional rights. At a minimum, there is a genuine issue of material fact as to the defendants' personal involvement in the denial of Mr. Cobbs' surgery.

B. CMS, Inc., and the Supervisory Defendants Are Liable for Adopting, Implementing, or Applying the MDOC/CMS Policies that Resulted in the Failure to Treat

Even if the corporate and supervisory defendants had no personal involvement in the denial of care, they can still be held liable if they applied MDOC/CMS customs or policies that resulted in deliberate indifference to Mr. Cobbs' constitutional rights. *See Shehee v. Luttrell and Miller v. King, supra.* Mr. Cobbs has met his burden of showing that the MDOC/CMS customs and policies deprived him of his constitutional rights.

As to CMS, although a government agency may not be held liable merely on a theory of *respondeat superior*, "a private contractor is, however, liable for constitutional violations caused by a policy or custom of that private contractor." *Johnson v. Karnes*, 398 F.3d 868, 877 (6th Cir. 2005); *Street v. Corr. Corp. of Am.*, 102 F.3d 810, 817 (6th Cir. 1996); *Hicks v. Frey*, 992 F.2d 1450, 1458 (6th Cir. 1993). A plaintiff may establish a private contractor's liability in this regard by pointing to the private contractor's official policies, informal customs or policies, or actions taken by the contractors' decision-making officials. *Thomas v. City of Chattanooga*, 398

F.3d 426, 429 (6th Cir. 2005) (citing *Monell*, 436 U.S. at 694.). A plaintiff may also satisfy this burden by illustrating the private contractor's "tolerance or acquiescence of federal rights violations." *Id.*

The MDOC and CMS adopted a cataract surgery policy that deprived Mr. Cobbs of his right to be free from cruel and unusual punishment under the Eighth Amendment. CMS (as well as the MSAC) repeatedly denied Mr. Cobbs' left-eye cataract surgery based solely on the visual acuity of his right eye. *See e.g.,* Hutchinson Dep., Exh. I, at 68; Medical Records, Exh. C, at 35 (denying surgery on 12/27/05 stating "Pt had good response to his surgery on RT eye."). Hutchinson, acting as CMS medical director in the state, also approved and employed this policy in denying Mr. Cobbs' surgery. *Id*., at 49 ("not authorized based on 20/20 vision in the right eye"). Utilization review nurse Jones said:

> Q Are you aware of cases in which the vision [in the good eye] was better than 20/40… but a second cataract [surgery] was nevertheless approved?
> A No.

Jones Dep., Exh. J, at 73. Despite the "pass-through" list, the MDOC and CMS had a custom or policy of denying cataract surgery without regard to other relevant factors, such as visual acuity in the affected eye, blurred or double vision or strain in the good eye, the level of pain or discomfort, or the disruption in daily living caused by the poor vision or other side effects. Even the cases the defendants cite recognize the importance of these factors in assessing a deprivation of an inmate's constitutional rights. *See, e.g.*, *Williams v. Shelton*, *supra* (surgical decision usually based on effect on activities of daily life); *Hurt v. Mahon*, *supra* (no evidence of pain).

Moreover, systemic failures in the MDOC/CMS customs and policies all but guaranteed that the decision for cataract surgery would not be based on anything but the Snellen Acuity score for the good eye. Although a request for specialty care had to be submitted by the patient's

treating doctor or optometrist, none of Mr. Cobbs' treating/referring physicians or optometrists *ever knew what criteria CMS or the MSAC were using to approve or deny requests for evaluation or cataract surgery*. Dr. Piper testified:

> Q. Have you ever been told by the Department of Corrections whether there is any criteria you should use to evaluate cataract surgery?
> A. No.
> Q. Have you ever been told by the Department that they have certain criteria that they use to evaluate cataract surgery?
> A. No.

Piper Dep., Exh. G, at 35-36 *et seq.*; McGrath Dep., Exh. F, at 17 (same). The treating doctors were in the dark, just like their patient.

Based on discovery, a reasonable jury could find that the MDOC/CMS *intentionally* kept the utilization review standards from the treating doctors. The "pass-through" list was not shared with anyone outside the CMS UR department. Jones Dep, Exh. J, at 52; Hutchinson Dep., Exh. I, at 28. Furthermore, none of Mr. Cobbs' treating doctors ever understood why their repeated requests for surgery were denied, or what new or different information it would take to get their requests approved. *See* Piper Dep., Exh.G, at 33-36; McGrath Dep., Exh. F, at 17.

