UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Case No. 10-2089

DALLAS COBBS,

Plaintiff-Appellee,

v.

GEORGE PRAMSTALLER, Chief Medical Officer,
Michigan Department of Corrections,

Defendant-Appellant,

and

CRAIG HUTCHINSON, Doctor, *et al.*,

Defendants.

Appeal from the United States District Court
Eastern District of Michigan
Honorable Anna Diggs Taylor

BRIEF FOR PLAINTIFF-APPELLEE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to 6th Cir. R. 26.1, Mr. Cobbs states that he is not a subsidiary or affiliate of a publicly owned corporation. There is no publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome.

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Dallas Cobbs requests oral argument under 6th Cir. R. 34(a). The case has a long and complicated factual record, and the Court may benefit from the chance to question both sides. Mr. Cobbs further requests that oral argument be conducted in person. The court rules do not suggest that representation by a clinical law program makes live oral argument less appropriate. *See* 6th Cir. R. 34(h)(4). Finally, many prisoners' rights cases are decided based on *pro se* briefs from the prisoner. Where the prisoner has counsel, and the case raises an issue of public concern that could affect other prisoners, oral argument should be granted.

STATEMENT OF ISSUE PRESENTED FOR REVIEW

Is defendant Pramstaller entitled to qualified immunity where (1) he denied evaluation and treatment of a prisoner's serious medical need for almost four years, (2) every doctor who examined the prisoner requested eye surgery, (3) the prisoner went blind in one eye and suffered from headaches, dizziness, double vision, and other serious side effects before the surgery was finally approved, and (4) the state corrections department's own standards said the surgery should be performed?

STATEMENT OF THE CASE

Plaintiff Dallas Cobbs filed this § 1983 lawsuit *in pro per* in October 2007, after being denied cataract surgery for almost four years. He named several defendants, including Michigan Department of Corrections (MDOC) chief medical officer Dr. George Pramstaller, as well as various agency and John Doe defendants. Mr. Cobbs sought damages and injunctive relief for the defendants' collective failure to approve his cataract surgery from 2004 to 2007.[1]

Defendant Pramstaller filed a motion to dismiss in January 2008. He argued that he had nothing to do with the decision to deny the surgery, and that therefore he could not be held liable. (R.12, Defendant's Motion for Summary Judgment, and Affidavit in Support, at 1-2.) Mr. Cobbs asked the district court to stay the motion pending limited discovery as to Pramstaller's role. Mr. Cobbs also wanted to identify the John Doe members of the Medical Services Advisory Committee (MSAC), which made the final decision to deny the surgery, and which Pramstaller chaired. (R.17, Motion for Stay.) Mr. Cobbs attached documents to his motion showing that the MSAC (and Pramstaller personally) had reviewed his doctors' requests for the cataract surgery, and had denied them. *Id*.

[1] From the spring of 2004, every optometrist, doctor, and ophthalmologist who actually *examined* Mr. Cobbs said that he needed surgery to remove the dense cataract on his left eye, and each sought MDOC approval for it. Their requests were denied at least 16 times between 2004 and 2008. (R. 106, Medical Records, Exh. C.)

In February 2008 the undersigned counsel interviewed Mr. Cobbs. Shortly thereafter, Mr. Cobbs was informed that his cataract surgery had been approved.[2] In April 2008, following a status conference, the magistrate judge issued a series of orders. Pramstaller's pending motion to dismiss and Mr. Cobbs' pending *pro se* motions were withdrawn. (R.29 and R.34, Orders.) In June 2008, the magistrate judge granted Mr. Cobbs leave to file an amended complaint and to conduct limited discovery. (R.37, Order.)

In June 2008, Mr. Cobbs (now by counsel) filed his amended complaint. He dropped state agency defendants with Eleventh Amendment immunity and added the individual MSAC members. (R.38, Amended Complaint, and R.34, Request for Identification of John Does.) He also added the MDOC's contract medical provider, Correctional Medical Services, Inc. (CMS), as well as two physicians who had served as CMS's Michigan medical directors.[3]

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

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[2] The defense maintains that there was no connection between the two events, but never submitted any affidavit from any defendant on the issue.

[3] At all relevant times, CMS, Inc., contracted with the MDOC to provide medical care to Michigan prisoners, including primary care within the prisons as well as all off-site specialty care.

the doctrine of qualified immunity. (R.66, MDOC Defs' Motion for Summary Judgment.) In December 2008, the magistrate judge entered a report and recommendation denying the defense motion as to qualified immunity. (R.77, Report & Recommendation.)[4] After objections, in February 2009 the district court adopted the R&R, finding that Mr. Cobbs' condition was "obvious enough that a layperson would recognize the need [for the surgery]." *Id.* (R.82, Order Adopting R&R.) Full discovery then commenced.

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 MSAC's denials of the requests for eye surgery. (R.90 and R.105, Stipulations and Orders to Dismiss.)

In November 2009 the parties completed discovery. In December 2009, defendant Pramstaller once again moved for summary judgment based on qualified immunity. (R.104, Defendant's Motion.) Again the magistrate judge recommended denial of the motion. (R.115, Report & Recommendation.) And again, following objections, the district court adopted the report and recommendation on that issue. (R.133 Order Adopting (in part) R&R.) Defendant Pramstaller then

[4] The magistrate judge dismissed the claims for injunctive relief as moot, because Mr. Cobbs had finally been approved for cataract surgery in March 2008, and the surgery had been successfully performed in April 2008.

filed this interlocutory appeal of right, limited to the issue of qualified immunity. (R.138, Notice of Appeal.)

STATEMENT OF FACTS

1. 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. (R.106, Cobbs Declaration (12/09), Exh. A, at 1; R.38, First Amended Complaint, at ¶ 6.) In early 2004, Mr. Cobbs had significant vision problems due to cataracts in both eyes. (R.106, 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 prevent it. (R.106, 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 at all times Mr. Cobbs wanted the surgery, and that there was no *medical* reason that would counsel against it, let alone preclude it.

Because prison doctors cannot perform cataract surgery themselves, they must instead submit a request for off-site "specialty care." (R.106, Pramstaller Dep., Exh. H, at 18-22; Hutchinson Dep., Exh. I, at 14-16; OP 03.04.100 (Review Process for Off-Site Health), Exh. B, at 14-16; Jones Dep, Exh. J, at 19-22.)

The process for off-site specialty care is straightforward. The treating physician submits a form to a utilization review ("UR") department, requesting the off-site specialty care. *Id*. UR nurses can approve some specific treatments but can never deny treatment. (R.106, Jones Dep., Exh. J, at 31-32, 40, 71.) Denials are made only by physician-supervisors in the UR department, or by the CMS medical director. *Id*. at 27.

The UR department can approve the request, deny the request, or "pend" it for more information. *Id*. (R.106, OP 03.04.100, Exh. B, at 14-15.) 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 request and response forms become part of the prisoner's medical record. (R.106, Piper Dep., Exh. G, at 14-15.)