Even the ophthalmologist who performed most of the cataract surgeries for the MDOC (Dr. Dastgir) said he was never told what criteria CMS used, nor was there a discernable pattern to the cataract approvals and denials CMS issued in his practice:

> CMS has never given me a copy of the standards it uses to approve or deny a cataract surgery. I simply receive notification that my surgery requests have been approved or denied. I almost never get a call from a CMS doctor or staff explaining why a cataract surgery request has been approved or denied, or telling me what more is needed for approval.
>
> CMS has both approved second cataract surgeries for inmates with good vision and denied second cataract surgeries for inmates with poor vision. I do not know why surgery for patients with hyper-mature cataracts is sometimes denied while at other times surgery for less-developed cataracts is approved.

Dastgir Decl., Exh. N, at 1. He said that in Mr. Cobbs' case, "Neither CMS [n]or MDOC told me why they denied Mr. Cobbs' second cataract surgery from 2004 until 2008." *Id.,* at 3.

CMS repeatedly denied the treaters' requests, saying only "does not meet criteria" or "MSAC already denied" or "right-eye 20/20." Medical Records, *passim*. Dr. McGrath was equally in the dark about the CMS appeals process:

> Q: Do you know what MSAC is?
> A: On Exhibit 3?
> Q: Yes.
> A: MS – I don't know. I don't know if it's – MSAC, I don't know if I'm familiar with that. MSP stands for medical service provider.
> Q. But MSAC is not anything you're familiar with?
> A. Not that I'm aware of.

McGrath Dep., Exh. F, at 48.

Although both MSAC denials (10/26/04 and 4/25/06) contained boilerplate language that invited re-evaluation of the case, CMS UR staff plainly viewed those denials as the final word on the subject. Even as Mr. Cobbs became increasingly symptomatic with each request, CMS's UR department cited the old MSAC decisions as the reason for nearly all subsequent denials. *See e.g.*, Exh. C, at 34-35 (denying evaluation/surgery based on MSAC decision more than a year before even though Mr. Cobbs' vision had decreased to 20/600 in seven months and new side effects had been reported). And so on for four years.

CMS policy was apparently to refuse cataract evaluation/surgery in all cases denied by the MSAC, regardless of how much time had passed since the previous MSAC denial, and regardless of whatever new complications, increased pain, or other symptoms the patient suffered. The severity of Mr. Cobbs' cataract was undeniable. He experienced pain, discomfort, and disruption of his daily activities. As his cataract got thicker, both his health risks and surgical risks increased. All of this information is vital to a decision regarding medical necessity, but the cus-

toms and policies for cataract surgery all but precluded CMS from looking at the *whole* medical chart (let alone from looking at the whole patient).[24] Instead it looked at a series of isolated referrals from Dr. Piper and the optometrists. Hutchinson's testimony illustrates the inadequacy of CMS's UR process for cataract surgery in assessing the medical necessity of surgery for Mr. Cobbs' hypermature cataract:

> Q. [Is it] CMS position that throughout [2004 – 2008] [Mr. Cobbs] could be maintained *without significant risk of further serious deterioration*, or significant reduction of the chance of repair after release, *or without significant pain or discomfort*?
> A. Yes. Every step of the way that the documents and the decisions you've taken me through, I could say that, yes.
> Q. And you say that because if any of those things had been present, [cataract surgery] would have been medically necessary, and he should have gotten the cataract removed?
> A. Well, I think those – if there were assertions that those [side effects]were present, that that probably would have been – that would have led to a different decision if they'd been brought to the decision-makers.

Hutchinson Dep., Exh. I, at 80-81 (emphasis added). But those side effects *were* brought to the decision-makers, yet CMS and the MSAC still denied the surgery. *See also* Pramstaller Dep., Exh. H, at 52-76 (conceding that glare, great disparity in vision, blindness, discomfort, disruption of daily activities, headaches, *etc*., are all reasons to approve second cataract surgery). Here the customs and policies in place made it nearly impossible for those side effects to be considered by CMS, and even when they were brought to CMS's attention, those side effects were rejected as a reason to perform the surgery!

[24] The defendants argue, on the one hand, that Mr. Cobbs' case involved a difference in "medical judgment," as if the UR department and supervisors and the MSAC were part of his treatment team. S*ee* CMS Defs' Brief, at 25. Mr. Cobbs' real treating doctors, however – the ones who actually charted his decline over time, and who examined him – were unanimous in their opinion that Mr. Cobbs needed surgery. It is interesting to note that when the defendants need to argue a lack of "personal connection" to the case, *see* CMS Defs' Brief, at 17, suddenly the same UR supervisory people "had no involvement in Plaintiff's medical care and treatment." *Id.* The defendants cannot have it both ways.