If the request is "pended," the prison doctor will submit whatever additional information the UR department asks for, at which point the UR office will make a decision. (R.106, OP 03.04.100, Exh. B, at 14-16.) If the request is denied – either originally or after having been "pended" – the requesting doctor can appeal. The first appeal goes back to the UR unit. *Id*. If the UR supervisor denies the request again, the doctor can file a second appeal to the MDOC regional medical officer. That officer makes sure that the file is complete, and then forwards the

case to the chief medical officer (Pramstaller), who brings it to the Medical Services Advisory Committee (MSAC) for decision at its next monthly meeting. *Id*.

2. The Facts of Mr. Cobbs' Case

The defense statement of facts, while chronologically accurate, presents as given some facts that are contested, and leaves out details of Mr. Cobbs' condition on which the case hinges. Because on a qualified immunity appeal this Court must take the facts in the light most favorable to Mr. Cobbs, the plaintiff will re-state his medical history from 2004 to 2008. (The devil is in the details.)

In March 2004, Mr. Cobbs saw an on-site contract optometrist to address his worsening vision caused by cataracts on both eyes. The optometrist recommended that Mr. Cobbs see an ophthalmologist. The UR unit denied this request because Mr. Cobbs' vision in his left eye (the eye with the less-advanced cataract) was 20/40. (R.106, Medical Records, Exh. C, at 5.) Mr. Cobbs' primary care physician, Dr. Paul Piper, appealed the UR denial. *Id*. The UR unit again denied his request, for the same reason: "Not authorized ophthalmology consult for cataracts. Criteria for cataract removal not met since vision [left eye] = 20/40." *Id*. (R.106, Care Enhance Records, Exh. L, at 1.)[5]

[5] From this and similar denials, the Court (and a reasonable jury) could conclude that the MDOC would never approve a cataract surgery if the best corrected vision (with glasses) in the healthier eye was better than 20/50. The CMS medical direc-

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." (R.106, Medical Records, Exh. C, at 6.) The appeal went to the MDOC regional medical director for forwarding to the MSAC.

In June 2004, the MSAC approved the ophthalmology consultation and the cataract surgery for the more advanced right-eye cataract.[6] (R.106, Exh. C, Medical Records, at 8.) The MSAC's decision is hard to explain, because at this point the vision in Mr. Cobbs' left eye was still 20/40. That is, nothing had changed *medically* from the earlier decisions denying the consultation and surgery on the ground that the corrected vision in Mr. Cobbs' healthier left eye was 20/40.

In fact, the MSAC approved the first (right-eye) cataract surgery *not* because of any change in Mr. Cobbs' medical condition, but because of his "lifer status." (R.106, Medical Records, Exh. C, at 8 ("MSAC decision based on lifer status").) As a lifer, Mr. Cobbs was not going to be released any time soon, so he would be unable to pay for the surgery himself (upon his release) in the foreseeable future.

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tor testified that cataract surgery would not be approved until the healthier eye was 20/50 or worse. (R.106, Hutchinson Dep., Exh. I, at 27.)

[6] For this request it appears that the MSAC and/or UR unit 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.

In July 2004, Mr. Cobbs had a consultation with ophthalmologist Dr. Ghulam Dastgir. (R.106, Exh. C, at 11-14.) At 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. 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*." (R.106, Exh. C, at 13; Piper Dep., Exh. G, at 55, 60-61 (emphasis added).)[7]

The ophthalmologist noted that Mr. Cobbs was unable to see out of his right eye and also had "*double vision with [left eye] – 6 months – it is getting worse." "[Patient] going blind."* (R.106, Medical Records, 7/27/09, Exh. C at 12, 13; Piper Dep., Exh. G, at 57-58 (emphasis added).) Dr. Dastgir recommended cataract surgery and lens implants in both eyes, the right eye first and the left to follow "a few weeks later." He then scheduled Mr. Cobbs for scans of both eyes in preparation for the surgery. (R.106, Exh. G, Piper Dep., at 59-60; Medical Records, Exh. C, at 13-14.)

[7] By this appointment in July 2004, Mr. Cobbs' corrected vision in his "healthier" left eye was well below 20/40, so he met the ostensible standard – at least as articulated by Dr. Hutchinson – for the right-eye surgery. *See* note 5, *supra*.

Dr. Piper sent a follow-up authorization request for Dr. Dastgir's "plan of management" to the UR unit, which approved the cataract removal surgery and lens implant.[8] (R.106, Medical Records, Exh. C, at 10, 15.) In August 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 have both operations "in the very near future." *Id*.

On August 30, 2004, Dr. Dastgir removed the cataract on Mr. Cobbs' right eye. (R.106, Exh. C, at 20.) 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.) 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; R.106, Piper Dep., Exh. G, at 65-66.)

In early September, Mr. Cobbs was told that the surgery on his left eye had to be re-scheduled because it had been inadvertently set for the Labor Day holiday. (R.106, Grievances, Exh. D, at 1.) When six weeks passed without Mr. Cobbs hearing anything about the surgery, he sent an inquiry to health services. (R.106,

[8] *See* note 6, *supra*. The UR approvals were mistakenly issued for the wrong eye.

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." (R.106, Medical Records, Exh. C, at 26 (emphasis added).) On October 7, 2004, Dr. Piper examined Mr. Cobbs and sent an off-site ophthalmology request, citing Dr. Dastgir's treatment plan that Mr. Cobbs was to have the second cataract operation. (R.106, Medical Records, Exh. C, at 27.)

At that point (October 2004), based on records that had already been submitted, the UR unit 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. (R.106, Med. Records, Ophthalmology Notes of July 2004, Exh. C, at 12-13.)

The UR unit first "pended" the request and then forwarded it 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. (R.106, Pramstaller Dep., Exh. H, at 54-58.) CMS's medical director testified that the UR unit *nurses* could approve second-cataract surgery if the patient had a posterior sub-capsular cataract that caused glare, a great disparity in vision, or

double vision in the affected eye. (R.106, Hutchinson Dep., Exh. I, at 26-32; Exh. O, Pass-Through Sheet.) In other words, approval of cataract surgery for Mr. Cobbs' precise condition and symptoms should have been routine.

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 had a dense posterior sub-capsular cataract and suffered from (a) sub-capsular glare, (b) a huge disparity in vision, and (c) documented double vision in his left eye for six months as of July 2004, the MSAC and defendant Pramstaller denied the left-eye surgery in October 2004. (R.106, Pramstaller Memo, Medical Records, Exh. C, at 29.) In doing so, they effectively vetoed the UR department's "pass-through" sheet, which allowed UR *nurses* (without a supervisor's okay) to approve second cataract surgeries if there was sub-capsular glare or great discrepancy in vision. (R.106 Exh. O, Pass-Through Sheet.)

In deposition, Dr. Pramstaller could not explain why the surgery was denied.

Q. And what would be … examples of medical reasons for not doing both [eyes]?
A. If a patient was extremely ill and doing the surgery would be a danger to their [*sic*] overall health, that would be a reason for not doing it.
Q. Other than reasons that have to do with the patients' health, and danger to the patient's health, are there any other reasons you can think of why a second cataract surgery would be denied?
A. Not right off hand, no.

(R.106, Pramstaller Dep., Exh. H, at 52.) In fact, Pramstaller testified repeatedly that someone with Mr. Cobbs' precise condition/symptoms should have the cataract removed:

> A. …the other thing is…if you have someone who…has 20/20 vision in the first cataract eye, but the second 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.
>
> A. I said that when the visual disparity between his two eyes was of such magnitude that it could cause him problems in seeing, that we would do the surgery.
>
> A. Well, as I stated previous, if you have a posterior sub-capsular cataract that's causing significant glare and affecting the vision on the opposite side, that that would be an indication for doing the cataract, yes.

Id. at 58-60, 71.

In November 2004, Mr. Cobbs sent another health care request (kite) asking if his surgery had been scheduled. (R.106, 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 told a reason for the 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. (R.106, Grievances, Exh. D, at 1.) Mr. Cobbs' grievance was denied and he exhausted the two appeals available to him. In his first appeal he said that he needed the surgery because the vision in his "left eye is getting worse by the day." *Id*. at 3.

The appeal was denied, citing the MSAC denial of October 26, 2004, 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*. 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 [mistakenly] approved the left eye surgery, but had rescinded that approval, and that Mr. Cobbs could pay for the surgery himself if he disagreed. *Id*. at 5.

Mr. Cobbs' vision in his left eye continued to fail. He requested new glasses in March 2005. (R.106, Kites, Exh. E, at 2.) He was examined in May 2005 by a different optometrist, Dr. Connolly. (R.106, Medical Records, Exh. C, at 31-32.) The new optometrist noted that Mr. Cobbs had a posterior sub-capsular cataract and nuclear sclerosis in his left eye. *Id*. (R.106, McGrath Dep., Exh. F, at 38 (interpreting Dr. Connolly's handwritten notes).) 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. (R.106, Kites, Exh. E, at 3; Medical Records, Exh. C, at 32; McGrath Dep., Exh. F, at 38-39.)

Dr. Connolly, like his predecessors, requested an off-site ophthalmology evaluation (as a prerequisite to surgery). (R.106, Exh. C, at 31.) This request was denied by the UR unit, citing the MSAC denial issued eight months earlier (in

October 2004), despite the fact that Mr. Cobbs' vision was "getting worse by the day." *Id*. at 33. (R.106, Grievances, Exh. D, at 3.)

After submitting two more futile health care kites, Mr. Cobbs filed another grievance in June 2005. *Id.* at 6. The July response said 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) an off-site "cataract eval and possible surgery." (R.106, Medical Records, Exh. C, at 32.)

Mr. Cobbs' vision continued to worsen. In November 2005 – 18 months after the MDOC's own contract ophthalmologist had first requested the left-eye cataract surgery – 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." (R.106, Kites, Exh. E, at 4.) In December 2005, Mr. Cobbs had another optometry exam. (R.106, Medical Records, Exh. C, at 34.) Dr. McGrath examined Mr. Cobbs and concluded that "cataract surgery [was] *needed*." *Id*. (emphasis added).

Dr. McGrath's report shows that Mr. Cobbs' best corrected vision in his left eye had deteriorated to 20/600 in just seven months. *Id*. (R.106, McGrath Dep., Exh. F, at 49-51.) By December 2005 the cataract had become so thick that it was

impossible to view the retina in the left eye.[9] *Id*. (R.106, Exh. C, at 34; McGrath Dep., Exh. F, at 50.) Dr. McGrath also reported serious side effects: "patient has trouble w/ depth perception; …patient has…walked into objects on left side." (R.106, Medical Records, Exh. C, at 34.)

Again, the UR unit denied the doctor's request for surgery, based on the previous MSAC denial and the fact that Mr. Cobbs "had a good response to surgery on his [right] eye." (R.106, Exh. C, at 35; McGrath Dep., Exh. F, at 64.) Dr. McGrath appealed the denial, explaining that he could not screen for glaucoma (because the cataract prevented him from seeing into the eye) and requesting more frequent follow-up visits if the cataract surgery were denied. (R.106, Medical Records, Exh. C, at 35; McGrath Dep., Exh. F, at 65-66.) The more frequent follow-up visits were never scheduled.

In March 2006, Mr. Cobbs had another eye exam. (R.106, Medical Records, Exh. C, at 36.) Dr. McGrath again indicated that Mr. Cobbs needed 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*. The UR unit again denied Dr. McGrath's request in March 2006, stating that the "MDOC/MSAC already re-

[9] Dr. McGrath's report read: "Please evaluate dense cataract [left eye]. … Cataract surgery needed. No view of retina in left eye." (R.106, Exh. C, at 37.)

viewed this case [in October 2004] and have not authorized." *Id*. at 38. Dr. McGrath appealed to the MSAC, stating, "surgery advised to prevent secondary glaucoma…*no view* of left retina possible to check eye health." *Id*. (emphasis in original). Dr. McGrath wrote on the appeal form, "patient needs cataract surgery – hypermature cataract surgery is more complicated and there is risk of [secondary] glaucoma." *Id*. at 39.

In April 2006, the UR unit sent the case to the MSAC with the note "already not authorized x 2 @ CMS." *Id*. On April 25, 2006, the MSAC "upheld non-approval for ophthalmology consult for cataract [left eye]." *Id*. at 40 (entry signed by Dr. Pramstaller). The MSAC denial memo said only, "upheld non-approval."[10]

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. (R.106, Cobbs 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*. In May 2006, Mr.

[10] The comments section read: "monitor closely for increase in interocular pressure and resubmit if pressure increases." Intraocular pressure is used to monitor for glaucoma. (R.106, 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.

Cobbs sent a health care request stating, "I can no longer see out of the [left] eye." (R.106, Kites, Exh. E, at 5.) He sent another kite in June 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. at 5. He filed yet another kite in July 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*. at 7.

Dr. Pramstaller was asked about the appropriate treatment for someone with Mr. Cobbs' symptoms:

> Q. …but once the cataract has grown to the point that the patient can see nothing in that eye, do you do the surgery, or do you still wait?
> A. No, you probably should do the surgery.
> * * * * * *
> A. [If] you put a patch on, that blocks out that [weaker] eye completely, so there is no more discrepancy.
> Q. Then why would you ever [remove] a second cataract, why wouldn't you say to everyone, Wear a patch?
> A. (Objection omitted.) That's not a very humane way to treat people.

(R.106, Pramstaller Dep., Exh. H, at 58-60, 74.)

Mr. Cobbs was again seen by Dr. Piper in July 2006. Dr. Piper noted that Mr. Cobbs "has [history] of losing sight in left eye" and asked the UR unit to take note of the significant deterioration in Mr. Cobbs' vision since 2004. (R.106, Medical Records, Exh. C, at 42.) Dr. Piper's request that Mr. Cobbs be revaluated

by an ophthalmologist was again denied based on the MSAC's April 2006 decision not to authorize an ophthalmology consult or surgery. *Id*. at 43.