In sum, the MDOC/CMS customs and policies on cataract surgery all but guaranteed that a prisoner like Mr. Cobbs would go for years without treatment of his serious medical needs, regardless of his headaches, dizziness, glare, blurred and double vision, risk of harm from others, inability to read or watch TV or work certain jobs, risk of surgical complications, and general pain and suffering. Indeed, even when the vision in his good right eye fell to 20/50 in May 2007, CMS *still* routinely denied the referral for an ophthalmology consult. Accordingly, the Court should deny summary judgment to CMS, Inc., and all MDOC and CMS supervisory defendants.

III. THE MDOC DEFENDANTS ARE NOT ENTITLED TO QUALIFIED IMMUNITY

The MDOC defendants incorrectly assert that they are entitled to summary judgment based on qualified immunity. Summary judgment is not proper on the grounds of qualified immunity because Mr. Cobbs has alleged facts which, construed most favorably to him, show that the MDOC defendants unreasonably violated his clearly established Eighth Amendment rights by showing deliberate indifference to his serious medical needs.

To determine whether a party is entitled to the defense of qualified immunity, a court should apply a three-pronged test:

> (1) Taken in the light most favorable to the party asserting the injury, do the facts alleged show the officer's conduct violated a constitutional right?
>
> (2) Did the official claiming immunity violate a clearly established right that would have been understood by a reasonable person?
>
> (3) Has the plaintiff presented sufficient facts, supported by evidence, to indicate that what the official allegedly did was objectively unreasonable in light of the clearly established right?

Higgason v. Stephens, 288 F.3d 868, 876 (6th Cir. 2002). If the plaintiff can establish these three prongs, the defendants are not entitled to qualified immunity. *Id.*

Mr. Cobbs satisfies the first prong because, as discussed in Part I, *supra,* he has alleged

facts which, taken as true, establish that the defendants violated his Eighth Amendment rights through deliberate indifference to his serious medical needs.[25]

Mr. Cobbs satisfies the second prong because the right to medical treatment is a clearly established right. A right is considered to be "clearly established" if a reasonable official would understand that his actions violate the right. *Scicluna v. Well*s, 345 F.3d 441, 446 (6th Cir. 2003) (citing *Anderson v. Creighton*, 483 U.S. 635, 640 (1987)). MDOC policy can provide evidence of clearly established prisoner rights. *Scicluna*, 345 F.3d at 445. MDOC policy says that "prisoners shall be provided with unimpeded access to a continuum of health care services that is timely." Exh. B, at 4. Corrective surgery is surgery the primary purpose of which is to "restore function." *Id.*, at 8. Under the MDOC's own definition, Mr. Cobbs' cataract removal surgery on his left eye was medically necessary. *See* Pass-Through List, Exh. O.

In their motion for summary judgment, the defendants state that they have found no cases holding that a delay in providing cataract surgery can constitute deliberate indifference, implying that therefore Mr. Cobbs' case does not implicate a clearly established right. MDOC Brief, at 5-6. Under *Anderson v. Creighton*, however, a right may be clearly established even if there is no previous legal case with identical facts. 483 U.S. at 640. A right is clearly established if a reasonable official would deem an action unlawful in light of established precedent. Mr. Cobbs' serious medical need was obvious: a reasonable health care official would have realized that deny-

[25] The cases cited by the MDOC defendants are factually distinct from the denial of Mr. Cobbs' surgery. *See Stevenson v. Pramstaller*, No. 07-cv-14040, 2009 U.S. Dist. LEXIS 25495, at *15-16 (E.D. Mich. Mar. 24, 2009) (holding that *pro se* plaintiff failed to rebut evidence that "defendants' decision was motivated by a medical finding that his eye condition was stable for almost a year"); *Samonte v. Bauman*, 264 Fed. Appx. 634, 636 (9th Cir. 2008) (concluding that a mere difference of opinion is "insufficient *by itself* to raise a triable issue of deliberate indifference") (emphasis added). Mr. Cobbs' well-documented medical condition steadily worsened for four years. The MDOC defendants cannot claim otherwise. Furthermore, Mr. Cobbs' denies that there was a difference of opinion. To the contrary, every one of Mr. Cobbs' treating physicians agreed that his surgery was medically necessary, and MDOC/CMS policies confirmed the same thing.

ing the surgery violated his constitutional rights (as well as MDOC policy). In fact, *all* of Mr. Cobbs' *treating* doctors realized that he needed the surgery, and nothing had changed when the MDOC finally approved the surgery.