Later that summer, Mr. Cobbs' father tried to intervene by writing directly to Dr. Pramstaller. Although no copy of that letter exists, a copy of the response is in the file. (R.106, Kites and Letters, Exh. E (9/13/06), at 8.) 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.

Id. 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 to date *disagreed* with the "current treatment plan" – which was to deny even an *evaluation* by an ophthalmologist, let alone surgery. Pramstaller's "treatment plan" was to provide no treatment at all.

Mr. Cobbs saw an optometrist again (this time Dr. Cook) in August 2006. Dr. Cook referred Mr. Cobbs for cataract surgery. Dr. Cook crossed out the box

labeled "routine" and marked the referral as "urgent." (R.106, Medical Records, Exh. C, at 44.) Dr. Cook noted that Mr. Cobbs' left eye was "opaque" and that he suffered from "extreme photophobia[11] – subjective and objectively" and "[wore] patch on left eye to function." *Id*. Dr. Cook noted that the "cataract is approaching hypermaturity – condition may preclude use of phacoemulsification."[12] Dr. Cook's request for cataract surgery was denied in three words: "See MSAC response," presumably referring to the MSAC decision of April 2006. *Id*.

On October 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." (R.106, Kites, Exh. E, at 9.)

Mr. Cobbs saw an optometrist again in December 2006. Dr. McGrath filed a request for off-site 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." (R.106,

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[11] "Photophobia" is "aversion to light." (R.106, Hutchinson Dep., Exh. I, at 109.)

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

Medical Records, Exh. C, at 46.) In March 2007, the UR unit denied the request for surgery "based on 20/20 vision in the right eye." *Id*. at 49.

As noted, in addition to his examining doctors' requests, Mr. Cobbs himself sought help repeatedly by filing numerous kites, grievances, and appeals. (R.38, Amended Complaint, ¶¶ 18-86; R.106, Cobbs Decl., Exh. A, ¶¶ 9-60.) His 2005 requests documented his worsening eyesight. (R.106, 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. (R.106, Grievances, Exh. D, at 7, 8, 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. (R.106, 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. (R.106, Cobbs Decl., Exh. A, at 8-9.) Mr. Cobbs' requests increased in urgency as the side effects got worse.

On April 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." (R.106, Kites, Exh. E, at 10.) He had another eye exam in May 2007. (R.106, 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. *Id.* (R.106, McGrath Dep., Exh. F, at 126.) Dr. McGrath also noted that

Mr. Cobbs complained of double vision in his right eye for the past two months. *Id*., (R.106, Medical Records, Exh. C, at 51.) Dr. McGrath made an "urgent" referral for an off-site ophthalmology consultation. *Id*. at 50.[13]

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 right eye, and the possibility of the formation of a secondary cataract in his right eye, the request for an off-site ophthalmology evaluation was again denied by the UR unit. (R.106, Medical Records, Exh. C, at 52; Care Enhance Forms, Exh. L, at 21.)[14]

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[13] Dr. McGrath attributed the worsening vision in the right eye to a possible new "secondary cataract" that Dr. McGrath thought might be forming in the right eye. (R. 106, McGrath Dep., Exh. F, at 126.) That turned out not to be the case. To the contrary, the Kresge Eye Clinic in Detroit examined Mr. Cobbs and told him that he did not have a secondary cataract in his right eye. He also never had laser surgery to treat such a cataract. (*Compare* Def's Brief, Statement of Facts, at 20, *with* R.106, Exh. A, Cobbs Declaration, at 11.)

[14] This denial is telling, because if the standard was that cataract surgery would be approved when the vision in the healthier eye fell below 20/40 (R.106, Hutchinson Dep., Exh. I, at 27), then this request for off-site specialty care 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. (R.106, Jones Dep., Exh. J, at 40, 71.) The optometrist's notes 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. (R.106, Medical Records, Exh. C, at 50-51.) Yet the UR unit routinely denied the request again in the spring of 2007, just as it had every time before.

Meanwhile, Mr. Cobbs' situation worsened. He sent another kite to health care in September 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." (R.106, Kites, Exh. E, at 11.) He saw a nurse in October 2007, who documented the same complaints. (R.106, Medical Records, Exh. C, at 53.) In late October 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. 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….

(R.106, 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 (8 out of 10 on a pain scale) headaches. (R.106, Kites, Exh. E, at 12-13; Medical Records, Exh. C, at 55-58.) Mr. Cobbs was not scheduled for cataract surgery or even an ophthalmology consult, based on the previous denials.

With the filing of the lawsuit, Dr. Pramstaller had the opportunity to review the entire file, to see if a mistake had been made. Instead of approving an off-site consultation with a specialist, Dr. Pramstaller filed a motion to dismiss, saying in effect that he had no connection to the case and that he had never been a decision-maker. (R.12, Motion to Dismiss and Affidavit in Support.)

On February 6, 2008, Mr. Cobbs saw the optometrist Dr. McGrath again. Dr. McGrath filed virtually the same request for an ophthalmology consult and surgery that he had been filing for four years. (R.106, Medical Records, Exh. C, at 59.)[15]

The UR unit approved the request on February 12, 2008. (R.106, Care Enhance Records, Exh. L, at 23.) On February 26, 2008 – after waiting almost four years – Mr. Cobbs finally saw the ophthalmologist (Dr. Datsgir) again. (R.106, Medical Records, Exh. C, at 62-65.) Dr. Datsgir found that Mr. Cobbs could barely detect light with his left eye at three inches on account of a "hypermature chalk white cataract." *Id.* at 62. He also noted that Mr. Cobbs had complained of "headache & double vision [for] 3 years." *Id.* at 64. Dr. Dastgir recommended

[15] In deposition, on leading questions from his own counsel, Dr. McGrath described Mr. Cobbs' double vision in February 2008 as both "monocular" (meaning that he was getting a double image in his right eye) *and* "binocular" (meaning that he was getting a double image from both eyes). (R.106, McGrath Dep., Exh. F, at 126, 128-29.) The defendant argues that this was somehow something *new* that at long last justified approval of an ophthalmology consult after four years of denials. This is hogwash. 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). (R.106, Cobbs Decl., Exh. A, at 5-7.) 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 February 7, 2008, did not highlight in any way that the complaint was of a new or different nature. (R.106, Medical Records, Exh. C, at 59-60.)

pre-operative procedures and cataract surgery for Mr. Cobbs' left eye, just as he had in the spring of 2004. *Id.* at 62-64.

On March 10, 2008, Dr. Piper submitted an off-site specialty care request form pursuant to Dr. Dastgir's recommendations. For unknown reasons, this request was routed directly to the MSAC, bypassing the UR unit and the appeals process. On March 14, 2008, the MSAC finally approved the left-eye surgery. (R.106, Medical Records, Exh. C, at 67.)[16]

Mr. Cobbs' second cataract surgery was finally performed in April 2008. As Dr. Dastgir had predicted (R.106, Dastgir Decl., Exh. M, at 2, 4-8), the surgery and recovery were tougher than the first time around. Mr. Cobbs had painful pressure in his eye immediately after the surgery, and he had to return for a follow-up procedure to stop the wound from leaking. (R.106, Medical Reports, Exh. C, at 77-82; Cobbs Decl., Exh A, at 10-11.) Mr. Cobbs fully recovered his sight; he seeks damages for the denial of care from 2004 to 2008.