Furthermore, federal courts have recognized that a delay in providing medically necessary eye surgery to an inmate can constitute deliberate indifference. *See e.g., Castillo v. Dashiell*, 2007 WL 609858, at *7 (E.D.Cal., Feb. 27, 2007) (*unpublished case*) (adopted at 2007 WL 933790 (E.D. Cal., Mar 27, 2007) (denying summary judgment on Eighth Amendment claim where surgery was not performed until 10 months after inmate lost vision in one eye and noting that providing some medical treatment will not preclude an Eighth Amendment violation unless it is "competent treatment"), attached as Exh. R. *See also Taghipour v. Chastine*, 43 F.3d 669 (5th Cir. 1994) (vacating dismissal to defendants on prisoner's Eighth Amendment claim based on delay in providing proper medical treatment after prisoner sustained an eye injury). Mr. Cobbs satisfies the second prong of the qualified immunity test because he was denied a clearly established right.

The third and final prong of the qualified immunity test is satisfied because the facts show that the defendants' actions were objectively unreasonable in light of the plaintiff's clearly established right. It is hard to imagine how Mr. Cobbs or his treating doctors could have underscored the need for the surgery any further. Objective medical evidence accompanied and supported their requests.

Mr. Cobbs has met all three prongs of the qualified immunity test. The defendants knew that Mr. Cobbs had a serious medical condition requiring treatment. A reasonable health official, knowing that the cataract surgery had been prescribed and that Mr. Cobbs' condition was worsening, would have approved the surgery (or would not have waited until the patient brought a

lawsuit to take action). On the facts presented, the denial of care from 2004 to 2008 was objectively unreasonable in light of Mr. Cobbs' clearly established right. In this case a reasonable jury could find that the defendants not only acted with deliberate indifference, but that the defendants knowingly and willfully violated Mr. Cobbs' Eighth Amendment rights. The MDOC defendants are not entitled to qualified immunity, as this Court already found in its previous order.

Conclusion

For the above reasons, the plaintiff respectfully requests that the MDOC and CMS defendants' motions for summary judgment be denied.

Respectfully submitted,

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s/ Ondrej Staviscak Diaz
Student Attorney for Plaintiff

Dated: December 23, 2009

Proof of Service

The plaintiff's brief in response to the MDOC and CMS defendants' motions for summary judgment, together with exhibits and this proof of service, were filed using the Court's ECF system, which will provide same-day e-mail service to all counsel of record.

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Dated: December 23, 2009

INDEX OF EXHIBITS

Exhibit A: Updated Declaration of Plaintiff Dallas Cobbs (12/09)

Exhibit B: MDOC Policy Directives and Operating Procedures

Exhibit C: Dallas Cobbs' Medical Records[26]

Exhibit D: Dallas Cobbs' Grievances and Responses

Exhibit E: Dallas Cobbs' Health Care Requests (Kites) and Letters

Exhibit F: Deposition of Dr. Michael McGrath, O.D.

Exhibit G: Deposition of Paul Piper, M.D.

Exhibit H: Deposition of George Pramstaller, M.D.

Exhibit I: Deposition of Craig Hutchinson, M.D.

Exhibit J: Deposition of Utilization Review Nurse Brenda Jones

Exhibit K: MDOC Defendants' Response to Interrogatories

Exhibit L: CMS Care Enhance Computer Medical Records

Exhibit M: Declaration of Ophthalmologist Ghulam Dastgir, M.D., and Letters Supplied to MDOC re. Surgical Risks of Late Caratacts

Exhibit N: Declaration of Ophthalmologist Alan Sugar, M.D.

Exhibit O: CMS "Pass-Through" List

Exhibit P: Snellen Eye Chart

Exhibit Q: *Titlow v. Corrections Medical Services*, 2008 WL 907450 (E.D. Mich. No. 07-CV-12083 (3/31/08)

Exhibit R: *Castillo v. Dashiell*, 2007 WL 609858, No. CV S-04-0737, at *7 (E.D.Cal., Feb. 27, 2007) (*unpublished case*) (adopted at 2007 WL 933790, No. CV-0737 (E.D. Cal., Mar 27, 2007)

[26] These documents are not filed under seal with the plaintiff's permission, because he wants the public to be able to see what happened to him. His date of birth and other data subject to identity theft have been redacted, pursuant to Local Rule 5.3 and Fed. R. Civ. P. 5.2.