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[16] The paperwork was unusual for the fact that (1) it was approved in four days, (2) no supplemental information was requested, and (3) the request was routed directly to the MSAC, bypassing the appeals process. The paperwork was nearly identical to the April 2007 request (that had been routinely denied despite the 20/50 "best corrected vision" score for the right eye), as well as to the requests that the treating doctors had been filing for the previous four years. Although the defense denies any connection, a reasonable jury could infer that the *only* thing that had changed was the posture of the litigation – that Dr. Pramstaller's motion to dismiss was in jeopardy (because he personally had overseen the denial of care), and/or that Mr. Cobbs had attracted counsel.

SUMMARY OF THE ARGUMENT

The defense presents a skewed view of the doctrine of qualified immunity. The defense asks: Was the law "clearly established" that prison officials must approve cataract surgery? Finding no case on point that requires the surgery, the defense argues that it should win as a matter of law.

But courts have never interpreted qualified immunity in this narrow way. If they did, no plaintiff could win unless the same facts had already been decided in a previous identical case. *See Anderson v. Creighton*, 483 U.S. 635, 640 (2000).

Qualified immunity requires a broader inquiry. What must be "clearly established" is not whether a class of medical conditions has been the subject of a prior case, but whether a reasonable defendant would know that withholding treatment from a person with the plaintiff's symptoms violates the Eighth Amendment. That inquiry is both legal and factual.[17]

Moreover, in this case Dr. Pramstaller denied treatment despite conceding that the MDOC should authorize treatment for someone with Mr. Cobbs' exact

[17] An example is helpful. Breast reduction surgery is typically viewed as cosmetic or elective surgery that can be routinely denied to prisoners. But if a prisoner suffers from severe breast pain and the only treatment is to remove tissue and tie off nerves, state defendants are not shielded from Eighth Amendment liability just because no court has previously "required" breast reduction surgery. Where the medical need is serious and obvious, and would be routinely provided in other settings, qualified immunity is no defense. *See, e.g.*, *Titlow v. Corr. Med. Services*, 2008 WL 2697306 (E.D. Mich. July 3, 2008).

condition/symptoms. Dr. Pramstaller also admitted that not treating someone with Mr. Cobbs' symptoms would be "inhumane,"[18] and Dr. Pramstaller was at a loss to explain how Mr. Cobbs could have been denied treatment for almost four years.

Qualified immunity is not available to Pramstaller because he violated Mr. Cobb's constitutional rights by denying all treatment for a serious medical need. The law is "clearly established" that a reasonable medical officer would understand that prompt treatment is required for a prisoner who is blind in one eye, who is suffering from pain and discomfort, whose treating doctors all note that the surgery is required, whose eye health cannot be diagnosed because of the severity of the cataract, and whose risk of complications from surgery increases as the cataract grows worse. Taking the facts in the light most favorable to Mr. Cobbs, defendant Pramstaller is not entitled to qualified immunity.

[18] 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." (R.106, Policy Directive 03.03.130, Exh. B, at 2, ¶ G (emphasis added).)

ARGUMENT

I. Standard of Review

This Court reviews de novo the district court's denial of summary judgment. *Elkins v. Summit County*, 615 F.3d 671, 674 (6th Cir. 2010). That the defendant's motion for summary judgment was based on claims of qualified immunity does not affect this standard of review. *Id.* The defendant, however, must "be willing to concede the most favorable view of the facts to the plaintiff for purposes of the appeal," even if "the defendant disputes the plaintiff's version of the story." *Moldowan v. City of Warren*, 578 F.3d 351, 370 (6th Cir. 2009) (citing *Berryman v. Rieger*, 150 F.3d 561, 563 (6th Cir. 1998)).

II. Pramstaller's Deliberate Indifference to Serious Medical Needs Violated Mr. Cobbs' Eighth Amendment Rights

A state defendant violates the Eighth Amendment if he is deliberately indifferent to a prisoner's serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). Deliberate indifference is made up of two parts, one objective and one subjective. *Blackmore v. Kalamazoo County*, 390 F.3d 890, 895 (6th Cir. 2004) (citing *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). Both components are met here.

A. Mr. Cobbs Suffered from an Objectively Serious Medical Need

The objective prong of deliberate indifference is satisfied when the plaintiff suffers from a serious medical need. 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.

In *Blackmore*, this Court held that the seriousness of the plaintiff's medical condition was obvious where the patient vomited, was kept in an observation cell for monitoring, and complained orally and in writing for over two days. *Blackmore*, 390 F.3d at 899. Based on those facts, this Court recognized that the need for medical care was "so obvious that even a layperson would easily recognize the necessity for a doctor's attention." *Blackmore*, 390 F.3d at 899 (internal citations omitted). In *Flanory v. Bonn*, 604 F.3d 249, 254 (6th Cir. 2010), this Court found that depriving an inmate of toothpaste for 337 days satisfied the objective prong.

The deprivation was obvious; the periodontal disease that resulted made the deprivation serious.

In this case, Mr. Cobbs' left eye deteriorated rapidly, from 20/40 in March 2004 to 20/400 with glare in July 2004. (R.106, Medical Records, Exh. C, at 6, 13; Piper Dep., Exh. G, at 55, 60-61.) He walked into objects, could not read or watch television or do anything that required concentration, had eye strain in his right eye, and had severe headaches. (R.106, Medical Records, Exh. C, at 34; R.106, Cobbs Decl., Exh. A, at 8-9; R.106, Kites, Exh. E, at 9 &11.) He filed a steady stream of medical kites and grievances. (R.106, Kites, Exh. E.) His treating physicians requested surgery at least 16 times, documenting the need for the surgery and the danger of delaying surgery. (R.106, Medical Records, Exh. C, *passim*.)

As in *Blackmore* and *Flanory*, the facts of this case show an obvious need for medical care that any layman could recognize, lasting for nearly four years and causing physical harm throughout that time. Every optometrist, physician, and ophthalmologist who examined Mr. Cobbs said that the cataract needed to be removed, yet all treatment was repeatedly denied. The district court found that "the condition that was known to the Defendants … is obvious enough that a layperson would recognize the need [for the surgery]." (R.77, Report & Recommendation; R.82, Order Adopting Report & Recommendation.) The court below twice denied

summary judgment on this ground, both before and after discovery. (R.115, Report & Recommendation; R.13, Order Adopting Report & Recommendation.) Mr. Cobbs' cataract constituted a serious medical need under *Blackmore*, 390 F.3d at 897, and it far exceeded the serious medical need described in *Flanory*, 604 F.3d at 255-56. Mr. Cobbs has established a serious medical need.

Once the seriousness of a prisoner's need for medical care is obvious, there must only be a substantial *risk* of serious harm – actual harm need not occur. The "violation is not premised on the ‚detrimental effect' of the delay, but rather that the delay alone in providing medical care creates a substantial risk of serious harm" and that the need was not addressed within a reasonable time. *Blackmore*, 390 F.3d at 899-90. Here the delay caused years of unnecessary suffering, and limited Mr. Cobbs' basic functions of daily life. Ultimately the surgery itself (in 2008) was riskier, more painful, and required follow-up care because of complications.

The "obviousness" standard for determining a serious medical need "is distinct from a separate branch of Eighth Amendment decisions where the seriousness of a prisoner's medical needs may *also* be decided by the *effect* of delay in treatment." *Blackmore*, 390 F.3d. at 897 (internal quotations omitted) (emphasis added). In "effect" cases – where the underlying condition is modest but the delay itself causes significant harm – the plaintiff must place "verifying medical evidence in the record to establish the detrimental effect of the delay in medical treatment to

succeed." *Napier v. Madison County*, 238 F.3d 739, 742 (6th Cir. 2001) (internal quotations omitted). But here the condition itself was both obvious *and* serious.

Even if Mr. Cobbs were required to show an "effect" of the failure to treat, he has easily done so here. As the district court found, "[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.)

Moreover, Mr. Cobbs suffered from an objectively serious medical need under the analogous treatment standards of other organizations, as early as 2004. The defendant suggests that Mr. Cobbs' second-eye surgery was authorized "at the same or at a less advanced stage" than would have been required under other treatment guidelines. Defendant-Appellant's Brief, at 21 n.20. This is untrue. Under the treatment standards cited by the defendant, Mr. Cobbs' surgery would have been routinely approved at the outset.

The defense cites the cataract removal policy standards of Aetna. Def's Brief at 21 n.20. Under Aetna's three-prong test, Mr. Cobbs' surgery would have been approved in 2004. Subjectively, Mr. Cobbs complained that his ability to carry out daily activities was impaired in the fall of 2004. (R.106, Cobbs Decl.,

Exh. A, at 8; R. 103, Aetna Policy, Exh. K, at 2.) Objectively, his vision was compromised, and there was evidence of glare-related visual loss going back to the summer of 2004. (R. 106, 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; R. 103, Aetna Policy, Exh. K, at 3.) And Mr. Cobbs was "educated" about the risks of cataract removal surgery in the summer of 2004. (R. 106, Medical Records, Exh. C, at 14; R. 103, Aetna Policy, Exh. K, at 4.) Under the Aetna standards, Mr. Cobbs would have received his second cataract surgery in 2004, right after the first surgery. That is the customary treatment throughout the U.S.

The defense also cites the local coverage guidelines of Medicare/Medicaid. Def's. Br. at 21 n.20. Under these standards, Mr. Cobbs' second cataract surgery was "medically necessary" at the time of his first surgery, for similar reasons: the cataract impaired his ability to carry out daily living functions; he had been evaluated by a specialist who recommended surgery; he was told about the risks; and his visual acuity had dropped significantly. (R. 103, Medicare/ Medicaid Guidelines, Exh. L, at 4.)[19] Mr. Cobbs' cataract surgery was "medically necessary" under the Medicare/Medicaid standards as early as 2004.

[19] To satisfy the Medicare/Medicaid guidelines' vision-impairment" criterion, a patient's visual acuity must drop by two lines when tested for glare. (R.103, Medicare/Medicaid Guidelines, Exh. L, at 5.) On a standard eye chart, a two-line drop from 20/70 means that the patient's vision goes down to 20/200. (R.106, Snellen

Finally, the defense cites a Federal Bureau of Prisons' "Ophthalmology Guidance" document of February 2008. (R.103, Ophthalmology Guidance, Exh. J, at 8.) Under the federal BOC standards, second-eye cataract surgery is appropriate once there is a "documented, best-corrected visual acuity of 20/100 or less."[20] *Id.* Mr. Cobbs met even this standard by 2005, when Dr. McGrath found a best corrected visual acuity in the left eye of 20/600. (R.106, Medical Records, Exh. C, at 36.) Moreover, the BOC guidelines require referral to an eye specialist when a patient exhibits "distortion of vision," "obscured vision," "loss of vision," "double vision," or "new onset of abnormalities or opacities in normal transparent media of the eye." (R.103, Ophthalmology Guidance, Exh. J, at 8.) Under the federal BOP standards, Mr. Cobbs would have been referred for off-site ophthalmology evaluations starting in 2004. The MDOC/Pramstaller denied even *evaluation* by an ophthalmologist from the fall of 2004 to 2008.

In any other setting, Mr. Cobbs' surgery would have been approved, underscoring the fact that Mr. Cobbs suffered from an objectively serious medical need.

Eye Chart, Exh. P.) In 2004 Mr. Cobbs' left-eye vision decreased from 20/70 to 20/400 when glare-tested, a drop of *more than two lines*.

[20] The text of the federal standards is unclear, but it appears to refer to the best corrected vision in the affected eye, not in both eyes taken together. *Id.*

B. Pramstaller Had a Sufficiently Culpable State of Mind

The second component of deliberate indifference is subjective: the official must have a "sufficiently culpable state of mind in denying medical care." *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). He must be aware of facts from which the inference could be drawn that a substantial risk of harm exists, and he must draw such an inference. *Id*. at 837. In this case, it was not necessary for Pramstaller to "draw an inference" from the facts of Mr. Cobbs' medical history. Pramstaller had direct notice that Mr. Cobbs' vision was impaired, that he was suffering from glare, headaches, double vision, and other serious side effects like loss of balance and depth perception, that Mr. Cobbs was at risk for glaucoma, that removal of thick cataracts was a more complicated and dangerous surgery, and that Mr. Cobbs was blind in one eye. All that Dr. Pramstaller had to do was read the file.

"At a minimum a plaintiff must show that the official at least implicitly authorized, approved, or knowingly acquiesced in the unconstitutional conduct of the offending officers." *Hicks v. Frey*, 992 F.2d 1450, 1455 (6th Cir. 1993). Dr. Pramstaller's behavior far surpassed this standard. He was instrumental in block-ing the surgery in 2004, 2005, and 2006, as chair of the MSAC. Moreover, when Mr. Cobbs filed suit in late 2007, Pramstaller had the chance to review the medical file completely and to address the patient's serious medical needs. At that time he

denied involvement in the denial of care, and filed a motion to dismiss Mr. Cobbs' lawsuit.

Pramstaller was deliberately indifferent to Mr. Cobbs' serious medical need. Pramstaller and the MSAC discussed Mr. Cobbs' left-eye cataract three different times and each time decided to deny the surgery. The denial was not the result of oversight or negligence, but rather was a considered decision to overrule multiple medical requests from the treating/examining staff, contrary to MDOC standards.

The defense correctly points out that an inmate may not establish an Eighth Amendment violation merely because of disagreement about the treatment provided. *Napier v. Madison County*, 238 F.3d 739, 742 (6th Cir. 2001). The defense argues that "where a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments.…" *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir. 1976). Mr. Cobbs' case, however, does not involve any disagreement about a range of acceptable treatment choices. The only *choice* was to approve cataract surgery (the one treatment for Mr. Cobbs' condition) or to deny it and provide no treatment whatever. Defendant Pramstaller willfully chose the latter.

Pramstaller's decision to deny treatment was not based on any medical reason – there was no danger to Mr. Cobbs in going through with the surgery. Pramstaller's decision was apparently based on the idea that in prison one eye is

good enough, regardless of the prisoner's suffering. Pramstaller stuck to this decision even after Mr. Cobbs was blind in one eye, had serious side effects that impaired the activities of daily living, and suffered deteriorating vision in his right eye. The risks of delaying treatment were also known. (R.106, Exh. M, Dastgir Decl., at 2, and *id.,* Letters from Ophthalmologists.) This Court has said that "a prisoner who is needlessly allowed to suffer pain when relief is readily available does have a cause of action against those whose deliberate indifference is the cause of his suffering." *Westlake*, 537 F.2d at 860.

Where denial of treatment is based on broad generalities rather than on the specific conditions of the plaintiff, it is "an administrative decision divorced from the specific circumstances of plaintiff's condition, rather than a medical treatment decision with which plaintiff simply disagrees." *Titlow v. Corr. Med. Services*, 2008 WL 2697306 (E.D. Mich. July 3, 2008). Here, Pramstaller and the MSAC decided that a person does not need cataract surgery if the best corrected vision in the healthier eye is 20/40 or better (actually 20/50 or better – *see* denial of May 2007, R.106, Medical Records, Exh. C, at 50), no matter how much pain or suffering the person is enduring, and regardless of the effects on the person's daily life.

C. Pramstaller Violated a Clearly Established Right

To determine whether the law is clearly established, the Court cannot simply look at whether cataracts generally have been found to be a serious medical need in other cases. To the contrary, a right can be clearly established even if there is no previous legal case with identical facts. *Anderson v. Creighton*, 483 U.S. 635, 640 (2000). A court must look at the details of a case to determine whether a reasonable official would deem the denial of medical treatment to be unlawful in light of established precedent. *Id.* at 641. The law is clearly established that where, as here, a state official is deliberately indifferent to a prisoner's serious medical needs, that official is not entitled to qualified immunity. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

The defense cites a number of cases for the global proposition that a cataract does not qualify as a serious medical need. But these cases are easily distinguishable. First, *none* of the cases cited by the defense involved a *posterior sub-capsular cataract with glare*, which Pramstaller himself admitted constitutes a serious medical need:

> A. Well, if [prisoners have] a posterior sub-capsular cataract and it causes glare, the glare interferes with the 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.

(R.106, Pramstaller Dep., Exh. H, at 48-79.)

Second, even the cases cited by the defense distinguish between cases where the cataract *caused pain and affected the prisoners' activities of daily living*, and cases where the cataract did not. Third, all but one of the cited cases were litigated by *pro se* plaintiffs. As a result, little or no record was developed, and the briefs were not prepared by attorneys. The Court should not rely on unpublished *pro se* cases to set the boundaries of important Eighth Amendment rights.[21]

The plaintiff will distinguish the cited cases briefly. In *Espinosa v. Saladin*, 2009 WL 3102483 (W.D. Mich. 2009), the court found that the *pro se* plaintiff's cataract was not a serious medical need. But there the plaintiff complained that he needed the surgery because the delay might cause his good eye's vision to deteriorate *in the future*, not because he was already suffering pain or because the cataract was affecting his daily life. *Id.* at *5. The record in *Espinosa* is also very thin: it is unclear how advanced or how fast-growing the cataract was, or how it affected the plaintiff's vision or his ability to lead a normal life in prison. *Id.*

In *Edwards v. Bradford*, 1997 U.S. Dist. LEXIS 15089, at *3 (D.S. Ala. 1997), the *pro se* plaintiff had a cataract which caused some blurry vision in one eye. The treating doctor did not recommend surgery, and different sets of glasses

[21] Most of these cases were also decided long after the events that took place in this case, and therefore could not have been relied upon by the defendant here. Most of the cases are also from courts outside the Sixth Circuit, and thus apply somewhat different standards under the Eighth Amendment. *See* accompanying text, *infra*.

were prescribed to help correct the plaintiff's vision. *Id*. at *4. The plaintiff did not have to withdraw from school, and though he complained of "incidents" arising in prison as a result of his cataract, the court noted that the plaintiff had not stated, "either generally or in detail, the nature of [the incidents complained of]" nor "informed the Court how those incidents were related to his visual impairment." *Id.* at *4 n.1. In contrast, Mr. Cobbs' treaters said that surgery was *required* or *necessary*; some of them listed the need as *urgent*. He lost all vision in one eye and glasses were not prescribed because they were useless. And he submitted kites and grievances detailing how the cataract impaired his daily life.

In *Hurt v. Mahon*, 2009 WL 2877001 (E.D. Va. 2009), the court found no Eighth Amendment violation where the *pro se* plaintiff complained that he would soon be released from prison and could not afford the cataract surgery on his own. "[N]owhere in any of his submissions to the Court [did the] plaintiff claim to suffer pain as the result of his condition." *Id*. at *2 n.3 & *3. Further, the Fourth Circuit uses the outdated "shocks the conscience" test for the subjective prong of the Eighth Amendment standard. In the Fourth Circuit, the defendants' actions must be "[s]o grossly incompetent, inadequate, or excessive … as to be intolerable to fundamental fairness." *Id.* at *2.

In *Williams v. Shelton*, 2008 WL 2789031 (D. Or. 2008), the court found that the *pro se* plaintiff's cataract did not constitute a serious medical need. But in that

case, the same as Mr. Cobbs is arguing here, the court noted that "[t]he decision for surgical removal is usually based on the cataract's effect on the activities of daily living." *Id.* at *3. The court also found that there was no evidence that the delay caused any harm. *Id.* Here, in contrast, Mr. Cobbs has submitted uncontested evidence showing both serious effects on his activities of daily living and harm caused by the delay in treatment.

In *Leyser v. D'Amico*, 182 F. App'x 697 (9th Cir. 2006), the court said that the *pro se* plaintiff's denial of cataract surgery was not an Eighth Amendment violation. But in the Ninth Circuit, "a delay in medical treatment must lead to further injury to support a claim for deliberate indifference." *Id.* at 698. *Cf. Blackmore*, 390 F.3d at 899-900 (prisoner plaintiff need not present evidence to show that his condition worsened or deteriorated because it is the failure to treat itself that is the constitutional violation). Further, the *Leyser* court gives no details as to the treating physician's recommendation or the extent of disagreement with any utilization review department. The panel cited *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989), for the proposition that a doctor's disagreement with a utilization review board is not deliberate indifference. In *Sanchez,* however, the plaintiff was treated for his ailment, and his symptoms cleared up. The plaintiff was unhappy because the efficacious treatment he got was different from the surgery his doctor first rec-

ommended, and that the patient wanted. Mr. Cobbs, on the other hand, got no treatment whatever, where the only possible treatment was surgery.

Likewise, in *Depuis v. Caskey*, 2009 WL 3156527 (S.D. Miss. 2009), the court found that the *pro se* plaintiff suffered no substantial harm while awaiting surgery so that any difference in medical opinion between the physician and the medical director did not amount to deliberate indifference. Moreover, there was no evidence that the treating physician reported the significant risks for the plaintiff in delayed surgery, or that his daily activities were being affected in any way. Mr. Cobbs, in contrast, suffered ongoing harm for four years, and the tardy surgery was itself riskier, more painful, and required a follow-up procedure to stop fluid from leaking from the surgical site.

In *Rylee v. Bureau of Prisons*, 2009 WL 633000, at *1 (D.S.C. 2009), *appeal dismissed as moot,* 343 F. App'x 865 (4th Cir. 2009), the defendants denied the *pro se* plaintiff's request for cataract surgery because he did not meet the requirements specified by the Federal Bureau of Prisons ophthalmology guidelines. The court determined that the "[d]efendants' decision to adhere to federal prison guidelines rather than follow the optometrist's recommendation of cataract surgery constitutes a difference of medical opinion" and not deliberate indifference. *Id*. at *4. As discussed above, however, where treating physicians unanimously request surgery, and where the defendants' denial is based entirely on general guidelines unrelated

to the patient's actual condition, deliberate indifference is established. *See, e.g.*, *Titlow*, 2008 WL 2697306, at *9.

Furthermore, even if "following guidelines" were a defense to a claim of deliberate indifference, that would not protect Pramstaller in this case. Here, the UR department's "pass-through" sheet showed – and Pramstaller agreed – that the prison standard was to *approve* cataract surgery for people with Mr. Cobbs' exact condition/symptoms. (R.106, Pass-Through Sheet, Exh. O; Pramstaller Dep., Exh. H, at 76.) Defendant Pramstaller also failed to approve the surgery after October 2007, when Mr. Cobbs filed suit, even though the medical file showed that the best corrected vision in his healthier eye had fallen below 20/40 as of the previous April. (R.106, Medical Records, Exh. C, at 62.) Pramstaller was *not* following the prison guidelines when he denied the surgery repeatedly requested by Mr. Cobbs' doctors.

Likewise, the court in *Samonte v. Bauman*, 264 Fed. Appx. 634 (9th Cir. 2008) (unpublished), found that a mere difference of opinion is "insufficient by itself to raise a triable issue of deliberate indifference." *Id.* at 636. In that case, however, the treating physician only indicated that surgery was an option, and the record did not indicate that the delay caused the plaintiff any harm, both factors easily distinguishable from the case at bar. *Id*. at 635-36.

Finally, Pramstaller relies on *Stevenson v. Pramstaller*, 2009 WL 804748, at *5 (E.D. Mich. 2009), a case in which the Eastern District of Michigan found that

the subjective prong of deliberate indifference was not met.[22] Once again, however, the plaintiff was *pro se* and did not fully develop the facts of the case. The plaintiff "failed to present any evidence refuting the Defendants' reason for denying the Plaintiff's surgery – that there was no documentation that delaying Plaintiff's surgery would adversely affect Plaintiff's daily activities or his ability to have the procedure done at a later time." *Id*. at *4. Unlike the plaintiff in *Stevenson*, Mr. Cobbs documented his pain and suffering and the adverse effect the denial of care had on his daily life. His doctors also documented the serious risks associated with delaying the cataract surgery. (R.106, Decl. of MDOC Ophthalmologist Dastgir, Exh. M, at 5-8.)

In sum, the defense cases denying either deliberate indifference or serious medical need are not analogous to the case at bar. In no case has the Sixth Circuit or lower courts addressed the seriousness of a posterior sub-capsular cataract with glare. In most of the cited cases the plaintiffs were *pro se*, the record was poorly developed, the applicable circuit law was different, or the cases were decided long after the decision to deny treatment was made in this case.

[22] The defendants incorrectly state that the court found neither the subjective nor objective prong met in this case. Def's. Br. at 33. In fact, the court reviewed only the subjective prong and did not reach the objective requirement of serious medical need. *See Stevenson*, 2009 WL 804748 at *4-5.

CONCLUSION

For the above reasons, the defendant Dallas Cobbs asks the Court to affirm the district court's denial of qualified immunity to defendant Pramstaller, and to remand the case for trial.

Respectfully submitted,

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Dated: November 8, 2010

PROOF OF SERVICE

The plaintiff-appellee's brief was 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: November 8, 2010

ADDENDUM: DESIGNATION OF RECORD ON APPEAL

Under 6th Cir. R. 28(c), 30(b), Mr. Cobbs designates the following portions of the record on appeal. This is in addition to the docket entries already designated by the defendant-appellant.

Description of Entry	Date filed	Record No.
Cobbs' Motion for Preliminary Injunction	Dec. 21, 2007	10
Pramstaller's Motion to Stay Discovery	Jan, 9, 2008	11
Pramstaller's Motion for Summary Judgment	Jan. 15, 2008	12
Notice Requesting Response to Motion for Summary Judgment (R.12)	Jan. 18, 2008	13
Cobbs' Motion to Stay Motion for Summary Judgment (R.12)	Feb. 6, 2008	17
Cobbs' Motion to Supplement Motion for Preliminary Injunction (R.10)	Mar. 7, 2008	22
Pramstaller's Motion for Summary Judgment	Mar. 25, 2008	23
Pramstaller's Motion to Withdraw Motion for Summary Judgment (R.12)	Mar. 27, 2008	26
Pramstaller's Notice of Withdrawal of Motion to Withdraw Motion for Summary Judgment (R.26)	Apr. 11, 2008	29
Cobbs' Notice of Withdrawal of Motion for Preliminary Injunction and Motion to Supplement Motion for Preliminary Injunction (R.10, 22)	Apr. 14, 2008	34
Cobbs' Request for Identification of John Does	Apr. 15, 2008	35
Order Granting Leave to File Amended Complaint	June 4, 2008	37
Pramstaller et al.'s Motion for Summary Judgment	Sept. 12, 2008	66
Response to Pramstaller et al.'s Motion for Summary Judgment (R.66)	Oct. 16, 2008	71
Report & Recommendation on Motion for Summary Judgment (R.66)	Dec. 5, 2008	77

MDOC Defendants' Objection to R&R (R.77)	Dec. 19, 2008	79
Cobbs' Response to MDOC Defendants' Objections to R&R (R.77)	Dec. 23, 2008	80
Order Adopting Report & Recommendation (R.77)	Feb. 12, 2009	82
Stipulation and Order Dismissing Defendants James Dillon and Roldert Fischer	June 24, 2009	90
Stipulation and Order Dismissing Defendant Bonita Neighbors	Dec. 8, 2009	105
Plaintiff's and MDOC Defendants' Stipulated Order [amending some pleadings]	May 27, 2010	129

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B). The brief contains fewer than 14,000 words, excluding those portions of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). The brief contains a total of 10,945 words, including footnotes.

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